NACADA

FOR A NATION FREE FROM ALCOHOL AND DRUG ABUSE

NATIONAL GUIDELINES FOR AFTERCARE AND REINTEGRATION FOR PERSONS RECOVERING FROM SUBSTANCE USE DISORDERS

REPUBLIC OF KENYA

NACADA

FOR A NATION FREE FROM ALCOHOL AND DRUG ABUSE

OUR VISION

A Nation Free from Alcohol and Drug Abuse

OUR MISSION

To lead a coordinated multi-sectoral campaign against alcohol and drug abuse in Kenya.

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FOREWORD

The recognition of drug dependence as a multi-factorial health disorder, which often follows the course of a relapsing and remitting chronic disease, has spurred calls to shift the focus of drug dependence treatment from acute care to an approach of sustained recovery management in the community.

Recognizing that no single organization or institution can provide all the essential resources needed to provide a continuum of care, NACADA favors and promotes developing recovery supports through community networking and collaboration with both state and non-state institutions. The focus is on educating the public, through advocacy, on the benefits of recovery, and collaborating with existing recovery support programs to develop integrated recovery strategies and services. Creating meaningful participation in the community is a key component of the recovery framework

These guidelines provide a recovery framework for both state and non-state institutions to effectively facilitate transition of persons in recovery, in line with the International Standards for Treatment, rehabilitation and social reintegration.

Our gratitude goes to the Technical Team formed in 2020 consisting of NACADA staff and resource persons, who worked together to develop these guidelines. It is our sincere hope and expectation that all state and non-state institutions will implement the guidelines in efforts to enhance recovery management.

Rev (Dr.) Stephen Mairori

CHAIRPERSON- BOARD OF DIRECTORS

ACKNOWLEDGMENT

The task of developing the National Guidelines for Aftercare and Reintegration for Persons with Substance Use Disorders was a consultative process, which involved a wide range of stakeholders.

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Prof. John Muteti

Ag. CHIEF EXECUTIVE OFFICER, NACADA

ABREVIATIONS AND ACRONYMS

ADA – Alcohol and Drug Abuse

CBO – Community Based Organizations

FBO – Faith-Based Organization

ICT – Information and Communication Technology

MOH – Ministry of Health

M&E – Monitoring and Evaluation

NACADA – National Authority for the Campaign Against Alcohol and Drug Abuse

NGO – Non-Governmental Organization

PESTEL – Political, Economic, Social, Technological, Environmental and Legal

SUD – Substance Use Disorder

SWOT – Strengths, Weaknesses, Opportunities and Threats

UNODC – United Nations Office on Drugs and Crime

UTC – Universal Treatment Curriculum

WHO – World Health Organization

DEFINITION OF TERMS

Addiction	Chronic relapsing brain disease characterized by compulsive drug-seeking and use despite harmful consequences.
Alcohol and Drug Abuse	A maladaptive pattern of use of alcohol and drugs that causes damage to health (physical, mental, social or occupational) and can lead to physiological and psychological dependence.
Alcohol and Substance Use	The consumption of alcohol or any other psychoactive substance. This includes all forms of tobacco (e.g. *kuber*, *chavis*, shisha, cigarettes etc), nicotine products, inhalants, non-medical use of prescription drugs and over-the-counter medicines.
Dependence	A cluster of physiological, biological and cognitive phenomena in which the use of a substance or class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.
Drug	Any chemical capable of altering the mind, body, behaviour or character of any individual and includes both lawful drugs (alcohol, tobacco, *miraa*, prescribed medications) or narcotic and psychotropic substances.
Drug Demand Reduction	Policies and programs aimed at reducing the desire for and use of alcohol and illicit drugs.
Evidence-based/Informed Programs	Practices which over the years have proved to be effective in recovery maintenance.
Incident Management	Procedures used to address situations arising from alcohol and substance use.

Para-professionals	These include the recovery coaches, peers, allies, community health volunteers among others.
Recovery Coaching	Programs meant to help individuals in addiction treatment gain access to needed resources, services, or support that will help them achieve recovery from their substance use disorder (heretofore referred to as an SUD).
Reintegration	The set of actions or process of assimilating a learner or staff back into the school community after they have undergone treatment.
Risk Factors	Characteristics that interact with personal vulnerabilities to increase the likelihood of alcohol or substance use.
Substance Use Disorders	A general term used to describe a range of problems associated with substance use (including alcohol, illicit drugs and misuse of prescribed medications), from substance abuse to substance dependence and addiction.
Supply Suppression	Intervention programs and activities designed to stop the production, manufacture and distribution of illicit drugs, including policy implementation and law enforcement.
Treatment and Rehabilitation	Healthcare services that help a person regain physical, mental, and/or cognitive abilities that have been lost or impaired as a result of addiction.

CHAPTER 1: BACKGROUND AND RATIONALE

1.1 INTRODUCTION

Kenya is committed to promoting interventions that ensure that every person enjoys the highest attainable standard of health, which includes the right to health care service. The social pillar of the Kenya Vision 2030 positions economic and social rights, where health services are domiciled, as essential vehicles for the country's attainment of middle-income status and improvement of the quality of life for all Kenyans.

Sustainable Development Goal (SDG) Agenda 3 seeks to ensure healthy lives and promote well-being for all persons at all ages. Target 3.5 specifically seeks to strengthen the prevention and treatment of people with substance use disorders, including narcotic drug abuse and harmful use of alcohol. The global strategy to reduce the harmful use of alcohol (2010) prescribes that governments should enhance the prevention and treatment capacity of health and social care systems for disorders due to alcohol use and associated health conditions as an integral part of universal health coverage and aligned with the 2030 Agenda and its health targets. Additionally, the African Union (AU) Plan of Action on Drug Control (AUPA) 2019-2023 advocates for the scaling up of social reintegration programs for people who use drugs in recovery after treatment, PWUD in contact with the criminal justice system, ex-residents of probation homes, and PWUD who suffer from morbid mental health disorders. Finally, the East African Community Regional Policy on Prevention, Management and Control of Alcohol, Drugs and other Substances, 2019, provides that member states will strengthen programs on psycho-social support including programs on stigma and discrimination, social reintegration to address the harmful effects of alcohol, drug and substance dependence.

Treatment for alcohol and drug addiction has been integrated within Kenya's health system and undertaken at all levels of health care. However, there have been challenges with regard to the provision and uptake of after-care services for clients in recovery of SUDs who have been discharged from various treatment and rehabilitation facilities in Kenya. These services are meant to strengthen internal and external resources to help persons in recovery voluntarily resolve problems related to drug use and actively manage the vulnerability to the recurrence of such problems.

The National Standards for Management of Persons with Substance Use Disorders (2021) describes after-care as a long-term recovery-oriented model of care for patients with drug use disorders that follows stabilization of abstinence achieved during outpatient or residential treatment.

These guidelines are, therefore, a response to the challenges stated above and seek to provide direction to addiction treatment professionals on strategies on after-care and reintegration for persons in recovery.
The guidelines are organized into four chapters. Chapter One discusses the background, rationale, situational analysis, legal and policy context and justification. Chapter Two outlines the goal, objectives, target groups, and the guiding principles. Chapter Three provides the thematic areas of implementation, and Chapter Four outlines the implementation framework and reporting mechanisms.

1.2 SITUATION ANALYSIS/STATEMENT OF THE PROBLEM

Alcohol and drug abuse continue to pose the biggest threat to health and wellbeing of humanity. Although significant strides have been made in the prevention, mitigation and control of alcohol and drug abuse globally, regionally and nationally, several challenges continue to undermine the efforts to address this problem. Globally, alcohol is one of the leading risk factors for the health of populations, which has a direct impact on many health-related targets of the Sustainable Development Goals (SDGs). Globally an estimated 900,000 reported deaths from injuries were attributable to alcohol. Around 370,000 of these deaths were due to road injuries, 150 000 to self-harm and around 90, 000 due to interpersonal violence (WHO 2018). Tobacco use is another major public health problem worldwide, killing more than 7 million people each year, including more than 890, 000 non-smokers who die from exposure to tobacco smoke. According to the WHO Report, nearly 80% of these deaths occur in low and middle-income countries that are still grappling with communicable diseases; while up to half of the world's 1 billion smokers will eventually die of a tobacco-related disease.

According to the United Nations Office on Drugs and Crime (UNODC), the World Drug Report (2018) and WHOs Global Status Report on Alcohol and Health (2018), global challenges on alcohol and drugs have been compounded by the common use of cannabis as a preferred drug of choice by young people; the emerging complex global supply chain of drugs and other substances, whose use is attributed to poverty and lack of opportunities for socio- economic growth; advanced transnational organized crimes such as piracy and international terrorism associated with alcohol and drug abuse; and lack of tailored services, with few treatment programs to address the specific needs of those abusing alcohol and drugs.

Kenya faces a number of challenges concerning ADA. The problem, which is no respecter of persons, race, income level, economic or social status, continues to permeate and to address this problem in collaboration with other state and

non-state actors, has been carrying out various studies and the results presented below show alarming statistics demonstrating the gravity of the situation in the country.

In a study conducted by NACADA in 2016 it was established that alcohol abuse contributes the highest burden of substance use disorders (SUDs). The prevalence of alcohol use disorders among respondents aged 15-65 years stood at 10.4% in 2017.The NACADA Survey of 2017 indicated that 12.2% of persons aged between 15 and 65 years or about 3.3 million Kenyans are active users of alcohol, with 10.4% of them being addicted. This survey also indicates abuse of tobacco by 8.3% of the population or 2.2 million persons; miraa at 4.1% or 1.1 million persons; and cannabis at 1.0% or 270,000 persons. NACADA reports indicate that ADA is prevalent in Kenya across religions, gender and regions though disparities exist. The most commonly abused drugs and substances in Kenya are alcohol, tobacco, bhang, glue, miraa (khat) and psychotropic substances.

In terms of drug use, alcohol is the biggest and number one problem. Cannabis is the second major problem faced by the East Africa region. Urban slum youth also widely abuse paint thinner and other solvents including petrol. Injecting drug use has also been reported in Kenya, Zanzibar and Tanzania and is spreading widely. Recent studies by UNODC have confirmed the increasing availability and accessibility of heroin, cannabis and cocaine in Eastern Africa. The region has continued to access the drugs through the ports and coastlines in Djibouti, Eritrea, Kenya and Tanzania, owing to inadequate monitoring controls, unethical practices at the entry points, among other reasons. Trafficking in drugs has also increased in the region as evidenced by the various seizures by state border control officers and the police. On co-operation, police chiefs in the region regularly meet to review and discuss efforts to deal with the emerging challenges related to drugs. UNODC has been very supportive of efforts to help the states improve their capacities in prevention, law enforcement and treatment.

Various reports also show that ADA is more prevalent among persons between 15-35 years, who fall within the prime working age, thus undermining national development. In a NACADA study conducted in 2016 focusing on secondary schools, it indicated that 23.4% (508,132) of students had at some point used alcohol; 17% (369, 155) had used miraa; 16.1% (369, 613) prescription drugs; 14.4%(314, 869) tobacco; 7.5%(162, 863) bhang; 1.2% (26,058) heroin; and 1.1% (23, 887) cocaine.

In its final declaration, the 30th Special UN Assembly held between 19th and 21st April, 2016, commonly referred to as the UNGASS 2016, noted that drug abuse and illicit drug trafficking are shared global problems requiring concerted control mechanisms. Member states, therefore, reaffirmed their commitment to the goals and objectives of the three international drug control conventions and other UN related instruments as well as concerns for the health and welfare of humankind.

The declaration further observed that the world drug problem remains a common and shared responsibility that should be addressed in a multilateral setting through effective and increased international cooperation. It also noted that the problem demands an integrated, multidisciplinary, mutually reinforcing, balanced, scientific, evidence-based and comprehensive approach. Member states further committed themselves to ensuring that all aspects of demand reduction and related measures and supply reduction and related measures are fully addressed in conformity with the UN Charter, international law and the Universal Declaration of Human Rights. It also underscored that the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, and other relevant international instruments, continue to constitute the cornerstone of the international drug control system.

Further, while adopting the United Nations 2030 Agenda for Sustainable Development, member states committed to strengthen prevention and treatment of substance abuse, including abuse of narcotic drug and harmful use of alcohol and tobacco towards promotion of healthy lives for all and at all ages, noting that efforts to achieve the Sustainable Development Goals and to effectively address the world drug problem are complementary and mutually reinforcing.

Owing to persistent, new and evolving challenges that member states face regarding drug abuse and trafficking, the declaration aptly recognized the flexibility of state parties to design and implement national drug policies according to their priorities and needs, consistent with the principle of common and shared responsibility and applicable international law. The need to mobilize adequate resources to address and counter the world drug problem as well as the enhancement of assistance to developing countries was also recognized. Further recognition included the need for specific assistance required by transit states that continued to face multifaceted challenges, hence requiring enhancement of their capacities to effectively address and counter the world drug problem.

The Common African Position (CAP) for the UNGASS on the World Drug Problem (2016) also reaffirms that the Conference outcome document provided an opportunity for Member States to address substantive issues on the basis of the principle of common and shared responsibility and in full conformity with the purposes and principles of the Charter of the United Nations, International Law and the Universal Declaration of Human Rights. African Member states, among other issues, observed that:

i. That the main objective of drug policies should be to improve the health, safety, welfare and socio-economic well-being of people and societies by adopting appropriate measures to combat illicit crop cultivation and the illicit production, manufacture, transit, trafficking, distribution and use of narcotic drugs and psychotropic substances, as well as its associated crimes, as outlined in the AU Plan of Action on Drug Control (2019-2023);
ii. That effective drug policies are those that achieve a balanced and integrated approach between supply reduction, demand reduction, harm reduction and international cooperation as agreed in 2009;
iii. That the consumption of drugs and drug addiction should be considered as public health problems that have socio-economic root causes and consequences. As such, drug education should be prioritized in education curricula. People Who Use Drugs (PWUDs) must be given support, and must benefit from treatment, health services and protection. Resources should be allocated towards treatment programs, including in prisons. In this regard, the integration of the drug treatment and prevention services within broader health programs should become an imperative for all Member States;
iv. That there is an urgent need to respond to the serious challenges posed by the increasing links between drug trafficking, corruption and other forms of organized crime, including trafficking in persons, trafficking in firearms, cybercrime, and in some cases terrorism and money-laundering, including money-laundering in connection with the financing of terrorism, and to the significant challenges faced by law enforcement and judicial authorities in responding to the ever-changing means used by transnational criminal organizations to avoid detection and prosecution; and
v. To support the collaboration of public health and justice authorities in pursuing alternative measures to conviction or punishment for appropriate drug-related offences of a minor non-violent nature, in accordance with the

international drug conventions.

The AU Plan of Action on Drug Control (2019-2023) has an overarching goal of improving the health, security and socio-economic well-being of the people of Africa by reducing drug use, illicit trafficking and other associated crimes. Four priorities are indicated as being key to addressing the problem, including:

i. Regional, sub-regional and national management, oversight, reporting and evaluation;
ii. Scale-up of evidence-based services to address the health and social impact of drug use;
iii. Countering drug trafficking and related challenges to human security, in accordance with fundamental human rights principles and the rule of law;and,
iv. Capacity building with the aim of improving research and data collection.

Under the African Union's current Plan of Action on Drug Control and Crime Prevention, the African Union Commission has strengthened its cooperation in the areas of drug control and crime prevention with relevant international organizations, such as INTERPOL, the African Institute for the Prevention of Crime and the Treatment of Offenders and UNODC, and with the European Commission within the framework of the Africa-European Union Strategic Partnership.

It is also imperative to note that regional economic communities in Africa are expected to play a key role in the implementation of the African Union Plan of Action (2019-2023). In this regard, particular progress has been made by the member states of East Africa Community who have adopted a sub-regional action plan on drug trafficking, organized crime and drug abuse. The region has also launched a joint programme to build national and regional law enforcement capacity including in the areas of drug interdiction, forensics, intelligence, border management, money-laundering and criminal justice.

The national aftercare guidelines are informed by International, Continental and National scientific findings, declarations and recommendations, and will set a platform for comprehensive implementation mechanisms of aftercare interventions for reducing the harmful effects of alcohol and drug abuse, provide succinct, user-friendly guidelines to key stakeholders on how to participate in the aftercare program for SUDs, and encourage and secure the meaningful participation of poor, marginalized and vulnerable groups in their participation in SUD continuum of treatment.

1.3 LEGAL AND POLICY CONTEXT

Kenya has enacted a number of laws to govern the diversity of state response to alcohol and drug abuse in the country. Key among them was the enactment of the National Authority for Campaign against Alcohol and Drug Abuse (NACADA) Act, 2012, which re-established NACADA with an expanded mandate to coordinate a multi sectoral campaign against alcohol and drug abuse.

To address the challenges emerging from the situation above, it is therefore extremely important for the country to put in place a legal framework to address them. These guidelines recognize that there are various existing laws and institutions that deal with the management of alcohol and drug abuse, but the duty bearer to the highest standards of health is vested in the state. As such, these guidelines expect all institutions to address ADA corporately.

The various laws that address different aspects of the control of alcohol and drugs include:

i. SDGs in particular Goal 3. Target 3.5 on Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol and on ensuring healthy lives and promotion of well-being for all at all ages;
ii. UNGASS Document (2016);
iii. African Union Plan of Action (2019-2023);
iv. Narcotic Drugs and Psychotropic Substances (Control) Act No. 4 of 1994;
v. EAST AFRICAN COMMUNITY ON HARM REDUCTION;
vi. Tobacco Control Act 2007;
vii. Mental Health Act Cap 248, 2022;
viii. Alcoholic Drinks Control Act, 2010;
ix. Public Health Act, Cap 242;
x. The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) Act, 2012; and
xi. The Constitution of Kenya;
xii. National Standards for Treatment and Rehabilitation for Persons with Substance Use Disorders;
xiii. National Protocol for Treatment of Substance Use Disorders in Kenya-2017.

The above legislations address both possession and use of alcohol and drug abuse and will be harmonized to establish a more efficient platform for addressing the ADA situation in the country.

1.4 RATIONALE

There are two broad rationales for development of an aftercare programs. The first set of reasons is a legal imperative that derives its mandate from the duty of the state to realize the human rights and democratic demands of its people as enshrined in national and international legal documents.

At the international level these include:

i. The Sustainable Development Goals (SDGs): in particular Goal 3. Target 3.5 on strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol, and on ensuring healthy lives and promotion of well-being for all at all ages;
ii. UNGASS 2016: which is geared towards meeting targets set by the international community in countering the global drug problem. The policy in particular focuses on the Common African Position for the UNGASS World Drug Problem;
iii. WHO Concept on Health for All: which seeks to provide not just availability of health services within reach of everyone in the country but a personal state of well-being that enables a person to lead a socially and economically productive life.

At the national level these include:

i. Article 2 (6) which provides that any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution;
ii. Article 43. (1) (a) on the right to the highest attainable standard of health by all, e.g. the right to health care services including reproductive health care.

The second broad rationale is one of the after-care being part of the continuum of care. The rationale for the aftercare programs is to help people who have been through treatment and rehabilitation to learn how to navigate life without drugs or alcohol and to continue their recovery after they leave the treatment or rehabilitation facility. In addition, it helps them avoid relapsing and returning to using drugs or alcohol. The guidelines will act as a blueprint that will guide both state and non-state practitioners at community and all other levels to offer evidence-based interventions and programs.
The other rationale of the existence of aftercare programs is that they have been shown to help prevent relapse, improve long-term outcomes, and reduce the risk of re-entry into primary treatment programs. People in recovery often find themselves isolated from friends and family, which can be a major contributor to their addiction. Aftercare programs provide a space for them to connect with others in recovery so that they can build a support network. This helps them stay sober long-term and avoid relapse.

CHAPTER 2: PURPOSE

2.1 PURPOSE OF THE GUIDELINES

The document is developed to guide implementation of strategies measures and practices towards reducing harm and improving the health outcomes of those affected by SUDs by providing guidelines on how to strengthen and operationalize aftercare programs for persons with SUDs and their significant others.

Aftercare refers to services that help persons with SUDs to adapt to everyday community life, after completing earlier phases of treatment and rehabilitation or recovery support services. It provides an opportunity to address important issues and problems associated with abstinence and recovery. Aftercare provides a safe environment for continued support until it is no longer needed.

A good aftercare program needs to be individualized. All clients differ as regards their individual problems, needs, and psychological as well as social capacities and resources. A flexibility that allows more individual choices, makes a program more attractive and effective.

The journey of recovery continues even after treatment and rehabilitation, and may be a long-term process. Since clients may take a year or even more to complete this last part of the recovery journey, they need support and guidance during this period.

Aftercare includes working on:

i. Recognition, review and consolidation of treatment gains;
ii. Addressing the issue of drug-craving in terms of
    a) Identification of drug-craving,
    b) Identification of psychological and other cues that trigger craving,
    c) Tracking of craving urges,
    d) Anticipating situations that may lead to drug use,
    e) Handling craving;
iii. Establishing a new social network by
    a) Developing social and intimate relationships with non-drug-using persons and peers,
    b) Carrying out non-drug using 'fun' activities,
    c) Establishing healthy social activities;
iv. Beginning or resuming new roles and responsibilities as
    a) An employee, worker or student,
    b) A family member,
    c) A parent, son, daughter or homemaker,
    d) A friend, colleague or co-worker;

v. Lifestyle changes required for Whole Person Recovery. This includes helping the client handle work/employment, family and relationships, finance, as well as social and recreational activities, without resorting to substance use.

Aftercare shall:

i. Be an integral component programed into a treatment and rehabilitation service;
ii. Include training to prevent relapse and other crises;
iii. Focus on reviewing and consolidating the gains made during treatment and aim at Whole Person Recovery (with strategies for being substance-free, crime-free and gainfully employed);
iv. Impart new skills for maintaining recovery, including help in handling everyday responsibilities, managing family and other relationships, making new friends, developing alternative recreational activities, adjusting to work and employment or acquiring/re-learning occupational skills, overcoming the stigma and shame of the past, and developing new insights;
v. Based on the aftercare issues outlined above, the staff of the program should formulate a set of client goals. These should be in tune with the recovery model being used in the treatment and rehabilitation services. Well-defined goals provide a focus for both the client and the staff and also set criteria and standards for client entry into and completion of aftercare.

The major dimensions that support a life in recovery and aftercare shall include the following:

i. Health: overcoming or managing one's disease(s) as well as living in a physically, mentally, and emotionally healthy way;
ii. Home: a stable and safe place to live;
iii. Purpose: meaningful daily activities, such as a job, schooling, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and
iv. Community: relationships and social networks that provide support, friendship, love and hope.

2.2 GOAL

To develop guidelines – this ensures evidence-based effective and culturally adapted approaches to aftercare programming.

2.3 OBJECTIVES

I. To provide user-friendly guidelines to key stakeholders on how to operationalize the aftercare program for SUDs;
II. To develop a more consistent, innovative and strategic approach to work with aftercare practitioners delivering aftercare Services;
III. To provide guidelines for the satisfaction of clients and outcome indicators;
IV. To provide a recovery-oriented system of aftercare that is responsive to the needs of individual clients.

2.4 SCOPE

These guidelines shall be applicable to clients discharged from primary treatment programs, in continuing care plans in community-based programs, their significant others and organizations providing recovery-oriented support services.

2.5 GUIDING PRINCIPLES

The guiding principles of aftercare and recovery specifies that recovery:

i. Emerges from hope;
ii. Is person-driven;
iii. Occurs via many pathways;
iv. Is holistic;
v. Is supported by peers and allies;
vi. Is supported through relationship and social networks;
vii. Is culturally based and influenced;
viii. Is supported by addressing trauma;
ix. Involves individual, family and community strengths and responsibilities;
x. Is based on respect.

CHAPTER 3: STRATEGIES FOR AFTER-CARE AND SOCIAL REINTERGRATION

The following shall be the major components of aftercare programs:

3.1 PHYSICAL, EMOTIONAL AND MENTAL HEALTH SUPPORTS

Physical and mental health supports are important elements of SUD rehabilitation and aftercare processes. Beneficiaries shall not only be persons in the process of recovery, but also their families, their immediate environments, and the community at large. They shall include:

i. Integrating SUD treatment into primary health care system;
ii. Facilitating Individual Counseling and Group Counseling as may be needed;
iii. Addressing physical and mental health needs as part of aftercare;
iv. Putting in place a system to facilitate referrals for further assessments and treatment services;
v. Ensuring that sustained recovery management is carried out by an interdisciplinary team of professionals, involving paraprofessionals (peer groups), as far as possible;
vi. Making available follow-up services within the community through networking with primary health care institutions, government agencies, CBOs, NGOs and peer-group supports;
vii. Ensuring that adequate assessment and screening tools are easy and quick to administer by staff members with varied levels of clinical training, (see Appendix) for WHO's Quality of Life Assessment tool, and the Treatment Addiction Severity Index) and are able to identify both substance dependence and other co-occurring diseases;
viii. Offering psychosocially assisted pharmacological treatment of opioid dependence, alcohol use disorder, Alcohol Use Disorders (See Appendix for available medications) co-occurring psychiatric and medical disorders;
ix. Having in place specialized programs for women and other special populations who are most vulnerable when drug dependence is coupled with interpersonal violence such as child abuse, rape, and battering.

3.2 FAMILY, SOCIAL SUPPORT, AND LEISURE ACTIVITIES

Family involvement, social support, and leisure activities have been shown to contribute to better outcomes in the treatment and rehabilitation process. The following actions show how families can play a key role in the treatment and rehabilitation process for persons with SUDs and shall be included as part of aftercare:

i. Include the family throughout the treatment, rehabilitation and aftercare process;
ii. Offer training and educational programs to family members and significant others that educate them about the adverse effects of SUD; early detection; the basic components and process of the treatment and aftercare plan; and the key steps of the client's recovery goals to help prevent relapse and improve treatment outcomes;
iii. Provide family-based therapy that includes information on building communication skills, parenting skills, couples support, recognizing and preventing child abuse, and other supports to help restore family structure, vitality, trust, and build an environment that is conducive to recovery processes;
iv. Set up family-focused post-treatment monitoring and follow-up aimed at identifying and addressing obstacles to long-term recovery and preventing relapse;
v. Make available gender-specific and relational models to help women and men learn appropriate strategies for positive relationships with partners and social networks that could encourage relapse and thus hamper their recovery;
vi. Link clients to significant others or relevant support networks that provide companionship, communication, and affection where lacking, necessary, and appropriate. This include but are not limited to significant others who can be the extended family members, friends, neighbours, community members, or housemates in community safe spaces such as halfway houses.

3.3 SAFE HOUSING AND ENVIRONMENTS CONDUCIVE TO HEALTH AND RECOVERY

Loss of safe housing and environments conducive to health and recovery is a common situation for SUD clients. It is a serious risk factor for relapse and decreases the chances of social reintegration and a healthy lifestyle. Providing safe and supportive housing is an important factor in the recovery process. It allows continued contact with service providers but grants a higher level of independence and reintegration into the community than is the case with inpatient treatment. A range of benefits can be ensured depending on the needs of the individual client. Options shall include but not limited to the following:

i. Supported housing (half-way houses) that provide a drug-free ambience that may help sustain abstinence and support the recovery process;
ii. Collective housing which promotes the development of positive peer interactions and building up support groups and networks;
iii. Stable housing provides an adequate setting for family contacts and visits and the re-establishment of trust among family members.

3.4 PEER-BASED SUPPORT

Peer-based support is necessary for persons in the process of rehabilitation and aftercare who may be going through a transition period in their lives that requires changes in social behaviors and roles. During this period client may feel insecure, fearful, and anxious, and such feelings may increase the risk of relapse. While facing uncertainty, it is important to have positive life strategies that may include self-help, peer group, or tutoring groups support. Support groups may act as positive mirrors, generate confidence, and offer support in times of crises. Ways of providing this critical support in a more structured way shall include:

i. Sharing experiences through the individual recovery process and implementing this action (of sharing) in every rehabilitation process in a self-help group setting;
ii. Having clear rules and regulations, particularly those regarding confidentiality, that are known to all members in the group;
iii. Moderating self-help groups using professional or especially trained staff, if resources and group consensus or organizational setting allow (their main function would be the modulation and monitoring of individual and group achievements);
iv. Developing a qualification model for self-help tutors who can update their knowledge on SUD and group moderation with the support of treatment institutions;
v. Assigning a tutor or guide for orientation and counselling to each group member, so that the tutor can establish a close and trusting relationship with the person and act as a positive role model in the rehabilitation process (a tutor who is knowledgeable about SUD treatment and rehabilitation could make the best use of contact mechanisms with the therapeutic team to assess the advances, achievements, and difficulties in the rehabilitation process);
vi. Employing Recovery Coaches as peer support.

3.5 (SELF-)EMPLOYMENT AND RESOLUTION OF LEGAL ISSUES

(Self-)Employment issues are frequently linked to drug dependence. Many persons with long years of SUD have had difficulties with finding jobs. Unemployment is usually one of the major reasons for relapses. Invariably, such persons need support and guidance in reintegrating themselves into the job market. The following initiatives, when integrated into an aftercare program,

can positively contribute to recovery outcomes, when current market needs are taken into account:

i. Employment counselling, including job seeking training;
ii. Development of vocational skills;
iii. Screening for potential barriers (personal, social, structural) to achieving economic self-sufficiency, and providing assertive linkages between services to help persons with SUDs obtain meaningful and rewarding employment, while resolving challenges, such as legal and criminal issues, lack of safe housing, and access to transportation (the easing of these barriers significantly improves the abilities of persons in recovery to participate in meaningful activities and reintegrate into their communities and society at large);
iv. Establishing a close working relationship between treatment providers and industry, private sector companies, and/or employment agencies to make it easier for persons in the rehabilitation process to (re)enter the job market;
v. Making it possible for persons in recovery and/or their family members to learn how to access and manage micro-credits so that they can get small-scale loans to set up small enterprises, which is an important aspect of creating sustainable livelihoods;
vi. Implementing programs for the development of micro enterprises with the support of governmental and nongovernmental institutions.

3.6 VOCATIONAL SKILLS AND EDUCATIONAL DEVELOPMENT

Acquiring occupational and vocational skills builds self-worth. This is also true for persons with SUDs. Work supports the creation of individual and social participation and responsibility. Some of the positive outcomes of acquiring marketable vocational skills and involvement in productive activities are experiencing higher levels of satisfaction and security, and reducing the risk of relapse. Steps to make this possible include:

i. Making vocational assessment and counseling services part of rehabilitation and social reintegration programs aimed at the creation of sustainable livelihoods;
ii. Developing the vocational component of the program and embedding it into the aftercare plan based on the client's initial assessment;
iii. Conduct a market analysis to identify current needs for skills and products;
iv. Making vocational training responsive to market needs;
v. Adapting and renewing vocational support and counseling services to respond to technology and market changes, in order to enhance sales options for the programmers' products and services;
vi. Making simple and easy-to-manufacture products that are useful, have low production costs, and a ready market.

Education is a necessary asset for a full life and the assurance of a sustainable livelihood. Access to different educational schemes and models is one way to address problems related to drug use and drug dependence.

3.7 COMMUNITY INTEGRATION AND CULTURAL RENEWAL

Community integration and cultural support often have a startling effect on alcohol and/or drug dependence. In some more traditional settings, complementary cultural and indigenous activities when embedded in or are closely linked to a treatment program may help to induce relaxation; facilitate self-regulation of physiological processes; release emotional trauma; alleviate isolation and alienation; encourage personal transformation; promote spontaneous manifestations of leadership skills; and, more importantly, create a sense of interconnectedness between the self and the community. These methods are most helpful when:

i. Applied as complementary components to SUD treatment and rehabilitation programs to address relapse; Integrated into major rehabilitation programs, community centers, training programs, weekend retreats, as well as prison systems;
ii. Provided as additional counselling approaches that may help address severe psychological and emotional trauma through culturally accepted (traditional) methods;
iii. Used to facilitate cognitive-emotional integration, social bonding, and community affiliation;
iv. Incorporated in promoting self-expression and conflict resolution;
v. Used to promote a sense of purpose and grounding in life;
vi. Employed as a means to engaging traditional/community leadership and encouraging training for indigenous/traditional leaders and healers to organize recovery circles;
vii. Applied to hosting indigenous recovery celebration events;
viii. Employed in advocating for culturally informed social policies and treatment approaches. Also, in less traditional settings, activities that create a sense of community and open opportunities for (re-) integration can be helpful and may serve some of the above-mentioned functions.

3.8 MEANING AND PURPOSE IN LIFE

Meaning and purpose in life is central to leading a full and healthy life. Regardless of how this desire for meaning in life manifests itself, most persons know when it is absent and often seek it actively. The following steps are suggested in assisting

clients in the process of rehabilitation and aftercare to uncover what, for them, constitutes meaning in life:

i. Making an initial assessment, taking into account spiritual interests of clients, is useful in defining the content of the therapeutic counseling process;
ii. Suggesting different types and practices of spiritual practice, depending on the
iii. cultural context, might have an added value (e.g., as a relaxation strategy to face fears, anxiety, anger, and create a mental sense of recovery and well-being);
iv. Encouraging spiritual practice in groups, if applicable in the cultural setting, might support the connection with others and a sense of belonging;
v. Working with therapeutic staff to develop skills to approach and explore the spiritual and religious interests of clients in the process of rehabilitation and social reintegration. Once the "what" and the "how" of implementing the various aspects of recovery capital—an essential part of sustained recovery management—have been realized, the next step is to increase recovery support, through a systems approach, additional funding, or in kind-contributions, for drug dependent persons.

CHAPTER 4: IMPLEMENTATION, MONITORING & EVALUATION FRAMEWORK

4.1 MANAGEMENT AND COORDINATION/ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

i. **NACADA shall:**
   a. Develop and disseminate the guidelines;
   b. Support the implementation of the guidelines;
   c. Promote the implementation of evidence-based interventions in regards to aftercare and reintegration guidelines;
   d. Monitor compliance to the implementation of the guidelines;
   e. Increase the uptake of the aftercare and reintegration interventions by conducting awareness-raising campaigns;
   f. Strengthen the capacity of stakeholders to adapt and implement evidence-based aftercare and reintegration and interventions;
   g. Facilitate the implementation of appropriately targeted aftercare and reintegration interventions for poor and vulnerable populations;
   h. Establish Networks and linkages.

ii. **County Governments shall:**
   a. Implement the aftercare and reintegration guidelines;
   b. nclude aftercare and reintegration guidelines in County Integrated Development Plans, Strategic Plans, and Annual Implementation Plans;
   c. Increase the uptake of the aftercare and reintegration interventions by conducting awareness-raising campaigns;
   d. Institute and strengthen policy and legal frameworks in support of the implementation of aftercare guidelines;
   e. Prioritize and allocate adequate resources for implementation of aftercare and reintegration interventions;
   f. Allocate and build capacity for ADA management and reintegration;
   g. Promote support for family-based prevention interventions in the workplace.

iii. **Government Ministries and Agencies shall:**
   a. Support social and economic interventions in their areas of competence;

iv. **The Civil Society and Faith-Based Organizations shall:**
   a. Implement the aftercare and reintegration guidelines;
   b. Act as a community feedback mechanism;
   c. Act as a source of primary data for monitoring and evaluation of the guidelines;

d. Promote public awareness;
e. Lobby for resources;
f. Advocate for the uptake of the services.

v. **The Private Sector shall:**
   a. Develop employee assistance policies that incorporate continuum of care services at the workplace;
   b. Allocate resources for implementation of aftercare and reintegration interventions;
   c. Promote corporate social responsibility programs that support aftercare and reintegration interventions.

vi. **The Media shall:**
   a. Create awareness on matters recovery management;
   b. Conduct campaigns to advocate for social inclusion of people with substance use disorders with no room for stigma and discrimination.

4.2 MONITORING AND EVALUATION

There will be monitoring, evaluations and a learning framework. The framework will be adopted at all levels of the society by NACADA. There will be indicator tracking from non-state to state actors at the community level. NACADA will facilitate the tracking and reporting on the implementation of the guidelines and required action, and determine the lines of responsibility for respective stakeholders in order to ensure efficiency and effectiveness in the implementation of these guidelines.

NACADA shall, in collaboration with stakeholders, monitor the realization of the guidelines every year and propose correction interventions when needed. There will be an evaluation of the delivery of the guidelines every five years. The results of the guidelines monitoring, and evaluations will be used to inform the review and adoption of lessons learned.

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ANNEXURE 1: TECHNICAL WORKING GROUP MEMBERS

1)	Prof. Catherine Gacutha	–	Maranatha
2)	Dr. William Sinkele	–	SAPTA
3)	Seth Oketch	–	APRAK Representative
4)	Jeff Maganya	–	Sante Vida Rehabilitation Center
5)	Emma Ngutu	–	Sante Vida Rehabilitation Center
6)	Anthony Njeru	–	Eden House Rehabilitation Center
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10)	Adrian Njenga	–	NACADA
11)	Josephine Akisa	–	NACADA
12)	Wilfred Mbogo	–	NACADA
13)	Mornicah Akumu	–	NACADA
14)	Judy Muthoni	–	NACADA

ANNEXURE 2: ORGANIZATIONS AT VALIDATION WORKSHOP

1) Civil Society Organizations
2) County Government of Makueni
3) Drop in Centers
4) Faith-Based Organizations
5) Kenya Counselors and Psychologists Association
6) Kenya Psychologists Association
7) Kenya Red Cross Society
8) Ministry of Health
9) Representatives of Rehabilitation Centers

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