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EVALUATION OF PHASE ONE OF THE CORE PROGRAMME ON TREATMENT AND REHABILITATION: DISSEMINATION OF BEST PRACTICES AND THE INTERNATIONAL NETWORK OF DRUG DEPENDENCE TREATMENT AND REHABILITATION RESOURCE CENTRES (TREATNET)

Independent Evaluation Unit

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Evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet)

Independent Evaluation Unit

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Summary

The present report is an external evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (GLO/H43-E89).

The project focuses on the role of the United Nations Office on Drugs and Crime (UNODC) in two areas: the synthesizing and dissemination of current knowledge on what works with regards to treatment and rehabilitation; and the expansion of that knowledge by developing an international network of resource centres. Initially, it was foreseen that the project would have three phases. Phase one (2005-2008) would result in the establishment of an operational network of treatment and rehabilitation centres covering all regions and working together to improve the quality of services they offer. Subsequent phases would support country-level adaptation and demonstrate the relevance and effectiveness of the good practices identified in phase one. In the project document, three outputs are listed, to be achieved in phase one: the global network of resource centres itself; four good practice documents on priority areas; and a capacity-building component for the resource centres.

The purpose of the current evaluation is to assess: (a) whether a network of treatment and rehabilitation services has been established and is operational, and (b) whether the establishment of the network has lead to an improvement of the quality of services offered in the respective centres.

In the course of the evaluation, relevant documents were reviewed, UNODC staff members at and away from headquarters were interviewed, project sites in four countries were visited and key persons involved in the project in three additional countries and with major stakeholders in the project were interviewed by telephone.

The evaluation shows that the three phase one outputs have been achieved within the period foreseen.

A global network of 20 resource centres has been established, 12 of which are located in developing countries. The centres approached in the course of the evaluation were found to be prepared to act as resource centres and spread the knowledge acquired. In the centres, action initiated in the framework of the project (such as training of staff and standardizing of procedures) has been undertaken to improve the quality of the services offered. Some of the centres have also started to offer similar training to partner institutions in the region.

The capacity-building component of the project has produced excellent training materials and modules which have been introduced in the participating centres. That material is now also available on the Internet. Feedback received on the capacity-building component was very positive.

Drafts of four best practice documents have been produced by working groups of the network of resource centres. Some work still remains to be done before those documents can be finalized and disseminated. It remains unclear how the documents will be utilized and how they will relate to other international guidance documents.

The project was initiated, designed and implemented by the responsible technical unit at UNODC headquarters; UNODC field offices were then involved and links were established with other technical units and international organizations. The beginning of phase two provides an opportunity to make a step further in the direction of sharing responsibilities and building partnerships, in particular with the World Health Organization

and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and to decentralize the project.

Phase one of the project has had some lasting positive effects (such as a stronger client orientation) on the kind of service provided by the centres that were approached in the course of the evaluation. In the future, the systematic streamlining of efforts and the systematic creation of links to policymaking will improve the likelihood that the project will have a greater impact on service provision and, ultimately, on the drug problem in countries where the project is implemented.

In this connection, it is recommended that a proper baseline assessment be carried out (including of the needs and opportunities of service provision) in countries or communities that may participate in the project in the future (something that was not done at the beginning of phase one) so that a reliable judgement can be made, in due course, on the appropriateness and effectiveness of the project in the target areas and on the impact it has on the community.

The feedback received on the management of the project was unanimously positive: the project team was seen as proactive in steering the activities of the project, prompt in responding to any setback or query that arose, and encouraging of all partners to continue improving the delivery of services for drug users.

I. Introduction

1. This report contains the findings of an external evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (GLO/H43-E89).

2. Treatnet was launched in August 2005 to strengthen demand reduction strategies worldwide by promoting evidence-based, locally appropriate treatment and rehabilitation opportunities. The meeting with all stakeholders to launch Treatnet took place four months later. The mission of Treatnet, which was agreed upon by project stakeholders, was to reach out to service providers to improve the quality, accessibility and affordability of drug treatment and rehabilitation services. The project's immediate objective was to develop a network of centres capable of delivering and disseminating a variety of effective treatment and rehabilitation interventions in all regions of the world.

3. The project was originally designed to be carried out in three phases. Phase one, which would run between 2005 and 2008, would focus on the setting up of a global network and the building of capacity in the network. During the phases two and three, effective treatment approaches would be demonstrated and disseminated and treatment services would be scaled up, building on the network established in phase one.

4. At the time of the evaluation, which was conducted during the first half of 2008, phase one of Treatnet had already ended and phase two was about to get under way, albeit in a form different from that originally envisaged. The findings of the present evaluation are meant to be used for finalizing the planning of phase two of the project.

5. The present report follows the standard structure of evaluation reports drafted at the United Nations Office on Drugs and Crime (UNODC). Following this introduction, some background is given on the project's lead-up, its objectives and activities, the arrangements for its implementation and information on the principal partners in the project. The next section, on the purpose and objective of the evaluation, deals with the focus, scope and limitations of the evaluation. The subsequent section, on methodology, describes the framework and the activities carried out in the course of the evaluation.

6. The major findings of the evaluation are presented in two sections: one on the effectiveness of the project, which looks at whether the intended outputs of the project were achieved, and one on the project's relevance, its outcomes and impact, its sustainability and the way in which it was managed. The second of the two sections also deals briefly with constraints that had an impact on project delivery. Each subsection in this part of the report ends with a concluding paragraph.

7. The following session contains some lessons learned. The report finishes with a section on conclusions, which range from general to specific matters, and a section on recommendations, which draw on the conclusions.

II. Background

A. Strategic background

8. UNODC was mandated, through the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex) and the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand

Reduction (Assembly resolution 54/132, annex), to develop and disseminate good practices in the field of drug abuse treatment. In 2003, the Commission on Narcotic Drugs adopted its resolution 46/1, entitled "Renewing emphasis on demand reduction prevention and treatment efforts in compliance with the international drug control treaties". In that resolution, the Commission stressed the importance of promoting evidence-based treatment and rehabilitation programmes for drug-dependent users. It also called upon States to extend treatment and rehabilitation programmes so as to reduce the negative health and social consequences related to illicit drugs, for both the individual and the community.

B. The role of Treatnet

9. The evaluated project aimed to support Member States in the development and implementation of treatment and rehabilitation strategies and programmes. A priority challenge for service development was regarded to be the limited technical capacity for the provision of diversified and effective drug treatment and rehabilitation services, including the capacity to support efforts aimed at preventing the spread of HIV/AIDS[1] and at providing care to people with HIV/AIDS.

C. The objectives of Treatnet

10. Through Treatnet, the objective was to develop and disseminate best practices and to support Member States in building their technical capacity to provide diversified and effective drug treatment and rehabilitation services, including by supporting efforts aimed at preventing the spread of HIV/AIDS and at providing care to people with HIV/AIDS, in all regions. The project's core component would be to develop the knowledge base on drug abuse treatment and rehabilitation already initiated by UNODC through the production of materials such as *Contemporary Drug Abuse Treatment: a Review of the Evidence Base* (available at http://www.unodc.org/pdf/report_2002-11-30_1.pdf) and *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* (available at http://www.unodc.org/pdf/report_2003-07-17_1.pdf).

11. In the original project document, two self-contained phases were foreseen. In phase one (the subject of the present evaluation), the aim was to establish an international network of resource centres through which the project would channel support and advice from leading experts to others with less experience. Phase two would consolidate and expand the network of resource centres and develop local capacity for training and the dissemination of good practices identified earlier. The idea for a phase three appears in later project documentation, which identifies the aim of that phase as the provision of support for the further regionalization and self-sustainability of the network.

12. The overall objective for phase one, as identified in the relevant project document, was to facilitate increased and easy access for drug users to effective and diversified drug treatment services with a view to reduce drug use and its related adverse consequences. The immediate objective for phase one was to enhance drug abuse treatment systems in

[1] Throughout this report, the term "HIV/AIDS" is used to refer to the complex of HIV and AIDS as a whole (these days more often referred to separately as "HIV" and "AIDS"), as much of the documentation used in the project dates to a time when "HIV/AIDS" was the most commonly used term.

Member States and to establish an international network of drug treatment and rehabilitation resource centres in all regions. The identified outputs are listed below:

(a) Output 1: resource centres are identified and agree to participate in the network;

(b) Output 2: four good-practice documents on priority topics are made available;

(c) Output 3: a training package is developed and training of trainers is implemented;

(d) Output 4: proposals for scaling up services on priority topics in 12 locations are available and funding is identified;

(e) Output 5: technical advice and assistance is provided to UNODC and Member States as required;

(f) Output 6: policy-related technical reports and other papers on drug abuse treatment and rehabilitation are made available for use within and outside UNODC.

13. The project document further provides an overview of the activities to be undertaken to achieve those outputs.

14. The resource centres were to be selected among well-established centres in each region. Selection criteria included the existence of ongoing or planned UNODC drug treatment projects or other international links and high prevalence of drug abuse and related problems, such as HIV/AIDS. In selecting the centres, UNODC field offices were to play an important role.

D. Process

15. The project actually got under way in December 2005, at a launching meeting in which all the resource centres and other stakeholders participated. In addition to discussing the overall project plan and its implementation (including capacity-building), participants also selected and agreed that the following priority topics should be addressed:

(a) Community-based treatment;

(b) Drug treatment and rehabilitation in prison settings;

(c) Drug treatment and rehabilitation in the context of HIV/AIDS prevention and the provision of care to people with HIV/AIDS;

(d) Sustainable livelihoods for rehabilitation and reintegration.

16. Representatives of the resource centres were assigned to the various working groups on these topics in accordance with their preferences. Each working group was tasked with producing a best-practice document and awarded a grant of US$ 50,000 to support its work. The working groups prepared a grant proposal and disbursement plan, which was reviewed and approved by staff at UNODC headquarters.

E. Management

17. The design, management, execution, monitoring, review, reporting and evaluation of the project was to be carried out by the Prevention, Treatment and Rehabilitation Unit in the Health and Human Development Section at UNODC. According to the project

document, relevant sections at UNODC headquarters, in particular the HIV/AIDS Unit, would be consulted on issues of relevance to the project. Further, UNODC regional and country offices would be involved in planning, identifying and coordinating with resource centres and also in mobilizing local authorities to make in-kind contributions in the form of resources and commitment. An advisory role was ascribed to experts from other United Nations entities, including the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), and regional organizations, such as the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States and the European Monitoring Centre for Drugs and Drug Abuse of the European Union.

F. Monitoring and evaluation

18. The project document did not include much detail concerning the monitoring, review and reporting of the project, but it did mention that a final evaluation would be carried out at the end of the project to assess project impact and achievements and to derive lessons learned.

19. An internal evaluation component was introduced, mainly on behalf of the participating resource centres providing them with tools for monitoring and evaluating actions taken to strengthen the evaluation at the level of the resource centres. On the basis of that internal evaluation, a report was produced on the overall progress of the project by Ambros Uchtenhagen of the Research Institute for Public health and Addiction associated with the University of Zurich in Switzerland.

G. Key players

20. The resource centres were the locus of the project's activities. The centres were to agree on networking modalities, contribute to the development of the good-practice documents, participate in capacity-building events, take charge of arrangements for local project meetings, provide for on-site training and ongoing technical assistance to other resource centres and help in the execution of the training capacity-building plan. Originally, all of the centres were also scheduled to participate in the planning of local projects for phase two of the project.

21. In phase one of the project, the Treatnet network consisted of 20 centres worldwide. Most resource centres (12) were located in middle and low-income countries. The centres provided different kinds of services: some were psychiatric hospitals with a unit for substance abuse, while others were centres dedicated solely to drug users; some were centres mainly interested in carrying out research, while others were centres that provided assistance and care only to young people; some were governmental entities, while others were non-governmental agencies. Most centres offered treatment and rehabilitation services for drug and alcohol users.

22. According to the information included in the project document, key criteria for the selection of project sites were the existence of ongoing or planned UNODC drug treatment projects or of recognized international experts. The centres were selected for being well established and for their potential to disseminate acquired knowledge. In the selection process, UNODC field offices played an important role. Government authorization or approval was not sought. Many of the centres were already involved in some way in other international projects or belonged to the group of WHO Collaborating Centres.

H. Capacity-building

23. The other important player in the implementation of the project was the capacity-building contractor, who would be responsible for conducting a training needs assessment upon which the capacity-building plan was to be developed. That included drafting, testing and implementing the capacity-building plan and training trainers. The plan could include distance learning and train-the-trainer modules, as well as on-site training sessions at an internationally recognized centre.

24. Following an open competition, the Integrated Substance Abuse Programs of the University of California at Los Angeles (UCLA/ISAP) was selected. With the support of members of a training consortium, UCLA/ISAP developed, implemented and monitored the capacity-building component of the project.

I. Follow-up

25. Phase two of the project was expected to demonstrate and disseminate effective treatment responses and scale up treatment services in Member States by building on the network of resource centres established in phase one. It was also expected that training at the national and regional levels would take place during phase two of the project.

26. At the time of writing the present report, a drastic revision of the original plans took place. The new project title, "Partnership for Action on Comprehensive Treatment: Treating Drug Dependence and its Health Consequences/OFID-UNODC Joint Programme to prevent HIV/AIDS through Treatnet Phase II", reflects the rather drastic changes made to the original project concept.

III. Purpose and objective of the evaluation

27. As per the terms of reference contained in annex I, the purpose of this external evaluation is:

(a) To assess whether a network of treatment and rehabilitation resource centres covering all regions has been established and is operational;

(b) To assess whether the establishment of the network has improved the quality of drug treatment and rehabilitation services in the respective centres.

28. Usually the term "network" refers to hardware and software data communication systems or broadcasting systems. More generally, the word includes the notion of an intricately connected system of things, institutions or people. Over the last 20 years or so, the term "network" has become widely used within the health and welfare sectors to refer to a group of institutions or people working together towards a common goal, whereby a specific additional feature is the mutual support demonstrated by the members of the group. In the project documentation, these various connotations of the term "network" remain implicit. It is therefore assumed that a loose notion of "network" in the sense of a working group is meant, whereby the notions of "having a common goal", "providing mutual support to each other" and "constituting one identifiable group" are core components.

29. The term "operational" may also require some further explanation. In the documentation related to project GLO/H43-E89 the "operations" of the "network" consist mainly of capacity-building activities and the production of best-practice documents.

Strictly speaking, the question of whether a network is "operational" or not depends on whether communication channels exist between the partners in the network and on whether those communication channels are actually used. A third aspect of "operational" may refer to the question of whether the activities of the network are contributing to the overall purpose of the network (the project's drug control objective being "increased and easy access for drug users to effective and diversified drug treatment services with a view to reducing drug use and its related adverse consequences"). In the present evaluation, attention will be given to these three different meanings of "operational".

30. Regarding the scope of the present evaluation, the terms of reference specify that the this evaluation should focus on assessing the relevance and effectiveness of the project. Relevant research questions addressed are listed below:

(a) How relevant is the establishment of a network for the treatment and rehabilitation resource centres involved?

(b) Have project outcomes (both related to networking and to capacity-building) been achieved as intended?

(c) What major lessons were learned during phase one of the project?

31. As indicated in the terms of reference, a great number of practical concrete questions were to be addressed in the course of this external evaluation, which aimed specifically at assessing the achievement of outputs 1-4 of phase one of the project (see paragraph 12 above). With regard to output 5, the evaluation was only interested in the work of the Prevention, Treatment and Rehabilitation Unit of UNODC in terms of managing Treatnet, including the services provided to the resource centres involved, and in terms of fulfilling UNODC core functions such as backstopping and technical support to field offices on behalf of Treatnet. Output 6 was not included in this evaluation exercise since it relates to work of the Unit that is not directly linked to Treatnet.

32. The evaluation period covered the entire phase one of the project (August 2005-December 2007). As was mentioned above, the launching meeting of Treatnet only took place in December 2005.

33. In line with management decisions, preparations for the phase two of Treatnet, to be undertaken in consultation with Treatnet member centres, were put on hold early 2007. A new phase two project document was subsequently developed, significantly changing the focus and direction of the project's second phase. The results of this evaluation are expected to be taken into account in the design of phase two.

IV. Methodology

34. The terms of reference for this evaluation were prepared with the close involvement of the Prevention, Treatment and Rehabilitation Unit and the practical details were dealt with by the Independent Evaluation Unit and the external evaluator.

35. In line with the terms of reference, the evaluation was to include:

(a) Desk reviews of relevant documents from all Treatnet members (UNODC headquarters, field offices, training consortium, resource centres and other relevant partners);

(b) Country visits and interviews with key informants, including UNODC coordinators, focal points, clients, capacity-building consortium leaders, donors and other relevant persons;

(c) Telephone interviews with resource centre focal points, trainers, clients and local data collectors;

(d) Telephone interviews with UCLA/ISAP representatives and other important stakeholders;

(e) Group interviews;

(f) Participatory interventions.

36. At the start of the evaluation, an external evaluation framework (see annex II) and a timetable for the various activities to be carried out were developed and agreed upon.

37. The following kind of information were collected and utilized for conducting the evaluation:

(a) Written information provided by the Health and Human Development Section in UNODC, which was made available to the external evaluator by the Independent Evaluation Unit and by persons interviewed in the course of the evaluation;

(b) Observations and spoken information collected during the country visits;

(c) Information collected through telephone interviews;

(d) Information gathered from other sources, including the websites of the resource centres, UNODC, UCLA/ISAP and other stakeholders.

38. The country visits turned out to be the most important sources of information, as they provided opportunities for observation and face-to-face contact with the core stakeholders in the project, the ultimate target group (drug users in treatment) and key informants such as scientists and politicians. In the course of the country visits additional written materials were collected.

39. Given the importance of the country visits, it was unfortunate that two of the scheduled visits could not take place. The country visit to the Islamic Republic of Iran was cancelled at the very last moment by the host country and the visit to Spain was replaced by written communication in order to save time. To compensate for the missed opportunity to visit Spain, a list with questions was sent to the national coordinator, who responded with prompt and valuable answers.

40. The countries to be visited were selected by the Independent Evaluation Unit in consultation with the Treatnet team at UNODC headquarters. The main criteria for selecting a given country were:

(a) Representation of the regions of the world where the project had been implemented;

(b) Representation of developed and developing countries,

(c) Degree of participation in the previous (internal) evaluation exercise;

(d) Degree of involvement in the project;

(e) Representation of the four working groups.

41. A large number of documents were reviewed, including: the project document, the internal evaluation report, evaluation reports by assistants in the internal evaluation, reports of training sessions, materials from the websites of Treatnet partners and reports collected during country visits. In addition, more general substance abuse policy documents were taken into account, including publications in the Evidence for Action

Technical Papers series, UNODC publications (such as *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings*) and UNODC discussion papers (such as *Reducing the Adverse Health and Social Consequences of Drug Abuse: a Comprehensive Approach* and *Principles of Drug Dependence Treatment*).

42. Country visits to Egypt, Sweden, the United States of America and Colombia were organized locally by staff members of the resource centres in consultation with the relevant UNODC field office on the basis of a general proposal for persons and institutions to be met, as suggested by the external evaluator. Prior to the visits, a list of topics to be dealt with in the interviews with the various categories of persons had been drafted by the external evaluator and agreed upon with the Independent Evaluation Unit. Upon completion of the four country visits, draft travel reports were shared with key persons met, whose comments were incorporated in the final travel reports (see annex III).

43. Telephone interviews with relevant persons in Kenya, Mexico and India were arranged by the Independent Evaluation Unit and the national coordinators concerned (see annex IV). The dates and times for the interviews were established by the external evaluator in coordination with the persons concerned. The telephone interviews were carried out following the same interview schedule as that of the country visits. The telephone interviews lasted 60-90 minutes. Telephone interviews on the capacity-building component of the project were also held with two UCLA/ISAP staff members.

44. Among the topics touched on during the observations and interviews were: information on the scope and extent of participation in Treatnet (capacity-building, networking and involvement in working groups); deviations from plans; involvement of other institutions; consequences of participation within and, if relevant, outside the centre; links to local and national policies; lessons learned; sustainability; participation in and products of the assessment working groups; and expectations for the future.

45. With regard to the effectiveness of the project, the evaluation focused on the assessment of outputs and outcomes. Baseline information was not available and consequently any assessment on possible changes brought about by the project could only be made on the basis of retrospective self-assessments by the persons interviewed. Trying to find evidence on the impact of the project obviously proved to be one of the more complicated issues, not least because impact essentially refers to long-term sustainable changes and the project has only been running for about two years.

46. In line with the terms of reference, no systematic effort was made to collect information from resource centres other than the ones visited and interviewed over the telephone. In an effort to get at least some idea of the impact that Treatnet was having in other places, the external evaluator scanned the websites of almost all of the other centres. Unfortunately, this did not yield any substantial information; most of the websites of the centres did not refer to the given centre's participation in Treatnet.[2]

47. An external peer reviewer provided feedback on the draft evaluation report.

48. In conclusion, the methodology used for the evaluation followed the terms of reference and the external evaluation framework. A large amount of information was collected from the centres and countries involved in the evaluation. Sufficient information was collected to allow for conclusions to be made with regard to the relevance and

[2] The absence of any mention of Treatnet in the websites of resource centres may be due to concerns over the use of the project logo and cannot, therefore, be taken to reflect a lack of involvement of the resource centres in Treatnet.

effectiveness of the project in terms of achieving the goals. The findings presented in this report apply only to the centres who participated in the visits and telephone interviews.

V. Major findings

49. The major findings are grouped into two sections. In the first section, the focus will be on the effectiveness of the project as formulated in the project document in terms of results to be achieved; in the second section, the focus will be widened to assess the relevance, outcomes/impact, sustainability and management of the project.

A. On the effectiveness of the project

50. Under the project's immediate objective (to enhance drug abuse treatment systems in Member States and establish an international network of drug treatment and rehabilitation resource centres in all regions), the following outputs are listed in the original project document on phase one of the Treatnet project:

(a) Output 1: resource centres are identified and agree to participate in the network;

(b) Output 2: four good-practice documents on priority topics are available;

(c) Output 3: a training package is developed and training of trainers is implemented;

(d) Output 4: proposals for scaling up services on priority topics in 12 locations are available and funding is identified;

(e) Output 5: technical advice and assistance is provided to UNODC and Member States as required;

(f) Output 6: policy-related technical reports and other papers on drug abuse treatment and rehabilitation are made available for use within as well as outside UNODC.

51. The present chapter elaborates on the achievement of the project's immediate objective as well as on the achievement of outputs 1-3 (see para. 12 above). It was structured to better reflect the key evaluation questions. Output 4, which is about preparations for phase two of Treatnet, was discussed above (see paras. 25 and 26). Management issues pertaining to the achievement of output 5 are analysed in the following chapter VI below. As already mentioned, output 6 was not included in this evaluation.

52. Overall, the expected results of the project have been successfully achieved in all of the project sites visited and in the centres that participated in the telephone interviews. Below is an assessment of the degree to which the expected results were achieved.

1. An operating network

53. The 20 resource centres fully participated in the various network meetings, in the training sessions and in other network activities such as study visits. With one or two exceptions, they also fully participated in the meetings of the four working groups and in the activities of the working groups (identifying good practices and writing reports).

54. Leaders and other staff members in the resource centres involved in the evaluation felt that their centres rightfully belonged to Treatnet, as they shared the common goal of

"increased and easy access for drug users to effective and diversified drug treatment services".

55. The extent to which the staff members in the centres were involved in Treatnet on a daily basis varied depending largely on the function of the person concerned and on the role assigned to that person in Treatnet. For example, for two trainers working at Maria Ungdom, the resource centre in Sweden, Treatnet was a day-to-day reality, as they worked full time on building the capacity within and outside the centre in the framework of Treatnet.

56. For most therapists at resource centres, the tangible result was that they had received some form of training as part of their centre's involvement in Treatnet. The network also represented a source of satisfaction, motivation and pride for many staff members at participating centres. Exhibits about the centre's participation in Treatnet – often in prominent places in the centre, such as near the entrance, as was the case for the resource centres visited in the United States and Sweden – reminded staff members and visitors of the centre's participation in this international project. Such visual reminders are also present on the websites of some of the resource centres. For example, the websites of the Maria Ungdom centre in Sweden and of the Stanley Street Treatment and Resources (SSTAR) in the United States prominently display the Treatnet logo on their home pages.

57. In the course of the implementation of phase one of the project, all possible forms of communication were used between the centre of the network (the Prevention, Treatment and Rehabilitation Unit at UNODC headquarters) and other network members: network meetings, working group meetings, correspondence (mostly through e-mail), telephone calls and an e-forum. Interviewees confirmed that most of the communication within the network flowed from the Prevention, Treatment and Rehabilitation Unit to the focal points of the resource centres and back, either by e-mail or through the e-forum. Some communication also took place between members of the network, resulting sometimes in the exchange of practical advice and support.

58. Respondents said that they learned about new treatment possibilities when meeting colleagues from other resource centres or visiting other resource centres. For example, they learned about setting up alternative workshops for service users, about decentralizing services and about integrating services. Respondents also said that such meetings allowed them to correct preconceived opinions about the quality of treatment services available in developing and developed countries.

59. Almost none of the respondents used the electronic forum set up in the framework of the project; some had only accessed it once or twice. Some of the respondents mentioned that they did not find the forum very user friendly. On the other hand, most respondents said that e-mail exchanges did take place.

60. Mutual support was given in a number of instances. For example, site visits organized within the group resulted in enhanced understanding about previously unknown treatment methodologies and experts exchanged knowledge at conferences.

61. The extent to which the network had become operational could also be measured, to some extent, by outsiders' perceptions. The Treatnet e-mail account, for example, continues to receive requests from institutions to join the network. The project coordinator in the Prevention, Treatment and Rehabilitation Unit recently received an award for international leadership in this field from the National Institute on Drug Abuse (NIDA) International Program for her work on Treatnet.

62. At the time of this evaluation, much of the networking effort initiated during phase one (in the form of effective communication within the group) had stopped, although a few individuals and institutions continued to be in contact.

63. In conclusion, during the implementation of phase one of Treatnet, the 20 resource centres constituted a global working group of institutions working together under the leadership of the Prevention, Treatment and Rehabilitation Unit of UNODC to upgrade treatment and rehabilitation services to drug users. Treatnet was operational in the sense that it carried out planned activities (mainly capacity-building efforts and joint work on topics regarded to be important for further development). In addition, some mutual support also took place. Staff members at the centres who were interviewed felt they were part of an international initiative and were proud of it. Treatnet provided them with learning opportunities, either through planned training sessions or by exposing them to the experiences of staff members at other resource centres. The relationship with UNODC provided the centres with added authority to offer training opportunities to similar institutions. Most of the staff consulted felt that the network was something very concrete, in which they could participate through training sessions or through the study visits that were organized as part of the project.

2. Improved services for patients

64. Although interviews were held with patients at all the centres visited, this did not allow for a reliable assessment of whether services had improved as a result of Treatnet. To give a reliable answer to this question would have required considerable research, including the development of a baseline and a current status assessment of the level of client satisfaction and of the effectiveness and efficiency of the interventions provided by the agency concerned.

65. The evaluation revealed, however, that in general patients and their relatives at the centres visited were very positive about the treatment they were receiving. This may not be a surprising finding: acquiescence might play a role and the responding patients may have been selected because they were happy with the service provided, thus influencing the feedback received (at one centre, however, the evaluator was able to choose which patients to interview and at another centre he simply met all the patients of the largest unit in the house). Nonetheless, the overall impression, which was confirmed by the internal evaluation, was that services for patients were of a relatively high quality.

66. In that connection, it should be noted that the services provided by the resource centres participating in Treatnet are not representative of the general level of services provided at the national level. This is because the resource centres are supposed to be leaders in terms of improving the service provided. Staff members at the centres acknowledged that their centres were of a considerably higher standard than the average centre in the country.

67. Probably the most important improvement noted in the service provision had to do with a change in mentality of staff as promoted by the Treatnet project. In particular in Egypt and Kenya – and to a somewhat lesser extent also in Colombia – it appears that participation in the project had brought about a more humane, less judgemental attitude by staff, in addition to, or in combination with a perceived improvement in therapeutic technical competence. Such a change in attitude might have taken place anyway but the participation in Treatnet certainly contributed to accelerating this change.

68. In the notion of improved services for patients, explicit reference is made to more diversified services. It appeared that in most of the centres involved in the evaluation changes in that sense had taken place as a result of the centres' participation in Treatnet.

For example, SSTAR had expanded its community services and minimized waiting times for clients. The airport hospital in Cairo is opening another day-care facility; Maria Ungdom in Stockholm had opened a number of community outreach centres and the Centro de Atención y Rehabilitación Integral en Salud Mental de Antioquia (CARISMA) in Medellin, Colombia, had identified decentralization as a major theme. Although these changes may not be entirely attributable to Treatnet, stakeholders felt that they were encouraged by Treatnet to implement those changes.

69. In conclusion, patients and relatives who were consulted in the centres visited generally appeared to be positive about the services offered. Staff who were asked about the improvement of services for clients said that the changes made were positive and that they had fostered a less judgemental attitude. An objective assessment of this aspect of the project would only have been possible if a genuine research effort had taken place.

3. A training package

70. A central strategic component of the Treatnet project was to improve the treatment practices of health-care professionals in substance abuse treatment settings through training.

71. A training consortium was established (consisting of representatives of UCLA/ISAP and of a group of leading drug treatment, rehabilitation and research institutions throughout the world) to ensure that the best possible knowledge available worldwide would be utilized in the capacity-building component of the project. UCLA/ISAP was commissioned to develop the Treatnet training package. Following a needs assessment among the resource centres, the training package was developed so as to also serve as a scheme for train-the-trainer courses.

72. The training package consists of an introductory presentation describing the critical considerations for conducting effective training sessions. The core of the clinical training materials is contained in three volumes containing PowerPoint presentations (each addressing a major domain of clinical knowledge on addiction and skill development material) along with a training leaders' guide, written training materials and a bibliography of resource materials.

73. The resource centres had nominated persons from their staff to receive intensive train-the-trainer courses on those parts of the total training package that were regarded to be particularly relevant to the respective centres. Participants in the train-the-trainer courses were grouped accordingly. Intensive train-the-trainer courses took place in various sites across the world (Australia, United Kingdom of Great Britain and Northern Ireland and United States). This meant that people could be trained very well on those modules that their centres were particularly interested in but not on the full training package materials.

74. UCLA/ISAP submitted comprehensive reports to UNODC on the needs assessment and on the presentation of the training materials, in addition to a final report on the actual training sessions, the technical assistance and supervisory activities provided to the resource centres by UCLA/ISAP and the consortium, and on the training given in the resource centres.

75. In both the internal evaluation report and the final UCLA/ISAP report reference is made to the effective knowledge transfer and the high degree of satisfaction felt with regard to the capacity-building programme as reported by the trainers. Important features in the overall capacity-building exercise appear to be the successful effort towards taking into account local needs, the flexibility of the capacity-building programme, the individual

guidance and supervision provided to individual trainers, the high degree of implementation of the training schedule in the resource centres and the very impressive amount of training materials provided.

76. Without exception, interviewees were positive about the capacity-building experience in terms of the quality of the learning experience, the quantity and quality of the training and materials offered, the supervision of the ultimate actual knowledge transfer to staff in the resource centres and beyond, and other aspects. As could be observed in some resource centres visited, the training materials are still being used by staff members and trainers. In fact, at the time of the evaluation, training sessions were still being organized both for staff and representatives of other agencies. For example, trainers at the resource centres in Egypt, India and Sweden were all engaged in the preparation and implementation of training courses for similar institutions.

77. However, one or two criticisms were also made. In two cases, respondents felt that that the capacity-building exercise was organized in the traditional framework of North-South dialogue, with participants from developing countries being unable to contribute to the teaching and feeling no ownership of the exercise. A similar observation was made in the internal evaluation report.

78. Another criticism concerned the large distances that some trainees had to travel, for example from Latin America to Australia and from Africa to the United States. Indeed, the three train-the-trainer courses that took place, as mentioned, in Australia, the United Kingdom and the United States involved extensive travelling for many trainees (and trainers). Some participants asked whether it would not have been more cost-effective to carry out the training courses closer to the resource centres involved.[3]

79. A review of the training materials, available as PowerPoint presentations on the Internet, shows that this is undoubtedly excellent material, based on evidence and best practice. Some of the material has recently been updated even though the contract for the production of this package has expired.

80. The capacity-building component of the project utilized a relatively large part of the overall budget of the project. More than half of that money was used to cover the travel expenses of staff at resource centres participating in the various training sessions and other training-related activities, thereby also contributing to the networking component of the project. Only a quarter was used for the development of the training materials and the courses. According to staff at UCLA, a significant amount of work done for the project by UCLA and the University of Adelaide was done for free.

81. In conclusion, the training package developed by UCLA/ISAP in cooperation with other partners in the training consortium contains an impressive amount of current, evidence-based knowledge on essential issues relevant to drug abuse treatment and rehabilitation. The investment done in the capacity-building component of the project and the quality of the materials warrant making an extra effort to keep this material updated. Although it looks as if the contract concerning the training package has used up a sizeable portion of the overall budget of the project, more than half of that money was spent on travel (including for staff at resource centres) and can thus be said to have contributed to the networking component as well.

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[3] In fact, such a shift might have lead to even higher costs and other problems, for example in terms of administration.

4. Good practice documents

82. At the beginning of the Treatnet project, the representatives of the resource centres selected four topics for inclusion in the good practice documents (out of a longer list, prepared in cooperation with staff at UNODC field offices, that were regarded to reflect priority areas for the further development of treatment and rehabilitation practice). Those topics were:

(a) Community-based treatment;

(b) Sustained recovery management (previously called sustainable livelihoods for reintegration and rehabilitation);

(c) Drug dependence treatment for preventing the spread of HIV/AIDS and providing care to people with HIV/AIDS;

(d) Drug dependence treatment in prison settings.

83. Working groups were established on those four topics. Participants from the resource centres joined the working group of their choice. The working groups developed their own working method and meeting schedule, then started assembling best practices and producing documents containing the collected knowledge. The ultimate aim of the documents was to assist service providers to improve the quality of their services and to guide policymakers in programming and planning.

84. In the course of the project, the working groups made progress towards the production of the best practice documents. This was an ambitious and complicated undertaking. In some cases, one or two persons were responsible for writing a draft document while the other members of the working group contributed by submitting case studies or commenting on the draft. In two cases (community-based treatment and sustained recovery management) all the members of the working groups contributed to assembling materials and texts for the final draft of the best practice document. Some of the people involved, however, felt that neither the process nor the outcome was clear.

85. In the end, drafts of the best practice documents were made available and peer reviewed. Some of the people who had been involved in preparing the documents felt somewhat dissatisfied, as, at the time of the evaluation, they were not clear about what would happen to the texts in which they had invested a good deal of time and energy.

86. A quick review of the available documents showed that a great deal of effort had gone into them and that the draft documents contain, albeit to varying degrees, a good amount of good practice and some interesting case studies. At the time of the evaluation, the drafts were being peer reviewed or amended to incorporate comments resulting from the peer reviews.

87. In the project document, it is foreseen that the four good practice documents will be used as guidance documents in phase two of the project. All four documents are quite long and it remains to be seen whether they will be useful as guidance documents.

88. While many persons interviewed on the subject were of the opinion that the technical contribution given by the various members of the working groups was not always satisfactory, the final product was very much worthwhile and that the working groups had provided another concrete opportunity to network.

89. In conclusion, the project has produced final drafts of four best practice documents that, at the time of the evaluation, still need to be edited before being made available. Tests need to be carried out to assess whether the documents will indeed be useful as guidance

documents. Thus, it might be better to use the documents as working papers in the following phase instead of investing heavily in publishing them. From a technical perspective, it also remains to be tested how the documents will be used in combination with existing guidance documents produced by UNODC and other international agencies active in this field.

5. Increased technical capacity

90. Unanimously, interviewees reported that their competence in the field of treatment and rehabilitation had increased as a result of Treatnet. This was also true in high-income countries where one might have expected the project to have less to offer.

91. Trainees received training on only one of the four volumes of the training package, which means that resource centres usually did not receive the full training package. This was in accordance with the flexibility of the capacity-building programme and the great variety of competencies available in the resource centres as well as to the needs assessed.

92. In conclusion, although no objective measurements are available to gauge the change in technical capacity in terms of improved treatment practices, the external evaluation did find that the resource centres had reportedly increased their technical capacity in the course of the project. While some of this change might have taken place anyway, the Treatnet project has certainly encouraged such changes or accelerated their impact. The increased technical capacity is mainly in the domain of therapeutic practice and of procedures and protocols on treatment and rehabilitation.

B. On relevance, outcomes, sustainability and management of Treatnet

1. Relevance

93. The Treatnet project constitutes one of relatively few concrete examples in UNODC of giving priority to demand reduction strategies, in particular to treatment and rehabilitation, in the fight against drug abuse. The overall mission of the project is "to reach out to service providers to improve the quality, accessibility and affordability of drug treatment services for those affected by drug abuse". Quite rightly, the project focuses on evidence-based approaches. The global need for implementing evidence-based methods in the treatment and rehabilitation of substance abusers has been referred to repeatedly in the relevant literature and various authors have documented the gap between research findings and clinical practice.

94. The project has functioned to promote treatment and rehabilitation in many ways. To the service providers involved, the project has served to confirm, at a high international level, that treatment and rehabilitation are important. To local and national politicians and policymakers, the project serves as an illustration of how UNODC has placed treatment and rehabilitation higher on its agenda. In meetings with policymakers in the countries visited, the external evaluator was able to observe this effect.

95. In general, the feedback received in the course of the evaluation confirmed that the training sessions provided were very relevant to the needs of the resource centres. Most striking in this regard was the repeated observation that the training and the exposure to other components of the project brought about a much-needed change in attitude on the part of staff in some centres, in addition to increasing technical competence. The flexibility in the capacity-building component further ensured that adaptations could be made to meet local needs.

96. In conclusion, against the backdrop of the high-level political declarations, Treatnet is one example of a UNODC programme that gives expression to the need to give more priority to demand reduction practices within overall policies on drug abuse and is thus extremely relevant. Furthermore, the literature on the subject has repeatedly referred to a clear need to ensure that treatment and rehabilitation services be based, as much as possible, on evidence of effectiveness and on proven good practices, which is one of the key features of Treatnet. The exposure offered through the project to staff of the resource centres through the networking and the training was felt to be relevant for improving their level competence and their attitude as care providers. Also, the encouragement towards more standardization of procedures and protocols in treatment and rehabilitation is regarded to be relevant to the resource centres.

2. Outcomes and impact

97. An assessment of the outcomes and impact of phase one of Treatnet contains a judgement on the long-term effects of the project.

98. These long-term effects might be categorized into different levels ranging from those closest to the actual operations of the project to those furthest away. It might thus be possible to discern the outcome at the level of the operations of the resource centres, the impact at the level of the drug abuse problem in the communities where the resource centres are located, and, subsequently, the impact at the level of drug abuse policies in the communities and countries where the project is located. Ultimately, it might be possible to see what the impact is at the level of the drug abuse problem worldwide.

99. It is still too early to expect Treatnet to have an impact in circles wider than the resource centres and their immediate surroundings, including the drug abuse problem in the community. In the project document, it is correctly specified that any impact in the wider circles cannot be expected before the end of the project.

100. With regard to outcomes in the resource centres visited and consulted over the telephone, new treatment methods have been introduced through the capacity-building component of Treatnet, in particular in the form of motivational interviewing and community based treatment. Given the interest shown by management and staff at the resource centres and the measures taken for follow up, it may be concluded that these new methods will persist, at least until new contradictory evidence is produced. The same goes for the new procedures and standardized methods that have been introduced in the course of Treatnet.

101. Some of the resource centres were, at the time of the evaluation (which means on an ongoing basis after the end of phase one of the project), still engaged in disseminating the newly acquired knowledge to other treatment centres. It probably will depend on the continued participation in phase two of the centres whether the activities will be continued in the future.

102. It is also still too early to assess what long-term effects the working group documents will have since the documents have not even been distributed yet. Except for some individual relationships between individual participants in the working groups, no other long-lasting effects of the working groups could be identified in the course of the external evaluation.

103. In conclusion, in the centres approached for this evaluation, Treatnet has led to a change in treatment practices. In particular in the centres with fewer resources, the training provided through Treatnet has led to a change in attitude among staff towards a more humane, less judgemental approach to the drug user. It is too early to assess the impact of

the project on the scope and extent of drug abuse in the communities of the resource centres, let alone the countries. In the design of the project, such long-term effects are to be achieved in the following phases of Treatnet.

3. Sustainability

104. Various measures have been taken by the resource centres consulted to ensure the sustainability of the project's efforts with regard to capacity-building. Capacity-building materials were translated and made available to staff in resource centres. Follow-up courses have been organized to ensure the implementation of the material learned in daily practice. New standardized procedures and treatment protocols have been incorporated in the routine management practice of the centres visited and phoned.

105. The Treatnet training package, which was developed by UCLA/ISAP in cooperation with other members of the capacity-building consortium, is a very valuable resource. It is currently accessible through the Internet at http://www.uclaisap.org/InternationalProjects/html/unodc/training-package-intro.html. However, for it to be utilized widely it will need to be promoted and kept updated.

106. Since UNODC has played an important role in the network, the sustainability of Treatnet is very much dependent on the measures that the office will adopt regarding phase two of the project. Without the active contribution and management of UNODC, the network will become less active even though some individual relationships between persons and institutions that have been established in the course of the project may survive.

107. As the project has not yet developed strong links for its various components with more general structures or movements, its overall sustainability is currently not particularly strong. No structural efforts have yet been undertaken, for example to integrate the training package materials in institutions for the education of medical practitioners or social welfare professionals.[4] Nor had the working group on HIV/AIDS established a real working relationship with UNAIDS beyond asking for and receiving advice and comments (the issue of whether joint planning and implementation would have been possible within the administrative constraints of both organizations has not been considered).

108. Although at the beginning of the project contacts were made with other international agencies (such as WHO and UNAIDS), those relationships were not strengthened in the course of the project. As a result, no other agency felt ownership of the project, nor could it be expected to make investments in its sustainability.

109. In view of the overall goal of the project to disseminate good, evidence-based practices, project partners were asked about their relations with other health and welfare centres. The centres visited and the centres telephoned all seemed to have the kind of reputation that allowed them to disseminate new knowledge to other centres. In some cases, for example in Colombia, Egypt, India and Sweden, the centres had already started disseminating acquired knowledge.[5] This process of local and national networking and knowledge transfer had been facilitated by the fact that the centres could use the logo of Treatnet and the name of UNODC, which provided them with authority and some sort of stamp of approval by a United Nations agency.

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[4] Although sustainability was scheduled to be taken care of in phase two (in fact, the phase two project document does refer to sustainability), concrete strategies for how to reach sustainability are not proposed.

[5] According to the Prevention, Treatment and Rehabilitation Unit of UNODC, this process had also started in China and Kazakhstan.

110. In that regard, there seemed to be no clarity on the status of the centres' continued link to Treatnet once phase one of the project was completed. The resource centres have been encouraged to disseminate new knowledge to others in their field, and those visited and phoned have taken that encouragement seriously. However, it is not clear to them whether they should and can continue to do so, nor is it clear to them whether they can still use the official framework of the Treatnet project.

111. In conclusion, some efforts have been made in the resource centres to ensure sustainability of the projects' achievements. Also, those responsible for the capacity-building component (UCLA) have made some provisions for updating the training materials and continuing to make them accessible on the Internet, thus contributing to the sustainability of the projects' achievements. However, the centres' ability to sustain the benefits arising from the work of the working groups and the draft documents that have been produced is currently doubtful. Moreover, it seems that structural measures to integrate the projects' products in more general structures or movements and to ensure that other agencies feel joint ownership of the project have not been taken. Sustainability of the achievements of phase one of the project will therefore largely depend on phase two of Treatnet.

4. Management of the project

112. In the paragraphs below, the following aspects of how the project was managed will be considered: global-level management, the involvement of other international organizations and monitoring and evaluation.

Global level management

113. Phase one of Treatnet was managed, at the global level, by the Prevention, Treatment and Rehabilitation Unit of UNODC.

114. UNODC field offices were involved from the beginning by participating in what is referred to in some project documents as the "field task force" for the project. The field offices were involved in many other ways as well. They were frequently consulted, not only on matters related to their respective areas of responsibility, but also on the overall design and implementation of the project. Representatives of field offices also participated in the project's launching meeting and in some other project management meetings. Field offices also helped with the organization of events in Member States. However, at no stage was a country or regional UNODC office given the ultimate responsibility for executing or implementing the project or for managing its financial component.

115. In the course of the two years of phase one of the project, an impressive amount of activities took place. These ranged from the design of the project, the holding of management meetings, the identification of various categories of partners in the project, the development, implementation and dissemination of the training package, the organization of working group meetings and the drafting of best practice documents, communication between the technical unit and all the partners, the financial management of the project and the day-to-day communications with a large number of partners, among other activities.

116. There is no doubt that the Prevention, Treatment and Rehabilitation Unit has worked hard to complete all the tasks associated with managing the project. The Unit has achieved this within the time limits set at the beginning of the project and, apparently, with a great deal of enthusiasm. In the majority of the interviews held by the external evaluator, praise

was expressed by the project partners over the managerial capacity of the Unit and over the enthusiasm with which the work was carried out.

Involvement of other international organizations

117. Other international organizations and United Nations agencies have been invited at various stages (in particular at the beginning of the project) to consult, advise or comment. As mentioned above (see para. 108), however, they have not been able to take ownership of the project and their commitment to the project remained marginal.

118. In that connection, special attention is due to WHO, as the United Nations agency specialized in health and UNAIDS as the coordinating United Nations agency for HIV/AIDS, as treatment and rehabilitation efforts are primarily taking place within the health sector and an important goal of the project was to reduce the risk of HIV/AIDS infection among drug users. As far as could be ascertained, there was no substantial relationship between WHO and UNODC regarding this project, at least at the level of the regional and country offices. At headquarters, UNODC was involved with WHO and UNAIDS to some degree.

119. The lack of substantial cooperation between and within United Nations entities has been a source of concern among some Member States and donors for a long time. Unfortunately, although serious efforts were made in the beginning of the project to involve other international agencies, this project confirms these concerns. The start of phase two provides an opportunity to remedy the situation.

Monitoring and evaluation

120. In the original project document it is mentioned that the Prevention, Treatment and Rehabilitation Unit "will continuously monitor the project progress"; and that "an independent final evaluation will be carried out at the end of the project". The project document itself does not provide further information about how the monitoring and evaluation would be carried out.

121. The logical framework of the project was built around the objectives, outputs and activities identified in the project document. The logical framework does not make reference to results to be achieved at the level of outcomes (for example related to improved treatment services offered to clients by the centres as a result of their involvement in Treatnet). As a consequence, the link between the various result levels has not been clearly established in all cases. Furthermore, the indicators listed in the logical framework do not always correspond to the level where they are put; others are not precise enough and therefore not measurable.

122. In short, the logical framework might have provided some guidance for monitoring the implementation of activities and the achievement of outputs, but it certainly did not provide a real tool for systematic monitoring and evaluating progress made towards the results to be achieved at the outcome level and at the level of the immediate (project) objective.

123. That problem seems to remain in the latest revision of the project document for phase two, where one long list of outputs (with activities) is provided without however identifying a clear hierarchy of objectives to be achieved at all levels (outputs, outcomes and project objective), with the corresponding indicators.

124. That does not mean that the Prevention, Treatment and Rehabilitation Unit did not make any effort to monitor progress. In fact, there has been a great deal of communication

between the Unit and the various partners in the project (through the management meetings and through the multitude of contacts with all the partners and the field offices), thus allowing the technical unit to keep track of what was happening. In turn, that enabled the Unit to produce interim reports that give insight into the status of implementation of the various activities that had been planned.

125. Additionally, the capacity-building contractor (UCLA/ISAP) conscientiously kept track of what exactly happened in that part of the project and duly followed up (by making telephone calls and communicating through other means) on agreements made in the course of the training sessions for continued training to be provided in the resource centres and other venues. Very good quality interim reports on the training activities and on the capacity-building project as a whole were delivered.

126. The project managers commissioned an internal evaluation, which provided for a framework with indicators at the level of the resource centres. The internal evaluation was carried out in eight of the participating centres and an overall report of the results was submitted. It provided participating resource centres with tools for monitoring and evaluating progress made in order to strengthen the evaluation at the level of the resource centres. Earlier in the report, reference was made to some of the findings of the internal evaluation.

127. The project did not make provisions for a real baseline assessment of the situation with regard to drug abuse and service provision at the level of the communities where the participating centres were located. Thus, no reliable objective judgement can be made on the impact of the project at the community level.

128. In conclusion, the Prevention, Treatment and Rehabilitation Unit has managed the project and carried out a large number of activities within the established time frame and apparently with great enthusiasm. Aside from the advisory function that UNODC regional and country offices had and the involvement of those offices in the organization of training events, responsibility for the execution and implementation of the project was not decentralized. The Prevention, Treatment and Rehabilitation Unit, which monitored progress made through the project, would have benefited from a more consistent logical framework matrix and a method for systematically tracking progress made towards the achievement of indicators that are specific, measurable, achievable, relevant and time-bound (SMART). UCLA/ISAP staff monitored the training activities. An internal evaluation increased the level of scrutiny and monitoring at the resource centres. While in the beginning a serious effort was made to engage other international organizations, that effort was not sustained, resulting in decreasing interest in the development of the project by potentially important partners such as WHO and UNAIDS. The start of phase two of the project provides an opportunity to remedy the situation.

5. Constraints affecting project delivery

129. The project was delivered as scheduled in terms of achieving results. However, the good practice documents had not yet been finalized at the time of the evaluation.

130. The good practice documents had not been finalized on time because the time, competencies and resources needed to produce such documents had been underestimated. Language problems, organizational changes (for example, some working group participants changed employers) and insufficient writing skills, among other issues, all played a role. As the scheduled time available to the working groups ran out, some of the groups decided to have the real work done by just one or two people in the group, resulting in delays in producing the draft documents.

131. Towards the end of phase one, decisions were taken by UNODC executive managers to make some changes in the planned transition to phase two. As a result, and because of the funding situation, it remains unclear whether all the resource centres involved in phase one will continue to be involved in phase two. Such confusion about the future was also present in the resource centres, some of which did not know whether they would be included in phase two or not. Therefore, in some places, no measures were taken to capitalize on the achievements made to date and no measures were taken to ensure a good continuation or expansion of the local project's activities in the future. Lack of clarity had affected the whole network: while some form of group cohesion was established during the two years of phase one, that feeling was much diminished by the time of the evaluation.

132. In the internal evaluation report, reference is made to the lack of resources at some of the resource centres for full project implementation, in particular when it came to providing training. In the present evaluation, that constraint was also identified in the centres visited and called in developing countries. Staff at one centre mentioned that the centre had successfully sought aid from donors to cover expenses related to the provision of training. While some investment, showing real commitment, might be required from the centres, there needs to be recognition for coverage of all sorts of "trivial" costs, varying from relatively cheap travel options and photocopying to meals.

VI. Lessons learned

133. The lessons learned from the project, which are particularly important in view of phase two of the project, are the following:

(a) *Lesson 1*. The link between the project's activities and policymaking has been weak. If the project aims to prioritize the issues of treatment and rehabilitation in the wider context of policies on drug abuse, ensure that treatment and rehabilitation approaches are increasingly based on evidence and promote decentralized and diversified treatment options, links to policymaking must be established. There are various ways to do this. One way is to redefine the role of the resource centres and make them into pilot institutions for promoting intended policy changes;

(b) *Lesson 2*. The project started off on the basis of general assumptions of the situation that it wished to change. The information collected on the resource centres was rather generic and did not give much insight into the characteristics of the centres that the project wanted to change. One of the changes it wished to make was to increase the degree to which treatment practices were based on evidence; although the relevant literature refers to this, no baseline assessment was made of the level of sophistication or competence of the candidate resource centres. Another change the project wished to make was to diversify available treatment options. Again, no baseline data were assembled on the level of diversification of services in the communities of the resource centres. In order to be able to make judgements on the achievements of the project in subsequent phases, it is advisable to set aside some resources for baseline and situation assessments. If there are no baseline data available on the situation that a project wishes to change (as was the case here), resources should be set aside for a baseline assessment so as to avoid a situation in which, upon completion of the project, no solid evidence can be provided to demonstrate the objective results of a project;

(c) *Lesson 3*. Real commitment to a project's goals by potential internal partners (in this case, UNODC regional and field offices, for example) and external partners (in this case, UNAIDS and WHO, for example) can usually be achieved by giving them a sense of ownership, also in the execution of the project; without financial implications partnerships

can, at best, provide some moral support. In the beginning, efforts were made to involve many international partners (perhaps too many), but as the project progressed the involvement and interest of these partners in the project waned. The start of phase two provides an opportunity to share responsibility in the planning and implementation of the project with the most relevant partners, internally as well as externally;

(d) *Lesson 4*. It was apparently possible to have centres from middle, low and high-income countries participate in one project and to have them all benefit and feel positive about the combination. One sensitive issue concerned the utilization of limited project resources. In principle, centres from developed countries should not have participated in the project at the expense of the developing countries involved. Project managers approached the issue well by, for example, having the partners from developed countries pay for their own capacity-building activities. In subsequent phases of the project, it might be possible to continue reaping the benefits arising from bringing together centres from developed and developing countries in one project. It might also be a good idea to stipulate the different financial status regarding the use of project funds by different categories of partners right from the start of the project;

(e) *Lesson 5*. Some of the centres (in particular those in Colombia, Egypt, India and Mexico[6]) have the potential (taking into account the scope of their activities, their reputation, their connectedness to local and national authorities and their competence) to extend their ongoing capacity-building activities to similar institutions within their countries and regions. That might be possible in subsequent phases of the project if activities are more decentralized and if a different project management approach is adopted whereby responsibilities are given to regional institutions. Support would also have to be mobilized for this expanded function of the resource centres.

VII. Conclusions

134. In the course of this external evaluation, a great deal of information was collected through desk reviews, interviews and site visits on 8 of the 20 centres participating in Treatnet. The findings of this evaluation may therefore not be applicable to the entire project or to all of the projects' participants and stakeholders.

135. The conclusions below are presented in the order of the issues dealt with in section V above on major findings:

(a) *Conclusion 1. Treatnet is one of the few UNODC projects dedicated to promoting treatment and rehabilitation*. As one of the few UNODC projects dedicated to promoting treatment and rehabilitation, Treatnet signals the importance of demand reduction strategies, which is also how it is being interpreted by external stakeholders. Phase one of Treatnet has engaged many people and centres around the world in a serious effort to upgrade the quality of treatment and rehabilitation services provided to drug abusers;

(b) *Conclusion 2. The goals set for phase one of Treatnet at the beginning of the project were achieved*. A global network of resource centres was established, best practice documents were produced and the capacities of the resource centres were built up;

(c) *Conclusion 3. A global network of treatment and rehabilitation centres was established and became operational during phase one of the project*. The aim was to

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[6] The Prevention, Treatment and Rehabilitation Unit feels that this also applies to the centres in China, Iran (Islamic Republic of) and Kazakhstan.

improve services and disseminate good practices. Activities included the exchange of experiences, improving the technical competence of staff and carrying out some joint work in order to produce best practice documents. The engine of the network was the technical unit responsible for the project in UNODC;

(d) *Conclusion 4. The participating resource centres that were contacted in the course of this external evaluation had the preparedness, competence and reputation required to act as resource centres in their respective areas*. More policy support and, in developing countries, more financial support would have enabled the centres to carry out their work more effectively;

(e) *Conclusion 5. Bringing together resource centres from low-, middle- and high-income countries in one project had beneficial effects.* In addition to getting exposure to new treatment methods, staff from high-income countries could correct their prejudices regarding the quality of the work done in low- and middle-income countries and vice versa. In addition, staff from low-income countries had immediate access to more sophisticated work methods used in centres in developed countries, which tended to have more resources;

(f) *Conclusion 6. Draft best practice documents were produced*. The working groups in phase one produced draft best practice documents on themes that had been identified as critical for improving treatment and rehabilitation services (HIV/AIDS among drug users, drug users in prisons, community-based treatment and sustained recovery management). These documents are being finalized, but additional thought should be given to their production, utilization and dissemination;

(g) *Conclusion 7. The working groups provided a practical means of working together in the network*. By providing a practical means of working together in the network, the working groups made the network a reality. Their effectiveness as joint ventures varied. In two of them, the actual drafting was done by not more than two members of the working group;

(h) *Conclusion 8. An impressive amount of training materials resulted from the capacity-building component*. The capacity-building component in phase one of Treatnet produced an impressive amount of training materials in the form of training modules on important elements of treatment and rehabilitation. The materials are available on the Internet at http://www.uclaisap.org/InternationalProjects/html/unodc/training-package-intro.html;

(i) *Conclusion 9. The training provided was useful***.** The training provided in phase one of Treatnet was successful in the sense that those persons who participated in train-the-trainer sessions went on to provide training sessions, as planned, in their own centres. Feedback received on the training was positive. Some of the training that was initiated during phase one is still ongoing;

(j) *Conclusion 10. The training material developed in the course of the project was of a high quality.* The training material developed in the course of the project was of a high quality and was very well received by the trainees and, subsequently, by staff at the resource centres;

(k) *Conclusion 11. Treatnet capacity-building components were not integrated elsewhere*. No evidence was found of Treatnet capacity-building components being incorporated in broader educational systems such as schools for social workers or medical professionals;

(l) *Conclusion 12. Most of the funds for capacity-building were used to cover travel costs, thereby contributing to networking*. While a substantial amount of the overall budget of the project was used for the capacity-building component of the project, the majority of that money was used to cover the travel costs of trainers and trainees, thereby also contributing to the networking component of the project. Only a relatively small part of the funds was used to develop the materials and provide training courses. This relatively small part of the budget was complemented by work done by UCLA and the University of Adelaide for free;

(m) *Conclusion 13. Treatnet did not establish a link to drug abuse policymaking mechanisms.* Treatnet did not plan for and consequently did not establish links to national or local drug abuse policymaking mechanisms or to institutions responsible for such policymaking. If a link was made between the activities developed in the respective resource centre as part of the Treatnet project, such an outcome was unplanned. The lack of links to policymaking mechanisms implies limits on sustainability and obstacles to dissemination;

(n) *Conclusion 14. Only the participating centres have been affected by Treatnet*. The outcomes of phase one of Treatnet are, for the time being, limited to the participating centres, whose therapeutic practices and whose processes and procedures have changed as a result of the centres' participation in the network;

(o) *Conclusion 15. Substantial partnerships with other international organizations have not been established*. Initially, relevant international organizations other than UNODC were involved in starting up the project. As the project continued, however, those organizations' input became less and less, to the extent that Treatnet became a UNODC-only business. Establishing real partnerships with other organizations, most notably UNAIDS and WHO, would have strengthened the project's dissemination and sustainability;

(p) *Conclusion 16. UNODC country and regional offices were not made responsible for project implementation*. UNODC country and regional offices were involved in the project through their participation in consultations and communications; moreover, their advice was sought. Full decentralization of responsibility for the execution and implementation of the project had not been planned for and therefore did not take place;

(q) *Conclusion 17. Project managers introduced an internal monitoring and evaluation exercise in the project*. The internal monitoring and evaluation exercise introduced by project managers provided a framework with indicators and tools for measuring influence at the level of the resource centres. The internal evaluation included 14 of the resource centres; the overall report helped direct the management of the project. The evaluation tools developed in the course of that evaluation were meant to be used for the establishment of baseline assessments carried out in phase two project sites;

(r) *Conclusion 18. The project did not provide for a proper baseline assessment of needs and opportunities*. The project did not provide for a proper baseline assessment of needs and opportunities with regard to the services available to drug users in the communities concerned, nor was there a proper assessment of the influence of the project at the level of the communities, thus pre-empting assessments as to the appropriateness of the strategy of the project and the possible influence of the project at the community level;

(s) *Conclusion 19. A large number of activities were carried out by the project managers within the established time frame*. The team managing the project carried out a large number of activities within the established time frame. Many positive comments

were received concerning the way in which the project was managed; project staff apparently managed to motivate and enthuse the participating centres so as to prompt a high level of commitment and sense of loyalty to the project.

VIII. Recommendations

136. The recommendations, listed in the order of the conclusions in section VII above, are as follows:

(a) *Recommendation 1*. As soon as possible, inform all existing members of the network about the status of the project;

(b) *Recommendation 2*. Review the suitability of each of the resource centres that was involved in phase one for possible inclusion in phase two. Suitable centres should, as a minimum, meet the following criteria: endorsement by local and national government, continued commitment to the goals of the project, potential for acting as a resource centre at the national and regional levels and (potential) availability of resources;

(c) *Recommendation 3*. Should additional resource centres be involved in phase two, ensure that they meet the selection criteria included in recommendation 2;

(d) *Recommendation 4*. Consider the continued involvement of centres in high-income countries at their own expense. More centres in high-income countries need to adopt evidence-based approaches to treatment and rehabilitation. Centres in high-income countries might also be involved in transferring knowledge to centres with fewer resources;

(e) *Recommendation 5*. Capitalize on the results of the capacity-building component of phase one by ensuring that the material produced and made available is updated and maintained, as well as relaunched if needed;

(f) *Recommendation 6*. Include in the project design of phase two the integration of capacity-building components in the curricula of regular educational or regular in-service training institutions for health and welfare professionals and for staff involved in providing substance abuse treatment and rehabilitation services;

(g) *Recommendation 7*. Include relevant national health authorities in the planning of the activities to be carried out in follow up and involve national institutes for substance abuse (or their equivalent) in the countries where the project is implemented;

(h) *Recommendation 8*. Engage UNODC country and regional offices in planning and implementing follow-up activities to phase one. Empower staff at field offices by giving them increased responsibility for the design and execution of phase two;

(i) *Recommendation 9*. Make arrangements for the concrete involvement of the most relevant international organizations, in particular UNAIDS and WHO, as well as of relevant units in UNODC, for example the HIV/AIDS Unit, by establishing full partnerships with them in the planning and implementation of the project and ensure that synergies between the work done by the various organizations or units are created where possible (see para. 135 (o) above);

(j) *Recommendation 10*. Ensure that the project document and the logical framework matrix for phase two contain a clear hierarchy of objectives to be achieved at all levels (outputs, outcomes and project objective) and corresponding SMART indicators to allow the systematic tracking of progress made towards the achievement of the objectives. Also ensure that a sound monitoring and evaluation system is put in place for

phase two and all subsequent project phases, in order to provide managers with the information needed to exercise leadership;

(k) *Recommendation 11*. Make provisions for the full utilization of the evaluation and monitoring tools developed in the internal evaluation exercise phase of phase one;

(l) *Recommendation 12*. Provide for a thorough baseline assessment of the drug abuse situation, including the needs and the opportunities for service delivery in communities or countries that will be participating in the next phase of Treatnet. Make sure that the project's strategy responds to existing needs and takes opportunities for service delivery into account;

(m) *Recommendation 13*. Explore the opportunities for concrete streamlining within broader movements, with the aim of reducing social exclusion and reducing poverty;

(n) *Recommendation 14*. Bring the project in line with the Millennium Development Goals and focus project activities on countries and communities where the need is great and where resources are limited while at the same time keeping as partners countries with more resources, as they can act as providers of support and up-to-date knowledge, keeping in mind that countries with fewer resources might need different strategies from those that are appropriate in high-income countries;

(o) *Recommendation 15*. Ensure that linkages are made with policymaking entities (see para. 135, subpara. (m) above);

(p) *Recommendation 16*. Arrange for practical linkages with existing institutions for education and with agencies supportive of treatment and rehabilitation, including academic institutions and national and local umbrella agencies operating in the field of substance abuse (see para. 135, subparas. (k) and (m) above);

(q) *Recommendation 17*. Decentralize the project as much as possible so as to reap the most benefits by strengthening cooperation and achieving real commitment at the regional level (see subpara. 135 (p) above);

(r) *Recommendation 18*. Devise a strategy for the dissemination of the four good practice documents to ensure that other stakeholders in Member States served by UNODC, not only the centres involved in their preparation, will benefit.

IX. Final remarks

137. Phase one of the Treatnet project was successful in that it achieved its goals to establish a global network of resource centres and to develop four good practice documents. The underlying concept of the project also makes sense: to create centres of excellence for the treatment of drug users in all parts of the world and, in subsequent phases of the project, to support them in disseminating relevant good practices. By so doing, the quality of therapeutic and rehabilitation services offered should improve, leading, in turn, to decreasing the burden of drug abuse to societies and individuals.

A. Strategic questions

138. It is perhaps appropriate to ask whether strategies other than the one adopted in the Treatnet project might also have achieved the goals and whether a different strategy might

have done so even better. In looking at some alternative strategies, it is important to consider whether they would fit in the "constitutional" framework of UNODC.

B. Opportunities available to UNODC

139. UNODC is in a position and has the mandate to adopt many different strategies aimed at the reduction of the incidence of drug abuse and its negative consequences. Such strategies include holding high-level political conferences, funding small-scale initiatives at the local level, prescribing or recommending the adoption of certain policies and supporting their implementation (for example, by setting standards) and providing support for research and action. The real strength of a United Nations entity like UNODC lies in its ability to influence policymaking.

C. Normative, analytical and operational functions

140. One of the challenges in policymaking (and supporting policies), as identified in the strategy for the period 2008-2011 for the United Nations Office on Drugs and Crime (Economic and Social Council resolution 2007/12, annex), is the need to find the right mix of normative, analytical and operational functions within the mandates of UNODC programmes. The contribution made by phase one of the Treatnet project to this mix of functions is primarily of an operational nature (training and capacity-building) and, to a lesser extent, a normative nature (the good practice documents).

D. Mix of functions

141. The question of whether the Prevention, Rehabilitation and Treatment Unit of UNODC has aimed at achieving the right mix of normative, analytical and operational functions goes beyond this particular evaluation but should be taken into account in identifying the contribution that phase two of the project can make to the mix of functions of UNODC. However, if it is assumed that all three functions (normative, analytical and operational) should have been addressed in phase one, it looks as if the analytical function needed more attention. Typically, the evaluation has referred to the need for more investment in researching the baseline situation.

E. Targeting other structures

142. In that connection, two aspects in particular need to be looked into: the provisions for primary health care in communities where the project might be working and the possible role of informal health and welfare provision, for example through traditional healing and religious groups. Notwithstanding the value of the formal professional health and welfare institutions, there is widespread recognition of the possible contribution to changing lifestyles, including drug addiction, by informal health and welfare agencies. This cannot be neglected.

F. Primary health care

143. The focus of the Treatnet project on centres specialized in substance abuse treatment and rehabilitation precludes the possible role of the primary health-care sector (and the

informal health and welfare institutions, as referred to in para. 142 above). One of the critical questions here seems to be whether communities or States can afford to have a specialized treatment and rehabilitation system at all. In a situation where communities or States hardly even provide for institutional mental health care, a focus on specialized treatment is obviously amiss. This leads again to the need to carry out a thorough baseline assessment and, possibly, to consider a strategy focusing on primary health-care institutions.

G. Focus on resource centres

144. The focus on a limited number of resource centres (whether there are 20 or 2,000 participating centres is immaterial) may have adverse consequences for the widespread and neutral acceptability of the project's methods and materials. In communities and countries where there are more specialized treatment and rehabilitation centres available, there may be a certain degree of competition that leads to a method or material used in one clinic being unacceptable in another. Such trivial realities do influence the provision of treatment in facilities. In such a situation, the strategy is to liaise with institutions uninvolved in the rivalry between institutions. National institutes for drug abuse or governmental counterparts, for example, may be strategically better placed partners for an initiative aiming at upgrading the competence of professional service providers.

H. Focus on the drug user

145. It is laudable to have qualified staff in substance abuse treatment and rehabilitation centres (available research suggest that there is indeed room for improvement) but if the client does not benefit from the investment, the effort is to no avail. At the end of the day, it is the client of the service provider who counts. This indicates the need for assessing the level of satisfaction of the client and for assessing the results of the treatment interventions before and after the project has been implemented.

I. Consistency

146. In order to be consistent regarding treatment, UNODC might wish to promote a more unified strategy, building upon one or two basic methods or philosophies. For example, should the newly developed *Principles of Drug Dependence Treatment* be useful, UNODC might wish to build its activities around this basic document, which provides a good framework for promoting treatment and rehabilitation while also providing technical advice for the development of the system. Building phase two of the project on the basis of the *Principles of Drug Dependence Treatment* may open up avenues to national institutes for substance abuse; it might lead Governments to pilot the principles contained in the document and give guidance at the same time. It would not be difficult to build a whole programme that includes normative, analytical and operational functions on the *Principles of Drug Dependence Treatment*. This would also effectively deal with the criticisms made by those who lament the ever-growing number of guidance documents produced by international agencies.

Annex I

Terms of reference for the evaluation of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89)*

I. Background

1. UNODC was mandated, through the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex) and the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution 54/132, annex), to develop and disseminate good practices in the field of drug abuse treatment. In 2003, the Commission on Narcotic Drugs adopted its resolution 46/1, entitled "Renewing emphasis on demand reduction prevention and treatment efforts in compliance with the international drug control treaties". In that resolution, the Commission stressed the importance of promoting evidence-based treatment and rehabilitation programmes for drug-dependent users. It also called upon States to extend treatment and rehabilitation programmes so as to reduce the negative health and social consequences related to illicit drugs, for both the individual and the community.

2. Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89) responds to the programme of work adopted by the Commission and to Commission resolution 46/1 through its objective to diversify and extend quality drug treatment and rehabilitation programmes in order to address the adverse social and health consequences of large numbers of people using drugs. It also addresses the identified need for more good practices to be disseminated by the United Nations Office on Drugs and Crime (UNODC) in various sociocultural circumstances.

3. Scientific evidence shows that drug use, especially by injection with contaminated equipment, is closely linked to HIV transmission. In fact, in many regions, that is the major route of HIV transmission. Problem drug use has also been observed in prison settings, where harmful drugs are used in such a way as to increase the risk of transmission of infectious diseases like HIV and hepatitis. The availability of drug treatment and rehabilitation programmes in addition or as an alternative to punishment has proved both cost effective and useful in terms of the social reintegration of drug-using offenders and in the prevention of HIV.

4. In order to respond to such problems, resources need to be mobilized and the capacity of existing service providers needs to be built. An important strategy is to provide information on successful treatment and rehabilitation approaches to policymakers, programme planners, service providers and practitioners. UNODC can contribute effectively by being involved at the global, regional and national levels. The Treatnet project aims to address these needs and coordinate the ongoing activities on treatment and rehabilitation being carried out by UNODC at headquarters and in the field.

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* The terms of reference were prepared on 11 December 2007.

5. Treatnet is a network of 20 treatment centres from around the globe whose aim is to enhance the ability of centres to provide diverse and effective drug dependence treatment and rehabilitation services by disseminating knowledge and building organizational capacity.

6. The overall objective of the project is to facilitate increased and easy access for drug users to effective and diversified drug treatment services with a view to reduce drug use and its related adverse consequences. The immediate objective of the project is to establish an international network of drug treatment and rehabilitation resource centres in all regions.

7. The key elements of the project strategy are:

(a) The identification and bringing together of leading drug treatment and rehabilitation centres from all regions;

(b) The provision of support to the working groups of resource centres to synthesize good practices on four selected priority topics;

(c) Build capacity, including through the development of a capacity-building package, train trainers and pilot the delivery of training in accordance with assessed needs.

8. At the end of the project, it is expected that an operational network of treatment and rehabilitation resource centres covering all regions will have been established and that participating centres will be working together to improve the quality of drug treatment and rehabilitation services that are offered in their respective centres. The term “operational network” describes a system of centres with defined objectives, tasks, responsibilities, means of communication, decision-making mechanisms and ongoing interaction. The term “resource centre” describes a treatment or rehabilitation organization with the competence (in terms of evidence-based best practice) and the capacity (in terms of human and economic resources) to serve as a mediator for best practice training in a defined geographical or structural area.

9. Expected outputs of the project are the following:

(a) An evidence-based training package is developed, piloted and ready for publication;

(b) There is increased technical capacity to provide effective, quality and affordable drug dependence treatment at participating centres;

(c) Four good practice documents are ready for piloting and demonstration;

(d) A feasibility study and a proposal for phase two of the project have been completed.

II. Purpose and objective of the evaluation

10. The purpose of the evaluation of the Treatnet project is:

(a) To assess whether a network of treatment and rehabilitation resource centres covering all regions has been established and is operational;

(b) To assess whether the establishment of the network has improved the quality of drug treatment and rehabilitation services offered in the respective centres.

11. The stakeholders of the evaluation are UNODC, the training consortium led by the Integrated Substance Abuse Programs of the University of California at Los Angeles

(UCLA/ISAP), the 20 resource centres participating in phase one of the Treatnet project, drug demand reduction focal points at UNODC field offices and relevant international partner organizations. Stakeholder representatives will be invited to join the core learning partnership to be established as part of the evaluation.

III. Scope of the evaluation

12. The evaluation will focus on the relevance and effectiveness of the project. Special emphasis will be placed on assessing the outcomes of the Treatnet project, both with regard to the establishment of an operational network of treatment centres and to the improvement of the quality of drug treatment and rehabilitation services offered by the centres.

13. The evaluation will cover the entire phase one of the project (December 2005-October 2007). The results of the evaluation are expected to inform phase two of the project, which is currently being prepared.

14. In line with these goals, the following research questions will be addressed:

(a) How relevant is the establishment of a network for the treatment and rehabilitation resource centres involved?

(b) Have project outcomes (both related to networking and to capacity-building) been achieved as intended?

(c) What major lessons were learned during phase one of the project?

15. The following core questions also need to be addressed by the evaluation:

(a) How relevant and effective is Treatnet as an international mechanism for the transfer of knowledge on drug dependence?

(b) What is the relevance of a network of drug dependence treatment and rehabilitation resource centres in the context of national policies and strategies dealing with drug dependence treatment and rehabilitation and HIV/AIDS?

(c) What are the identifiable anticipated and unanticipated outcomes of the project (beyond the training of staff and the development of relevant documents)?

(d) Has an operational network of drug dependence treatment and rehabilitation resource centres been established?

(i) What are the characteristics of this network? Does it work?

(ii) Has it been expanded to include peers from centres participating in Treatnet and stakeholders from other institutions?

(iii) How many clients benefit from the centres participating in the network?

(iv) Why have different centres achieved different levels of progress?

(v) What obstacles to project implementation have been faced at the centre level?

(vi) What obstacles to project implementation have been faced at the project level?

(vii) What approaches have been adopted to overcome obstacles at the centre and project levels?

(viii) What have been the results of such approaches?

(ix) How satisfied are staff with the project and its activities? What is their attitude?

(x) How has the network changed in terms of its membership and the way it functions?

(xi) What are the major obstacles for engagement?

(xii) If the centres are engaging in the network in different ways and at different levels, why is that?

(xiii) What are the evident benefits of the project having been conceived as a network?

(xiv) What are the unintended effects has the project had on the participating centres?

(xv) What would be needed to improve the above?

(xvi) How could network members best reach out to treatment centres interested in working with them (review the advocacy strategy of Treatnet and its implementation)?

(e) Have the working groups produced the expected products?

(i) Has the approach adopted in the framework of the project adequately supported the working groups (review the approach)?

(ii) Do the issues covered by the working groups reflect key priority topics for the improvement of treatment and rehabilitation services in developing countries?

(iii) How could the products be described (develop criteria for qualifying the products and qualify the products according to such agreed criteria)?

(iv) What problems have been experienced in achieving acceptable products?

(v) Have the needs of both men and women been addressed adequately?

(vi) What benefits do these products bring and how are the products used?

(vii) How does the quality of the work of each working group differ? What are these differences and what are they due to?

(viii) Will the effort made to achieve the product be sustained? Should it?

(ix) In what ways have the working groups cooperated with and learned from each other?

(f) Capacity-building:

(i) Has a training package been developed in accordance with the original specifications?

(ii) Have gender issues been addressed adequately in the project?

(iii) Was the methodology used for assessing training needs appropriate and successful?

(iv) Is the information in the training package evidence based, user friendly and applicable to target populations in different sociocultural circumstances?

(v) What training has been provided to whom? (include information on number, method and content of sessions (whether they were train-the-trainer sessions or sessions for training service providers at resource centres))

(vi) Have the methods and approaches used been adequate and effective?

(vii) What problems have there been in terms of training implementation?

(viii) Has the competence (knowledge and skills) of trainers from resource centres improved?

(ix) Has the competence (knowledge and skills) of staff trained at the resource centres improved?

(x) Has knowledge been transferred from trained staff to teams?

(xi) What other examples of capacity-building can be identified?

(g) What lessons learned and best practices can be identified, especially in view of the development and implementation of phase two of the Treatnet project?

(i) What are the major lessons that can be learned from project implementation in phase one of the project? In what ways are they relevant for phase two of the project?

(ii) Does the project have the potential to be expanded to the regional level?

(iii) What, if any, adjustments would the project have to undergo in order for it to be replicated and expanded?

(h) Were resources managed efficiently?

(i) Has a basis for network sustainability been established?

16. Additional issues may be covered if the evaluators judge them to be relevant and following a discussion with the evaluation manager and members of the core learning partnership.

IV. Evaluation methods

17. At the beginning of the evaluation process, the consultant or team charged with the evaluation should review the draft terms of reference, propose amendments or ask for clarifications if necessary and present a specific evaluation plan and methodology that includes a detailed description of tasks, evaluation methods and procedures, and instruments and quality assurance mechanisms. The following activities may be carried out as part of the evaluation:

(a) Desk reviews of relevant documents from all Treatnet members (UNODC headquarters, UNODC field offices, the training consortium, the resource centres and other relevant partners);

(b) Country visits and interviews with key informants, including UNODC coordinators, focal points, clients, capacity-building consortium leaders, donors and other relevant persons);

(c) Telephone interviews with resource centre focal points, trainers, clients and local data collectors;

(d) Telephone interviews with UCLA/ISAP representatives and other important stakeholders;

(e) Group interviews;

(f) Participatory interventions.

V. Composition of the evaluation team

18. An external independent evaluator will carry out the evaluation. The evaluator will have had no involvement with the project idea, design or implementation. He or she will be assisted by members of the Independent Evaluation Unit of UNODC. Both the draft evaluation framework and the draft evaluation report to be produced by the evaluator will be peer-reviewed by an external expert.

19. The external evaluator will have expert knowledge on and experience in the area of drug dependence treatment and rehabilitation, as well as knowledge and experience in conducting project evaluations.

20. At the end of the evaluation, the evaluator will provide a final and comprehensive evaluation report that is based on his or her findings and that complies with the Independent Evaluation Unit's recommendations for the final evaluation report.

VI. Planning and implementation arrangements

21. Preparations for the evaluation started in April 2007, when consultations were held between the Prevention, Treatment and Rehabilitation Unit and the Independent Evaluation Unit of UNODC. The lead evaluator is expected to become engaged on 1 January 2008 and the total evaluation process, including the finalization of the evaluation report, to end by 18 April 2008.

22. Annexes to the evaluation report should be kept to an absolute minimum. Only those annexes that demonstrate or clarify an issue related to a major finding should be included. Existing documents should be referenced but not necessarily annexed. Annexes should be no more that 15 pages long.

VII. Tasks, expected outputs, performance indicators and qualifications of the evaluator

A. Tasks

23. The evaluator should carry out the following tasks:

(a) Review all background material provided by the Independent Evaluation Unit, including UNODC operational strategy papers, project documents for the project being evaluated (project number GLO/H43-E89) and other relevant documents, as needed;

(b) Based on the objective of the evaluation, develop an overall plan (e.g. a design matrix) and framework, including specific survey instruments and interview protocols (guided interview templates);

(c) Set up meetings and interviews to be held while on mission, in coordination with Treatnet focal points and staff at UNODC headquarters;

(d) Conduct country visits to selected resource centres in seven countries and prepare short field reports on the topics assigned;

(e) Conduct telephone interviews with stakeholders in three additional countries;

(f) Prepare a draft of the final comprehensive evaluation report on the Treatnet project (based on the outline of the evaluation report in the box below);

(g) Revise the draft report in line with feedback received from the project coordinator and comments made by staff of the Independent Evaluation Unit;

(h) Present the draft to stakeholders in Vienna;

(i) Finalize report.

Box
Outline of the evaluation report*

I.	Executive summary (maximum four pages)
II.	Introduction
III.	Background (description of programme or project)
IV.	Purpose and objective of the evaluation
V.	Methodology of the evaluation
VI.	Major findings
VII.	Lessons learned (from both positive and negative experiences)
VIII.	Constraints that affected programme delivery
IX.	Recommendations and conclusions

* See also the revised report format of the Independent Evaluation Unit, available at http://www.unodc.org/documents/evaluation/Guidelines/evaluation-report.pdf.

B. Expected outputs

24. The evaluator should produce the following outputs:

(a) A detailed evaluation plan or framework with specific evaluation instruments, including guided interview templates;

(b) Short country reports and profiles on specific themes assigned, as stipulated in the evaluation plan;

(c) A draft evaluation report, to be presented to staff at UNODC headquarters for feedback;

(d) A final evaluation report, incorporating all comments and feedback received from UNODC on the draft evaluation report.

C. Performance indicators

25. The performance of the evaluator will be assessed based on whether the evaluator has produced an evaluation plan or framework instruments and a final evaluation report that is acceptable to the Chief of the Independent Evaluation Unit within the stipulated time frame and in accordance with UNODC guidelines for evaluation.

D. Qualifications

26. The external consultant (evaluator) will have, as minimum qualifications, a first-level university degree and 12 years of relevant work experience in at least one of the following areas:

(a) Drug dependence treatment and rehabilitation (either in the provision of services, research or academia);

(b) Institutional capacity-building, organizational management and training on issues related to drug dependence treatment;

(c) Programme management, monitoring and evaluation.

27. Preference will be given to candidates with experience in evaluating projects on drug dependence and capacity-building or with similar experience working with other regional or international organizations.

Annex II

External evaluation framework

A. Introduction

1. This paper describes the framework for the external evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89). The project was set up by the United Nations Office on Drugs and Crime (UNODC) in order to fulfil its mandate pursuant to the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex), the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution 54/132, annex) and Commission on Narcotic Drugs resolution 46/1. In that resolution, the Commission stressed the importance of promoting evidence-based treatment and rehabilitation programmes and called upon States to extend treatment and rehabilitation programmes for drug users so as to reduce the negative health and social consequences related to illicit drugs, for both the individual and the community.

2. As per the terms of reference of the evaluation (see annex I), the purpose of the evaluation is:

(a) To assess whether a network of treatment and rehabilitation resource centres covering all regions has been established and is operational;

(b) To assess whether the establishment of the network has improved the quality of drug treatment and rehabilitation services offered in the respective centres.

3. The stakeholders of the evaluation are UNODC, a training consortium led by the Integrated Substance Abuse Programs of the University of California at Los Angeles (UCLA/ISAP), the 20 resource centres participating in Treatnet, drug demand reduction focal points at UNODC field offices and relevant partner international organizations.

4. The terms of reference provides, in detail, the scope of the evaluation (including an extensive list of issues to be addressed), instructions on the methods to be used in the evaluation, the expected outputs of the exercise, an outline of the final report and a proposed time frame.

B. Preliminary observations

5. The scope of the evaluation is determined by the project document and other basic documents, such as progress reports, meeting reports and the above-mentioned terms of reference. While the principal question that the evaluation aims to answer is whether the project has delivered what it promised and in the way it was meant to as per the objective, outputs and activities described in the relevant project document, the evaluation will also take into account the broader context of the project. Hence, it will first focus on the outputs identified for phase one (such as the establishment of a network of resource centres); second, it will consider the broader goal of the project as described in the immediate objective (improvement of services); and, third, it will—to the extent possible—further broaden its scope by examining the overall objective (to facilitate increased and easy

access for drug users to effective and diversified drug treatment services with a view to reduce drug use and its related adverse consequences).

6. The resource centres and their partners will be the primary sources of information used in the evaluation, but other sources will also be consulted, for example the ultimate target group (drug users), other key players in the field (such as law enforcement, health and social welfare agencies) and other administrative key players (such as local and national governments and other international agencies). At the planning stage, it is not quite clear what the contribution of the core learning partnership could be.

7. In the project document and in other basic documents, reference is made to rehabilitation centres and treatment centres. In the majority of the references, however, only treatment centres are mentioned. While the distinction between the two may not always be clear, efforts will be made to include the rehabilitation aspect of the project in the evaluation.

8. The actual provision of treatment and rehabilitation services is set within the context of local and national policies, affecting the adequacy and applicability of the project's goals and outputs. Although the basic documents do not contain any reference to this aspect of the project, the impact of national and local policies will be borne in mind and may be reflected in the final evaluation.

C. The project

9. Although the texts of the basic documents vary slightly, the following description seems to encapsulate the essence of the whole purpose of phase one:

> The International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) is a network of 20 treatment centres from around the globe whose aim is to enhance the capacity of centres to provide diverse and effective drug dependence treatment and rehabilitation services, including by disseminating knowledge and building organizational capacity.

10. The immediate objective of the project is to establish an international network of drug treatment and rehabilitation resource centres in all regions.

11. The key elements of the project strategy are:

(a) The identifying and bringing together of leading drug treatment and rehabilitation centres from all regions;

(b) The provision of support to the working groups of resource centres to synthesize good practices on four selected priority topics;

(c) Build capacity, including through the development of a capacity-building package, train trainers and pilot the delivery of training in accordance with assessed needs.

12. At the end of the project, it is expected that an operational network of treatment and rehabilitation resource centres covering all regions will have been established and that participating centres will be working together to improve the quality of drug treatment and rehabilitation services that are offered in their respective centres. The term "operational network" describes a system of centres with defined objectives, tasks, responsibilities, means of communication, decision-making mechanisms and ongoing interaction. The term "resource centre" describes a treatment or rehabilitation organization with the competence (in terms of evidence-based best practice) and the capacity (in terms of human and

economic resources) to serve as a mediator for best practice training in a defined geographical or structural area.

13. Expected outputs of the project are the following:

(a) An evidence-based training package is developed, piloted and ready for publication;

(b) There is an increased technical capacity to provide effective, quality and affordable drug dependence treatment at participating centres;

(c) Four good practice documents are ready for piloting and demonstration;

(d) A feasibility study and a proposal for phase two of the project have been completed.

D. The scope of the evaluation

14. In the course of the evaluation, the following will be investigated:

(a) The nature and status of the network (whether it is global, operational, effectively leading to the improvement of services, representative of axes such as development and the nature of services offered) (see also the core questions in para. 15, annex I);

(b) The nature of the participating centres (whether and how they are leading or influencing others, how they relate to law enforcement, health and welfare institutions, whether they are also influencing policymaking etc.);

(c) Changes in the technical capacity of the centres brought about by the project (through, for example, the use of tools for increasing technical capacity such as treatment protocols and handbooks, the incorporation of evidence contained in protocols and handbooks, the inclusion of treatment evaluation and follow-up procedures, in-service training mechanisms, data on retention rates, indicators of the satisfaction of patients and clients, confidence of staff in their capacity as agents of change or catalysts etc.);

(d) The work of the working groups of (four to five) resource centres to synthesize good practices on priority topics (identified in the course of the project to deal with: the situation in prisons and detention centres; drug dependence treatment and HIV/AIDS prevention and care; community-based treatment; and sustainable livelihoods for reintegration and rehabilitation (how did various partners participate, what is being done to follow-up on the work achieved etc. See also the question in para. 15 (e), annex I);

(e) The four good practice documents, which should reflect the latest knowledge on matters relevant to different socio-economic situations (the status of development or production of the documents will be examined, as well as their scientific soundness, relevance, practicality and applicability);

(f) The training package on treatment and rehabilitation, which should be based on evidence, the results of piloting the package, whether the package is user-friendly, how it is actually being utilized, whether and how it has been translated, published and disseminated, the continued management of its utilization etc. (see also the question in para. 15 (f), annex I);

(g) Changes brought about by the project that contribute to the prevention of HIV/AIDS, tuberculosis and other communicable diseases, beyond the production of the good practice document (whether there are indications of changes in the resource centres

to address the matter and, if so, what kinds of changes, whether there is any information on the effects of such changes etc.);

(h) The need for and the direction of a phase two of the project (a number of suggestions and proposals are already circulating) (see also the question in para. 15 (g), annex I above).

15. The overall objective of phase one of the project (increased and easy access for drug users to effective and diversified drug treatment services with a view to reduce drug use and its related adverse consequences) raises other matters, including the following:

(a) With regard to the diversification of services: the concept of diversified services includes the notion that it is desirable to have a great variety of services in order to meet the individual needs of drug users. In the course of the external evaluation, an effort will be made to assess the extent to which the project's partners advocate and implement the concepts of diversity and continuity of care (from outreach through residential treatment to rehabilitation and community services). Related questions are: why offer a great variety of services if evidence suggests that only a limited variety is required and to what extent are services involved in drug abuse prevention activities and policymaking;

(b) With regard to the accessibility of services: are the services accessible in terms of cost, and in terms of cultural, social, religious and geographical proximity and does service provision respond to the results of a treatment needs assessment;

(c) With regard to the impact of treatment services on the reduction of drug use and its related adverse consequences: although it is a complicated issue, efforts will be made throughout the evaluation to see if the project can provide any additional information on the issue;

(d) With regard to the relevance of the project: what importance do local and national governments and other stakeholders attach to this project.

16. As part of the evaluation, the management of the project will also have to be addressed (see the question in para. 15 (h), annex I above). Thus, the following issues, among others, will be given consideration:

(a) Definition of project goals in relation to the means for achieving those goals;

(b) Mechanisms for adapting the project to changing circumstances;

(c) Mechanisms for adapting the project to different social, cultural, economic and political environments;

(d) Internal communication mechanisms;

(e) Administrative management at global, regional and national levels;

(f) Involvement of national agencies;

(g) Involvement of international agencies;

(h) Coordination mechanisms;

(i) Management of the budget;

(j) Utilization and mobilization of other resources;

(k) Mechanisms for sustainability.

17. Although feedback on those issues will be sought throughout the exercise, this evaluation is not a management review. However, the role of UNODC field offices specifically will be examined, both in terms of technical and managerial involvement.

E. Limitations

18. It is foreseen that six of the 20 resource centres will be visited and telephone interviews will be held with staff at four other centres. It is unlikely that the six centres to be visited will be representative of the entire group and the telephone interviews will only provide access to a very limited number of persons. Although documentation is assumed to be available, the limited access to informants means that it will not be possible to make a definitive assessment of the nature of the network and the participating resource centres.

19. It is assumed that the programme of the visits will be organized by the resource centres and the UNODC field offices. As they are interested parties, a certain bias in the programming of meetings and visits cannot be excluded.

20. An assessment of the impact on drug use and its related adverse consequences (and hence on the overall objective) is beyond the scope of this evaluation. Such an assessment would require specific research to be carried out on the basis of identified baseline measurements, control areas etc.

21. In the framework of the project, evidence-based treatment is advocated. It is possible that promoting evidence-based treatment could conflict with another goal of demand reduction activity, in other words the diversification of services (as mentioned in para. 15 (a) above, why have a great variety of services when science tells us that only a limited number of interventions are effective). Placing emphasis on evidence-based interventions may also conflict with the experiences of institutions that treat substance abuse and mental illness and that question the paradigm of evidence-based interventions.

F. Evaluation methods

22. The terms of reference provides an overview of the evaluation methods to be used and lists the activities foreseen (such as desk reviews and interviews). In preparing for the country visits, it might be a good idea to ask the programme organizers to arrange meetings not only with the representatives of the resource centres, but also with appropriate representatives of local and national government entities (from law enforcement, health and social welfare sectors), any organizations of drugs users that might exist, institutions for communicable diseases prevention and care, parents' and women's organizations, international agencies concerned and academic organizations interested in the subject.

23. In order to prepare for the interviews with the different stakeholders, lists of topics to be discussed will be drafted.

24. Information available from the internal evaluation will be taken into account.

25. The principle method to be used in the evaluation will be the collection and analysis of feedback from the various participants in the project and persons affected by the project, including, to the extent possible, the ultimate target groups, in other words the drug users and the community.

G. Evaluation design matrix

26. The following matrix provides an overview of the framework of the evaluation, pointing out key points for attention (without being exhaustive) in the various boxes:

Subjects	*Elements/aspects*	*Topics of questions*	*Sources*	*Comments*
The network	Global	Geopolitical distribution/ balance of needs	UNODC headquarters, UNODC field offices and documents	Evaluation network largely researching documents
	Composition	Representation of diverse stages/relationship drug control objective	Headquarters and documents	Overall question: how good is the network for the purpose
	Target-oriented	Consensus/accordance with overall policy	Documentation and interviews	Same
	Cooperation/operational	Participation/investments/ actual activity/actual product delivery	Internet and documents/interviews UNODC headquarters, UNODC field offices and other partners	Describing/collecting/ quantifying network activity/assessing/analysing
Resource centres	Profile	Reflecting reality	Country visits including government	Appropriateness involvement
	Sphere of influence	Institutional/geographical	Resource centres and environment	Perspective: the community and other service providers
	Leadership	Stability/involvement of entire agency	Resource centres	Appropriateness for demonstration purposes
	Changes in orientation and practice	What difference as a result of project	Resource centres' staff and clients	Sustainability of changes needs special attention
Working groups (four)	Structure	Representing technical competence and interest	UNODC headquarters/ participating centres	Does structure add up for quality of work
	Process	Adequate input	Same	Facilitating and obstructing factors
	Production	Unexpected pitfalls and advantages	Same	Same
Good practice documents (four)	State of development	Draft/final	UNODC headquarters/ centres/external references	Concrete indicators about product
	Evidence base	Based on experiences/ peer reviewed	Centres/references	Fairly concrete indicators about quality
	Production	Responsibility/financial aspects	UNODC headquarters and centres	Clarity
	Distribution	How	Same and national relevant agencies	Same
	Practicality/applicability/ demonstration	Feedback from outsiders	Centres/UNODC field offices/national substance abuse agencies	Perhaps early for assessment
Capacity-building/training	Action	Sessions held/feedback	UNODC headquarters, UCLA and beneficiaries	Crucial in this block are investments and impact
	Isolated/regular	Opportunities for routine	Same	Same
	Impact	Indications of changed practice	Same and national agencies drug abuse/mental health	Is research or literature available

Subjects	*Elements/aspects*	*Topics of questions*	*Sources*	*Comments*
Capacity-building/ package	Status development	Availability/translations/ institutional links/sustainability	UNODC headquarters/UCLA/ beneficiaries	Draft/final/future developments/adaptations
	Production	Who/how	UNODC headquarters/ UCLA	Clarity
	Dissemination	Who/how	Same	Same
	Quality	Incorporation treatment phases/research and development/evidence/ applicability	Outsiders' reviews	Scientific rigour
Technical capacity at resource centres	Institutional involvement versus individuals	Protocols/tests/ accreditation	Stakeholders/governments	Evidence of impact on treatment/community
	Supervision	Agencies' procedures	Centres	Quality/satisfaction
	Other support mechanisms for sustainability and impact	Wider agency procedures	Same	Same
Nature of resource centres	Changes in accessibility/ diversification of services	Concrete indications	Centres/environment/ beneficiaries/governments	Project's impact must be tangible
Project management	Role of field offices	Technical/managerial	UNODC headquarters and UNODC field offices	Interest/involvement/ sustainability/partnerships
	Relating/streamlining	Links adjacent institutions	Governments/"external" stakeholders	Same
	Sustainability	Incorporation local and national policy/resources	Same	Same
	Advocacy	Efforts advocating treatment and rehabilitation	UNODC headquarters, UNODC field offices and partners	Contribution to drug demand reduction objective
Overall objective	Project's sustainable impact on demand reduction	Possibly extending beyond narrow scope of project	Partners/stakeholders/ governments/external literature	Summarizing

H. Conclusion

27. The final external evaluation report will follow the structure laid out in the terms of reference (see annex I). Throughout the evaluation, the leading questions will be:

(a) What lessons have been learned?

(b) How will the experiences gained to date affect the continuation of the project?

28. The aim is to ensure that there can be a logical flow from the final report of the evaluation to the proposal for phase two of the project.

Annex III

Travel reports

A. Egypt

1. Introduction

1. The evaluation team visited Cairo from 17 to 21 March 2008 to collect information for the evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89). Pertinent information was collected mainly through interviews and meetings with project staff and other stakeholders; some documents related to the project (such as the National Mental Health Survey of Egypt by Prof. Emad Hamdi) were also received in situ.

2. The programme for the visit of the evaluators had been set up jointly by the national focal point for the project, the Regional Office for the Middle East and North Africa and the Independent Evaluation Unit of the United Nations Office on Drugs and Crime (UNODC). The visit coincided with a national holiday, which made it difficult to have a full work programme for one day; however, some meetings could still be held. The team was able to meet with many of the people and institutions that had been involved in the development and implementation of the project in Egypt, as well as with some other important stakeholders (see para. 24 for a list of persons met).

3. In Egypt, the resource centre participating in the project was the addiction unit of Airport Hospital. Some staff from the addiction unit of Behman Hospital, located outside of Cairo, were also involved. The director of Behman Hospital, Dr. Nasser Loza, is also the director-general of mental health in the Ministry of Health and the national focal point of the project. The UNODC Regional Office for the Middle East and North Africa had already cooperated with Dr. Loza before the Treatnet project started. Both of the units mentioned above are part of psychiatric hospitals. Behman Hospital is a private hospital; its addiction unit is relatively small and gives the impression of being well equipped and well run. Airport Hospital is a public hospital. Its addiction unit, which has an inpatient and an outpatient facility, in addition to a day-care department, has a large patient population and limited facilities. Nonetheless, it is one of the best psychiatric hospitals in Egypt.

2. Analysis and major findings

4. Based on observations made and conversations had with the staff of the hospitals, it appeared that the Treatnet project had had and continued to have a positive influence on the way the institutes and the staff worked with patients and clients.

5. Airport Hospital had been involved in Treatnet in various ways:

(a) It had assisted in hosting the first Treatnet capacity-building event, held from 18 to 26 September 2006;

(b) It had participated in network communications;

(c) It had participated in one of the four working groups (the one on community-based treatment);

(d) Some of its staff had participated in train-the-trainer workshops;

(e) It had carried out the training modules for its own staff and for staff from other centres in the country.

6. In the course of the project, there had apparently been a good flow of communication between the people involved in Treatnet in Egypt and the managers of the project at UNODC headquarters. Stakeholders interviewed felt that the focal points at UNODC headquarters had been responsive and had always tried to answer queries and requests in a timely and constructive manner.

7. The role played by the UNODC Regional Office for the Middle East and North Africa, based in Cairo, in terms of project design, monitoring and implementation was limited. The Regional Office had been kept well informed by UNODC staff at headquarters and had asked for assistance and guidance at critical moments in the course of the project, for example with regard to the selection of a national Treatnet focal point and the identification of training participants. The Regional Office had also provided administrative and logistical support for activities organized in the framework of Treatnet.

8. With regard to the objectives and outputs laid out in the project document for phase one (the participation of resource centres in Treatnet, the development of four good practice documents and the implementation of a training package) the evaluation team's assessment can be summarized as follows:

(a) *Participation in the network*: staff at Airport Hospital had been actively involved in the network, mostly through their participation in the training sessions conducted in the framework of the project and in the meetings of the working group that prepared the best practice document on community-based treatment. Although those activities were over at the time of the visit, some staff members were still using the Treatnet e-forum to communicate with colleagues based in other countries whom they had met in the course of phase one of the Treatnet project. Even though it seemed that informal relations between Treatnet members from Egypt and other participating countries continued to exist, the project had not sustained relations systematically beyond the work of the working groups and the training sessions;

(b) *Development of a good practice document*: staff at Airport Hospital and other experts had been actively involved in the development of the draft good practice document on community-based treatment. They felt very satisfied about the work carried out by the working group and the quality of the draft. However, it was their Swedish counterparts who had done most of the drafting of the document. There was some concern over the production and the future dissemination of the document;

(c) *Implementation of a training package*: three staff members had participated in train-the-trainer courses and subsequently trained other professionals on the four modules (screening, assessment and treatment planning; elements of psychosocial treatment; pharmacological treatment; programme management and service development). Participants in the local intensive training events included physicians, nurses, psychologists and other paramedical staff from the resource centre and other institutions. The evaluators were able to meet with a few of the professionals who had been trained. Training sessions continued to be carried out. Such training events, which were reportedly one of the very few opportunities for Egyptian professionals in that field to become acquainted with evidence-based treatment practices, seemed to be in high demand. The model PowerPoint presentations and the capacity-building package that had been developed by the capacity-building consortium were apparently being used intensively in the training events;

(d) *Utilization of models and instruments introduced in the capacity-building activities*: the project includes, among other tools and models, the Addiction Severity Index (an instrument, based on a questionnaire, that is widely used in the United States and Europe to better assess a client or patient at intake and to adapt a patient's treatment to the needs of the individual). The Addiction Severity Index was regarded as a very useful tool, which is why efforts were under way to produce an Egyptian version in Arabic. One of the few drawbacks of introducing the Index into Egypt might be the long time needed to apply the instrument, making therapists sometimes feel more like an interrogator than a therapist;

(e) *Introduction of evidence-based treatment*: it appeared that in the resource centre the treatment and management processes were being carried out more systematically: service provision was being planned better, schedules had been introduced in the daily routine of the various departments of the centre and data on patients were being monitored and registered systematically.

3. Outcomes, impacts and sustainability

9. The main change that could be attributed to the project was the development of a different attitude towards drug users among staff in the centres. Stakeholders interviewed reported that the project had stimulated managers and staff at the institutes to adopt a different attitude towards drug users: instead of seeing addicts as criminals or, at best, as deviants, staff had begun to see addicts as people with a disease who needed to be treated with the best medical, psychological and social care available.

10. This attitudinal or cultural change was also reflected in the terminology used. The old, traditional term "narcotics" was being replaced by the term "psychoactive substances", which was being promoted actively by the staff of the centre.

11. Although a great deal of the clinical practice (strict protocols and assessment tools, for example) had not yet become part of the daily routine, a different attitude towards patients had been adopted and a much more therapeutic attitude to community work had taken root in the professionals involved in the project, including among the managers and leaders of the resource centre.

12. Although such changes have not been included in the objectives of the project, these are no small achievements in the direction of the Treatnet project's overall objective of facilitating increased and easy access for drug users to effective and diversified drug treatment services with a view to reduce drug use and its related adverse consequences.

13. Another unplanned effect of the Treatnet project in Egypt was the backing of the position of crucial players in the introduction of a new philosophy underlying the drug abuse policy debate in the country. At the time of writing, a new law on mental health was being debated in Parliament, the draft of which was expected to be finalized in the following months. The new law would replace a decades-old law on mental health. The national focal point for Treatnet, the Director of Mental Health in the Ministry of Health, was someone who played an important role in the debate. His efforts to modernize the mental health system were being strengthened by the Treatnet project, which aims to prioritize the provision of treatment and rehabilitation services based on modern and evidence-based methods and tools.

14. The sustainability of what has been achieved by Treatnet to date depends significantly on what will happen with regard to the political debate surrounding the piece of mental health legislation referred to in paragraph 13, on whether it will be possible for the Treatnet project to continue and on whether the resource centre will continue to be involved. Certainly, staff of the resource centre and other stakeholders whom the

evaluators met demonstrated great interest in having the Egyptian centre involved in a possible phase two of the Treatnet project.

15. Also relevant to the issue of sustainability was a new project being launched with financial support of the European Union and for which the UNODC Regional Office for the Middle East and North Africa was the executing agency. That project's aims included the application and dissemination of the packages, tools and instruments developed in the framework of Treatnet, thus providing some guarantee that the work done through Treatnet would continue.

16. The Treatnet project had also led to greater awareness of those aspects of service provision that were very underdeveloped. Outreach and outpatient work were concepts that were just starting to be developed: a day-care centre was being built and an outpatient facility was operating with a high turnover of clients and patients, both on the premises of Airport Hospital. Even though the staff of the resource centre seemed to spend a great deal of time on community work, education and prevention, the system as a whole seemed very much centred on the clinic instead of on the community. As a result of the project, staff at the resource centre had become more aware of the shortcomings of the system.

4. Lessons learned and best practices

17. In Egypt, the links between the Treatnet project and Government institutions were particularly good owing to the fact that the national focal point of the project was the Director-General of Mental Health in the Ministry of Health. Following the suggestion of the UNODC Regional Office for the Middle East and North Africa, the predecessor of the current Director-General of Mental Health was chosen as national focal point for Treatnet.

18. Airport Hospital and Dr. Loza were long-standing cooperation partners of the UNODC Regional Office for the Middle East and North Africa. Treatnet could therefore build on existing relations and count on an institute that was already way ahead of the majority of similar institutes in the system in terms of improving practices. The challenge for creating substantial change in the entire system lies in creating links with agencies representing the rest of the system. Additional barriers, such as the lack of basic resources and language, will also have to be dealt with.

19. In connection with the need to create links with less privileged institutions representing the majority of the system, phase one of the Treatnet project was probably too academic. The whole methodology of phase one was too sophisticated to be applied to a poorly resourced system.

20. Although the international training sessions were regarded to be excellent, some stakeholders felt that training of a similar quality could have been provided closer to them, thus saving money and offering follow-up opportunities more easily.

21. While the results of the project were unanimously regarded to be very positive, some stakeholders interviewed felt that a closer involvement by professionals from developing countries in the development of Treatnet might have been possible so as to ensure a stronger feeling of ownership by all involved.

22. One of the long-standing challenges for building capacity on substance abuse treatment and rehabilitation lies in the lack of inclusion of health and welfare professionals in the development of curricula. This is not only a problem in Egypt; it is a problem all over the world. Although a possible phase two of Treatnet might not be able to solve this, more encouragement should be provided to link the professionals with regular professional training and education facilities.

5. Conclusions

23. The following conclusions can be drawn:

(a) *Conclusion 1*: in Egypt, the goals of phase one of the Treatnet project were achieved in terms of including a resource centre in Treatnet, exposing a growing number of professionals to modern treatment and rehabilitation theories and practices, and involving Egyptian counterparts in the work of one of the working groups;

(b) *Conclusion 2*: in Egypt, the Treatnet project seemed to have served to reinforce a small movement for giving more priority to demand reduction strategies and introducing a more humane attitude towards drug users;

(c) *Conclusion 3*: the Treatnet project had certainly had a positive influence on the resource centre's staff and clinical practice. Phase one did not pretend to be much more ambitious than that. In view of the dire need for change in the system as a whole, it is worth asking whether more or different centres could or should have been involved from the beginning or whether more pressure could have been exerted on national policymakers through the project;

(d) *Conclusion 4*: through the Treatnet project, a great amount of enthusiasm and professional interest had been sparked among those involved with regard to the application of methods of work that were more based on evidence. In principle, there were opportunities for expanding the reach of change towards evidence-based interventions to the wider treatment and rehabilitation system in the country. Continued promotion of such change by international agencies such as UNODC and the World Health Organization (WHO) would certainly be helpful;

(e) *Conclusion 5*: the relatively short duration of phase one had posed restrictions for the dissemination of the results obtained (continued cooperation was expected to be part of subsequent phases of the project). The uncertainty over the possible continuation of the Treatnet project among those involved did not contribute to the rapid absorption of the changes into the wider system;

(f) *Conclusion 6*: notwithstanding conclusion 5, some external factors (such as the national debate on the new law on mental health and the European Union's support for upgrading the treatment and rehabilitation system) may contribute to the sustainability of the work started during phase one of the Treatnet project.

6. Persons met in Egypt

24. The evaluator met with the following persons (listed in the order in which they were met):

Nael Hasan, psychiatrist, Behman Hospital, Helwan (naelm68@gmail.com)

Maj Kotb, psychologist, Behman Hospital, Helwan

Emad Sidhom, psychiatrist, Behman Hospital, Helwan (evaluator of Treatnet)

Khaled Elsiagy, psychiatrist, Head of addiction department, Airport Hospital, Cairo

Wael Mansour, Chair of Training Department, Assistant Chair of the Addiction Branch, General Secretary of Psychiatry, Cairo

Mohamed Elhendawy, Chair IT, Airport Hospital, Cairo

Tamer Elamrousy, psychiatrist, Chair, Department Dual Diagnosis, Airport Hospital, Cairo

Salwa Guerges, Deputy Director, HPH, Airport Hospital, Cairo

Ibrahim Abdel Halim, resident psychiatrist, Airport Hospital, Cairo

Sayed Hamid, Chief Nurse, Airport Hospital, Cairo

Leif Villadsen, Regional Programme Coordinator, UNODC Regional Office for the Middle East and North Africa (leif.villadsen@unodc.org)

Wadih Maalouf, Project Coordinator, UNODC Regional Office for the Middle East and North Africa (wadih.maalouf@unodc.org)

Nagwa El Fawal, Chair, Fund for Drug Control and Treatment of Addiction (nagwa26@yahoo.com, ncdrug1@ncdrug.org.eg, ncdrug2@ncdrug.org.eg)

Zaida Abd El Guad, Fund for Drug Control and Treatment of Addiction

Mohamed Saad, Fund for Drug Control and Treatment of Addiction

Nasser Loza, Director-General for Mental Health, Ministry of Health, and Director of Behman Hospital (nloza@behman.com)

B. Sweden

1. Introduction

25. The evaluator visited Sweden from 7 to 10 April 2008 as part of the evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89). One of the 20 resource centres participating in phase one of the Treatnet project is Maria Ungdom, a drug abuse treatment and rehabilitation facility in Stockholm.

26. Staff at Maria Ungdom, in close consultation with staff at the UNODC Independent Evaluation Unit and the evaluator, had prepared a very good programme for the visit. While in Stockholm, the evaluator received a thorough introduction on the work of the centre and met with a number of clients and their relatives. The evaluator also met with the chief of the youth department of Stockholm police and with staff at the social services centre associated with Maria Ungdom, and visited one of the centre's branches, in Södertalje. In addition, the evaluator held a number of unscheduled interviews with staff members who were not aware of the purpose of the visit and met with a senior staff member of the Ministry of Health and Social Affairs in order to learn about the views of the Government on the project.

27. Maria Ungdom is a facility for young people up to the age of 20 years. Shortly before the visit, the centre had established a number of branches to increase its community orientation. Maria Ungdom is a governmental agency but, as a result of an ongoing debate in Sweden, the centre might be privatized.

28. Although the focus is on people with substance abuse problems, this does not have to be an exclusive criterion for admission. Maria Ungdom has an emergency unit where young people in a crisis can be admitted for a couple of days. It has a day-care centre, operates a residential facility, is involved in rehabilitation activities for its clients and also engages in prevention and education activities. Maria Ungdom employs some 140 staff members who work in various units, including a research unit.

2. Analysis and major findings

29. Maria Ungdom's participation in the core activities of phase one of the Treatnet project entailed participating in management meetings by senior staff of the centre, training at the University of California at Los Angeles (UCLA) of two senior staff as trainers, the acting as host and learning centre for staff of other resource centres, cooperating in one of the working groups and helping with the drafting of the best practice document, in addition to the regular participatory activities.

30. All the staff members met were very positive about the effects that the Treatnet project had had on the centre. The fact that the centre had shared its knowledge and experience with other centres in the world was regarded to be very positive, as was the feeling of belonging to an international effort to make treatment more important.

31. Through the meetings and interviews held, it also appeared that staff throughout the whole centre were well aware of the centre's participation in the project. Most staff had received training as planned in the capacity-building part of the project and many of them had materials resulting from the project available in their workplaces.

32. It had been agreed from the beginning that the modules on community-based training and relapse prevention, in particular, would be most relevant to Maria Ungdom (neither the module that included the Addiction Severity Index or the module on pharmacological therapy, however, were seen as applicable to the centre). The most pertinent project materials had been translated into Swedish. Everybody confirmed that the training and the follow-up to the training had influenced the daily therapeutic practice in the sense that the principles of community-based training, relapse prevention and motivational interviewing had been incorporated in the daily routine. There was some concern that the changes in daily therapeutic practice might not be sustainable and it was suggested that perhaps more follow-up training would be desirable.

33. Another result of the centre's participation in the Treatnet project was the increased emphasis on standardizing protocols and processes in-house. As with the increased emphasis on the principles of motivational interviewing referred to in paragraph 32, those changes might have taken place in the centre anyway. However, participation in Treatnet had certainly accelerated change and also prompted staff to take those changes more seriously.

34. Few staff members were aware of the e-forum of the project and even fewer were aware of the fact that the home page of the website of the centre had a direct link to UNODC and Treatnet. Not surprisingly, the e-forum was seldom used as a means of communicating with staff at other resource centres. Contacts with other participants in the Treatnet project were usually maintained on a bilateral basis.

35. Maria Ungdom had participated in the working group on community-based treatment. In practice, this meant that managers of the centre had participated in the meetings and in other activities of the working group, all of which were regarded to have been very valuable. There was some concern about the finalization and production of the resulting document, which was felt to be a very good paper. Few people other than the managers of the centre and two trainees, however, were aware of the fact that the centre had participated in one of the working groups.

36. Further dissemination of lessons learned in the course of the Treatnet project, mainly with regard to community-based training, relapse prevention and motivational interviewing, had started with offering the training course to other drug abuse treatment centres. That process had just begun and only one centre had received training, although plans were under way for reaching another centre.

37. Although there were good and frequent contacts between Maria Ungdom and policymakers at the local and national levels (managers at Maria Ungdom were well respected in Government circles), there had never been an explicit effort to link the activities being carried out in the framework of Treatnet with possible policy changes. In retrospect, that was felt to have been a missed opportunity.

38. There was much appreciation and praise for the way the Treatnet project had been managed and for the way that staff managing the project had been receptive to the individual needs of the different resource centres, prompt in responding to day-to-day issues and devoted and committed to the project.

3. Outcomes, impact and sustainability

39. The main outcomes of Treatnet on the resource centre in Sweden seemed to consist of an overall change in therapeutic methods (towards utilizing motivational interviewing), as promoted in the training provided by the training consortium. It is doubtful if this can be attributed solely to Treatnet. Rather, Treatnet encouraged the intensive use of community-based training, relapse prevention and motivational interviewing methods. The sustainability of those new methods seems to be guaranteed, as dedicated staff have been made available to the centre to ensure continuing change.

40. The same is more or less true for a more intensive use of standardized protocols and processes in the centre.

41. An unforeseen outcome of the centre's participation in the project was the improved reputation of the centre. The "stamp of approval" given by its association with the United Nations had certainly facilitated the introduction of changes and the work with other agencies.

42. The courses given and the materials on community-based training, relapse prevention and motivational interviewing were generally regarded as being very valuable in daily therapeutic practice.

4. Lessons learned and best practices

43. It is apparently possible for an already relatively sophisticated treatment centre such as Maria Ungdom in Stockholm to improve its way of working through participating in an international project led by UNODC. Participation in Treatnet has had an impact on the way staff members work with clients of the centre and is also starting to influence staff at other centres. However, most of the interest in participating in the training courses came from social workers, nurses and psychologists, not physicians.

44. In order to make full use of the opportunities for disseminating Treatnet's products and achievements (the training packages, the best practice documents etc.), the resource centres need to feel secure about their status. In that regard, the current uncertainty over Maria Ungdom's continued participation in a possible phase two of the Treatnet project seems to be seriously hampering opportunities for dissemination.

45. Participation in an international network widens the horizon of staff and provides recognition of the quality of the work that is being done.

5. Conclusions

46. The following conclusions can be drawn:

(a) *Conclusion 1*: Treatnet had had a positive impact on the way patients and clients were being treated in the centre. Most staff members, in particular the nurses, social workers and psychologists, had integrated motivational interview techniques into their daily therapeutic practice;

(b) *Conclusion 2*: the work of the working groups of the Treatnet project had little direct bearing on the practice of the resource centre. The capacity-building part of Treatnet (the training by the training consortium) did not seem to be related to the work of the working groups;

(c) *Conclusion 3*: the e-forum was hardly being used by staff of the centre, not even by those most involved in Treatnet. In order to be an effective instrument for communication between the partners in the project, probably more work has to be done to promote the e-forum, which has to be made more user-friendly. An additional barrier may have been the culture of the caregiver, which was not always conducive to utilization of this sort of communication;

(d) *Conclusion 4*: relatively sophisticated centres such as Maria Ungdom have a lot to offer in terms of sharing best practices. Whether this shared knowledge is actually being utilized by practitioners once they return to their home institutions could perhaps be found out by conducting telephone interviews with staff members from other resource centres who have been on study visits to Maria Ungdom in the framework of the Treatnet project;

(e) *Conclusion 5*: unforeseen effects, such as the additional status that resource centres acquire through their participation in Treatnet, may help in providing centres with more authority to act as resource centres within their countries or regions.

6. Persons met in Sweden

47. The evaluator met with the following persons (listed in the order in which they were met):

Paula Liljeberg, General Director, Maria Ungdom (paula.liljeberg@sll.se)

Stefan Sparring, Deputy Director, Maria Ungdom

Anders Tengstrom, Deputy Director of the research unit, Maria Ungdom (anders.tengstrom@ki.se)

Dieter Carlsson, Counsellor, Trainer, Maria Ungdom (dieter.carlsson@sll.se)

Mariana Dufort, evaluator of phase one, Maria Ungdom (mariana.dufort@sll.se)

Helen Nilsson, Head of the inpatient ward, Maria Ungdom

Jesper Krosnes, Staff of the inpatient ward, Maria Ungdom

Ulf Wahlgren, Research Coordinator, Maria Ungdom (ulf.wahlgren@sll.se)

Stefan Borg, Director, Maria Ungdom

Sheila Hodgins, Director, Maria Ungdom

Göran Hagglund, Director of the social services at Maria Ungdom

Kjell Gardeland, Social worker

Jonas Wendel, Detective Chief Inspector, Stockholm police

Ralf Löfstedt, Director, Special Expert, Division for Public Health, Ministry of Health and Social Affairs (ralf.lofstedt@social.ministry.se)

C. United States of America

1. Introduction

48. The evaluator travelled to Fall River, Massachusetts, United States of America, from 14 to 18 April 2008 for the evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89). One of the 20 resource centres participating in the Treatnet project is the Stanley Street Treatment and Resources (SSTAR), a facility for the treatment and rehabilitation of drug users in Fall River. In line with the terms of reference for the evaluation (see annex I), pertinent information was collected by studying relevant documents, some of which were made available to the evaluator before the mission and some of which were collected during the mission, conducting interviews and meetings with staff at the centre, clients, representatives of health and social welfare agencies, as well as policymakers and politicians in the community. The programme for the visit had been carefully prepared by staff of the resource centre in consultation with the Independent Evaluation Unit and the evaluator.

49. SSTAR started operating in 1977 as an alcohol detoxification centre. It then developed into a community health and welfare centre offering a wide range of services, from detoxification and (short-term) residential treatment (including a step-down unit for women) to various forms of outpatient treatment (including through a licensed mental health clinic, HIV outreach, counselling and case management service), a primary health-care centre for the community and a telephone helpline. Its focus is on the underprivileged in society. SSTAR has expanded its services also to the State of Rhode Island, where a residential and day-care centre have been opened. SSTAR currently employs some 150 professionals.

50. Fall River is a community in Massachusetts that had undergone, shortly before the visit, major social changes, in particular as a result of the closing down of important manufacturing companies. That had resulted in relatively high unemployment rates, insecurity and social problems such as a high prevalence of drug abuse. SSTAR had played an important part in the way the community responded to those problems and was, therefore, a great asset for the community.

51. SSTAR is one of the few facilities with a policy of having no waiting lists, of almost always offering some form of help immediately (or at least on the same day) and of catering to the widest possible range of problems experienced by people with substance abuse problems. Few other centres provide such a great variety of services in such a low-threshold, seamless and well organized way. The centre also seems to have struck a good balance between professionalism and community involvement. It is also involved in research projects as a regular partner in studies carried out in the framework of the National Drug Abuse Treatment Clinical Trials Network of the National Institute on Drug Abuse of the United States. The centre can be said to be an example of good practice.

2. Analysis and major findings

52. SSTAR started participating in Treatnet after it was recommended by the Robert Wood Johnson Foundation, one of the sponsors of Treatnet.

53. While the clinical practices in the centre have been influenced by the centre's participation in Treatnet, SSTAR has mainly served to act as an example of good practice within Treatnet. Most of what was offered to participating centres through Treatnet (for

example, the training manuals) was already part of daily practice in the centre. Through Treatnet, all SSTAR staff members have been encouraged (and are being monitored) to utilize motivational interviewing, an important element of Treatnet's package.

54. Staff members at the centre had been kept informed on the participation of the centre in this global exercise. A special event had even taken place in which some of the national focal points of resource centres from other countries had been invited, thus providing staff with a direct link to institutions involved in Treatnet elsewhere in the world.

55. SSTAR managers had taken part in capacity-building exercises organized in the framework of Treatnet (for example, on the utilization of a programme developed through the Network for the Improvement of Addiction Treatment for improving patient access and retention) and in the individual coaching of a number of national focal points from developing countries. It had also participated in training and supervision provided by the consortium led by the Integrated Substance Abuse Programs of UCLA (UCLA/ISAP).

56. SSTAR was involved in the Treatnet working group on HIV. The working group's process was probably more important than the end product, even though many of the participants in that working group left before the work had been completed. A disproportionate investment was made by the management of SSTAR to produce the best practice document, which was felt to be of a good quality if not a prize winner in technical terms. There was uncertainty about whether the document had been finalized at the time of the evaluation and about the production and dissemination of the document.

57. SSTAR had developed an efficient system of internal monitoring through standardized protocols and evaluation of interventions.

3. Outcomes, impacts and sustainability

58. Overall, Treatnet has helped to bringing about changes in the centre (for example, an approach that is even more client centred). While the changes would have taken place anyway, the support of an international, UNODC-sponsored, project facilitated and accelerated those changes.

59. Participation in Treatnet has further provided the centre with easy access to substance abuse treatment centres elsewhere in the world and has thus broadened the vision on drug abuse in the centre; it has triggered a process of more intensive involvement in aftercare and strengthened efforts towards the provision of labour for patients as part of the rehabilitation process.

60. As a result of the centre's participation in Treatnet, a number of relationships had been established with other substance abuse and mental health centres in other countries; some of the relationships were still alive. Partnering with one or two other centres was seen to bring benefits to all partners in terms of exchanging experiences and making knowledge available.

61. Participating in Treatnet has given the centre more authority and thus helped it to emphasize the importance of providing substance abuse care in mainstream medicine and health care.

62. SSTAR had contributed, in no small degree, to improving the availability of existing knowledge in the field (in particular with regard to organizing the delivery of an integrated service).

4. Lessons learned and best practices

63. Even for a country such as the United States, which has a relatively sophisticated substance abuse treatment system, the participation of SSTAR in Treatnet has brought about changes in clinical practice that might otherwise have taken place much later. Such changes include the application of motivational interviewing methods, substitution treatment, the more explicit inclusion of HIV counselling and testing in the overall package of services provided and, in general, a more client-centred approach.

64. A global network like Treatnet also benefits from having ready access to the kind of experience and knowledge accumulated by a centre like SSTAR, specifically with regard to the immediate availability of help and the offer of a wide variety of services (ranging from treatment for psychiatric co-morbidity, the provision of assistance in cases of violence against women and a well-structured day-care facility to a residential programme for addicted mothers and their children).

5. Conclusions

65. The following conclusions can be drawn:

(a) *Conclusion 1*: the project objective of linking resource centres around the world has certainly worked for SSTAR, a centre that has actively participated in Treatnet, including by investing funds in order to improve the availability of existing knowledge;

(b) *Conclusion 2*: the move towards an even more client-centred approach in SSTAR has been reinforced by the centre's participation in Treatnet;

(c) *Conclusion 3*: SSTAR has also been active in building capacity in institutions elsewhere by promoting materials of the Network for the Improvement of Addiction Treatment and integrating them into Treatnet;

(d) *Conclusion 4*: the technical capacity available in SSTAR, the exemplary combination of services provided and the dedication of staff make SSTAR a valuable partner in international efforts to bring substance abuse treatment to a higher level of competence and effectiveness;

(e) *Conclusion 5*: participating in Treatnet has given SSTAR additional authority in the region, a recognition that the centre fully deserves as an example of good practice;

(f) *Conclusion 6*: through the participation of SSTAR in Treatnet, additional knowledge and experiences have become available to SSTAR partners in the community and to policymakers and politicians in the area. As SSTAR is well linked to technical and political institutions in the area (Massachusetts and Rhode Island), it has the potential to function as a resource centre and an example of good practice provided it is included in phase two of Treatnet.

6. Persons met in the United States

66. The evaluator met with the following persons (listed in the order in which they were met):

Nancy Paull, Chief Executive Officer, SSTAR (npaull@sstar.org, nancypaull@hotmail.com)

Marilyn Roderick, President Board of Directors (Massachusetts), SSTAR

Arthur Sampson, President Board of Directors (Rhode Island), SSTAR

Patricia Emsellem, Coordinator, SSTAR

Jon Brett, Program Director (Rhode Island), SSTAR

Robert Hitt, Director, Project Aware, SSTAR

Andrew Putney, Medical Director, SSTAR

Sandy Daeganto, Clinical Director, Inpatient service, SSTAR

Crystal Cote, Coordinator, SSTAR

Denise Wright, Registered Nurse, SSTAR

Patty Garber, Project Coordinator, Ontrac, SSTAR (pgarber@sstar.org)

Jackie Roy, Registered Nurse, SSTAR

Barry Bostock, Case Manager, outreach worker, SSTAR

Albert Ruffin, HIV Access Coordinator, SSTAR

Soriya Penn, Case manager, SSTAR

Vaughan Grae Dinsmore, consumer, SSTAR

Willie Cabral, HIV and Hepatitis C Counsellor, SSTAR

Kris Swist, HIV and Hepatitis C Counsellor, SSTAR

Lynn Raposa, Case Manager, SSTAR

Dawn Givens, HIV/AIDS Case Manager, SSTAR

Wanda Cruz, Case Manager, SSTAR

Richard Oates, Clinician, SSTAR

Diane Gouveia, Coordinator, SSTARBIRTH

Ron DiBiaso, Counsellor, SSTAR

Jackie Luz, Case Manager, SSTAR

Erica Saehlin, Counsellor, SSTAR

Genie Bailey, Psychiatrist, SSTAR

Maggie Cook, Coordinator, SSTAR

Lorranne St Pierre, Suboxone Program, SSTAR

Dale Brown, Women's Center, SSTAR

Mandy Crow, Staff (Rhode Island), SSTAR

Cynthia Adams, Registered Nurse (Rhode Island), SSTAR

Steven A. Peligian, Medical Director, CODAC Behavioral Healthcare

Neil A. Corkerey, Executive Director, Drug and Alcohol Treatment Association of Rhode Island (ncorkery@dataofri.org)

Rebecca Boss, Substance Abuse Coordinator, State of Rhode Island

D. Colombia

1. Introduction

67. The evaluator travelled to Medellin, Colombia, from 20 to 24 April 2008 to collect information for the evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89). In Medellin, the evaluator visited the Centro de Atención y Rehabilitación Integral en Salud Mental de Antioquia (CARISMA), a drug abuse treatment facility. Pertinent information was collected mainly through interviews and meetings with project staff and other stakeholders, as well as through the review of many documents related to the project and its various stakeholders.

68. Staff members at CARISMA had carefully prepared the visit in consultation with the Independent Evaluation Unit, the evaluator and the UNODC Country Office in Colombia, located in Bogota. The programme included:

(a) An extensive tour of the centre;

(b) Meetings with the management of the centre;

(c) A special meeting with the previous chief executive officer of the centre (who was the national focal point for the Treatnet project);

(d) A teleconference with the UNODC Country Office in Colombia;

(e) A meeting with users of the service and representatives of user organizations;

(f) A meeting with local experts;

(g) A meeting with the persons who had carried out an internal evaluation in 2005;

(h) A meeting with local mental health and substance abuse policymakers.

69. During the visit, the evaluator was given many documents of relevance to the resource centre and its partners, a copy of the report of the national evaluation carried out in 2005 by the university and a summary of national policies aimed at reducing the consumption of psychoactive substances.

70. CARISMA is a governmental agency located in the western part of the city of Medellin. As the only institute of its kind in Colombia, it provides services for treating both substance abuse and mental illness. According to CARISMA staff members, abuse problems can be caused by legal and illegal substances. The facility has close to 50 beds in its inpatient unit, but also operates a day-care programme and offers extensive educational and prevention services, including through a telephone helpline and a weekly national television programme. The new chief executive officer of the centre, who started working at the centre just a couple of weeks prior to the visit, has a long experience in managing health-care facilities. The centre is well equipped and has a staff of some 40 professionals working in various units.

71. While the quality of the care provided seems to be very good, the centre does not appear to be very accessible since it is located on the western outskirts of the city. There is no public transportation to the facility, there is a high fence around the centre (for security reasons) and the psychological distance for people most in need of the centre's services must be considerable. Outreach efforts are not well developed either, but managers and senior staff at the centre felt that that was an area where progress had to be made.

72. The accessibility issue is to a great extent due to the health-care system: current legislation and the financial situation of the treatment system do not allow for more diversified treatment services. Hardly any financial provisions exist for long-term treatment. Also relevant is the very modest role of primary health care in the treatment of mental health and substance abuse problems, an issue that does not only affect Colombia.

2. Analysis and major findings

73. In Colombia, the issue of mental health and substance abuse is currently receiving more political attention than it used to and has been identified as a priority area for action by the Ministry of Health in the national plan for public health issued in 2007. In addition, the National Policy for the Reduction of the Consumption of Psychoactive Substances and their Impact was introduced in April 2007 by the General Directorate for Public Health of the Ministry of Social Protection. Because Colombia has traditionally given the highest priority to drug supply reduction strategies, that is where the money still goes despite the normative changes.

74. Another problem is the lack of reliable data on the extent of addiction in the country. Although efforts are under way to establish a monitoring centre, at the time of the visit no statistics were available in the country to show the extent of the problem or identify trends. That was regarded as one of the main obstacles to the development of an adequate treatment and rehabilitation system.

75. The treatment of drug users is not a priority in the health and welfare system or in the governmental programmes on drug abuse; treatment and rehabilitation are considered marginal issues. As mentioned in paragraph 73, the emphasis at the national level is very much on drug supply reduction and law enforcement.

76. Nonetheless, there are some positive signs: since April 2007, a White Paper has been developed with the involvement of many partners and governmental bodies, including the Ministry of Social Affairs, the Ministry of Education, the national police and the UNODC Country Office in Colombia. However, the real impact of that paper is, allegedly, limited.

77. The relatively favourable position of CARISMA is partly due to the priority that the local government of the Department of Antioquia, of which Medellin is the capital, gives to the issue of drug abuse and mental health. That is also the reason why Medellin has a relatively extensive system for caring for the homeless, among whom the prevalence of drug abuse is very high. A centre of the quality of CARISMA could not to be found elsewhere in the country.

78. In spite of, or perhaps thanks to, its uniquely favourable situation, CARISMA is in a position to act as an example or as a resource centre for the whole of Colombia and is, in fact, frequently being asked to act in that capacity. However, it often cannot honour such requests because of financial constraints. Thus, although the centre seems to fulfil the criteria for a national resource centre in principle, that role is only being carried out to a limited extent with regard to implementing and improving treatment interventions.

79. The management of CARISMA is keen to continue implementing the changes brought about by the centre's participation in Treatnet in terms of diversifying the services offered and decentralizing the centre, both of which are key features of the centre's planning for the next four years. In that way, the goals of Treatnet are still being pursued.

80. CARISMA seems to be well linked to a number of other relevant institutions in the Department of Antioquia, including universities, institutions dealing with mental health, institutions for socially deprived groups and political entities.

3. Outcomes, impacts and sustainability

81. CARISMA has participated in Treatnet since the beginning of the project, when the centre was invited by UNODC to apply for participation in the network and won the national competition. CARISMA has participated in the Treatnet project by:

(a) Participating in the various international management meetings of Treatnet;

(b) Participating in the training programme led by UCLA/ISAP (one senior staff member participated in training in Los Angeles, United States, and one senior staff member went to Australia);

(c) Participating in the working group on sustained recovery management;

(d) Participating in the international network established through the Treatnet project;

(e) Participating in a regional exchange of experiences programme (two staff members went to Puerto Rico) that resulted from the centre's participation in Treatnet.

82. CARISMA management has ensured that the participation in Treatnet would not be something for a few staff members only but that all staff members would be involved and feel ownership of the project. To achieve that, various methods have been used, such as the provision of continuous feedback from management to the rest of the staff and the implementation of the special Treatnet training programme aimed at transferring the knowledge acquired to all staff. More recently, a process has been started to transfer the newly acquired knowledge also to other institutions; a course was organized for some 80 staff members of the National Plan on Reintegration and yet another course was organized for some 70 persons working in the educational system in Medellin.

83. It was felt that the centre's participation in one of the working groups of Treatnet had been an enriching experience. The result of that participation (the document on best practices concerning sustained recovery management) was felt to be an important draft publication and it was hoped that the document would become widely available.

84. The existence of the network was felt to be very useful in daily practice. At the time of the visit of the evaluator, staff were in regular contact with people elsewhere in the world participating in the network. Such communication would usually not take place through the e-forum but, rather, directly between the individual members of Treatnet. One way in which Treatnet was used was for accessing the Network for the Improvement of Addiction Treatment in the United States. Treatnet's backing of CARISMA was felt to provide strong moral support for the process of change that had been initiated in the centre.

85. One aspect that was also referred to as important for staff and the whole community of CARISMA was the feeling of belonging to an international effort and to a project led by the United Nations, which implied recognition of the work being done. As a result of the participation of CARISMA in Treatnet, the centre had implicitly received "official" recognition by the United Nations of its competence in the field, thus enabling it to disseminate the acquired knowledge and experience to other centres more easily. In carrying out the training activities to staff (its own and that of other centres) CARISMA utilized the material and the models acquired in the course of the project. In giving out a certificate of participation to trainees, they also utilized the logo of Treatnet. At the moment of the visit, there was great confusion in the centre about whether such a practice could be continued or not.

86. The development of a more humanistic approach to drug users was another benefit ascribed to the centre's participation in Treatnet. While the prevailing attitude among staff

with regard to treatment goals had been abstinence oriented, at the time of the visit the dominant attitude aimed at demand and harm reduction. A methadone substitution programme could thus be introduced. While a more disease-oriented (instead of a more criminal justice-oriented) approach might have occurred anyway, it was felt that such a change in attitude had been greatly facilitated and accelerated as a result of participating in Treatnet.

87. Through Treatnet, the development of treatment protocols and standardized processes in the centre had been promoted. The availability of standardized treatment protocols and treatment processes and the monitoring of their use could be observed. This development too might have taken place without participation in Treatnet, but it was certainly accelerated as a result of such participation. At the time of the country visit, CARISMA was using standardized processes and protocols for treatment that were most certainly not common practice for most drug treatment centres, especially not in Colombia. There was also a system in place to constantly evaluate activities. All of those features were greatly enhanced by the participation in Treatnet.

88. In Colombia, Treatnet has also helped to draw more attention at the national level to the need for drug treatment and demand reduction instead of making huge investments for reducing the supply of drugs.

4. Lessons learned and best practices

89. One of the lessons learned was that it is possible to introduce and accelerate the implementation of more evidence-based treatment practices. This move, initiated by Treatnet, could effectively take place because of a number of favourable "environmental" factors:

(a) A Government policy that promoted, at least morally, the prioritization of drug treatment and rehabilitation;

(b) A local government (that of the Department of Antioquia) that was very supportive of strengthening drug demand reduction policies;

(c) Good relations between the management of the centre and important stakeholders, such as local politicians and policymakers, and between the management of the centre and that of Treatnet.

90. In comparison with other parts of the health and welfare system and the facilities for drug users, CARISMA certainly had a privileged position. Such a privileged position did not hamper the possible dissemination of knowledge acquired in the course of participation in Treatnet to other parts of the system at the national, regional or international levels. On the contrary, the UNODC "stamp of approval" provided the centre with additional authority to act as a pioneer and serve as an example.

91. The uncertainty over the continuation of Treatnet and the possible participation of CARISMA in phase two of Treatnet had paralyzed progress made to date both in the centre and among important partners such as the department of mental health in the local government and relevant staff at the UNODC Country Office in Colombia in Bogota.

92. It might have been a good idea to establish links with the work of other United Nations bodies, other international organizations or broader social movements. The absence of entities like WHO was felt to be a missed opportunity to make the project stronger and provide it with more authority within health and welfare circles. While the absence of WHO might be in part attributable to the management of Treatnet, it might also

be due to the fact that in Colombia the work of UNODC is very much identified with supply reduction strategies, thus limiting the scope of possible partners.

5. Conclusions

93. The following conclusions can be drawn:

(a) *Conclusion 1*: in Colombia, the primary goals of phase one of the Treatnet project had been achieved: the resource centre was connected to the rest of the global network and Treatnet had brought about changes in the practices of the centre and in the competence and attitudes of staff, who had adopted a more client-centred and evidence-based approach to treatment. CARISMA had participated actively in the network, had benefited from the training activities and had been actively involved in one of the working groups;

(b) *Conclusion 2*: CARISMA is in a good position and has now the goodwill and reputation required to become instrumental within and beyond the borders of Colombia in improving the treatment and rehabilitation system. If CARISMA received the necessary support, it could serve as an example and resource for other centres in Antioquia and in the rest of the country. Professionals from other centres could come and learn at the centre. CARISMA could build a network of national and international reach. Depending on the available resources, it could function as a training and capacity-building centre;

(c) *Conclusion 3*: CARISMA staff and the local government had made serious investments in the centre in order to assist its development as a centre of excellence within the framework of Treatnet. Interrupting that development would have negative consequences for service delivery in CARISMA and damage the goodwill and reputation of the centre, which would then be less able to serve the system as a whole. The opportunity created through Treatnet would disappear. Expectations from the centre and its staff and many other stakeholders that CARISMA would be able to participate in a phase two of the Treatnet project were high. It seemed important, also for the image of UNODC, to rapidly clarify the situation and lay out the possibilities for future development;

(d) *Conclusion 4*: the goals of Treatnet would have been easier to achieve had the project explicitly included policy recommendations and had it made appropriate links with the policymaking process. Influencing the treatment system requires appropriate policies. Without such policies, capacity-building becomes an isolated and unsustainable activity. It is necessary for such activities to be imbedded or integrated into a policymaking process. In Colombia, the move initiated by Treatnet happened to coincide with policy changes taking place in the country (and in the community), thus providing some guarantee of sustainability;

(e) *Conclusion 5*: CARISMA might well fulfil the role of national or international resource centre in the region. The knowledge, capacity, reputation, backing of the local political leadership and the dedication of its staff are there. However, taking on such a role would require additional resources and the full involvement of the UNODC Country Office in Colombia;

(f) *Conclusion 6*: mainstreaming the project or integrating it into other major approaches to social problems (in particular, social exclusion and poverty) would strengthen the project and, maybe, attract additional resources. In that connection, establishing links with the work of WHO and the United Nations Development Programme, in particular, would give the project (and the centre) better opportunities and more authority within the health system and socio-economic reform process.

6. Persons met in Colombia

94. The evaluator met with the following persons (listed in the order in which they were met):

Carlos Arturo Restrepo, Gerente, CARISMA

Francisco Sierra, Coordinador Asistencial, CARISMA

Diana Valencia, Coordinadora promoción y prevención, CARISMA

Claudia Álvarez, Comunicadora social, CARISMA

Luis Fernando Giraldo, Coordinador equipo terapéutico, CARISMA

Claudia Ceballos, Asesora Jurídica y control interno, CARISMA

Luz Amparo Patiño, Enfermera jefe hospitalización, CARISMA

Carlos Herrera, Médico Psiquiatra, CARISMA

Leonor Arango, Médica especialista en fármacodependencia, CARISMA

Martha Cecilia Arroyave, Líder de Calidad, CARISMA

Natalia Arango, Trabajadora Social, coordinadora oficina atención al usuario, CARISMA

Paulo Andrés Ossa Benítez, President and Representative of the Asociación de Usuarios, CARISMA board of directors

Socorro Benítez, Secretaria Asociación de Usuarios, CARISMA board of directors

Alexis Vladimir Benito Devia, Representative of the scientific sector, CARISMA board of directors

Mario Alberto Zapata Vanegas, ex gerente ESE CARISMA and national focal point of Treatnet, CARISMA board of directors (mzapatav@une.net.co)

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Diana Patricia Salazar, Asesora Departamental para la Juventud

Marco Antonio Pedreros Rivera, Comandante, Policía Metropolitana del Valle de Aburra

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Annex IV

Summary of telephone interviews with stakeholders in Kenya, Mexico and India and staff in UNODC field offices

1. Introduction

1. Various sources were used to carry out the external evaluation of Phase One of the Core Programme on Treatment and Rehabilitation: Dissemination of Best Practices and the International Network of Drug Dependence Treatment and Rehabilitation Resource Centres (Treatnet) (project number GLO/H43-E89), including: documents on the project, its activities and its partners; field visits to four resource centres; and telephone interviews. The present annex provides a summary of the telephone interviews held with the focal points and other staff at resource centres in Kenya, Mexico and India, as well as with staff of the United Nations Office on Drugs and Crime (UNODC) in field offices in those countries (see paras. 28-30 for lists of persons interviewed).

2. The telephone interviews had been planned by the Independent Evaluation Unit of UNODC in consultation with the persons concerned and the external evaluator. The telephone conversations, which typically lasted between 60 and 90 minutes, were held in March and April 2008.

3. The resource centre in Kenya is the Drug Rehabilitation Unit at Mathari Hospital in Nairobi, but the psychiatric hospital in Mombasa is also involved. The Drug Rehabilitation Unit was established in 2003. In the course of the Treatnet project, some personnel changes took place so that the current head of the unit was not involved from the start of the Treatnet project.

4. The Centros de Integración Juvenil in Mexico is a relatively big governmental agency for the rehabilitation of drug users with many treatment centres throughout the country. Its scope is also broad, including residential treatment, outreach and outpatient programmes and educational programmes on addiction in general.

5. The resource centre in India is called the TT Ranganathan Clinical Research Foundation and is based in Chennai. The centre is a non-governmental organization that was established in 1980. It offers a wide range of services, from residential addiction treatment to training and prevention programmes.

6. Two of the centres did not only work for drug users; the central focus of the centre in Kenya was on mental health, while the centre in India worked also for people with alcohol problems and people with other psychosocial problems. The centre in Mexico worked mainly with young people but also with adults, dealing with drug abuse, alcohol problems and other addictions.

7. All the centres were known to UNODC prior to the start of the Treatnet project.

2. Analysis and major findings

8. All resource centres participated fully in the various components of the Treatnet project. All were involved in the networking aspect of the project through their participation in project management meetings (in Kenya, however, the main person involved in the project did not always participate in the management meetings because of the changes in staffing), training sessions (part of the capacity-building component) and, albeit to varying degrees, in the working groups.

9. The experience gained through networking was unanimously regarded as very positive and as providing many learning opportunities, exposing staff to previously unknown ways of working with drug users, providing recognition and a feeling of moral support for the difficult work the centres were carrying out, and establishing working relationships globally aimed at improving services for drug users. In some cases, the flow of communication that had started in the course of Treatnet meetings had been kept up, for example in the case of the focal point in India, who mentioned that she continued to communicate, more or less regularly, with some seven members of the Treatnet network. That focal point also said that there had been some unexpected side effects, for example the opportunity for a Canadian non-governmental organization to liaise with and support tsunami-affected communities in Sri Lanka through contacts made through Treatnet.

10. The e-forum was used sporadically and not by all. Some did not make use of the e-forum because they had problems accessing the Internet, while others perceived the e-forum to be user-unfriendly.

11. Participation in the train-the-trainer courses was rated by all as a very positive experience. The courses, faculty and training materials were regarded as being very relevant for improving the provision of services in the resource centres. The follow-up training was implemented without any great problems in the resource centres. None of the problems encountered had to do with the technical content, but with a lack of resources (a relatively small amount of money might have been provided to cover, for example, the costs of photocopying or travelling for course participants). That aspect of the programme implementation had not been fully recognized by the managers of the project. In the case of India, the resource centre was successful in finding additional resources from external sources to cover the costs of follow-up training activities. The availability of training materials in the form of PowerPoint presentations and slides greatly facilitated the provision of the training sessions.

12. Of the various training modules presented, the assessment and brief interventions module was found to be particularly useful. Both in India and Mexico the Addiction Severity Index had been translated into the local languages and was being used routinely to assess patients at the intake stage. Adapting the Index to the local context was found to be a minor issue, as only some relatively small changes had to be made. It was felt that the introduction of the Index had also contributed to improving monitoring, data collection and patient administration.

13. Although not everything in the training courses was new or immediately useful (for example, introducing substitution treatment would not have been legal in Kenya), in general the course offered new perspectives on how to treat for substance abuse and prompted many participants to approach drug users in a different way. While the more usual way of approaching the drug user or patient would be to give him or her instructions on what to do, the new approach would be to motivate the patient towards changing their behaviour.

14. Staff in the resource centres had been trained as planned and efforts were under way to train staff in other institutions as well. In Mexico, training materials had been disseminated widely to non-governmental and governmental institutions.

15. The persons interviewed were involved in the working groups to varying degrees: some rather intensively (the focal points from India and Mexico) and others marginally or not at all. The value of this part of the project was also interpreted differently: either very positively (because, for example, of the fact that concrete case studies from developing countries had become available for others to learn from and apply to their own

environment) or neutrally. Those participating in the working groups felt that this provided the most substantial way of working with colleagues in other parts of the world.

16. All staff at UNODC field offices were very positive about their involvement in the running of the project. They felt very involved in the setting up of the project, having participated also in the management meetings. As the project progressed, the role of the field offices became less prominent to the point that they had no role in the implementation of the project. It was felt that the "regionalization" of the project would have brought additional benefits and it was hoped that the field offices would play a more important role in the follow-up to phase one.

3. Outcomes, impact and sustainability

17. All the national focal points and their staff to whom the evaluator could speak in the course of the evaluation were very positive about the project as a whole. The training in particular was perceived as an excellent opportunity to become acquainted with modern therapeutic techniques and treatment procedures. Staff in the resource centres were trained in the new methods and applied their newly-acquired capabilities. In India and Mexico, activities were also undertaken to teach the new methods to peer agencies of the institutes.

18. In Kenya and Mexico, in particular, it was felt that participation in Treatnet had also had a positive effect on substance abuse policymaking: it confirmed the need to invest more in demand reduction activities and at the same time gave confidence to staff of their capabilities. A good relationship with Government existed, in particular, for the centre in Kenya (a governmental institution that is also the principal hospital for mental health in the country) and the centre in Mexico (a national governmental centre for the treatment of addiction). The nature of the relationship between the Government and the centre in India, which is a typical non-governmental organization, was less clear.

19. Much of the provision of specialized services in developing countries is in the hands of non-governmental organizations. To date, there has been relatively little control over the quality of the service provision. In Mexico, for example, some 95 per cent of treatment agencies are non-governmental organizations and the role played by non-professionals is substantial. In such a situation, it is all the more important to upgrade the quality of service provision, which is why the Treatnet strategy to invest in such activities and to focus on capacity-building was felt to be correct. The availability of training materials (once translated) was considered to be a guarantee that the activity would not remain just a one-time event but that its effects on daily practice throughout the entire agency would continue.

20. However, some of the people interviewed felt that the project should focus more on the primary health-care system instead of on specialized services. After all, many developing countries offer very few specialized health and welfare services and often cannot even afford to have more than one or two psychiatric hospitals for the whole population. Given such constraints and the fact that specialized services would not be able to cater for the entire population, the conclusion was that the focus should be on the primary health-care system.

21. In that connection, some of the persons interviewed referred to the potential role of the World Health Organization (WHO) in the project. It was argued that WHO would be better suited than UNODC to have an impact on the primary health-care system; nonetheless, the role of WHO in this project at the country level was more or less non-existent.

22. Likewise, some respondents referred to the need for more cooperation with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. In order to play a role of some significance in countries experiencing an HIV epidemic, some form of integration into the initiatives supported by the Global Fund are necessary. Although Treatnet did not exclude such cooperation, it did not establish any structural relations with organizations working on HIV/AIDS either.

23. In all three centres, it was felt that a greater emphasis on regional cooperation (even at the expense of global cooperation) would be beneficial. Various regional cooperation structures were available and it was argued that Treatnet could have benefited more from such regional opportunities. Some of the products of the Treatnet project would be used in regional cooperation projects, for example in Central America. In that regard, it was pointed out that the travel expenses would have been lower had regional opportunities been used more intensively.

24. All those interviewed felt that the Treatnet project should be continued, in some form or other, so as to ensure the proper follow-up of actions started within the resource centre and beyond and to ensure the good utilization and dissemination of the manuals and good practice documents produced in the course of phase one.

4. Lessons learned

25. It was important that the capacity-building component of the project produced replicable training materials and models. This facilitated the opportunities for wider dissemination and for application of the training courses in situ.

26. Another lesson learned concerns the need to take fully into account the local situation before the principal strategy is chosen. The Treatnet project chose to focus on specialized institutions. While that might be the appropriate choice in countries where a specialized health and welfare system is already in place, it might not be in countries where there are hardly any specialized health and welfare services available. In the latter case, it seems appropriate to also involve the support systems for primary health care to make sure that, ultimately, the target population is reached.

5. Conclusions

27. The following conclusions can be drawn:

(a) *Conclusion 1*: Treatnet had a positive influence on capacity-building in the resource centres concerned. Everywhere it was felt that there was a noticeable improvement in service delivery, in the sense that staff were better equipped to deal with patients and drug users as a result of the training provided;

(b) *Conclusion 2*: the working groups had little influence on the daily practice of the resource centres, but participation in them did, however, result in a concrete way of working together with other professionals elsewhere in the world on a document that was regarded to have positively influenced service delivery at the macro level;

(c) *Conclusion 3*: through the project, it was possible to link a participating centre with (national or subnational) substance abuse policymaking mechanisms. That came about in the case of the centre in Kenya because the participating resource centre was already linked to policymaking institutions. In order to increase the sustainability of the project's outcomes, the links with policymaking institutions might have to be made more explicit;

(d) *Conclusion 4*: every person interviewed was keen to continue working towards the objectives of Treatnet (building capacity for treatment and rehabilitation) and be involved in a phase two of the project. It would be appropriate to make more use of regional structures, including the field offices, to ensure that the project takes fully into account local circumstances and is in a position to disseminate better the acquired knowledge and project products.

6. Persons interviewed over the telephone

28. The following persons in India were interviewed over the telephone:

Shanthi Ranganathan, Director, TT Ranganathan Clinical Research Foundation, Chennai (ttrcrf@md2.vsnl.net.in)

Jayasree Subramanian, Counsellor, TT Ranganathan Clinical Research Foundation, Chennai

Aditi Ghanekar, Counsellor, TT Ranganathan Clinical Research Foundation, Chennai

Adline Andrews, Counsellor, TT Ranganathan Clinical Research Foundation, Chennai

Ashita Mittal, Officer-in-Charge, UNODC Regional Office for South Asia (ashita.mittal@unodc.org)

29. The following persons in Kenya were interviewed over the telephone:

J. A. Kisivuli, Head, drug dependence unit, Mathari Hospital, Nairobi (manuazenga@yahoo.com)

Reychad Abdool, Drug Abuse and HIV/AIDS Adviser, UNODC Regional Office for East Africa (reychad.abdool@unodc.org)

30. The following persons in Mexico were interviewed over the telephone:

Eduardo Riquelme, Subdirector, Centros de Integración Juvenil AC (eduardoriquelme876@hotmail.com)

Rubi Blancas, Project Coordinator, UNODC Regional Office for Mexico and Central America (rubi.blancas@unodc.org)

Annex V

List of persons consulted

A. Persons consulted at UNODC headquarters

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Stefano Berterame, Chief, Prevention, Treatment and Rehabilitation Unit (stefano.berterame@unodc.org)

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Christian Kroll, Global Coordinator for HIV/AIDS, HIV/AIDS Unit (christian.kroll@unodc.org)

Fariba Soltani, Expert, HIV/AIDS Unit (fariba.soltani@unodc.org)

B. Staff of the Integrated Substance Abuse Programs of the University of California at Los Angeles consulted over the telephone

Rick Rawson, Director (RRawson@mednet.ucla.edu)

Anne Bellows, Project Director (ABellows@mednet.ucla.edu)

C. Stakeholder consulted by e-mail

Antonio Jesús Molina Fernández, Asociación Proyecto Hombre, Proyecto Hombre Granada (amolina@proyectohombregranada.org)

D. Peer reviewer of the external evaluation

Prof. Gerhard Bühringer, Director of the Institut für Therapieforschung in Munich, Germany, and Professor for Addiction Research at the Technische Universität in Dresden, Germany (buehringer@ift.de)

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