Mendel University in Brno
Faculty of Regional Development and International Studies

COMPARATIVE REASEARCH ON DRUG ADDICTION TREATMENT IN THE CZECH REPUBLIC, PERU, AND NICARAGUA

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Brno, 2015

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Abstract

The main topic and purpose of the thesis is to compare and contrast different inpatient addiction treatment methods used in particular institutions in the Czech Republic, Peru and Nicaragua. In the first part of the thesis there are different inpatient addiction treatment methods described in terms of specific environment and methods of treatment. The other part of the thesis is devoted to the comparative research based on the content analysis of 15 semi-structured interviews with inpatients in three particular treatment centres in the Czech Republic, Peru, and Nicaragua. The comparative research provides a background for the grounded theory development and brings conclusions. Conclusions of this thesis contain information and proposals for development in drug addiction treatment approaches inspired by different socio-cultural context of the treatment methods.

Keywords: drug addiction, treatment, therapeutic community

Resumen

El tema y el objetivo principal de la tesina es comparar y contrastar diferentes métodos de tratamiento de adicción utilizados en instituciones concretas en la República Checa, Perú y Nicaragua. En la primera parte de la tesina diferentes métodos de tratamiento de adicción de pacientes hospitalizados se describen en términos de ambiente y de métodos de tratamiento específicos. Otra parte de la tesina se dedica a la investigación comparativa basada en el análisis del contenido de 15 entrevistas semi-estructuradas con pacientes hospitalizados en tres concretos centros de tratamiento en la República Checa, Perú y Nicaragua. La investigación comparativa proporciona un fondo para el desarrollo de la teoría fundamentada y aporta conclusiones. Conclusiones de esta tesina contienen información y propuestas para el desarrollo de posturas de curación de drogadicción inspiradas en diferente contexto sociocutural de los métodos de tratamiento.

Palabras clave: drogadicción, tratamiento, comunidad terapéutica

List of Abbreviations

AA	Alcoholics Anonymous
ASI	Addiction Severity Index
CEA	Centro de Especialidades en Adicciones
CNLCD	National Anti-Drug Council
DAYTOP	Drug Addicts Yielding to Persuasion
DEVIDA	The National Commission for Development and Life without Drugs *(Comisión Nacional para el Desarrollo y Vida sin Drogas)*
EEA	European Economic Area
EFTA	European Free Trade Area
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EUROPAD	European Opiate Addiction Treatment Association
GCDPC	The Government Council for Drug Policy Coordination in the Czech Republic
IC & RC	International Certification and Reciprocity Consortium
ICAD	Institute against Alcohol and Drug Dependence
INCSR	International Narcotics Control Strategy Report
LSD	Lysergic acid diethylamide
MDMA	3,4-methylenedioxy-methamphetamine
MPSV	Ministry of Labour and Social Affairs in the Czech Republic
NGO	Non-Governmental Organization
Popol NA	Foundation for the Promotion and Municipal Development
RIDET	Information Network on the Demand for Treatment concerning Abuse or Dependency of Psychotropic Substances
UCLA/ISAP	University of California Los Angeles/Integrated Substance Abuse Program
UNODC	United Nations Office on Drugs and Crime
WFTC	World Federation of Therapeutic Communities
WHO	World Health Organization

Contents

F Informed Consent Form

1 Introduction

"Every form of addiction is bad, no matter whether the narcotic be alcohol, morphine or idealism" (Jung, 2011).

The addiction is a contentious and compound expression that has different meanings for different people according to Ray & Ksir (2002). Other authors say that there are somewhat positive addictions for instance work or exercise (Sussman & Sussman, 2011). However, the same authors claim that all addictions could lead to negative effects. It is assumed in this thesis that addiction with its potentially negative consequences should be eliminated. The thesis seeks to identify drug addiction treatment methods in selected socio-culturally diverse countries to construct unique cross-cultural comparison and propose opportunities for development in the field of drug addiction treatment.

Therefore, the main topic of the thesis is to compare and contrast different inpatient[1] drug addiction treatment methods used in particular institutions in the Czech Republic, Peru and Nicaragua. Prior to the comparative research in particular institutions, it is significant to understand general status of drug addiction treatment in the selected countries. Thus, the analysis of current and previous ways of dealing with drug addictions in the Czech Republic, Peru and Nicaragua is performed. The assessment of international assistance level in drug addiction treatment is essential for identification of the international concern intensity in the field of drug addiction treatment and possible shortcomings indication.

For the purpose of the drug addiction treatment comparative research in three particular institutions in selected countries, it has been recorded all together 15 semi-structured interviews in all selected therapeutic communities (TCs). Afterwards, the content analysis of the interviews will be performed, followed by a comparative research which will brought grounded theory and conclusion of the thesis.

[1] The participation of inpatients in treatment is rather long-term and creates conditions for cohabitation in a therapeutic community (TC) with its therapeutic effects.

The conclusions provide information about the summary of comparative research and proposals for development in the field of drug addiction treatment based on grounded theory. The conclusions validate or invalidate the hypothesis whether the drug addiction treatment in the Czech Republic, Peru and Nicaragua is diverse and offers space for development in the field of drug addiction treatment inspired by different socio-cultural setting and methods of treatment in selected countries.

2 Methodology

The aim of this chapter is to describe the utilized methodology performed throughout the thesis. In the chapter below will be explained the approach of data mining, data processing and data analysis with the appropriate tools.

2.1 Quantitative Data Mining

The instrument utilized for quantitative data mining is called DCI (Dimensions of Change Instrument). The processed quantitative data were used as a basis for qualitative data mining which were crucial for semi structured-interviews recording, content analysis performance and the grounded theory construction which has brought the conclusions of the thesis.

The DCI instrument is a self-administered questionnaire which was developed to measure retention of in-patients in TCs. It has been tested and approved by RAND Institute in the USA. The Instrument was translated into Spanish and Czech and has been utilized for research with written permission of Dr. Maria Edelen Orlando, Ph.D (Edelen, Wenzel, Ebener, Edwards, Mandell, & Becker, 2006).

It determines the procedure of treatment in residential therapeutic community background. It sums up eight features of treatment procedure from a client/patient viewpoint: "*Community Responsibility*; *Clarity and Safety*; *Group Process*; *Resident Support*, *Sharing and Enthusiasm*; *Introspection and Self-management*; *Positive Self-Attitude and Commitment to Abstinence*; *Problem Recognition*; and *Social Network*" (Ibid.).

The scale consists of 54 entries which were created derived from a conceptualization that the treatment procedure composes of the community setting within the program, in addition to a clients'/patients' personal growth for the duration of the treatment. All entries are formulated in a positive manner and request respondents to specify their degree of agreement on a 5-point scale (1 = Not at all to 5 = Completely), where higher scores are sign of a greater degree of agreement (Ibid.).

The DCI was meant to assist with providing clinicians and program directors with a measure which would be utilized continuously in order to advance the program which would as a result enhance the outcomes of the treatment and therefore advance the quality of the treatment (Ibid.).

The quantitative data gathered by DCI Instrument are fundamental for the diploma thesis comparative research analysis and its conclusions. The further qualitative data collection and semi-structured interviews recordings allow the performance of content analysis, construction of a grounded theory based on the analysis and will brought conclusions.

2.2 Quantitative Data Processing

The quantitative data acquired by DCI Instrument were transcribed and subsequently statistically analyzed using statistical methods (Tukey's HSD test and method of confidence interval) to assess the changes in motivation of patients/clients to finish the treatment programme. Moreover, some key variables were identified on the DMI scale (Horák, Verter, & Somerlíková, 2014). Those key variables were the background for further qualitative research via semi-structured interviews performed in therapeutic communities in Peru, the Czech Republic and Nicaragua. The data from the ultimate outcomes (semi-structured interviews) were utilized as a source for following thesis. The semi-structured interviews were utilized to carry out a content analysis which is necessary for comparative research and subsequent grounded theory formation. The methodology utilized to perform the content analysis and comparative research to support the hypothesis is based on a book by Strauss & Corbinová (1999).

2.3 Qualitative Data Mining

The data has been collected by performing qualitative research via recording 15 semi-structured interviews in therapeutic communities: *Sejřek* in the Czech Republic, *Takiwasi* in Peru and *CEA* in Nicaragua with the informed consent of interviewees (see Appendix F). It has been carried out by Dr. Horák and the assistant of the project who is the author of this thesis as well. Prior to the qualitative research, there has been also quantitative research performed by Dr. Horák together with the assistant of the project.

The results of the quantitative research brought outcomes significant enough to be further analysed and utilized for advanced qualitative research. The ultimate results of qualitative research were presented by Dr. Horák as results of the project *"Efektivita léčby."*

An important part of the project is research which would deal in detail with the valuable data gathered by the qualitative research in order to perform a unique cross-cultural comparison research in the field of drug addiction treatment in three socio-culturally diverse countries. And this is the idea behind the following diploma thesis. The semi-structured interviews consist of questions on several topics (see Appendix E), the most significant questions concerning drug addiction treatment in diverse socio-cultural settings were utilized for comparative research and grounded theory construction.

2.4 Qualitative Data Processing

After the mining procedure has come to the end, the data processing part is to be triggered off. Significant role in data processing plays MS Excel which allows the author to sort the data from semi-structured interviews accurately and establish a system of the processing activities. Sorted data serve as a background for a content analysis. The analysis acts like a background for comparative research and grounded theory. The data are classified according to the place recorded in separated MS Excel sheets.

2.4.1 Open Coding

Once the data are sorted in MS Excel, the content analysis of the data is allowed to start. The utilized methodology was introduced by Strauss & Corbinová (1999) and the following Methodology sub-chapters are referring to the book and the particular method of qualitative research. This *open coding* part of the analysis deals with *categorization* and labelling of *concepts* while studying the data.

The data acquired via recording of 15 semi-structured interviews has been carefully read through first to identify *codes* (similarities within the data), thereafter the *concepts* were labelled (e.g. faith in drug addiction treatment) and *categories* were derived quite naturally afterwards (e.g. spirituality and religion in drug addiction treatment). Majority of answers in every interview in all of the therapeutic communities were assigned to a most suitable category. For illustration, assuming that the patient/client responded*: "... yes, drug abuse caused a lot of problems in my family life,"* it would be assigned to a category called: *"Family problems as a drug abuse consequence."*

As a result a certain pattern and repetition among the categories has been observed which lead to a construction of *key categories*. By identifying the key categories we have a sufficient background for *axial coding* which is another stage of the analysis which leads to a creation of *grounded theory*. The *central category* is identified based on similarities among *key categories* which correspond with the names of the sub-chapters in chapter 4, *Cross-Cultural Comparative Research on Drug Addiction Treatment.*

2.4.2 Axial Coding

The actual axial coding means putting categories and subcategories in relations using *paradigmatic model*, see Fig. 1.

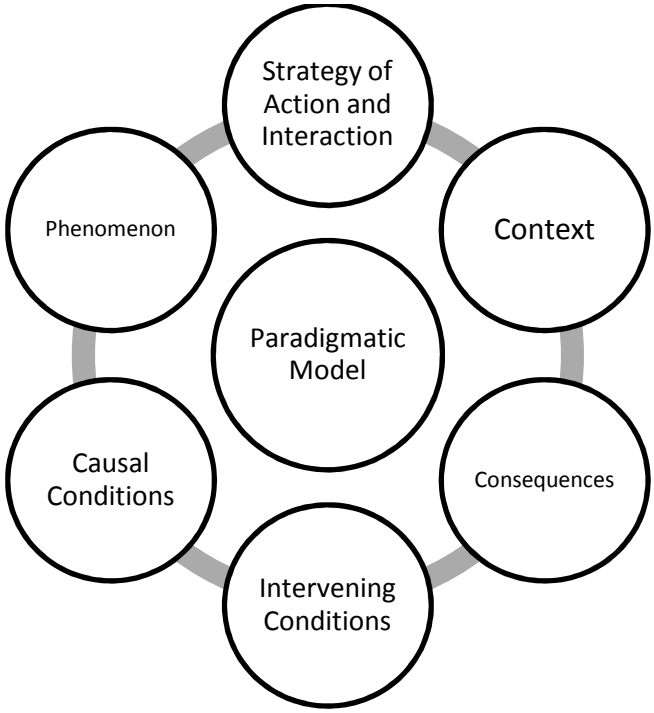

Fig. 1 Paradigmatic Model

Source: Author's Archive

Paradigmatic model is necessary to use in order to reach a desired *grounded theory.* Connecting categories and subcategories using paradigmatic model is essential for identification of *causal conditions* which are events that lead to the occurrence of the *phenomenon*. For instance, to identify causal conditions of category called *"Spirituality and Faith,"* it is crucial to propose a question: *"Why patients/clients usually do believe in something?"*

Thereafter, the phenomenon needs to be defined: *"What are the data related to? What is the interaction/action about?"* The phenomenon must be described within a *context*, which is a set of properties which belong to the phenomenon. For instance, the context of *"Spirituality and Faith"* can be a specific description of a religion or a God which a patient/client is inclined to.

However, fundamental parts of the context are also *conditions* and *strategies*. Context means placing the events or cases of phenomenon on dimensional scales. Placing a phenomenon on dimensional scales means depicting its properties. These properties can be further defined by spreading it on dimensions. For example, property of *"faith"* can be *"blind faith"* and dimension of *"blind faith"* can be *"everlasting blind faith."*

Thus, context indicates placement of events or cases of phenomenon on dimensional scales and it is also set of conditions under which strategies of actions or interactions define managing/controlling/performing/responding to the phenomenon. An instance of context related to *"faith and spirituality:" "I believe in myself since I have been here in therapeutic community and it helps me believe in my recovery as well."* In this sentence *"believe"* represents *the phenomenon*, *condition* is the *"... here in therapeutic community"* and *strategy* is *"... it helps me believe in my recovery,"* it is a response to *the phenomenon.*

Last two essentials to be identified in order to connect categories to each other are *intervening conditions* and *consequences.* Intervening conditions either facilitate or complicate the use of strategy of acting or interaction in certain context. The conditions are usually: "*time, space, culture, technical or economical status, history, biographical data, occupation,"* etc.

A specific instance of intervening condition in the context of *"Faith and Spirituality"* can be: *"I believe in myself since I have been here in therapeutic community, it helps me believe in my recovery, but sometimes I am losing my faith in recovery, because of my previous relapse."* It is also important to track the *consequences*, because what is at some point a consequence of acting or interaction might be later part of condition of other acting.

Axial coding stands for putting categories and subcategories in relations using paradigmatic model, which parts were explained above. The actual relation is created by question which results (if proven by data from content analysis) into *statement* which is the base for grounded theory. An instance of such statement and question in the context: *"I am addicted and I am using certain personal strategies to support the treatment.", "What strategies do you use to support your recovery from addiction?"*

It is crucial to check the questions that put the categories and subcategories in relations in data and seek evidence that prove or invalidate the questions. The data also should be tracked for patterns on dimensional scale that relate to the properties of the phenomenon. Such as, *"... differences and regularity in faith or spiritually loaded activities among patients with different period of time spent in therapeutic community."* Recording regularities is a basis for the *Selective Coding.*

2.4.3 Selective Coding

In selective coding, a *central category* is identified. This category is usually being put together in relation with the rest of the categories. Subsequently, a frame of the story is to be created. It is significant to ask certain questions to spot the frame of the story: *"What is most surprising? "What is the biggest issue here?" "What phenomenon is repeatedly evident in the data?" "What is most important in this field?"*

Following steps are similar to axial coding it is required to put categories and subcategories in relation to the central category according to the paradigmatic model. The categories must be put together in relation on dimensional level. These relations have to be checked and proved in the data from the content analysis and to be amplified and clarified as needed. The *central category* identified in the thesis is included in the names of the chapters in the comparative research and it is the diverse *drug addiction treatment* in each of the three socio-culturally dissimilar settings.

2.5 Grounded Theory

Grounded theory is a method of analysis which uses constant comparison and questions proposing. It also puts focus on action or interaction oriented on managing/controlling/performing/responding to a *phenomenon* which is present in a certain context in every research. A key action to develop a grounded theory is to search for differences and its specifications among and inside categories, as well as similarities among and inside categories.

To form a grounded theory it is necessary to connect categories derived from *data* within *paradigmatic model* (see Fig. 2) and to integrate a *process* into analysis. The *process* arises usually naturally throughout the performance of the analysis, because it is the connection of certain actions and interactions within categories. Significant terms for grounded theory are deduction (suggestions, proposing) and induction (authentication), the combination of both forms grounded theory.

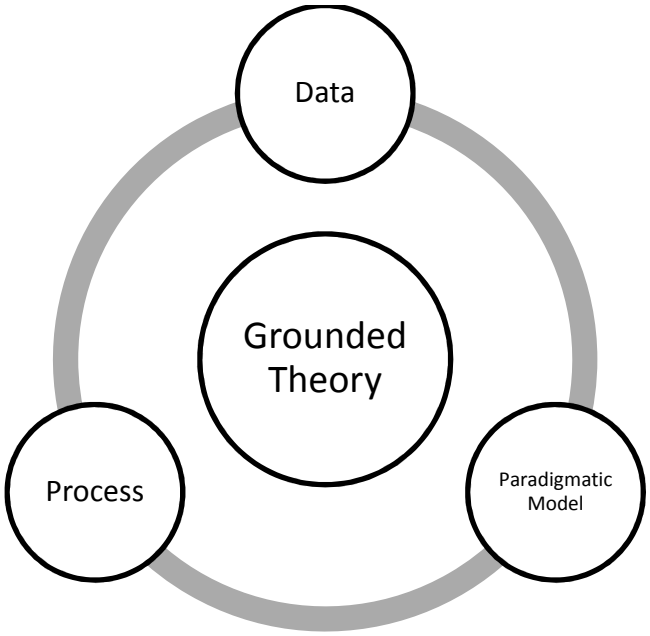

Fig. 2 Grounded Theory

Source: Author's Archive

An instance for such process can be an answer to a following question: *"What do we do to treat drug addiction in two particular therapeutic communities in different socio- cultural settings?"* This question consists of two categories and thus also two diverse actions how to deal with drug addiction in different socio-cultural settings. The answer and thus also the statement that forms grounded theory can be for instance, *"the utilization of plants"* to treat drug addiction treatment in one setting and in another it could be *"spirituality."*

Always, after constructing such statement, it is necessary to go back to content analysis and check whether the statement correlates with the data. This authentication explains reason why grounded theory is called grounded – it is grounded in data. The ultimate grounded theory comprises of categories, dimensions and statements about relations, which are actually present in the data.

2.6 Data Processing Languages

It is important to indicate, that the whole process of data mining has been performed both in the Czech and Spanish language, due to the locations of selected countries and the nationalities of interviewed in-patients. Nonetheless, data processing and content analysis have been completed in the Czech language. The reason behind this choice is higher degree of sensitivity while analysing the content in author's native language as opposed to the opposite approach.

The thesis is supposed to be written in English, considering the author's language of studies. Therefore, the results derived from content analysis (concepts, categories, key and central categories) were subsequently translated into English language in order to develop a grounded theory in English language.

Also the methodology book by Strauss & Corbinová (1999) was utilized in its translated version in Czech language. The motive of this decision is again the degree of sensitivity while studying the grounded theory method which is rather sophisticated and relying on good comprehension of concepts which is more accurate in one's native language.

2.7 Limitations of Research

The author is aware of the limitations of the research and consider as necessary to inform the readers as well. The sample of both patients/clients and TCs in all three selected countries is limited. Generally, in TCs the number of patients/clients is theoretically maximum up to 15 participants in treatment. For the purposes of the thesis were utilized 5 recorded semi-structured interviews in each of the TCs. Though, it has been evaluated as sufficient number with regards to the extensive data containing each of the interviews and regarding the requirements for diploma thesis and the supervisors' recommendation.

Also the choice of TCs was limited due to geographical distances, financial resources and available data. However, the choice of TCs was based on diverse approaches in drug addiction treatment which might or might not represent distinctive local culture, which is not precisely known due to insufficient data concerning the inpatient treatment in some of the localities. Nonetheless, the diverse methods are interesting enough to be analyzed and compared for the purposes of cross-cultural development.

3 Drug Addiction Treatment in Different Socio-Cultural Settings

3.1 Introduction

According to National Institute on Drug Abuse in the United States (NIDA), there are numerous universal types or modalities of addiction treatment programs. Most of them start with detoxification, which clears body from drugs, but certainly is not able to solve social, psychological or behavioural problems which are linked to addiction. The essential behavioural changes which bring the recovery are ought to be resolved by the follow-up treatment (Adler, Brady, Brigham, Carroll, Clayton, Cottler, Friedman, Jones, Mello, Miller, O'Brien, Selzer, Simon, Szapocznik, & Woody, 2012). The thesis aims to focus on the follow-up long-term in-patient treatment which normally takes place in non-hospital sites, though in some cases in psychiatric departments of hospitals. The most known residential treatment type is therapeutic community (TC).

Though, prior to description of the concept of TC it is necessary to focus on other significant notions which comprehension will allow better understanding of the drug addiction treatment challenges and the concept of TC and its residents.

3.2 Patient versus Client

Throughout the thesis, the notion of patient and client in each TC was utilized with respect to the particular TCs' philosophy of addiction. As perceived during the research, in TC Takiwasi in Peru, the participants in the treatment are deemed as patients. Similarly, as recognized from treatment participants' testimonies in TC CEA in Nicaragua, the participants in treatment are deemed as patients as they surrender to God to be treated (see Appendix B). Conversely, in the Czech Republic in TC Sejřek, the participants in treatment are referred to as clients of the TC.

Kalina (2008) describes the patient and client notions as development stages of participants in the treatment. The patient in the TC is according to him an opposite of the healthy man, dependent on the environment and on others, not aware of his problem. As opposed to the client of the TC, who is aware of all matters concerning the professional service provided by TC. His role as a client is confirmed and signed by all sides in an agreement.

The reasons behind the diverse interpretations of participants' in treatment role in different TCs could be examined from multiple viewpoints and might be a topic for another thesis. Ultimately, it won't necessarily bring the right or wrong resolution. However, for the purposes of this thesis was the complex issue resolved by simply respecting each TCs attitude towards the notion as it is. In cases when all of the three TCs are compared, it is referred to participants in treatment as to patients/clients.

3.3 Is Addiction a Disease?

Having analyzed the concept of patient and client, a question whether addiction is a disease or not has arose. According to McKenna (2015), addiction is not a disease it is an instrument to keep away from pain. As he identifies himself with the statement that every addiction begins and ends with pain, while substance abuse is the instrument to control it.

It is assumed that the pain could be of psychic or physical nature. As researched by Horák (2014), in the TCs is important to identify the reasons behind the addictive behaviour – the pain – and becoming aware of it might be the first step towards recovery. Nonetheless, the term recovery signalizes again the potential identification of addiction as a disease. It is significant to mention that addiction is not connected only to psychoactive[2] substances which affect brain and cause physical dependence. Some of the patients/clients were for instance gamblers as well.

A vast number of addiction definitions are available. Alas, it is likely that there is no hypothesis that could give explanation for one exact concept of addiction that would include all the phenomenon of concern (Sussman & Sussman, 2011). Hence, from another viewpoint and for the purposes of the thesis is any kind of addiction considered as bad referring to the introductory quote from C. G. Jung, and therefore an attempt of addiction elimination is in place. Though, the elimination should be connected with methods of treatment that seek to identify the reasons for addictive behaviour and a total abstinence, as opposed to a method substituting the abused substance by another *"legal"* substance.

3.4 Spirituality versus Religion

Throughout the research, the patients/clients were asked whether it is important to believe in something in order to terminate the treatment successfully. Majority of the patients/clients responded in affirmative way. Some of them stated particular religion and some others referred to a less specific spiritual entity which helps them to proceed with treatment. Others mentioned believing in self as beneficial in treatment. A whole chapter 4.2 in the thesis is devoted to the topic religion and spirituality in drug addiction treatment.

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[2] "Psychoactive substances are substances that, when taken in or administered into one's system, affect mental processes, e.g. cognition or affect. This term and its equivalent, psychotropic drug, are the most neutral and descriptive term for the whole class of substances, licit and illicit, of interest to drug policy. 'Psychoactive' does not necessarily imply dependence-producing, and in common parlance, the term is often left unstated, as in 'drug use' or 'substance abuse'" (World Health Organization, 2015).

It is significant to mention that both, religion and spirituality, two compound terms difficult to comprehend correctly, are understood in the comparative research simply as favourable in treatment. Though, when accepted voluntarily. All of the TCs practice method of total abstinence (no substitutes for abused substances are administered), thus spirituality or religion, regardless of the difference between the terms, could play an important role in *"placebo healing."* Diverse spiritual approaches are obvious in all TCs: The 12 steps of Alcoholics Anonymous (see Appendix B) in TC CEA in Nicaragua; catholic masses and other religious workshops in TC Takiwasi in Peru; or a cleric commuting regularly to the TC Sejřek in the Czech Republic.

3.5 The Concept of Therapeutic Community

The first notion of therapeutic community (TC) entails a type of therapeutic community which is democratic. J. R. Rees in the beginning of the 2nd World War was the first who focused more on the treatment via relations in a group rather than a solely individual treatment. He was the main army psychiatrist during 2nd World War. The hospital facilities were overloaded with soldiers suffering with psychological trauma. The conditions required solution to treat all the soldiers and sent them back to battlefront. The essentials of the concept of therapeutic community were formed as results of this situation (Kalina, 2008).

Nonetheless, as stated by Lipton (1998), the actual term *"therapeutic community"* was invented by Thomas Main in 1946, which Lipton (1998) described as *"therapeutic model combining community therapy with ongoing psychoanalytic psychotherapy."*

The first democratic TCs operated as usual communion, members were stimulating mutual support and cooperation in everyday life. There were non-directive group discussions to understand the process of treatment and to monitor it as well. Significant role plays in further democratic TCs development Maxwell Jones. He specified 5 principles of TC: "*mutual communication at all levels, seeking mutual consensus in decision making, social learning by interaction, the process of decision making at all levels and joint management."* However, the democratic type of TC was established to treat mental health disorders and it is so till nowadays (Kalina, 2008).

Later on, for the purposes of drug addiction treatment were established hierarchical or *"new"* therapeutic communities, as opposed the *"old"* democratic TCs. At the beginning of this was Synanon, established in 1958 by C. E. Dederich. Nevertheless, according to Kalina (Ibid.) the facility cannot be deemed as TC, as it was merely an experiment or even sect. Even though it brought several findings what is effective in treatment and what is not.

The first TC as such was therefore, Daytop Village in New York 1963. Comparing the Daytop Village with Synanon, Synanon offered long-term accommodation in drug-free community as a substitute for real life. Conversely, Daytop Village came up with approach which aim was to change the lives of its members and enable them after a treatment period to pursue a drug-free life also outside the community (Ibid.).

In 1980 was established World Federation of Therapeutic Communities (WFTC) and later in 1981 were adopted a standards and goals for TCs (see Appendix D). Nonetheless, Kalina (Ibid.) claims that no definition is able to describe all TCs approaches. Each community is said to be to unique modification for the particular needs of its members

The designed length of a stay in TC varies usually around 6 to 12 months and the centre of its program is re-socialization of the resident. The community as a whole, counting with other residents, employees and social interactions between them, operate as *"active components"* of treatment. The addiction is viewed in the context of individual social and psychological deficits. Thus, the treatment concentrates on the development of personal and social responsibility with the intention to overcome those deficits (Adler *et al.*, 2012).

Speaking more specifically, the residents of TCs learn and relearn basic social rules allowing them to fit again into society, via ergo-therapy (household maintenance, cooking, daily routine) or arte-therapy (dancing, painting, etc.) and cohabitation itself as treatment method. Even though, all TCs and their program schedule and content differ greatly among various socio-cultural settings, TCs are all based on the principle the community itself functioning as a doctor (Kalina, 2008). The following chapters deal with diverse treatment program schedules and methods in socio-culturally dissimilar settings of selected TCs in the Czech Republic, Peru and Nicaragua.

3.6 Therapeutic Community Sejřek in The Czech Republic

As traced from the web sites of TC Sejřek (http://www.tksejrek.kolping.cz), the community is a member of non-governmental organizations association in the Czech Republic dealing with the prevention and treatment of drug addiction. It is located in a municipality Sejřek in micro-region Bystřicko which lies on boarders of three regions in south-eastern part of the Czech Republic: Southern Moravian region, Vysočina (Highlands) and Pardubice region.

TC Sejřek is also a holder of a Certificate of proficiency issued by the Government Council for Drug Policy Coordination (GCDPC) in the Czech Republic. And the TC is a registered social service according to Ministry of Labour and Social Affairs (MLSA) pursuant to Act No. 108/2006 Coll. The project runs since 1999 and its goal is to provide community facility which offer long-term residential/in-patient program for drug addicted women and men.

Fig.3. TC Sejřek in the Czech Republic – The Main Building

Source: Author's Archive

3.6.1 TC Sejřek Approach

The essentials of long-term care according to the TC Sejřek is therapeutic and re-socializing program, which consists of group and individual therapy, ergo-therapy[3], responsibility training, pedagogical work, social service and recreational programs including sports and culture. A significant part of the program is cooperation with families of clients. As stated on the web sites of TC Sejřek, the model of TC is the most effective, but most demanding approach to the treatment of drug addiction.

[3] Ergo-therapy is a therapeutic method which considers work as a part of therapy.

The treatment proceedings are divided into four phases as it has been researched in TC Sejřek. In the zero phase, client is mainly present in the building of the community, he writes an assignment where is stated what the client wants to change in his/her life. After minimum one moth the client applies for next stage admission. All present community members vote about the client's admission. The next, first phase, lasts two to three months, in this phase clients can once a month have family members visit and is getting familiar with community rules. The client starts to save financial resources for after treatment facility and is dealing with his/her past debts.

The second phase lasts three to six months. The client is allowed to leave the community building, though he/she has to announce it in advance. One a month the client goes to a weekend trip and he/she has ten days work duty, but the financial reward belongs to community. The client has the opportunity to have a free day alone outside the community. The third phase clients are expected to work and take part at least in one community session in a working week and two community sessions during weekend. In case the client does not work, he/she takes part in usual program schedule (see Appendix A) and is searching for a job. A condition of a proper treatment termination is agreed participation in an after treatment facility.

The cost of the treatment in TC Sejřek is paid from grant funds (GCDPC, MPSV, Highlands County, South Moravian Region, etc.). The clients contribute to the treatment up to 250 CZK per day. However, the clients' contribution is usually paid from their social or sickness benefits. There are set fundamental principles of care in TC Sejřek: equal access to the drug addiction treatment service, voluntary admission to treatment, individual approach, balanced attitude towards the needs of individuals and community, the relationship heals approach, structure supports attitude.

3.6.2 Kolping Work

The founder and operator of TC Sejřek is a civic association Kolpingovo dílo České republiky o. s. (transl. Kolping Work in the Czech Republic). Adolph Kolping was - as stated on the web sites dedicated to the Kolping (http://www.kolping.cz) - a priest and journalist writer born in 1813 in Germany. His goal was to show young people that life is not just work and then sitting in a pub. Kolping focused on young people to encouraged them to be independent and became committed Christians. He believed that community life, faith and trust in God but also firmly grounded family would assist them to follow this path.

Adolph Kolping work is association that offers family community setting which guide its members through life. The main objectives are renewal and humanization of society in the spirit of Christianity and offering assistance to its members and the public in various life situations. Significant part of the Kolping work is also development cooperation. The basic principle of development cooperation in Kolping work is the concept of self-help.

Members of Kolping families in poor countries can through educational activities and material assistance achieve free and sui juris life. In the year 1968 the initiative *"Brazil"* started the development cooperation. Later in 1972 another initiative called *"Social and Development Aid,"* was set off. And since that time, the Kolping Association gathers people in developing countries who support and believe in Adolph Kolping Work and unites them in self-help groups and associations which are connected to global network Internationales Kolpingwerk (IKW).

3.7 Therapeutic Community Takiwasi in Peru

As researched on the web sites of TC Takiwasi (http://www.takiwasi.com), the foundation of Takiwasi centre in Tarapoto located in Peruvian province San Martín dates back to 1992. The location of the centre can be found on former area of cocaine paste production. Since the year 1986 there was executed preliminary research in Takiwasi which focused on the active observation of the work of Amazonian healers (shamans), particularly concerning the ritualized utilization of medicinal plants for the drug addiction treatment on coca paste, cannabis, cocaine and alcohol consumers.

The centre originated as French government project focusing on traditional Amazon medicine utilization in drug addiction treatment. And as claimed by Horák (2013), it operates now as non-governmental organization (NGO) and whereas it provides drug addiction treatment its concern is research in the field of traditional medicine production as well.

In Takiwasi the provided treatment is holistic and it consists of combination of psychotherapy and ingestion of psychoactive and emetic (Ayahuasca, Rosa Sisa, Uchu Sanango, etc.) and dietary (Ushapawasha Sanango) plants under professional surveillance of psychotherapist with good command of traditional techniques (Horák *et al.*, 2014).

The main objective of the treatment in TC Takiwasi – as stated on the web sites of the centre - is the reassessment of the natural and human resources of the traditional medicines, and to develop a real therapeutic alternative to drug addiction. Centre Takiwasi disposes of *"recognition to operate as a Health Centre, issued by the Regional Health Department of San Martín 039-DG-DIRES/SM-96 Directorial Resolution."* Therefore it is one of the few therapeutic communities in Peru which are legally recognized.

Fig. 4 TC Takiwasi in Peru – Maloca Chica, building designed for detoxification

Source: Author's Archive

3.7.1 TC Takiwasi Approach

The therapeutic model according to the TC Takiwasi is based on three main pillars:

- *Cohabitation*
- *Psychotherapy*
- *Traditional medicine plants*

Cohabitation represents in Takiwasi the model of therapeutic community as known also in the Czech Republic. It involves self-assessment, daily routine in community and ergo-therapy. *Psychotherapy* in Takiwasi is utilizing numerous psychotherapeutic approaches (both individual and collective) and its dealing with issues which occur due to the cohabitation of clients in centre or as a result of the ingestion of traditional medicine plants.

Traditional medicine plants are the part of therapy which differs greatly from the strategies in TCs in the Czech Republic or in Nicaragua. Every stage of treatment includes a plant associated with it. Some plants are utilized for detoxification (purgatory or dietary plants), others are used for discoveries of own inner world (psychoactive). A significant role plays a ritual setting within this part of treatment consistent with the Amazonian traditions. The plants ingestions go along with certain diet regulations, obligatory sexual abstinence and other features concerning healthy lifestyle.

According to the director of the Takiwasi Centre, Jacques Mabit M. D. (Mabit, 2002) the natural psychoactive substances from Amazonian rainforest utilized by indigenous people, do not cause addiction. The substances are used to treat the modern-day occurrence of drug addiction. He stated that it is our responsibility to change our attitude of passive tolerance regarding an unavoidable ingesting of psychoactive substances. On the contrary, we have to vigorously investigate the intelligible therapeutic utilization of psychoactive substances with no outcome of dependence. He also claims in his article, that our post-modern civilization basically omits all possible everyday experiences with altered states of consciousness, via diverse methods such as dance, isolation, physical exercise, pain, etc. Psychoactive substances are always ingested orally which does not cause dependence, even though the psychoactive substances have influential psychoactive consequences (Ibid.).

According to the experience of Dr. Horák (2013), who has done research in Takiwasi centre in the past years, the minimal stay in the centre to undergo the whole process of treatment is nine months. The number of months is significant and figurative, because it symbolizes a process of *"rebirth"* of the addicted person into a *"newborn"* person. Also the number of patients in the centre has its maximum value and that is 15 persons, otherwise the therapeutic group would split into fractions, influence the efficiency and goal of the treatment.

The stages of treatment include preliminary stage, when a social contact with potential candidate for the treatment is being established and the person is being assessed whether the incentives for the treatment are sufficient. At the end of this phase, the person is accepted to a treatment and set into internment. Afterwards, the physical rehabilitation phase follow, the person is accommodated in an isolated facility within the centre for two months (Horák, 2013).

Thereafter, the person undergoes personality, existential, social and family restructuration. These stages are divided according to the level of diet the person has already undertaken. In the last phase, the person is reintegrated into the society and the phase usually takes place within the two last months of the treatment. However, there is a possibility of consequent care up until five years after the cessation of the treatment (Ibid.).

According to the director of the TC Takiwasi, the experience during and after ayahuasca ingestion, *"is allowing the subject to confront his habitual problems on his own and from a new angle."* As stated earlier, an overdose is technically not possible, because the body has its own barriers and protects itself by emesis, therefore it is also necessary to follow dietary restrictions. And as the healing process, that is the ayahuasca ingestion ritual, continues, the reaction to the substance is getting more sensitive, as opposed to the addictive substances, where the tolerance occurs and the amount of the dose must be increased to reach the desired altered state of consciousness as before. As for ayahuasca, the dose decreases with regards to the increasing level of the treatment process, therefore the brew cannot be perceived as a replacement for the original abused drug (Mabit, 2002).

The cost of the treatment is as reported on the web site of TC Takiwasi is S./3000 (nuevos soles) per month. This equals approximately to 1000 USD per month per patient. Nonetheless, it is important to mention that those with limited economic resources are according to the TC Takiwasi eligible to access funding or payment facilities, via previous evaluation by the administrative department in TC Takiwasi.

3.7.2 The Use of Ayahuasca in Drug Addiction Treatment

"Ayahuasca is a psychotropic brew prepared from the Amazonian vine Banisteriopsis caapi and leaves of the bush Psychotria viridis. These plants contain, respectively, alkaloids and dimethyltryptamine (DMT)[4], which when ingested in combination orally induce several hours of a dream-like altered state of consciousness characterized by intense visual, auditory, ideational and emotional effects" (Thomas, Lucas, Capler, Tupper, & Martin, 2013).

As perceived from the *The Yage Letters* which is a correspondence between authors, William S. Burroughs and Allen Ginsberg (Burroughs & Ginsberg, 1963), the brew causes quite heavy vomiting and hallucinations. Nonetheless, the diletant term *"hallucination"* is not precise and has stigmatized the brew and other substances such as LSD or MDMA, which cause altered states of consciousness and can be useful in psychotherapy. Though, when misused, that is without professional assistance and disobeying natural ways of ingestion (e.g. injection is not a natural way of ingestion) the substances are harmful (Mabit, 2002).

The brew has been drunk conventionally by Amazonian indigenous and mestizo people in ceremonial context for many reasons, such as, magical, spiritual, aesthetic and for folk healing procedures. During late 20th and early on in 21st century, drinking the brew has developed into *"transnational phenomenon,"* and tourism into Amazon has increased, while it has caused growing scientific attention to the brews possible therapeutic value (Thomas *et al.*, 2013).

[4] DMT is able to induce aversive psychological reactions or transient psychotic episodes that resolve spontaneously in a few hours (Gable, 2007).

At the first glance, for an average inhabitant of a Western hemisphere after a brief internet research, the ayahuasca might be generally perceived as a drug, and it indeed is a psychoactive drug according to Thomas *et al*., (2013), and therefore, logically there is no sense for a diletant to recognize the brew as a natural addiction treatment. And similar statement is a part of a publication issued by director of a therapeutic community Takiwasi, where practices with ayahuasca-assisted drug addiction treatment is a major part of the program: *"... psychoactive substances may be a treatment for 'drug addicts,' a fact that still seems paradoxical or impossible even to the specialists in question"* (Mabit, 2002).

Nonetheless, the opposite has appeared to be truth, the ritual of ayahuasca drinking has been linked to *"lower amounts or severities of substance dependence"* (Thomas *et al.*, 2013). The utilization of ayahuasca to help solving drug addictions is essential part of the treatment programs in TC Takiwasi.

The approach of the community includes different features of traditional Amazonian folk medicine, use of diverse medicinal jungle plants and use of ayahuasca. Even though these programs assert improved health outcomes for patients who finish them, it has not been evaluated with adequate scientific rigor to present ultimate evidence of the success of their methods. But researchers are speculating on possible *"neurochemical, psychological or transcendent mechanisms of ayahuasca's purported therapeutic action,"* based on claims about treatment success in Takiwasi and other similar institution in Brazil (Ibid.).

3.8 Therapeutic Community CEA in Nicaragua

The location of therapeutic community (CEA) Centro de Especialidades en Adicciones is on the periphery of the capital city of Nicaragua, Managua and is active since 2009 (Horák, 2014). As perceived on the web sites of the TC CEA (http://ceanicaragua.org), it is a member of the international certification agency for addiction professionals, the IC & RC (International Certification and Reciprocity Consortium) since 2011.

3.8.1 TC CEA Approach

As stated on the web sites of the TC CEA, the CEA Internment Program is intended to be a residential/in-patient drug addiction facility for both women and men. But what is important, the facility has separated spaces for women and men, allowing privacy and respect. Though, the program within the treatment offers group sessions for both sexes together, while other sessions may be specific to gender.

TC CEA claims to offer holistic approach which focuses on combining Matrix model with the principles of the Twelve Steps of Alcoholics Anonymous (AA). As reported on the web sites of TC CEA, this model seeks treatment of each person in diverse dimensions: physical, mental, social and spiritual. Furthermore, the Matrix Model is claimed to be an evidence-based protocol which effectiveness has been proven.

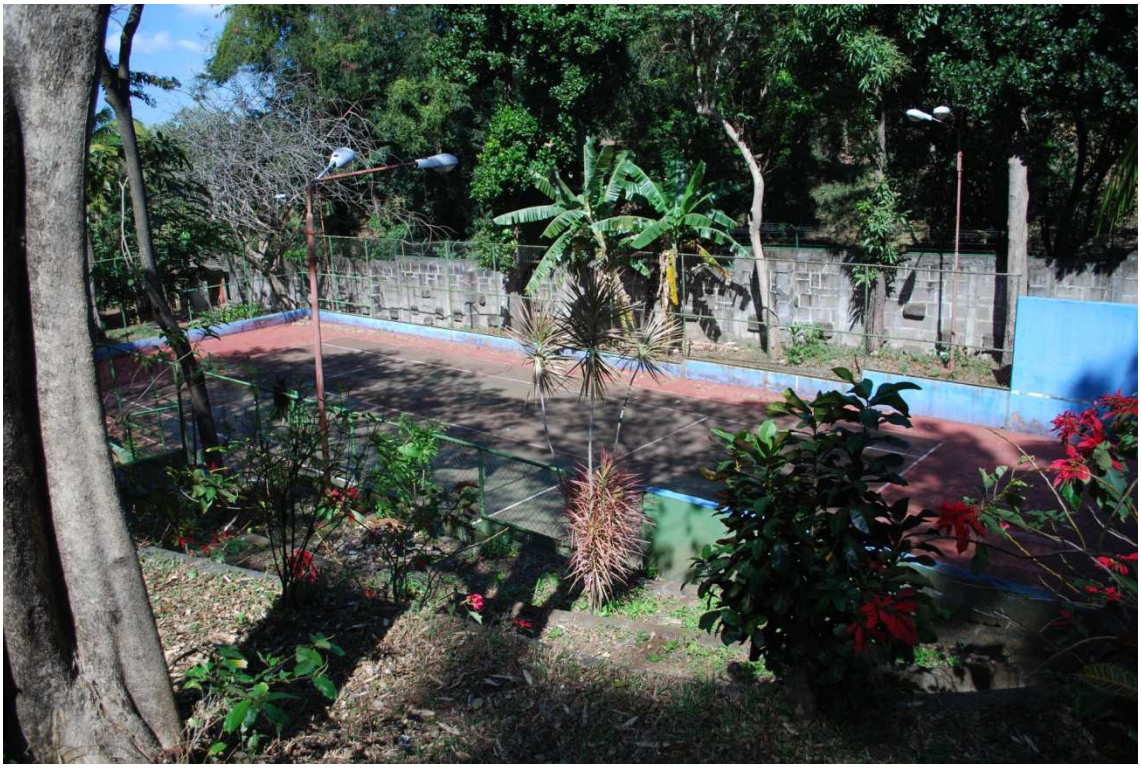

Fig. 5 TC CEA in Nicaragua – Sports Field

Source: Author's Archive

3.8.2 The Matrix Model

As stated on the web sites of TC CEA, the Matrix model includes Twelve Step of AA facilitation (see Appendix B) and cognitive-behavioural therapy with the philosophy of motivational interviewing. The therapeutic approach is performed via individual meetings, joint sessions with a loved ones, relapse prevention group, a group of early recovery skills, group of family education and social support group. There are also educational sessions covering topics such as addiction as a disease, anger management, self-esteem, stages of change, grief, abuse, etc.

The TC CEA provide an information that in-patients begin with a stage designed for stabilization and physical and psychological evaluation until they are eligible for admission to the treatment with other in-patients. The minimum duration of in-patient treatment depends on the individual needs of the person. In any case, after completing the program internally, the person will assist the monitoring program in a less structured treatment modality.

As stated by Horák *et al.* (2014) the TC CEA's aim is also to spread expert knowledge and awareness in the field of drug addiction prevention and treatment. The TC CEA envisions arranging prevention and treatment programs on national and international level via education and qualifications of its experts along with international benchmark.

As reported by TC CEA, the personnel have been officially trained in the Matrix Institute on Addictions in California, Los Angeles. This Institute dispose of 25 years experience in the implementation of Martrix Model. It is a science-based approach and is listed by the National Institute on Drug Abuse of the United States (NIDA) as one of efficient behavioural therapies in treating substance abuse in its publication *Principles of Drug Addiction Treatment: A Research Based Guide.*

In the same publication is according to TC CEA also claimed that number of studies have revealed that in participants who undergone the Matrix Model treatment were proven statistically significant decrease in the use of alcohol and drugs. The cost of the treatment is as researched recently by Horák (2014) for in-patient treatment approximately 1000 UDS/month, likewise in TC Takiwasi.

3.9 International Assistance with Drug Addiction Treatment in the Czech Republic, Peru and Nicaragua

The aim of this chapter is identification and assessment of international assistance with drug addiction treatment in the Czech Republic, Peru and Nicaragua. Alas, it has been researched that there is merely one extensive project which direct aim is to develop drug addiction treatment in Peru, Nicaragua and other developing countries worldwide. In the Czech Republic, the international assistance is provided mainly in form of international grants and funding.

3.9.1 UN Assistance with Drug Addiction Treatment in Peru and Nicaragua

A unique and only exstensive project developed specifically for the purposes of drug addiction treatment assistance in developing countries was launched by UNODC (United Nations Office on Drugs and Crime) and is called *Treatnet.* This chapter deals with the specific description of the project and its impact (UNODC, 2006).

Treatnet is an international network of drug dependence treatment and rehabilitation rescue centres. According to the information provided on the web sites, it operates currently in 5 regions worldwide and in Latin America directly in Peru and Nicaragua. The project has been implemented between years 2009 and 2011 in 26 countries in 5 regions. Treatment strives to remove obstacles to the cost-effective and evidence-based drug treatment services in developing countries and to deliver effective and quality drug dependence treatment and rehabilitation services, including HIV/AIDS prevention and care guarantee.

The strategy to deploy the goal involve: promoting understanding of drug dependence treatment and care and the perception of drug dependence as a disease that requires a multidisciplinary and inclusive approach. Furthermore, the strategy includes also capacity building of drug addiction treatment and care service providers and improving technical skills of the providers as well. Another strategic activity comprises of evidence-based distribution of *"good practice in drug dependence treatment"*, incorporating availability of treatment together with social integration and therapy.

The last activity on the web sites regarding the region Latin America is dated back to September 2009 under the name *"Training of Trainers in Latin America"* which was a process of selection of 50 professionals from various fields, such as medicine, psychiatry, psychology, sociology, etc. Selected professionals were trained on *"Training Package"* and approved on sharing the obtained knowledge once they depart back to their countries.

The Training Package has been developed by of international experts, trainers and researches from international Capacity Building Consortium which is led by the University of California Los Angeles/Integrated Substance Abuse Program (UCLA/ISAP). It is said to be essential part to the endeavour by the UNODC *Treatnet* initiative to intensify the level of information and skills on the topic of substance abuse worldwide.

The Training Package is perceived as an elaborated publication to provide future trainers with comprehensive knowledge concerning screening, assessment, treatment planning, basic counselling skills, motivating clients for treatment, strategies for relapse prevention, basics on addiction topic and on psychoactive substances and treatment for special populations (youth, women and people with co-occurring disorders).

All the study materials are available on-line and supply future trainers with role plays, workshops, presentations featuring tools supporting substance abuse treatment process, such as tool developed by World Health Organization (WHO) called *ASSIST.* It is used for brief intervention which collects information regarding abused drugs portfolio during lifetime and last three months. Another tool is manual for administering Addiction Severity Index (ASI) which is utilized to gather information about character and severity of problems which substance abusers frequently experience.

Other available materials on-line are provided in three different languages (English, Russian, Spanish) or only in English. These publications are mainly drug abuse implementation guides, case studies an lesson learned on different topics concerning drug addiction treatment, discussion papers, good practice documents on topics related to community based treatment or interventions for drug users in prison. There are numerous publications available for research and development for anyone interested in the topic published either by WHO or UNODC on the web sites of *Treatnet.*

The *Treatnet* is assumed to be the most elaborated and ambitious project on the topic international assistance with drug addiction treatment in developing countries available. Alas, the project provide little evidence and results of indicated activities on the official web sites. It briefly describes Phase I which key topic is cooperation and information exchange among twenty selected resource centres representing all three regions. Unfortunately, the Phase I incorporated nor Peru neither Nicaragua.

Regarding the Phase II, it is stated on the web sites of *Treatnet* that Phase II is currently active in 5 regions worldwide including Latin Americas' Peru and Nicaragua. The Phase II is supposed to be administering and developing service improvement projects in all 5 regions and each region has its own Regional Coordinator for the whole Latin American region, it is Ms. Isabel Palacios, based in Lima, Peru.

As for presented data and facts concerning Phase II, there are MS Word documents containing drug abuse and drug dependence treatment situation in Peru, Nicaragua and other three countries in Latin America in year 2006 and some data without any year reference. The document consists of statistical data or facts rather than evidence of results to the effort. It is for instance stated that in not specified year the consumption of PBC, cocaine and marihuana was at that time 4 times time greater in men than in women in Peru. However, regarding consumption of inhalants women outweighed men at that time in Peru and 85,6% of registered drug users were men and 14,4% women.

Furthermore, according to the *Treatnet*, in Peru was being implemented Information Network on the Demand for Treatment concerning Abuse or Dependency of Psychotropic Substances (RIDET) in order to met objectives of the Drug Consumption Prevention and Drug Addicts Rehabilitation Program ran by Comisión Nacional para el Desarrollo y Vida sin Drogas (National Commission for Development and Life without Drugs) (DEVIDA) which was in charge of invention and creation of the information system which would bring awareness of persons and their profiles who require treatment as a result of drug abuse or drug addiction.

Though, the type of treatment centres which presented itself to RIDET to be part of the informational network were merely out-patient[5] treatment centres which aim is only a counselling as opposed to in-patient treatment centres which point towards treatment in form of therapeutic community. Additionally, the document concerning Peru and its drug abuse and drug dependence treatment situation published by *Treatnet* and UNODC describes available drug addiction treatment services in rural and urban areas in Peru then and comment on HIV/AIDS situation in year 2009 in Peru.

[5] The out-patient method of treatment is ambulatory, thus consists merely of counselling and do not provide community treatment.

Ultimately, results are presented by introducing number of trainers trained to develop and advance drug addiction treatment in Peru, the number of trainers trained in the course of year 2009 were 9. Two Peruvian academic institutions and five governmental institutions took part in the action including DEVIDA, Peruvian Ministry of Health and Peruvian National Network of Therapeutic Communities and five treatment centres in Peru. Moreover, in 2016 DEVIDA plans to supply Lima, Peru with the *"first hospital for drug addiction and treatment"* (Rivera, 2014).

Treatnet operated also in Nicaragua and similarly presented little evidence of real outcomes to the effort. *Treatnet* web sites introduced MS Word document describing Drug Abuse and Drug Dependence Treatment Situation similar to the Peruvian by uncovering statistical data such as that Nicaragua with its capital Managua disposes of 31 treatment centres which as opposed to Peruvian treatment centres offer both in-patient and counselling services.

Majority of treatment centres in Nicaragua are located in the capital city and nearby, alas all of the specific treatment centres are private according to the source and most of them were established by families of ex-addicts. The source also comments on HIV/AIDS situation in Nicaragua and introduces number of trainers trained in order to advance and develop drug addiction treatment. The number of future trainers involved in the *Treatnet* network was 6 for Nicaragua.

Academic and governmental institutions involved into the network were for instance National Anti-Drug Council (CNLCD), Institute against Alcohol and Drug Dependence (ICAD), Nicaraguan Ministry of Health and three Nicaraguan Universities. Merely one treatment centre in Nicaragua was involved in the project.

While evaluating the international assistance with drug addiction treatment in Peru and Nicaragua, it is significant to mention that due to unstable political and economical situation in both developing countries there are many obstacles in launching such developing projects. Though, according to the internet research, merely one extensive program using professional tools, trainers and methods has been found. And unfortunately, the program brought little evidence of the *Treat-net* impact on drug addiction treatment development in Peru and Nicaragua. This is considered as an insufficient with regards to the global nature of the problem. It is significant to highlight this issue and by performing further research promoting the importance of international assistance on the topic of drug addiction treatment assistance in developing countries.

3.9.2 International Assistance with Drug Addiction Treatment in the Czech Republic

In the Czech Republic, the assistance with drug addiction treatment is as research has shown provided usually via opportunities to apply for financial resources in form of grants. Merely one instance of international assistance with drug addiction treatment in from of funding was identified in the Czech Republic nowadays.

As stated on the websites of the EEA Grants and Norway Grants (http://eeagrants.org), the initiative embodies the effort of Iceland, Lichtenstein and Norway to reduce social and economic inequalities and to reinforce mutual relations among 16 countries within EU in Central and East Europe.

The name of the EEA Grants is associated with the establishment of EEA (European Economic Area) Agreement in 1994. The agreement brought together 27 EU member states plus three EFTA (European Free Trade Area) states – Lichtenstein, Iceland and Norway. Next to the economic benefits which came with the *"internal market"* commencement between the member states, the agreement also include cooperation in areas such as development, education, environment, etc.

The funding of EEA and Norway Grants is aiming at regions where there is an evident need for advancement within national and further European goals. In this context, it is mentioned that in 2004 and 2007 the EU has been 20% enlarged in the means of population, though the GDP has increased just 5%. An instance of EEA and Norway grants assistance with drug addiction treatment is the establishment of rehabilitation centre for women in 2011. Alas, no specifications concerning the rehabilitation centre are provided on the EEA and Norway Grants web sites.

Currently, a project *Drogové závislosti - násilníci a oběti* (transl. Drug addiction – bullies and victims) is running in the Czech Republic with the support of EEA and Norway Grants. The aim of the project is to introduce specific models in TCs Karlov and Němčice in the Czech Republic. The models focus on the victims of violence and managing aggression of aggressors. The target group are persons diagnosed with drug abusive behaviour in rehabilitation process within an inpatient treatment facility.

The outcomes of the project shall bring instructions and guidelines for therapists on the topic of group therapy for persons diagnosed with drug addiction whose experienced or committed violence. The project will be ended in 2016 with conference on the same topic and is also funded by EEA and Norway Grants.

As derived from the research, the international assistance with drug addiction treatment in the Czech Republic consists mainly of grant opportunities utilization. The only currently running project focused directly on the drug addiction treatment issues is the project project *Drogové závislosti - násilníci a oběti* (transl. Drug addiction – bullies and victims) funded by EEA and Norway grants. However, there is another suitable organization for funding in the area of drug addiction treatment. The SAMHSA organization (Substance Abuse and Mental Health Service Administration) which offers funding for Substance Abuse Treatment Centres and could be a good opportunity for potential development of drug addiction treatment in the Czech Republic.

Surprisingly, it appears according to the research results that European Union provides merely drug addiction treatment monitoring and evaluation in Europe carried out by EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) rather than focusing directly on treatment programs or treatment programs assistance. The United Nations provide for instance, Standards on Drug Use Prevention by UNODC or treatment program *Treatnet*, though the activities are focused more on non-European regions.

Nonetheless, there are some other available European organizations focusing on drug addiction treatment, such as European Opiate Addiction Treatment Association (EUROPAD) based in Switzerland. Though, there is no evidence whether their direct assistance with drug addiction treatment is available in the Czech Republic. The research implies that international assistance with drug addiction treatment in the Czech Republic consists mainly of grant opportunities, though there are several more options for funding which could be utilized in order to develop drug addiction treatment.

3.10 Current State of Drug Addiction Treatment in the Czech Republic, Peru and Nicaragua

As stated in the 2014 International Narcotics Control Strategy Report (INCSR) issued by Bureau of International Narcotics and Law Enforcement Affairs, in Peru DEVIDA disposes of a budget of $13.1 million for drug abuse prevention and treatment. DEVIDA supply funding to local governments for drug consciousness and prevention campaigns countrywide (INL, 2014).

The INCSR discuss in 2014 report the overall number of beds available for drug addiction treatment in Peru which is 160. The private treatment centres are available in urban areas, nonetheless numerous of which are not endowed with qualified staff. It is as well asserted in the Report that Peru has approximately 300 *"therapeutic community centres"* which the source describe as *"a group-based approach to drug addiction treatment"* countrywide (Ibid.).

Unfortunately, the most of these centres are unregistered (just 43 centres are registered) and in many cases run by ex-addicts with no proper education likewise in Nicaragua according to the *Treatnet* by UNODC. As claimed in INCSR latest report, there are no treatment centres or hospitals purposely established to treat young people, women or children. Barely 15 out of 80 prisons countrywide proffer treatment programs for convicts on the report of the source (INL, 2014).

In Nicaragua, especially on the Caribbean Coast region, the risk of drug intake continues to rise due to increased trans-shipment quantity in the region. Non-governmental organizations (NGOs) carry on with the endeavour to provide treatment to drug addicts, for instance in February 2014, the Foundation for the Promotion and Municipal Development (Popol NA) issued *"the first medical guide for the diagnosis and primary care of drug addicts in Nicaragua."* The private treatment centres in Nicaragua proffer both out-patient and in-patient treatment models, however in some of these centres treatment costs monthly around $2,000 and $3,000 per patient/client. Treatment services free of charge are rare (Ibid.).

As maintained in the latest Czech Republic Drug Situation – 2013 annual report, in the Czech Republic were merely 50 (20%) core residential or in-patient treatment services as opposed to 200 (80%) out-patient programmes at the time of the report issue. Approximately half of the treatment services dispose of expert capability certification evidence issued by The Government Council for Drug Policy Coordination (GCDPC) which is an enduring body of the Government of the Czech Republic operating in the field of drug policy. The 40% of treatment centres are registered as social services. Considerable part of the treatment services were provided by NGOs, particularly those associated with the category of social services (Government of the Czech Republic, 2014).

Approximately 1/3 of the clients/patients in addiction treatment centres in the Czech Republic are women. Currently valid National Drug Policy Strategy has been published for years 2010-2018, as well as Action Plan valid for years 2013-2015 which is based on the Strategy. The Action Plan addresses directly the challenges of drug addiction treatment in the Czech Republic in 3 areas each as maintained in Czech Republic Drug Situation – 2013 annual report:

- *Network of services for drug users, its accessibility and quality*
- *Developing programs for drug users and maintaining their availability*
- *Developing and improving the quality of substitution treatment*

Moreover, drug policy strategies are being developed also on regional level and operate at or further than regional level. The in-patient program models for drug addiction treatment are represented in the Czech Republic by a network of psychiatric hospitals, addiction treatment wards within hospitals and also by therapeutic communities founded after 1990 (Government of the Czech Republic, 2014).
The evaluation of the current situation of drug addiction treatment in Peru and Nicaragua has been considered as insufficient, based on the treatment unavailability, inadequate quality of services or expensive treatment in contrast with the relatively high budget for treatment and prevention purposes. In the Czech Republic, the situation is adequately better. Nonetheless, drug addiction treatment services are not distributed in an even way, as stated in the 2013 Annual Report, in three regions (Central Bohemia, Liberec and Pardubice regions) the accessibility of the treatment is lacking.

3.11 Previous Ways of Dealing with Drug Addiction Treatment in the Czech Republic, Peru and Nicaragua

Since the 1960's Latin America together with many other countries throughout the world encountered steady intensification in abuse of numerous substances. It has been identified as severe public health crisis and many international agencies and governments took action steps towards the crisis resolution. The local assistance services such as hospitals and prisons were excessively busy due to drug trafficking, violence and health consequences of drugs abuse (Didia Attas, de Pabón, & Cueva, 2010).

Fortunately, in 1950's the concept of therapeutic community was developing as Maxwell Jones defined 5 principles of TC, yet merely for persons suffering mental disorders. Later on, in 1963 first hierarchical TC Daytop Village (Drug Addicts Yielding to Persuasion) in New York was established. In Latin America, the TC concept to treat drug addictions commenced in1960's. Speaking about Peru, one of the first such facility was established in 1969 – Rehabilitation Centre of Nana, Peru (Didia Attas et al., 2010).

In 1987 Latino-American Federation of Therapeutic Communities was established (FLACT), in Campinas – Brazil as part of the 1st Latin American Conference of Therapeutic Communities. Currently, practically all countries in the Latin American region have their respective national associations, bearing different levels of development (FLACT, 2013).

And once in two years, the FLACT makes a Latin American conference. In Peru was the Conference held in 1992 and in Nicaragua was not held yet. Nonetheless, both Peru and Nicaragua are member states. The most significant issues of the network of institutions under the FLACT throughout the years are lack of funding, the extensive duration of the treatment and desertion of the clients/patients (Ibid.).

Concerning situation prior to the beginning of the concept of therapeutic community, Kalina refers to WHO (World Health Organization) comment from 1953 on the state of affairs regarding psychiatric hospitals – where the drug addiction treatment took place - was not good at all. As the hospitals while attempting to provide drug addiction treatment appeared more as a prisons (Kalina, 2008).

In the Czech Republic development prior to the concept of TC as it is known today was formed also by the specific political situation under the influence of USSSR, closed towards western ideas and solutions. The notion which was according to Kalina, (2008) ideologically acceptable was *"léčebný kolektiv"* (transl. treatment community) which aim was to seek treatment in social structure of the community. However, no details and proper schedule or specific rules are mentioned (Ibid.).

The Apolinář method of TC is based within Charles University, the School of Medicine founded by doc. MUDr. Jaroslav Skála in 1982, it focuses on individual and collective responsibility. Other typical features are group therapy, community gathering and work with the family of the patient. Nonetheless, as reported by Kalina, (2008) the approach is rather closer to Alcoholics Anonymous (AA) than the TC method, although without the most significant feature of AA which is spirituality. The features corresponding with AA are devotion to community, expiation, positive change focus, etc. For comparison with AA 12 steps (see Appendix B).

In 1990 was founded SANANIM association which was more focused on drug addiction treatment as opposed to Apolinář which approach was suitable rather for alcohol abuse treatment purposes only. The TCs established under SANANIM association were inspired by Daytop Village method, it is a combination of social rehabilitation, educational program and psychotherapeutic component is included as well (Ibid.).

Nowadays, 15 similar TCs exist in the Czech Republic which are generally non-profit organizations receiving grants from state or regional funds to operate. It is important to mention, that TC Sejřek which is a subject of comparison in the thesis is not under SANANIM association, but Kolping Work. However, while doing research no significant differences were observed except for slightly less physically demanding program due to dual diagnosis[6] of particular clients in TC Sejřek (Ibid.).

The most universal model of treatment is the therapeutic community approach (Didia Attas *et al.*, 2010), alas the ways of dealing with addiction treatment prior to the beginnings of the TC model are not sufficiently scholarly researched and it is proposed to initiate such study in order to understand the ways of drug addiction development in the past to move in the right way towards the future development.

[6] The dual diagnosis describes cases when patient/client is addicted to a certain substance while being diagnosed also with psychological disorder.

4 Cross-Cultural Comparative Research on Drug Addiction Treatment

4.1 Introduction

Each sub-chapter in the following part of the thesis represents key categories identified while performing content analysis. The central category and the frame of the whole identified story is the different approach towards drug addiction treatment in each diverse socio-cultural setting. Every sub-chapter also sets light to the concepts involved.

Throughout the comparative research there are references to responses of patients'/clients' recorded in semi-structured interviews. These responses were transcribed and are available in full version in the MS Excel in the Czech language. The MS Excel is not attached to the thesis due to a large content. However it is available upon request as well as the recordings of the semi-structured interviews. For basic information about interviewed patients/clients from all three TCs whose responses were utilized for comparative research, please see the Tables 1., 2., 3., below. An instance of a patients'/clients' response reference in the text of following chapters might be code (SG185) which then refers to patient/client with code SG. The number 185 in the reference refers to specific location of the response in the MS Excel document.

Tab. 1 Clients from TC Sejřek in the Czech Republic, Source: Author's Archive

Record #	Code	Age	Nationality	Status	Date
S03	SA	24	Czech	single	20.12.2014
S06	SC	26	Czech	N/A	20.12.2014
S07	CE	27	Czech	N/A	20.12.2014
S09	SG	27	Czech	single	20.12.2014
S10	SI	26	Czech	N/A	20.12.2014
Total time		1:37:51			
Average time		0:19:34			

Tab. 2 Patients from TC CEA in Nicaragua, Source: Author's Archive

Record #	Code	Age	Nationality	Status	Date
C01	CA	21	Nicaraguan	single	26.5.2014
C04	CC	24	Nicaraguan	N/A	26.5.2014
C06	CE	28	Nicaraguan	married	26.5.2014
C07	CG	43	Nicaraguan	divorced	26.5.2014
C10	CI	22	Nicaraguan	married	26.5.2014
Total Time		1:3:24			
Average Time		0:12:41			

Tab. 3 Patients from TC Takiwasi in Peru, Source: Author's Archive

Record #	Code	Age	Nationality	Status	Date
T01	TA	31	Argentine	divorced	15.9.2014
T03	TC	23	Peruvian	single	15.9.2014
T05	TE	30	Peruvian	single	15.9.2014
T07	TG	29	Spanish	single	15.9.2014
T08	TI	30	Chilean	single	15.9.2014
Total Time		1:49:17			
Average Time		0:21:51			

4.2 Spirituality and Religion in Drug Addiction Treatment

In each of three therapeutic communities were regarding spirituality and religion interviewed 5 clients/patients - from maximum number of 15 patients/clients in each TC utmost. The fundamental and leading question in the semi-structured interviews concerning spirituality and religion was whether patients/clients consider the concept of religion or spirituality as significant for drug addiction treatment. The question was proposed in more or less modified versions.

Spirituality is according to Galanter (2006) expressed as a *latent construct,* because similarly like the notion of a *personality* - it must be examined from *"multiple component dimensions."* However, he admits also that the concept can be researched via *"empirically-grounded"* parts, such as physiology, clinical psychiatry and psychology. And from the psychological point of view, spirituality must be present in case of placebo healing. Believing in some *"transcendent entity"* is predisposition for successful healing without any physiologic interference. Galanter (2006) also points out that multidisciplinary attitude towards the dormant notion of spirituality could enable better understanding of the potential opportunities it offers in the field of drug addiction treatment.

The purpose of religion is according to Miller (1998) to assist and convey the development of one's spirituality. Even though, patients/clients of therapeutic centres often mention spirituality as beneficial influence, not much is known if and how it is possible to include spirituality into proper treatment in a way that needs of individuals are met.

Heinz, Disney, Epstein, Glezen, Clark, & Preston (2010) point out that the position of spirituality conveying successful drug addiction treatment results has been only lately recognized as a field of possible significance to addiction research and medical practice. And thus, the skills achieved by professing religion and being spiritual could be underused drug addiction treatment source. And another challenge is the inconsistency among clinicians and patients/clients concerning the recognized significance of spirituality in treatment which might get in the way to the integration of spirituality into treatment.

4.2.1 TC Sejřek in the Czech Republic

In TC Sejřek in the Czech Republic, all participants of the interviews responded that they do believe either in Jesus Christ (SE201) or in their personal perception of God (SA220), love (SG177), own power (SE197) or believing in *"self"* (SC209). And 4 out of 5 clients in TC Sejřek responded that it is important or it helps them to believe in something in drug addiction treatment (SA216; SC213; SE195; SI133). Interesting case is a client who responded that he/she believes in Jesus Christ, however he/she does not approve of religion from the historical point of view (SE207), to be more accurate the necessary church visits (SE202; SE203) and dogmatic blind believing (SE209; SE210).

Another participant of the interview from TC Sejřek, stated that the possibility to ask questions to father Sebastian (cleric who commutes to the community) (SG181; SG183) brings him/her some hope (SG185). However, one client in TC Sejřek responded to question whether it is normal to speak in the therapeutic community about religion or faith – that it is not usual and nobody pays attention to it (SI139), as a reason why it is so, he/she claimed that perhaps it is because they (members of the whole therapeutic community including therapist) were not growing up in religious conditions (SI141).

Derived from the data in the content analysis, in TC Sejřek there is an opportunity to search for one's spirituality, ask questions to a competent person in the field, however as opposed to TC Takiwasi, the spiritual level of the drug addiction treatment is perceived merely additional to the treatment and is less recognized as a part of the therapy.

The evidence for this phenomenon is obvious for instance in daily schedule of activities in the TC Sejřek and TC Takiwasi. In TC Sejřek there is no written record of any spiritually oriented session in daily schedule (see Appendix A) as well as in the content analysis, where clients from TC Sejřek mention spirituality as significant for drug addiction treatment, however the treatment facility provide them with only a little opportunity to develop one's spirituality in form of optional consultations with a cleric (SG181; SG183).

As opposed to Takiwasi where, as claimed by Horák (2013), spirituality can be deemed as significant part in the Takiwasi treatment program and as derived also from the content analysis results and patients'/clients' testimonies in the chapter below.

4.2.2 TC Takiwasi in Peru

As resulted from content analysis, in TC Takiwasi, one patient response contains assurance that the aspect of spirituality is being reinforced in the therapeutic centre (TA138) and another respondent from Takiwasi claims that the centre focuses on remedy in approach to religion (TG159). Derived from 4 affirmative out of 5 patients' responses, it is clear that that spirituality and religion plays an important role in treatment in TC Takiwasi (TA138; TC167; TE158; TI204).

Although, it is not compulsory to attend religious ceremonies in the therapeutic centre Takiwasi (TC171), there is an exception of first Catholic Mass in a month according to one patient (TG163; TG166). Alas, the same patient noted subsequently that there is another workshop with father Christian which is compulsory (TG168).

The question is whether the approach of introducing Catholic Masses as compulsory – even though just once in a month – together with workshops with clerics is not hindering one's faith in favour of Catholicism. And whether it is a rational solution for seeking remedy in approach to religion, although, it is utilized as a tool for spiritual growth among the patients.

Heinz *et al.* (2010) suggested launching a spiritual program within a drug treatment facility. There has been a support of this idea among the members of the community where the research was conducted. However, they required integration of non-compulsory spiritual program into the drug addiction treatment.

Nonetheless, Heinz *et al.* (2010) admit also the fact that further investigation and clinical experimentation will be necessary in the future for the purpose of identifying such form and arrangement of a group which would be rather of practical nature and beneficial in a drug addiction treatment facility. Furthermore, it is mentioned that spirituality programs within drug addiction treatment facilities may bring about risk. As the *"one size fits all"* spiritual program do not necessary comply with *"the need for cultural sensitivity"* and according to this attitude to recovery is in particular improper for minority groups.

One patient in TC Takiwasi mentioned that faith no matter if it is Catholic or Evangelical, it is one's personal issue. He continued with a statement that he searches for his own spirituality and believes in God, but is not keen on becoming Catholic and being baptized (TI216) as it is happening – presumably voluntarily - in TC Takiwasi as stated by Horák (2013).

4.2.3 TC CEA in Nicaragua

In the dimension of spirituality is the concept of drug addiction treatment most similar to Alcoholics Anonymous (AA) as researched by Kalina (2008). According to Heinz *et al.* (2010) is AA *"spiritually lay program"* which is also known in a version for other than alcohol abusers under a name Narcotics Anonymous (NA). As claimed by Galanter (2006) spirituality in AA is an important attachment to psychiatric services. He also writes about the origins of Alcoholics Anonymous back in 1935, when a laic in the field encountered *"spiritual re-awakening"* which allowed him to discover a way in direction of recovery from alcoholism.

A modification of AA called Matrix method is administered in TC CEA in Nicaragua. Matrix model is according to Horák *et al.* (2014) modified version AA, which was originally designed as outpatient program for drug addiction treatment. As further claimed by TC CEA, research has shown that combining formal treatment with involvement of 12 Steps of AA fellowships increases the chances of successful treatment. It has been proven in content analysis, that the majority of patients from TC CEA stated that the program is rather of spiritual than religious nature (CG105; CG107; CI107) and one patient asserted that no religion is being promoted in the program (CC106; CC107).

Interesting evidence brought the content analysis where a patient in TC CEA alleged the program as his God or higher power (CG115; CG117), however as a reason for this fact is mentioned the absence of any God or religion in a patients' life so far (CG113). Though, it makes sense, because Matrix, a modified version of AA for inpatients which is administered in TC CEA, shares with AA *"12-step spiritual concept for AA,"* which carries obviously spiritual meaning as evident from the step 3. (see Appendix B).

As for the spirituality within any drug addiction treatment program which would be rather of practical and beneficial nature, AA or modified version Matrix performed in TC CEA is a treatment program which is administered in a religion like way, however as confirmed by interviewee from CEA (CA156; CA158) – it is spiritual program rather than religious – assuming that no specific religion is being enforced in the program as also confirmed by Horák *et al.* (2014)

To sum it up, three out of five patients from TC CEA confirm a spiritual manner of the program, rather than religious (CG105; CG107; CI107) obvious in 12 Steps of AA. Furthermore, two patients compare the program to God's commandments and as God they perceive the program itself (CA154; CC111; CC113). Patient (CC106; CC107) agreed that regardless of type of a religion or spirituality - to believe in something in the course of the program is essential (CC109).

Another patient from CEA comments that it is necessary to have a faith or something to believe in to fill the emptiness which appears after the drugs and certain persons' exclusion out of one's life. And it is important to fill it with anything which makes one happy and prevent you from relapse (CI107). Resulting from four affirmative out of five patients responses, it is clear that spirituality or religion plays important role in drug addiction treatment (CC105; CE88; CG103; CI 107).

Kalina (2008) claims that the moment when an alcoholic accepts his inability to cope with his/her addiction is a turning point and important first step towards future ability to master a one's life and its challenges. This statement is to be proven also by patients from TC CEA. A patient (CE88) from CEA admitted that his illness (meaning addiction) is so widespread that he has to seek support everywhere, but he trust primarily God who is to him a higher power. Another patient from CEA (CG103) claimed that addicted person is deemed to be unable to get alone on the right way out of the addiction without any additional help.

According to one patient (CG103), sometimes not even experts have sufficient skills to assist addicted person with successful treatment, even though the addicted person is willing to take part in the treatment. In this case, addicted person has to search for some transcendental power which would be here in case everyone else will be gone. And the same patient asserted that religion is important in a drug addiction treatment, because it provides the addicted person with power and allows him/her to proceed with treatment (CG103).

Another case is a patient from CEA who responded to a question - what kind of role plays religion in drug addiction treatment – describing his effort to treat himself with religion with no success. The patient tried Catholic or Evangelical religion (CA144). Nonetheless this approach was not successful as he was administering drugs and being intoxicated while being in church (CA144). However, he admitted his fault and stated that he has found the resolution and a reason for his failure, which was the way he believed in the God not the fact that he did not believe in God (CA146).

4.2.4 Paradigmatic Model

The categories *religion* and *spirituality* in *drug addiction treatment* were identified as key categories within the content analysis of semi-structured interviews of all TCs in the Czech Republic, Peru and Nicaragua. In the thesis the central category is *drug addiction treatment* and key categories are connected to the central category. The categories were connected based on axial and selective coding via paradigmatic model in order to form a grounded theory according to approach set by Strauss &Corbinová (1999).

The *causal conditions* within the *paradigmatic model* are events leading to the occurrence of the *phenomenon* which was assigned to a category. The relevant questions to recognize such conditions are: *"What are the events that lead to the occurrence of the phenomenon?"* Causal conditions identified while developing grounded theory is that spirituality is necessary to be present in drug addiction treatment according to majority of patients/clients in all the TCs in Peru, the Czech Republic and Nicaragua.

Some patients associate religion within drug addiction treatment as quite negative notion, as opposed to spirituality. They link religion within drug addiction treatment program to a *"one size fits all"* religion prescribed to all. On the other hand, spirituality is considered to be highly individual and connected to an individual faith. However there are exceptions, some patients accepted the promoted religion in a treatment facility.

The next stage of *paradigmatic model* deals with the *phenomenon* (assigned to a category in a content analysis). The relevant questions for the phenomenon are: *"What are the data (from content analysis) related to? What is the interaction/action about?"* The phenomena identified in the data of all three TCs are: the *spirituality* and *religion* in *drug addiction treatment*.

The interaction between the all three identified phenomenon assigned to categories is the healing nature of spirituality within drug addiction treatment grounded in data from content analysis and confirmed by several authors (Miller, 1998) (Horák, 2013). The incorporation of spiritual programs in substance abuse treatment, such as AA and its 12 Steps (see Appendix B), is also an evidence for the assumed significance of spirituality in drug addiction treatment. The distinction between spirituality and religion is as stated by Miller (1998) obvious in religion. Religion is a *"social phenomenon"* and *"organized structure"* one of which purposes is to build up spirituality in its associates. Therefore, in this research both spirituality and religion carry similar significance in the drug addiction treatment.

Another stage of *paradigmatic model* is connecting *categories* within a *context,* which are set of properties belonging to the category and its dimensions. Throughout the comparative analysis the categories were interconnected based on the properties which belong to each category. Identified context within *spirituality* and *religion* in *drug addiction treatment* is the perception of patients/clients whose support on searching for spirituality within treatment requires more individual approach than merely promoting certain religion which might be hindering one's personal way of search for spirituality.

The last two fundamental features in *paradigmatic model* are *intervening conditions, strategies of action and interaction* and *consequences.* Intervening conditions assist with or complicate the utilization of strategy of acting or interacting in certain context. The conditions are usually: economical status, time, culture, space, biographical data, occupation, etc.

Throughout the comparative analysis, there have been identified several *intervening conditions* while interconnecting categories via *paradigmatic model*. The issue that complicate drug addiction treatment is the challenge to deploy a spirituality development program within drug addiction treatment without utilizing *"one size fits all"* approach and inhibiting one's freedom of religion. Conversely, the facilitating feature is the natural spiritual seeking of patients/clients who believe that to have faith or confess certain religion or be spiritual is supporting them in treatment.

The *strategies of action* and *interaction* basically create the *context*. It is a set of conditions, where certain *strategies* are applied in order to manage or react to a *phenomenon* which was assigned to a *central category*. In the thesis the central category is *drug addiction treatment* and *key categories* connected to the central category in this chapter are: *spirituality* and *religion*. The identified strategies how to provide functional drug addiction treatment is the presence of spirituality program within the therapeutic community.

In TC Sejřek, there is a cleric who commutes to the community and is in charge of consultations with patients/clients concerning their questions related to religion. In TC CEA, the whole Matrix program is based on AA 12 Steps (see Appendix B) which is highly spiritual itself. In TC Takiwasi, spirituality is encouraged in treatment and is in some cases obligatory. Nevertheless, the main focus is put on specific religion. As derived from the patients/clients attitudes and the sources of literature, the recommended model would be drug addiction treatment in TC with spiritual program with no focus on specific religion. It is suggested to perform further research in TC CEA which seems to provide the closest approach towards the suggested model.

The *consequences* within *paradigmatic model* are necessary to track in order to create grounded theory, because what is at some point a *consequence* of *action* or *interaction* might be later part of condition of other acting strategies. The *consequences* result from *strategies of action* and *interaction* to manage or administer a *phenomenon* which appears in a certain *context*. In framework of this thesis there are *consequences* which stem from strategy of action and interaction by including *spirituality* and *religion* in order to provide drug *addiction treatment* in therapeutic community.

The consequences is the fact that patients/clients who can in their treatment seek a support in form of higher power or their own perception of God claim that it is beneficial in treatment. Nonetheless, promoting a single religion within treatment can inhibit one's freedom of religion or a way of search for spirituality. Thus it is proposed to establish optional spiritual programs within TCs which might be inspired by TC CEA and its Matrix model or might be of spirituality supporting nature. It is suggested to further research the Matrix model in TC CEA and also to develop a study on program schedule within TC which would encourage spirituality without promoting merely a single religion.

4.3 Use of Plants and Individual Therapy in Drug Addiction Treatment

The individual therapy plays an important role in each of the three socio-culturally different TCs. Fourteen interviewees out of fifteen from TC Sejřek (SA129;SC121; SE91; SG92, SI70), TC Takiwasi (TA60; TC60; TE101; TG87; TI131) and TC CEA (CA56; CC60; CE52; CG60) have personal therapist within the drug addiction treatment. There is an exception in TC CEA where an interviewee (CI49) was a newcomer, being in TC only 6 days and has not been yet appointed to any personal therapist.

The therapeutic focus of individual therapy as claimed by Kalina (2008) are emotions and development of personality. Nonetheless, one of the features which influence the efficacy of treatment in TC, as proved in research by Horák *et al*. (2014), is the resolution of a problem which is the cause of one's addictive behaviour. The efficacy of the treatment in TC is presumably the key outcome, thus such therapeutic procedure to resolve the issue is supposed to be a part of therapy.

Supposing that searching for one's roots of addiction is an issue of highly personal and sensitive character, it is possible that a part of individual therapy would be a discussion on the topic of one's lifelong history with all its obstacles in order to find the beginning and source of addictive behaviour. An evidence for it has been identified in TC Takiwasi (see Chapter 4.3.1).

Even though, individual therapy is part of drug addiction treatment in all three TCs program in the Czech Republic, Peru and Nicaragua, no scholarly sources which elaborate on the content of individual therapy has been found. As opposed to group therapy, which together with the issue of clients/patients and therapists cohabitation in a therapeutic community, where individuals learn from each other while proceeding with treatment according to the daily schedule, is the whole idea of the community treatment.

4.3.1 TC Takiwasi in Peru

Being interviewed on the topic why he has been abusing drugs, a patient from TC Takiwasi commented on how he has unlocked many of his problems (TC49) while being six months in the therapeutic community. Some of the identified problems were his doubts whether his family is his real family and thanks to his individual therapist (TC60), to whom he had opened up, he found the truth about his father who is in reality his brother (TC49), the therapist organized a visit of the family.

The patient commented on the topic that perhaps drugs might be the reason why he never fully realized the family problem. He only had doubts about it (TC49; TC51). Nonetheless, it might have been vice versa, the drugs might have been solution or reaction to the doubts and insecurity in the family. However, important is that the patient on account of an individual therapy is able to resolve his personal problems. And most probably, as a result he proceeds with uncovering the roots of his addictive behaviour.

In TC Takiwasi, where as stated by patients and as claimed by Horák (2013), the administering of traditional indigenous medicine in ritualized setting – psychoactive plants from Amazonian rainforest – in order to proceed with treatment is the key element in the rehabilitation program. A patient from TC Takiwasi claims that the most beneficial therapy is a combination of administering plants, his effort and therapists influence (TE95).

Furthermore, another patient in TC Takiwasi stated that a beneficial part of the therapeutic program is next to cohabitation with other patients, the administering of ayahuasca and both purgative and dietary plants as well (TA50; TA51; TA52). The purgative plants are utilized for detoxification and ayahuasca belongs to this group as well, although it is a psychoactive plant too.

Dietary plants are utilized for diets. Diets are procedures when patients stay for 8 days in rainforest unaccompanied, eating only prescribed meals, drinking substances from plants. The ultimate aim of the diet next to detoxification is regeneration via contact with nature, stimulation via psychoactive plants, and introspection. The process of administration of dietary plants is performed within a ritual (Horák, 2013). Thus, also dietary plants with no psychoactive effects lead in combination of solitude to self-introspection and potential roots of addictive behaviour identification.

It is known that ayahuasca provide patients with an altered state of consciousness and self-knowledge. And individual therapy – as derived from data in the content analysis – follows with discussion of personal issues. The personal issues experienced when administering ayahuasca in TC Takiwasi (e. g. vision concerning past events which might lead to addictive behaviour) are most likely discussed within individual therapy taking into account the personal nature of it and as confirmed on the web sites of TC Takiwasi.

The individual therapy aim is to consult with patients/clients personal issues, problems, doubts and potentially seek for the source of addictive behaviour. The administration of plants in drug addiction treatment in combination with individual therapy, might apparently lead to a higher possibility of the retrieval of one's source of addictive behaviour, which is according to Horák *et al.* (2014) one of the key aspect which influence the efficiency of drug addiction treatment within the TC.

The majority of patients in TC Takiwasi stress the significance of all the plants collectively (purgatory, dietary and psychoactive) as a whole beneficial unit in the treatment (TA50; TA51; TE95; TI128;) with an exception of one patient who stresses the dietary plants as the most beneficial (TG74) and a patient who was not questioned on the topic.

The potential application of the use of healing plants in combination with individual therapy in other TCs in the Czech Republic, Nicaragua or possibly in any other TC worldwide should be considered for further research. The ayahuasca and the plants containing the mixture which creates ayahuasca are *"not internationally prohibited under the 1971 Convention on Psychotropic Substances"*, however one of them, the plant *Psychotria viridis* contains DMT, a *"controlled substance under the International Convention on Psychotropic Substances"* (McKenna, 2004).

Fortunately, the purgatory and dietary plants from Peruvian Amazon are not illegal in the Czech Republic and Nicaragua in case they do not contain any controlled substances. Alas, the plants most probably require specific conditions for growing which could be costly in diverse climate conditions. It is suggested to perform further research on plants with similar effects but culturally specific for the Czech Republic and Nicaragua. It is also proposed to research the possible efficacy of administering such plants in combination with individual therapy. And it is suggested to measure the outcomes whether plants serve as catalyst in the search of the roots of one's addictive behaviour in order to eliminate it.

4.3.2 Paradigmatic Model

Throughout the chapter, the categories *individual therapy* in *drug addiction treatment* were identified as key categories within content analysis of the semi-structured interviews of the TC in the Czech Republic and TC in Nicaragua and additionally the category *use of plants* was identified in TC Takiwasi in Peru. In the thesis the central category is *drug addiction treatment* and key categories are connected to the central category. These categories were based on axial and selective coding connected via *paradigmatic model* in order to form a grounded theory according to approach by Strauss & Corbinová (1999).

The *causal conditions* within the *paradigmatic model* are events leading to the occurrence of the phenomenon which was assigned to a certain category. The relevant questions to recognize such conditions are: *"What are the events that lead to the occurrence of the phenomenon?"* Causal conditions identified while developing grounded theory is that the occurrence of the individual therapy within all of the three TCs signalizes the importance of it, even though as researched no elaborated study put focus on the topic so far.

The individual therapy within the drug addiction treatment facilities occurs – as derived from data in content analysis – as a tool for discussing personal issues of patients/clients and uncovering personal problems, which might lead to identification of the source of addictive behaviour. And therefore, such therapeutic procedure to resolve the issue is supposed to be a part of therapy. The recognition of the problem which is the cause of one's addictive behaviour influences the efficacy of the treatment in TC, which is presumably one of the key outcomes of the therapy (Horák *et al*., 2014).

The reason for occurrence of the *phenomenon: use of plants* in *drug addiction treatment* in TC Takiwasi has been identified originally as the intention of French government to develop a project where the indigenous medicine of the Peruvian Amazon would be utilized for drug addiction treatment on a former cocaine production field. Supposedly, also because of the rich history of Amazonian rainforest healing plants usage in traditional medicine by indigenous people of the Amazonia.

The next stage of *paradigmatic model* deals with the *phenomenon* which was assigned to a category in a content analysis. The identified phenomena in this chapter are the key categories *use of plants* and *individual therapy* in *drug addiction treatment*, where drug addiction treatment is the central category. The relevant questions for the phenomenon identification are: "*What are the data (from content analysis) related to? What is the interaction/action about?"* The data from content analysis have revealed that individual therapy is important part of drug addiction treatment in all three TCs. The data have also disclosed that utilization of plants is one of the most beneficial parts of the drug addiction treatment in TC Takiwasi.

The interaction to develop and advance the administration of drug addiction treatment in all three TCs is the inspiration and potential cooperation of all TCs to merge the individual therapy with plants utilization. Having combined these two methods successful among patients/clients in three socio-culturally different countries would seemingly lead to unique results.

Another stage of *paradigmatic model* is connecting *categories* within a *context,* which are set of properties belonging to the category and its dimensions (Strauss & Corbinová, 1999). Throughout the comparative analysis the categories were interconnected based on the properties which belong to each category. Identified context within *use of plants* and *individual therapy* in *drug addiction treatment* is – as derived from data in content analysis – the usage of plants in drug addiction treatment is according to majority of patients from TC Takiwasi a key aspect and most beneficial part of the therapy in the treatment. This statement is confirmed by several authors as well.

An assumption, based on method of induction, is that the usage of plants in the therapy is potentially a catalyst of the individual therapy, where a patient/client together with a therapist seek to resolve personal problems and potentially identify the roots of the addictive behaviour of the patient/client. The usage of plants as a supplement to individual therapy is considered – based on data in content analysis – as helpful while resolving past problems. The self-reflections caused either by the dietary plants with the combination of solitude in the rainforest or in form of visions caused by psychoactive mixture of Amazonian plant – ayahuasca – might presumably be the catalyst and supplemet of individual therapy.

The last essential features in Paradigmatic Model are *strategies of action and interaction, intervening conditions* and *consequences.* Intervening conditions assist with or complicate the utilization of strategy of acting or interacting in certain context. The conditions are usually: economical status, time, culture, space, biographical data, occupation, etc.

The *strategies of action and interaction* basically create the *context*. It is a set of conditions, where certain *strategies* are applied in order to manage, administer or react to a *phenomenon* which was assigned to a central category. In the thesis the central category is *drug addiction treatment* and key categories connected to the central category in this chapter are: *use of plants* and *individual therapy in drug addiction treatment.*

The identified strategies are to consider the usage of plants within the drug addiction treatment therapy as a supplement to individual therapy, where personal issues are discussed and thus also personal issues experienced while administering plants (purgatory, dietary and psychoactive) could be discussed either. The combination of both might in all probability have effect on one's roots of addictive behaviour problem search which is according to Horák *et al.* (2014) the key aspect which influence the efficiency of drug addiction treatment within TC.

Throughout the comparative analysis, there have been also identified several *intervening conditions* while interconnecting categories via *paradigmatic model.* The usage of plants in drug addiction treatment in the combination with individual therapy is only performed in TC Takiwasi in Peru out of the 3 TCs. Alas, there are conditions that might in the future limit the usage of the psychoactive plants within the TCs drug addiction treatment programs in the Czech Republic and in Nicaragua, for instance legal or cultural.

As for the *consequences*, it is significant to track them in order to create grounded theory, because what is at some point a consequence of acting or interaction might be later part of condition of other acting. The *consequences* within the categories *use of plants* and *individual therapy* in *drug addiction treatment* are suggestions for further research in the field of dietary and purgatory plants utilization within drug addiction treatment as a supplement to individual therapy which is now present in all of the 3 TCs in the Czech Republic, Peru and Nicaragua.

4.4 Cohabitation in Gender Mixed and Gender Separated Therapeutic Community for Drug Addiction Treatment

All fifteen interviewees from TCs Sejřek (SA190; SA192; SC177; SE149; SG153; SI106), TC Takiwasi (TA110; TA115; TC145; TE135; TG143; TI166) and TC CEA (CA100; CC89; CE74; CG78; CI91) have responded that cohabitation in the TC is important aspect in the treatment in order to be functional.

It is important to mention that TC Sejřek in the Czech Republic and TC CEA in Nicaragua are gender mixed therapeutic communities, as opposed to TC Takiwasi in Peru which is solely male therapeutic community. In order to investigate more on the topic of gender separated TC – which is rather unusual model in the Czech Republic - and its patients/clients opinions and attitudes towards the model, questions related to gender roles in drug addiction treatment have been raised in TC Takiwasi.

As said, all interviewees regardless of whether they are patients/clients in gender mixed or in gender separated community they value the cohabitation as an important part of the treatment. However, it should be further researched whether a type of community (gender mixed or gender separated) plays role in drug addiction treatment in TCs.

In TC Takiwasi, solely male TC, have been patients interviewed on the topic of gender role in drug addiction treatment. A patient asserts that mixed gender community would rather cause problems. The presence of women would according to him cause difficulties (TA149). Another patient admits that there would be breaking the rules when both sexes would be in one TC (TC179).

Other question raised in TC Takiwasi was whether differences exist between drug addiction treatment for men and women. Majority of the patients were not able to respond surely in affirmative or negative way. One stated that there are no communities for women in Peru and he cannot imagine drug addiction treatment for women (TA156).

Some stated that there are some minimal differences between men and women, though men and women are influenced by the same things (TE209); or there has been an opinion that women are more mature and men are emotionally weaker than women (TI261), hence probably women as reported by a man, would deal with addiction better than men. Other patient replied that among women the drug addiction treatment would be more difficult, as an instance he claimed that women only cohabitation could be one of the issues (TG198).

Another patient from Takiwasi (TA115) commented on cohabitation in only male TC, he stated that cohabitation of solely one sex might be harsh as for the sex abstinence and substance abuse withdrawal syndromes combined. Though, sex abstinence is required by community regulations in TC Takiwasi (Horák, 2013) and also in TC Sejřek (See Appendix C) and in TC CEA presumably as well.

In Peru the legislation bans to treat both sexes in one therapeutic facility (Horák, 2013). As assumed, significant reason for the legislation that bans gender mixed communities in Peru is the concept of *machismo* apparent till nowadays in Peruvian society. This statement is confirmed in two patients' responses.

One patient stated that women in machismo Peru are more dependent on men and thus it is for women more difficult to proceed successfully with drug addiction treatment (TG198). Other patients answered more indirectly, responding to a question what do women in Peru do to fight drug addiction, that there are no drug addiction treatment facilities for women. As claimed by one patient in TC Takiwasi, women in Peru can deal with the issue without support by visiting merely psychologist, because they are stronger than men (TE181). Different opinion among patients in Takiwasi is that women can deal with addiction because they are emotionally stronger (TI261) and can cease the drug abuse because of their children (TE103).

In a book by Melhuus & Stølen (1996), is discussed the concept of *machismo* and the history of challenges and strategies aspiring to change women subordinate position in Peru. The *machismo* concept is basically a comprehensive label for women subordination in Latin America. The *machismo* concept of men dominant position in Peru implies the logic behind mixed therapeutic community ban in Peru.

Interesting example of gender mixed TC is the Nicaraguan TC CEA, it provides drug addiction treatment for both sexes with an area designated for women and men separately. It is done so for privacy purposes as stated on the web sites of CEA. Also a patient confirmed in the interview the separated model of cohabitation in CEA (CA102). Nonetheless, in CEA are also specific session where both women and men meet, depending on the treatment – CEA offers next to inpatient treatment, also outpatient program, program for families and monitoring program.

The idea of gender separated, but on certain levels mixed community, similarly like in TC CEA might seem as a solution for easier rehabilitation of patient/clients who were sexually abused. It is necessary to mention that in TCs are no exceptions victims of sexual violence, for instance in TC Sejřek (SG117; SE36) or a victim of physical violence also in TC CEA (CA135).

To support the idea of gender mixed, but separated community on the level of treatment program, Kalina (2008) asserts that drug addiction concern in men and women differs significantly and the treatment often requires diverse approach.

Conversely, the idea of gender separated TCs with no contact with the opposite sex, might assumingly meet the gender specific needs of both sexes completely, but the exclusion and unnatural separation of both sexes could cause disruption of the whole idea of cohabitation.

The cohabitation as a part of treatment was first examined by of J. R. Rees during 2nd World War. He was the main army psychiatrist and proposed treatment of a bigger group of soldiers by living together also with therapist who facilitate the treatment Kalina (2008). In addition, cohabitation in therapeutic community and its consequences in drug addiction treatment are - as stated by patients/clients and as researched by Horák (2013), one of the most significant parts of the therapy in all three TCs.

It is assumed that, the representation of both sexes in TCs simulates the reality better than completely gender separated TCs. And most probably, the goal of every TC is to incorporate patient/client - who successfully terminates the treatment regardless of gender - back into society being properly prepared to socialize and communicate with both sexes.

Kalina (2008) devotes an entire chapter to gender specific needs of women in drug addiction treatment. The author admits that traditional profile of hierarchical therapeutic community (which is the first concept of TC for mental health disorders) was established by men for men and gender sensitivity is not at anchor in it. A solution could be *"gender-responsive programs"* that weigh up women needs and propose responsive programs, which are based on the identified specific needs for instance, program schedule, personnel, etc. (UNODC, 2004)

The UNODC (2004) proposed a solution for gender mixed TCs, which on the other hand dispose of separate common areas. The solution seeks to provide a structure within a gender mixed program which separate men and women in terms of *"living and sleeping areas"* and it suggests entrances and *"programming rooms"* separation as well. Furthermore, it calls for women therapist/staff presence on all shifts, maximization of safety in outside setting of the TC, design of program policy that prevents the risk of harassment and more.

This implies that UNODC proposes more attention to women in drug addiction treatment in future and suggest a method which might be called: *"equal in treatment, but separate due gender needs."* Similar programs for women within mixed gender TCs are also being established within TCs in the Czech Republic, but skilled staff is lacking (Kabíčková, 2014). It is suggested to perform further research on the topic of gender mixed, but separated TCs on the level of treatment program, which could be solution for meeting both genders' specific needs and ensuring that cohabitation in such facilities would imitate successfully the life outside the wall of TC.

4.4.1 Paradigmatic Model

While performing the cross-cultural TCs comparison, the categories *cohabitation in gender mixed* community and *cohabitation in gender separated community* in *drug addiction treatment* were identified as key categories within content analysis of the semi-structured interviews of the TC in the Czech Republic and TC in Nicaragua and in TC Takiwasi in Peru. In the thesis the central category is *drug addiction treatment* and key categories are connected to the central category. These categories were based on axial and selective coding connected via *paradigmatic model* in order to form a grounded theory according to approach by Strauss & Corbinová (1999).

The *causal conditions* within the *paradigmatic model* are events which lead to the occurrence of the phenomenon which was assigned to a category. The relevant questions to recognize such conditions are: *"What are the events that lead to the occurrence of the phenomenon?"* Cohabitation in gender separated therapeutic community for drug addiction treatment is a phenomenon which comes about due to specific gender needs or as a result of legislation – the case of Peru - in certain cultural settings. Conversely, cohabitation in gender mixed communities is better in simulation of a real life conditions outside the TC.

Originally, the idea of the treatment via relations in group treatment facility is a result of the work of J. R. Rees, who was an influential psychoanalytic in London in 1930s'-40s'. He was the main army psychiatrist during 2nd World War and the first aim was a different approach to treatment for mentally disturbed soldiers during 2nd World War. The enormous number of soldiers and the need to provide treatment for all of them in order to be able to go back to war field was the idea behind the first therapeutic community (Kalina, 2008) and cohabitation as a part of treatment in the community.

In order to connect key categories identified while performing content analysis there is another stage of the paradigmatic model - *the occurrence of the phenomenon*. The relevant questions to recognize phenomenon are: *"What are the data (from content analysis) related to? What is the interaction/action about?"*

The data related to the phenomenon of *cohabitation* in *gender separated TC* in Peru has been recognized as the need for gender specific solution in drug addiction treatment in therapeutic community. In this case, it basically means exclusion women from treatment secured by Peruvian legislation. And unfortunately, there is little evidence whether there are any such drug addiction treatment facilities in Peru for women only.

In gender mixed TC Sejřek, in the Czech Republic, there is no gender specific program for women neither for men. See Daily Schedule in TC Sejřek (see Appendix A). A solution for drug addiction treatment for both sexes might be sought in Nicaragua. The TC CEA offers gender mixed community, but with separated rooms for treatment purposes. Therefore, women have the opportunity to seek drug addiction treatment as well and both women and men have program according to gender specific needs, moreover both sexes are represented in TC without exclusion.

The *paradigmatic model* is connecting categories in order to proceed with grounded theory within a *context,* which is set of properties belonging to the category and its dimensions. In the comparative analysis the categories were interconnected based on the properties which belong to each category. Identified context within *cohabitation in gender mixed* and *gender separated TCs* in *drug addiction treatment* is – as derived from data in content analysis – drug addiction treatment in gender separated TC Takiwasi prevents from violence or rivalry among patients, though violence could most likely be present also in gender mixed communities.

In the future would gender mixed communities seemingly focus more on women as derived from UNODC strategy and publications; because TCs have been originally established *"by men, for men"* and it is in place to incorporate more programs which would focus particularly on women. Alas, currently in the Czech Republic are gender specific programs within TCs for drug addiction treatment of poor quality (Kabíčková, 2014). As a result, it is proposed to perform further research and assess and compare the results of treatment in TC CEA or other gender mixed TC where both sexes meet, but on the treatment program level women and men are separated.

The last essential features in *paradigmatic model* are *intervening conditions, strategies of action and interaction* and *consequences.* Intervening conditions assist with or complicate the utilization of strategy of acting or interacting in certain context. The conditions are usually: economical status, time, culture, space, biographical data, occupation, etc.

The *strategies of action and interaction* basically create the *context*. It is a set of conditions, where certain *strategies* are applied in order to manage or react to a *phenomenon* which was assigned to a central category. In the thesis the central category is drug addiction treatment and key categories connected to the central category in this chapter are: *cohabitation* in *gender mixed and gender separated TC.*

The identified strategies to provide drug addiction treatment is the idea of cohabitation in either gender mixed or gender separated TC. Both strategies were identified as useful, as all patients/clients responded that cohabitation significant part of the treatment (Horák, 2013) in both types of TCs.

The negative identified intervening condition is legislation in Peru, where establishing gender mixed community is not allowed by laws. In TC Sejřek and in the Czech Republic the intervening conditions are insufficient skills of staff to provide such gender specific program schedule (Kabíčková, 2014). In TC CEA the intervening conditions are insufficient available information concerning program schedule of the therapeutic community which would lead to better understanding of functioning of the mixed community with separated program for both sexes.

Regarding the *consequences* in paradigmatic model, it is important to track them to create grounded theory, because what is at some point a consequence of acting or interaction might be later part of condition of other acting. The consequences within the categories *cohabitation* in *gender mixed* and *gender separated TC* in *drug addiction treatment* are suggestions for further research inspired by diverse sociocultural methods of treatment in the field of cohabitation in gender mixed communities with gender separated treatment program.

5 Conclusion

The thesis aimed to identify drug addiction treatment approaches in selected socio-culturally diverse countries to carry out unique cross-cultural comparison and suggest proposals for development in the field of drug addiction treatment inspired by diverse methods of treatment in different socio-cultural settings.

Therefore, in three particular drug addiction treatment institutions in the Czech Republic, Peru and Nicaragua were performed all together 15 semi-structured interviews. Thereafter, the interviews were transcribed into MS Excel document and content analysis was carried out. The performed comparative research was based on the content analysis of the data and a method of qualitative data processing by Strauss & Corbinová (1999) of which outcome is the grounded theory.

The content analysis of the transcribed interviews from all three TCs has revealed significant concepts and categories which were, based on *paradigmatic model,* interconnected into three key categories: *spirituality and religion in drug addiction treatment; use of plants and individual therapy in drug addiction treatment; and cohabitation in gender mixed and gender separated therapeutic communities for drug addiction treatment.* The central category, connecting the topics of all key categories, of the comparative research, is the *drug addiction treatment* itself.

The grounded theory has brought following findings within the three key categories. Patients/clients who are able to seek a support in the treatment in form of spirituality or their own religion claim that it is beneficial for them to proceed with treatment. Nonetheless, the promotion of a single religion within treatment facility can inhibit one's spirituality. It has been proposed to establish optional spiritual programs within TCs which might be inspired by TC CEA and its Matrix model or might be of spirituality supporting nature. It is suggested to further research the impact of Matrix model in TC CEA and also to develop a study on a specific program schedule within TC which would encourage spirituality.

Thereafter, it has been researched that a combination of individual therapy in drug addiction treatment and purgatory, dietary and psychoactive plants utilization might function as a catalyst of understanding of one's roots of addictive behaviour. It is suggested to perform further research on plants with effects similar to plants from Amazonia utilized in TC Takiwasi, Peru; but culturally specific in selected regions of utilization. It is also proposed to research the efficacy of administering such plants in combination with individual therapy and to promote further research of psychoactive plants utilization in drug addiction treatment. It is also suggested to measure the outcomes whether these plants serve as catalyst in the search of the roots of one's addictive behaviour in order to eliminate it and proceed successfully with treatment.

The comparative research outcomes regarding cohabitation in gender mixed and gender separated community in drug addiction treatment outcomes has brought following grounded theory: it is neither right to separate both sexes completely, nor to provide treatment solely in mixed gender facility. It has been proposed to perform further research on the topic of gender mixed, but separated TCs on the level of treatment program, which could be solution for meeting both genders' specific needs and ensuring that cohabitation in such facilities would imitate successfully the life outside the walls of TC.

The research has shown general status of current and past drug addiction treatment in the Czech Republic, Peru and Nicaragua, which has in all three cases its limitations. Furthermore, the level of international assistance with drug addiction treatment and its significant deficits have been assessed. The conclusions validated the hypothesis that drug addiction treatment in the Czech Republic, Peru and Nicaragua is diverse and offers space for further development in this field inspired by different socio-cultural settings and methods of treatment in selected countries.

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7 Appendices

A Daily Schedule in TC Sejřek

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7:00 Wake-up Call	7:00 Wake-up Call	7:00 Wake-up Call	7:00 Wake-up Call	7:00 Wake-up Call	7:00 Wake-up Call	8:00 - 10:00 Breakfast
7:15 Warm-Up	7:15 Warm-Up	7:15 Warm-Up	7:15 Warm-Up	7:15 Warm-Up	7:15 Warm-Up	
7:30 Morning Activities	7:30 Morning Activities	7:30 Morning Activities	7:30 Morning Activities	7:30 Morning Activities	7:30 Morning Activities	
7:45 Breakfast	7:45 Breakfast	7:45 Breakfast	7:45 Breakfast	7:45 Breakfast	7:45 Breakfast	
8:15 – 8:50 Morning Community Session	8:15 – 8:50 Morning Community Session	8:15 – 8:50 Morning Community Session	8:15 – 8:50 Morning Community Session	8:15 – 8:50 Morning Community Session	8:15 – 8:50 Morning Community Session	10:00 - 12:30 Personal Free Time
9:00 Working Block	9:00 Working Block	9:00 Working Block	9:00 Working Block	9:00 Working Block	9:00 Working Block	
10:45 Break	10:45 Break	10:45 Break	10:45 Break	10:45 Break	10:45 Break	
11:00 Working block	11:00 Working block	11:00 Working block	11:00 Working block	11:00 Working block	11:00 Working block	
12:00 Break	12:00 Break	12:00 Break	12:00 Break	12:00 Break	12:00 Break	
12:30 Lunch	12:30 Lunch	12:30 Lunch	12:30 Lunch	12:30 Lunch	12:30 Lunch	12:30 Lunch
13:00 Break	13:00 Break	13:00 Break	13:00 Break	13:00 Break	13:30 Joint Activity	13:00 Personal Free Time
13:30 - 16:00 Working block	13:30 - 16:00 Sports Afternoon	13:30 - 16:00 Working block	14:00 - 17:00 Artetherapy	13:00 Specialized Group Session		
		14:45 – 15:00 Break		14:00 - 16:00 Ceramics		
16:00 – 16:30 Break				14:00 - 18:00 Free Time (2nd phase clients)		16:00 Community Trip
16:30 - 17:45 Group Session	16:30 - 17:45 Group Session	16: 30 - 17:45 Interactive Group	17:30 - 17:55 Relaxation	16:30 - 17:15 Time for Studying (0 and 1st phase clients)		
18:00 Dinner	18:00 Dinner	18:00 Dinner	18:00 Dinner	18:00 Dinner	18:00 Dinner	18:00 Dinner
18:45 - 20:00 Specialized Group Session	18:45 - 20:00 Group session	18:45 - 20:00 Group session	18:45 - 20:00 Group session	18:45 - 23.00 Personal Free Time	18:45 - 23.00 Personal Free Time	18:45 - 20:00 Evaluation Group
20:00 – 23:00 Personal Free Time	20:00 – 23:00 Personal Free Time	20:00 – 23:00 Personal Free Time	20:00 – 23:00 Personal Free Time			20:00 - 23:00 Personal Free Time
23:00 Good-night Call	23:00 Good-night Call	23:00 Good-night Call	23:00 Good-night Call	23:00 Good-night Call	23:00 Good-night Call	23:00 Good-night Call
			Once in a month at 18:45 - Relapse Prevention		Day trip or other day trip program	

Source: TC Sejřek's Archive

B The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Source: Service Material from the General Service Office, http://www.aa.org/assets/en_US/smf121_en.pdf

C Ground Rules in TC Sejřek

1. The client of TC Sejřek obeys the rules of therapy and the regime of the program. The client accepts the decisions of the community and the groups. The client is obliged to active cooperation.
2. In the community is prohibited:
    a. any handling and usage of drugs or alcohol
    b. physical aggression and psychological pressure
    c. racism
3. Among the members of the community is prohibited sexual contact and intimacy.

Source: TC Sejřek's Archive (translated)

D Standards and Goals for Therapeutic Communities

Therapeutic Communities represent a design of treatment which is directed primarily towards recovery from substance abuse through personal growth and which requires abstinence from mood-altering substances, including prescription drugs used illegally.

1. The members of the World Federation of Therapeutic Communities are required to:

   a) Recognize the human and civil rights of all persons associated with their therapeutic community and clearly state the rights, privileges and responsibilities of clients and staff.

   b) Vest in each individual within the Therapeutic Community the right to be free from the threat of the negative use of power by any individual or group.

   c) Develop a statement on the philosophy and goals of the program.

   d) Adopt regulations for their Therapeutic Community which afford protection from apparent or actual abrogation of local and national laws.

   e) Function within environments which provide maximum opportunity for physical, spiritual, emotional and aesthetic development and which will ensure the safety of everyone.

   f) Facilitate the structure of a society/community based on the optimal use of the integrity, good will and humanity of all its members in which the dignity of persons is a priority value.

   g) Train and provide adequate supervision for staff.

   h) Be accountable to an external Executive or Community Board with meetings predetermined and at regular intervals during the year for the purpose of maintaining supervision and responsibility for the activities of the program and each facility.

i) Produce an annual audited financial report, authorized by the member's Executive or Community Board.

2. The Board of the World Federation of Therapeutic Communities will require adherence to the Standards and Goals when considering applications and renewals of membership and will also require active compliance with the criteria established by the World Federation's By-Laws under the "Definition" Article lll and the "Membership" Article Vl (with particular reference to paragraphs A1, A2, B1, B2 and C3).

Source: WFTC World Federation of Therapeutic Communities, http://www.wftc.org/standards.html

E Semi-Structured Interview Form

PERSONAL INFORMATION

1. How old are you?
2. Where are you from?

DRUG USE

3. What type of drugs did you consume?
4. For how long?
5. What was the reason for the drug use?

BEFORE TREATMENT

6. Did you have any previous treatment?
7. What type of treatment (outpatient, inpatient)?
8. How long did your previous rehabilitation last?

TREATMENT

9. How long are you in this particular treatment facility?
10. Why did you decide for treatment here?
11. Who told you about this treatment facility?
12. Does anybody support you in treatment (e.g. family, employer)?

TREATMENT EFFECTIVITY

13. What aspect of treatment helps you the most in your rehabilitation?
14. Do you have a personal therapist? Who is it?
15. Is there anything that attracts you to leave the treatment facility?
16. Have you ever felt like finishing the treatment?
17. For how long have you stopped taking drugs in your life?
18. What was the reason to start taking drugs again?
19. What is the motivating factor for you to stay in treatment facility?

DCI

20. Would you say that the co-existence of patients in the treatment facility is important for the functioning of the therapeutic program?
21. Would you say that your attitudes, feelings or behavior may cause you problems with your physical health?

22. Have you ever had problems at school or at work because of the drug abuse?
23. Do you agree that drug use can cause you problems in your family life relationships?

RELIGION

24. What is the role of religion in treatment?

GENDER

25. Why is this treatment only for men?
26. Is it allowed to have sex during the rehabilitation process?
27. Does the absence of sex some meaning in the process of rehabilitation?
28. Have you ever been to Peru in a mixed community where men and women would be together?
29. Do you think there is a difference in treating addiction in men and women?
30. According to statistics there are more men than women addicts. Why is that so?

Source: Dr. Horák's Archive

Faculty of Regional Development and International Studies

F Informed Consent

COMPARATIVE RESEARCH ON DRUG ADDICTION TREATMENT

NAME AND LAST NAME OF PARTICIPANT IN RESEARCH:

…….

I agree to participate in this research, because I was provided with all the basic information. I had the opportunity to ask questions necessary for me to understand the research purpose. These questions were answered clearly and thoroughly. Moreover, it was explained to me that to participate in this research does not mean any risk.

According to Law No. 101/2000 coll. of personal data protection as amended, I give my consent to participate in this research and providing research material. My participation is voluntary and I can interrupt it whenever it deems necessary.

In ....., on ..... 2014.

.....
Signature

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