MPM - Master of Project Management

Benchmarking best practice:
Excellence in rehabilitation, recovery and social reintegration for people with substance abuse problems

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Nafn Nemand: Helga Sif Friðjónsdóttir
Leiðbeinandi: Dr. Guðfinna S. Bjarnadóttir
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Abstract

According to the World Health Organization (WHO), estimated global prevalence of alcohol abuse ranges from 0%-16% and global prevalence of drug use disorders from 0%-3% for adults. There are multifaceted gains for an individual, community and society in empowering people with substance abuse disorders to make a positive change for themselves toward a life without these substances. Substance abuse treatment is accessible in Iceland and the high rates of available treatment can be considered unique worldwide. Data on the impact of substance abuse treatment in Iceland are not conclusive, however it may be stated that treatment could be further improved to better serve the needs of the users, community and society. The purpose of this study was to use a benchmarking best practice methodology to explore the fundamental treatment components of San Patrignano, a rehabilitation, recovery and social reintegration residential community for people with substance abuse problems founded in Italy in 1978. Over 70% of the residents who have completed this residential community treatment have subsequently fully integrated into society, which is an exceptional outcome. The average resident was known to be a poly-drug user who had been using for many years with severe consequences to their health, relationships and life in general. The core therapeutic processes are embedded in the day-to-day living and learning in the San Patrignano community as the rehabilitation is tailored depending on each resident’s individual needs. The services are human centered, empowerment aimed, motivational driven, educational embedded and reintegration oriented. The experience of San Patrignano could be a useful model for further development of substance abuse treatment services in Iceland.
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1. Introduction
From prehistorical time people have been using psychoactive substances to alter perception, mood or consciousness as a part of their existence. These psychoactive substances can be used recreationally without significant consequences for the user and others. However, most psychoactive substances have immediate rewarding and positive reinforcing effect on the user which increases the probability of recurrent use of a substance, this may subsequently lead to dependency and abuse. The World Health Organization (WHO) has defined substance abuse as follows: “substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs” (World Health Organization, n.d.-d). Furthermore, WHO suggests that recurrent use of psychoactive substance “can lead to dependence syndrome – a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug.” (World Health Organization, n.d.-d). In addition to compulsion at least two of the following are present in substance abuse dependency disorder: (a) difficulties in controlling substance-taking behavior, (b) physiological withdrawal state when substance use has ceased or been reduced, (c) evidence of tolerance, (d) progressive neglect of alternative pleasures or interest because of the drug use and (e) persisting with substance use despite harmful consequences (World Health Organization, n.d.-e).

1.1. Prevalence of substance abuse
Based on the Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10) definition of substance abuse disorders, WHO has estimated that in 2004 the global prevalence of alcohol use disorders ranges from 0%-16% and the global prevalence of drug use disorders ranges from 0%-3% for adults (World Health Organization, n.d.-a; World Health Organization, n.d.-b).

In a report by the Health Minister of Iceland (2005) it is stated that in Iceland the estimated prevalence of alcohol use disorder is from 3.5-6.3%. It has been argued that assessing the prevalence of illicit drug abuse by epidemiology studies is challenging as people are reluctant to answer questions about illegal activities. Therefore, some professionals suggest that data collected at substance abuse treatment centers could be used to shed light on the matter. SAA-National Center for Addiction Medicine (SAA) is Iceland’s main detox- and treatment center. Approximately 1880 individuals are admitted to the center each year, whereof 600 are newcomers. SAA provides the largest proportion of addiction treatment services in Iceland (SAA, n.d.-a). Data from SAA stated that by the end of 2015 7.6% of all living Icelanders 15 years of age and older had at some point been admitted to the treatment center (SAA, n.d.-b). SAA’s 2015 annual report showed that for n=1689, 38% of subjects were dependent on alcohol, 15% where depended on alcohol and other drugs, 21% had cannabis dependency, 14% amphetaminedependency, 4% cocaine dependency, 4% where dependent on sedatives and 4% had opioid dependency (Tyrfingsson, 2016).

1.2. Negative consequences of alcohol and substance abuse
The hazardous and harmful use of alcohol and other substances can be defined as a public health problem. In a document published by the Fifty-eighth World Health Assembly of WHO it is emphasized that 3.2% of all deaths globally were attributed to alcohol and that
harmful drinking and the use of drugs is the underlying cause of multiple diseases, injuries, violence and social problems. Furthermore, drinking and drug abuse have a serious impact on human welfare and contributes to social and health inequalities. The World Health Assembly stated in the document that harmful alcohol consumption leads to an economic loss to society because of costs to health care, social welfare and criminal justice systems in dealing with events where the cause is most often a derivative of alcohol or drug abuse of an individual (World Health Organization, n.d.-c). In addition, people with substance use disorder often suffer due to stigmatization, discrimination, social exclusion and criminalization of their substance use behavior or the behavior financing their drug use such as prostitution and theft. (INPUD, n.d.).

People who use drugs intravenously are sometimes considered to have the most chronic substance abuse problem and thus at risk for multiple negative consequences (Gunnlaugsson, 2013). In Gunnlaugsson, (2013) findings are reported from a study done in Iceland in 2008 among 189 persons who had used drugs intravenous but were at that time in treatment at SAA. This study showed that half of the participants were on disability payments and had limited vocational experience. Most participants had only completed primary school and at least a third had been arrested due to violence or theft. Over half of the participants had hepatitis C infection and over 70% had experienced suicidal ideation in the past. Most of the 56 women participants had experienced physical and emotional violence and 75% of them had experienced sexual violence.

Therefore, it should be evident that there are multifaceted gains for an individual, community and society in helping or empowering people with substance abuse disorders to make a positive change for themselves toward a life without these substances.

1.3. Substance abuse treatment in Iceland and measured outcomes

Conducting an evaluation of substance abuse treatment effectiveness can be considered a challenge. Firstly, the desired outcome of substance abuse treatment services could be different based on the individual´s needs at entry. Thus, for some it could be to improve their social conditions while for others it could be to acquire better quality of life and social reintegration without substance use. It is also important to keep in mind that therapeutic needs vary for different target groups. Then there are inherent methodological challenges whereas it is impossible to control for all contextual factors influencing a person after discharge (Health Minister of Iceland, 2005).

Treatment of substance abuse problems in Iceland has a history spanning more than 50 years. In Iceland substance abuse treatment is highly accessible and it has been estimated that 50% of those who are in need of treatment receive it. A person with substance abuse problems who wants to get help can self-admit to different services and waiting time is thought to be relatively short. The high rates of available substance abuse treatment in Iceland can be considered unique in the Western World. As addiction is mostly seen as a biological disorder in Iceland, substance abuse treatment has been a part of mainstream health care where treatment is provided by multidisciplinary teams of health care professionals (SAA, n.d.-a).

Treatment of substance abuse in Iceland have involved different treatment services where mental health services and specialized alcohol and drug services are the main
providers (SAA, n.d.-a). Currently, in Iceland, there are three main non-governmental organizations (NGOs) providing services for people with substance abuse problems, i.e. SAA-National Center for Addiction Medicine, Hlægerðarkot and Krýsuvík. In addition, Iceland’s National University Hospital (Landspitali) provides treatment services for people with co-occurring psychiatric and substance abuse disorders. The NGO organizations are partially funded by the Icelandic government with an annual budget, but in addition they rely considerably on public donations and grants to finance their operations. These three treatment providers structure the treatment modalities into inpatient, outpatient or residential treatments. The length of substance abuse treatment at the provider’s facilities ranges from 10 days to 12 months.

Some studies have been conducted in Iceland attempting to explore the effectiveness of substance abuse treatments with emphasis on various outcomes. At least two studies have been conducted in Iceland that explored abstinence rates after discharge from substance abuse treatment. In a report from the Health Minister of Iceland (2005) findings from a study done in 1998 are discussed. This study had 351 participants that had either been in treatment at SAA or Landspitali for their substance abuse disorder. The findings showed that 50% were abstinent after 12 months and 16% were still abstinent after 28 months (Health Minister of Iceland, 2005). SAA (n.d.-a) discusses findings from a study surveying 920 patients who had sought treatment at SAA. The results showed that 59% had been abstinent for the past year and 51% for the past two years.

Furthermore, researchers suggest that re-admission rates are not a relevant indicator of clinical outcome or substance abuse treatment performance. In contrast, they suggest that re-admission rates can be a manifestation of the severity of substance abuse problems and lack of housing or other contextual factors that obstruct a person’s path to recovery and reintegration into society following treatment services (Humphreys, K and Weingardt, 2000). Over the past three decades, 78% of people seeking treatment at SAA have been admitted three or fewer times to SAA’s facilities and about 4% have been admitted more than 10 times (Tyrfingsson, et al. 2010). At Landspitali the re-admission rate per year for people with co-occurring psychiatric and substance abuse disorder is about 20-30% whereas the people re-admitted often have a severe substance abuse problems and adverse consequences (K. Kjartansson, personal communication, April 25, 2017).

The data on treatment impact in Iceland are not conclusive, however it may be stated that substance abuse treatment in Iceland could be further improved to better serve the needs of the users, community and society. Given the prevalence of alcohol- and drug abuse in Iceland and the tremendous payback for individuals and societies it is imperative that politicians, policymakers, health care and social welfare professionals join forces in searching for and developing additional effective services that will successfully provide rehabilitation, recovery and social reintegration for people with substance abuse disorders. From a project management stand point the first step in such a journey is to define the desired outcome of developing additional treatment services and subsequently study best practices that deliver this desired outcome.

Therefore, the aim of this paper is to explore the fundamental components of extremely effective rehabilitation, recovery and social reintegration services that will facilitate the reintegration of people with substance abuse disorder into society, where they
can serve as well functioning members. The method of benchmarking best practice will be used for exploration and recommendations based on information and data analyzes.

2. Literature review
For many people addiction is a chronic, recurrent problem and a reality that is hard to imagine for those who are not suffering from substance abuse. In a video that was produced by the Triple R: Rehabilitation for Recovery and Reinsertion project the following testimony was given of what it is like to be caught in the realms of addiction:

…We are caught in a lie because what we once saw as freedom is now holding us hostage, we crossed the lines we said we’d never cross, losing our dignity, our respect, our families and our friends, we slowly lose hope…”,”…we lie, we cheat, we steel and all for what?, for tiny scraps of happiness, we are desperate, so desperate to sacrifice all of ourselves for those little moments, so desperate to hide ourselves from reality…”,”…the drugs don’t work anymore, the bridges have all been burned and we end up on our own, no longer part of society and parasites on our towns and cities, desperate for help.(San Patrignano, 2017, April 28).

2.1. Different treatment philosophies
Scholars, professionals and researchers within the field of addictions have somewhat different views on addiction and its underlying causes. There are fundamental differences in treatment philosophy pertaining to the most effective way to help people with substance abuse problems (Zerger, 2002). This paper focuses on two different treatments philosophies, a disease model and a social model.

2.1.1. Disease model of addiction
The American Society of Addiction Medicine (ASAM) is a highly influential entity that leads the research and discourse on addiction around the world. ASAM defines addiction as “a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestation. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors” (ASAM, n.d.). Thus, according to this model, the underlying causes of addiction are mainly neurobiological. Genetic predisposition is also thought to play a role in how the disease of addiction becomes actualized in a person through the interactions of the environment with a person’s biology which leads to the manifestation of addictive behavior. Therefore, addiction is a chronic brain disease which involves cycles of remission and relapse but can progress and result in disability or premature death if a person does not get treatment or engage in recovery activities (ASAM, n.d.).

2.1.2. Social model of addiction
Another camp of professionals in the field of addiction and medicine have argued that the root cause of addiction is emotional trauma and isolation. This argument is somewhat based on a study done by Bruce Alexander, a psychologist, called the Rat
Park experiment (Maté, 2010). The findings of this study showed that rats who lived in a lush cage where they could play in a park-like environment, the Rat Park, eat the best rat-food and be around plenty of friends did consume less than a quarter of the drugs the isolated rats used in their laboratory cages. None of the rats at the Rat Park became heavy users whereas in comparison the rats in isolation all became heavy users of drugs. Further it is stated that a similar phenomenon may have occurred in the Vietnam War where substance abuse of the soldiers had been reported high when they were in the extremely stressful and cage-like environment of the theater of war. Thus, 20% of the soldiers met the criteria for addiction during their participation in the Vietnam war. Surprisingly, 95% of these addicted soldiers stopped using substances, most of them without rehabilitation, once they got back home. This suggests that people use psychoactive substances to cope with highly stressful environments and isolation (Maté, 2010).

Professionals and researchers who have challenged the disease model of addiction belief that trauma is the core factor that leads to excessive drug use and can thus lead to the development of addiction. Particularly emotional trauma that happens in childhood is thought to have a great impact on the development of the three dominant brain circuits of reward, motivation and memory which are all involved in addiction as well as on the development of the stress-response mechanism. Adverse childhood experience such as family violence, substance abuse of parents, sexual, physical or emotional abuse, bullying or lack of parental attachment are all thought to alter brain development and create susceptibility of the individual for addiction. Thus, suggesting that trauma impairs the brain’s reward circuitry and that a person will be more likely to use psychoactive substances to escape from the psychological pain or stress experiences (Maté, 2010).

Based on these arguments, some professionals belief that treatment, whether based on a disease model or a social model of addiction, needs to be trauma-informed and focused on the creation of new internal and external resources. The idea being that via neuroplasticity users can develop new brain circuits that can facilitate more adaptive responses and behaviors to deal with their psychological pain and stress (Maté, 2010).

2.2. Different treatment modalities
Hamza and Silverstone (2014) published a systematic review of treatment modalities for alcohol use disorder pointing out that research evidence was not strong enough to identify optimal treatment strategies for diverse populations. In this systematic review three main treatment structures and environments were described as follows: (1) Outpatient treatment services allow an individual to maintain their responsibilities to family, work or school while they are engaged in daily treatment. (2) Inpatient treatment usually involves detoxification from substances at the start of the treatment and has the benefit of removing the individual from their environment, thus providing a safe place for the individual to practice abstinence and learn skills that will help with their recovery. (3) Residential treatment also removes the individual from their environment and in most cases for a longer duration that an inpatient treatment. The length of stay most often ranges from 21 days to 1 year. Successes of these treatment modalities were usually measured in outcomes such as rate and duration of
abstinence, lower unemployment rates, reduced interactions with law enforcement and reduced use of medical emergency services. Hamza and Silverstone (2014) reported evidence which suggested that the longer an individual stayed in a program, the better the outcomes.

The disease model of addiction dominates the substance abuse treatment field (Zerger, 2002). Thus, majority of outpatient, inpatient and residential treatment structures view substance abuse as a medical disorder and offer treatment based on ASAM’s suggested best practice. ASAM suggests that recovery from the disease of addictions is achieved through a combination of self-management, mutual support and care provided by trained and certified professionals (ASAM, n.d.). The treatment should include the integration of psychosocial rehabilitation and ongoing care, sometimes with evidence-based pharmacological therapies to provide the best results. The aim of monitoring and managing this chronic disease over time should been to: (1) decrease the frequency and intensity of relapse, (2) sustain periods of remission and (3) optimize the person’s level of functioning during periods of remission (ASAM, n.d.).

The treatment philosophy based on a social model is at the core of some residential treatment facilities. The main emphasis in these programs is supporting a resident through a natural recovery process. It is acknowledged that the recovery process is multifaceted, different for each and every individual and develops over a relatively long period of time, or at least two years. Such residential facilities or communities aim to address the multiple intra-and interpersonal individual elements as well as contextual factors that have led to chronic substance abuse. These residential programs rely on employers, or treatment participants, who are in recovery themselves and can therefore serve as explicit role models who guide and support the resident on the path to recovery. It has been hypothesized that this form of residential treatment is the most beneficial for individuals with the most severe addiction problems (Silbert, 2002; Zerger, 2002). The main challenge for programs based on the social model is to secure funding from public agencies. Critiques of programs based on the social model point out that there are limited outcome studies available and that some of them have methodological weaknesses. Thus, the effectiveness of such programs can be challenged (Zerger, 2002).

2.2.1. Example of a successful residential treatment program
One of the leading residential programs in the United States of America is The Delancey Street Foundation which maintains eight residential educational communities in different cities. The Delancey Street residential community was a pioneering facility founded in San Francisco in 1971 by Mimi Silbert and John Maher and can be viewed as adhering to the philosophy of the social model. The age of the residence ranges from 18-68 and all have been severely abusing substances for many years. Over 95% of the residence have experienced physical, emotional and/or sexual abuse. Many of them are illiterate, never held a job and have been incarcerated multiple times. Thus, they can be viewed as the worst of the worst cases of substance abuse (Delancey Street Foundation, n.d.). There are 400 residents at any given time at their San Francisco facility whereof 70% are directed from courts, either probated, paroled or sentenced as an alternative to prison. The minimum stay is two years but the average length of stay is four years (Silbert, 2002). All of the Delancey project facilities are in prime locations, have an exceptional atmosphere and the aesthetics of buildings and
interior design are of the highest quality. There are several principles underlying the organization function, one of the most important is the “each one teach one” principle. This means that each resident is both a receiver and a giver or caretaker at the same time. For example, a resident who reads at a ninth-grade level tutors another who reads at sixth grade level, who in turn tutors one who reads at a fourth-grade level. Thus, every resident is responsible for one another and serves to support all other residents. This concept applies to all aspects of life. Through this core process, residents learn academic and vocational skills, interpersonal and social-survival skills as well as gaining new attitudes, values, sense of responsibility and self-reliance (Cowen, n.d.). Furthermore, each resident learns three marketable skills by working in the different Delancey training vocational schools within the businesses that the project runs. For example, there are no professional staff members working at the facility in San Francisco whereas all support, treatment, training and schooling is managed by the residence themselves. Delancey Street functions is thought of as an extended family and a community that is self-governed by a council of residents and all resources, including financial are pooled. To give an idea of their financing, the Delancey Street project in San Francisco is housed in prime location where residents run several businesses on the campus. The Delancey street foundation program is financially self-sustainable and receives no governmental funding. Between 55-65% of the revenue comes from the resident-run businesses such as a moving company, restaurant, café and Christmas tree sale project to name only a few. The remaining 35-45% of the funding comes from product-or financial donations from individuals and foundations. There are over 14,000 individuals who have graduated from Delancey Street and have reintegrated successfully into society (Delancey Street Foundation, n.d.).

2.3. Recovery model paradigm - HERMESS model
Four project partners: San Patrignano, Rimini, CeIS Roma, Dianova Spain and Basta Sweden completed a 2-year long European research project whereby they exchanged decades of experience in the field of drug treatment, recovery, rehabilitation and reintegration in Europe (Triple R, n.d.). This research project led to the creation of a recovery model paradigm, the HERMESS model, that presents the key concepts emerging from the best practice exchange between the facilities. The model and its seven concepts are presented in figure 1.
There are seven dimensions or key concepts in the HERMESS model. The key concept **Human centered** pertains to how a recovery program assesses and addresses the individual needs and works on the root causes that led the person into addiction to help that person find the best way towards rehabilitation and recovery. The **Empowerment aimed** concept speaks to the purpose of recovery which is to empower a person with substance abuse problem and help them build necessary self-esteem, life skills and professional skills that are lacking due to the drug addiction and factors that contributed to the addiction. **Reintegration oriented** emphasis that the recovery path is intrinsically connected with the social reintegration. Thus, there is a continuum between rehabilitation and social reinsertion. The concept **Motivational driven** addresses the fact that motivation is the trigger for changes in the beginning of the program and a crucial determinant in the recovery path. Motivation is the force that helps a person face the challenges of rehabilitation and is the underlying force that brings about the necessary changes that will enable social reintegration. **Educational embedded** is a key concept emphasizing that education plays a crucial role in the recovery programs and provides opportunities for people to continue their studies or vocational training that most often have been interrupted by substance abuse. Thus, education and skill-building are thought to be an investment for the future for each person and will solidify the recovery process. The concept **Self-sustainability** addresses the continuous challenge of searching for funding for the programs and organizations. Thus, the suggestion is that self-sustainability and financial autonomy should be a long-term goal for each organization. The seventh concept is **Social need oriented** pertaining to the fact that the experience and expertise from decades of working with rehabilitation, recovery and reintegration of people with substance abuse problems could be applied to new forms of social marginalization such as migration or homelessness. (Triple R, n.d.)
2.4. Treatment of addiction in Iceland
Substance abuse treatment services in Iceland have mostly been based on the disease model philosophy in addition to the 12-step program of Alcoholic Anonymous (AA) and cognitive behavioral therapy (Health Minister of Iceland, 2005).

The disease model is the underlying principle for substance abuse treatment at the mental health services at Landspitali. The hospital inpatient, outpatient and day treatment units provide treatment for people with co-occurring psychiatric and substance abuse disorder. The treatment at the hospital is tailored to the needs of an individual and provided by multidisciplinary team of psychiatrist, nurses, nurse’s aids, psychologists, social workers, occupational therapists, chemical dependency counselors and other staff. The main pillars of treatment are rooted in motivational interviewing, cognitive behavioral therapy, pharmaco-therapy and family therapy (Landspitali, n.d.).

SAA was founded in October 1st 1977 and has been treating people with addiction diseases for 40 years. This is the main detox-and treatment center in Iceland and operates a hospital, two inpatient rehabilitations centers (at Vik and Stabarfell) with a total of 60 beds and two outpatient units, one in the capital Reykjavik and one in Akureyri a town on the north coast of Iceland. SAA also operates a recovery housing facility with 20 beds for former intravenous drug users who were without a home when entering treatment. SAA offers multiple different treatment options tailored to various levels of disease severity and specific needs of different target groups (SAA, n.d.-a). People self-admit to the treatment program and there are about 350 people on a waiting list at any given time (SAA, n.d. -a). Most individuals start the treatment process in detoxification at SAA’s Hospital Vogur and the average stay there is 7-10 days. The hospital has 60 beds for adults and 11 beds for adolescents. A multidisciplinary team including doctors, nurses, nurse’s aids, certified chemical dependency counselors, psychologists and social workers provide multifaceted treatment at the SAA hospital that aims to help a person detox and acquire recovery based on a recovery model that has been developed by SAA over the years. This recovery model is an eight-step process: (1) substance use, (2) substance abuse with increasing consequences, (3) substance abuse where help is sought, (4) abstinence with minimal stability, (5) first stage of recovery, (6) second stage of recovery, (7) third stage of recovery and (8) permanent recovery (SAA, n.d.-c). At SAA’s inpatient rehabilitation centers and outpatient units the focus of treatment is on steps 3 to 5 of the recovery model. After detoxification, one-third of patients continue their treatment in rehabilitation centers for 4 weeks and one-third move into intensive treatment at the outpatient units for 4 weeks (SAA, n.d.-a). At discharge people are encouraged to continue the recovery process by using self-help groups such as Alcoholics Anonymous and/or support groups offered by SAA at the outpatient facilities (SAA, n.d.-a; SAA, n.d.-c). It should be noted that since April 2016 SAA has been in the process of building a new treatment and rehabilitation center at Vik which is situated in Kjalarnes, a 20 min driving distance from Reykjavik. The new building will be 3000 square meters and the old 800 square
meter facility already in use at Vík will be renovated. SAA aims to have services there up and running by October 1st 2017.

Samhjálp is a non-governmental charity organization where the main goal is to provide help and relief for underprivileged people in the community who suffer from homelessness, poverty and/or substance abuse. Samhjálp has a strong connection to the Pentecostal congregation in Iceland. Hlaðgerðarkot is Samhjálp’s treatment center which has been run since 1974. There is room for 30 (20 male, 10 female) people in treatment at Hlaðgerðarkot and the average length of stay is three months. People can self-admit and there is a waiting list at any given time. Hlaðgerðarkot does not provide detoxification and the treatment philosophy is the 12-step program of AA, provided by chemical dependency counselors in groups and individual sessions. Samhjálp also operates three recovery housing facilities for people in recovery as well as running a soup kitchen for marginalized people (Samhjálp, n.d.). In addition, Samhjálp has started the preparation and planning for a construction of a new facility at Hlaðgerðarkot, replacing the buildings currently housing the treatment services.

Krýsuvík is run by the NGO Krýsuvíkursamtökin which is a member of the European Federation of Therapeutic Communities. Since 1997 Krýsuvík has had the main goal of helping people, who are addicted to psychoactive substances, to help themselves towards recovery. People can self-admit and there is a waiting list at any given time. The minimum length of stay is 6 months with 21 residents being in there at the same time. The treatment is based on the 12-step program of AA treatment philosophy, it is individualized and aims to foster personal growth and development at the same time as to address the reasons of disintegration. Thus, people in treatment have access to educational opportunities, vocational opportunities, work within the facility and take part in individual and group sessions with chemical dependency counselors or a psychologist (Krýsuvík, n.d.).

2.5. Summary

There are different and often competing views on the causes of substance addiction, what it is and how it should be treated effectively. There is however a consensus in the field of addiction and recovery that the length of stay in treatment is a predictor of successful rehabilitation and recovery. Thus, it could be hypothesized that residential treatment programs where individuals stay for more than one year would be most beneficial, at least for the individuals with the most chronic substance abuse problems. The residential program should aim towards supporting a person’s natural process of recovery as well as the development of multifaceted intra- and interpersonal skills and vocational skills that will help a person reintegrated successfully into society after discharge. Furthermore, compassion, empowerment and shared human experience can be thought to lay the foundation for a healing process that will lead to recovery and social reintegration.

3. Methodology

The purpose of this exploratory study was to use a benchmarking best practice methodology to locate some exceptional treatment facilities and explore the fundamental components of extremely effective rehabilitation, recovery and social reintegration services that facilitates
the reintegration of people with substance abuse disorder into society, where they can serve as well functioning members.

In today’s ever changing and fast developing world, organizations and businesses that are serious about improving their performance and outcomes are increasingly using the approach of benchmarking best practice to learn and adapt best practices from others who are highly successful in the field of interest. There is also the possibility for an organization to explore best practices in another field or in industries whereas the goal would be to understand how those best practices could potentially influence innovation within their own field of industry or business. Benchmarking best practices studies may involve: (1) performance benchmarking, analyzing key performance indicators, (2) process benchmarking and (3) strategic benchmarking. This study used process and strategic benchmarking with the focus on successful components of treatment processes and patterns of winning strategies (Bogan and English, 1994). Thus, process and strategic benchmarking was believed to create an understanding of best practices in relations to the ideology and main pillars of the service systems as well as how they empower people with substance abuse disorders to rehabilitate, recover and successfully reintegrate into society.

It is understood that best practices benchmarking is not a scientific method but a search for models of excellence that may inspire successful changes. There is great variation in how the benchmarking best practice methodology is used at different organizations or companies. Companies adapt their own benchmarking approach, and most often the number of steps in the process vary from five to 12-steps. At least four benchmarking approaches are introduced in a book by Bogan and English (1994). The four processes were integrated for this study. The five-step benchmarking method used in the study is presented in table 1.

Table 1. Benchmarking method used in the study (adapted from Bogan and English, 1994)

<table>
<thead>
<tr>
<th>Number</th>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Launch</td>
<td>1. Decide what practices to benchmark</td>
</tr>
<tr>
<td>2</td>
<td>Organize</td>
<td>2. Identify services to benchmark</td>
</tr>
<tr>
<td>3</td>
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3.1. Benchmarking best practice executed

1. Launch

This benchmark best practice study explored the fundamental components of extremely effective residential treatment services that successfully facilitated rehabilitation, recovery and reintegration of people with substance abuse disorder into society.
2. **Organize**  
San Patrignano, Rimini, Italy was founded in 1978 and is the largest residential treatment facility/community in Europe. This residential facility provides long-term treatment completely free of charge for the residents, their families and taxpayers. There are 1400 individuals in the residential community at any given time and over 25,000 people have received rehabilitation and recovery from onset.

3. **Reach out**  
A data collection plan was created as well as benchmarking questions. The questions are presented in Appendix I.

Data collected were published research, manuals, reports, videos and website information pertaining to the San Patrignano community program. Furthermore, data and field notes were collected during a site visit to San Patrignano, Rimini, Italy in April 26th–27th, 2017.

4. **Assimilate**  
An analysis of the data was conducted and the findings are presented in the results section of this paper.

5. **Act**  
Recommendations based on the findings are presented in this paper’s discussion chapter.

4. **Results**  
San Patrignano is the largest residential rehabilitation community in Europe for people with substance abuse problems. It was founded in 1978 by Vincenzo Muccioli, a visionary who wanted to help people in need due to their substance abuse problems. Muccioli was committed to the values of respect for human beings, dignity, humanity and had a high sense of justice. He hosted the first drug dependent person in a country house of the Muccioli family and soon other persons with substance abuse problems joined. A group of volunteers and family friends moved in as well and Muccioli donated his estate and thus his country house became the first house of the San Patrignano community. Today San Patrignano is a residential community or a village occupying 650 acres overlooking the Adriatic Sea. It is a self-sufficient mini-city nestled with 260 hectares of fine wine yards and farmhouses (Triple R, n.d.). It should be noted that at San Patrignano community there is an emphasis on aesthetics and respect for the environment and nature. Furthermore, attention is given to surrounding ecosystems, organic gardening, humane farming and sustainable and renewable energy and material.

4.1. **Philosophy of San Patrignano**  
San Patrignano is committed to the values of its founder. The emphasis is on providing a home and a family for people who have lost their way in life due to substance abuse. It is a place of rebirth, founded on human values such as honesty, determination, commitment,
respect for oneself and others, solidarity and exchange. San Patrignano welcomes residents with patience and love instead of judgement so they can find their own path to recovery and build a new life with self-esteem, dignity, responsibility and enthusiasm. Substance abuse is not viewed as a medical disease but rather as an ailment of the soul. Thus, the drug of choice is uninfluential and the focus is on tackling the root causes that brought people to substance abuse in the first place. Or in the words of Vincenzo Muccioli:

> Among the problems that affects the drug addict, drug use is the least relevant. The core of the problem is not drugs, nor the abstinence crisis: it is the human being with his fears and black holes that threaten to suck him.
> That is why I do not like to say nor hear that ours is a community for drug addicts. Ours is a community for living, where you can restart after years spent as a social outcast. Ours, if we really need a definition, is a community against social marginalization. (Triple R, n.d., pg.10).

### 4.2. Guiding principles of San Patrignano

The experience at San Patrignano is that after years of severe substance abuse it takes years to recover. Thus, the program is long term and residents stay there for three to four years. The duration is not standardized but customized to the progress and challenges of each resident. This extended period of time allows sufficient time to produce skill-building, behavioral change and life changes which play a crucial role in recovery and reintegration into society.

San Patrignano is completely free of charge for the residents and their families. In addition, the community does not require public funding to carry on its activities. The choice to offer the services free of charge is based up on the rational that it will empower the residents to feel responsible for and in control of their own rehabilitation instead of being a receiver of services. Thus, free of charge as an indispensable pillar of the community model and was set by the founder in the beginning. Instead San Patrignano adheres to the philosophy of self-sufficiency. The community is organized as a social enterprise which produces and sells products and services that create 50% of the financial resources needed to run the community. The remaining funds are collected from private donations.

At San Patrignano there is a fundamental belief in the importance of vocational training, skills and education as the ultimate empowerment of individuals to recover and carry on to independent and meaningful lives after discharge. There are more than 57 types of job trainings for residents to choose from and the vocational and job trainings are considered to be a real training for life. The residents are encouraged to aim for excellence and top quality in their training and subsequent work. Thus, the universal principles of the educational and training opportunities are based respect for life, for one’s self, for others and for the environment.

### 4.3. Target group and outcomes

San Patrignano welcomes persons of all ages and gender who are willing to quit their addiction. In addition, persons can choose to become a resident as an alternative to incarceration. Parents with their children can come to San Patrignano as well as minors who most often are involuntary admitted. The average resident is a poly-drug user who has been using for many years with severe consequences to their health, relationships and life in general. Most of the residents have been through multiple treatments before, without much
success. Some of the residents consider this to be their last hope for recovery. There are only three conditions that would discourage admission to San Patrignano and they are: schizophrenia, anti-social personality disorder and severe eating disorder. This is due to the fact that people with these disorders need multidisciplinary professional treatment which is not readily available at the community.

As stated before in this paper there are methodological challenges pertaining to studying the impact of substance abuse treatments. Nonetheless, independent researchers at Bologna and Urbino University have opted to explore the characteristics of individuals who become residents at San Patrignano and conducted follow up studies of the former residents. Findings, from such studies suggest that over 70% of the residents who have completed the program of San Patrignano have fully integrated into society and no longer use any drugs (San Patrignano, n.d.). Therefore, San Patrignano can be considered to have exceptional treatment outcomes.

At least one study explored the characteristic of San Patrignano residents at entry and how they were doing regarding holding a steady job, secure residence and relapses after discharge. There was a total number of 252 participants in the study and data was collected with sociological tools and toxicological exams. At point of entering, 2.6% of the participants were 21-25 years old, 29.8% were 26-30 and 37.7% were 31 years or older. Of the 252 participants 38.6% had been using substances for 6-10 years and 18.3% for 11-15 years, suggesting that 56.9% of the residents could be viewed as chronic and incurable by most national and international standards. The results showed that 37% of the participants were working one job after leaving the community and 19% were working two jobs. The study showed that after discharges 63% of the former residents got reinserted in the same city they used to live in before entering the community. Furthermore, 33% participants were living with their parents, 46% had a family of their own and about 20% were living on their own. The results also indicated that there was a considerable difference regarding relapse between participant who left the community with mutual consent and those who left without fully completing. Additionally, the length of stay in the community was a predictor of relapse (Manfré, Piazzì, and Polettini, 2005).

4.4. Admission
A referral of residents is most often made by a network of supporting groups, called associations, operating in multiple cities in Italy and other European countries such as United Kingdom, France and Croatia. There are no formal admission criteria and only a genuine motivation to change is required to enter the therapeutic community. Volunteer staff at the associations, who most are former residents of San Patrignano, start the admission procedure with a phone call or a letter to establish the first connection to the community for an applicant. Following are a series of interviews, either in person at the associations or via Skype with a person in Admissions office at the community. The purpose of these interviews is to assess and test the applicant’s motivation to change, to gather information about their story and find a good fit with a suitable mentor and vocational trainings in the community. When the right match of mentor and vocational training becomes available the applicant can enter the community without much delay. However, about 80% of the soon to be residents are first admitted to Botticella a residential community run by San Patrignano, located about
30 min driving distance away. Botticella can house 90 residents and there they get their first experience in vocational training and how it is to live in the residential community. Some of the applicants opt to not continue on to be admitted to San Patrignano but majority continue the admission process and become residents of San Patrignano. There are 1400 residents at the community at any given time and over 25,000 people have received rehabilitation and recovery from onset.

4.5. Core therapeutic processes

In San Patrignano the core therapeutic processes are embedded in the day-to-day living and learning in the community and rehabilitation is tailored depending on each resident’s individual needs. Every newcomer is paired with a mentor who has been living in the community for at least one year. This peer to peer support aims to create bond that develops into a relationship of trust and friendship over time. The mentor is the key person to guide the new resident and lead through the structures of the community and daily activities, as well as being a support person around the clock who will listen and help through the first phase of the program. Becoming a mentor is a huge step in the individual recovery process as it stimulates empathy and fosters accountability for another human being. The mentor and the follower live in the same room with 2-3 other peer-to-peer duo. These 6-8 people who share accommodations are responsible for each other as well as collaboratively responsible for the daily chores in the accommodation. One of the residents in each room has the responsibility of being in charge of the 6-8 person group. The residents (6-8) who share accommodations are placed in the same training sector. Each training sector has a reference educator/responsible. Thus, a resident spends the day-to-day life with the same group of people who through daily interactions will support personal growth by helping to point out critical issues, weaknesses and destructive behavior and suggest alternatives that will foster recovery. Over time a resident therefore is entrusted with more responsibility and becomes a tutor for others in need for help which in turn fosters the feeling of contributing and being of use for other people and the community. There are 57 trainings sectors were residents are placed to create the platform of vocational training. By working and learning in each sector residents can see the value of their contribution which in turn fosters self-worth.

Education, and skill-building, is one of the core processes at San Patrignano. There is a study center within the community that aims to offer opportunities to get back to the individual’s interrupted education due to drug use as well as start a new educational path. Hence, residents can begin to work in getting diplomas of primary, secondary school and college degrees. There are also opportunities to complete an internship in various trades such as professional hairdresser, baker or electrician. Some of the residents have started their university studies at San Patrignano and gone on to complete their degrees in universities outside the community after discharge. Former residents have completed degrees, for example in medicine, law, sociology, psychology, nursing, interior design, architecture, business, economy and political science. Some of them have returned to San Patrignano as staff members and thus continued to contribute to the recovery of others.

The restoration of a relationship between residents and their families is one of the goals during the stay at San Patrignano. Initially, after admission to the community there is a separation period where the contact between a resident and family is only by letters. On
average, after one year in the community the family is allowed to visit the community for the first time and spend time with their loved one. These meetings subsequently increase to three or four times a year for the second year and usually after two years residents can go for a visit with their families for seven to ten days. The family is encouraged to attend group sessions at the associations to help them work through their experiences.

4.6. Organizational structure
San Patrignano is a non-profit foundation that owns a large part of the land where the community is situated. The community has a juridical structure of two social cooperatives and two associations. An organizational chart is presented in Figure 2.

![Organizational chart of San Patrignano](image)

Figure 2. Organizational chart of San Patrignano

The Social cooperative oversees all the activities connected with treatment and rehabilitation activities of the residents of San Patrignano. The Farming cooperative runs all the agricultural and food related activities of the community in accordance to the Italian national regulations and standards. Within both the cooperatives there are different sectors pertaining to different vocations, for example: bakery, laundry, textile etc. Each sector is managed by a person called responsible by the residents. The responsible’s role is at least twofold, to be the site manager as well as a therapeutic helper for the residents who work in the sector. In April 2017 there were 215 employees at San Patrignano whereas 35% of them are former residents.

The Association of School and Educations is responsible for management of vocational courses, it partners with and is registered to the Emilia Romagna regional formation. The Sport Association is responsible for enabling residents to carry out sport activities and to enroll the sports teams in national and international challenges.

These four entities have signed an agreement delegating the overall management to a Steering group that is in charge of securing internal coordination. There are three members in the steering group who’s responsibility is to watch over the community and monitor the
implementation of the social and economic plan approved by the CEOs of the cooperatives and associations. Lastly, San Patrignano has a Foundation that is financially and morally supporting the work of the community. The Foundation also collaborates with international stakeholders and professionals who are willing to develop social projects in favor of the community.

5. Discussion

As stated in the previous sections of this paper substance abuse treatment in Iceland is readily available and addiction is mostly viewed as a medical disorder. This philosophy as well as the 12-step AA philosophy underlie most treatment services in Iceland. SAA-National Center for Addiction is the main treatment provider in Iceland for people with substance abuse disorder, tailoring the services according to ASAM best practice guidelines and SAA’s recovery model that has developed through the years. SAA has reported that at least 51% of people that have discharged from the services were still abstinent from substance use after two years. In addition, there is some indication that at round 4% of people seeking services at SAA have been admitted 10 times or more and there-admission rate has been known to be up to 20% per year at the treatment services for people with co-occurring psychiatric and substance abuse at Landspitali-university hospital. These numbers suggest that there is group of people in Iceland who most likely have a chronic substance use problems which need further attention and treatment services, in addition to what is currently available. Most professionals in the field of addiction agree that for this group a long-term comprehensive treatment and social integrations is likely to have the most benefits and positive outcome for the individual, and therefore the community and society as well. But there are other necessary factors than time that most likely need to be in place in such treatment services, this includes vocational training and educational opportunities. This paper sheds light on the fundamental philosophy, main pillars and processes that are in place in an exceptional residential treatment services that facilitates rehabilitation, recovery and successful reintegrations into society for people with severe substance abuse problems.

The results from this benchmarking best practice study suggest that there could be a call for a paradigm shift relating to the underlying philosophy of substance abuse treatment in Iceland. In addition to treatments based on the disease model readily available in Iceland it could be argued that there is a need to develop further services that have alternative ideologies known to facilitate successful outcomes. It is evident that residential communities or micro-cosmos that emphasize education, skill-building and peer-to-peer helping relationships have been successful in helping people reintegrate into society following the treatment. These communities are based on the values of trust, respect, love, empathy, compassion and connections which have been successful in helping people recover from addictions. These values are often referred to as core family values which serve to connect family members and support their personal and interpersonal growth and development over extended period of time. At San Patrignano the average length of stay is 3-4 years and there is evidence that suggests that residents who stayed longer have the lowest rates of relapse after discharge (Manfré, Piazzi, & Polettini, 2005). Thus, it could be hypothesized that a long-term residency and participation in the multifaceted therapeutic environment at San Patrignano fosters the development, growth and reinforcement of new neuropathways via
neuroplasticity over time. These new neuropathways most likely lead to mastery of new cognitive, emotional and social skills that support intra-and interpersonal growth and development. Thus, at discharge a person is likely to be more competent to deal with life’s multiple challenges with more positive coping mechanisms than substance use.

People with substance abuse problems are often at the margins of society which influences their self-esteem, self-worth and self-respect in negative ways. Thus, creating self-loathing and feelings of disempowerment. As stated previously in the paper 56.9% of people that get services at San Patrignano could be considered chronic and incurable by most international standards. Nevertheless, the community reports that 70% are in recovery and successfully integrated into society after discharge. At San Patrignano the key concepts of the HERMESS recovery model (see pg. 8) are embedded into the program. Thus, by being human centered, empowerment aimed, motivational driven, educational embedded and reintegration oriented, San Patrignano creates an opportunity for individuals within residential community to recognize and put into action their own talents, skills and contribution to the development of other human beings. Thus, starting and fostering the process of empowerment. The peer-to-peer relationship, or giving as well as a receiving seems to be one of the fundamental core processes that leads to rehabilitation and recovery. Vocational training, skill-building and education are also known to be fundamental pillars in a successful residential program.

It could be argued that there is a need in Iceland, as well as in other societies, to move forward to develop effective residential community services that will help individuals with chronic substance abuse problems to reintegrate successfully into the community. If we act on this need, it is important to build upon the experience of communities such as San Patrignano and at the same time be aware of how their learning over the past few decades could translate into more successful treatment services in the Icelandic context. Hence, the goal should not be to start a social enterprise but rather begin to explore what services and opportunities there are already in place in Iceland that could be integrated to best serve the multifaceted needs of a person, with severe substance abuse problem, in a residential community.

The next step in moving forward to start the preparation for creating a residential community inspired by San Patrignano could be to bring together stakeholders such as: policy makers, people with substance abuse problems, people who have experience working in Iceland’s residential program facility, people interested in treatment for substance abuse based on social model, executives from organizations such as the Vocational Rehabilitation Fund in Iceland (VIRK) and the Education and Training Service Center owned by ASÍ and representatives from different trade unions and begin the discussion of collaboration.

6. Conclusion
It is a fundamental human right to be treated with respect and dignity regardless of race, gender, color, behavior and psychoactive substances abuse. Therefore, policy makers, politicians, professionals in health care and social welfare in Iceland, as well as in other developed societies, have the responsibility to explore and create services based on best practices for all members of society including the people with severe substance abuse problems. The author hopes that this benchmarking study of San Patrignano, an extremely
successful residential community, can be useful to start the course of further discussion and development in Iceland.
7. References


8. **Appendix I**

1. What is the main philosophy of San Patrignano?
2. What are the main guiding principles of San Patrignano?
3. Where does the revenue come from?
4. What do outcome studies show?
5. What is the target group?
6. What is the admission process?
7. What are the core therapeutic processes?
8. What is the organizational structure and number of staff?