

Future of Drug Policy

Real Solutions

Grounded in Global Evidence

This publication of Drug Policy Futures is protected by copyright. Drug Policy Futures accepts no responsibility or liability for any consequences arising from the use of the data contained in this document.

More information on Drug Policy Futures is available at <http://drugpolicyfutures.org/>.

© Drug Policy Futures, 2015

Reproduction is authorised provided the source is acknowledged.



This report is produced in partnership with World Federation Against Drugs and European Cities Action Network for Drug Free Societies (ECAD).

Edited by Linda Nilsson (Secretary General, World Federation Against Drugs) and Erik Leijonmarck (Secretary General, European Cities Action Network for Drug Free Societies).

Design and Typesetting by Elizabeth Tompkins.
Printed in Mexico.

Introduction

Drug Policy Futures is a global platform for a new drug policy debate based on health. We believe in an open dialogue on the strengths and weaknesses of global drug policies. We advocate for evidence-based strategies to promote public health, safety and the wellbeing of society, including those addicted to drugs and their families.

In 2014, DPF published the Ten Points Declaration outlining the principles that should guide drug policy. In this report, we want to elaborate upon these principles, delving into the rationale behind each, as well as how they are manifested in reality, with a focus on solutions that can be implemented by non-governmental organizations (NGOs) and UN Member States around the world. Many global efforts currently underway focus on reducing the non-medical use of illicit drugs and their negative consequences: of these, many have been very successful. The drug problem is global and through this report we present a global answer from a grassroots perspective.

As the world prepares for UNGASS, we need to move beyond simplistic calls for legalization of drugs and policies that emulate the public health disaster of tobacco and alcohol. We also should avoid inaction or turning a blind eye to the problems that drug control inadvertently has produced.

It is our belief that:

- **Contemporary drug control should address harms produced by drugs as well as the drug trade.**
- **Contemporary drug control should have prevention of drug use as its primary aim.**
- **Contemporary drug control should rest upon available research and evidence-based policies that protect the health and safety of drug-users, their families, and the wider community.**

Luckily, a number of such policies and actions exist and are implemented by governments and NGOs as we speak all over the globe – they just need to be given a voice. Drug Policy Futures is with this report combining theoretical arguments on drug policy, in combination with practical hands-on perspectives from the grassroots level on how drug control should be implemented in practice. The report covers many important dimensions of the drug problem in ten chapters, with the aim of providing ample evidence on a variety of successful drug policies which fit under the umbrella of the existing UN drug conventions. We also want to show the great diversity of the NGOs active in the field of demand reduction of drugs. Many NGOs have contributed to this report and many more will contribute in our continued discourse.

Stig Erik Sørheim
Global Coordinator, Drug Policy Futures



Table of Contents

1: The Global Drug Problem

An Introduction 7

2: The Importance of Prevention

An Introduction 11

Case Study: Kampala Young People's Initiative Towards Drug Abuse Prevention in Slum Communities 30

Case Study: Community-Based Infrastructure for Drug Prevention 35

3: Drugs, Children, and Human Rights

Human Rights and the International Drug Control Regime: Myths and Realities 41

Case Study: The Impact of Drugs in Latin America and Caribbean Societies 47

Testimony: More than 'Just Pot': Caring for Children in a Legalized Marijuana State 53

4: Drugs and Societies

An Introduction 56

Case Study: New Perspectives on the Role of Relatives 59

Testimony: Stay Close: A Mother's Story of her Son's Addiction 62

Testimony: Stay Close: A Therapist's Story 64

Testimony: Simon (Sweden) 66

5: Hearts and Minds in Addressing the Drug Problem

Case Study: The Swedish Drug Policy Experience: Past to Present 70

Case Study: Japan's Success in Coping with Illicit Drugs in the 1950s 76

6: Lessons Learned from Tobacco and Alcohol

Case Study: What Can Alcohol and Tobacco Teach Us About Legal Marijuana? 83

Case Study: Malfunction of Legal Drug Markets, Comparison Between Legal and Illegal Drugs in Malawi 88

Case Study: Alcohol and Tobacco as Legal Drugs: A Valuable Lesson Before Legalizing Other Drugs 90

Testimony: Legalization in Practice 92

7: Recovery from Drug Addiction

Rediscovering Recovery in the Treatment of Dependent Drug Use 96

Testimony: Kenneth Arctander Johansen (Norway) 106

Testimony: John (Montenegro) 107

Testimony: Elizabeth Cucco 109

Testimony: John (USA) 111

8: The Crucial Role of the Justice System in Addressing the Use of Drugs

An Introduction 114

9: Tackling International Drug Trafficking

An Introduction 131

Alternative Development in Coca-Growing Basins and Valleys of Peru 139

10: Conclusion

Progressing Drug Control into the 21th Century .
..... 144

Chapter 1

The Global Drug Problem

“

Drug use is a risk factor for a wide range of negative outcomes including mental and other illness, school dropout and academic failure, road accidents, unemployment, low-life satisfaction and relationship problems. Drug use and other social and health problems are intertwined so that drug use is associated with and commonly exacerbates other problems.”

The Global Drug Problem: An Introduction

Robert L. DuPont, M.D.

President, Institute for Behavior and Health, Inc.

First Director, US National Institute on Drug Abuse (1973-1978)

Drugs are natural and synthetic chemicals that stimulate the brain's reward center far more intensely than natural behaviors such as sex and eating. This intense stimulation leads people, and laboratory animals, to repeat drug use behaviors and to work harder for the drug reward than for natural rewards. In the span of human history, there have been relatively few substances that produce this superior reward with alcohol being a prominent early example. Other relatively early brain rewarding substances include opium, the dried sap from poppies, as well coca leaves and cannabis. Early drug use behaviors were generally isolated to a few areas in the world, with relatively poor routes of administration and often to narrow sections of the populations.

During the second half of 19th century purified drugs became available through their production in laboratories. In the United States the synthetic and the purified drugs became widely used as "patent" medicines, creating an early national drug abuse epidemic. Drug abuse at that time became an international threat, as demonstrated by widespread opiate dependence in Asia. The growing global drug problems led to the first international efforts to curtail drug dependence in the early decades of the 20th century. The central feature of these

early public health efforts was the separation of medical use of drugs from their nonmedical use leading to the criminalization of production, sale and nonmedical use of these drugs. There was also a public education effort to discourage nonmedical drug use that was reinforced by strong legal penalties.

A dramatic shift in drug use took place in the 1960s and 1970s when for the first time entire populations were exposed to many drugs of abuse by highly reinforcing routes of administration, including smoking, snorting and intravenous injection. The drug menu became virtually limitless with multiple, and often simultaneous use, of drugs at higher doses becoming common. Due to the striking increase in drug demand, the supply and distribution of drugs became global and far more effective than ever before. In response to this epidemic of drug abuse in the United States, for the first time, the federal government shifted from a law enforcement-only stance that had previously characterized national drug policy for half a century to a new strategy that included well-funded efforts focused on prevention, treatment and research. This shift "balanced" the earlier, virtually exclusive criminal justice responses to drug sale and use.

Global leadership in drug policy was provided through the three comprehensive international drug treaties from the United Nations. The Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971, and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 provide a global framework for drug policy. Together, they sought to limit the production, use and supply of substances of abuse outside of medical use and combat drug worldwide drug trafficking. These widely adopted treaties included provisions against money laundering and diversion of chemicals to produce substances of abuse, and they established international control system for substances of abuse. Additionally, Article 33 of the Convention on the Rights of the Child emphasizes the responsibility of governments to protect children from the use and trafficking of drugs.

There is universal potential for drug dependence among all mammals including humans.¹ Although drug use commonly begins in adolescence and is often most intense among the disadvantaged, the young and the mentally ill, it is not just these groups or those with particular genetic vulnerabilities who run the risk of serious drug problems. The risk of substance use disorders is universal; it is hard-wired into the brains of all mammals. The threat to health and safety from nonmedical drug use is serious extending from health problems to other areas including but not limited to education, family life, highway safety and economic productivity.

In the past two decades the drug problem has changed in menacing ways. A serious public health epidemic of prescription drug abuse has emerged, with the nonmedical use of opiate pain medicines driving up the rates of overdose deaths. In addition, new psychoactive substances have emerged as an entire new category of drugs. These synthetic drugs include synthetic cannabis, K2/Spice, and bath salts, all of which are “designed” to evade drug laws and drug tests. Scientific innovations have created a virtually unlimited number of chemicals that produce brain reward backed by a global supply system that is resourceful. Recently a new form of drug delivery called “vaping” has emerged

which heats drug chemicals to produce vapors instead of burning them to produce smoke. This is changing current patterns of nicotine and cannabis use and poses significant new threats from increasing higher doses of multiple drugs to appearing to offer a “safer” way to use drugs to would-be drug users, and especially youth. Additionally, over the last few decades a new global cultural movement has emerged working to normalize nonmedical drug use and sale. Well-funded, powerful efforts are working to “end prohibition” by legalizing drug sale and use with a “tax-and-regulate” strategy in the model of alcohol and tobacco. While the focus of these initial efforts has been to legalize cannabis, it is clear that the same shifting attitudes towards cannabis will be applied to all nonmedical drug use and sale. At the same time, there has been a call for a new drug policy, posing the future of drug policy as a choice between “prison” or “treatment” and a choice between the goals of “drug-free” or “harm reduction.” Harm reduction aims to reduce some of the problems created by nonmedical drug use while tolerating continued drug use.

The primary challenge facing the future of drug policy is determining how to reduce the threats of nonmedical drug use in the most cost-effective ways that are compatible with contemporary values and laws. It is clear that a new and better drug policy is needed. The questions remaining are: What should that new and better drug policy be? How can the world achieve that better drug policy?

Drug Policy Futures (DPF) has joined the

“DPF strongly disagrees with proposals to legalize the production, sale and use of drugs of abuse. This is because legalization of drugs will normalize nonmedical drug use”

global debate over the future of international drug policy. We have clear proposals for a better drug policy in the future. The overarching goal of drug policy must be to limit the damage done by nonmedical drug use to the lowest level that is practically possible.

DPF strongly disagrees with proposals to legalize the production, sale and use of drugs of abuse. This is because legalization of drugs will normalize nonmedical drug use and promote commercial interests supporting increases in nonmedical use. Global experiences with alcohol and tobacco, the two legal drugs for adults, demonstrate that they are used by dramatically more people than illegal drugs, resulting in serious social costs that vastly exceed their revenues. This is not because alcohol and tobacco are more biologically attractive than the illegal drugs but because they are accessible and their use is normalized.

The notion of “treatment or incarceration” belies the complexity of the drug issue. Many people commit crimes under the influence of drugs, so solutions that solely rely on treatment, or solely on incarceration, are incomplete and simplistic. DPF rejects the notion that the future of drug policy is a choice of the criminal justice system or substance abuse treatment. We believe the criminal justice system can be an essential tool to curb drug supply and to reinforce both prevention and treatment. We are committed to finding new and better ways to use the criminal justice system to promote prevention and recovery while also reducing the rate of incarceration. Numerous innovative criminal justice programs – including Drug Treatment Courts,² Mental Health Courts, Juvenile Courts, Family Courts, HOPE Probation³ and 24/7 Sobriety⁴ – demonstrate that the criminal justice system can be leveraged to reduce drug use, promote prevention and recovery and significantly reduce both crime and incarceration.

DPF rejects the notion that harm reduction – defined here as reducing the harmful effects of drug use – is in conflict with the drug-free goal. We are in favor of using harm reduction to the extent that it does not perpetuate and normalize nonmedical drug use.

There are many aspects of the standard menu of harm reduction policies that are attractive, such as the widespread access to naloxone to reduce opiate overdose deaths or the use of medicated-assisted treatment. But unlike a typical harm reduction standard for naloxone which includes reviving someone from opiate overdose without any follow-up intervention, we insist that people who are revived by naloxone be treated at a hospital after their initial recovery and that they be required to be evaluated for treatment to ensure that they receive the help they need and to ensure that they do not simply return to dangerous and self-destructive nonmedical drug use.

Endnotes

1. DuPont, R. L., Madras, B. K., & Johansson, P. (2011). Drug policy: A biological science perspective. In J. H. Lowinson & P. Ruiz (Eds.) *Substance Abuse: A Comprehensive Textbook* (5th ed., pp. 998-1010). Philadelphia, PA: Lippincott Williams & Wilkins.
2. Marlowe, D. B. (2010, December). Research Update on Adult Drug Courts. Need to Know. Alexandria, VA: National Association of Drug Court Professionals. Available: http://www.nadcp.org/sites/default/files/nadcp/Research%20Update%20on%20Adult%20Drug%20Courts%20-%20NADCP_1.pdf
3. Hawken, A. & Kleiman, M. A. R. (2009). Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii’s HOPE. Document No. 229023. Award No. 2007-IJ-CX-0033. Available: <http://nicic.gov/Library/024156>
4. Kilmer, B., Nicosia, N., Heaton, P., & Midgette, G. (2013). Efficacy of frequent monitoring with swift, certain, and modest sanctions for violations: Insights from South Dakota’s 24/7 Sobriety Project. *American Journal of Public Health*, 103(1), e37-e43.

Chapter 2

The Importance of Prevention

“

The first task of a public health-oriented drug policy is to prevent drug-related problems from occurring. Environmental strategies that discourage drug use and reduce the availability of illegal drugs are a central element of prevention. Community-based strategies that promote drug-free environments and supportive social norms are shown to reduce the use of both legal and illegal substances. Environmental strategies should be supplemented by education and evidence-based prevention as well as more targeted interventions that reach high-risk groups and problem drug users.”

The Importance of Prevention: An Introduction

Charli Eriksson

Senior Professor, School of Health Sciences, Faculty of Medicine and Health,
Örebro University, SE-70185 Örebro, Sweden (charli.eriksson@oru.se)

It is always better to prevent an unwanted health problem than to treat the problem itself. Much has been said on the issue. Indeed, a search in a recently updated database on prevention gave nearly 1 million hits. An important starting point for discussion of the importance of drug prevention is what the words importance and prevention mean in the context of future drug policy.

A vital part of a public-health-oriented drug policy is to prevent drug-related problems from occurring. It is a key aspect of promoting health in the twenty-first century, and involves a multidisciplinary endeavor, ranging from surveillance through to the provision of health advice and information. Moreover, it includes actions taken by individuals through both national and international agencies. And it also takes place in many different settings, such as in homes, workplaces, schools, youth centers, health facilities, restaurants, and other community locations.¹

The importance of prevention in the context of drug prevention is related to the prevalence of substance use and abuse in the population, and the impact it has on health and well-being in the population. The undeniable magnitude of the problem and its tremendous

social and economic costs has made a response a priority for policy-makers at all levels of government.² The health-economic realities described in other chapters in this book make it clear that governments must be involved in the prevention of substance abuse. However, drug prevention needs effective weapons to hit its intended targets. There is no single cause of drug use and abuse. Nor can a single targeted bullet eradicate substance abuse. Good intentions are not enough. So, realization of the potentials of drug prevention is a challenge.

A common view on drug prevention, especially among lay people, is that it consists of warning young people about the dangerous effects of drug use. However, the provision of information on drug effects alone, mostly using media campaigns, has, according to current research, no impact on drug-use behavior. Now, science allows us to tell a more complicated story.³ This chapter gives an overview of modern prevention approaches based on the notion that prevention is about the healthy and safe development of children and adolescents. Prevention strategies, based on scientific evidence, that work with families, schools and communities can ensure that children and young people, including the most marginalized

and poor, grow and stay healthy and safe into adulthood. Drug prevention is an integral part of a larger effort to ensure that the young are less vulnerable and more resilient. By targeting early liability factors rather than substance-use problems later in adolescence, interventions may reduce the adverse impact substance use has on the developing brain as well as preventing associated harms.⁴

Investing in prevention can also save money. According to a US study, every dollar invested in prevention can give a return of at least ten dollars through reductions in future health, social and crime costs.⁵ An estimate of the global burden of disease found that 12.6 percent of all deaths and 9 percent of disability adjusted life years (DALYs) lost were due to substance abuse.⁶ The figures were found to be higher in high-income countries, where 10.2 percent of DALYs lost were attributed to tobacco, 6.7 percent to alcohol, and 2.1 percent to illicit drugs. However, transitions of individuals into dependency, substance abuse and early death are additional losses for the family, the social network, and working life.

In reality, the challenge of drug prevention lies in helping young people to adjust their behaviors, capacities, and well-being in multiple fields of influences, such as those represented by social norms, interaction with peers, living conditions, and their own personality traits. Moreover, substance abuse shares several vulnerabilities with a number of other risk behaviors. This means that preventing other problem behaviors may have positive effects with regard to the preventing of substance abuse.⁷ Also, a drug policy can make a drug-free life easier to achieve while reducing exposures to the substances that may be abused. This view is reflected in modern prevention approaches which also aim to reduce the risk related to substance abuse.⁸ It is in these approaches that opportunities for success in preventing drug use reside.

The Concept of Prevention

Prevention is one of the main components of a public-health-centered system mandated to address substance abuse through the existing

“According to a US study, every dollar invested in prevention can give a return of at least ten dollars through reductions in future health, social and crime costs.”

three international conventions⁹ that focus on the prevention of the initiation of drug use and of the transition to drug-use disorder. Moreover, there are other types of prevention, such as those involving the health and social consequences of drug use,¹⁰ drug dependency treatment, and law enforcement.

The classic typology of prevention in medicine is into primary, secondary and tertiary prevention.¹¹ Primary drug prevention is exemplified by drug prevention programs in schools, secondary prevention by interventions targeted at risk groups such as the children of alcoholics, and tertiary prevention by interventions aimed at preventing relapses into substance abuse. This typology, which uses a medical paradigm, has been superseded by a new classification that is better suited to the description of complex human behaviors.¹² The new classification comprises three types of prevention, which are complementary to one another. What is important for distinguishing between the types is known level of vulnerability for developing substance-use problems, not whether or not, or how much, people actually use the substances. Universal, selective, and indicated prevention are distinguished by differences in the levels of risk within target groups or individuals.

Universal prevention – intervening with populations – addresses defined populations, and targets the development of skills and values, norm perceptions, and interactions with peers and social life. In universal prevention, all members of a population are treated as having the same general risk of drug use, and the target group comprises all these members, without considering different levels of vulnerability

and risk. The aim of universal drug prevention is to prevent or delay the onset of drug use by providing all necessary information and skills. It addresses an entire population, such as a local community, school pupils, or neighborhood. Among the approaches to universal prevention are school-based prevention, family-based universal prevention, and community-based prevention. School-based interventions have been repeatedly questioned,¹³ but there is evidence that they can be effective in reducing some types of drug use.¹⁴ Moreover, there is evidence of the positive impacts of family-based interventions, which include the coaching and training of families.¹⁵

Selective drug prevention – intervening with vulnerable groups – addresses groups where substance use is often concentrated, and focuses on improving the opportunities of people in difficult living and social conditions. In selective prevention, social and demographic indicators are used to identify target groups with higher levels of vulnerability, such as marginalized ethnic minorities, youth in deprived neighborhoods, young (drug) offenders, vulnerable families, or in specific settings, such as the nightlife environment. In selective prevention, specific subpopulations are addressed since they show significantly higher than average risk, either in the short term or over a lifetime. The main advantage of selective prevention is that vulnerable populations are readily identifiable, in many places and contexts. There is great potential for drug prevention among these vulnerable groups. However, evidence-based activities targeting motivation, skills, and decision-making are needed, since just distributing information leaflets has been shown

to be ineffective.¹⁶ Interventions for vulnerable families have been found to be effective in a number of studies.¹⁷

Indicated drug prevention – intervening with (vulnerable) individuals – addresses particular individuals and helps them to deal with the individual personality traits that make them more likely to escalate their drug use. On this approach, a vulnerable individual is identified by screening, or through the diagnostic procedure of a health professional, as having a condition, such as attention deficit disorder, conduct disorder, etc., that increases the risk of drug use. The aim is to target individuals at risk of developing substance abuse and progressing into dependency and related dangerous substance use.

Environmental prevention strategies – intervening with societies and systems – reflect a different approach to that applied in universal, selective or indicated prevention, which predominantly use persuasion to change the behaviors, or at least the attitudes, of individuals. Environmental prevention can effectively change human behavior by modifying the social, physical or economic context. This fourth type of prevention addresses societies or social environments and targets social norms, including by market regulation. That is, it is designed to change the immediate cultural, social, physical and economic environments in which people live and make their choices about drug use. For public-health advocates, substance abuse is not only a matter of private concern, since there are strong economic interests entangled in the background. Accordingly, drug policies are needed to protect vulnerable groups, such as young people.

An important distinction to make is between supply reduction and demand reduction strategies. These strategies use different methods but can work in synergy. The supply reduction strategy is based on drug legislation, drug enforcement and interdiction activities aimed at the availability of drugs, i.e., at the supply of substances for use and abuse. Demand reduction and related measures include general prevention and treatment, and also consideration of other health-related issues,

“For public-health advocates, substance abuse is not only a matter of private concern, since there are strong economic interests entangled in the background.”

including HIV/AIDS prevention, and treatment and care with a particular focus on vulnerable groups. Examples of demand reduction include interventions, such as school programs, aimed at developing protective factors and resistance to persuasive drug positive communications. A restrictive drug policy, which need both supply reduction and demand reduction strategies, may also include a vision of a society free of drugs outside scientific and medical usage. In the literature, the concept of early intervention refers to both primary prevention and the early detection of individuals using drugs before developing an advanced dependency disorder. In what follows, the concept of intervention is applied to both programs and policies. The importance of prevention will be demonstrated by indicating the potential impacts of evidence-based programs and policies.

Do We Know What Works in Drug Prevention?

There is a growing evidence base for what works and does not work in the field of drug prevention. This is a reflection of the increased research in preventive science over the last 20 years. Moreover, several international and national agencies have developed into clearinghouses for drug-related knowledge. It is beyond the scope of this chapter to present a comprehensive review of the literature, although several high-quality reviews will be referred to.¹⁸ We offer a selective presentation, based on some key publications and high-quality websites.

The International Standards on Drug Use Prevention,¹⁹ published by the United Nations Office on Drugs and Crime (UNODC), will be used to describe drug prevention in relation to the developmental phases of target groups. Also, the annual reports of the UNODC give important updated knowledge.²⁰ The work of the European Monitoring Centre for Drugs and Drug Addiction (EMDDCA),²¹ its website and publication such as *Prevention of Substance Abuse*²² provides evidence on drug prevention at European, national, regional, and municipal levels. The drug-prevention guidelines and standards developed by the EMDDCA and its partners are also used as key references in this

chapter.

Due to the development of preventive science, we also know a lot about what is effective in preventing substance abuse. The majority of the science originates from a handful of high-income countries in North America, Europe and Oceania. There are few studies from other cultural settings, or from low- or middle-income countries. The Society of Prevention Research has updated its standards of evidence for efficacy, effectiveness, and scale-up (dissemination).²³ Most drug-prevention studies are “efficacy” studies that examine the impact of interventions in well-resourced, small, controlled settings. There are very few studies that have investigated the effectiveness of interventions in “real life”. Further, there are only limited studies of interventions (programs and policies) with regard to costs and benefits or cost-effectiveness. Only a few studies report data disaggregated by sex. In order to have the greatest population impact, evidence-based prevention methods need to be scaled up, which includes decision-making at policy level.

Meta-analyses and systematic reviews have been undertaken to give evidence-based information to prevention professionals and policy-makers. However, generally, there are not enough studies to be able conclusively to identify the component or components necessary for an intervention or policy to be efficacious, effective, or worth scaling up. Possible components include the methods employed (Which ones?), methods of delivery (Who delivers them best?), the qualities and training needed (Which and how much?), and so on. There is a lack of resources and opportunities to undertake rigorous evaluations in some settings, particularly in low- and middle-income countries.

The gaps in the science should make us cautious, but not deter us from action. It is important that preventive interventions are evidence-based and implemented with quality and persistence. Moreover, it should be mandatory for new interventions to be evaluated with regard to implementation, processes, and outcomes.

Drug-Prevention Interventions and Policies by Target Group

Knowledge of the extent and distribution of drug problems in a population is an important prerequisite for planning successful prevention. In addition, knowledge of risk and protective factors further strengthen the preventive potentials of drug policy when put into action.²⁴ The vulnerability of certain individuals and groups to substance abuse is due to a variety of individual and contextual factors (Table 1). Factors differ by age and developmental group, and successful drug prevention needs to take the differences into account.

UNODC's *International Standards on Drug Use Prevention*¹⁹ and *World Drug Reports*²⁰ are key resources for summarizing the state of the science of drug prevention. Reviewing the published research literature, and including systematic reviews and meta-analyses, enables high-quality recommendations on drug prevention to be given. Interventions, programs and policies are grouped by the ages of the target groups, which represent major developmental stages in the life of an individual. Moreover, appropriate strategies are specified for the population at large (universal prevention), or for groups that are particularly at risk (selective prevention), or for individuals who are specifically at risk (indicated prevention), who include those who have started experimenting and may therefore progressing into a state of disorder.

Policy-makers need to consider how a comprehensive drug policy should be composed and what elements need to be included for different segments of the population. There follows a brief itemized summary of what can be found in the UNDOC reports.

Infancy and Early Childhood

Challenge: In developmental terms, the key goals for early childhood are the attainment of safe attachment to caregivers, age-appropriate language skills, and other executive cognitive functions, such as self-regulation, and pro-

Table 1: Factors increasing vulnerability to drug use (Adapted from World Drug Report 2015)²⁰

Community/Society: Laws and norms favorable to drugs, Availability, Accessibility, Extreme poverty, Anti-social behavior in childhood
School/Education and Peers: Childhood/adolescence: School failure, Low commitment to school, Not college bound, Deviant peer group, Peer attitudes to drugs, Associating with drug-using peers, Aggression toward peers, Interpersonal alienation, Peer rejection Young adulthood: Attending college, Substance using peers
Family: Early childhood: Cold and unresponsive mother behavior, Parental modelling of drug use Childhood/Adolescence: Permissive parenting, Parent-child conflict, Low parental warmth, Parental hostility, Harsh discipline, Child abuse/maltreatment, Parental/Sibling modelling of drug use, Parental favorable attitudes toward drugs, Inadequate supervision and monitoring, Low parental involvement, Low parental aspirations for child, Lack or inconsistent discipline Young adulthood: Leaving home
Media: Norms, e.g. advertising favorable towards drugs
Individual: Preconception: Genetic predisposition, Prenatal alcohol exposure Early childhood: Difficult temperament Middle childhood: Poor impulse control, Low harm avoidance, Sensation seeking, Lack of behavioral self-control regulation, Aggressiveness, Antisocial behavior, Anxiety, depression, ADHD, hyperactivity, Early persistent problem behavior, Early substance abuse Adolescence: Behavioral disengagement coping, Negative emotionality, Conduct disorder, Favorable attitudes towards drugs, Antisocial behavior, Rebelliousness, Early substance abuse Young adulthood: Lack of commitment to conventional adult roles, Antisocial behavior

social attitudes and skills. Acquisition of these attributes is best supported within the context of a supportive family and community. Mothers' intake of alcohol, nicotine and drugs during pregnancy negatively affect developing fetuses. Such deficiencies impede children's attainment of significant developmental competencies, and make them vulnerable and at risk for negative behaviors later on.²⁵ There is evidence for the effectiveness of the three selective interventions that follow.

Interventions targeting pregnant women with substance-abuse disorders:

Evidence-based and comprehensive treatment for substance dependence tailored to the needs of the patient can be accompanied by early training in parenting. Providing evidence-based integrated treatment to pregnant women can have positive impacts on child development and emotional and behavioral functioning, and on parent skills. Some interventions are associated with positive prevention outcomes, including "providing integrated treatment services to pregnant women who suffer from substance disorders, including concurrent mental health disorders; and including attachment-based parenting interventions."²⁶

Guidelines for the identification and management of substance use and substance-use disorders in pregnancy have recently been published by WHO.²⁷ Prioritizing prevention is one recommendation. Ceasing, or at the very least reducing, use of alcohol and drugs during pregnancy and in the postpartum period are essential elements in optimizing the health and well-being of women and their children.

In **perinatal and infancy visits** to women with alcohol and drug disorders, a trained nurse or social worker meets mothers-to-be and new mothers to provide them with the parenting skills and support they need with health, housing, employment, or legal issues. This has proven to be effective in improving children's behaviors when they reach adolescence.²⁸

Early childhood education supports the social and cognitive development of pre-school children (2 to 5 years of age) from deprived communities (selective prevention). According to relevant studies, offering early education

services to children growing up in disadvantaged communities can reduce marijuana use at age 18, and can also decrease smoking and the use of other illicit drugs. Further, early education can prevent other risky behaviors, and support mental health, social inclusion and academic success.²⁹

Middle Childhood (6-10 Years)

Challenge: Among the main developmental goals in middle childhood are the continued development of age-specific language and numeracy skills, and of impulse control and self-control. The development of goal-directed behavior, together with decision-making and problem-solving skills, starts at these ages. The roles of social skills and pro-social attitudes grow in middle childhood, and they become key protective factors, impacting also the extent to which school-aged children will cope and bond with school and peers.

Parenting skills programs help parents become better parents. A warm child-rearing style, where parents set rules for acceptable behaviors, closely monitor free time and friendship patterns, help to acquire skills to make informed decisions, and are role models, has been shown to be one of the most powerful protective factors against substance abuse and other risky behaviors. These programs can also be delivered for the parents of early adolescents. Interventions can be delivered at both universal and selective level.

Family-based universal programs prevent alcohol use in young people. The measured effect size is small, but is generally consistent and persistent in the medium- and long-term.³⁰ There is also strong evidence that these kinds of programs can prevent self-reported drug use at follow-up of 12 months or more.³¹ Family-focused work may be the most potentially effective for vulnerable young people, and those exhibiting multiple risk factors, in producing long-term reductions in substance abuse (selective prevention). Finally, parent- and family-focused interventions also produce significant and long-term improvements in family functioning (including parenting skills, and child behavior).

Moreover, such interventions may also improve the behavior, and the emotional and behavioral adjustment, of children under the age of three years. Parenting programs have been implemented in Africa, Asia, the Middle East, and Latin America.

A number of characteristics are associated with positive prevention outcomes: enhancing family bonding, i.e., the attachment between parents and children; supporting parents on how to take a more active role in their children's lives, e.g., monitoring their activities and friendships, and being involved in their learning and education; supporting parents on how to provide positive and developmentally appropriate discipline; and supporting parents on how to be a role model for their children.¹⁹

Personal and social skills education consists of programs where trained teachers engage children in interactive activities to give them the opportunity to learn and practice a range of personal and social skills. Typically, these programs are structured universal programs that provide opportunities for children to learn skills for coping with difficult situations in daily life in a safe and healthy way. They support the development of general social competencies, and address social norms and attitudes. These programs do not typically have a content that covers specific substances, since, in most communities, children of this age are too young to have initiated drug use. But the programs do target children of different ages where developmental challenges are addressed in age-appropriate ways.

Supporting the development of personal and social skills in a classroom setting can, according to several reviews,³² prevent later drug use and alcohol abuse. Such programs also influence substance- abuse-related risk factors, e.g., commitment to school, academic performance, self-esteem and mental well-being, resistance skills, and other social skills. Moreover, programs focusing on improving self-control delivered to children younger than 10 reduce general problem behaviors. As well as Australia, Canada, Europe and the United States, the evidence reported above comes from Africa, Latin America and India.

The following characteristics are associated with positive prevention outcomes: improving a range of personal and social skills; delivered through a series of structured sessions, often providing booster sessions over multiple years; delivered by trained teachers or facilitators; and sessions that are primarily interactive.¹⁹

Classroom environment improvement programs strengthen the classroom management abilities of teachers, and support children to become better students, while reducing early aggressive and disruptive behavior. The universal programs support day-to-day practices with all students in order to teach pro-social behavior, and prevent and reduce inappropriate behavior. These programs facilitate both academic and socio-emotional learning. Teachers' classroom-management practices significantly decrease problem behaviors in the classroom, including disruptive and aggressive behaviors (large effect sizes at classroom level), and strengthen the pro-social behavior and the academic performance of the children.³³ Some characteristics are, according to the UNODC, associated with positive prevention outcomes: often delivered during the first school years; including strategies to respond to inappropriate behavior; including strategies to acknowledge appropriate behavior; including feedback on expectations; and eliciting active engagement from students.¹⁹

Early Adolescence

Challenge: Adolescence is a developmental period when youth are exposed to new ideas and behaviors through increased associations with people and organizations beyond the ones they have encountered in childhood. It is a time to "try out" adult roles and responsibilities. It is also a period when the development of the adolescent brain suggests that, like with infancy, this is a time when interventions can either reinforce or alter earlier experiences.³⁴ The development of neurocognitive processes responsible for the development of executive functions, self-regulation and higher-order decision-making is crucial for reducing substance-use vulnerability

during adolescence. Teaching strategies for enhancing early competencies with an executive-function foundation, such as self-control, emotional regulation, and decision-making, are included in social-emotional learning programs. The substance abuse and deviant behaviors of peers, as well as their rejection by peers, are important influences on behavior, although the influence of parents remains significant. Healthy attitudes related to various substances and safe social normative beliefs are also important protective factors against drug use. Good social skills and resilient mental and emotional health remain key protective factors throughout adolescence.

In **preventive education based on personal and social skills and social influence**, trained teachers engage students in interactive activities to give them the opportunity to learn and practice a range of personal and social skills. These programs focus on coping with challenging life situations in a healthy way, and fostering peer-refusal abilities that allow young people to counter social pressures to use substances. Moreover, they provide the opportunity to discuss, in an age-appropriate manner, the different social norms, attitudes and positive and negative expectations associated with substance abuse, including the consequences of abuse. According to the literature,³⁵ certain interactive school-based programs can also prevent substance abuse in the long term (with a large effect size for cannabis use). Such interactive programs develop personal and social skills and permit discussion of the social influences (social norms, expectations, normative beliefs) related to drug use. They generally yield positive results for all substances, and also for other problem behaviors, such as dropping out of school and truancy.

Most of the evidence is from universal programs, but there is some evidence that skills-based education can also be preventive among (selected) high-risk groups. These programs are typically delivered by trained facilitators, mostly teachers. However, programs delivered through computers or the Internet can also reduce substance abuse.³⁶ Most of the evidence is from the United States, Europe and Australia.

According to the UNODC, some

characteristics are associated with positive prevention outcomes: using interactive methods; delivered through a series of structured sessions (typically 10-15) once a week, often providing booster sessions over multiple years; delivered by trained facilitators (including trained peers); providing an opportunity to practice and learn a wide array of personal and social skills, including coping, decision-making and resistance skills, particularly in relation to substance abuse; impacting perceptions of risks associated with substance abuse, emphasizing immediate consequences; and dispelling misconceptions regarding the normative nature and the expectations linked to substance abuse.¹⁹

School policies and culture can enhance student participation, positive bonding and commitment to school. Policies on substance use stipulate that substances should not be used on school premises or during school functions and activities by either students or staff. Policies also create transparent and non-punitive mechanisms to address incidents of use, which transforms them into educational and health-promoting opportunities. Interventions of this kind tend to be universal, but may also include selective components, such as cessation support and referral. They are typically implemented alongside other preventive interventions, such as skills-based education or supporting parenting skills and parental involvement. There is a series of findings with regard to these policies,³⁷ such as prevention of smoking, increasing commitment to school and student participation, and enhancing positive social relationships, and also discouraging negative behaviors that may reduce drug use and other risky behaviors. Among older students in colleges and universities, school policies and cultural interventions can reduce alcohol abuse, especially when they are brief (with a medium effect size in reducing drinking quantities).

School-based random student drug testing (RSDT) is a controversial tool. It should not be a stand-alone prevention strategy, but can reinforce other components of a school's substance-abuse prevention initiatives. Reviews have found that there is insufficient empirical evidence definitively to support or refute the efficacy of RSDT in school.³⁸ In one recent

study, student drug testing was found not to be associated with changes in substance use, whereas a perceived positive school climate has been seen to be associated with a reduction in cigarette and marijuana initiation and a reduction in escalation of frequency of cigarette use at 1-year follow-up.³⁹

According to the UNODC¹⁹, some characteristics are associated with positive prevention outcomes: supporting normal school functioning, not disruption; supporting positive school ethos, commitment to school and student participation; policies developed with the involvement of all stakeholders (students, teachers, staff, parents); policies clearly specifying the substances that are targeted, as well as the locations (school premises) and/or occasions (school functions) to which they apply; applied to everyone in the school (students, teachers, staff, visitors, etc.); reducing or eliminating access to and availability of tobacco, alcohol, or other drugs; addressing infractions of policies with positive sanctions by providing or referring to counseling, treatment and other health-care and psychosocial services rather than punishing; enforcing consistently and promptly, including positive reinforcement for policy compliance.¹⁹

Addressing individual psychological vulnerabilities, such as sensation-seeking, impulsivity, anxiety, sensitivity, and hopelessness, are valuable, since they are associated with increased risk of substance abuse. Such indicated prevention programs help adolescents to deal constructively with emotions arising from their personalities, instead of adopting negative coping strategies, including harmful alcohol use. Randomized control trials have reported that addressing individual psychological vulnerabilities among adolescents can lower rates of drinking (reducing odds by 29 percent compared with high-risk students in control schools) and binge-drinking (reducing odds by 43 percent) at two-year follow-up.⁴⁰

Some characteristics are associated with positive prevention outcomes: delivered by trained professionals (e.g., psychologists, teachers); participants identified as possessing specific personality traits on the basis of validated instruments; participants provided with skills on how to positively cope with the emotions

arising from their personality; and short series of sessions.¹⁹

Mentoring in relationships and interactions between children/adolescents and non-related adults, such as teachers, coaches and community leaders, has been found to be linked to reduced rates of substance abuse and violence. Such programs match youth, especially those in marginalized circumstances (selective prevention), with adults who commit to arrange activities for and spend some of their free time with the young people on a regular basis. It has been shown that mentoring programs prevent alcohol and drug use among high-risk youth, and have sustainable positive outcomes one year after intervention.⁴¹ Some characteristics are associated with positive prevention outcomes: providing adequate training and support to mentors; and being based on a highly structured program of activities.¹⁹

Adolescence and Adulthood

Challenge: As adolescents grow older, they become involved in many more settings where pro-drug messages and drug availability are prevalent. Accordingly, relevant drug-prevention interventions may be delivered in settings other than the family and the school, such as the workplace, the health sector, entertainment venues, and the community at large.

Brief intervention consists of one-to-one counseling sessions delivered by a variety of trained health and social workers to people who might be at risk because of their actual substance abuse. A brief psychosocial intervention is motivational interviewing (MI), where a person enters into a discussion of his/her abuse, and is then supported in making decisions and setting goals. MI can include follow-up sessions or additional information to take home. It is often delivered in the primary health-care system or in emergency rooms, but it has also been found to yield positive results when delivered as part of school-based and workplace programs, and also when delivered online or via computers. There is high-quality evidence⁴² showing that brief intervention and MI can also significantly reduce substance abuse in the long term. The effect sizes for alcohol and drug use, which are

large immediately after intervention, have been shown substantially to be sustained over time, one year after the intervention.

There is evidence that brief intervention and motivational interviewing benefit adolescents and adults alike⁴³. As well as in the United States, Europe and Australia/New Zealand, and trials in Africa, the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST),⁴⁴ a brief intervention package developed by WHO, has been used in Latin America and Asia. Similar results have been obtained in both European and non-European countries.⁴⁵

Some characteristics are associated with positive prevention outcomes: one-to-one session identifying if there is a substance abuse problem, and provision of immediate basic counseling and/or referral; delivered by a trained professional.¹⁹

Workplace prevention programs are typically multi-component, including both prevention elements and policies, and also counseling and referral to treatment. There are good reasons for establishing drug-prevention programs in the workplace. The vast majority of substance abuse occurs among working adults. Substance-abuse disorders expose employees to health risks and difficulties in their work, and also to safety risks in the workplace. Employers also bear significant costs of substance abuse, since employees with abuse problems have higher absenteeism rates and lower productivity, are more likely to cause accidents, and have higher health-care costs and turnover rates. Moreover, employers have a duty to provide and maintain a safe and healthy workplace in accordance with the law and more specific regulations. According to the literature,⁴⁶ workplace prevention programs can prevent alcohol use. Some characteristics associated with positive prevention outcomes are: developed with the involvement of all stakeholders (employers, managers, employees); guaranteeing confidentiality to employees; including and being based on a policy on substance abuse in the workplace that has been developed by all stakeholders and is non-punitive; providing brief interventions (including web-based), as well as counseling, referral to treatment and reintegration services

to employees who need them; including a clear communication component; embedded in other health- or wellness-related programs (e.g., for the prevention of cardiovascular diseases); including stress management courses; training managers, employees and health workers in fulfilling their roles in the program; including alcohol and drug testing only as part of a comprehensive program with the characteristics described above.¹⁹

Tobacco and alcohol policies are important tools in drug prevention since the use of tobacco and alcohol by early adolescents, when the brain is still developing, considerably increases the likelihood of their developing substance-use disorders and addiction later in life. Moreover, young people who use drugs often also use alcohol in excessive quantities and/or in combination with other substances. There is positive evidence with regard to alcohol policies⁴⁷ as well as tobacco policies.⁴⁸ Raising the price of alcohol and tobacco reduces their consumption in the general population. Raising the minimum legal drinking age and enforcing regulation reduces alcohol consumption and alcohol-related accidents, whereas lowering the legal drinking age increases consumption and related problems.⁴⁹

Some characteristics are associated with positive prevention outcomes: increasing the price of tobacco and alcohol through taxation (in the case of alcohol policies, outcomes might be not as strong as in the case of countries where the vast majority of the production and consumption is unrecorded); increasing the minimum age of sale of tobacco and alcohol products; preventing the sale of tobacco and alcohol to young people under the legal age through comprehensive programs including active and ongoing law enforcement and education of retailers through a variety of strategies (personal contact, media and information materials; banning advertising of tobacco and restricting advertising of alcohol to youth).¹⁹

Community-based multi-component initiatives bring together different actors in a community to address substance abuse by mobilizing efforts to create partnerships, task forces, coalitions, action groups, etc. Community-based initiatives are normally multi-component, taking place in different settings (e.g., schools,

families, the media, enforcement, etc.). For example, one systematic review has reported that comprehensive approaches involving community, school and family initiatives have been effective in preventing, delaying or reducing the use of drugs, alcohol and tobacco in high-risk youths.⁵⁰ The successful Icelandic model represents a theoretical, evidence-based approach to adolescent substance-use prevention that has grown out of collaboration between policy-makers, behavioral scientists, field practitioners, and community residents.⁵¹ In this model, leisure-time, including sport, is used as a setting for prevention. However, sports clubs have been described both as a setting with great potential for promotion, and as a risk environment for drugs.⁵²

Some characteristics are associated with positive prevention outcomes: supporting the enforcement of tobacco and alcohol policies; working in a range of community settings (families and schools, workplaces, entertainment venues, etc.); involving universities to support the implementation of evidence-based programs, and their monitoring and evaluation; adequate training and resources to communities; and sustaining initiatives in the medium term (e.g., longer than a year).¹⁹

Media campaigns are often the first and only intervention delivered by policymakers concerned with preventing the use of drugs in a population, since they are visible and have the potential to reach a large number of people relatively easily. But, as standalone interventions, they do not influence substance use. Media campaigns, in combination with other preventive efforts, can prevent tobacco use (with a reported median reduction of 2.4 percent). But no significant findings have been reported for alcohol abuse, and only weak findings for drug use. It has been noted that “media campaigns that are badly designed or poorly resourced should be avoided as they can worsen the situation by making the target group resistant to or dismissive of other interventions and policies.”⁵³

Media campaigns can also be aimed at setting the agenda and creating opinion for a restrictive drug policy. Most fields of public health have objectives that are highly contested.⁵⁴

Opponents can come from a variety of external directions, such as government, industry, and community and religious organizations, and sometimes also from within the public-health field itself. The industrial influence on policymaking has been documented for tobacco,⁵⁵ but similar patterns can be seen with regard to alcohol and food,⁵⁶ where a wide range of tactics and strategies are used to defend, and indeed to promote, a ‘license to operate.’ Therefore, the support of highly credible public-health organizations and eminent researchers, as well as that of the general public, is crucial to the advancement of public health. Public health advocacy has an important role to play in the fight for a future drug policy.

Entertainment venues include bars, clubs and restaurants, and also outdoor and special settings where large-scale events may occur. These venues can have both positive and negative impacts on the health and well-being of citizens. They provide social meeting spaces and support the local economy, but, at the same time, they are high-risk settings for many risk behaviors, such as harmful alcohol use, drug use, drugged driving, and aggression. Most prevention programs utilizing entertainment venues have multiple components: training of staff and managers in responsible beverage service (RBS) and the management of intoxicated patrons; changes in laws and policies on serving alcohol to minors or to intoxicated persons, or with regard to drinking and driving; high-visibility enforcement of existing laws and policies; communication to raise awareness and acceptance of a program and to change attitudes and norms; and, offering treatment to managers and staff.

Research indicates⁵⁷ that training of staff, policy interventions and enforcement may reduce intoxication. Some characteristics are associated with positive prevention outcomes: training staff and management on responsible serving and handling of intoxicated clients; providing counseling and treatment for staff and management who need it; including a strong communication component to raise the awareness and the acceptance of the program; including the active participation of the law enforcement, health and social sectors; enforcing

existing laws and policies on substance abuse in the venues and in the community.¹⁹

Characteristics of an Effective Prevention System

An effective drug-prevention system consists of an integrated range of evidence-based interventions and policies, in multiple settings, targeting relevant ages and levels of risks. Given the complex interplay of protective and risk factors for substance abuse and other risky behaviors, a single intervention is never sufficient. Moreover, the overarching goal is to support the healthy and safe development of individuals. An effective prevention system delivers added values:

- "Supports children and youth throughout their development and particularly at critical transition periods where they are most vulnerable, e.g. infancy and early childhood, at the transition between

childhood and adolescence.

- Targets the population at large (universal prevention), but also support groups (selective prevention) and individuals (indicated prevention) that are particularly at risk.
- Addresses both individual and environmental factors of vulnerability and resilience.
- Reaches the population through multiple settings (e.g. families, schools, communities, the workplace, etc.)."⁵⁸

An effective prevention system requires **strong structural foundations** for delivering an integrated range of interventions and policies. It is embedded in a comprehensive and health-centered system for drug control and treatment. It is based on the understanding of drug dependence as a chronic and relapsing disorder impacting the brain. It is linked to a national public-health strategy for the healthy and safe development of children, young people, and

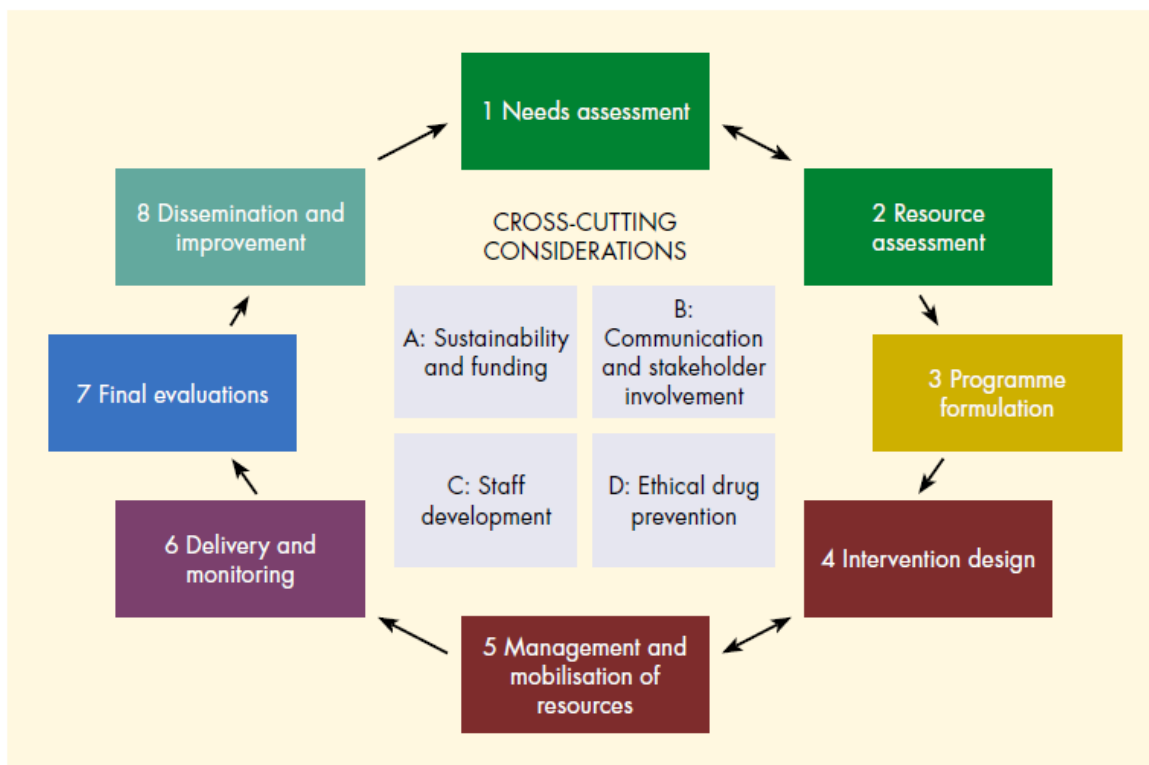


Figure 1: The drug prevention project cycle, taken from the EMCDDA's *European Drug Prevention quality standards* (2011).

adults.

The delivery of prevention programs by governmental and non-governmental agencies is facilitated at the national level by appropriate **supportive policies and regulatory frameworks** concerning national standards, policies for schools, workplaces and health, social and education services, and the availability of policy-informing local and national surveillance and monitoring data systems.

An effective drug-prevention system needs a **strong basis in research and scientific evidence**. The system should both be based on scientific evidence and support research for improving the evidence base. It is important that research is peer-reviewed, published, disseminated and translated into action. Evidence-based planning is advocated to put the necessary information in place to understand the situation, and to ensure that evaluations of specific programs and policies are used in the planning process. In order to facilitate the use of existing evidence-based programs in new cultural and socio-economic contexts, special regard should be taken to maintaining core program components.

All relevant sectors involved at different levels need to be involved in the planning, implementation, monitoring and evaluation of the components of a drug-prevention system. They include education, health, social welfare, youth, labor, law enforcement, etc. This can be organized in different ways to maintain the key involvement of a full spectrum of key stakeholders, including NGOs, private-sector organizations, community leaders, and residents. **Strong infrastructure for the delivery system** is needed. Interventions and policies must be supported by adequate resources: agencies, practitioners, policy-makers, technical assistance, and academic and research institutions. Moreover, **sustainability** is a vital concern. Visible medium-to long-term investment is necessary to realize the potentials of a drug-prevention system.

Good intentions are not enough. The results of investment in drug prevention can be much improved if a systematic evidence-based approach is adopted. One such approach is reflected in the European **drug prevention**

quality standards,⁵⁹ which are ordered chronologically in a project cycle describing the development, implementation, and evaluation of drug-prevention work (Figure 1). The standards highlight the following aspects of quality in prevention work: "relevance of activities to target populations and (inter)governmental policies; adherence to accepted ethical principles; integration and promotion of the scientific evidence base, as well as internal coherence, project feasibility and sustainability."⁶⁰

For the drug preventive interventions to be successful, it is helpful to apply a quality standard in assessing the need, resources and formulation of the program. This guideline includes some general considerations that need to be addressed initially and during each project stage. These are in the center to Figure 1. **Sustainability and funding** are important considerations. The long-term viability of prevention work should be ensured as far as possible. Programs should be seen as embedded in a wider framework of drug prevention activities. **Communication and stakeholder involvement** is crucial. Relevant stakeholders should be contacted and involved in the program as necessary. A communications strategy enables exchange between the various groups involved in the program. **Staff development** including staff training, further development, and professional and emotional support is important for ensuring that the program is delivered to a high standard. Professional competence is important.⁶¹ **Ethical drug prevention** is a must as drug prevention activities represent a form of intervention in people's lives. Prevention is typically targeted at young people. In the case of selective and indicated prevention, these young people can be among the most vulnerable in society. Moreover, it should not be assumed that drug prevention activities per definition are ethical and beneficial for participants. Therefore, the following ethical principles should be considered: "the providers' lawful conduct; respect for participants' rights and autonomy; real benefits for participants; no harms for participants; providing truthful information; obtaining consent; voluntary participation; ensuring confidentiality; tailoring the intervention to participants' needs; involving participants as partners; and health and safety."⁵⁹

The drug prevention cycle includes eight stages. (1) Before the intervention can be planned in detail, **needs assessment** is important for exploring the nature and extent of drug-related needs, as well as possible causes and contributing factors to those needs. This includes: knowing drug-related policy and legislation; assessing drug use and community needs; describing the need and justifying the intervention; and understanding the target population. (2) **Resource assessment** includes assessing target population and community resources and assessing internal capacities in the organization or agency planning the drug prevention intervention. (3) **Program formulation** outlines the necessary foundation to allow targeted, detailed, coherent, and realistic planning. This includes defining the target population, using a theoretical model, defining aims/goals/objectives, defining the setting, referring to evidence of effectiveness and determining the timeline. (4) **Intervention design** builds on the outlined cornerstones and includes planning evidence-based activities that are engaging and meaningful for the participants. These should be designed as a logical progression of activities facilitating the goal-achievement of the project. If an existing intervention is selected special concern should be taken to adapt this to match the specific context. The tailoring of the intervention to the target population should be in line with the needs assessment and govern by cultural sensitivity and some flexibility should be built into the intervention design. Monitoring, process and outcome evaluation should be planned at this stage. (5) **Management and mobilization of resources** need to be considered alongside the intervention design. It includes several linked activities: planning the program including illustrating the project plan; planning financial requirement; setting up the team; recruiting and retaining participants; preparing program materials; and providing a program description. (6) **Delivery and monitoring** of the implementation of the plan into practice. A particular concern is the balance between fidelity (adhering to the intervention plan) and adaptation or flexibility. A pilot intervention, i.e.

testing the implementation of the intervention on a smaller scale, can give information for a more successful implementation of the drug prevention intervention that is effective, feasible, and ethical. Monitoring the implementation and adjusting the implementation are also included at this stage. (7) After the intervention has been completed, **final evaluations** assess its outcomes focusing on the behavior change in participants and the process of delivering the intervention. Both outcome evaluation and process evaluation is needed for gaining a thorough understanding of the success of the intervention, program or policy. There are good guidelines for evaluation of drug preventions⁶². (8) **Dissemination and improvement** includes producing a final report, determining whether the program should be sustained, and disseminating information about the program.

Translating Policy into Preventive Actions

A challenge is to develop a drug policy that is proactive with regards to the changing scene of psychoactive substance that exists or will appear in different parts of the world. The UN system plays an important role due to the global nature of the substances for use and misuse. Moreover, the substance abuse and subsequent dependency disorder is not just an information problem as these substances have the dependency potential. Therefore, it is important to see prevention as a vital part in a more comprehensive drug policy also including early intervention and dependency treatment as well as environmental intervention aimed at reducing the use of legal and illegal psychoactive drugs. It is therefore of vital importance to use environmental strategies that discourage the drug use and the availability of illegal drugs.

The drug scene in the population or the community needs to be known in order to develop an optimal mix of intervention including programs and policies that proactively can meet the present and future needs. The cultural, social, physical, economic and legislative contexts where the planned drug policy is embedded could both be beneficial and a barrier. The case

from Uganda gives a concrete example from the African scene.

In order to have a population impact the preventive interventions need to be scaled up to the community level. Preventive effects are seen in multi-component programs including a combined approach of a school and a family intervention embedded in the structure of a community coalition and based on a survey on risk and protective factors. The Icelandic model is such an approach.

A guiding principle is to go from belief to knowledge. This means that learning and knowledge-production⁶³ for public health and drug prevention must be comprehensive and include knowledge from five different domains: distribution of health and drug problems, determinants or causal web, consequences, intervention methods as well as policy options. What are the personal implications of, for instance, substance use dependence? How is daily life affected? What are the consequences for work and family life? This includes also evaluating prevention and estimating the costs to society of substance use.

Future challenges are to do the right things in the right way. This requires clear priorities; what are the important issues for analysis, advocacy, and actions? However, gaps in knowledge should make us concerned, but not inactive. There is room for more policy-relevant research, but action is important and it should be based on the best available evidence. Future drug policies need grounding in political decisions and in ethical considerations as well as actions be based on scientific knowledge and practical experiences.

Endnotes

1. Earle S., Lolyd C.E., Sidell M., & Sour S. (2007). *Theory and research in promoting public health*. London: Sage Publications.
2. Morin S.F., & Collin C. (2000). Substance abuse prevention: moving from science to policy. *Addictive Behaviors*, 25(6): 975-982.
3. There a number of websites that report on relevant development in the science of drug prevention: United Nations Office on Drugs and Crime, www.unodc.org; European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), www.emcdda.europa.eu; Canadian Centre on Substance Abuse (CCSA), www.ccsa.ca/Eng/; Inter-American Drug Abuse Control Commission (CICAD) at the Organization of the American States, http://cicad.oas.org/main/default_eng.asp; Mentor Foundation (Mentor), www.mentorfoundation.org/; National Institute on Drug Abuse (NIDA), www.drugabuse.gov/; World Health Organization (WHO), www.who.int/.
4. Castellanos-Ryan, N., O'Leary-Barrett, M., & Conrod, P.J. (2013). Substance-use in Childhood and Adolescence: A Brief Overview of Developmental Processes and their Clinical Implications. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 22(1): 41-45.
5. Spoth R. L., Clair S., Shin C., & Redmond C. (2006). Long-term effects of universal preventive interventions on methamphetamine use among adolescents. *Archives of Pediatrics & Adolescent Medicine*, 160(9), 876.
6. WHO (2009). *Global health risks: mortality and burden of disease attributable to selected major risks*. WHO. http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf?ua=1&ua=1
7. Rohde P., Stice E., Gau J.M., & Marti C.N. (2012). Reducing substance use as a secondary benefit of an indicated cognitive-behavioral adolescent depression preventive program. *Psychology of Addictive Behaviors*, 26(3): 599-608.
8. Sandler I., Wolchik S.A., Cruden G., Mahrer N.E., Ahn S., Brincks A., & Brown, C.H. (2014). Overview of meta-analyses of the prevention of mental health, substance use, and conduct problems. *Annual Review of Clinical Psychology*, 10: 243-273.
9. *Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol; Convention on Psychotropic Substances of 1971; and United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988*.
10. Livingstone J.D., Milne T., Lan Fang M., & Amari E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, 107, 39-50. doi:10.1111/j.1360-0443.2011.03601.x
11. Caplan D. (1964). *Principles of Preventive Psychiatry*. New York: Basic Books.
12. Mrazek P.J., & Haggerty R.J. (eds). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Institute of Medicine. Washington DC: National Academy Press, 1994.
13. See, for example, Coggan (2006), Gorman 2007.
14. Faggiano F., Minozzi S., Versino E., & Buscemi D. (2014) Universal school-based prevention for illicit drug use. *Cochrane Database of Systematic Reviews* 2014, Issue 12. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub3.
15. Hannes K. (2015). Prevention of alcohol and drug misuse in adolescents: An overview of systematic reviews. *Nordic Studies on Alcohol and Drugs*, 32(2): 183-198.
16. Petrie J., Bunn F., & Byrne G. (2007), Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review, *Health Education Research*, 22 (2), pp. 177-191.
17. Sussman S., Earleywine M., Wills, T., Cody C., Biglan T., Dent C.W., & Newcomb M.D. (2004). The Motivation, Skills, and Decision-Making Model of Drug Abuse Prevention, *Substance Use and Misuse*, 39 (10), pp. 1971-2016.
18. Petrie J., Bunn F., & Byrne, G. (2007), Parenting programmes for preventing tobacco, alcohol or drugs misuse in children <18: a systematic review, *Health Education Research*, 22 (2), pp. 177-191.
19. Davoli, M., Amato, L., Clark, N., Farrell, M., Hickman, M., Hill, S., Magrini, N., Poznyak, V., & Schünemann, H. J. (2015). The role of Cochrane reviews in informing international guidelines: a case study of using the Grading of Recommendations, Assessment, Development and Evaluation system to develop World Health Organization guidelines for the psychosocially assisted. *Addiction*. Jun2015, Vol. 110 Issue 6, pp. 891-898. DOI: 10.1111/add.12788.
20. UNODC, United Nations Office on Drugs and Crime (2013), *International Standards on Drug Use Prevention*, Vienna, United Nations. Updated 2015. <http://www.unodc.org/unodc/en/prevention/prevention-standards.html>
21. UNODC (2015). *Word Drug Report 2015*. http://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf
22. EMCDDA has an up-to-date websites (www.emcdda.europa.eu), which includes a useful prevention section in its Best Practice portal, where evidence is presented by target group: families, school students, community members, as well as a for the general population useful resource: EMCDDA (2010) *Prevention and Evaluation Resources Kit (PERK). A manual for prevention professionals*. Luxembourg, Publications Office of the European Union. Available with on-line resources at <http://www.emcdda.europa.eu/publications/perk>
23. European Monitoring Centre for Drugs and Drug Addiction (2008). *EMCDDA Insights – Prevention of substance abuse*. Luxembourg: Office for Official Publications of the European Communities, ISBN 978-92-9168-313-0. <http://www.emcdda.europa.eu/html.cfm/index52388EN.html>
24. Gottfredsson D.C., Cook T.D., Gardner F.E.M., Gorman-Smith D., Howe G.W., Sandler I.N., & Zajt K.M. (2015). Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Preventive Science: Next Generation. *Preventive Science*, published on-line 07 April 2015, DOI 10.1007/s11121-015-0555-x
25. Hawkins J.D., Catalano R.F., & Miller J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*. 112: 64-105.
26. Doyle L.R. & Mattson S.N. (2015). Neurobehavioral disorder associated with prenatal alcohol exposure (D-PAE): Review of evidence and guidelines for assessment. *Current Developmental Disorder Report*, 2:175-186.
27. Niccols A., Milligan K., Smith A., Thabne L., & Henderson, J. (2012). Integrated programs for mothers with substance abuse issues and their children: a systematic review of studies reporting on child outcomes. *Journal of Child Abuse and Neglect*, 36 (4): 308-322.
28. WHO (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Geneva: World Health Organization. ISBN

28. Spoth R.L., Greenberg M., & Turris R. (2008). Preventive interventions addressing underage drinking: state of the evidence and steps toward public health impacts, *Pediatrics*, 121, (Suppl. No. 4): S311-S336.
29. D'Onise K., McDermott R.A., & Lynch J.W. (2010). Does attendance at preschool affect adult health? A systematic review. *Public Health*, 124(9), 500-511.
30. There are many good reviews. See, for example, Barlow J. & Parsons J. (2005). Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children. *Campbell Systematic Reviews* 2005:2, DOI: 10.4073/csr.2005.2; Foxcroft D.R. & Tsertsvadze A. (2011). Universal family-based prevention programs for alcohol misuse in young people. *Cochrane Database of Systematic Reviews* 2011, Issue 9. Art. No.: CD009308. DOI: 10.1002/14651858.CD009308; Furlong M., McGilloway S., Bywater T., Hutchings, J., Smith, S.M., Donnelly, M. (2012). Behavioural and cognitive-behavioural group-based parenting programmes for early onset conduct problems in children aged 3 to 12 years. *Campbell Systematic Reviews* 2012:12, DOI: 10.4073/csr.2012.12; Meija A., Calam R., & Sanders M.R. (2012). A review of parenting programs in developing countries: opportunities and challenges for preventing emotional and behavioral difficulties in children, *Clinical Child Family Psychological Review*, 15: 163-175; Miller S., Maguire L.K., & Macdonald G. Home-based child development interventions for preschool children from socially disadvantaged families. *Campbell Systematic Reviews* 2012:1, DOI: 10.4073/csr.2012.1; Petrie J, Bunn F., & Byrne G. (2007). Parenting programmes for preventing tobacco, alcohol or drugs misuse in children < 18: a systematic review. *Health Education Research*. 22(2): 177-191; Piquero A.R., Farrington D.P., Welsh B.C., Tremblay R., & Jennings W.G. Effects of early family / parenting programs on antisocial behavior and delinquency. *Campbell Systematic Reviews* 2008:11, DOI: 10.4073/csr.2008.11; Thomas R.E., Baker P.R.A., & Lorenzetti D. Family-based programmes for preventing smoking by children and adolescents. *Cochrane Database of Systematic Reviews* 2007, Issue 1. Art. No.: CD004493. DOI: 10.1002/14651858.CD004493.
31. Spoth R.L., Clair S., Shin C., & Redmond C. (2006). Long-term effects of universal preventive interventions on methamphetamine use among adolescents. *Archives of Pediatrics and Adolescent Medicine*, 160 (9): 876-882.
32. See, for example: Faggiano F., Vigna-Taglianti F.D., Versino E., Zambon A., Borraccino A., & Lemma P. (2008). School-based prevention for illicit drugs use: a systematic review. *Preventive Medicine*, 46(5):385-96; Faggiano, F., Vigna-Taglianti F.D., Versino E., Zambon A., Borraccino A., & Lemma P. (2005). School-based prevention for illicit drugs' use. *Cochrane database systematic review* 2005:2; Durlak J.A., Weissberg R.P., Dymnicki A.B., Taylor R.D., & Schellinger, K.B. (2011). The impact of enhancing students' social and emotional learning: a metaanalysis of school-based universal interventions. *Child Development*, 82, 405-32; Foxcroft D.R., & Tsertsvadze A. (2011). Universal school-based prevention programs for alcohol misuse in young people. *Cochrane Database of Systematic Reviews* 2011, Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113; Piquero A.R., Jennings W.G., & Farrington, D.P. Self-control interventions for children under age 10 for improving self-control and delinquency and problem behaviors. *Campbell Systematic Reviews* 2010:2. DOI: 10.4073/csr.2010.2.
33. Oliver, R., Wehby J.H., & Reschly D.J. (2011). Teacher classroom management practices: effects on disruptive or aggressive student behavior. *Campbell Systematic Reviews* 2011:4
34. Riggs, N.R. (2015). Translating developmental neuroscience to substance use prevention. *Current Addiction Reports*, 2:114-121. DOI 10.1007/s40429-015-050-2.
35. There are several systematic reviews, for example: Faggiano F., Vigna-Taglianti F.D., Versino E., Zambon A., Borraccino A., & Lemma P. (2008). School-based prevention for illicit drugs use: a systematic review. *Preventive Medicine*, 46 (5): 385-396; Porath-Waller A.J., Basley E, & Beirnes,D.J. (2010). A metaanalytic review of school-based prevention for cannabis use. *Health Education and Behavior*, 37 (5): 709-723; Foxcroft D.R. & Tsertsvadze A. (2011). Universal school-based prevention programs for alcohol misuse in young people. *Cochrane Database of Systematic Reviews* 2011, Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113.
36. Champion K. E., Newton N.C., Barrett E.L., & Teesson M. (2013). Systematic review of school-based alcohol and other drug prevention programs facilitated by computers or the Internet. *Drug and Alcohol Review*, 32 (2): 115-123; Wood S.K., Eackley L., Hughes K., Hardcastle K.A., Bellis M.A., Schrooten J., Demetrovics Z, & Voorham L. (2014). Computer-based programmes for the prevention and management of illicit recreational drugs: A systematic review. *Addictive Behaviors*, 20: 30-38.
37. For reviews, see Bonell C., & Hargreaves, J. (2008), School Effects on Young People's Drug Use: A Systematic Review of Intervention and Observational Studies. *Journal of Adolescent Health*, 42:209-20; Moreira M.T., Smith L.A., & Foxcroft D. (2009). Social norms interventions to reduce alcohol misuse in University or College students. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD006748. DOI: 10.1002/14651858.CD006748.pub2.
38. DuPont R. L., Merlo L. J., Arria A. M., & Shea C. L. (2013). Random student drug testing as a school-based drug prevention strategy. *Addiction*, 108: 839-45 (see also the comments); Gilvarry E. (2013). Limited evidence: many pitfalls. *Addiction*, 108: 846-7; Sznitman S. (2013). Exploring the promise of random student drug testing by comparing it to other school drug prevention strategies. *Addiction* 2013; 108: 848-50; Galea S. (2013). Values, compelling ideas, the pace of science and the implementation of evidence-based policy. *Addiction* 2013; 108: 847-8; and the authors' responses to commentaries on random student drug testing *Addiction*, 108: 850-851.
39. Sznitman S.R., & Romer D. (2014). Student Drug Testing and Positive School Climates: Testing the Relation between Two School Characteristics and Drug Use Behavior in a Longitudinal Study. *Journal of Studies on Alcohol and Drugs*, 75(1), 65-73 (2014).
40. Conrod P.J., Castellanos-Ryan N., & Mackie C. (2011). Long-term effects of a personality-targeted intervention to reduce alcohol use in adolescents. *Journal of Consulting and Clinical Psychology*. 79(3): 296-306; Conrod P.J., Castellanos N., & Mackie, C. (2008). Personality-targeted interventions delay the growth of adolescent drinking and binge drinking, *Journal of Child Psychology and Psychiatry*,

- 49: 181-90; Conrod P.J., Castellanos N., & Strang J. (2010). Brief, personality-targeted coping skills interventions prolong survival as a non-drug user over a two-year period during adolescence. *Archives of General Psychiatry*, 67: 85-93.
- Conrod, P. J., O'Leary-Barrett, M., Newton, N., Topper, L., Al-Khudhairy, N., Castellanos-Ryan, N., & Mackie, C. (2013). A cluster randomized trial demonstrates the effectiveness of a selective, personality-targeted prevention program for adolescent alcohol misuse. *JAMA Psychiatry*, 2013; 70(3):334-342. doi:10.1001/jamapsychiatry.2013.651.
41. Thomas R.E, Lorenzetti D, & Spragins W. Mentoring adolescents to prevent drug and alcohol use. *Cochrane Database of Systematic Reviews* 2011, Issue 11. Art. No.: CD007381. DOI: 10.1002/14651858.CD007381.pub2; Tolan P., Henry D., Schoeny M., & Bass A. Mentoring interventions to affect juvenile delinquency and associated problems. *Campbell Systematic Reviews* 2008:16. DOI: 10.4073/csr.2008.16.
42. There are several systematic reviews, for example: Ballesteros J, Duy JC, Querejeta I, Arino J, Gonzalez-Pinto A. Efficacy of brief interventions for hazardous drinkers in primary care: Systematic review and metaanalysis. *Alcohol Clin Exper Res* 2004; 28: 608-618; Beich, A., Thorsen, T., Rollnick, S. 2003. Screening in brief intervention trials targeting excessive drinkers in general practice: systematic review and metaanalysis. *British Medical Journal*, 327 (7414): 536-542; Bertholet N., Daeppen J.B., Wietlisbach V., Fleming M., Burnand B. (2005) Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis. *Archives of Internal Medicine*, 165:986-995; Carney T., & Myers B. (2012): Effectiveness of early interventions for substance-using adolescents: findings from a systematic review and meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*, 7:25. <http://www.substanceabusepolicy.com/content/7/1/25>; Jensen, C.D., Cushing, C.C., Aylward, B.S., Craig, J.T., Sorell, D.M., & Steele, R.G. (2011). Effectiveness of motivational interviewing interventions for adolescent substance use behavior change: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 79, 433-440; Kaner E.F., Beyer F., Dickinson H.O., Pienaar E., Campbell F., Schlesinger C., Heather N., Saunders J., & Burnand B. 2007. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*. 18(2):CD004148; McQueen J., Howe T.E., Allan L., & Mains D. (2009). Brief interventions for heavy alcohol users admitted to general hospital wards. *Cochrane Database Systematic Reviews*. 3: Art. No.: CD005191; Nilsen P., Baird J., Mello M.J., Nirenberg T., Woolard R., Bendtsen P., & Longabaugh R. (2008). A systematic review of emergency care brief alcohol interventions for injury patients. *Journal of Substance Abuse and Treatment*, 35: 184-201; Riper, 2009; Smedslund G., Berg R.C., Hammerstrøm K.T. et al. (2011). Motivational Interviewing for substance Abuse. *Cochrane Database of Systematic Reviews* 2011, Issue 5. Art.No.:CD008063. DOI: 10.1002/14651858.CD008063.pub2
43. Although the quality of evidence for adolescents is low, see Carney T, Myers BJ, Louw J, Okwundu Cl. Brief school-based interventions and behavioural outcomes for substance-using adolescents. *Cochrane Database of Systematic Reviews* 2014, Issue 2. Art.No.: CD008969. DOI: 10.1002/14651858.CD008969.pub2.
44. See the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) package for primary health-care professionals and their patients, available at <http://www.who.int/>.
45. Elzebi C., Donoghue K. & Drummond C. (2015). A comparison of the efficacy of brief interventions to reduce hazardous and harmful alcohol consumption between European and non-European countries: a systematic review and meta-analysis of randomized controlled trials. *Addiction*, 110 (7): 1082-1091.
46. Webb G., Shakeshaft A., Sanson-Fisher R., & Havard A. (2009). A systematic review of work-place interventions for alcohol-related problems. *Addiction*. 104(3):365-77.
47. For reviews see: Anderson P, Chisholm D, Fuhr DC. (2009). Effectiveness and cost-effectiveness of policies and programmes to reduce harm caused by alcohol. *Lancet*. 373(9682):2234-46; Campbell C.A., Hahn R.A., Elder R., Brewer R., Chattopadhyay S., Fielding J., Naimi T.S., Toomey T., Lawrence B., Middleton JC (2009). The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. *American Journal of Preventive Medicine*, 37(6):556-69; Elder R.W., Voas R., Beirness D., Shults R.A., Sleet D.A., Nichols J.L., Compton R. (2011). Effectiveness of ignition interlocks for preventing alcohol-impaired driving and alcohol-related crashes: a Community Guide systematic review. *American Journal of Preventive Medicine*, 40(3): 362-76; Hahn R.A., Middleton J.C., Elder R., Brewer R., Fielding J., Naimi T.S., Toomey T.L., Chattopadhyay S., Lawrence B., Campbell C.A. Community Preventive Services Task Force. Effects of alcohol retail privatization on excessive alcohol consumption and related harms: a Community Guide systematic review. *American Journal of Preventive Medicine*, 42(4): 418-27; Middleton, J. C., Hahn, R. A., Kuzara, J. L., Elder, R., Brewer, R., Chattopadhyay, S., & Lawrence, B. (2010). Effectiveness of policies maintaining or restricting days of alcohol sales on excessive alcohol consumption and related harms. *American Journal of Preventive Medicine*, 39(6), 575-589; Popova S, Giesbrecht N, Bekmuradov D, Patra J. (2009) Hours and days of sale and density of alcohol outlets: Impacts on alcohol consumption and damage: A systematic review. *Alcohol and Alcoholism*, 44(5):500-16; Rammohan V., Hahn R.A., Elder R., Brewer R., Fielding J., Naimi T.S., Toomey T.L., Chattopadhyay S.K., Zometa C. (2011). Task Force on Community Preventive Services. Effects of dram shop liability and enhanced over service law enforcement initiatives on excessive alcohol consumption and related harms: two Community Guide systematic reviews. *American Journal of Preventive Medicine*, 41(3): 334-43; Toumbourou J.W., Stockwell T., Neighbors C., Marlatt G.A., Sturge J., & Rehm J. (2007). Interventions to reduce harm associated with adolescent substance use. *The Lancet*, 369, 1391-1401; Wagenaar AC, Salois MJ, & Komro KA. (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction*, 104(2):179-90; Wagenaar A.C., Tobler A.L., & Komro K.A. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. *American Journal of Public Health*, 100(11):2270-8. Epub 2010 Sep 23.
48. For reviews, see: Callinan J.E, Clarke A., Doherty K., & Kelleher C. Legislative smoking bans for reducing secondhand smoke exposure, smoking prevalence and tobacco consumption. *Cochrane Database of Systematic Reviews* 2010, Issue 4. Art. No.: CD005992. DOI:10.1002/14651858.

- CD005992.pub2; Chaloupka F.J., Straif K., & Leon M.E. (2011). Effectiveness of tax and price policies in tobacco control. *Tobacco Control*, 20(3), 235-8; Lovato C., Watts A., & Stead, L.F. (2011). Impact of tobacco advertising and promotion on increasing adolescent smoking behaviors (Review). *Cochrane Database of Systematic Reviews*, Issue 10.
49. Wagenaar A.C., & Toomey T.L. (2002). Effects of minimum drinking age laws: review and analysis of the literature from 1960 to 2000. *Journal of Studies on Alcohol*. Suppl No. 14: 205-225.
50. Jones L., Sumnall H., Witty K., Wareing M., McVeigh, J., & Bellis M.A. (2006). *A review of community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people*. National Collaborating Center for Public Health, Liverpool John Moores University, November 2006. <http://www.dldocs.stir.ac.uk/documents/nice.pdf>
51. Sigfusdottir I.D., Thorlindsson T., Kristjansson A.L., Roe K.M., & Allegrante J.P. (2008). Substance use prevention for adolescents: the Icelandic Model. *Health Promotion International*, 24(1): 16-25.
52. Geidne S., Quennerstedt M., & Eriksson, C. (2013). The youth sports club as a health-promoting setting: an integrative review of research. *Scandinavian Journal of Public Health*, 41(3): 269-283.
53. Brinn M.P., Carson K.V., Esterman A.J., Chang, A.B., & Smith B.J. (2006). Mass media interventions for preventing smoking in young people (Review). *The Cochrane Database of Systematic Reviews*, Issue 8; Elder R.W., Shults R.A., Sleet D.A., Nichols J.L., Thompson R.S. Rajab, W., & Task Force on Community Preventive Services (2004). Effectiveness of mass media campaigns for reduced drinking and driving and alcohol-involved crashes: a systematic review. *American Journal of Preventive Medicine*, 27: 57-65; National Cancer Institute (2008). The role of the media in promoting and reducing tobacco use. *Tobacco Control Monograph* No 19, NIH Pub No 07-6242. Bethesda, MD: US Department of Health and Human Services, National Institutes of Health, National Cancer Institute; Wakefield M.A., Loken B. & Hornik R.C (2010). Use of mass media campaigns to change health behaviour. *Lancet*; 376: 1261-71. DOI: 10.1016/S0140-6736(10)60809-4.
54. Chapman S. (2004). Advocacy for public health: a primer. *Journal of Epidemiology and Community Health*, 58:36-365.
55. Landman A., & Glantz, S.A. (2009). Tobacco Industry Efforts to Undermine Policy-Relevant Research. *American Journal of Public Health*, 99: 45-58. Doi:10.2105/AJPH.2007.130740.
56. Miller D., & Harkins, C. (2010). Corporate strategy, corporate capture: Food and alcohol industry lobbying and public health. *Critical Social Policy*, 30: 564. DOI: 10.1177/0261018310376805.
57. Bolier L., Voorham L., Monshouwer K., Hasselt, N. van, & Bellis M. (2011). Alcohol and drug prevention in nightlife settings: A review of experimental studies. *Substance Use & Misuse*. 46 (13): 1569-1591. Brennan I.R., Moore S.M., Byrne E., & Murphy, S. (2010). Interventions for disorder and severe intoxication in and around licensed premises, 1989-2009. *Addiction*, 106(4):706-13. DOI: 10.1111/j.1360-0443.2010.03297.x.
58. UNODC 2015, p. 31.
59. EMCDDA European Monitoring Centre for Drugs and Drug Addiction (2011), *European drug prevention quality standards: a manual for prevention professionals*, EMCDDA Manuals 7. Luxembourg, Publications Office of the European Union.
60. Brotherhood A, & Sumnall H.R., EMCDDA (2013). *European drug prevention quality standards: a quick guide*. Centre for Public Health, Luxembourg: Publications Office of the European Union. ISBN: 978-92-9168-665-0, doi: 10.2810/15341.
61. See the Competencies for Canada's Substance Abuse Workforce developed by the Canadian Centre on Substance Abuse (CCSA), available at <http://www.ccsa.ca/Eng/topics/Workforce-Development/Workforce-Competencies/Pages/default.aspx>
62. European Monitoring Centre for Drugs and Drug Addiction (2012). *Guidelines for the evaluation of drug prevention. A manual for programme planners and evaluators*. Second edition. Luxembourg: The Publications Office of the European Union, EMCDDA Manuals No 8. ISBN: 978-92-9168-499-1 doi: 10.2810/51268 http://www.emcdda.europa.eu/attachements.cfm/att_184810_EN_188138 EMCDDA_Guidelines.pdf
63. Eriksson C. (2000). Learning and knowledge-production for public health – a review of approaches to evidence-based public health. *Scandinavian Journal of Public Health*, 28: 298-308.

case study

Kampala Young People's Initiative towards Drug Abuse Prevention in Slum Communities

Rogers Kasirye

Executive Director, Uganda Youth Development Link (UYDEL)

Drug prevention has become an issue to grapple with in Africa, a continent largely with limited resources, where the vice of drug abuse has been expanding like wildfire. Public and private actors have been forced to rethink their social, biological and infrastructural strategies in order to stem drug abuse. This article highlights and reflects on the delivery of prevention interventions addressing drug abuse in Uganda.

The Scale of the Drug Abuse Problem

Countries in Africa report that the continent is a producer of large quantities of cannabis, which is the major drug of consumption among young people, both in and out of schools. Availability, culture and new trends are attracting this subpopulation to cannabis consumption, and most African states have reported large seizures and destruction of the plant. The climate and the soil make it easy to grow cannabis, and vast farms have been destroyed in Africa by narcotics

law enforcement agencies. Uganda has been identified as a major producer of cannabis, as well as a consumer and transit country.

Substance abuse has been described as a problem among marginal groups like children on the street, slum youth, school and out-of-school youth, as well as soldiers; heroin tends to be consumed by urban youth; and cocaine abuse is prevalent among high income groups. The widespread abuse of cannabis by young people is of particular concern in sub-Saharan Africa.

Khat chewing, though prohibited in the U.S., Canada and some countries in Europe, is another psychotropic habit which is largely practiced by people within the Horn of Africa. An increase was reported in the abuse of opiates and cocaine, as well as in the abuse of cannabis and volatile solvents. This trend has been attributed to inadequate laws and weak border controls. Africa is now known as a producer, consumer and transit region for drug trafficking. This has been fuelled further by

unemployment, peer pressure, social upheavals, poverty, family disruptions, as well as high rates of drop-outs from school and increased availability of the drug. Pockets of injecting drug users have been reported in big cities such as Nairobi, Mombasa, Dar es Salaam, Lagos, Cape Town, Johannesburg and on Zanzibar Island. This problem is compounded further by the HIV/AIDS emergency.

Prevention Interventions in Africa

Most prevention interventions in Africa target young people in both rural and urban centres. There has been a proliferation of treatment programs initiated by NGOs, though mental health services largely remain a government domain. Many prevention programs are intended for hard-to-reach adolescents, not necessarily those who live in rural areas and have to trek long distances to get services. This may mean those who have significant challenges to access health and other social services, including those in urban centres as well. It also reflects limited participation due to social isolation: many young people may be homeless, underserved, or even incarcerated. Others are simply disengaged from services. Professor Dan Kaye (2015) observed the term “hard-to-reach” young people may refer to characteristics such as “urban or rural poor, orphaned, vulnerable, obstinate, disabled, recalcitrant, chronically uninformed, disadvantaged, have-nots, illiterate, malfunctioning, and information poor. The factors that lead to adolescents being hard-to-reach are many: Related to their attributes as adolescents, related to their circumstances as adolescents, related to how people around them perceive them.” Most prevention programs have made significant efforts to help the most vulnerable among the general populations in Africa.

Uganda Youth Development Link

Uganda Youth Development Link (UYDEL) is a national non-profit NGO founded by a

group of professionals in 1993 with a mission of empowering disadvantaged young people (10-24 years) with skills that will enable them to reach their full potential and become useful citizens. UYDEL implemented a one-year project supported by the United Nations Office on Drugs and Crime (UNODC) and the Drug Abuse Prevention Centre (DAPC) entitled “*Kampala young people’s initiative towards drug abuse prevention in slum communities.*” The goal of this project was to empower 40 young people to become initiators of drug abuse prevention programmes in their slum communities, making young people appreciate and apply the International Standards on drug use prevention (UNODC, 2015).

Most of the activities under this project were based on the concept of “Participatory Inquiry in Practice (PIP),” defined as a systematic inquiry with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change. Young people are considered the foremost experts in what happens in their lives. The purpose of using the PIP Approach in the project was to recognize slum youths and peers as holding a sense of common identity and shared fate. It was important that the peers identified their strengths and the knowledge they already possessed together in their slums as well as the support they needed, to work together to improve their lives.

This approach involves peers, slum youths and slum community members in every phase including the problem identification, data collection, interpreting results of the study and how to use the results to address drug abuse. The project activities helped to recognize the inherent inequalities between marginalized slum communities and social workers, to use the knowledge of the community, and to share information, resources and their decision-making power. Young people in the same age group were trained to run prevention activities with minimal guidance from the assigned social workers and the project coordinators. Once involved, they became stakeholders in the problems and identified issues that needed to be addressed through advocacy and information

sharing amongst their peers.

The project involved peers from the six slum drop-in centres in Kampala city. The main objectives of the project were (1) supply and demand reduction of illicit drugs among youth; (2) developing the potential of youths to improve their living conditions; and (3) establishment of public campaigns, counselling and referral promotion for treatment and rehabilitation of young people.

Description of the Activities

The project started with several activities which included the following:

Identification and screening of the young people to act as peer educators. This was done with the aim of recruiting young people at UYDEL drop-in centres to be the initiators of drug abuse prevention in slum communities. The project targeted 40 young people between the ages of 10-24 years.

Training of the peers to be role models in drug abuse prevention and data collection. The peers were trained in basic concepts of drug abuse prevention, UN International Standards and the importance of evidence-based interventions. During training, peers also discussed their roles and what exactly they needed to do and deliver. There was also training on basic drug abuse data collection skills and ethics of collecting data, using the UNODC materials on evidence-based family skills training, school-based education for drug prevention programs (UNODC 2004), and peer led activities for young drug users (UNODC 2005).

Peers developed the possible research questions and conducted a study to determine the magnitude of drug use among slum young people. This activity was conducted by peers in their slum communities in which they lived. This took a period of two weeks. Over 102 youths in the slum communities were interviewed and data was collected, entered and analysed by the peers themselves. The initial report was shared among the peers to compile a field report and later develop drug abuse prevention messages.

The report noted that drug abuse was

initiated earlier and both sexes were affected. The most common drugs used were alcohol and cannabis, which were easy to access and to buy. 76% used drugs (alcohol and cannabis) daily and most of the respondents (71%) had been introduced to drugs by a friend. Other drugs mentioned were khat and inhalants like glue, and aviation fuel was also mentioned. Injecting drug users were cited in Kawempe and Makindye areas but sites could not be located. The research findings also revealed that civil society organizations were still handicapped in expanding their activities in order to help promote a healthy and safe generation free from drugs. Most of the slum youths interviewed acknowledged that there were limited interventions to prevent drug abuse.

Peers designing drug abuse prevention messages. This activity involving 40 peers was preceded by training on drug abuse and roles of peers. The project peers designed key messages and materials including posters and stickers for future use in drama and other interactive activities such as role plays and poems. The peers reflected on their intended slum youth audience, and the relevant influencing factors for abuse of drugs. They also reflected on the channels best used to communicate that young people want a lot of sports, fun and drama activities. The peers discussed the barriers to be encountered in promoting messages such as low literacy levels of many of the slum youths, poor housing, homelessness, and idleness; as well as the desired change they wanted to see to increase awareness and skills to resist drugs.

Outreach

The project used two main outreach strategies to reach youth in the slums:

Slum Community Dialogues. The project aimed to support the slum youths efforts to resist the temptation of drugs and help those who had not yet started to keep away from drugs completely. The social workers also helped this latter group through discussions, setting up dramas, role plays, Q&A's and identification of alternatives as way to spread the knowledge

and skills to prevent drug initiation. Community dialogues were mostly conducted by the social workers, not forgetting the peers who were actively involved in the dialogues as the initiators of drug abuse prevention in slum communities. The targets were mostly parents, youths, local leaders, and others responsible for taking care of youths. Activities included mobilization, local seminars, community drama shows, testimonies, talks and film/video shows on drug abuse sharing of information and referral of affected groups. These dialogues were well attended, interactive and educative. Examples include radio, talk shows, referrals, and distribution of educational materials (e.g., brochures, leaflets, posters and t-shirts, use of film van).

Additionally, school activities involved reaching out to 10 schools. Peers under the project were able to reach out to 10 schools with dramas and short film shows, and debates to interact with youths in other slum schools. Out of 40 peers, 10 had phones that could use Facebook. The others had phones that could only send text messages. All these were trained to use Facebook online and to use phones to send messages to their friends about drug abuse prevention.

Outcomes

Young people were actively involved and participated in project activities and 48 young slum inhabitants were referred for counselling and life skills (e.g., vocational skills in hairdressing and motor biking). Many felt a sense of ownership and became more responsible in their communities.

Use of social media by peers. This is the first time in Uganda that Facebook was used to post project activities and experiences. Facebook was also used to educate the young population to live a healthy lifestyle, make good decisions and live in safety. An example of a post includes, *"Drugs make you high but they deduct the days you have on this earth"* by Ntongo Dorothy, one of the peers.

The project evaluation was conducted at a rehabilitation centre in Masooli. The evaluation

examined the project's activities and reflected on the success and challenges met during project implementation. Generally the project activities had helped to increase knowledge about dangers of drug abuse and increased youth skills to resist drug use.

One of the lessons learnt was that once peers were involved, more young people could be reached. We anticipated that on average each one of the 40 peers would reach 10 additional peers, amounting to 400 total. These then would reach another 10 to make 4000 total contacts in one year. Promotion of youth participation in an interactive way, where peers increase their confidence, self-esteem, self-control and knowledge against drug abuse and the ability to express themselves in public, greatly enhances their self-efficacy to live better and healthier lives.

Following the launch in 2011 of the UNODC International Standards, the peers participated in the commemoration of the International Day Against Drug Abuse and Illicit Trafficking on June 26, 2014. They reached out to over 6000 students with the theme *"A message of hope: Drugs are preventable and treatable"* using talks, dances, drama, skits and sharing experiences.

The message was passed on very well through drama and presentations. The students were able to ask questions which were responded to by UYDEL social workers. The project coordinator explained the theme of the UN day and the UYDEL drama group entertained the youths together with the project peers. Students listened attentively to the voices of their peers who presented a skit about drug abuse. Peers under the project used interactive activities, using social skills to prevent drug use among them and other young people. The use of the UYDEL prevention newsletter also helped to highlight further the prevention efforts of peers among other activities to increase information on drug abuse.

It was a challenge to reach the group aged 10-14 years appropriate information. Some young people were unable to regularly text drug prevention messages to their fellow

peers via phones due to limited internet voice bundles and high phone costs .. Many young people were coming from far off places and had difficulties affording transportation. . In the future this needs to be raised based on distance.

Conclusion

Young people's participation has helped increase information against drug use as well as on issues concerning public health and safety, especially on drug abuse, increasing self-esteem and looking forward to transforming the lives of their fellow youths in communities.

References

- Kasirye, Rogers. (2009). Drug Abuse trends, magnitude and response in the Eastern African region. [http://uydel.org/downloads/Drug Abuse in East Africa-20110908-094730.pdf](http://uydel.org/downloads/Drug%20Abuse%20in%20East%20Africa-20110908-094730.pdf).
- Green, Lawrence W.; M. Anne George; Mark Daniel; James Frankish; Carol P. Herbert; William R. Bowie and Michel O'Neil (2003). "Appendix C: Guidelines for Participatory Research in Health Promotion," in Minkler, Meredith and Nina Wallerstein (eds), Community-Based Participatory Research for Health. San Francisco, CA: Jossey-Bass Inc.
- Israel, Barbara; Amy Schultz; Edith Parker and Adam Becker. (1998). Review of community-Based Research: Assessing Partnership Approaches to improve Public Health. *Annual Review of Public Health* 19:173-202. http://www.unodc.org/docs/youthnet/Compilation/10-50018_Ebook.pdf
- UNODC. (2004). School-based education for drug abuse prevention. <http://www.unodc.org/documents/middleeastandnorthafrica//drug-prevention-health-publications/schools.pdf>
- Dan Kaye. (2015). Bridging gaps and breaking barriers: strategies for Reaching the hard-to-reach adolescents: paper presented at Society of adolescent Health In Uganda at Protea Hotel.
- UNODC. (2015). International standards on drug use prevention. <http://www.unodc.org/unodc/en/prevention/prevention-standards.html>
- UNODC 2005 Peer-led intervention for reducing risk-taking behaviour in young drug users. http://www.unodc.org/pdf/india/publications/Drug_Users_in_SE_Asia_Vol1/05_PLIForReducingRisk.pdf

case study

Community-Based Infrastructure for Drug Prevention

Sue Thau, MCRP

(Master of City and Regional Planning)

Community Anti-Drug Coalitions of America (CADCA)

The infrastructure necessary to achieve population-level changes in drug use/abuse requires communities to engage in the following five-step evidence-based process: (1) assess prevention needs based on epidemiological data¹; (2) build prevention capacity²; (3) develop a strategic plan³; (4) implement effective community prevention programs, policies and practices⁴; and (5) evaluate efforts for outcomes.⁵

The strength of this comprehensive approach is that it not only identifies a community's issues, problems and gaps, but also its assets and resources. This allows a community to plan, implement and evaluate its efforts across all community sectors in all relevant settings for individuals, families, schools, workplaces and the community at large.

No single entity bears the sole responsibility for preventing youth drug use and abuse; rather, a comprehensive blend of individually and environmentally focused efforts must be adopted and multiple strategies must be implemented across multiple sectors of a

community to address this issue. Generalized universal prevention programs to help build strong families and provide youth with the skills to make good, healthy decisions are necessary; however, there is also a need to focus specifically on environmental strategies which include changing social norms and reducing access and availability through systems and policy changes. In order to achieve population-level reductions in drug use, a multi-sector and community-based drug prevention infrastructure must be organized to strategically plan, implement and evaluate community wide comprehensive strategies as well as evidence-based drug prevention programs throughout multiple community sectors and settings. These strategies, programs and services are developed and delivered by the community as a whole and include multiple community partners, such as parents, youth, schools, youth serving organizations, healthcare providers, and other relevant community departments, sectors and participants.

The above described coalition infrastructure has allowed those communities that are properly organized and data-driven to not only reduce youth marijuana, underage drinking and tobacco use, but to also push back against emerging drug trends. Communities with this coalition infrastructure in place can identify and combat synthetic drug problems like K2 and Spice, meth, and prescription drugs, quickly and before they attain crisis proportions, because they are on top of their local data, and are ready to implement environmental strategies, policy changes and programs to improve conditions at the local level. These coalitions have been successful in both the United States and internationally. In the United States, this coalition model has been taken to scale through the Drug-Free Communities (DFC) program, which has been independently evaluated and shown impressive population-level outcomes in 30-day use of alcohol, tobacco and marijuana among both middle and high school aged students.

The Drug-Free Communities (DFC) Program

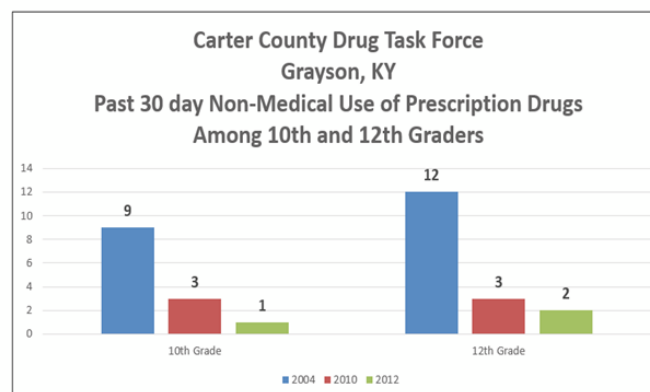
The DFC program has been a central component of the United States' demand reduction strategy since its passage in 1998. The program provides the funding necessary for communities to identify and respond to local drug, alcohol, and

tobacco issues among youth. In order to be eligible for a DFC grant, a local coalition must (1) be in existence for 6 months prior to applying and (2) have community-wide involvement of the following 12 sectors, which each commit to work together through the coalition, to reduce youth drug, alcohol, and tobacco use—youth, parents, businesses, media, schools, youth-serving organizations, religious or fraternal organizations, law enforcement, civic and volunteer groups, health care professionals, state/local/tribal agencies, and other organizations involved in reducing substance abuse—(3) have community-wide data for planning, implementation, and evaluation; and (4) target the entire community with effective strategies.

DFC grantees have reduced drug use and abuse in communities throughout the United States because they are organized, data-driven, and take a comprehensive, multi-sector approach to solving and addressing drug issues. DFC coalitions are singularly situated to deal with emerging drug trends because they have the necessary infrastructure in place to effectively address all drug-related issues within their communities.

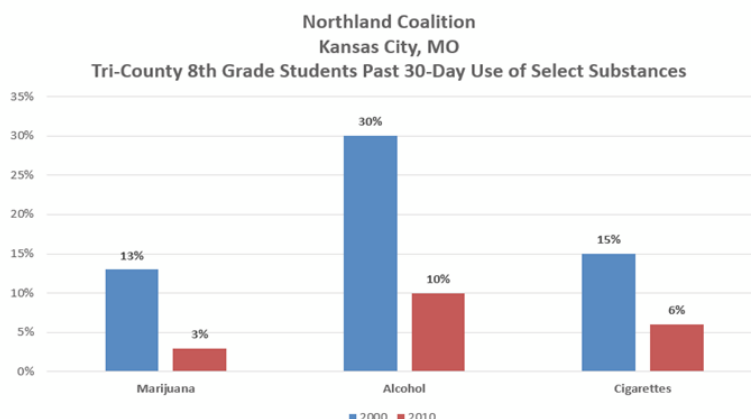
2014 National Evaluation of the DFC Program Shows that Rates of Substance Use are Dropping in DFC-Funded Communities: Prevalence of past 30-day use in DFC-funded communities declined significantly across all

In this DFC community, past 30 day non-medical use of prescription drugs **decreased at a rate of 88.9% among 10th graders; 83.3% among 12th graders.**



Selected Outcomes of Drug-Free Communities Grantees

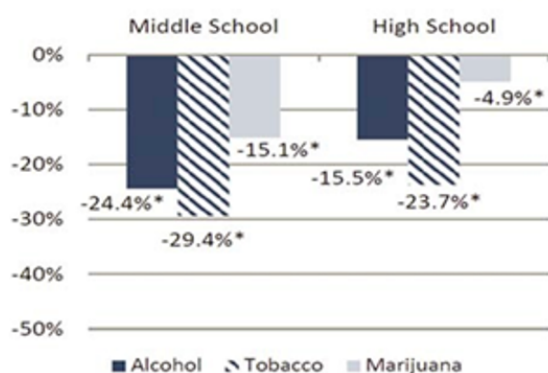
In this DFC community, past 30 day use of marijuana **decreased at a rate of 76.9%**, from 13% in 2000 to 3% in 2010; past 30 day use of alcohol **decreased at a rate of 66.7%**, from 30% in 2000 to 10% in 2010; and past 30 day use of cigarettes **decreased at a rate of 60%**, from 15% in 2000 to 6% in 2010



Selected Outcomes of Drug-Free Communities Grantees

substances (alcohol, tobacco, marijuana) and school levels (middle and high school) between DFC coalitions' first and most recent data reports.⁶

FIGURE 1: PERCENTAGE CHANGE IN PAST 30 DAY USE: FIRST REPORT TO MOST RECENT REPORT (ALL DFC GRANTEE EVER FUNDED)



The most recent (2014) national evaluation of the DFC program showed that "both perception of risk and perception of parental disapproval of illicit use of prescription drugs increased significantly within middle school and high school youth" in DFC-funded

communities, while the percentage change in past 30-day illicit use of prescription drugs also decreased significantly within both middle school and high school youth."⁷

The Seven Strategies to Affect Community Change

CADCA trains community coalitions throughout the world in effective community problem-solving strategies so that they are able to use local data to assess their specific substance use and abuse-related issues and problems and develop comprehensive, data driven, multi-sector strategies to address them.

When coalitions get to the implementation phase of the 5-step evidence-based process, CADCA trains them on how to execute seven strategies to affect community change and achieve population level reductions in youth drug use. These seven strategies have been developed by researchers to categorize interventions.

Based on what their local data and conditions indicate, coalitions implement a mutually reinforcing combination of all of the following seven strategies:

Providing Information – Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication).

Enhancing Skills – Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development).

Providing Support – Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs).

Enhancing Access/Reducing Barriers – Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity).

Changing Consequences (Incentives/Disincentives) – Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges).

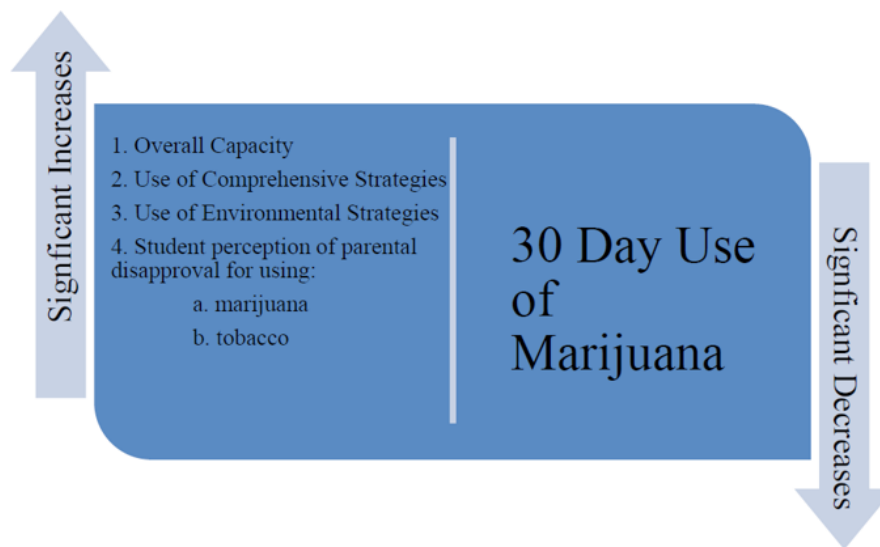
Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

Independent, published research indicates that CADCA's community problem-solving approach, which is based on the five evidence-based processes and the seven strategies to affect community change, is an

effective model for coalitions trying to achieve both community changes and population level changes. Coalitions begin their success by receiving training from CADCA. This training then leads to significant improvements for all elements of the model, including increasing coalition capacity, implementing essential processes (such as community assessments, logic models, work plans, sustainability plans and evaluation plans), and using comprehensive strategies. This approach leads directly to effective community changes⁸ and population level changes.⁹ The research also demonstrates that success is sequential, beginning with CADCA's training on the model and ending with population-level changes in substance use. Coalitions trained by CADCA see statistically significant improvements in all areas of coalition function including capacity, planning, implementation and the use of environmental strategies. These coalitions also see statistically significant outcomes such as impacting policies at a variety of levels, and creating population-level change in risk factors and substance abuse rates. This research fits into an ever expanding body of research demonstrating that properly trained coalitions implementing effective practices are critical to community success in the prevention of substance use and abuse.

In the international context, the community anti-drug coalition model has been successfully calibrated and implemented in 22 different countries on 5 continents in 7 languages around the world. The global adaptation of this model focuses on the development of local community capacity to form effective community coalitions. These communities are also trained to follow and adapt CADCA's Community Problem Solving model, a best practices framework that guides both domestic and international coalitions in their development and intervention activities. As with coalitions in the United States, in the international context, when community coalitions develop and adapt essential core processes (e.g., logic models, strategic action plans) and pursue environmental change strategies (e.g., changing policies and procedures; shifting local practices; providing information), they



Pennie Foster-Fishman and Mei You, "Longitudinal Evaluation of the Impact of CADCA's Institute's Training & TA on Coalition Effectiveness: Tracking DFC Coalitions for 48 Months Post Training", Michigan State University, February 7, 2015.

can achieve population level reductions in targeted community problems. To date, over 130 community coalitions have been developed outside of the United States, and most of these coalitions follow, with a high degree of fidelity, what they were trained to do by CADCA in pursuing essential coalition processes and implementing numerous effective community change strategies.

3. Collie-Akers VL, Fawcett SB, Schultz JA, Carson V, Cyprus J, Pierle JE. (July 2007). Analyzing a community-based coalition's efforts to reduce health disparities and the risk for chronic disease in Kansas City, Missouri. *Preventing Chronic Disease* [serial online]. 2007 Jul. Available from http://www.cdc.gov/pcd/issues/2007/jul/06_0101.htm. Hays, C.E., Hays, S.P., DeVille, J.O., & Mulhall, P.F. (2000). Capacity for effectiveness: The relationship between coalition structure and community impact. *Evaluation and Program Planning*, 23, 373-379.
4. Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobson, S., & Allen, N.A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, 29(2), 241-261.
5. KU Work Group for Community Health and Development. (2007). *Use Promising Approaches: Implementing Best Processes for Community Change and Improvement*. Lawrence, KS: University of Kansas. Retrieved November 12, 2008, from the World Wide Web: <http://ctb.ku.edu/en/promisingapproach/>.
6. Roussos, S.T. & Fawcett, S.B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health*, 21, 369-402.
7. National Evaluation of the Drug-Free Communities Support Program. Summary of Core Outcomes, Findings through 2013. ONDCP | DFC National Evaluation Outcome Status Update.
8. Ibid.
9. Yang, Evelyn, Foster Fishman, Pennie, Collins, Charles, and Ahn, Soyeon. "Testing a Comprehensive Community Problem-Solving Framework for Community Coalitions", in *Journal of Community Psychology*, Vol. 40, No. 6 (2012), 681-698.
10. Pennie Foster-Fishman and Mei You, "Longitudinal Evaluation of the Impact of CADCA's Institute's Training & TA on Coalition Effectiveness: Tracking DFC Coalitions for 48 Months Post Training", Michigan State University, February 7, 2015.

Endnotes

1. Butterfoss, F.D. (2007). *Coalitions and partnerships for community health*. San Francisco, CA: Jossey-Bass.
2. Ibid.

Chapter 3

Drugs, Children, and Human Rights

“

Drug use is particularly harmful to youth. Drug use usually begins in adolescence, making youth the major target for prevention. Drug related harm affects all regions of the world.”

Human Rights and the International Drug Control Regime: Myths and Realities

Saul Takahashi

Human Rights Lawyer

In recent years, the notion that drug control by definition violates human rights has started to gain acceptance in some international policy circles. Advocates of this view argue that the international drug control regime has brought about widespread human rights abuses, and therefore should be either revised fundamentally or, preferably in their view, discarded completely. These opponents of drug control point to drug law enforcement policies and practices in several countries that have resulted in human rights violations, and attempt to argue that any and all efforts against drugs result in such violations. The current “prohibition-based” and “punitive” drug control regime must be done away with, they say, and replaced with policies that are “evidence-based”, “rights-respecting”, and cognizant of the “reality” that the “war on drugs has failed.”

This article posits that there is no conflict between the international drug control regime and international human rights law: indeed, the two are more closely linked than opponents of drug control admit. Does drug control necessarily result in human rights violations? Certainly not

in the vast majority of countries. In the countries where there are human rights abuses, these are generally not violations uniquely specific to drug control, but indicative of wider systemic problems in law enforcement.

The Two Legal Regimes: Really in Conflict?

The international drug control regime is founded on the three international drug control conventions: the 1961 Single Convention on Narcotic Drugs (1961 Convention), the 1971 Convention on Psychotropic Substances (1971 Convention), and the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988 Convention). All three of these conventions have near universal ratification,¹ indicating the commitment of the international community towards controlling drugs. The underlying premise of the international drug control regime is that states must take measures against the illicit abuse of and traffic in controlled substances, while at the same time ensuring there is an adequate supply for medical and

other licit use – an endeavour which even the most staunch opponents of international drug control admit has been largely successful.² Application of the three international drug control conventions is monitored by the International Narcotics Control Board (INCB), an independent monitoring body that reviews state performance in a quasi-judicial manner.

Opponents of the international drug control regime are quick to point out that the international drug control conventions do not mention human rights specifically. They present this as evidence that the two international legal regimes have evolved in complete isolation from each other, and, more to the point, that the drug control conventions were prepared and adopted with no recognition of the importance of human rights protection.

While it is true that there is no specific mention of human rights in the drug control conventions, to present this as a conscious, even meaningful omission is somewhat disingenuous. Though several recent international conventions related to law enforcement issues do contain general references to human rights and to the need to ensure that human rights obligations are abided by,³ this is a relatively recent development, postdating the international drug control conventions. Outside of the realms of law enforcement, it would be extremely rare to find any international convention that mentions human rights specifically. Whether or not this may be desirable, it is hardly unique to drug control, and certainly not indicative on its own of any lack of willingness to abide by human rights obligations.

Indeed, often overlooked by opponents of drug control is the inconvenient truth that the Convention of the Rights of the Child (CRC), one of the core international human rights conventions (also with near universal ratification at 194 state parties) *does* mention the need for drug control. Article 33 of the CRC states that state parties must “take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties.” Though this Article refers specifically to children, it is clearly an endorsement of the vision of a

drug-free world.

The CRC was being drafted at the same time as the 1988 Convention, and discussions took place as to how the two documents could be developed in sync. Article 33 of the CRC is a result of these discussions, and refutes the notion that the two legal regimes evolved in complete isolation and are in conflict with each other. Likewise, the preamble of the 1988 Convention expresses the concern of the international community that “children are used in many parts of the world as an illicit drug consumers market.” While there is no specific mention of human rights, it is clear that this is a reference to the link between the two international legal regimes.

In addition, every year the UN General Assembly adopts without a vote a resolution titled “International Cooperation Against the World Drug Problem.” The preamble of this resolution reproduces the language of CRC Article 33, reaffirming every year the consensus of the international community to strive for a drug-free world. The resolution, which has a large number of references to the need for states to comply fully with the international drug control conventions, also states that “countering the world drug problem is a common and shared responsibility ... [that] must be carried out in full conformity with ... the Universal Declaration of Human Rights.” This certainly indicates that the international community does not see any inherent conflict between drug control and human rights.

Human Rights Violations: Really About Drug Control?

As noted above, opponents of drug control have spent significant resources gathering and publishing information of human rights violations that have taken place within the context of drug law enforcement in several countries. Oft-cited examples include the mass incarceration of racial minorities in the United States; the execution of drug related offenders in China; arbitrary detention and slave labour in drug treatment centres in Southeast Asia; and the militarization of anti-drug efforts and the attendant violations in Mexico and Colombia.

“...there is no human right to abuse drugs, and the suggestion that the choice to abuse drugs is somehow fundamental to an individual’s identity, on the same plane as one’s political opinion, religion, or sexual orientation, is clearly unconvincing.”

A detailed examination of each of these situations would be out of the scope of this paper, and in any case is not necessary for its purposes. The above human rights violations are abhorrent, and must be condemned in the strongest terms by the international community. Nevertheless, there are no grounds to suggest that the above violations take place *because* of the international drug control regime. Law enforcement in all of the above countries is characterized by systemic and widespread abuses, not only during the enforcement of drug control laws but of any laws. China executes a large number of persons for corruption and other economic crimes, also in violation of international human rights standards – yet we do not question the legitimacy of efforts against corruption. Abuses such as arbitrary detention and torture are widespread in many countries in both Southeast Asia and Latin America, and the systemic brutality of many police forces in the United States is widely recognized. The reality is that the human rights problems put forward as “examples” are examples of human rights issues in law enforcement in general in these countries, not human rights issues within drug control as a whole, and it is somewhat disingenuous to suggest otherwise. In addition, it strains credibility to argue that, should drug control be eradicated and drug abuse legalized, these abuses would disappear.

In examining human rights issues in law enforcement, the conduct of law enforcement officials in the implementation of a particular law

must be looked at separately from the legitimacy of the law itself. Arbitrary or abusive behaviour by police or judicial officers must be prevented, but such conduct does not necessarily indicate that the law itself is flawed – the two are separate matters. By mixing these two issues, opponents of drug control argue that drug control laws necessarily result in human rights violations, under any circumstances. This can only be correct if one accepts the underlying (yet often unstated) premise of these opponents: namely, that there is a human right to abuse drugs, and, as with all human rights, the state should not attempt to prevent people from exercising this right. Contrary to what the opponents of drug control might wish, there is no such right in international law.

Linked with these arguments regarding law enforcement and drug control is the characterization by these opponents of persons who abuse drugs as a “vulnerable group” requiring special protections under human rights law, somewhat akin to racial or religious minorities. This is clearly without foundation: a “vulnerable group” in human rights terms is a group of individuals who are targeted for violations because of their exercise of a human right, or because of a defining characteristic that is fundamental to their identity. As noted above, there is no human right to abuse drugs, and the suggestion that the choice to abuse drugs is somehow fundamental to an individual’s identity, on the same plane as one’s political opinion, religion, or sexual orientation, is clearly unconvincing.

On a related point, opponents of drug control often point to the immense wealth and power that criminal organizations have amassed through the illicit drug trade, arguing that legalization of drugs would result in these criminal organizations losing their source of income and eventually going bankrupt altogether. As attractive as this scenario may seem, it strains credibility to suggest that these criminal organizations would simply disappear – serious studies indicate that the larger organizations have a wide range of both illicit and licit sources of income, and would be well able to absorb any hit that may take place from the legalization of drugs.

The International Drug Control Regime: Really an Overly Punitive Approach?

Opponents of drug control argue that the international drug control regime is based on an “overly punitive” approach. The suggestion, stated or implied, is that the international drug control conventions require that state parties, for example, engage in mass incarceration of persons solely because of possession of illicit drugs. State parties, in other words, have no choice but to violate human rights en masse to comply with their obligations under the international drug control regime.

This is false, as even a cursory reading of the international drug control conventions shows. The provision most often cited by opponents of drug control is Article 3 of the 1988 Convention, titled “Offences and Sanctions.” This Article essentially obligates state parties to criminalize drug trafficking: in Article 3(2), the Convention states that each state party should, “subject to its constitutional principles and the basic concepts of its legal system,” establish as a criminal offence the “possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption.” However, this Article then goes on to state that “in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.” The two other international drug control conventions also contain similar provisions.

In other words, the international drug control regime does not require that persons who abuse drugs be incarcerated or otherwise punished heavily. An argument may even be sustained that the international conventions *encourage* (though do not require) states to refrain from imprisoning persons solely for possession of drugs for personal consumption. In its 2007 Annual Report, the INCB suggested this strongly, pointing to some of the many problems caused by mandatory imprisonment for persons who abuse drugs in some countries,

and recommending that states “consider widening the range of custodial and non-custodial options for drug-related offences” so that punishments are proportionate.

The model of mass incarceration of persons who abuse drugs is, therefore, neither required nor recommended by the international drug control regime, and in any case is a model that is adopted only by a small number of countries. That does not make the human rights issues less urgent, but it does put them into perspective. Opponents of drug control would have one believe that in nearly every corner in the world, police are engaging in widespread roundups and arbitrary shakedowns of persons solely because of their abuse of drugs. Outside of a few countries, this picture has very little foundation in reality, and the notion that international drug control is at the heart of what problems exist is in any case without merit.

Nor does the international drug control regime encourage states to engage in arbitrary detention or police brutality, contrary to what opponents of drug control would have one believe. It goes without saying that there is nothing encouraging such behaviour in the international drug control conventions, and both the INCB and UNODC have stated clearly that criminal sanctions of drug-related crimes should respect human rights.⁴

Opponents of drug control have levelled criticisms of these international bodies, in particular INCB, stating that, despite these general statements, INCB does not pronounce itself on human rights issues in specific countries. However, this is for the simple reason that INCB has neither the mandate nor the expertise to examine human rights issues in any concrete manner; that is not what it was established to do. There are many other bodies within the UN system far better placed to do this.

“Harm Reduction”: Really Prohibited Under the International Conventions?

A related notion often advanced by opponents of drug control is that the international drug control regime prohibits “harm reduction.” “Harm reduction” is a relatively new concept

that did not exist (or at least was not prominent internationally) when the international drug control conventions were adopted. The term is not defined internationally, but is generally understood to include a wide range of policy approaches that are aimed, not at eradicating drug abuse, but at mitigating the health (both public and individual) problems that are caused by it. Since there is no international definition of “harm reduction,” there is no consensus as to what specifically it entails, but it is generally understood to include measures such as needle distribution, pill testing at rave parties and other venues, and so-called “injection rooms.” Methadone treatments are also sometimes included under the “harm reduction” umbrella.

Opponents of drug control often point to “harm reduction” as a “rights-based approach” aimed at ensuring the right to health of persons who abuse drugs (the right to the highest attainable standard of health being an internationally recognized human right, enumerated in particular in the International Covenant of Economic, Social, and Cultural Rights). These opponents then go on to characterize the international drug regime as a whole, and in particular the INCB, as being against “harm reduction,” and by extension against human rights. Not all public health measures are necessarily “rights-based,” but insofar as they provide some semblance of health protection, “harm reduction” measures can, under the right circumstances, be desirable. However, the notion that INCB is somehow “against harm reduction” is not true: INCB has

stated on many occasions that “harm reduction” has a part to play in a comprehensive strategy against drug abuse, and, indeed, INCB has endorsed in principle some measures (such as needle distribution and methadone treatments).

At the same time, INCB has pointed out that “harm reduction” should not be the sole goal of a country’s drug policy. By definition, “harm reduction” does not have the eradication of drug abuse as its goal: its objective is merely to lessen the harm that drug abuse causes. This is a worthy goal, and arguably one in accordance with states’ obligations to protect the right to health of all individuals, including persons who abuse drugs. Nevertheless, “harm reduction” measures do not attempt to address the root cause of the problem, namely the drug abuse itself. While temporarily protecting the right to health of persons who abuse drugs through “harm reduction” measures is important, the true way to ensure the highest attainable standard of the right to health of all is to eradicate drug abuse.

How to advance the goal of a drug-free world is a topic of legitimate debate. However, when opponents of drug control argue that the current “prohibitive” regime should be revised and approaches towards drugs should be based solely on “harm reduction,” they are essentially advocating for the abandonment of the goal of a drug-free world. They are arguing that states should simply accept drug abuse as inevitable, and should work only on mitigating the harm caused by it. Whatever one may think of this argument, it is not based on human rights. The near universal ratification of the three international drug control conventions, plus the commitments made by states on countless occasions, indicate that it is not the desire of the international community either. Indeed, legalization of drugs would most likely lead to a dramatic increase in abuse, and major public health problems. This is hardly the most effective way to ensure the right to the highest attainable standard of health.

Conclusion

To suggest that drug control is inherently in conflict with human rights is false. The two

“They are arguing that states should simply accept drug abuse as inevitable, and should work only on mitigating the harm caused by it. Whatever one may think of this argument, it is not based on human rights.”

legal regimes are not in conflict, but actually complement each other. The notion that human rights violations are a necessary and inescapable result of drug control efforts is equally false – while violations have taken place in some countries, these are not inevitable consequences of drug control efforts, but rather indications of systemic problems in law enforcement in those particular countries. In addition, the arguments that the international drug control regime requires an overly punitive approach towards persons who abuse drugs, or that it prohibits “harm reduction,” are without merit.

Opponents of drug control are correct in stating that human rights should not be violated in the name of drug control – indeed, human rights should not be violated under any circumstances. However, these opponents are abusing the language of human rights to further an unrelated agenda, namely the agenda of drug legalization. This is unacceptable, both from a drug control standpoint and from the standpoint of human rights.

Endnotes

1. The 1961 Convention as amended by the 1975 Protocol has 185 state parties; the 1971 Convention has 183 state parties; and the 1988 Convention has 189.
2. Though problems in this area remain in many countries in the developing world, they are not a result of the international drug control regime being overly vigorous in its attempts to stop a free flow of licit drugs – rather, they stem largely from a lack of capacity in the public health care systems in those countries. INCB in particular is vocal in calling on countries to ensure an adequate supply of drugs for licit purposes, in particular medical purposes.
3. See e.g. the Palermo Protocol against the Smuggling of Migrants by Land, Sea and Air; and the Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children.
4. “Joint UNODC/INCB Statement on the International Drug Control System and Human Health and Human Rights”, 2010. See https://www.incb.org/documents/Publications/PressRelease/PR2010/Joint_UNODC_INCB_statement_on_drugs_health_and_human_rights.pdf.

case study

The Impact of Drugs in Latin American and Caribbean Societies

Mina Seinfeld de Carakushansky

President, Brazilian Humanitarians in Action (BRAHA)

Latin America and the Caribbean (LAC) comprise 26 countries, with a total population of over 600 million. Many of the LAC countries have vast territories and in most cases also have valuable natural resources.

In spite of the above, most of these countries are in urgent need of the capacity to offer good education and possibilities for advancement and development for their young populations, which represent 20% of the total. Over one-third of workers in the 15-29 age group are employed in the informal sector. Less than 9% of young people 20-29 complete university education. There are socioeconomic disparities in access to and completion of secondary and tertiary education. For instance, 10% of women 15-19 are adolescent mothers and this phenomenon is markedly more common among poor adolescents.

Youth in LAC confront a series of challenges. Despite having higher levels of education than previous generations, they face higher levels of unemployment and receive lower wages. Other significant challenges are

the use of drugs and the lack of understanding or capacity of individual governments regarding effective ways to solve the problems posed by drugs. Drug use is not a disease that is restricted only to the users. The social, economic and psychosocial problems extend far beyond users. One of the biggest public health and security problems for the Latin American populations is the epidemic of drug use. A substantive part of the violence to which the Brazilian population is exposed has a close causal link with drug use, which has been increasing continuously in Brazil over the last twenty years, while other countries of the world have been able to reduce drug use.

According to recent data released by the Federal University of São Paulo, for each individual addicted to illicit drugs, on average, there are four people directly affected in a devastating form, compromising, in many dimensions, a population of nearly 30 million Brazilians.

The Confederation of Brazilian municipalities did a major survey in December of 2010 which showed that 90.7% of the

Brazilian municipal had social problems such as vandalism, domestic violence and robberies caused by crack use in their cities.¹

In a report by the International Narcotics Control Board (INCB) it was stated that in the six years between 2005 and 2011, the consumption of cocaine in Brazil increased from 0.7% to 1.75% of the population aged 12 to 65 years. This is equivalent to four times the world average and is 25% higher than the average for South America. Cannabis is the main illicit drug used in Brazil, with about 10% of teens making regular use. It is estimated that 1 million cannabis users make daily use of the substance, being addicted. Despite what science is showing about cannabis, there is a steady increase in the consumption of this drug, due to a perception that this drug does not pose any health problems.

The Brazilian government has established 223 free clinics for crack users, which is an insufficient number, considering the 600,000 crack addicts which the government admits exist in the country.²

The Situation of Adolescents and Youth

As many as 25-32% of the 12- to 24-year-old population in the region are suffering the consequences of at least one kind of risky behaviour (as defined by the World Bank): dropped out of school, are young parents, are not employed, are addicted to drugs, or have been arrested.

“Despite what science is showing about cannabis, there is a steady increase in the consumption of this drug, due to a perception that this drug does not pose any health problems.”

The Economy of a city or a country is certainly affected by drug use, because this causes more unemployment, violence, unplanned pregnancies, sexually transmitted infections, etc. Each of these problems reduces a country's output by up to 1.4% of GDP.

Latin America and the Caribbean are considered to be one of the most violent regions in the world. Each year about six million children and adolescents in Latin America and the Caribbean suffer severe abuse, including abandonment. It is the region in the world presenting the highest rates of armed violence, accounting for 42% of global homicides. The Caribbean ranks first globally when it comes to murder rates and claims the highest rates of homicides among young people aged 15–17. In terms of abuse, adolescent boys are most at risk for beatings in home and at school, while adolescent girls are most at risk for sexual harassment and abuse from adult men in the family, school, and the work place. Adolescents may be recruited into hazardous jobs and fall prey to crime-related syndicates, including drug trafficking. Gang and drug-related violence is on the rise, with young people being the most visible culprits but also the most common victims. There are approximately 25,000 to 125,000 active gang members in Guatemala, El Salvador, and Honduras.

The Caribbean has the second highest prevalence of HIV in the world, after sub-Saharan Africa, and the face of HIV/AIDS in the region is becoming increasingly an adolescent female face. 35 million children between 3 to 18 years of age do not go to school at all (a number close to the population of Colombia). Thirty million (one in every three) secondary school-aged people in LAC are not enrolled in school. There are 10 million unemployed young people in the region. Thirty million young people do informal work under precarious conditions.

Drugs Cause Family Violence and Lack of Proper Child Care

Issues related to substance abuse are seen in higher numbers among homeless persons than the general population. Between 20-25% of homeless persons are living with a severe mental

illness. While information about addiction is less definitive, alcohol and drug use is also noted among a large number of homeless persons. Untreated mental illness and drug use issues clearly affect housing stability and success. Households where one or both parents are drug users tend to have children who have inadequate care, are undernourished, beaten and many times run away from their family or are abandoned and need to provide food and shelter for themselves.

Drugs and Functional Illiteracy

The rate of Brazilian illiteracy is greater than that of 70% of LAC countries, some of them with a lower per capita income and a lower HDI, like Peru and Ecuador (INEP 2003a). Academic failure and delinquency, violence, and crime are welded to reading failure. Functional illiteracy is still a major problem in Brazil because 38% of the students enrolled in college-level courses do know how to read and write but are unable to interpret or make associations regarding the information contained in the text they are reading or derive meaning from sentences in context.

The Organization for Economic Co-operation and Development (OECD) presented in May 2015 the results of the biggest ever global school rankings of 76 countries. Singapore leads, followed by Hong Kong, South Korea, Japan and Taiwan, followed by Finland as the sixth. The African countries are at the bottom of the ranking, with Ghana being the very last. The UK is the 20th and the US in the 28th. Brazil, in spite of having the eighth best economy of the world in terms of its 2015 GDP (Gross Domestic Product), occupies only the 60th place in the OECD chart. These figures show the urgent need for a study correlating drug use, strict laws, and success in education.

Drugs and School Violence

One of the main reasons for school violence is the use and trafficking of drugs (illegal or not). Many students use and sell drugs in and around schools. This also attracts bad elements to the outskirts of the institutions. A survey of

schools report that 27% of students carried and consumed alcoholic beverages during class. 19% of schools were invaded by strangers, in order to commit crimes, including theft, robbery, rape, and trafficking in drugs.

Traffic Crashes Caused by Drugged Drivers in Latin America

While alcohol and licit substances dominate traffic crashes, a number of prescription drugs contribute to injury and death on the roads in Latin America. 13% of Brazilian truck drivers use drugs with methamphetamines, the so-called "*rebite*."³ According to the Columbia University School of Public Health, the risk of an automobile crash is almost 2.7 times higher among cannabis users than non-users. The more cannabis smoked in terms of frequency and potency, the greater likelihood of a crash.

Initial partial success has, however, been obtained in Brazil regarding the use of alcohol and tobacco on the roads. Under the so-called Lei Seca (Dry Law), since 2009, police stop and use a breathalyser test on drivers not only in crash hotspots but also on unexpected times or routes, and enforce what is essentially a zero-tolerance policy. Penalties include having a driver's license suspended, being fined and having the car towed away. There has also been an advertising campaign to raise awareness. The death rate because of drunk drivers has dropped in cities which have adopted this control model.

Two decades ago, Brazil had a tobacco smoking rate of 35%. Thanks to intense awareness and education media campaigns, together with strict laws and high fines, and prohibition of smoking in restaurants, movie theatres, public agencies and buildings, airports, public transportation, etc., the rate of smokers has dropped to only 13.5%.

What these cases show is that when there is a will to change the culture of a negative issue regarding the wellbeing of society, it is possible to do so if the citizens understand why it is necessary to adopt certain restrictive measures. If prevention gained a much greater role in educating populations about the harms caused by drug use, success could also be obtained

regarding illegal drugs.

Use of Drugs and the Workplace

According to a report by the International Labour Organization (ILO), drugs cause 20% of accidents at work in the world. The most common drugs at work are cocaine and alcohol. ILO also reports that one in five work accidents is caused by drug use.

As is the case elsewhere in the developing world, the majority of firms in LAC are small and medium enterprises (fewer than 100 employees). 91% of LAC firms fall into this category. The average firm in LAC employs 47 full-time workers.⁴

This type of data is important in order to understand how serious the negative impact of drug use can be. It is well-documented and known all over the world that employees under the influence of drugs have a higher rate of absenteeism from work, cause more altercations, have longer sick episodes, and cause more accidents and financial losses for the firm where they are employed. Since firms may be very small, each employee has a key role to the success of the firm. If one or more employees use drugs, this will be a fatal blow for the success of the firm.

Recent data showed that 24% of the workers who had been involved in workplace accidents had drugs in their system (18% had alcohol, 3.7% had cocaine and 1.5% had other drugs such as amphetamines, cannabis, etc.).⁵

Social Costs of Drug Use

Countries in LAC are very diverse and their capacities for dealing with social problems vary immensely. Chile, Argentina, Uruguay, Costa Rica, Mexico, and Colombia are countries which by certain standards can be considered developed and have social services in place that deal reasonably well with drug use issues. On the other hand, countries such as Venezuela, Ecuador, Guatemala, El Salvador, Honduras and even Brazil have high crime rates and struggle with many issues such as corruption, violence, functional illiteracy, etc. Some have gigantic

populations and economies while others struggle with great poverty and lack of education and employment. Some are full democracies while others have governments that are worse than dictatorships in terms of the wellbeing of their populations.

To compare numbers is a daring task. A serious study must analyse items such as: attention to health, loss of productivity, costs related to offer and demand, general costs, and costs due to loss of productivity, harm to property, loss because of health problems, and many other variables. Since presently LAC countries still suffer from a major lack of studies and statistics done with reliable scientific rigor (with exceptions in some fields, and countries), it is almost impossible to infer real comparable results.

As examples we will mention some amounts in USD so as to give a slight idea of the situation. (Data from *"Políticas de drogas en México y Chile: Estimación de costos económicos y sociales y de escenarios alternativos."*)

The social costs of drug addiction in Chile in 2009 totalled \$60.05 USD per citizen. The total cost in 2008 was \$1.1 billion USD.⁶

The numbers for Brazil also confirm what we see globally: the tax revenues from alcohol and tobacco are only a fraction of what the harms of alcohol and tobacco cost society. The revenues from alcohol in Brazil represent only 25% of the government expenditures to address the harms caused by alcohol use.⁷ In the case of tobacco, the tax revenues for the government represent only 10% of the total it spends on the consequences of tobacco use.⁸ In today's world, we should mirror our actions with those taken by countries which were able to overcome wars, huge economic problems, climate hardships, etc., and become advanced world actors in science and technology, thus allowing their citizens a better life. Those countries show us clearly that we have to take good care of the brains of our younger generations and not allow the harms caused by drug use.

Endnotes

1. <http://veja.abril.com.br/noticia/saude/90-dos-municipios-brasileiros-enfrentam-problemas-com-o-consumo-de-crack-diz-estudo>
2. <http://www.antidrogas.com.br/mostrasosvida.php?c=52>.
3. <http://noticias.r7.com/sao-paulo/pesquisa-aponta-que-13-dos-caminhoneiros-usam-drogas-a-base-de-anfetaminas-13092014>
4. <http://www.enterprisesurveys.org/~media/FPDKM/EnterpriseSurveys/Documents/Topic-Analysis/Mapping-Enterprises-LAC-Note2.pdf>
5. <http://www.uvv.br/news/6033/acidente-de-trabalho-x-uso-de-drogas.aspx> Published in 24/06/2014
6. http://www.espolea.org/uploads/8/7/2/7/8727772/estudio_de_custos_mexico-chile_es.pdf
7. <http://dx.doi.org/10.1590/S0101-60832008000700007>
8. http://www.terra.com.br/saude/especiais/drogas/drogas_custos.htm

Additional Reading

1. American Academy of Pediatrics (2004). Legalization of marijuana: Potential impact on youth. Retrieved from: <http://pediatrics.aappublications.org/content/113/6/1825.full.pdf>
2. American Academy of Pediatrics (2015). The impact of marijuana policies on youth: Clinical, research, and legal update. Retrieved from: <http://pediatrics.aappublications.org/content/early/2015/01/20/peds.2014-4146.full.pdf+html>
3. American Epilepsy Society (2014). AES position on medical marijuana. Retrieved from https://www.aesnet.org/sites/default/files/file_attach/AboutAES/PositionStatements/AES%20Position%20on%20Medical%20Marijuana.pdf
4. Benson, M. & Bentley, A.M. (1995). Lung disease induced by drug addiction. *Thorax*, 50, 1125-1127. doi:10.1136/thx.50.11.1125
5. Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon, C. J., Brewer, R. D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Prevention Medicine*, 41, 516-524. doi: 10.1016/j.amepre.2011.06.045.
6. Brownstein, J. (2014, January 21). Marijuana vs. alcohol: Which is really worse for your health? *Livescience*. Retrieved from <http://www.livescience.com/42738-marijuana-vs-alcohol-health-effects.html>
7. Budney, A. J., Roffman, R., Stephens, R. S., & Walker, D. (2007). Marijuana dependence and its treatment. *Addiction Science & Clinical Practice*. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797098/>
8. Centers for Disease Control and Prevention (2013). The high cost of excessive drinking to states. Retrieved from: <http://www.cdc.gov/features/CostsOfDrinking/>
9. Colorado Department of Public Health & Environment. Monitoring health concerns related to marijuana in Colorado: 2014. Retrieved from: https://www.colorado.gov/pacific/sites/default/files/DC_MJ-Monitoring-Health-Concerns-Related-to-Marijuana-in-CO-2014.pdf
10. Denver Police Department Versadex and OSI databases (2014). Marijuana arrest at Denver schools. Retrieved from: http://www.cpr.org/sites/default/files/marijuana_arrests_at_schools_aug_12_-_jul_14updated.pdf
11. ElSholy, M. A. (2009). Quarterly report potency monitoring project report 104 December 16, 2008 thru March 15, 2009. Retrieved from: <http://medicalmarijuana.procon.org/sourcefiles/UMPMC-quarterlymonitoring-report.pdf>
12. Gilman, J. M., Kuster, J. K., Lee, S., Lee, M. J., Kim, B. W., Makris, N., & Breiter, H. C. (2014). Cannabis use is quantitatively associated with nucleus accumbens and amygdala abnormalities in young adult recreational users. *Journal of Neuroscience*, 16, 5529-5538. doi:10.1523/JNEUROSCI.4745-13.2014.
13. Hashibe, M., Straif, K., Tashkin, D. P., Morgenstern, H., Greenland, S., & Zhang, Z. (2005). Epidemiologic review of marijuana use and cancer risk. *Alcohol*, 35, 265-275. doi: 10.1016/j.alcohol.2005.04.008
14. Lacson, J. A., Carroll, J. D., Tuazon, E., Castela, E. J., Bernstein, V. K. & Cortessis, V. K. (2012). Population-based case-control study of recreational drug use and testis cancer risk confirms an association between marijuana use and nonseminoma risk. *Cancer*, 118, 5374-5383. doi:10.1002/cncr.27554
15. Manrique-Garcia E., Zammit S., Dalman C., Hemmingsson T., & Allebeck P. (2012). Cannabis use and depression: a longitudinal study of a national cohort of Swedish conscripts. *BMC Psychiatry*, 12, 112. doi: 10.1186/471-244X-12-112.
16. Moir, D., Rickert, M.S., Levasseur, G., Larose, Y., Maertens, R., White, P. & Desjardins, S. (2008). A comparison of mainstream and sidestream marijuana and tobacco cigarette smoke produced under two machine smoking conditions. *Chemical Research in Toxicology*, 21, 494-502.
17. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. (2014). Fact sheets: Alcohol use and your health. Retrieved from <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>
18. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. (2014). Tobacco-related mortality. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/
19. National Highway Traffic Safety Administration. (2010) Drug Involvement of Fatally Injured Drivers. U.S. Department of Transportation (Report No. DOT HS 811 415). Washington, DC: National Center for Statistics and Analysis.
20. Rocky Mountain High Intensity Drug Trafficking Area (2014). The legalization of marijuana in Colorado: The impact. Retrieved from: <http://www.rmhidta.org/html/August%202014%20Legalization%20of%20MJ%20in%20Colorado%20the%20Impact.pdf>
21. Smart Approaches to Marijuana (2015). Lessons after two years of marijuana legislation: Short Report. Retrieved from: <http://learnaboutsam.org/wp-content/uploads/2015/01/FINAL-REPORT-1.pdf>
22. Steinmetz, K. (2014). Colorado marijuana activists don't want to pay pot taxes. *Time*. Retrieved from: <http://time.com/2857524/colorado-marijuana-lawsuit/>
23. Substance Abuse and Mental Health Administration (2013). National Survey on Drug Use and Health: Comparison of 2011-2012 and 2012-2013 model-based prevalence estimates (50 states and the District of Columbia). Retrieved from: <http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.htm>
24. Tashkin, D.P., Gliederer, F., Rose, J.E., Change, P., Hui, K. K., Yu, J.L., Wu, T.C., (1991). Effects of varying marijuana smoking profile on deposition of tar and absorption of CO and Delta-9-THC. *Pharmacology, Biochemistry and Behavior*, 40, 651-656.
25. Tax Policy Center (2015). State and local alcoholic beverage tax revenue, selected years 1977-2012. Retrieved from: <http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=399>
26. Wang, G. S., Roosevelt, G., & Heard, K. (2013). Pediatric marijuana exposures in a medical marijuana state. *JAMA Pediatrics*, 167, 630-633. doi:10.1001/jamapediatrics.2013.140.
27. Wu, T.C., Tashkin, D.P., Djahed, B. & Rose, J.E. (1988). Pulmonary hazards of smoking marijuana as compared with tobacco. *New England Journal of Medicine*, 318, 347-351. Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/3340105>

testimony

More Than 'Just Pot': Caring for Children in a Legalized Marijuana State

Sean LeNoue, M.D.

I am a child and adolescent psychiatry fellow completing my post-graduate medical training at the University of Colorado in the United States of America. I came to Colorado in the middle of the legalization haze during the summer of 2011. Since that time and long before, cannabis — for both 'medicinal' and recreational use — has been a constant topic of discussion. Nussbaum et al. 2011 gives a nice overview of the complicated relationship that exists with medical marijuana and the physician-patient relationship.¹ Important timeline information regarding the decriminalization, commercialization, and approval for medical cannabis can also be found in that article.

The decriminalization of cannabis in Colorado began in 1978 with eased restrictions on the possession of the substance.² Amendment 20 was passed in November of 2000, which allowed for "medical use of marijuana for persons suffering from debilitating medical conditions."³ Over the course of the next decade, concern arose regarding maintaining the integrity of the patient-physician relationship. For that and other reasons, Senate Bill 109 was passed

in the state of Colorado in order to ensure the establishment and maintenance of a "bona-fide physician-patient relationship" regarding the prescription and use of medical marijuana.⁴ The push for further regulation and decriminalization of cannabis continued. Amendment 64 or "The Use and Regulation of Marijuana" in Colorado was ratified on November 6, 2014.⁵ Through that amendment, individuals at least 21 years of age (regardless of legal residency in the state of Colorado) may now purchase cannabis for recreational purposes from a licensed dispensary, maintain three immature and three mature cannabis plants in a secured, locked private space, possess up to one ounce of cannabis in public, and gift up to one ounce of cannabis to another individual of legal age as defined by Amendment 64. The legal driving under the influence of a drug (DUID) limit was set at 5 nanogram per milliliter of blood.

Since the legalization of recreational cannabis use in Colorado, public opinion seems to be mixed, especially for groups living in different areas of the state. There are certainly ardent defenders of the legalized use of

cannabis on one end of the spectrum, as well as those in staunch opposition on the other end. Nationally, despite changing public perception of cannabis, parents continue to “want strict controls of its (cannabis) distribution and use because of concerns regarding its health impacts on youth.”⁶ I have had the opportunity to travel around the state of Colorado and speak with different groups consisting of youth, young adults, parents, students, police officers, medical professionals, educators, and law enforcement officials. No matter where I go, nearly everyone I have encountered has an opinion about this important issue. One of the most pervasive messages I have taken away from those groups is that there appears to be a lack of attention being given to the harmful effects cannabis can have on the health of an individual, most notably children, adolescents, and young adults.

There have been a number of studies and published articles in the medical literature which detail the harmful effects of cannabis use. Just a couple of the most profound findings from peer-reviewed medical journal articles pertaining to the negative impact of cannabis use include a decrease in IQ by 6 points (on average) when heavy cannabis use occurs between 13-38 years of age,⁷ as well as a two-fold increased risk for developing psychosis during adulthood when used frequently.⁸

I have the privilege of working with resilient individuals who have overcome astounding odds. The toll drug use, including cannabis, has taken on their lives is real, and I see that every day. When legislators pass bills and amendments to legalize the use of a substance, there is far-reaching impact. Youth, in particular, are especially vulnerable to those impacts from a social and developmental perspective. Society must do all it can to protect the safety and well-being of our youth, for they are the leaders of tomorrow. When considering the harmful effects of a substance like cannabis, I hope people will remember that it’s more than just pot and its effects are very real.

Endnotes

1. Nussbaum, AM, Boyer, JA, Kondrad, EC, (2011). “But my Doctor Recommended Pot: Medical Marijuana and the Patient-Physician Relationship.” *Journal of General Internal Medicine*. 26(11):1364-1367.
2. Pacula, RL, Chriqui, JF, King, J., (2003), “Marijuana Decriminalization: What Does it Mean in the United States?” National Bureau of Economic Research; <http://www.nber.org/papers/w9690.pdf>. Accessed on May 1, 2015.
3. Colorado Constitution - Amendment 20. https://www.colorado.gov/pacific/sites/default/files/CHEIS_MMJ_Colorado-Constitution-Article-XVIII.pdf. Accessed on June 6, 2015.
4. Colorado State Senate - Senate Bill 109. [http://www.leg.state.co.us/clics/clics2010a/csl.nsf/fsbillcont2872576A8002B8BBD/\\$FILE/109_01.pdf](http://www.leg.state.co.us/clics/clics2010a/csl.nsf/fsbillcont2872576A8002B8BBD/$FILE/109_01.pdf). Accessed on June 22, 2015.
5. Colorado Constitution - Amendment 64. <http://www.fcgov.com/mmj/pdf/amendment64.pdf>. Accessed on June 8, 2015.
6. Caywood, K, Riggs, P, Novins, D. (2015) “Adolescent Substance Use Disorder: Prevention and Treatment.” *Colorado Journal of Psychiatry and Psychology*. (1): 42-49.
7. Meier, MH, Caspi, A, Ambler, A, Harrington, H, Houts, R, Keefe, RS, McDonald, K, Ward, A, Poulton, R, Moffitt, T., (2012). “Persistent Cannabis Users Show Neuropsychological Decline from Childhood to Midlife.” *Proceedings of the National Academy of Sciences of the United States of America*. 109: E2657-E2664.
8. Moore TH, Zammit S, Lingford-Hughes A, Barnes TR, Jones PB, Burke M, Lewis G., (2007). “Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review.” *The Lancet*; 370(9584): 319-328.

Chapter 4

Drugs and Societies

“

Drug use does not only affect the drug user. Often, family and friends are the first to experience the problem caused by drug use. In addition, drug use has serious consequences for society as a whole, e.g. in the workplace, schools, on the roads, in the criminal justice system and in the health and social services.”

Drugs and Societies: An Introduction

Social and Economic Consequences of Drug Use to Society

This chapter will focus on the people surrounding a drug user, in particular the immediate family, who are often the first to experience the problems caused by drugs.

We know that illicit drug use poses immeasurable harm to our society through the economic consequences of drug consumption and trafficking. One of the main challenges here is finding reliable data, as data insufficiency is a threat to understanding the social and economic consequences of drug abuse. Below we have collected some of the economic, social and safety consequences of drugs, but we would also like to emphasize that more data and understanding is needed in this aspect.

Economic Consequences of Drug Consumption and Trafficking

"Drug abuse occurs most frequently among young people in the 15-35 age group, with a particular concentration in the 18-25 age group. It thus includes those who have entered or who are just about to enter the workforce. Given the high unemployment rates in many countries, entry into the workforce is often a major problem. Consumption of illicit drugs limits chances of entering or remaining in the workforce, while frustration caused by failure to find adequate employment favours drug consumption, thus creating a vicious circle."¹

Drug use produces a worldwide loss

in productivity. This can be manifest as incapacitation to reach the production goals set by the business sector, and thus reducing competitiveness, but also as the indirect consequences of hospitalization, incarceration, treatment or mortality.

Productivity loss refers to the work and production that would have happened (and thus reinforced the national GDP) without having to cope with drug impairment. A society will undoubtedly find it hard to keep producing, and therefore advancing, if its workforce is impaired by drug use. Different studies have been carried out in order to raise government awareness of the heavy impact of drug use on productivity. A specific study from the U.S. shows that the "lost productivity in the United States as a result of labour nonparticipation is significant: \$120 billion (or 0.9 per cent of GDP) in 2011, amounting to 62 per cent of all drug-related costs."²

Productivity loss from drug use also includes incapacitation due to incarceration, hospitalization, treatment participation, and mortality. Drug users are, in this case, unable to participate in work and unable to contribute to the national GDP. "In Europe in 2010, 56 per cent of patients entering drug treatment programmes were unemployed, and that percentage has increased over the past five years."³

Health

The most obvious, visible and direct impact of drug use and abuse is on health. The societal costs can be seen in treatment and healthcare expenditures, as well as in morbidity and

mortality rates. As INCB notes, even though funnelling resources into treatment can be expensive, “studies have shown that for every \$1 spent, good prevention programmes can save governments up to \$10 in subsequent costs . . . Research findings clearly show that investment in treatment is cost-effective compared with the cost of untreated and continuing abuse. Research conducted in the United States of America reveals that every \$1 invested in treatment yields a return of between \$4 and \$12 in reduced crime and healthcare costs.”⁴

The magnitude of the drug abuse problem and its expenditures can be easily shown with the following figure: 532,000. This is the number of drug-related emergency room visits in 1995 in the United States of America.⁵ Those visits, whether they result in quick release or long-term hospitalization, are due to episodes of overdose, adverse reactions to the substance, psychosis or infectious diseases caused by injection drug use. Drug-related mortality is a relatively small proportion of the global figure: between 0.5 and 1.3 per cent of all causes of death for a population aged between 15 and 64 years old. Though, when translated into real numbers, it results in about 211,000 drug-related deaths throughout the year, with younger people at higher risk. “The substances most commonly associated with drug-related deaths are heroin and other opiates, cocaine, and, to a lesser extent, barbiturates and amphetamine-type stimulants, notably methamphetamines.”⁶

We face a continuous problem of data insufficiency regarding psychoactive-substance-induced mortality rates. We know that in Europe the average age of death for drug-related cases is in the mid-thirties. However, the knowledge on drug-related mortality in Asia and Africa is very low. In some areas like North and Central Africa, as well as Central Asia (particularly Afghanistan), drug production, trafficking and consumption claim a relevantly high number of lives each day. Studies have shown that out of 43 risk factors, drug use was nineteenth in the ranking of main global killers, with alcohol ranked as third and tobacco as second.

Even within the dialogue on drug-related mortality, there are some positive trends: as

reminded by the UNODC, we should note that “the existing drug control mechanisms (prevention, education and law enforcement), although unable to prevent substance-abuse related mortality, do seem to have prevented the actual number from reaching the levels currently being experienced with the abuse of licit psychoactive substances.”⁷

Public and Environmental Safety

A drug consumer does not only harm himself/herself. People under the influence of a psychoactive substance can pose a major threat to public safety, for example by driving while intoxicated. “Roadside surveys conducted in 13 countries across Europe, in which blood or oral fluid samples from 50,000 drivers were analysed, revealed that alcohol was present in 3.48%, illicit drugs in 1.90%, medicines in 1.36%, combinations of drugs or medicines in 0.39% and alcohol combined with drugs or medicines in 0.37%.”⁸

The illegal manufacture of drugs also greatly damages the environment. Deforestation is one manifestation of this: the massive forest clearing in Bolivia due to coca plantation, growing crops as monocultures, processing harvested plants into drugs (resulting in loss of natural resources for food production), and the use of improper toxic waste and chemicals as part of the production chain, threatening biodiversity, both in the immediate area and downstream.⁹

Crime

The international need to improve cooperation towards a society- and science-based drug policy is a topic of utmost importance, especially when faced with the transversal nature of the global psychoactive threat. Drug production, trafficking, possession and consumption (to an extent) intimately intertwine with a vicious criminal cycle. Crime is an innate and inseparable part of the “psychoactive game,” strictly connected from the first stage up to mass distribution and consumption, at which point the likelihood

of crime happening exponentially increases: criminal gangs fight between each other and with law enforcement agencies in order to gain key pieces of the illegal market.

Moving to the demand side of the "game," we encounter other systematic criminal phenomena that are strictly related to the drug use and abuse problem: crimes are committed worldwide as the result of intoxication from legal (alcohol) and illegal drugs (for example, in a study in Dominica, Saint Kitts and Nevis, Saint Lucia and Saint Vincent, and the Grenadines, up to 55 per cent of convicted offenders reported being under the influence of drugs at the time of the offense, with 19 per cent having précised that they would have committed the crime even if not intoxicated¹⁰); and as a result of the attempt to support drug addiction (robbery in order to buy drugs being one of the most common examples). Drug-related crime is costly for societies and governments: it is estimated that drug-related crime costs the US \$3 billion annually. These costs are the burden placed on law enforcement agencies and the judiciary system, intended both as preventive activities (police training and equipment) and repressive activities (the increased incarceration rates resulting from drug consumption or trafficking).

Endnotes

1. The EMCDDA Activity Report 2010, refers to the dichotomy "labelled" and "unlabelled" public expenditure as to the difference between the costs planned by a government in order to carry out tasks purposely designed as drug-related activities in the official public budget and not identified costs intrinsic into the drug problem at national level. The latter being considered the greater part of drug-related public expenditure, an astonishing 4.2 billion euros is the total "labeled" expenditure reported by 22 Member States of the European Union in 2008 to the European Monitoring Center for Drugs and Drug Addiction (EMCDDA).
2. UNODC, Economic and Social Consequences of Drug Abuse and Illicit Trafficking, 1998
3. INCB, Economic consequences of drug abuse, Activity Report 2013.
4. *Ibidem*.
5. *Ibidem*.
6. UNODC, Economic and Social Consequences of Drug Abuse and Illicit Trafficking, 1998
7. *Ibidem*.
8. *Ibidem*.
9. INCB, Economic consequences of drug abuse, Activity Report 2013.
10. *Ibidem*.

case study

New Perspectives on the Role of Relatives

Christina Wall

Social Worker and team leader of the family support groups, Administration for allocation of social welfare, City of Gothenburg, Sweden

The right to support for relatives of addicted persons is since 2009 legally granted in Sweden. The law aims to be preventive and health-promoting, which means that the objective of the support should be to decrease the relatives' stress and anxiety. The law is also based on a family and network perspective, which emphasizes the importance of relatives and others close to the person dealing with addiction. The relative is seen as a resource in this context, and it is important that the professional embraces that point of view. When the new law entered into force, all the municipalities were encouraged to support and to develop new forms of support for relatives, first and foremost to establish procedures to ensure a positive reception of the relatives.

"We need a new perspective when it comes to people who help, treat or support another person," wrote the National Board of Health and Welfare in its guiding document (Socialstyrelsen 2013) and hence led the way for a novel perspective on relatives within social services and healthcare that had not been obvious before.

One example of this new perspective in action is the 5-step method that a group

of researchers in Birmingham developed (Copello et al. 2010) for targeting relatives. The foundational assumption is that the whole family is influenced by addiction; addiction is a strain for the whole family, not only for the person with addiction. The relative should thus be seen as a person that is exposed to stress, and reacts the same way any person would do in a stressful situation. The method involves listening, giving information about drugs and their effects, creating awareness, increasing the relatives own coping skills, and activating support networks. The attitude and approach of the professional is critical. The first step of the method is to listen to the relatives' stories without judging, i.e. a non-judging approach. The principles and content of the method are completely in line with the Swedish authorities' approach, nevertheless knowledge about this and similar methods have yet to be widely circulated.

I will now summarize the 5-step model as it is described in the article "The 5-step method: Principles and practice" (Copello et al. 2010).

The 5-step model is a brief intervention based on stress and coping theory (Oxford et al. 2010) and aims to increase a person's or a family's capability to handle the situation and

hence lessen the risk of stress and fatigue. It is formed for relatives but has also shown effects on the person with addiction. The method is flexible; the five steps can work as a checklist in a single session, and they can also be a series of sessions. The researchers emphasize that no matter how the professional does it, it is important that the first session is not rushed. There needs to be enough time for the relative to tell his/her story.

Step 1: Getting to know the family member and the problem – Exploring stresses and strains

In the first step, the relative is encouraged to tell his/her story in as much detail as possible. The relative is asked to describe the situation for the one who is using drugs, but also to describe how he/she is affected by the situation. The researchers mention nine usual stress factors: Concern over the user's health, living with the user, financial irregularities and effects, impact on the whole family and the home, other members of the community becoming involved, concern over quantity or form of the relative's drug use, user disappearances, the effect on the social life for the family member or the whole family, and accidents/crises. The first session includes asking questions in a non-judgmental, empathetic and encouraging way around the above stress factors and how relatives are coping with these factors. It also includes normalizing: explaining to the relative that these are problems that also occur for other relatives in the same situation.

“The foundational assumption is that the whole family is influenced by addiction; addiction is a strain for the whole family, not only for the person with addiction.”

Step 2: Providing relevant information

One reason for concern for the relative is the lack of information about drugs and their effects, what kind of help there is and where they can get help. Step two is to provide the relative with information in a balanced way. The researchers stress that it is important how the information is provided and also the amount of information is important, as both too much and too little information may increase anxiety.

Step 3: Exploring and discussing coping behaviours

The relatives' coping strategies are in the centre in the third step. The concept of coping is here seen in a broad sense and refers to the family's or relative's reactions to the situation and the thoughts or emotions brought up by what has occurred. The researchers use three positions to describe different coping strategies. The first concept is “standing up to it,” where the relative is capable of putting up boundaries to protect their own life and independence at the same time as they are urging a change of behaviour and setting limits for the person with addiction. The second concept is “putting up with it,” whereby the relative is adapting to the person with addiction's needs and whims and letting their own needs stand back. The third concept is “withdrawal,” where the relative has minimal contact or no contact at all with the person. The researchers say that all three strategies have pros and cons, which are important to highlight, but the concept of “standing up to it” seems to be the strategy that in the long term causes less psychological stress to the relative.

The relative's coping strategies are studied and discussed. The relative is informed about the three coping strategies and asked to describe his/her own strategies and/or action alternatives and their pros and cons. The three positions contains a number of concrete actions, for example to buy food instead of giving money, not allowing intoxicated friends to visit, changing locks, doing ordinary things together, etc. It is the concrete actions that are the bases for the conversation. The professional's role is to stay non-judgmental, neutral and convey that there are pros and cons with most of the actions,

within reasonable limits. The researchers say that the relatives often find the action option that suits them best themselves, and the best option differs between different individuals and families because people and their possible actions are different.

Step 4: Exploring and enhancing social support

Research around stress has shown that social support, i.e. support from family, friends and other networks, is important for a person's capability to handle difficult situations. The relative and the professional are in this step mapping the network to be able to identify and activate supporting persons. Even the less supportive or the counter-productive persons in the network are identified and "neutralized." Worth noting is that there are often persons who judge, criticize or "know better," and "neutralizing" is here to have less contact with them since this sort of commentary often drains the relative's own energy. It is also worth noting that the same person can be both supportive and less supportive depending on the circumstances and situation. The main aim of the fourth step is to activate already existing support networks.

Step 5: Ending and exploring additional needs and further sources of help

In the last step, more need for help is discussed, needs that have been identified during the previous steps. It could be the relative who needs more help within a specific area, for example training in new coping strategies or help with issues around health or financial problems. It can be the person who uses drugs who need more help, and it can be both.

In the last session it is particularly important to summarize and convey hope for the future. The relatives can often themselves continue to take control over the direction of their lives after this brief intervention. To get the possibility to discuss pros and cons of different ways of handling difficult situations that emerge when a family member is using alcohol or other drugs is a very important intervention. The researchers have found that such interventions are useful for relatives if approached with

the attitude that the relatives are competent persons with the capability to handle crises and difficulties that emerge in life. Not taking advantage of the family's resources can increase the suffering and societal costs of addiction.

References

- Copello, A., Tempelton, L., Orford, J., Velleman, R., (2010). The 5-step method: Principles and practice. *Drugs: Education, Prevention and Policy*, 17(S1):86-99.
- Orford, J., Copello, A., Velleman, R., Tempelton, L. (2010a). Family members affected by a close relative's addiction: The stress-strain-coping-support model. *Drugs: Education, Prevention and Policy*, 17(S1), 36-43.
- Socialstyrelsen, (2013). Stöd till anhöriga – vägledning till kommunerna för tillämpning av 5 kap.10 § socialtjänstlagen. Stockholm: Socialstyrelsen

testimony

STAY CLOSE:

A Mother's Story of Her Son's Addiction

Libby Cataldi

Author of STAY CLOSE: A Mother's Story of Her Son's Addiction, published in May 2009 by St. Martin's Press (NY) and in May 2010 by Rizzoli (Milan).

My son is a heroin addict. He wasn't born this way, or maybe he was and the addiction was there, hiding, all through his childhood years. That's the thing with addiction: No one knows the cause. I have spent a lot of time trying to ferret out the answer to why one son is an addict and the other isn't, but I've given that up. I now spend my time learning about how best to support my son through his recovery. My son is clean for eight years today, sober and productive after fourteen years of addiction. This story is about addiction, but more importantly, it is about hope.

Addiction isn't going away. At one of my son's first rehab centres, a place in Maryland called Father Martin's Ashley, the counsellors told me that for every one addict at least four other people are affected. Addiction attacks the family first, then moves outward, affecting extended family and close friends: a cousin, a husband, a sister, a co-worker... None of their lives will ever be the same. In our home, addiction took on the characteristics of another living member:

demanding attention, caused trauma, concealed itself, never went away and never will go away. My son will always be an addict. There is no finish line.

Every addict has a mom and dad. We parents suffer as we see our children dying a little at a time. We want to save them, jump into the fire, grab them and bring them to safety, but we can't. Tell that to a parent, that he or she can't save her child: the pain is incomprehensible. But as Jeff said, "I know the writing of the book was hard, Momma, but the living of it was harder."

When I first started attending Al-Anon Meetings more than fifteen years ago, I sat in on three different meetings before I found a group where there were other parents of addicted children. At that time, we were in the minority: we were only four parents out of more than twenty people. These days, when I attend meetings, I find that most members of the group are parents. It seems as if the number of young people who are addicted to drugs has increased greatly. Words like heroin, crack, and crystal

meth are common. Sadly, Jeff's story is not the exception.

Many experts claim that "an addict has to hit his bottom," but I could never gauge where Jeff was on his descent. Alcoholics Anonymous defines addiction as a progressive and fatal illness, and I saw that Jeff's bottoms got continually worse. Each time he fell lower and faster until I feared he would die. With every new low, I would rush in thinking, "This is the time. This is his bottom. Go, Lib."

The recovery centres, the psychologists, Jeff's arrests, and all his many interventions must have made a difference, but I don't know how much of one. Jeff was in rehab programs, jails, and many kinds of institutions. He lived on the streets and the beach; he was beaten up. He stole, had things stolen, and ultimately he pawned almost everything he owned. He lost friends and destroyed his veins. At times, my articulate, ambitious son could hardly put two words together. I banished him from the house. I threatened, cajoled, pleaded, wept, and wrung my hands. I punished, screamed, fought, ached, had nightmares, stuffed my emotions into my belly and suffered in silence. His father and I followed the advice of experts and friends and even people who knew nothing. We wrote intervention letters, paid for psychologists, recovery centres, and medicines. His father, brother, and I were like a starving family ready to latch onto anything that might alleviate our pain and Jeff's hunger for drugs. I would have sold my soul for his recovery, made a bargain with the Devil himself, but all this was to no avail. Addicts live a tortured existence. Jeff has told me that he was filled with shame, regret, self-blame, and self-loathing. He says that addicts, even those who can't mouth these words, hate themselves for what they are doing, despise the destruction they are causing, but they can't imagine a life without drugs. About the final days of Jeff's last descent, he wrote, I chalked death up to an unfortunate repercussion, not a deterrent. I couldn't imagine my life without drugs in it. I didn't want to die, but I didn't want to stop using. They say that addicts aren't afraid to die, they're afraid to live without drugs.

My family knows well the Hell of addiction,

but we know only our own Hell. Those who love addicts suffer. The addict suffers. No one is immune. In our family, we each handled our grief differently. Jeremy, the younger brother by twenty months, held things inside, caught in that gap between loving his brother and hiding the truth and loving his brother and telling the truth. How does a brother handle these conflicted loyalties? Tim and I suffered and responded in our own divergent ways. He became quiet, withdrawn; his absence spoke for him. I whirled into action, trying anything that I thought would help, running from one possible solution to another. Grandparents, uncles, aunts, cousins, friends, no one knew what to do. During one Christmas, when neither son came home for our large Italian family gatherings, my brothers didn't know what to say. They didn't even know whether to invite me to the festivities. The cousins were confused; could they ask about Jeff or would it be kinder to leave him out of the conversation?

It is time to bring addiction out of the shadows and into a place of healing. There is great shame associated with this illness, I know. However, I also know that when I was young, we didn't talk about topics like breast cancer or homosexuality. Today we talk openly about these things. We name the issues and try to face them.

Jeff, Jeremy and I are committed to carrying the message of hope and compassion, of reaching out a hand to help another family, another parent, maybe even another brother. Jeff says this is his Twelfth Step: Having had a spiritual awakening as the result of these steps, we try to carry this message to alcoholics (and addicts), and to practice these principles in all our affairs.

Every day we're grateful. Every day, in the very marrow of our bones, we give thanks that today Jeff is okay, that he is alive and productive, that he has hope for creating a better future. But we know that we only have today.

Jeff once asked me, "Never quit believing, OK, Momma?"

I won't quit believing, Jeff.
Never.

testimony

STAY CLOSE:

A Therapist's Story

Patrick MacAfee, Ph.D.

Dr. MacAfee has been working in the fields of addiction and recovery for forty-five years with individuals, couples and families. He resides in Riverside, California.

Addiction: A Legitimate and Treatable Malady

In the world at large, relatively few people respect the addictive condition as a legitimate life-threatening illness. Rather, there is general disgust not only for addiction, but for the addicts themselves. This disdain and contempt permeate society down to the level of the individual family. These attitudes internalize and re-emerge from within addicts themselves, honing their stealth, duplicity and their self-loathing, which is already established in their identity. This condition serves to permeate their malady even further.

I am no apologist of or advocate for drug use. I am writing this from the perspective and voice of a clinician having worked with countless individuals and families through difficult times, some with happy outcomes, others with bad endings. In all cases, these families suffered unbearable pain along the way. This writing is born from my own education and being taught by this population.

What I have learned is that it is difficult to inform and educate the public; however, the bias, prejudice and loathing of the addict are not insurmountable. From brain research and

the dedication of the recovering community, there has been an emerging understanding of the depth of despair of the addict and an understanding of addiction as a disease. The medical and psychological communities have become increasingly aware of addiction's serious hold and recognize it as a legitimate, life threatening and treatable illness. However, it seems to me that few people outside these professions really comprehend the depth of the problem and understand addiction as an illness. This is a worldwide problem.

Many people look at the addict with contempt and disgust. This attitude is fostered by society at large and seeps into the level of the family and to the addict himself. The shame of addiction is as toxic as the substance, perhaps more so, because it is always present. Being drawn into the addictive culture seems a friendly calling, one that is filled with a promise of permanent soothing and a powerful sense of well-being. As one patient observed, "No addict ever intends to end up where they're really going."

For years, the criminal justice system

has dictated the rules in dealing with addiction. Already overburdened, stretched and burned out, they are given the task of "correcting" this condition. Meanwhile, the addict is placed out of sight as a charge of the state. So how do we, as treatment professionals, deal with the addict and his addiction? With care, respect, compassion and acceptance. We help the addict to see the communalities of the condition and to help him clarify and assess the consequences of the addiction, without shaming him. We need to hear more from the emerging recovery community. We need to define addiction as a public health issue.

The families in this nightmare are the ones often left out. While families often do not know where to turn when this crisis emerges in their midst, there is an extraordinary body of literature and services available. Stephanie Brown tells us that the pathology of addiction lies in the defence structure, and that we must look at the family structure as a traumatic environment (1985). Alan Rappoport tells us that safety is the organizing principle of counselling and psychotherapy (1997). All too often these simple insights are overlooked. The need for safety as the organizing principle is essential to addictive disorders. Because addicts are defensively oriented, we will not have the impact we desire if we attack the individual with a jackhammer. Instead, we will drive the condition underground, where addiction does its best and dirtiest work.

The family adapts to increasing dysfunction, becoming inured to increasingly chaotic behaviour. The polarization is defensively based. No-talk rules abound, and the family simply adapts. The organizing principle in the family becomes the addict's using, all covered up with silence and a defensive orientation. The enforcement of the no-talk rule has a distorting influence on all facets of the family function.

This is the simple fact: substance drives the person, and families grow ever more dysfunctional and stressed as they try in vain to cope with addiction using the tools that society has given them to deal with this condition. What is needed is an open discussion where we begin to view the individual addict as a person, a real

human being having been snared in the trap of addiction, instead of marginalizing the person. We need to reframe addiction as a legitimate and treatable malady.

testimony

Simon (Sweden)

Trygga Barnen Foundation

For as long as Simon can remember, he has had a strange feeling that something isn't right at home, but hasn't been able to identify exactly what is it. Simon is 14 years old and has two younger siblings, Lisa (10) and Agnes (5). They live together with their mother and father in a big villa just outside of Stockholm. His mother is working as a teacher at a local primary school and his father is working as a lawyer at a small law firm in the city. Simon once visited him at work and got lost in the long corridors. He liked the people there. They were all very friendly, some were funny and made jokes all the time and one of them knew that Simon did well in school and enjoyed sports. He loved the few moments he had alone with his father, like when they spontaneously went to Disneyland two years ago.

Usually his father is preoccupied with work, both when at the law firm and at home. But lately, he'd spend more time in the house. He also grabbed Simon so hard by the arm that it left a bruise. The day after that incident (which happened on a Friday evening), his father took him fishing and on the way back home bought the new smart phone Simon had been asking for. Simon has always been keen on spending time with his father, but now that he was finally working less, Simon doesn't feel happy about it. Friends, neighbours and relatives would all

describe Simon as a happy, active yet focused, clever young man with lots of friends and a good sense of humour, appreciated by both kids and adults. In school, most things are perfectly fine. Simon is popular among classmates and respected. In order to gain such respect, he'd had to bully some of the weaker children. In fact, he did it so subtly that no grown up would ever notice. Keeping actions, information or feelings away from any adult has become a sport to Simon. It keeps him busy.

At home, he often helps his siblings. Sometimes, their mother forgets important things like reminding Agnes to brush her teeth before bedtime. And at night, if Lisa has nightmares (which still happens quite often), she'll run into Simon's room rather than to their parents. As you understand, Simon has a big responsibility as their older brother.

Simon is not sure why, but lately, he has started to feel somehow uncomfortable, worried, sometimes almost afraid. Actually, it has escalated, now bothering him daily, rather than just on Fridays, Saturdays and holidays. It's a heavy, even painful, extremely disturbing feeling and yet diffuse, because he can't put his finger on what it might be. But he knows it's certainly not normal and probably not really physical, so it's definitely something he shouldn't mention to anyone, especially not to any grown-up (adults

tend to make bad things worse). And when he plays football or computer games, concentrating in school or going biking with Alex, it disappears and he feels normal again.

On a rainy September morning, when Simon is late for class, he finds a young woman being introduced by the sports teacher. When the woman starts speaking, he's not sure what it's about, at first, but when he realises that she's describing a family situation that is so much like his own, it's as if someone is squeezing his chest using more and more power, until he can hardly breathe. It's as if Simon's frozen in his chair, neither daring nor being able, it seems, to move. After a little while, he calms down and finally, relief has replaced the horror he just felt. Listening to another's story, so similar to his own, yet very different, is a new experience and something he certainly wasn't prepared for.

"I always thought that I was alone in experiencing what I did, but there are many sharing these experiences. It was important for me to realise that I wasn't alone and that is the reason I'm here, talking to you guys today," she says. It makes him wonder how many others like him there might be. Strangely enough, that particular thought never occurred to him before...

He must act normal, so that no one suspects anything. Simon is good at that, normally. But this isn't a usual situation and he finds it harder than ever to keep up appearances. At home, the situation is tenser than ever. Simon's father has taken time off work. For how long, Simon doesn't know and doesn't dare ask either. His father now stays in the house for several days without going outside. His temper has worsened.

Simon's mother is quieter than before and has no patience with his siblings. Simon himself rarely sleeps throughout the night. Months pass and it isn't until the day before Christmas Eve, that Simon finally does what he's intended to do ever since that rainy September morning.

He doesn't know how to start the conversation, so he just writes a simple "hello." Then he adds, "My father is drinking all the time and acts strange, and my mother is like a zombie most of the time. It's kind of bad sometimes." Then he waits. Minutes seem like hours, until there's a

message back, saying hello, reassuring him that he's anonymous and that he's not alone. After chatting a few times over the coming weeks, he knows a lot more than before about the cramp in his stomach, the disease called alcoholism, which he now strongly suspects that his father is suffering from, and the fact that this is never any child's fault.

Six months later, Simon is enrolled in a self-help group with other teenagers (all girls except one other guy). On the way to one of these meetings, he realises how ridiculous attending a self-help group would have seemed to him a month ago. He'd have recommended something like this to his mother (now that he knows what a self-help group is), sure, but certainly not for himself.

At first, he didn't want his mother to know about all this, but after a while, he's convinced that it might make things easier to tell her, which, finally, he does one afternoon. She cries and hugs him and supports his decision. After that, things are different. Or rather, he feels different. Most things actually stay the same. At least his father does. Several meetings with a therapist later, his mother gives his father an ultimatum: "Stop drinking or I'll leave you." Simon wasn't supposed to hear this, but he's gotten very good at eavesdropping on his parents' conversations. His father had said he'd stop but wasn't able to keep his word.

Finally, Simon speaks to Alex (the young woman) about important things. It turns out they share similar experiences. Alex's mother had even forgotten Alex's 14th birthday (Simon can't imagine that happening). Alex's father also drinks a lot, but never throws up or become aggressive (like Simon's father does increasingly often). Instead, he'd just fall asleep on the sofa. In retrospect, it's easy for Simon to see that talking about these issues is better than keeping it all to himself. This is what Simon wrote in the self-help group evaluation form at the end of the semester: "By joining the group, I got a lot of support that I had never had before, without playing the clown. It made me realise that none of all this craziness going on at home is my fault, plus I deserve better! This group has made me feel OK again, even if things are still pretty much the same at home."

Now you might wonder: if things stayed pretty much the same, then what good did talking do? Well, for Simon, like for so many other children, teenagers and young adults, it makes a huge difference knowing that you aren't alone, that there's hope and there's support available. Without someone trustworthy to turn to, negative ideas, feelings and actions may take over and in the long run destroy not only this person's wellbeing, but others' too. Please remember: Simon's story is neither unique, nor extreme.

At Trygga Barnen Foundation, we have a policy to never expose the identity of any of the children or youth that we meet. Thus, Simon is a fictitious character, although his experiences represent the situation of many children and youth encountered by Trygga Barnen Foundation.

Chapter 5

Hearts and Minds in Addressing the Drug Problem

“There is a need for a comprehensive approach to drug-related harm, with a strong focus on prevention and early intervention, as well as control measures, health services, treatment and rehabilitation for users. Drug problems are particularly intractable in the nexus of mental health problems, crime, deprivation and social exclusion. Problem drug users often need comprehensive services including health, housing, education and work. The essential point here is that drug addiction is not only a health problem, nor only a crime problem.”

case study

The Swedish Drug Policy Experience: Past to Present

Per Johansson

Secretary General, National Association for a Drug-Free Society (RNS)

Sweden's history of drug abuse began in the late 1940s when abuse was limited to a few bohemian circles in Stockholm. As more young people were introduced to nonmedical drug use in the early 1960s, Sweden became one of the first countries in Western Europe to experience a large-scale drug problem among its population, creating the Swedish drug epidemic.

At this time, the illegal drug market in Sweden was dominated by stimulants of the amphetamine type. Because these drugs were seen as non-addicting and had widespread clinical use at the time, it is not hard to understand why many Swedish physicians were attracted to the idea of prescribing drugs in order to keep individuals from obtaining them through illegal sources. This idea was quickly adopted by some health and law enforcement authorities. Between 1965 and 1967, nonmedical drug users in Stockholm could obtain their favorite drugs (including not only stimulants, but also opiates) with a prescription from a handful of doctors who took part in a special program sanctioned by the National Board of Health. Initially, around 110 drug-addicted patients were enrolled in the program, for whom more than 4 million doses were prescribed. Out of those, about 3.4 million

doses were stimulants; most of the rest were opiates. Unsurprisingly, a large percentage of these legally prescribed drugs were resold or given away, flooding the city with drugs and spreading the drug epidemic in Sweden rather than limiting it as the program's sponsors naively expected. This legal prescription experiment came to an abrupt end in June of 1967, two years after it started, following the tragic and widely publicized death of a 17-year-old girl who had been offered drugs by one of the patients in the prescription program.¹

As a psychiatrist working with the Stockholm police, Nils Bejerot was one of the few physicians in Sweden at this time with firsthand experience of drug addiction. Bejerot's work with criminals since the 1950s in Stockholm gave him a unique perspective with regard to the National Board of Health's drug policy experiment. He tried in vain to stop this legal prescription experiment by offering his expertise and experience to the authorities. Out of frustration, and in the hopes that this initial experiment would never be restarted, in 1965 he initiated a study of drug injection marks among arrestees at the Remand Prison in Stockholm. He later linked the changes in the frequency of

“During those years in Sweden it was legally safe for drug users to possess up to 20 grams of hashish for personal use.”

injection marks to the changes in the Swedish drug policy.² In 1969 he founded the National Association for a Drug-Free Society (abbreviated RNS in Swedish) in order to promote the idea of restrictive drug policy by educating both the public and his medical colleagues.

Bejerot's views on drug policy initially were not universally accepted in Sweden. There was a strong counterargument based on the belief that medicalizing nonmedical drug use would reduce not only drug use but the many serious and even fatal problems that drug use created. This view was attractive to many Swedish health officials because it appeared to be more compassionate and humane. During the 1970s the debate about drug policy in Sweden picked up momentum gradually. Official drug prevention policy at that time directed the police to concentrate on trafficking and smuggling rather than arresting drug users for drug possession and street peddling, on the presumption that this would make it more attractive for them to voluntarily seek treatment and other help from social services providers or hospitals. During those years in Sweden it was legally safe for drug users to possess up to 20 grams of hashish for personal use. Naturally the street pushers never had more than this legal limit. This legal practice was criticized by Bejerot and RNS for several years. Public debates, demonstrations and media debates were organized and finally achieved results. The Swedish Prosecutor General issued a directive to all prosecutors in January 1980 that waivers of prosecution for small amounts of narcotic drugs would not be allowed any longer. Overnight, this announcement changed Swedish drug policy as a practical matter. It was the tipping point, when Swedish drug policy swung from being

a permissive to a restrictive drug policy. The restrictive policy has continued to the present time.³

Based on this newly articulated drug policy, the Swedish police changed its priorities to focus on small crimes of possession, making small-scale trafficking of drugs a much riskier business. Unsurprisingly, the number of drug crimes rose initially while at the same time drug use surveys showed a consistent decline all through the 1980s. In those years the economy in Sweden was good. The city councils were generally willing to fund drug treatment and anti-drug prevention activities in schools. The general debate in society about drug policy receded as all parties adopted the restrictive policy, which was an important inspiration to everyone working professionally with the drug problem.

In 1983 the Supreme Court of Sweden ruled that the Narcotic Drugs Act did not cover the act of consuming illegal drugs. Simply speaking, it was forbidden to have any drug of abuse in your pocket or in your possession in any other way—but to smoke, eat, inhale or inject drugs was not illegal. The following year RNS began campaigning to make the consumption of illegal drugs itself a crime. An opinion poll in 1984 showed that 95% of the public were in favor of this change in the law. The debate went on for several years, engaging all of Sweden's political parties in the Parliament. In 1988 the Swedish law was changed so that consumption of narcotic drugs was made illegal. Initially the law did not allow the police to take a urine or blood test as evidence of use. The law was rewritten in 1993 so that the police could use drug tests for evidence of drug consumption.³

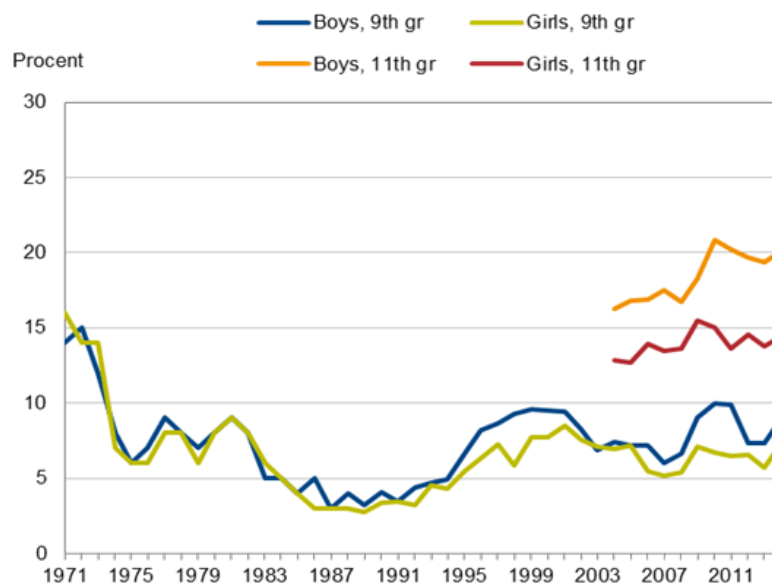
If the 1980s were the Golden Age of drug prevention in Sweden, then the 1990s were the Dark Age. Sweden was hit by a severe economic crisis in the early part of the decade, a crisis that took the rest of the decade to sort out. Virtually all segments of Swedish society experienced an economic decline, or ground to a halt. Since the drug problem, especially among the young, was at such a low level at the beginning of the 1990s, drug policy did not receive much attention from those with political power. As a consequence,

anti-drug efforts declined in the 1990s, and drug treatment became much harder to obtain. For these same economic reasons, schools did not focus on the drug problem in the 1990s. It is not surprising that drug abuse levels in Sweden went up during this decade, although they never again reached the levels seen in the late 1960s and early 1970s. Still, by the end of the 1990s drug abuse was again serious enough for the government to take action to rectify this trend. In 1998 the government appointed a Narcotics Commission which put forth many suggestions for action and change. With the general debate about the drug problem heating up, funding for various types of projects was made available by the government. During the first years of the new century the rising trend in illegal drug use rates among 9th-graders (age 16) was broken and is now fluctuating at a comparatively low level. New figures show a worrying trend among 11th-graders (age 18), which is discussed widely in the drug policy debate in Sweden.

There are many in Sweden who believe

there are further challenges in the nation's efforts to curtail illegal drug use. However, with unusually low rates of drug use, Sweden compares very favorably to other developed nations. Since 1971 the Swedish Council for Information in Alcohol and other Drugs (CAN) has administered drug use surveys among teenagers during the year they have their 16th birthday. The model used in these surveys was adopted from a European survey conducted in 1995 in 26 countries, the European School Survey Project on Alcohol and other Drugs (ESPAD). The latest ESPAD survey shows data from 2011.⁶

Figure 2 shows a comparison among self-reported lifetime cannabis and hashish use by 16 year-olds from 35 European countries. The reported drug use of boys can be found in the left-side graphs, while the reported drug use of girls appears in graphs on the right. The average of the reported use of the boys and girls combined can be found as a number to



Lifetime prevalence of illicit drugs among students in grade 9 (primary school) and in grade 11 (secondary school), by gender. Percentages. 1971-2014.

Figure 1. Source: Swedish Council for Information on Alcohol and other Drugs, CAN, Stockholm.⁴

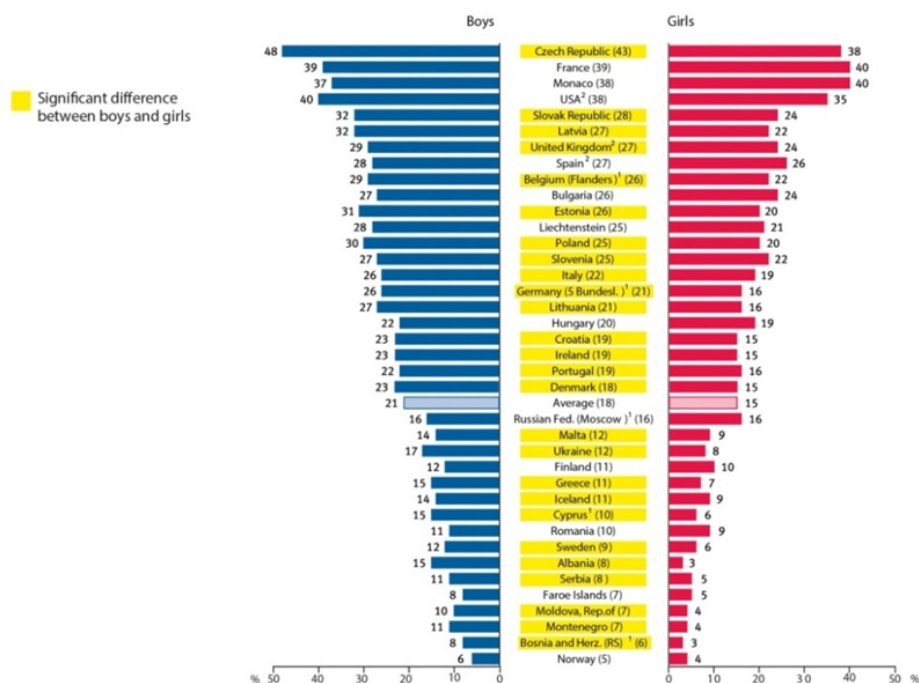


Figure 2. Lifetime use of illicit drugs by 16 year olds, by gender. 2011. Percentages.
Source: The 2011 ESPAD Report, Substance Use Among Students in 36 European Countries. 5

- 1) Belgium (Flanders), Bosnia and Herz. (RS), Cyprus, Germany (5 Bundesl) and Russian Federation (Moscow): limited geographical coverage.
- 2) Spain, United Kingdom and USA: limited comparability.

the right of the country name. The differences in self-reported use of cannabis are very large between the European countries with the lowest and the highest prevalence levels. Several comparisons of other countries with Sweden are of interest. There is a striking difference between Sweden and the United Kingdom, even though the modern drug epidemic started at about the same time in both countries and even though both are liberal welfare states with high levels of economic development. In another comparison, it is interesting to note the reported drug use between teenagers in Sweden and in the Netherlands. During the 1970s, Sweden, after a heated internal debate, began enforcing stricter drug laws. The Netherlands in 1976 decided to go the opposite way by passing the Opium Act, making a distinction between the permissive enforcement of soft drug use and a more restrictive enforcement of hard drugs.⁶

It is helpful to consider the impact

of significant change in a country's political structure and the resulting impact on drug policy when viewing these data. For example, a number of these countries endured harsh and repressive experiences of dictatorship. It can be inferred that some countries, such as the Czech Republic, Slovak Republic, Spain and Estonia, having become democratic, include the freedom to use illegal drugs in their concept of freedom. However, this is not a uniform experience, as other countries such as Greece have had a similar historical experience, yet maintain a restrictive drug policy and experiences low levels of drug use among their teenagers. Portugal, which became a democracy in 1974, has adopted a less stringent policy, with resulting reported teenage use approximately midway between the data reported by teens in Spain and Greece. From this ESPAD scale it is possible to infer that the presence of permissive drug policy is associated with the increased prevalence levels of illegal

drugs.

The authors of the ESPAD survey concluded in their summary that in the 2007 data there are apparent associations between the aggregated use of different substances at the country level. In countries where teenagers drink more, they also tend to use illegal drugs more.⁷ A nation's drug policy reflects a cultural set of values, beliefs and behaviors, and its associated laws result in normative actions on the part of its citizens. People, especially young people, adapt quickly to laws that impact behavior related to the use of illegal drugs.

One of the common stereotypes in global drug policy debates is that successful welfare states adopt permissive drug policies as part of their commitment to compassion and tolerance of diversity. Sweden, a country noted for its liberal views, stands out as an exception to this stereotype and offers a model for a more restrictive drug policy, not because it is repressive politically but because it promotes the public health and lowers both drug use and the harms caused by drug use. Unfortunately there is no universally accepted standard model for comparing countries as to the level of their drug problems. The United Nations Office on Drugs and Crime (UNODC) did, however, make a comparison between Sweden and other EU nations in its 2006 report *Sweden's Successful Drug Policy: A Review of the Evidence*. Executive Director Antonio Maria Costa writes in the Preface: "It is my firm belief that the generally positive situation of Sweden is a result of the policy that has been applied to address the problem. The achievements of Sweden are further proof that, ultimately, each government is responsible for the size of the drug problem in its country. Societies often have the drug problem they deserve."⁸

Conclusion

The Swedish approach to drug policy has been restrictive but not repressive, which is an important distinction. The prison population rate (prisoners per 100,000 inhabitants) in Sweden is 57, which is just a fraction of the rate for USA (707) and Russia (467). The rate for The Netherlands is 75, a difference to Sweden many

would think to go the opposite way. United Kingdom has the rate of 148 and Portugal 136.⁹

The focus on the consumer end of the illicit drug market, in line with the analysis Bejerot presented in the late 1960s, is most likely the reason why Sweden's drug policy has been comparatively successful. There is no legal free zone in Sweden when it comes to illicit drugs. The legal consequences are not harsh but they exist and are for real. The debate about drug policy has gone back and forth for over four decades and involved more or less all levels of society. A great majority of public opinion is behind a restrictive and balanced policy that includes law enforcement as well as good access to treatment for those in need of it. However, Sweden is not an island and very much a part of the international community. What the future will bring for us in that respect when it comes to drug policy is yet to be seen.

Endnotes

1. Bejerot, N (1968) *Narkotikafrågan och samhället* (English: *The Drug Problem and Society*). Aldus/Bonniers, Stockholm.
2. Bejerot, N. (1975). Drug abuse and drug policy: An epidemiological and methodological study of drug abuse of intravenous type in the Stockholm police arrest population 1965-1970 in relation to changes in drug policy. *Acta Psychiatrica Scandinavica Supplementum*, 256: 3-277.
3. Hartelius, J. (2008). *Narcotic Drug Control Policy in Sweden: The Post-war Experience*. Fri Förlag, Stockholm.
4. Englund A (2014). *Skolelevers drogvanor 2014 (Drug habits of Students 2014)*. Swedish Council for Information on Alcohol and other Drugs, CAN. Stockholm.
5. Hibell B, Guttormsson U, Ahlström A, Balakireva O, Bjarnsson T, Kokkevi A and Kraus L (2012). *The 2011 ESPAD Report. Substance Use Among Students in 36 European Countries*. Swedish Council for Information on Alcohol and other Drugs, CAN, Stockholm.
6. Olsson, P (1994) *Tre dog, en blev galen*. (English: *Three Died, One Turned Crazy*). Sober, Stockholm.
7. Hibell B, Guttormsson U, Ahlström A, Balakireva O, Bjarnsson T, Kokkevi A and Kraus L (2009). *The 2007 ESPAD Report. Substance Use Among Students in 35 European Countries*. Swedish Council for Information on Alcohol and other Drugs, CAN, Stockholm.
8. United Nations office on Drugs and Crime. (2006). *Sweden's Successful Drug Policy: A Review of the Evidence*.
9. World Prison Brief (2015). International Centre for Prison Studies, <http://www.prisonstudies.org/highest-to-lowest/prison-population-total>

case study

Japan's Success in Coping with Illicit Drugs in the 1950s

Bert Edström

Senior Research Fellow, Institute for Security and Development Policy

Japan is a country well-known for its well-organized society, economic successes, advanced technology, exquisite food, and sophisticated art. Yet, one of its remarkable successes seems to be largely unknown to both present-day Japanese and the outside world: the fact that Japan is one of the few countries that has been able to cope with, and eradicate, a drug epidemic. In Japan, a serious methamphetamine epidemic emerged in the wake of the country's defeat in World War II. Society was in chaos, the economy in ruins and the industrial and social infrastructure in shambles. The bottomless disaster that the Japanese faced became the breeding ground for a wave of drug abuse that evolved into an epidemic. In a sense, this epidemic was quite unexpected. While opium and other narcotic drugs were certainly not unknown to the Japanese, their country had so far been spared widespread abuse.

Opium has been used in Japan for medicinal purposes since 1722, but was strictly controlled. Opium peddlers faced the death penalty according to a law introduced in 1742. In the mid-19th century, when Japan's door was

swung open to intercourse with the west by American gunboat diplomacy, Japan succeeded in keeping drugs out. The two Opium wars (1839–42 and 1856–60) had demonstrated to the horrified Japanese how the colonial powers were able to use the monopoly of opium trade both to suppress and enslave the Chinese people and to enrich themselves. In 1868 new political leaders came to power in Japan and succeeded in continuing the country's strict opium policy despite pressures from foreign powers. The laws restricting use and distribution made opium abuse virtually non-existent in Japan; opium continued to be used on a limited scale and only for medicinal purposes.

Japan's new leaders embarked on a policy of expansionism and imperialism that they had learnt from the Western powers. Gradually, foreign lands came under Japanese control. In these areas a different opium policy than in the Japanese homeland was introduced. In Taiwan, an opium monopoly was established by the Japanese. In Chinese treaty ports, drugs were smuggled by carpetbaggers under the protection of extraterritoriality. In Manchuria,

Japan adopted a policy that permitted, organized, and encouraged drug trafficking. Cultivation and marketing were used to generate revenues for the Japanese government. Proceeds were used to finance collaborator states and undercover operations facilitating Japanese aggression.¹ In China opium smoking was supported by the Japanese as a means of enhancing servility and control and used as a tool to ensure that the population was unable to put up resistance.² Thus, Japan pursued a bifurcated policy of strict control domestically and state-initiated excessive use of opium in overseas Japanese-controlled areas.

A significant change took place during World War II. When the Japanese military learned of German research on the positive effects and benefits of methamphetamine, they began to produce large quantities of the drug. Tablets blended with green tea powder were stamped with the emperor's crest and provided to pilots and signal corps in order for them to stay awake and alert. Methamphetamine became known as "the drug to increase the fighting spirits," *senryoku zokyozei*.³ Methamphetamine was also put onto the market as a medicine in 1941, and more than twenty Japanese companies produced and marketed methamphetamine in the 1940s.⁴ It became generally known as *hiropon*, the trademark registered by The Dai-Nippon Seiyaku Co.⁵ *Hiropon* is the japanized version of Philopon, a word based on the Greek words *philo* (love) and *ponos* (labor) and is an indication on how the new drug was looked upon.

"...in a situation when stimulants were cheaper than alcohol, the effects of the regulations were limited, and abuse continued to spread."

When the war ended, the situation was disastrous in Japan. In the prevailing confused conditions, large amount of methamphetamine, which had been produced and stored by the military, reached the market, despite efforts by the Occupation authorities to keep control over drugs. With appalling working conditions (for the lucky ones who had jobs) and widespread starvation, many found relief in alcohol and drugs.⁶ At this stage, people as well as the authorities were unaware of the adverse effects of the drug. That users could become addicted was unknown. However, it began to dawn that soldiers and workers, who had been given methamphetamine in order to fight fatigue and hunger and increase physical endurance, had become addicted. Reports began also to appear that repatriated soldiers had returned home with drug habits.⁷

What one saw was something new to Japan – the country's first encounter with serious drug abuse.⁸ The first abuse cases reported were noted among entertainers, artists, musicians, writers and students; later, vagrants, the unemployed, and those who lived under marginal circumstances were added. Especially noticeable among users were juveniles which drug specialists speculated was a result of their pessimism and pleasure seeking.⁹

The deaths of two celebrities in 1948 became a warning signal. The famous comedienne Miss Wakana and the popular novelist Oda Sakunosuke died in ways that implicated use of *hiropon*. Their cases alerted the Japan Medical Society to the sudden poisoning that it was suspected methamphetamine use could result in.¹⁰ It made the Ministry of Health designate *hiropon* as a dangerous drug and later set an age limit for buying. However, in a situation when stimulants were cheaper than alcohol,¹¹ the effects of the regulations were limited, and abuse continued to spread. The frightful physical and mental conditions of addicts and increasing crime rates were a great concern to the public. As a result of the intense debate in media that ensued, the Stimulants Control Law was introduced in May 1951. The import, manufacture, trafficking, receipt, possession and use of stimulant drugs were criminalized.

The maximum penalty was set at three years' imprisonment.¹²

The Stimulants Control Law came into force in June 1951. Subsequently, 17,528 persons were arrested for stimulant offences that year. However, the new law did not curtail abuse. The number of arrested, the amount of confiscated drugs and the number of arrested addicts continued to increase. One also saw an unexpected result of the law. Its introduction "rather than curbing the drug problem, simply increased the role of organized crime (*yakuza*) in drug trafficking."¹³ The production and distribution of methamphetamines went underground and were taken over by the *yakuza*.¹⁴ Production facilities were built all over the country by gangs and distribution networks were also established by them. By supplying drugs to abusers, their number had increased five-fold within three years after the legislation had been adopted.¹⁵ According to a national survey of drug consumption practices conducted by the Ministry of Welfare in May 1954, it was estimated that 200,000 persons were mentally disordered as a result of methamphetamine, 550,000 were abusers, and over two million had used methamphetamine.¹⁶ It was clear that Stimulants Control Law had done little to lessen the incidence of drug addiction.

What became a divide was a murder case in April 1954. A ten-year old primary schoolgirl was viciously murdered by a 20-year-old unemployed man, who turned out to have used twenty to thirty ampoules of *hiropon* daily for two years. This murder case was widely covered by newspapers. The debate that ensued soon boiled down to the report that the reason for the murder was not ill will on part of the suspected murderer but *hiropon*.¹⁷ This incident and other murder cases committed by addicts upset the general public, and a nationwide movement against the drug was initiated. As a result, the 1951 Stimulants Control Law was amended in June 1954. Harsher penalties for stimulant offences were introduced, i.e. terms of imprisonment of up to five years for a first stimulant offence and seven years for recidivists and traffickers. Also the Mental Hygiene Law was amended so that drug-addicted persons

with symptoms of psychosis could be placed in compulsory treatment in mental health care facilities. Furthermore, in 1955, it became compulsory to send abusers to mental hospitals.¹⁸ The same year, the Stimulants Control Law was amended so that it covered also intermediates and precursors of stimulants.

A Comprehensive Anti-Drug Program

The serious nature of the drug abuse that had evolved was seen by authorities to necessitate more counter-measures. Apart from the above amendments of laws, a set of measures was introduced to counter drug abuse. What was actually a comprehensive package of measures was instituted.

Police anti-drug work was intensified. Trafficking was interrupted by arrests of illicit manufacturers and traffickers.¹⁹ Police crackdowns against clandestine laboratories and distributors took place, and if foreigners ran them they were deported. Harsher penalties made it possible for the police to incarcerate members of criminal gangs for much longer than before, which had the effect of cleaning the streets of gangsters involved in trafficking.

To coordinate the functions of the governmental agencies in the work against drug abuse, a new national body, the General Headquarters for Promotion of Policy Against Stimulants, was established.²⁰ It was a public advisory body and liaison between state and society with local headquarters in 36 of Japan's 47 prefectures. The Headquarters coordinated the anti-drug efforts of law enforcement agencies, schools, and the private sector and became a centre for the work against drugs.

The new Headquarters began a massive propaganda campaign for the eradication of methamphetamine. Propaganda materials were produced and distributed throughout Japan. Its prefectural headquarters arranged lectures and round-table conferences, distributed posters, drawings, films, slide shows, pamphlets, and leaflets, and staged campaigns in adult community centres, welfare offices, prisons, and in businesses and factories where

“The most important lesson is that it was the comprehensive battery of measures and actions that worked.”

methamphetamines were likely to be abused. Anti-illicit drug sentiments were drummed up in the population by the campaign. Public understanding of abuse, to the degree it still remained, was eradicated and voices for harsh measures were prominent.

A counsellor system for illicit drug addicts was also established. It was based on the view that informal control through social groups, e.g., family and neighbourhood, is essential for success in the work against criminality related to illicit drugs.²¹ In order to help addicts reintegrate themselves into society, citizen volunteers served as counsellors. The task assigned to them was to promote rehabilitation. Addicts were counselled at their houses and workplaces and given advice about treatment. In order to improve employment conditions, employment offices were contacted.²²

Last but not least, drug-treatment programs were introduced, so that addicted persons with symptoms of psychosis could be placed in treatment programs.²³ However, the number of arrests decreased considerably after 1954. The result was that only a few addicts were actually confined for compulsory treatment.²⁴

The effects of the battery of measures and actions toward stimulant abuse were seen immediately. In October 1954, four months after the amendment of the law, there were nearly 6,000 methamphetamine-related arrests: 46 per cent of which were for possession, approximately 28 per cent for buying or selling, and nearly 22 per cent for using.²⁵ The result was that after 1954, the top year, with 55,664 people arrested for drug-related offences, the numbers of methamphetamine-related arrests fell sharply – 32,145 in 1955; 5,233 in 1956; 803 in 1957

and 271 in 1958. In fact, the decrease was so drastic that the problem of methamphetamine abuse and dependence that had evolved after the war was actually put to an end in Japan.²⁶ It took decades until it re-emerged but as a long-lasting effect of measures taken in the 1950s, abuse of illicit drugs is rather modest compared to most other Western countries.

The Lessons to be Learned

The measures taken in Japan targeted both the demand side and the supply side of drug abuse. Demand was brought down by stricter criminal penalties and compulsory hospitalization that made the price to be paid heavy if a person was caught engaging in drug abuse. The government-initiated campaign was a move in educating or, rather, indoctrinating the people about the frightful physical and mental conditions that awaited addicts. The Japanese are generally law-abiding, and the stigma attached to using illicit drugs, which is a criminal activity, contributed to making people abstain from engaging in such activities. To bring down supply, intensified police crackdowns against clandestine domestic laboratories and rounding up of distributors, combined with much heavier sentences, turned out to be an effective means to lower the propensity for engaging in abuse. Furthermore, drug addiction was treated as if it were a contagious disease. A key idea behind the way those arrested for drug offences were treated in Japan was the belief that “segregation is the only useful and effective way of treatment and it also gives a chance of self-insight into the human life of each individual confined.”²⁷ With the much heavier penalties that people arrested for drug-related crimes faced, the period of incarceration became longer and thus the period when others would not come into contact with abuse and abusers and risk being “infected.”

Thus, there are important lessons for other countries to learn from the Japanese way of handling methamphetamine abuse in the 1950s. The fact that it took more than a decade for illicit drug abuse to re-emerge is noteworthy. The most important lesson is that it was the comprehensive battery of measures

and actions that worked. More so, the Japanese anti-drug campaign shows the importance of information. It was so effective that its effects have been enduring. The campaign taught the Japanese that once you start using methamphetamine, you are doomed to end up in a disaster. According to a poll carried out by the Japanese government in 2006, 70 percent of the respondents accepted this view as true; furthermore, 98.3 percent of respondents found methamphetamine terrifying.²⁸ Thus, according to this poll, a majority of Japanese agree that once you begin to use illicit drugs, it's game, set, and match for the drug.

Endnotes

1. Eguchi Keiichi, *Nitchū ahen sensō* [The Japanese-Chinese opium war] (Tokyo: Iwanami shoten, 1988).
2. Bob Tadashi Wakabayashi, "'Imperial Japanese' Drug Trafficking in China: Historiographic Perspectives," *Sino-Japanese Studies* 13:1 (October 2000), p. 5.
3. Tatetsu Masanori, "Kakuseizai chūdoku" [Stimulant drug intoxication], *Sōgō rinsho* 14:4 (1963), pp. 378–80.
4. Akihiko Sato, "Methamphetamine use in Japan after the Second World War," *Contemporary Drug Problems* 35:4 (Winter 2008), p. 721.
5. Ibid., p. 720.
6. Masaaki Kato, "An Epidemiological Analysis of the Fluctuation of Drug Dependence in Japan," *The International Journal of the Addictions* 4:4 (1969), pp. 615f.
7. Russell R. Monroe and Hyman J. Drell, "Oral use of stimulants obtained from inhalers," *Journal of the American Medical Association* 135 (1947), pp. 909–14.
8. Tadokoro Sakutarō, *Mayaku to kakuseizai: Yakubutsu ran'yō no iroiro* [Narcotics and stimulants: Aspects of drug abuse] (Tokyo: Seiwa shoten, 1988), p. 27.
9. Fukui Susumu et al., "Study on causal factors of methamphetamine abuse," Department of Drug Dependence Research, National Institute of Mental Health, NCNP (1987), as quoted in Kiyoshi Wada, "The history and current state of drug abuse in Japan," *Annals of the New York Academy of Sciences* 1216 (Jan. 2011), p. 63.
10. Satō Akihiko, "Kakuseizai to Nihon: Mō hitotsu no sengoshi" [Stimulants and Japan: Another postwar history], in Satō Akihiko, Seino Eiichi and Yoshinaga Yoshiaki, *Mayaku to wa nani ka: "Kindan no kajitsu" gosennenshi* [What is narcotics? The 5000 years history of "the fruit of prohibition"] (Tokyo: Shinchōsha, 2009), pp. 149f.
11. Masayuki Tamura, "The Yakuza and Amphetamine Abuse in Japan," in Harold H. Traver and Mark S. Gaylord, eds., *Drugs, Law and the State* (Hong Kong: Hong Kong University Press, 1992), pp. 112f.
12. Ibid.
13. H. Richard Friman, "The United States, Japan, and the International Drug Trade: Troubled Partnership," *Asian Survey* 31:9 (Sep. 1991), p. 877.
14. Tamura Masayuki, "Kakuseizai no ryūkō to hōkisei" [The epidemics of stimulants and laws and regulations], *Hanzai kagaku kenkyū* 7 (1982), p. 11.
15. Hemmi Takemitsu, "Kakuseizai ran'yō no shakaiteki sokumen to sono taisaku" [Social aspects of stimulant abuse and countermeasures], in Yanagida Tomoji, Hemmi Takemitsu, eds., *Kakuseizai izonshō* [Dependence on stimulant drugs] (Tokyo: Chūgai igakusha, 1982), p. 116.
16. Tatetsu Seijun, Gotō Akio and Fujiwara Takeshi, *Kakuseizai chūdoku* [Stimulant drug intoxication] (Tokyo: Igaku shoin, 1956), pp. 8–9.
17. Satō Akihiko, *Doraggu no shakaigaku: Kōseishin busshitsu wo meguru sakuho to shakai chitsujo* [The sociology of drugs: Psychotropic substances, etiquette and social order] (Tokyo: Sekai shisōsha, 2008), p. 169.
18. Kato, "An Epidemiological Analysis of the Fluctuation of Drug Dependence in Japan," p. 596; M. Tamura, "Japan: stimulant epidemics past and present," United Nations Office on Drugs

- and Crime, January 1, 1989, http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1989-01-01_1_page007.html (accessed September 12, 2013)
19. Masamutsu Nagahama, "A review of drug abuse and counter measures in Japan since World War II," United Nations Office on Drugs and Crime (UNODC), January 1, 1968, http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1968-01-01_3_page004.html (accessed September 10, 2013)
20. Kato, "An Epidemiological Analysis of the Fluctuation of Drug Dependence in Japan," p. 594.
21. Hans Joachim Schneider, "Crime and its Control in Japan and the Federal Republic of Germany," *International Journal of Offender Therapy and Comparative Criminology* 36 (1992), p. 312.
22. Michael S. Vaughn, Frank F. Y. Huang, and Christine Rose Ramirez, "Drug abuse and anti-drug policy in Japan: Past history and future directions," *British Journal of Criminology* 35:4 (1995), p. 513.
23. Tamura, "Japan: Stimulant epidemics past and present".
24. Vaughn, Huang, Ramirez, "Drug abuse and anti-drug policy in Japan", p. 514.
25. Tamura, "Japan: Stimulant epidemics past and present".
26. Wada Kiyoshi, *Izonsei yakubutsu to ran'yō-izon-chūdoku: Jidai no hazama wo mitsumete* [Dependence drugs and abuse, dependence, intoxication: Observations on the loopholes of an era] (Tokyo: Seiwa shoten, 2000), p. 20; Wada, "The history and current state of drug abuse in Japan", p. 63.
27. Takemitsu Hemmi, "How we have handled the problem of drug abuse in Japan," in Folke Sjöqvist and Malcolm Tottie, eds., *Abuse of Central Stimulants: Symposium Arranged by the Swedish Committee on International Health Relations, Stockholm, November 25–27, 1968* (Stockholm: Almqvist & Wiksell, 1969), p. 160.
28. Cabinet Office, "Yakubutsu ran'yō ni kansuru yōron chōsa" [Opinion survey on drug abuse] (January 2006), <http://www8.cao.go.jp/survey/h17/h17-yakubutsu/> (accessed September 10, 2013)

For further information about the illicit drug problem in postwar Japan, see Bert Edström, "The forgotten success story: Japan and the methamphetamine problem," *Japan Forum* (Aug. 2015), pp. 1–25. DOI:10.1080/09555803.2015.1024710

Chapter 6

Lessons Learned from Tobacco and Alcohol

“

Nevertheless, the vast majority of the world population does not use drugs. Even for the most widely used illegal drug, cannabis, only 4% used it at least once in the past year, compared to over 40% for alcohol.”

case study

What Can Alcohol and Tobacco Teach Us About Legal Marijuana?

Kevin A. Sabet, PhD, and Jeffrey Zinsmeister

Smart Approaches to Marijuana

Legalizing marijuana creates the potential for broad scale development, manufacture, and marketing of marijuana products. To keep stockholders happy, businesses use profits to sell more of their products to generate even more money. Responsible business leaders exercise this power ethically. But if a business sells a product that is addictive and harmful, like alcohol or tobacco, ethics are ignored. We discuss the practices of the alcohol and tobacco industry in order to examine the potential effects of a marijuana industry.

Alcohol and tobacco kill about 80,000¹ and 430,000² Americans each year, respectively. Their industries must not only strive to keep increasing their annual profits, as all industries do, but they also must replace the customers their products kill with new customers every year. What's the most efficient way to do that? Target the less educated. Target minorities. Target the addicted to keep them addicted – 5 percent of the population consumes 53 percent of adult alcohol consumed, while the top 25 percent consumes over 94 percent.³ But the most efficient way to expand the market and

replace users who die prematurely each year is to target children, who are more vulnerable to becoming addicted the earlier they start drinking or smoking (or using other drugs). The National Survey on Drug Use and Health, for example, finds that teenagers who initiate use before age 14 are eight times more likely to become addicted to alcohol, and six times more likely to become addicted to marijuana. When it comes to children, today's initiates are tomorrow's addicts – and lifetime customers.

There is much to be learned about how successful and skilled the alcohol and tobacco industries are at marketing to children. First, they spend an incomprehensibly large amount of money on marketing and advertising. The alcohol industry spent some *\$15 million a day* promoting its products in 2003.⁴ The tobacco industry spent some *\$42 million a day* promoting its products in 2005.⁵ Much of this marketing effort was directed at children with wildly successful results. In 2006, 60 percent of Americans who smoked their first cigarette were under age 18, while 86 percent who had their first alcoholic drink were under age 21.⁶

Alcohol

Research confirms that marketing expenditures work to increase addiction. Studies with middle school children show that exposure to alcohol commercials on television increases both early onset and frequency of drinking.⁷ Exposure to in-store beer displays predicts onset of drinking two years later, while exposure to alcohol ads in magazines and to beer concessions at sports or music events predicts frequency of drinking two years later.⁸ Half of all teenagers report that they could get alcohol within a day; for cannabis, the number is 31 percent.⁹ The World Health Organization estimates that the alcohol industry shifted three-fourths of its marketing budget to indirect promotional activities, including the development of new products that appeal to children such as flavored alcoholic beverages that have low levels of alcohol and high levels of sugar.¹⁰

Beginning in 1980, the first of these flavored alcoholic beverages appeared in the U.S. in the form of wine coolers. These sweet drinks have an alcohol content of about 5 percent, are combined with fruit juices to mask the taste of alcohol, and serve as a bridge from soft drinks to traditional alcoholic beverages. The introduction of wine coolers was followed a decade later by "alcopops," imported from Britain and Australia. Alcopops are a kind of lemonade with a base of either malt, wine, or distilled spirits. The distilled spirits industry entered the alcopops market in 1999 with flavored malt beverages that also contain spirits. Brands like Smirnoff Ice and Bacardi Breezer enabled the spirits industry to introduce low-alcohol content "training wheel" drinks for young, potential consumers of the industry's full-strength products later on. They also enabled the spirits industry to claim alcopops were beer even though they also contained spirits, which pay a higher tax than beer. The researchers cite studies showing that flavored alcoholic beverages are popular with adolescents, especially young adolescents. A 1991 Department of Health and Human Services report showed that 12- to 18-year-olds drank 35 percent of all wine coolers. A Swedish survey of 15- to 16-year olds found that alcopops

accounted for half the increase in alcohol consumption among boys and two-thirds of the increase in consumption among girls between 1996 and 1999. A 2003 report from the German government estimated that fifty percent of all alcopops were bought by adolescents ages 14 to 19.¹¹ Large numbers of American adolescents also consume alcopops: nearly one-fourth (24 percent) of 8th grade students, nearly one-half (47 percent) of 10th grade students, and slightly more than three-fifths (61 percent) of 12th grade students have tried an alcopop.¹²

In fact, alcopops are so successful, they have crowded beer out of the market as young people's favorite alcoholic beverage, and have contributed to a reversal in the sale of distilled spirits. Advertising expenditures for alcopops went from \$27.5 million to \$196.3 million in just two years (2000 to 2002) and consumption increased from 105 million gallons to 180 million gallons in that time.¹³

Children and adolescents are inundated with alcohol promotions on the Internet. A Google search of the words "alcoholic beverages" produced *840,510,000 websites* that promote nine different kinds of alcohol under the broad categories of beer, wine, etc.¹⁴

Tobacco

Researchers have demonstrated that tobacco industry expenditures on advertising and promotion also bear fruit with children. Evidence has emerged that tobacco companies have targeted children as young as 13. More than 20 studies find that children exposed to tobacco advertising and promotions are more likely to become smokers.¹⁵ Being exposed to tobacco marketing (advertising, promotions, and samples) and media (pro-tobacco depictions in films, television, and videos) produces positive attitudes about tobacco use in adolescents and more than doubles the likelihood they will initiate use.¹⁶ Two studies have found that one-third of all adolescent smoking can be attributed to tobacco advertising and marketing.¹⁷ Adolescents who own cigarette promotional items are more likely to initiate and sustain smoking. The more items they own, the higher

“More than 20 studies find that children exposed to tobacco advertising and promotions are more likely to become smokers.”

their risk for initiation. Researchers say the dose-response relationship they found persisted even after controlling for confounding influences, and that their study provides further evidence for a causal relationship between tobacco promotion and adolescent smoking.¹⁸

Multiple studies show that price is a critical factor in determining whether adolescents use alcohol and tobacco. The higher the price, the fewer adolescent customers. The Master Tobacco Settlement Agreement of 1998 included a provision that expressly prohibited advertising and promotion to youth. Internal industry documents never meant to be seen by the public were made public as a result of the discovery process in the lawsuit. These documents reveal that the tobacco industry was completely dependent on getting underage children to start smoking. From the Liggett Group: “If you are really and truly not going to sell [cigarettes] to children, you are going to be out of business in 30 years.” From R. J. Reynolds: “Realistically, if our company is to survive and prosper, over the long term we must get our share of the youth market.” From Lorillard: “The base of our business is the high school student.”¹⁹

The settlement not only ended campaigns like Joe Camel (in which pre-school children become as familiar with Joe Camel as with Mickey Mouse), but also ended marketing to underage children, period. So how did the industry continue to attract young consumers? A Federal Trade Commission Report shows that industry advertising and promotional expenses in 1998 totaled \$6,733,157,000. These expenditures had nearly tripled by 2003 when the industry spent \$15,145,998,000 on advertising and promotion.²⁰ A whopping 71.4 percent of this budget five years after the settlement was devoted to price discounts, defined in the FTC report as

“price discounts paid to cigarette retailers or wholesalers in order to reduce the price of cigarettes to consumers.” No expenditures for price discounts are listed in the report prior to 2002, although it covers all expenditures for 1970 and all those annually from 1975 to 2003. Whether price discounts were traditionally such a small expense that they were included in other expense categories, whether they became so large starting in 2002 that the FTC began listing them in a separate category, or whether the tobacco industry began price discounts in 2002 as a way to circumvent the prohibition on advertising and marketing to youth so that it could reach the underage market is not clear. In 2005, when the tobacco industry had reduced its advertising and marketing expenditures by \$2 billion, the total amount it spent on price discounts rose to 74.6 percent.²¹

These two industries teach us that businesses that sell an addictive drug depend on addicting new users continuously, ostensibly to replace customers killed by their products. They target customers who are addicted and recruit new users by targeting children whose age makes them more vulnerable to developing addiction and becoming lifetime customers. These businesses are motivated, and have the resources, to create new and more addictive forms of their products – without regard for the dangers to consumers and society.

Why Not Legalization? Legalization Could Create “Big Marijuana” Just Like “Big Tobacco”

Other internal documents released when the states sued the tobacco industry in the 1990s reveal that Big Tobacco considers marijuana legalization a golden opportunity.²² “The use of marijuana...has important implications for the tobacco industry in terms of an alternative product line. [We] have the land to grow it, the machines to roll it and package it, the distribution to market it. In fact, some firms have registered trademarks, which are taken directly from marijuana street jargon. These trade names are used currently on little-known legal products,

but could be switched if and when marijuana is legalized. Estimates indicate that the market in legalized marijuana might be as high as \$10 billion annually.”²³

It should come as no surprise that Altria, the parent company of Phillip Morris, recently bought²⁴ the Internet domain names “AltriaCannabis.com” and “AltriaMarijuana.com.”²⁵ If this sounds frightening, it is: Big Tobacco tried for decades to conceal the harms of its products and 100 million lives were lost worldwide in the last century as a result. It is naïve to think the tobacco industry wouldn’t want a slice of the marijuana pie, if not the whole pie.

The alcohol lobby also has skin in the game. Adjusted for inflation, alcohol is taxed at *one-fifth of what it was during the Korean War*.²⁶ Naturally, the alcohol industry opposes any increase in taxes. It also relies on the heaviest drinkers to boost its profits, and it has a major incentive to encourage, not discourage, drinking among children and adults alike (it does—aggressively).

In fact, a commercial marijuana industry has already emerged in medical marijuana states. This industry not only produces an array of marijuana brands with increasingly higher levels of THC, but also has formed a national business association, which is attracting investors. Like the alcohol and tobacco industries, the marijuana industry has created other marijuana products such as marijuana tinctures, creams, and “edibles” like marijuana-laced chocolate chip cookies, caramels, fudge, and an endless variety of other food products.

The point is, the tobacco and alcohol industries—together with the fledgling marijuana industry—are the only examples of government-regulated purveyors of legal, addictive substances, and they offer a cautionary tale of the impact full marijuana legalization will have.

Endnotes

1. Centers for Disease Control. Alcohol Use and Health, Fact Sheets, Alcohol and Public Health. Accessed online January 4, 2013 at <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>
2. Centers for Disease Control. Fast Facts, Smoking and Tobacco Use. Accessed online January 4, 2013 at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/
3. Twitchell, G. (2003). Concentrated Alcohol Consumption by Heaviest Drinkers. UCLA, Accessed online January 2013: http://www.adp.state.ca.us/RC/pdf/Concentrated_Alcohol.pdf
4. Center on Alcohol Marketing and Youth. *Alcohol Advertising and Youth Factsheet*, 2006. Accessed online March 2007 at <http://camy.org/factsheets/index/php?FactsheetID=1>. Georgetown University. Washington D.C.
5. Federal Trade Commission. *Federal Trade Commission Cigarette Report for 2003. Issued 2005. Tables 2A-2C*. Washington D.C. Centers for Disease Control. Alcohol Use and Health, Fact Sheets, Alcohol and Public Health. Accessed online January 4, 2013 at <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>; Centers for Disease Control. Fast Facts, Smoking and Tobacco Use. Accessed online January 4, 2013 at http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/; Twitchell, G. (2003). Concentrated Alcohol Consumption by Heaviest Drinkers. UCLA, Accessed online January 2013: http://www.adp.state.ca.us/RC/pdf/Concentrated_Alcohol.pdf; Center on Alcohol Marketing and Youth. *Alcohol Advertising and Youth Factsheet*, 2006. Accessed online March 2007 at <http://camy.org/factsheets/index/php?FactsheetID=1>. Georgetown University. Washington D.C.; Federal Trade Commission. *Federal Trade Commission Cigarette Report for 2003. Issued 2005. Tables 2A-2C*. Washington D.C.
6. 2007 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, Bethesda, Maryland.
7. Stacey, A.W., Zogg, J.B., Unger, J.B., and Dent, C.W. Exposure to Televised Alcohol Ads and Subsequent Adolescent Alcohol Use. *American Journal of Public Health Behavior*. Volume 28, Number 6, 2004. pp. 498-509.
8. Ellickson, P.L., Collins, R.L., Hambarsoomians, K., and McCaffrey, D.R. Does Alcohol Advertising Promote Adolescent Drinking? Results from a Longitudinal Assessment. *Addiction*, Volume 100, 2005, pp. 235-246.
9. CESAR, adapted from National Attitudes Survey. <http://www.cesar.umd.edu/cesar/cesarfax/vol21/21-43.pdf>
10. Hastings, G., Anderson, S., Cooke, E., and Gordon, R. Alcohol Marketing and Young People's Drinking: A Review of the Research. *Journal of Public Health Policy*. Volume 26, Number 3, September 2005, pp. 296-311.
11. Mosher, J.F. and Johnsson, D. Flavored Alcoholic Beverages: An International Marketing Campaign that Targets Youth. *Journal of Public Health Policy*. Volume 26, Number 3, September 2005, pp. 326-342.
12. "Marijuana use stalls, synthetic marijuana use levels, and use of 'bath salts' is very low." University of Michigan News Service: Ann Arbor, MI. Retrieved 1/11/2013 from <http://www.monitoringthefuture.org>
13. Mosher, James F. "Joe Camel in a Bottle: Diageo, the Smirnoff Brand, and the Transformation of the Youth Alcohol Market." *American Journal of Public Health*, January 2012, Vol 102, No. 1.
14. Accessed online January 4, 2013. Kinds of alcoholic beverage websites are 532 million websites promoting beer, 14.1 million promoting wine, 111 million promoting vodka, 3.1 million promoting rum, 2.2 million promoting brandy, 99.1 million promoting gin, 2.01 million promoting tequila, 17.3 million promoting liquers, and 59.7 million promoting bourbon.
15. Committee on Communications, American Academy of Pediatrics. Children, Adolescents, and Advertising. *Pediatrics*, Volume 118, Number 6, December 2006, pp. 2563-2569.
16. Wellman, R. J. , Sugarman, D. B. , DiFranza, J. R. and Winickoff, J. P. The Extent to Which Tobacco Marketing and Tobacco Use in Films Contribute to Children's Use of Tobacco: A Meta-analysis. *Archives of Pediatrics and Adolescent Medicine*. December,; Volume 160, Number 12, pp. 1285-1296.
17. Committee on Communications, American Academy of Pediatrics. Children, Adolescents, and Advertising. *Pediatrics*, Volume 118, Number 6, December 2006, pp. 2563-2569.
18. Sargent, J.D., Dalton, M., and Beach, M. Exposure to cigarette promotions and smoking uptake in adolescents: evidence of a dose-response relation. *Tobacco Control*. June 2000, Volume 9, pp. 163 -168.
19. Legacy Tobacco Documents Library, University of California, San Francisco. [Accessed January 5, 2013 at http://legacy.library.ucsf.edu/tid/doq76b00](http://legacy.library.ucsf.edu/tid/doq76b00).
20. Federal Trade Commission. *Federal Trade Commission Cigarette Report for 2003. Issued 2005. Tables 2A-2C*. Washington D.C.
21. FTC—Federal Trade Commission. *Federal Trade Commission Cigarette Report for 2004 and 2005. Issued 2007. Tables 2C*. Washington D.C.
22. <http://www.washingtonpost.com/wp-dyn/content/article/2010/10/22/AR2010102205573.html?sid=ST2010102805974>
23. Rosenwald, Michael. The Washington Post, "The Year 2020. What is happening with marijuana?" <http://www.washingtonpost.com/wp-dyn/content/article/2010/10/22/AR2010102205573.html>
24. <http://domainnamewire.com/2009/12/28/altria-gearing-up-to-smell-marijuana/>
25. Domain Name Wire, "Altria Gearing Up to Sell Marijuana?" <http://domainnamewire.com/2009/12/28/altria-gearing-up-to-smell-marijuana/>
26. Kleiman, Mark. "Rethinking the War on Drugs." Wall Street Journal. April 22, 2012. <http://online.wsj.com/article/SB10001424052702303425504577353754196169014.html>

case study

Malfunction of Legal Drug Markets, Comparison of Impact Between Legal and Illegal Drugs in Malawi

Nelson Baziwelo Zakeyu

Founder and Executive Director, Drug Fight Malawi (www.drugfightmalawi.com)

Malawi is one of the poorest countries in the world. This is detailed in various reports, including the United Nations Development Assistance 2007-2011 by the UN Institutions in Malawi, and the Situation Analysis Report by UNICEF. Out of a population of 14 million, 52% earn their livelihood below the poverty line and about 23% are chronically poor.

Interestingly, Malawi is among the top 10 tobacco growers in the world, with over half its foreign earnings coming from tobacco export. Much of the tobacco leaf is cultivated by the rural peasant farmers who form part of the chronically poor population. They remain poor despite being engaged in tobacco cultivation, since what they earn after harvest and sale is miniscule compared with the huge profits the tobacco industries continue to make.

Tobacco leaf is not only exported but also consumed within the country, mostly by the poor rural people, likely due to its accessibility

and affordability since they grow it themselves. Unfortunately, due to under-equipped hospitals, many die without even knowing that tobacco use was the main cause of their illnesses.

Alcohol production and use has for a long time been traditional, particularly within the social and cultural fabric of Malawian society. Similarly, alcohol plays an essential role in generating personal and national incomes, as well as creating employment for the people. However, over the years, cases of harmful alcohol use have increased, which in turn has exerted enormous burdens across the health, social and economic systems. Alcohol's disproportionate costs far outweigh the benefits derived from its production

In 2009, the Malawian government, through the Ministry of Health in conjunction with the Centre for Social Studies at Chancellor College of the University of Malawi, conducted a rapid situation analysis on the relationship

between use of drugs and HIV in the country. They found that Malawi had three main drugs which were being abused: alcohol, tobacco and marijuana. The study indicated that the most highly consumed drug was alcohol, followed by tobacco and then marijuana.

The study also indicated that alcohol and tobacco are highly consumed by the poor who unfortunately form a large majority of the population of Malawi. The poor find it easy to consume alcohol and tobacco because of its accessibility and affordability. In other words, alcohol and tobacco are legal commodities in Malawi, produced cheaply at home and thus readily available without any controls. Tobacco is still completely unregulated, as is alcohol.

To sum up, Malawi stands as an example of a country where legal drugs are highly consumed by society, worsening not only the poverty but also the poor health of its population due to the drugs' link to non-communicable diseases. It is therefore not in order to think that legalizing marijuana would be a means of decreasing consumption. In fact, doing so would worsen the situation, heavily and negatively impacting many young people.

“Unfortunately, due to under-equipped hospitals, many die without even knowing that tobacco use was the main cause of their illnesses.”

case study

Alcohol and Tobacco as Legal Drugs: A Valuable Lesson Before Legalizing Other Drugs

Teera Watcharapranee

StopDrink Network Thailand

It is widely known that consumption of drugs—illegal substances—always causes harm to the body, mind, and society. Right now, there is a move in Thailand to legalize more drugs like marijuana and *mitragyna speciosa*, a local substance medically accepted for certain treatments. But with the allowance of use as medical substances, there comes a high risk of abuse. This becomes a gap between using it for medical purpose and misusing it. Along with alcohol and tobacco, these drugs still need to be understood better before being made legal.

Concerning drinking alcohol in Thailand's history, there are tales of alcohol being served only occasionally during festivals, and also of drinking during office hours being punished heavily, especially for government officers. Later on, in the name of development, the government decided to broaden its allowance of alcohol production, and eventually set up their own manufacturers following government

procedures. Production can take place at the local and community level. Alcohol is also imported from other countries—when “beer” was first introduced it led to expanded beer market all over the country. It took 50 years to turn Thailand into the country with the highest alcohol consumption rates in the ASEAN community (unfortunately, Laos has now taken this place after following in Thailand's footsteps and expanding its alcohol market). This drastic increase in the alcoholic beverage market is associated with a greater prevalence of health and societal problems.

In order for the alcohol industry to continue to profit, it depends on increasing substance abuse. Even though the government has put in place control measures for marketing and sales, businesses still advertise it, using product placement in mass media or even committing crimes in order to continue advertising alcohol even through trial. There

are a few places in Thailand which allow alcohol businesses to market and create a positive social value around alcohol consumption, in spite of the Alcoholic Beverage Control Act (to control alcohol advertisement, sale promotions, drinking and selling venues). But alcohol business has continued to get ahead, via the following actions:

1. Making the direct seller the one at fault: All the responsibility falls upon direct sellers, and law enforcement never gets further to the actual producers, the real culprits. Direct sellers are merely pawns, and as the justice system wastes time in court chasing after small sellers with exceptional lawyers, the product continues to be made and sold.

2. Accepting litigation after successful advertisement: The alcohol business frequently sponsors sporting, music, and other cultural events, helping familiarize the public with a positive image of their brand. Using the position of giving back to the community, this also cultivates feelings of acceptance and entrenches these companies in society.

3. Investing more in social network: Through online networking, advertising and promotion can be infinitely outsourced. Whenever consumers become aware of legalization, the product distribution and sale promotion increase rapidly through this channel—it's not even necessary to hire an advertising agency. The lesson learned from alcohol control during these past 10 years is that it's not easy to solve this problem. If the government means to increase the number of legal drugs, then there needs to be a great deal of thinking about the advantages to society as a whole.

testimony

Legalization in Practice

Christine Tatum

Veteran American journalist Christine Tatum is a co-author The (Colorado Springs) Gazette editorial board's series about marijuana legalization's impact on Colorado. Visit www.gazette.com/clearingthehaze. She and her husband, Dr. Christian Thurstone, who serves as medical director of the University of Colorado's addiction psychiatry fellowship program, are the co-authors of the recently published book, *Clearing the Haze: Helping Families Face Teen Addiction*.

The battle to unleash legal marijuana in the United States is waged on new and more grotesque fronts by the week. The misinformation and outright lies spun by the marijuana industry are amplified by inaccurate, incomplete and unfair news reporting and social media. The federal government's consistent references to "experimentation" and its lacking drug-law enforcement are buying the industry more time to confuse the public and to spend the money required these days to buy public policy — and more media. As more Americans link their household incomes and political aspirations to marijuana's production and distribution, well, it's amazing what they'll tell themselves and others to justify their ties to the drug.

Yet marijuana legalization is not inevitable — neither for the United States nor the world. Experience already is proving to be a hard teacher — and lending credence to the old saying in drug-prevention circles

that legalization's worst enemy is going to be legalization. While plenty of people are working overtime to launch another industry that profits from addiction and undermines other social causes they claim to support, more people are stopping to ask harder questions, if not reverse course.

Take, for example, residents of Colorado, where 55 percent of voters in 2012 chose to sanction recreational marijuana. A poll sponsored in July by Community Alliances for Drug Free Youth and conducted by SmithJohnson Research found that 51 percent of 600 likely voters would vote against marijuana legalization today. The poll, which was conducted over the phone with self-identified 2012 voters, has a margin of error of plus or minus 4 percent.

"Voters seem to be having some buyer's remorse," said Val Smith, SmithJohnson's polling and research director, in a press release. "They don't like the impact Amendment 64 has had

on their state across some very important dimensions, like edibles, teen drug use and driving.”

The problem, it seems, is that marijuana isn’t being regulated successfully to the extent voters anticipated. The poll found only 22 percent of respondents believe the state has done a good job of preventing marijuana use from increasing among youth; only 29 percent believe Colorado has done a good job of keeping marijuana edibles away from children to prevent poisoning; and only 28 percent think regulators have done a good job of preventing drugged driving and workplace accidents. Among the more damning poll results for Colorado’s marijuana industry is the finding that 55.2 percent of respondents believe the 2012 law has done a poor job of “making sure marijuana is not physically or mentally harming frequent users.” Only 26.3 percent think legalization has done a “good job” of helping frequent users avoid harm.

As the editorial board of The Gazette in Colorado Springs, the state’s second largest city, wrote: “Remember when this was sold? Everyone would win, including regular users. The industry would pay for drug education — which has become more of a marketing effort of ‘Use, but don’t be stupid, and drive a car.’ It has not funded programs to effectively steer people away from forming a new drug vice.”

While drug-prevention professionals and healthcare providers understand the fallacies of the mantra that “regulation works” and even predicted Colorado’s regret, average people who aren’t drug users tend to have to learn the truth the hard way. When they must see — and smell — dispensaries and marijuana warehouses every day, they begin to get the message. When they and their children no longer can visit a public park without seeing drug use, they begin to get the message. When they regularly encounter impaired drivers on city streets, they begin to get the message. When they understand how much more difficult it is for them to spot drug use in their children because of how easily THC is infused into foods and drinks, they begin to get the message. And when they must live with a spouse or child who is continually stoned, they

really get the message.

Yet, “marijuana advocates were correct in telling Coloradans the sky would not fall,” The Gazette editorial board wrote in an acknowledgment of the straw man argument spun by marijuana legalization supporters and politicians who want to hedge their bets in public. Indeed, there has been no chaos in Colorado’s streets — but no one standing against marijuana legalization said there would be, either. Nor did they predict there would be increases in adolescent use or marijuana-related traffic fatalities overnight. No, the real problems — which are, indeed, mounting — are those that must be studied over longer periods of time. In a replay of Big Tobacco, problematic trends are not likely to become obvious until many of today’s policymakers who are ushering in these massive problems for public health and safety are out of elected office.

And don’t look to Colorado for much in the way of accurate information about the impact of its decision.

State marijuana regulators — whose paychecks come from fees levied on the drug’s producers and sellers — admittedly have focused very little on analyzing the data they have collected. Instead, they have chosen to direct most of their time and resources to keeping the state’s cannabis industry from forcing the hand of federal officials who, in many ways, have opted not to enforce federal law — an abdication of responsibility in Washington, D.C.

Then there are the data Colorado officials know the state does not collect, but must if it’s ever going to have a shot at understanding the impact of the drug’s legalization. In January, a governor-appointed task force started meeting to determine the priorities and processes for gathering marijuana-related data. The costs of procuring, analyzing and reporting that voluminous information are many months — and maybe even years — away from being determined, said Marco Vasquez, chief of the Erie Police Department and a task force member.

“While the commercial marijuana industry continues to ramp up, Colorado still operates in a zone of not knowing what it doesn’t know about marijuana and the expansion of drug

legalization, and people are getting hurt," said Vasquez, who is also a former director of investigations for the Colorado Division of Medical Marijuana Enforcement. "Voters were sold a bill of goods, and I don't think they really understand what they did. Colorado is pumping a potent, addictive drug and false narrative about its successes with marijuana legalization into the marketplace and across the country — and the truth is that we're struggling with gathering accurate and uniform data across a number of areas and with addressing the problems we can already see right in front of us.

"But these are hard times for educating the public," he continued. "Marijuana is sexy and popular and preached on massive media platforms and within a context of individual rights over responsibilities to our communities and country. The industry behind it is another Big Tobacco that has millions and millions of dollars to spend on influencing media and public policy — which will always outpace the findings of reputable science and the public workings of government."

So, while the United States continues to flounder with this issue, it is imperative for more of the world to speak up — and to push back.

Chapter 7

Recovery from Drug Addiction

“

We believe that recovery is the best way for individuals who have developed drug-related problems to minimize their risk of further consequences, to enable them to function effectively in society, to take part in education, work or other activities, to mend the relationships with their families and to empower them to take control of their own lives. Community-based recovery fellowships such as Alcoholic Anonymous and Narcotics Anonymous provide important opportunities for mutual help. However, treatment systems must provide a wide range of effective services to assist people who use drugs in their efforts to recover. These services must be based on the same rigorous evidence and the same principle of non-discrimination that are expected in other sectors of the health system.”

Rediscovering Recovery in the Treatment of Dependent Drug Use

Neil McKeganey Ph.D

Director, Centre for Drug Misuse Research

Within the last few years, there has been an enormous shift in the world of drug dependency treatment: the rediscovery of recovery as an achievable goal of treatment. For at least the last fifteen years, the treatment of drug dependency within many countries has been influenced predominantly by the idea that drug dependency is a chronic relapsing condition from which the individual, once affected, never fully recovers. That view was articulated most powerfully by Professor Tom McLellan and colleagues in 2000 when, after having reviewed a wide range of studies evaluating drug treatment initiatives, they concluded that: "Our review of treatment response found more than 100 randomized control trials of addiction treatments, showing significant reductions in drug use, improved personal health, and reduced social pathology but not cure" (McLellan et al. 2000:1693).

According to McLellan and colleagues, drug dependency has more in common with other chronic illnesses such as Type 2 diabetes, hypertension and asthma than it does with other more acute illnesses. Specifically,

McLellan and colleagues suggested that drug dependence is best characterised as a chronic illness for the following three reasons: first, there is a significant genetic component in the development of addiction (to the extent that there is a generic component of dependence which will not be changed by environment or individual motivation towards recovery); second, the consumption of alcohol and other drugs produces physical changes in the individual's brain that persist even after the individual has ceased consumption, thereby placing the individual at risk of relapse even if they have not consumed alcohol or drugs for a protracted period; third, whilst it is recognised that there is a significant element of personal choice on the part of the individual as to whether to consume specific substances, in fact the element of apparent free will may itself be influenced by genetic and environmental factors acting beyond the individual's own volition. According to McLellan and colleagues, just as Type 2 diabetes, asthma and hypertension are seen as lifelong illnesses that require lifelong treatment,

so too should drug or alcohol dependence be recognized as a chronic illness for which “there is no reliable cure” and for which treatment itself is likely to be long-term, possibly lifelong (McLellan et al. 2000:1693). “The best outcomes from treatment of drug dependence have been seen among patients in long-term methadone maintenance programmes and among the many who have continued participating in AA support group” (McLellan et al. 2000:1694).

It would be impossible to overestimate the influence that these ideas have had on the world of drug and alcohol treatment, producing a set of assumptions around the perceived goals of treatment (to reduce harm rather than to facilitate abstinence or cure), and encouraging individuals to remain in treatment on a long-term basis, often with little or no expectation that they will ever reach a point where they do not need some level of treatment and support. The perception of drug dependency as being a chronic relapsing condition, requiring lifelong treatment, and in the case of opiate addiction the long-term prescription of substitute opiate drugs, very much resonated with the view of drug use as a normal behaviour promoted by those who favoured some form of legalisation or decriminalisation of drug use. From within this perspective, drug use (whether prescribed or illicit) was seen as a socially acceptable lifestyle choice, such that it would be quite wrong to exhort individuals through treatment to cease their drug consumption, or to prosecute those who were purchasing their drugs on the street.

Whilst hugely influential in shaping drug treatment policy, and provision, the notion of drug and alcohol dependence as a chronic relapsing condition requiring lifelong treatment has been reassessed more recently. There is a growing focus on the importance of ensuring that drug treatment services are focussed not so much on reducing the harm associated with individuals continuing drug use, but on the individual’s full recovery. In 2008, for example, the Scottish Government announced a new drug strategy that placed recovery at the very centre of drug dependency treatment: “In the government’s view, recovery should be made the explicit aim of services for problem drug users in Scotland. What do we mean by

“There is a growing focus on the importance of ensuring that drug treatment services are focussed not so much on reducing the harm associated with individuals continuing drug use, but on the individual’s full recovery.”

recovery? We mean a process through which an individual is enabled to move on from their problem drug use, towards a drug free life as an active and contributing member of society” (Scottish Government 2008:23).

Similarly, the UK National Treatment Agency in 2007 identified the primary aim of drug treatment services in the following way: “In the year ahead, all of us in the field face this challenge: to focus our efforts on the outcomes of treatment, to enable more addicts to become drug free” (National Treatment Agency 2007).

Within the United States, the widely respected Betty Ford clinic organised a consensus panel to produce an agreed definition of recovery that services could use in seeking to focus their efforts on the new recovery agenda: “Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship” (Betty Ford Consensus Panel 2007:221).

Within the UK, the influential UK Drug Policy Commission produced its own definition of recovery illustrating how central the notion of recovery had become in thinking about the goals of drug treatment services within the UK: “The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use, which maximises health and wellbeing and participation in the rights, roles and responsibilities of society” (UKDP 2008:6).

Whilst these definitions vary in part (for

example, one emphasises sobriety whilst the other stresses the importance of voluntary sustained control over substance use), both clearly indicate a move away from the notion of drug and alcohol dependence as a condition from which there is no cure and with which the individual will have to live for the remainder of his or her life.

David Best and Alexander Laudet have offered a different, and in a way more holistic and less medicalised, view of recovery than either the Betty Ford consensus panel or the United Kingdom Policy Commission: "The essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an on-going quest for a better life" (Best and Laudet 2010:2).

Within the areas where the recovery agenda has gained momentum, drug treatment services, and those shaping drug treatment policy, have had to reshape many aspects of their work. Within the UK, new guidelines were sent to drug treatment services by the National Treatment Agency, encouraging services to move away from the notion of drug dependency treatment being a lifelong process. Rather than seeing engagement with drug treatment services as an end in itself, the goal was now to view treatment as a process leading to recovery, within which an individual's engagement with drug treatment services was time-limited rather than lifelong: "Ensure exits from treatment are visible to patients from the minute they walk

through the door of your service. This means giving them enough information to understand what might comprise a treatment journey, even if their eventual exit appears some way off. And make visible those people who have successfully exited by explicitly linking your service to a recovery community, or employing former service users or using them as volunteer recovery mentors and coaches" (National Treatment Agency 2012:7).

The Rediscovery of Recovery in Drug Treatment

The development of a focus on ensuring that drug treatment services are focussed on recovery, rather than simply ensuring that drug users remain in drug treatment for many years, has been influenced by a number of factors. First, there has been a concern that in many instances drug users prescribed substitute opiate drugs as part of a methadone maintenance programme may have been "parked" on their substitute medication for many years without any real encouragement or expectation from prescribing clinicians that they may move on from their reliance on prescribed medication (Easton 2009). The concern was that treatment for too many drug users had become an end in itself, rather than a route to recovery, and that at least part of the reason for this was a lack of ambition on the part of prescribers in seeking to maintain momentum towards recovery: "The ambition for more people to recover is legitimate, deliverable and overdue. Previous drug strategies focussed on reducing crime and drug related harm to public health, where the benefit to society accrued from people being retained in treatment programmes as much from completing them. However, this allowed a culture of commissioning and practice to develop that gave insufficient priority to an individual's desire to overcome his or her drug or alcohol dependence. This has been particularly true for heroin users reducing OST (opiate substitution treatment), where the protective benefits have too often become an end in themselves rather than providing a safe platform from which users might progress towards further recovery" (National Treatment

"Second, research has shown that many drug users contacting drug treatment services are looking for assistance in becoming drug free."

Agency for Substance Misuse 2012:4).

Second, research has shown that many drug users contacting drug treatment services are looking for assistance in becoming drug free. In 2004, McKeganey and colleagues published their findings on drug user aspirations from drug treatment services. This study, which was based on structured interviews with 1007 drug users initiating treatment in Scotland in 2002, found that 56.6% of those questioned identified the goal of becoming drug free as their sole reason for contacting drug treatment services. In contrast, only 7.4% of those questioned said they were seeking to stabilise their continued drug use and less than 1% (.7%) said they were looking for advice on how to use their drugs with greater safety (McKeganey et al. 2004).

Alongside this research, there has also been a growing body of evidence showing that treatment services, configured in the right way, can assist a substantial proportion of drug users in becoming drug free. In 2007, Dawe and colleagues reported the results of long-term abstinence in the Australian Treatment Outcome Study (Dawe et al 2007). Based on interviews with 429 heroin users, followed over three years, the study showed that at the 36 month follow up interview 40% of drug users had been abstinent for the preceding 12 months. In looking at the characteristics of those drug users who were able to maintain a period of sustained abstinence, the researchers on this study identified some surprising findings, including that: "The abstinent were significantly less likely to be currently enrolled in treatment. In fact, two thirds of the abstinent were not enrolled in treatment at 36 months. It would appear that this group had successfully emerged from a longer, more stable treatment experience in the first year of follow-up, having made long-term change to their drug use which they were able to maintain" (Darke et al. 2007:1904).

In effect, "more treatment" did not necessarily equate to better outcomes from treatment (although the researchers on this study stress the likely value of stable treatment). Other studies have also shed light on both the extent to which those who have become drug or alcohol dependent can achieve sustained

abstinence, and on the characteristics of treatment services that may be most likely to produce such an outcome. McLellan and colleagues, for example, have reported on the experience of 904 addicted doctors admitted to the US physician health care programmes. Just over half of the doctors studied had a primary diagnosis of an alcohol problem, and 35% had an opiate problem. The treatment itself largely consisted of an abstinence-based, 12-step (i.e. Alcoholics-Anonymous-type) programme coupled with some element of residential care (where needed) and regular drug testing. In total, 81% of those completing the treatment programme remained drug or alcohol free over the study period (confirmed by urine testing) whilst 19% relapsed at least once over the five-year study period (McLellan et al. 2008). Those proportions indicate that abstinence can be achieved by a large number of those engaged in treatment.

One objection that may be directed towards the McLellan study is that doctors are likely to be highly motivated towards recovery and abstinence because their continued licence to practice depends on such a positive outcome. Other research with what many would regard to be less highly motivated treatment samples has also identified similar positive outcomes where abstinence is identified as an important goal of the treatment provided. The Hawaii Opportunity Probation with Enforcement (HOPE) is a community-based probation programme for methamphetamine users. The HOPE programme places particular emphasis on individuals remaining drug free during the period of their probation with individuals tested on a regular basis and "every positive drug test and every missed probation appointment met with a sanction." Importantly, the authors of the evaluation of the HOPE programme stress that sanctions resulting from a failed drug test or missed appointment adhere to the principles of being swift, certain, and proportionate. The evaluation of the HOPE programme showed that the proportion of participants in the study group producing positive drug tests reduced from 53% to 4% over a 12-month period, compared to a reduction of 22% to 19% amongst the comparison

group (Harken and Kleiman 2009). The learnings produced from these two evaluations appear to be that where treatment providers place importance on individuals remaining drug free, and where those services either reward abstinence or punish transgressions, services can achieve very substantial rates of improved behaviour. Importantly, the sanctions as shown by the HOPE evaluation do not need to be excessive; indeed, the authors of this study emphasise that sanctions are proportionate to the transgression, the punishment happens very quickly following the transgression, and there is no ambiguity about whether the punishment will occur.

Commenting on what they have described as a new treatment paradigm, Du Pont and Humphreys have observed that: "One distinctive feature of these ... interventions is the intense leverage that is used to sanction substance use and to reward abstinence. In the case of the PHP's, the leverage is the threat of removal from practice and ultimately the loss of the physician's medical license; the reward is continuing to practice in a prestigious and well-paid profession. For HOPE ... immediate brief incarceration is the sanction and freedom in the community is the reward" (DuPont and Humphreys 2011:4).

"Mandatory abstinence used in this new paradigm contrasts sharply with programmes that make treatment mandatory but do not impose meaningful consequences for any continued substance use. The ... programs for offenders sharply contrast with the far more common approach in the criminal justice system where consequences for noncompliance, including continued substance use, are long delayed, uncertain, and when applied are—often after many violations—draconian" (DuPont and Humphreys 2011:4).

In contrast to these examples of treatment initiatives that have successfully prioritised abstinence, there are many examples of the much more modest outcomes of treatment systems that have not prioritised abstinence. Within Scotland in 2008, the Scottish government announced a new drug strategy that required drug treatment services to be focussed on

ensuring that drug users were assisted to become drug free. Prior to this focus on recovery, drug treatment services within Scotland were very much focussed on retaining clients in long-term treatment without any clear expectation of recovery. Treatment was in this sense seen more as an end in and of itself, rather than as a route to abstinence-based recovery. During this period, the proportion of drug users becoming drug free (even after long-term contact with drug services) was very modest. McKeganey and colleagues followed a sample of drug users starting a new episode of drug treatment in 2002. Despite the fact that this study had shown that the majority of drug users in treatment were looking to become drug free, after 33 months of contact with treatment services: "Although becoming drug free was the expressed goal of the majority of drug users recruited into the Drug Outcome Research in Scotland study, at 33 months following recruitment only 5.95% of females and 9.0% of males had been totally drug free (excluding alcohol and tobacco) for the 90-day period in advance of being interviewed" (McKeganey et al. 2006:537).

In a treatment system where abstinence is not prioritised and where concurrent illicit drug use is not sanctioned, it is perhaps hardly surprising that even after extensive contact with drug treatment services only a tiny minority of individuals managed to remain drug free for even a relatively modest period (90 days).

One of the by-products of a treatment culture within which long-term contact with

"Treatment was in this sense seen more as an end in and of itself, rather than as a route to abstinence-based recovery."

treatment services is seen as the primary goal (rather than progress towards recovery) is that individuals may not only remain in contact with drug treatment services for much longer, but may also remain drug dependent for longer as a result. In a study carried out in Edinburgh, Scotland, to identify the impact of long-term methadone provision on drug user risks of premature death, the researchers found that those drug users who had been prescribed methadone were significantly less likely to die than those who had not been prescribed the drug: "For each additional year of opiate substitution treatment the hazard of death before long-term cessation fell 13% (95% confidence interval 17% to 9%) after adjustment for HIV, sex calendar period, age at first injection and history of prison and overdose" (Kimber et al. 2010).

However, the study also identified an inverse relationship between the provision of long-term opiate substitution treatment and the likelihood of individual's achieving long-term cessation in their drug use. Drug users who were prescribed methadone on a long-term basis remained drug dependent for substantially longer than those who were not prescribed the drug: "Opiate substitution treatment was associated with an increased duration of injecting ... for patients who did not start opiate substitution treatment the median duration of injecting was five years (with nearly 30% ceasing within a year) compared with 20 years for those with more than five years of exposure to treatment" (Kimber et al. 2010).

In effect, a treatment system which is focussed on providing methadone on a long-term basis, and which prioritizes treatment over recovery (long-term cessation), is much less likely to achieve full recovery. The situation within Scotland in advance of the new drug strategy focussing on recovery was very similar to the situation of some methadone programmes within the United States described by Du Pont and Humphreys: "This contrasts with the pattern among some methadone programmes today that do little or no drug testing and are not concerned in any meaningful way with continued alcohol and other drug use, relying instead on the hope that with some methadone,

heroin addicts will use a bit less heroin and commit somewhat less crime. That permissive type of methadone programme may affect those indicators modestly, but those programmes do not start many people on the pathway to recovery" (Du Pont and Humphreys 2011:5).

The recovery focus that is now a characteristic of many drug treatment systems in different countries has also thrown up many challenges that demonstrate the paucity of the available evidence that might otherwise have usefully guided practice.

The Challenge of a Recovery Focussed Drug Treatment System

Embracing the idea of recovery, and encouraging drug treatment services to focus on recovery, is an important first step in reconfiguring the world of drug dependency treatment. However, there are many challenges that flow from the attempt to realise a commitment to ensuring that drug treatment services are working towards recovery. Research has to date only partly contributed to answering some of those questions.

What Do You Offer Drug Users Who Are Not Interested in Recovery?

Whilst research has shown that the majority of drug users in contact with drug treatment services are looking for assistance in becoming drug free, it is certainly not the case that all drug users in contact with treatment services are motivated in this way. At any one time there will be a proportion of drug users in contact with drug treatment services who are not interested in recovery and who will have contacted drug treatment services for a variety of other reasons, including in some instances being required to do so by court-ordered treatment. At the moment, it is not at all clear what treatment services that are focussed on recovery can offer those drug users who are not interested in recovery and who, in the terms of the trans-theoretical model of recovery (Prochaska, Di Clemente and Norcross 1992), may be at a pre-

contemplative state in which they are resistant to or uninterested in recovery. Because recovery from dependent drug use is an intensive, long-term and costly process (in both financial and emotional terms), there is almost inevitably going to be a limitation to the extent to which recovery-focussed drug treatment services can work with drug users who are not interested in recovery. At the present time, individual services will be making their own judgements as to the proportion of recovery-motivated and recovery-unmotivated clients they can work with. Those judgements, however, are difficult to make, since we know very little about the factors that may increase or decrease the likelihood of an individual shifting from a stage when they are uninterested in recovery to a stage where they are willing to focus on recovery. We know that individuals with higher levels of recovery capital (individual family and social/community resources) will progress more rapidly into a state of sustained recovery, but at the present time we are not able to easily differentiate between those individuals for whom recovery is a realistic goal and those for whom recovery is a very distant, and in some instances unconsidered, goal.

Drug treatment services working within a recovery climate will need to determine how much of their services, and what kinds of services, they can offer to those drug users who are not interested in recovery – balancing the goals of abstinence and harm reduction (McKeganey 2005). For some individuals it may be most appropriate to provide information on how to use their drugs more safely; for example, encouraging a shift from injecting to non-injecting forms of drug use. For others, the goal may be to encourage the individual to cease his or her drug use entirely for increasingly long periods. Although at a superficial level it may seem straightforward for drug treatment services to combine these contrasting goals, in reality it can be very difficult for a service focussed on abstinence to encourage its staff to provide harm reduction advice, just as it can be very difficult for the staff working within a harm reduction service to encourage clients to embrace the goal of abstinence.

Although at the moment many services

may claim to be effectively combining the different goals of abstinence and harm reduction, we know relatively little in research terms as to how that is being achieved in practice. There have been concerns, nevertheless, that the focus on recovery within drug treatment services in some areas has resulted in some drug users being prematurely expelled from treatment with significant adverse effects (White et al. 2005). Where this occurs, it suggests that service providers have been unable to find a way of balancing the needs of those drug users who are focussed on recovery with those who committed to continuing their drug use.

How Long Should Individuals Remain in Treatment?

Research has shown that the outcomes from drug treatment are more likely to be positive where treatment itself is provided over an extended period of time. That evidence would caution against drug treatment being provided for only short periods of time, or for treatment being prematurely interrupted. However, there is a real danger that either through overly cautious judgements on the part of staff, or anxiety on the part of clients, that individuals may build up a dependence on drug treatment services, thereby potentially extending the length of time they are engaged with services beyond the point at which that engagement is necessary. Once again, the evidence base on how drug treatment services may be guided in establishing how long individuals can or should remain in treatment is far from extensive beyond the broad guidance that better outcomes arise from longer treatment. Research has not been able to show at what point individual treatment or combinations of treatment move from making an effective to an ineffective contribution in facilitating an individual's recovery. As a result, we know very little within the drug or alcohol dependency field about how long an individual should ideally remain in treatment. In many instances, the length of time an individual is engaged in treatment will be determined by extraneous factors such as the level of funding for treatment services or the extent of a waiting

list of clients hoping to access a service.

Whose Definition of Recovery Should Apply?

Whilst there has been a growing commitment to ensure that drug treatment services are working towards facilitating recovery, it is less clear how the definitions of recovery offered by some of the national organisations, and contained within national drug strategies, can be operationalized at an individual level. Some commentators have suggested that the definition of whether one is in recovery should be very much determined by the individual involved, in contrast to judgement being imposed by drug treatment professionals. Recovery in this sense becomes an individually determined state. Whilst defining recovery in this way ensures that recovery is seen as a process that is maximally inclusive, it also raises the deeper question of whether the process of recovery can ever end, or whether recovery is itself a potentially lifelong process. This question is important, since it leads into the issue of how long individuals may be expected to remain "in treatment." Part of the way in which the focus on recovery has been distinguished from previous characterisations is the importance given to ensuring that drug treatment services are maximising individuals' momentum towards recovery. If recovery is being seen as something that is largely determined by the individual him or herself then it raises the prospect that an individual could see themselves, and expect to be seen by others, as engaged in recovery, even though they are not in any significant sense progressing to the point where they no longer require contact with drug treatment services. Proposing that recovery is entirely determined by the individual could create a situation of lifelong engagement with treatment, very much a criticism of the view that engaging with drug treatment services is an end in and of itself. A further difficulty with adopting a purely individual view of recovery is that it becomes very difficult to challenge individuals in terms of either their commitment towards recovery or the pace of their progression in recovery, leading ultimately to a situation in which drug treatment services

may find themselves being overly determined by those in recovery.

The alternative scenario, in which drug treatment services largely determine the components of recovery, deciding when an individual has recovered enough to cease his or her contact with drug treatment services, may result in the individual feeling excluded from his or her own recovery. At an operational level then, in terms of how drug treatment services engage with clients, there will need to be a balance between the capacity of individuals to define their own recovery and the constraints (including funding constraints) that services are operating under in determining how much treatment or support an individual can receive for how long, and with what level of intensity.

How to Combine Professional Treatment Services with Family, Community, and Voluntary Services?

Within the current recovery climate there is a growing recognition that the contribution of statutory or privately funded drug treatment services towards recovery is relatively modest, compared to the contribution of friends, family, and the wider community. To an extent this is to be expected, since in the simplest of terms the amount of time an individual engages with drug treatment services is only ever likely to be a fraction of the time they are engaged with family, friends and the wider community. Where an individual is surrounded by positive supportive influences in their home life, there is an increased likelihood that their recovery will be positive. Equally, where an individual is surrounded by influences pulling them back into a pattern of dependent drug or alcohol use, there is indeed a greater likelihood of their relapse and the resumption of a pattern of chaotic and harmful drug or alcohol use.

Whilst there is now a growing awareness of the important contribution of family and friends, and of the wider community (often characterised as family/social/community recovery capital) in individual's recovery (White and Cloud 2008), there is much less clarity

with regard to establishing how these various influences can best be made to work together for maximum positive impact. Relatively little is known, for example, about how professional or statutory drug treatment staff can work most effectively with family members in facilitating an individual's recovery, i.e. what information to share about the individual's recovery, past drug use, past criminality, etc. Equally, we know relatively little about how best to moderate or ameliorate those influences within an individual's social world that may increase the likelihood of relapse, hampering rather than furthering the individual's recovery. In early studies on the factors influencing recovery from schizophrenia, researchers and clinicians identified that the patients who received the most visits from family members when they were hospitalised were often the patients that took the longest time to recover. The reason for this was that part of the psychopathology they were demonstrating was arising from the dysfunctional family relationships in which the individual was involved. The upshot of this research is that where individuals are hospitalised for certain mental health problems, family visits in the early stages of the individual's recovery and hospitalisation are discouraged. It has also been shown that the nature of the family environment into which the individual is discharged at the conclusion of treatment can have a significant impact on the nature and extent of the individual's subsequent recovery (Brown Birley and Wing 1972; Amaresha and Venkatasubramanian 2012). In the case of drug or alcohol dependency, there may well be individuals in the patients' social world that are more facilitative of their continued drug use than their recovery, although at the present time we know relatively little about how best to limit those influences whilst enhancing the positive ones.. This is an area where research is required.

Conclusion

The development of a recovery focus in drug and alcohol treatment has been an important recent development in drug treatment systems in a number of countries. Where previously addiction and dependency were seen as lifelong

states, often requiring lifelong treatment, where simply being in treatment was seen as an important goal in and of itself, there is now a growing commitment towards ensuring that drug treatment services are working towards maximising the opportunities for individuals' recovery. Treatment in these terms is seen as a process with an end, at which point individuals move on from being in treatment to taking up their responsibilities in the wider society. That shift in policy and practice has been driven in part by the evidence showing that most drug users contacting services are indeed looking for help in becoming drug free, and no doubt in part also by the circumstances of economic austerity in many countries that has made lifelong drug dependency treatment an option that is too expensive to provide. The goal of ensuring drug treatment services are working towards enabling drug users to become drug free, however, contains within it many fundamental challenges to do with the nature of treatment, its duration, the definitions of recovery, the respective contribution of family friends and the wider community in facilitating recovery, and, crucially, what one offers those drug users who are not interested in recovery. Each of these are areas where research can make an important contribution to guiding practice.

References

Amaresha, A., Venkatasubramanian, G. (2012) Expressed Emotion in Schizophrenia-An Overview Indian Journal of Psychological Medicine 34 (1) 12-20

Best, D., Laudet, A. (2010) The Potential of Recovery Capital RSA Projects available at www.thersa.org/globalassets/pdfs/blogs/a4-recovery-capital-230710-v5.pdf

Betty Ford Consensus Panel (2007) What is Recovery A Working Definition from the Betty Ford Institute Journal of Substance Abuse Treatment 33 pp 221-228

Brown, G. W., Birley, J., Wing, J. (1972) The Influence of Family Life on the Course of Schizophrenic Disorders: A Replication British Journal of Psychiatry 121 241-258

Darke, S., Ross, J., Mills, K., Williamson, A., et al (2007) Patterns of Sustained Heroin Abstinence amongst Long term Dependent Heroin Users: 36 Months findings from the Australian Treatment Outcome Study (ATOS) Addictive Behaviours 32 (9) 1897-1906

Du Pont, R., Humphreys, K. (2011) A New Paradigm for Long Term Recovery Substance Abuse 32:1 1-6

Easton, M (2009) Addicted to Methadone available at www.bbc.co.uk/blogs/thereporters/markeaston/2009/10/addicted_to_methadone.html

Harken, A., Kleiman, M. (2009) Managing Drug Involved Probationers with Swift and Certain Sanctions Evaluating Hawaii's HOPE Washington DC National Institute of Justice Office of Justice Programmes US Department of Justice

Kimber, J., Copeland, L., Hickman, M., Macleod, J., et al (2010) Survival and Cessation in Injecting Drug Users: Prospective Observation Study of Outcomes and Effects of Opiate Substitution Treatment British Medical Journal 341:c3172

McKeganey N. (2005) Abstinence and Harm Reduction: Two Road to One Destination? Drugs Education Prevention and Policy 12 (4) 251-253

McKeganey, N., Morris, S., Neale, J., Robertson, M. (2004) What are Drug Users Looking for When they Contact Drug Treatment Services- Abstinence or Harm Reduction? Drugs Education Prevention and Policy 11 (5) 423-435

McKeganey, N., Bloor, M., Robertson, M., Neale, J., MacDougall, J. (2009) Abstinence and Drug Abuse Treatment: Results from the Drug Outcomes Research in Scotland Study Drugs Education Prevention and Policy 13 (6) 537-550

McLellan, A., Lewis, D., O'Brien, C., Kleber, H. (2000) Drug Dependence: A Chronic Medical Illness. Implications for Treatment Insurance and Outcome Evaluation. Journal of the American Medical Association vol 284 no 13 pp1689-1695

McLellan, A., Skipper, G., Campbell, M., Du Pont, R., (2008) Five Year outcome sin a cohort study of physicians treated for substance use disorders in the United States British Medical Journal 337:a2038

National Treatment Agency for Substance Misuse (2007) Annual Report

National Treatment Agency for Substance Misuse (2012) Medications in Recovery: Re-orientating Drug Dependence Treatment

Prochaska, J., DiClemente, C., Norcross, J. (1992) In Search of How People Change: Applications to Addictive Behaviours American Psychologist 47 (9) 1102-1114

Scottish Government (2008) Road to Recovery: A New Approach

to Tackling Scotland's Drug Problem

Scottish Government (2008) The Road to Recovery: A new Approach to Tackling Scotland's Drug Problem Scottish Government

United Kingdom Drug Policy Commission (2008) A Vision of Recovery: UKDPC Recovery Consensus Group. United Kingdom Drug Policy Commission

White, W., Cloud, W. (2008) Recovery Capital: A Primer for Addictions Professionals Counsellor 9 (5) 22-27

White, W., Scott, C., Dennis, M., Boyle, M. (2005) Its Time to Stop Kicking People out of Addiction Treatment Counsellor April pp 2-13

testimony

Kenneth Arctander Johansen (Norway)

My name is Kenneth and I'm 34 years old. I used to be a drug addict, until I was 21 years old. I was an active boy growing up. Always into reading, writing, painting, drawing, music and sports. Even though my abilities were strong, I never became good friends with the education system. I found it depressing, to say the least. I still do.

Being a boy in opposition to the boredom of schooling leads to years of conflicts, and in my case, a certain degree of alienation from society. I was a decent skateboarder and had sponsorship with a shop in Oslo. It is true that I started drinking alcohol at the age of 9 and inhaling chemicals from the age of 13, eventually beginning to smoke cannabis at 14. Still, it was when I injured myself by skating that my substance use became truly problematic. At least in my personal view.

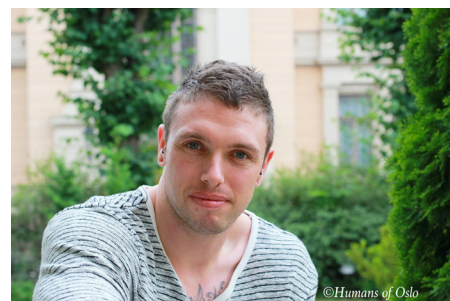
I had grown up with parents clearly on the political left. My mother raised me, but my father was partly around. I had seen his use of alcohol and cannabis from an early age and in many ways, I emulated him growing up. I never thought I would handle drugs as badly as I did.

From the age of 15, I started experimenting with psilocybin, benzodiazepines and cocaine. From 16, with amphetamines, ecstasy, LSD and all the other stuff. I didn't finish high school and I had some jobs, but distributing and consuming drugs was more important to me at the time. Eventually my life started looking bad and I had to realize I had a serious drug problem. I was physically addicted to benzodiazepines. My economic situation was depressing. I could not keep a job. I kept being arrested. I could see

my intelligence dropping rapidly. I never liked not being intelligent. I liked that less than I liked school. I was also increasingly sad about my whole life situation and my diminishing possibilities for a future.

I made a formal request to go into treatment at a therapeutic community when I was 21 years old. I completed the whole program. Looking back, I think all the relationships you make in such a place are a supporting factor and help you renew (or rewind) your identity. This, combined with supporting staff members encouraging you to do positive things like going back to school.

To me, going back to school was crucial. I finished high school in 2005. Finished a bachelor's degree in social work in 2008 and my master's degree in 2012. I wrote a thesis on sexuality in the therapeutic community. I have been working with therapeutic communities and other treatment modalities since 2007, until 2012 when I started to work politically. I'm currently working for a national advocacy group for recovery and I have plans to stay here for some time. In 2014, I enrolled in a PhD program at the University of Ghent and I'm currently doing a critical analysis of the addiction treatment field of Norway. I'm still not a huge fan of school.



©Humans of Oslo

testimony

John (Montenegro)

Hello. My name is John and I am from Niksic in Montenegro. I cannot remember for how long I was an addict. Around the end of primary and the beginning of high school I began to experiment with alcohol. This continued all through high school. This way of functioning began to reflect on my life. At first I was an excellent student in primary school and a relatively exemplary child, but as more evil entered into my life, the problems grew, and as a result, it was hard to finish high school.

I joined the army in 1991. And of course, nothing changed with my aspirations to live wild. Deep down I was aware of my family's expectations of me, and deep down I wanted to be "normal" and "desirable." I tried to go to university. And, of course, I failed. I tried to be someone, or at least, not to be nobody. I started to prove to myself that I am not a loser in various ways. I started to earn respectable money playing music in cafes, restaurants, hotels etc. I also worked in the media business, in marketing.

At one point I had come a long way, as far as marketing director in a radio station. Beside that I started to invest in my education. You have to admit, it looks and sounds pretty nice, but this was only an appearance. I became a master of camouflage, and my life was just about stacking masks and roles. That entire time "acting academy" was accompanied with alcohol, marijuana and cocaine sporadically. Eventually I passed to the greatest master of lies and deception, heroin. There is nothing that whitewashes your eyes like heroin. You see things as they aren't, it helps you to justify everything that you do, even when

you know that you need to stop. As time passed by, I got worse and worse.

Things have started to break: my jobs, money, family, everything. I didn't know of any treatment. When the situation became even more complex, there were a couple of short-term abstinence periods, that's all. One day, after years of madness, I finally realised that I didn't have anything. I had the choice to go to treatment, or ...

At that time (end of 2003), my brother heard about Avala Center in Belgrade. I didn't know anything about it, probably because I wasn't interested. But I started to call them, and finally I decided to go to Reto. Thank God. I entered Reto without desire, will, motive ... "A little to calm the situation, and I am back," I told myself. One night, the same night I had planned to leave the community and go back to my madness, I came to my room with my mentor, and on my pillow saw a postcard of Montenegro, for me.

At that time, I was the first and only Montenegrin in Reto. One of the leaders, who was in the city that day, bought me the card. Why is it important? On the back it said: Hebrews 10:39. I did not know what that meant. I asked the mentor to explain what that means, because I had no idea. He read: "But we do not belong to those who shrink back and are destroyed, but to those who have faith and are saved." I thought that I would go insane, because I hadn't told anybody that I planned to go home. Of course I hadn't told anybody (classic junkie). It turns out that this is actually the first time that I obeyed God. I

did not know that then, but I decided not to step down. I stayed in Reto for two years, until 2006, and then went out.

When I came home there was no “red carpet” in my hometown. My family was healthy, but that was all that was beautiful in my life. It was not enough. I was without community after exiting. There was no work for me. And then, I started to feel the responsibility that God has given to me, first from word of mouth (who was in trouble with drugs), then also from parents of boys with addiction problems, then finally from boys dealing with addiction themselves. They started to contact me to seek advice, guidance ... So I registered the organization “Preporod” to support and help addicts and their families. Again, I thank God for the opportunity to serve these young men in need.

Today, I am professionally engaged in the organization, and thanks to God, I’m not alone anymore. Already there are guys who went to treatment and are well and are active in the organization. I pray for them to get well. In the meantime, I got married and had a son.

So, when God gives, He doesn’t give a little bit, but abundantly as only He can.

“Forgetting what is behind me, I strive for that which is in front of me, looking at the target and running for the prize of the heavenly call of God in Christ Jesus” -Philippians 3:14

*“I became a master of camouflage,
and my life was just about stacking
masks and roles.”*



testimony

Elisabeth Cucco

Writing is not always as easy as you think, especially when you need to talk about yourself. You promise yourself to be honest—the ink has always been the guardian of the secrets it reveals.

Writing is one of my biggest passions, I've always had the certainty that for me it is the only way I really feel free to express who I am. At San Patrignano they understood this straight away.

When I entered the community I was very young. I had only just turned 20. Not long before I had left the university which I loved because I was no longer able to concentrate or study. Before falling into heroin I often used to think about my objectives and ideals but I used to feel like a pen without ink—with a million words to say but without the ability to say them. One afternoon, while talking with the "Responsible" of my sector, I talked about my passion for writing and my dream of writing a book one day. I didn't have to say it more than once, what was important for me was just as important for her and if this was the way for me to open up then she wanted to help me.

She would leave me writing in the office for hours, until communicating with a computer screen was not enough and my desire to speak with friends and my "Responsibles" increased. My trust in them became even stronger, as well as the belief that only together with them would I really be able to do what I needed to. It was certainly not an easy path to walk. Every day I confronted new truths about myself which I hadn't previously seen, some of which I didn't like but have had to learn to accept. I haven't always believed that I would be able to do it—

even if here and now I am happy and I am realizing my dreams, I am only doing so because someone before me believed in me and pushed me to follow them.

San Patrignano has given me the chance to restart university, and thanks to a study grant I now live and study in the beautiful city of Bologna. My faculty of study is history: I strongly believe that only by understanding our past can we live well in the present. I see the world as one inseparable whole with a present, a future and a past—just as for me it was necessary to overcome my past in order to create my present, I believe that humanity has the need to do the same. Just as San Patrignano has dug through my past, I would like to dig through the history of humankind.

After my degree I will specialize in International Cooperation. I want to change the things that don't work and further improve the things that do. I want to be one of the mechanisms that help humankind and what this means in terms of our rights, our duties, and equal opportunities for all. I believe in a world in which we are all responsible for one another—all of this I learned at San Patrignano. Tomorrow I will depart for Egypt, where I have decided to spend my summer working on a voluntary project with the University of Alessandria. The aim of the project, named Hewee, is to help spread women's rights and gender equality in a country where there is still a strong distinction between women and men. I will be the only Italian there, but working with me there will be Arabs, Europeans and Americans, and I believe that together we can be unstoppable.

I know that I couldn't spend my time and my life better than this: sustaining other women, eliminating discrimination, fighting violence and giving women an identity. I know this will be my life, and for this reason I have decided that my objective is to work for UN Women. In order to involve people in my trip—my friends and my classmates at university who have always stayed at my side at San Patrignano, I have decided to open a blog (nhympea.worldpress.com). I have decided to call this space Nhympea, like the flower whose roots are not anchored in solid earth, but which grow out of mud and are thus so beautiful and make special everything which surrounds it. With my blog I would like to be able to reflect together with other people on what is such an important theme and to be able to do it in a way in which others can see through my eyes: I will talk about my travels, everything I see, and will reflect on what every person here in Italy can do in order to break down barriers instead of creating them. San Patrignano has given me my life back, and now I have decided to spend mine giving this gift to others. Of course there are still sad days and periods more difficult than others—after all, that's life—but it is amazing now to know that I always have a place to come back to where I know I can always find my roots. In the end I have decided to unify all of the scattered thoughts I had written at San Patrignano by writing a book, which I will try to have published in September. If this dream becomes a reality it will also be thanks to San Patrignano.



testimony

John (USA)

Recovery Leadership Coordinator for the National Council on Alcoholism-Maryland Chapter

I was born into a white middle-class family with traditional values. The adults in my world—extended family and friends—used alcohol very moderately with the exception of one or two uncles or cousins who drank to excess.

I was a rebellious child and my father and I did not get along with one another. He expected me to “toe the line” and I wanted to do what I wanted to do when I wanted to do it!

He once told me that there were three things he would never except under his roof—an alcoholic, a drug addict, or a communist. Well... I never became a communist!

I started drinking at age 14 out of defiance towards my father, for the excitement, and for the comradery. I was a shy and very bashful kid—a “wallflower.” Drinking changed all that. When I drank I could talk to the girls, hang with the guys, come out of my shell, and experience a sense of confidence and wellbeing that I never had before. I’ve often said that “I would have been crazy not to drink” after I learned what alcohol could do for me.

I got married at age 18. My 18-year-old bride’s father was also an alcoholic. We both wanted to escape our homes and “play house.” I was drafted into the service a short time later. I went into the Air Force on a delayed-enlistment plan in order to avoid getting killed in Vietnam. Uncle Sam now owned me for the next four years. Being in the service was like an extension of living under my father’s roof. I rebelled! These

were the late 60’s: the days of “sex, drugs, and rock and roll.” I loved it!

By this time I was drinking alcoholically without realizing it. I also began to use marijuana, as it was just coming into vogue across the country and around the world. I loved smoking pot—at least initially.

When I was 20 years old my daughter Sherry was born. By this time my wife and I were having significant marital problems. Alcohol was definitely a contributing factor.

In addition to drinking and smoking pot for fun, I was now increasingly using substances to deal with the emotional pain that I was experiencing as my marriage deteriorated.

We separated. My drinking and drug use increased, and now included uppers, downers, and LSD.

I next fell head-over-heels in love with a woman I met in a bar. I was crazy in love with her. She also drank like a fish. I realized that I needed to get my head together in order to not blow this relationship. By taking advantage of my veteran’s benefits, I sought the help of a psychiatrist. He advised me to admit myself into Perry Point VA hospital, where I resided for the next 60 days on their psychiatric unit. The treatment team there suggested that I might be an alcoholic. Not me—I was too young to be an alcoholic! I worked hard on myself while in treatment trying to “get my head together” but was unwilling to stop drinking and drugging. I had

“By now I knew I couldn’t continue drinking and living my life the way that I had been, nor could I envision living out the rest of my life without alcohol or other drugs. I was broken! I had reached a turning point in my life.”

just turned 21 years old.

For the next year I attempted to control or stop my drinking through various means—none of which proved to be successful.

On January 21, 1976, I was involved in a head-on collision after drinking and drugging throughout the day. As I came to the next morning, I looked in the mirror and saw that my teeth were broken and my face was bruised, bloodied, and in stitches. My car had been totalled. I asked myself what I was going to tell my insurance agent about how my car got destroyed. I began to think of the excuses that I could tell him: blinded by the other car’s headlights, poor weather conditions, etc. However, I then asked myself what really happened—and it was at that moment that I experienced what I call my “moment of truth”! I realized beyond a doubt that the reason I had the accident was because I was drunk. I looked back on my life and could not think of any major jackpot that I had gotten into that did not include alcohol and/or other drugs—and believe me, there were many!

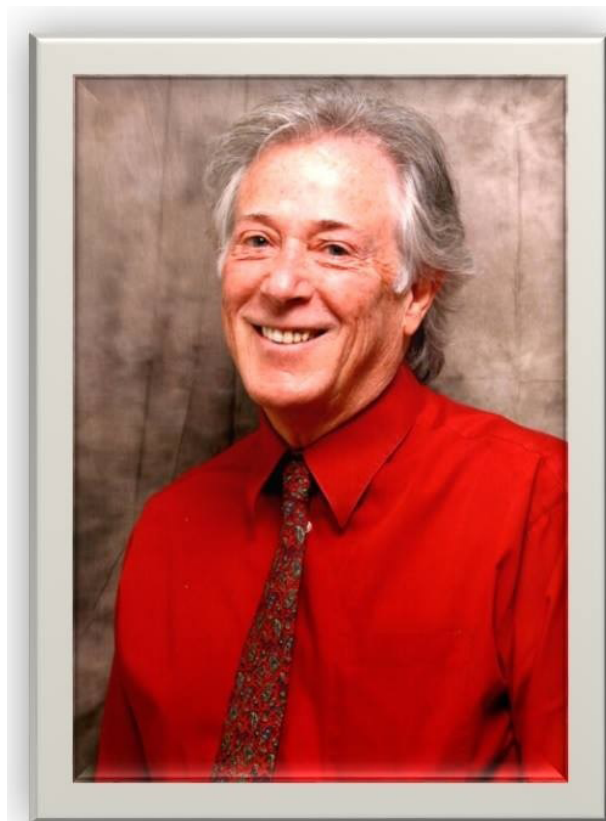
At the time, I was on a waiting list to enter into a residential treatment program for alcoholism as a result of a “last-ditch effort” of my employers to save my job. I was working as a civilian employee at Aberdeen Proving Ground, handling munitions/high explosives. Needless to say, a number of my co-workers were glad to see me going in to treatment.

I was taken to a place called “Chit-Chat Farms”—later to be renamed the Caron Foun-

dation. By now I knew I couldn’t continue drinking and living my life the way that I had been, nor could I envision living out the rest of my life without alcohol or other drugs. I was broken! I had reached a turning point in my life.

Fortunately, the 28-day treatment program that I attended was very 12-step oriented and it saved my life. I learn to follow the G.O.D. (good orderly direction) provided by my counsellors. I left treatment and immediately got a sponsor, got involved in meetings, began working the steps, and searching for a God of my understanding. Subsequently, I have followed along the same path in essence.

Now, at my 40th year of continuous recovery, I look back on my past in awe and amazement and with the deepest gratitude for all that has been given, all that has been taken away, and all that has been left behind.



Chapter 8

The Crucial Role of Law Enforcement and the Justice System in Addressing the Use of Drugs

“

Law enforcement plays an integral role in drug use prevention by protecting public safety, reducing the availability of drugs and discouraging drug use in the population. Alternative sanctions that require enforced abstinence, but also reduce the use of imprisonment for drug-related offenses should be developed, e.g. Drug Treatment Courts. Instead of being an obstacle to recovery, the criminal justice system should become a powerful engine of recovery. Alternative sanctions should empower people to become drug-free, crime-free and integrated members of society.

The Crucial Role of the Justice System in Addressing the Use of Drugs: An Introduction

Jamey H. Hueston, Caroline S. Cooper & Richard Bennett

During the past several decades, justice systems across the globe have been faced with a rapidly increasing influx of cases involving substance-dependent or addicted offenders whose drug use fueled their criminal conduct as well as presented a major threat to public safety and the wellbeing of individuals, their families, and their communities. The initial response to this “epidemic” of drug cases was tough prosecutorial policies, little if any “plea bargaining”¹ and harsh sentences. However, rather than curtail the surge of drug cases and associated criminal activity through these practices, the result was a burgeoning prison population, high recidivism rates for those released, escalating crime in many locales, including gang activity, family disintegration, and a justice system that was about to collapse from its own weight.

Long before the broad dissemination of research regarding the chronic disease nature of addiction that has occurred over the past decade, judges, prosecutors, defense counsel, law enforcement and others who dealt daily with drug addicts on their caseload recognized that drug addiction was a condition that could

not simply be controlled by “just saying no” and that drug addicts would continue to use drugs and commit crime without adequate treatment. Using the leverage of the sentencing authority of the court to promote engagement in treatment in lieu of incarceration, the concept of the “drug court” emerged in Miami and spread throughout the U.S. and beyond beginning in the early ‘90’s, along with a wide range of research confirming the effectiveness of the approach – e.g. mandated treatment rather than incarceration.

Today, public opinion polls in the U.S. demonstrate a strong public preference for alternatives to incarceration for drug users. Specifically, they support (1) policy changes that shift non-violent offenders from prison to more effective, less expensive alternatives, and (2) sentencing and corrections reforms including reduced prison terms.² The Pew Research Center also confirms these findings in 2014, reporting that two-thirds of the American public favor treatment, not jail, for drug use. Rather than using the authority of the justice system simply to punish drug users, public opinion is

clearly shifting toward using the authority of the justice system as leverage to promote a more therapeutic approach for dealing with drug users.

The developing field of therapeutic jurisprudence³, which began to take shape in the late 1980's, perhaps best reflected in the birth of the "drug court" model in 1989⁴, also made it apparent that the justice system – and particularly the judicial process – could, by introducing a wide range of alternatives to conventional practices, provide avenues for rehabilitation, restoration, and social reintegration in appropriate cases rather than serving only as a vehicle for punishment as had been the case. This approach embodied the essence of the principles of Therapeutic Jurisprudence, a then burgeoning field of justice study focusing on the role of law in promoting "healing" as well as punishment when necessary. In addition, it became increasingly recognized that this therapeutic role could begin at an individual's first contact with the justice system and extend throughout the numerous phases of the justice system process.

During the intervening years, efforts were undertaken to re-examine virtually every aspect of the justice system with a view to retool these components to promote alternative approaches, as appropriate, for addressing nonviolent drug-driven criminal activity – approaches that promoted treatment, rehabilitation, individual dignity, patience and respect while at the same time protecting public safety. A two-pronged methodology has emerged from these efforts, entailing therapeutic approaches where feasible, operating within the overall law enforcement framework and made possible through the authority and leverage the justice system provides – e.g., a "carrot" and "stick" approach. This framework has permitted substantial reform of the criminal justice system to deal with drug use while keeping the overall structure of criminal justice intact.

Drug reform efforts are now being touted by proponents of marijuana legalization under the guise of ineffective marijuana policies, improved regulation of marijuana, the right of individuals to use, medicinal qualities of the drug and the relatively minor risks of marijuana

usage compared to other drugs. However, where legalization measures have been passed, they have been confined to possession of small amounts of marijuana for personal use, enacted primarily to avoid the expenditure of justice system resources required to prosecute these cases as well as to raise revenues from the taxes imposed, with very mixed results reported.⁵

This chapter will describe a range of representative options and strategies that have been utilized effectively by the various justice system components to promote, where suitable, a more therapeutic approach for addressing drug use and associated mental health conditions. Although the bulk of the examples cited are from the U.S., where substantial documentation has been developed, many are also being effectively introduced outside of the U.S., with the resulting experience hopefully documented in the near future.⁶

Changing Role of the Criminal Justice System (CJS)

With increasing recognition of both the ineffectiveness and counterproductive outcomes resulting from traditional approaches within the criminal justice system and its law enforcement function applied to drug offenders, many jurisdictions have reassessed both traditional practices as well as the role of potential alternatives for more effectively addressing the problems of drug use and associated criminal activity in their communities. This reassessment has entailed triaging the arrestee populations to identify those committing crimes as a result of their drug addiction in contrast to those committing crimes for reasons unconnected with any addictive or related mental health disorders. For those falling into this second category, the traditional role of the criminal justice system has continued to be applied – focusing primarily upon the threat to public safety these offenders present, with, in some instances, expedited processes employed to ensure prompt attention to these cases. For those cases falling into the first category, however – offenders committing crime as a result of their drug addiction – the role of the criminal justice system has become substantially expanded to integrate public

health, social services, and other interventions within the traditional criminal justice process.

In countries that have pursued this triage approach, the role of the criminal justice system has generally moved from a primarily punitive orientation to one that also includes rehabilitation for appropriate situations. Focusing on cases involving drug-using offenders, both research and experience have demonstrated that (a) a therapeutic approach is more effective than a punitive one; and (b) punitive approaches per se only exacerbate the risks to public safety as well as the health of the individual, family and community, and can, in fact, be counterproductive. Through the development of partnerships between criminal justice agencies and public health, social service, and other community entities, the role of the criminal justice system and the agencies involved in its "law enforcement" function is being augmented to also take on the role of "first responder" to situations involving criminal conduct in which the underlying causes are rooted in addiction, mental health, trauma, and related disorders.

This change in the criminal justice system operating paradigm has been prompted by a response to emerging research, experience relating to drug offenders, and a respect for human rights as articulated in international treaties and conventions. The overall goal is to provide treatment to promote offender recovery, increase chances for successful reintegration into the community, and address the triggering causes of addiction and associated mental health disorders that underlie criminal conduct while, at the same time, protecting public safety. Translating this paradigm shift into practice has entailed the cooperation and collaboration of diverse components of the criminal justice and public health systems along with that of other service and community entities to provide more effective and meaningful alternatives to the traditional criminal justice response.

Why the Shift in Focus?

During the past decade, research from two very different disciplines has coalesced to provide momentum for a major reconsideration of the

role the criminal justice system should play in promoting public safety and human rights. The first body of research comes from the medical and scientific community documenting the chronic, relapsing disease nature of drug addiction, its effect on brain anatomy and chemistry, and its multiple ramifications that affect cognitive, behavioral and physiological brain functioning. Drug addiction not only contributes to continued drug usage and associated crime but also to an individual's capacity to cease drug use and to perform daily functions necessary to live responsibly in the community.

The second body of research comes from various sectors of the criminal justice field, addressing the dysfunctional impact of traditional, punitive-oriented criminal justice policies and practices, with a focus particularly on those geared toward incarcerating drug-addicted offenders who are often the most fungible actors and the weakest link in the drug supply chain. Among the topics addressed in this research has been the counterproductive and costly expansion of penal laws, including the application of mandatory sentencing provisions, lengthened prison terms, and increased use of pretrial detention for offenders. Research also documents the many negative economic results of imprisonment on the offender's family, often involving minor children and caretakers, many of whom are already living on the margin.

The resulting findings have coalesced to highlight the urgency of reconsidering the role of the criminal justice system in dealing with drug-addicted offenders:

- Rampant prison overcrowding, with a disproportionate expenditure of resources to warehouse drug-addicted offenders without treatment or recovery opportunities;
- Frequent diversion of attention and resources from those who are committing serious crimes to cover the high costs of incarcerating low-level drug offenders who eventually return to their communities without the necessary skills, treatment or recovery opportunities to survive, much less thrive; and
- Deplorable conditions of confinement for many detained drug addicts, most also suffering from mental health disorders, with frequently dysfunctional if not dangerous

situations jeopardizing their health, safety and welfare, as well as exposing them to violence and exploitation.

Research has also pointed to:

- The diminished sense of personal responsibility, trust, respect, safety, health, social skills and self-worth that develops for detained drug addicts, making reintegration into society all the more difficult;
- Unintended consequences that affect the prisoner's family, including children who are deprived of their parental relationships;
- The "collateral consequences" and stigma for the offender associated with a criminal conviction and the resulting decreased job opportunities, diminished life goals, hopelessness and low self-esteem; and, most significantly
- The futility of the entire traditional criminal justice process, as reflected by escalating recidivism rates for imprisoned offenders when released.

Key Elements of the Changing Criminal Justice System Paradigm Emerging

The changing paradigm for the role of the criminal justice system in addressing substance abuse is reflected on both a *systemic* level and an agency-by-agency level.

On a *systemic* level, greater cooperation and collaboration is developing among criminal justice agencies that have traditionally operated in "silos." This cooperation and collaboration is best characterized by increased exchange of information and ongoing multi-disciplinary discussion regarding appropriate – and alternative – responses to criminal activity committed by drug-addicted offenders, often in the form of substance use and mental health assessments conducted early on after entering the criminal justice system. Courts, specifically, are partnering with health centers to ensure that proper assessments are provided to identify the appropriate level of care that an offender may need. The resulting "treatment plans" can then be enhanced with provision of ancillary community resources needed to provide education, housing, job training, medical and mental health services and other resources to address those needs

which contribute to addiction and negative behaviors.

On an individual agency level, the changing role is characterized by increasing use of a wide range of alternatives to conventional practices and policies that reflect the triage approach referenced earlier to distinguish cases and offenders that are primarily driven by drug addiction and mental health disorders instead of other criminal matters. A therapeutic approach can then be applied to those cases involving drug addiction to provide appropriate treatment services to promote the individual's recovery while, at the same time, protecting public safety. This health and social intervention focus builds on the principles embodied in international drug control conventions based on the principles of the right to health⁷ including the United Nations Conventions focusing on reducing human suffering arising from the health and social consequences of drug use, and encouraging treatment, education, after-care, rehabilitation and social reintegration as alternatives to conviction and punishment.⁸

Changing Role of Law Enforcement

Traditional policing necessarily plays a critical role in the control of drugs. However, while law enforcement agencies have continued to employ traditional strategies designed to uphold societal norms on drug use, lessen availability of drugs, and discourage drug use/abuse in the population, two critical elements reflect the changing role of law enforcement vis-a-vis drug offenders: (1) The initial response to situations involving criminal conduct that may reflect drug use and/or associated mental health conditions; and (2) Efforts to develop ongoing relationships with local communities that promote joint efforts to promote both public safety and rehabilitation of nonviolent drug using community members.

The most appropriate starting point for exploring alternative justice system approaches for dealing with the drug-involved offender is at their first contact with the 'system' – with law enforcement. As first responders, the vast majority of disturbances and criminal situations encountered by police relate to alcohol, drug

or health problems. The decisions made by the police during initial contact will often determine the critical entry path into (or diversion from) the justice system for drug abusers. The change in paradigm for law enforcement's response to dealing with drug-using individuals creating threats to personal or public safety has built on the triage approach referenced earlier – e.g., to identify individuals whose behavior appears primarily motivated by their drug use and/or mental health disorder and to assess that there is no immediate threat to public or officer safety. For those who fit this category, law enforcement agencies are increasingly partnering with social service organizations and especially with health professionals who are better equipped to handle the issues generating the crisis to which law enforcement is responding⁹

The following are examples of the application in practice of the changing law enforcement paradigm for responding to situations involving drug-using individuals:

Diffusing Initial Contact

Crisis Intervention training for law enforcement for dealing with mentally ill offenders

Many local communities in the U.S. are providing Crisis Intervention Training (CIT) for Law Enforcement Personnel to respond to situations involving mentally ill offenders. The CIT for Law Enforcement concept is based on a successful crisis intervention program that began in Memphis, Tennessee (U.S.), where officers were trained to de-escalate potentially violent situations and ensure the safety of the citizen suffering from the mental health disorder, as well as divert such individuals to treatment centers.

CIT programs are conducted by specially-trained law enforcement personnel and mental health professionals and entail a partnership with the local Department of Health to conduct an intensive Crisis Intervention Training (CIT) program for Law Enforcement personnel. The CIT training program is designed to enable law enforcement officers to become more adept and increase their skills at assisting (a) persons in crisis as a result of a mental health disorder, (b) individuals with substance abuse issues, and

(c) individuals in crisis. Identification of types of mental illness, a mental health system overview, verbal skills for de-escalation of potentially violent situations, and suicide intervention are part of the training.

Key elements of CIT training for law enforcement involve developing strategies to train community members to recognize signs and symptoms of mental illness and to effectively intervene when a crisis occurs. The CIT skills have also been found to be particularly useful in domestic violence situations and in contact with youth, elderly citizens, and the general public.

The goals of CIT programs conducted by law enforcement agencies are to:

- Ensure the safety of officers and civilians;
- Increase officer understanding of mental illness;
- Improve relationships with the community, particularly with mental health professionals, persons suffering from mental illness, and family members.

Mobile support teams assisting law enforcement

Some communities, such as Sonoma County, California, have established Mobile Support Teams consisting of behavioral health professionals from the local Department of Mental Health Services partnering with the local law enforcement agency. The Mobile Support Team provides field support to law enforcement officers responding to crisis situations that can potentially be diffused without further law enforcement intervention. Mobile Support Teams are generally staffed by licensed mental health clinicians and certified substance abuse specialists who receive specialized field safety training by their law enforcement partners and who are available to respond to requests from law enforcement for field assistance when they encounter a behavioral health crisis. Once the situation is secure and stabilized, the Mobile Support Team personnel are available to provide crisis intervention, support, and referrals to medical and social services, as needed, including assistance to family members to help connect them with ongoing care and treatment to mitigate future crises.

Emergency administration of naloxone to

reverse heroin overdoses

Many law enforcement agencies in the U.S. are equipping their police and first responders with naloxone¹⁰ (also known as “narcan,” among other names) that the officer can administer through injection immediately upon arriving at a situation involving a heroin overdose, instead of waiting for paramedics to arrive. An overdose of heroin or other opiates can depress breathing and leave the user unconscious or cause death.

Community Policing Strategies

The concept of “policing” has evolved from the traditional role of crime-fighting to a broader role in promoting ongoing community safety and security. Researchers and police administrators have come to realize that investigating crimes and catching criminals is only a small part of the algorithm for increasing citizen security. Collectively, they have developed a new policing style which involves understanding the causes of insecurity and addressing them directly – termed Problem-Oriented Policing by Herman Goldstein who set the stage for Community Oriented Policing (COP).¹¹ Pursuant to the old crime fighter model, police officers dealt with disturbances through persuasion or arrest. Under the innovative COP model, police attempt to understand the underlying problem that resulted in the disturbance and address the *problem* rather than just the *disturbance* – considering the symptoms, not just the cure. Under this new model, police are learning to reach out to other governmental and nongovernmental agencies and professionals to help solve problems and increase community security.

Key elements of community-oriented policing approaches being used for dealing with drug and alcohol addicted offenders include:

- New policing styles that are proactive in nature, building upon an understanding of the causes and manifestations of disruptive behavior associated with drug addiction and mental health disorders and addressing them directly;
- Law enforcement responses that focus on understanding and addressing the causes of the underlying problems that resulted in the disturbance rather than just the disturbance.

- Promoting treatment and therapeutic approaches which are essential for dealing with crisis situations, using the leverage of the authority of the law enforcement agency. This leveraging requires all segments of the law enforcement agency to make radical changes in their paradigms, to introduce therapeutic/healing strategies, to break out of traditional “silos” and to partner with other “systems” – most notably the public health system.
- Establishing constructive relationships in local communities and ties with community groups through which the credibility and respect for law enforcement as a therapeutic agent as well as a public safety entity is enhanced.

Examples:

- A pilot project in Richmond, Virginia, paired a police officer with a social worker in responding to family disturbances. Under the old model, the police would likely be called over and over to the same residence to deal with an increasingly violent situation. The new response model demonstrated that bringing social services to citizens in need decreased the probability that the police would be recalled to the same locale – an assumption that was validated by the results of the pilot project.
- Direct referral of addicts to treatment programs by police in Gloucester, Massachusetts, with high early-stage enrollment reported. The program builds on partnerships the police have developed with other governmental and nongovernmental agencies and professionals to help solve community crime problems and increase community security. Police are also increasingly collaborating with social service organizations and especially with health professionals who are better equipped to handle these issues.

Other examples of this community-oriented approach include referral of nonviolent drug-using offenders to drug treatment programs, either as a diversion alternative for first offenders, or for formal drug court program enrollment for more seriously involved offenders. As discussed later in this chapter, many jurisdictions are employing drug courts

to help stem the rising tide of drug abuse and the petty crimes, such as street thefts and car/home burglaries, committed by drug abusers to obtain money to purchase drugs. By supporting the inclusion of drug courts in local justice system alternatives, the police can devote their resources elsewhere and the public becomes more secure.

Police Athletic Leagues (PALs)

Police Athletic Leagues have been formed by local law enforcement agencies in many U.S. cities to provide opportunities for youth to engage in recreational and educational activities that promote skill building and self-confidence, enhance connections with the community, and provide mentorship and other support for participating youth. The goal of PAL programs is to reduce juvenile crime and violence by establishing an environment that nurtures personal development, self-esteem, respect of the law, and positive relationships with community leaders who can also serve as role models. An overriding purpose of the PAL program is to bring together youth under the supervision and positive influence of law enforcement agency representatives to expand public awareness regarding the multi-dimensional role of police officers as they promote the safety and well-being of the community.

Combining Traditional Law Enforcement Strategies with a Community Policing Approach

Drug Market Intervention (DMI)

The “Drug Market Intervention” (DMI) program has been implemented in a number of U.S. cities where open drug markets were destroying neighborhood community life as a result of drug distribution, gang activity, and violence associated with these drug markets. The DMI approach builds on both traditional law enforcement practices and community policing strategies. Its goal is to eliminate open-air drug markets and the drug dealers that brought violence to local communities and destroyed most aspects of normal neighborhood life. The DMI program utilizes a *targeted law enforcement* strategy designed to prosecute the dealers

involved and a *community policing* strategy to provide alternative options for low level offenders living in the community who are involved with relatively minor aspects of drug distribution.

The DMI strategy involves law enforcement agencies working with local community leaders to analyze the nature of the drug market activity in the neighborhood, identifying those involved and conducting a triage assessment, to identify the lead drug dealers promoting violence (not nonviolent street-level distributors), and to arrest violent offenders. Law enforcement officials also develop prosecutable cases for nonviolent dealers but generally suspend arrest of these individuals to permit access to social, educational, drug treatment, and other services. The initiative is generally implemented through a “Call-In” meeting, which provides the opportunity for the DMI partnership to bring together dealers, their families, law enforcement, social service providers, and community leaders to send a clear public message that drug sales must stop and the neighborhood “market” must be closed. The “Call-In” also informs low-level dealers who reside in the community that community leaders care about them and are willing to provide opportunities to end their drug dealing activity and avail themselves of community services; however, continued dealing will result in immediate sanctions through the activation of their existing cases.

The DMI initiative was first implemented in High Point, North Carolina, and, subsequently in a number of other U.S. cities, all of which have reported reductions in violent and drug-related crime, strong community endorsement, and improved relationships between law enforcement and residents. In many cities where

“Police enforcement efforts which ensure public safety while addressing those with substance abuse or mental health issues by obtaining aid and care for the ill provide reasonable and humanistic solutions.”

the DMI initiative has been implemented, law enforcement agencies and the local community continue to work together even after the closure of the drug “market” to promote pro-social community activities, including picnics, community meetings, etc.

Police enforcement efforts which ensure public safety while addressing those with substance abuse or mental health issues by obtaining aid and care for the ill provide reasonable and humanistic solutions. Positive community policing efforts are receiving encouraging reviews from both police and citizens and studies suggest that police officers are willing to explore alternatives to law enforcement in order to tackle the underlying causes of community problems.

One study in particular indicated that public satisfaction with police encounters is significantly higher when citizens believe officers listen to them – an aspect of procedural justice. Factors included officer politeness; being treated objectively without consideration of race, gender, age, religion or sexual orientation; concern about citizen feelings and receiving adequate answers to questions.¹² In another survey, 98% of police officers indicated that assisting citizens is as important as enforcing the law.

Changing Role of the Prosecution Function

The laudable goal advanced by international drug control conventions and the world community is to develop alternatives to address underlying problems which contribute to criminal behavior before the individual becomes involved in the criminal justice system, deprived of liberty and possibly human rights. Identifying the earliest intervention points before initiating criminal processing, and affording opportunities for intervention alternatives, is a key part of this strategy.¹³ Once the decision to arrest has been made, however, the formal processes of the criminal justice system engage, shifting the focus from law enforcement to the prosecutor.

By virtue of prosecutorial investigative and criminal charging powers, prosecutors influence the trajectory of these target cases and individuals. The triage process continues to be

essential and prosecutor offices should consider the following:

- Whether the individual’s involvement in the criminal justice system is primarily the result of drug use and associated mental health conditions with minimal, if any, threat to public safety and if so, whether they are amenable to treatment and related support services; or
- Whether the individual’s involvement in the criminal justice system is reflective of conduct that presents a significant threat to public safety rendering them unamenable to treatment and related support services (e.g., including criminal conduct involving the use of violence, weapons, sexual assault, etc.).

For individuals who fall into the second category, traditional prosecutorial strategies are used. However, for individuals falling into the first category, a range of diversion opportunities may apply, with a view to afford individuals a “second chance” to avoid the potential punitive impact as well as collateral consequences of criminal justice system involvement, and which may differ among varying prosecutor offices based on numerous factors that are deemed relevant in any local jurisdiction. In some instances prosecutor policies apply to “first offenders” only; in other instances they apply more broadly to all offenders suffering from substance use and/or mental health disorders.

As discussed in Section VII below, some jurisdictions have also enacted specific legislation or strategies providing the opportunity for potential diversion from the criminal justice system or sentencing reductions for certain classes of offenders – first offenders; certain categories of offenders (e.g., women, veterans) and/or persons suffering from drugs and often co-occurring mental health issues who are charged with a low level or non-violent minor or misdemeanor offense – and designed to promote involvement in treatment instead of incarceration.

Diversion: Multiple Approaches

Prosecutor offices have a significant opportunity to provide for diversion and other alternative programs for drug offenders. The most effective

diversion models integrate diverse components of both the criminal justice and health systems with assistance of other available entities by providing more humane, cost-effective and meaningful alternatives to traditional criminal justice processing and incarceration.

In some instances “diversion” programs can result in dismissal of the charge by the prosecutor once the individual completes the requirements of diversion, which may include completion of treatment, restitution to the victim, obtaining employment, etc. In other instances, prosecutorial “diversion” may result in the prosecutor’s recommendation to the court for a substantially reduced sentence than might otherwise apply.

While this chapter addresses a range of alternatives that focus on drug users, some prosecutor offices also target small-scale dealers. In addition to the Drug Market Intervention Initiative (DMI) discussed above, the following is an example of a prosecutor program in San Francisco, California (“Back on Track”), that targets young adults between the ages of 18-30 with no prior convictions who were charged with micro-trafficking conduct that did not involve violence.

Eligible program participants were identified by the prosecutor’s office, required to enter a plea of guilty to the offense in court and participate in a 12-18 month program that included job training, community service, and other requirements while under the supervision of a designated judge. Upon successful completion of the program the charges were dismissed (e.g., the court struck the guilty plea that had been entered) and participants’ records were sealed. Guilty pleas and the applicable sentence of incarceration were immediately imposed with regards to participants who failed to meet program requirements. The program reports recidivism rates less than 10 percent among graduates and the program has been adapted in Philadelphia, where the local prosecutor’s office established “The Choice is Yours (TCY)” program serving a similar young adult population with similar services provided.

Several other programs merit mention as viable alternatives to prosecution. The Conviction and Sentence Alternatives (CASA) program in Los

Angeles California, is an example of targeting persons who have committed non-violent minor crimes and are involved in the drug market. In Manitoba, Canada, the Aboriginal Restorative Justice Project, operating since 2002, provides services to persons belonging to indigenous communities who live in urban settings and who are in conflict with the law for offenses related to drug possession or nonviolent offenses stemming from heavy or problematic use. The program provides culturally appropriate services to these individuals, based on the concept of restorative justice.

Changing Role of the Defense Function

With increasing knowledge regarding the chronic disease nature of drug addiction, the role of the defense attorney representing defendants who are both substance users and charged with criminal offenses has become complex. On the one hand, defense counsel must focus on his/her traditional obligations to protect the constitutional rights of the defendant, vigorously defend them against pending charges, and seek the best outcome – ideally dismissal of the charge but, if that is not feasible, an outcome that is least intrusive in terms of its impact on the defendant. However, defense attorneys know all too well that often a “good deal” at the time may only be a momentary “victory,” failing to address the underlying problems of addiction that will continue to bring the defendant into contact with the criminal justice system, let as well as further deteriorate his/her personal and family situation.

Additionally, counsel must consider that offenders are exposed to an array of criminal, civil, and regulatory sanctions, restrictions, and disqualifications which does not always end at the expiration of the sentence. These “collateral consequences,” particularly those impacting employment, housing, and health, take automatic effect upon a criminal conviction and effect many rights, licensing, employment options, and federal benefits.

The response among progressive, proactive defense counsel representing nonviolent substance-involved defendants has

been characterized by:

- Continued vigorous execution of the defense function (e.g., full investigation, legal research, advocacy, etc.) and protection of the defendant's constitutional and statutory rights;
- Obtaining professional substance use and mental health assessments from qualified clinicians to document the nature of the defendant's addiction and/or mental health condition and recommendations for treatment;
- Enrolling clients in treatment before the trial to present the defendant in the best light before the tribunal and demonstrate the active steps being undertaken to ameliorate the negative behavior;
- Communicating with prosecutors and law enforcement, in particular, to explore alternative dispositions acceptable to the respective agencies in light of the clinical assessment and active engagement in treatment; and
- Applying the concept of "Holistic Advocacy" to the defense function – e.g. analyzing the full scope of issues relevant to a defendant's situation and not simply the issues presented in the immediate charge, and then mobilizing the resources needed to address them.

An example of a holistic approach to criminal defense is represented by the Bronx Defenders, Civil Action Practice in New York, New York, which integrates civil representation with criminal, family and defense attorneys; advocates; and social workers to assess client legal needs, minimizing the repercussions from criminal and family proceeding and facilitating the reentry of clients into the community and towards the restoration of their rights.

Changing Role of the Court

With the increasing prevalence of drug users committing criminal offenses, and their repeated "revolving door" contacts with the justice system, courts have taken a proactive role to address the underlying causes of their criminal conduct in an effort to reduce recidivism that has fueled criminal court dockets, not to mention the associated burdens on the rest of the criminal

justice system and communities.

Cases involving criminal conduct by drug using individuals that are not summarily handled through the initial contact with law enforcement or diverted by the prosecutor enter the court system, where the *triage* process continues to be applied, augmented during the past decades by the application of therapeutic options (e.g., drug courts most frequently).

Triaging the Caseload

Many courts schedule cases for hearing and disposition based on the nature of claims presented (e.g., homicide, driving while intoxicated, etc.) and the potential complexity of the case process (e.g., multiple defendants, expert witnesses, forensic testimony, etc.). In the U.S., this process is commonly known as "Differentiated Case Management" (DCM). A major component of the DCM process is identifying cases that are amenable to assignment to "Drug Court" and "problem solving" court dockets and other diversionary and alternative options.

Expediting Access to Services and Overseeing Their Delivery

Substantial delays often occur between the commission of the offense and trial; and without intervention offenders frequently reengage in destructive behaviors. Ideally, the system should identify needs and provide services at the earliest intersection point to take advantage of the precipitating event, typically the arrest, to engage offenders in services and rehabilitation, thereby minimizing criminal justice system involvement. The earlier the intervention after arrest, the more quickly the offender can receive needed help to combat destructive behaviors. The bail review stage soon after arrest is an opportune time for judicial officers to set bail or pre-trial conditions requiring treatment as a condition of release. Offering drug treatment and other resources pre-trial, for example, can take advantage of an offender's motivation resulting from the arrest when there may be a greater willingness to engage in treatment and before this motivation diminishes as the offender

returns to the community and continues drug use and other old “habits.”

Drug Courts

Unlike other courts which are geared toward promoting prompt case disposition, cases assigned to drug courts and other problem solving court dockets are characterized by more extensive periods of court involvement, during which defendants remain under the court’s supervision, with frequent “status” hearings occurring during that period.

A “Drug Court” is a special docket which operates within a Court, targeting defendants arrested for criminal offenses determined to have been committed primarily as a result of their drug use. The Drug Court program provides judicial oversight of participating defendants and treatment and ancillary support services for a 15- 18 month period, with frequent (often at least bi-weekly) status hearings conducted by the judge. During the period of drug court program participation, the “adversarial” process is suspended, with the focus on services for each participant being *therapeutic* rather than *punitive*, recognizing the complexity of issues that underlie drug addiction – trauma, abuse, depression, and others – and the comprehensive, holistic recovery support services needed to address addiction and sustain recovery. The overall goal of drug courts is to provide adequate and effective treatment and other support services, rather than incarceration for individuals involved with the criminal justice system primarily as a result of their drug use.

Some offenders are considered ineligible for diversion programs either because of lengthy prior records or other criminogenic factors which suggest that more vigilant supervision is warranted to protect public safety. These programs blend the criminal justice and health systems by providing comprehensive screenings and assessments to ensure that offenders receive appropriate and vigorous treatment and an array of support services – educational, vocational and health. Immediate responses to both positive and negative behaviors are used as behavioral management strategies. A major

function of the drug court is to provide vigilant monitoring and supervision of offenders to ensure compliance with program requirements, as well as oversight and monitoring of service agencies to ensure proper and timely delivery of services. Persons who successfully complete drug court programs generally have their charges dismissed or reduced, or potential sentences of incarceration suspended. Drug Courts are an effective alternative to jail for offenders who are not otherwise eligible for or offered a diversion option.

The introduction of “drug courts” to the court process reflects a major change in the traditional court paradigm for handling case filings, characterized by proactive oversight of both defendant performance as well as the effectiveness of the entire program and the specific services being provided. Although the actual application of the drug court model will vary from locale to locale, reflecting local agency relationships and available services, it is framed by “Ten Key Components” (applied in the U.S.) and similar “Thirteen Principles” (applied outside of the U.S.). Over 2,600 drug courts currently operate in the U.S. and are established widely in North and South America, Europe, and Australia, in approximately 25 countries.

Numerous scientific studies have consistently documented the effectiveness of drug courts, pointing to the significant reductions in crime among participants and the substantial justice and community cost savings. Drug Courts also have profound effects on offenders and their families, which are echoed by countless participants during drug court graduations who profusely thank the drug court program for “saving their lives” and restoring their families, jobs and self-respect. It is also common for graduates to show individual appreciation to the arresting police officer and to the judge for their help and to the drug court team (prosecutor, defense counsel, and treatment service providers) for believing in them when they could not do so themselves. A drug court graduate with tears in his eyes credited drug court for helping him to see his children grow up and become “a real dad, drug free and proud.”

Other Problem-Solving Courts

The success of the Drug Court model in addressing underlying substance use, mental health, and related issues that prompt criminal conduct has generated other specialized dockets known as “problem solving court” programs. These include:

- family drug courts targeting child welfare cases involving parental substance abuse);
- community courts that apply a problem-solving approach to neighborhood-focused crime and safety issues; and
- homeless courts, targeting individuals whose criminal offense is primarily driven by lack of housing. Criminal trespass, prostitution, aggressive panhandling, and related offenses characterize this category.

Prison overcrowding and docket overload has occurred in some countries as a result of the disproportionate charging of many low-level drug users who are in desperate need of social, treatment and related community services. The attendant convictions and relatively short periods of incarceration will likely exacerbate their immediate situations; however, a problem solving approach offers numerous opportunities to examine the criminal conduct by addressing the underlying problems and offering alternative services. The result is to remove these cases from the general court caseload, to provide needed help and to ensure that these cases are truly “diverted” behavior

In Baltimore, Maryland, for example, arrestees meeting designated criteria are offered entrance in Homeless Court and Prostitution Court where targeted services are provided and the matter is dismissed upon successful completion. Treatment Alternatives and Diversion in Wisconsin (U.S.) is another example of a program which diverts nonviolent offenders into voluntary substance abuse treatment with case management and other risk reduction services – providing an alternative to confinement, saving bed space and costs.

Broadened Dispositional/Sentencing Options

In addition to dispositions that occur through drug court and other problem solving court

dockets, expanded dispositional and alternative sentencing practices reflect efforts of courts in many jurisdictions to triage cases that threaten public safety (for which incarceration is imposed) rather than those for which incarceration serves no benefit and, in fact, may be harmful.

Even where a prosecutor may not agree to “diversion”, a court may impose a Deferred Entry of Judgment Diversion disposition, or a similar option which suspends court proceedings while the defendant submits to drug testing and completes a drug rehabilitation program or substance abuse education class to avoid conviction. These options are generally open to low-level drug offenders who are not dealers or for whom there are no allegations of violence. An example of this type of programming is the Deferred Entry of Judgment Drug Diversion program in California (U.S.) in which the case is dismissed after successful completion of drug testing and completion of a drug rehabilitation program or substance abuse education class. Exclusionary factors include drug selling and allegations of violence. In other situations in which a conviction is deemed appropriate, courts often suspend or greatly limit any applicable period of incarceration, and order probation instead with associated probation services.

Continued Community Supervision of Drug-Using Probation Violators

Increasingly courts are also suspending automatic incarceration for nonviolent offenders who violate probation as a result of their drug use and, instead, order more intensive services – often through probation-focused drug courts.

Reentry Drug Court

Where laws permit, “reentry drug courts” have emerged to provide judicial supervision for drug using offenders who have been sentenced to a period of incarceration which is generally shortened if a post-release reentry drug court is available for their subsequent supervision and services. While reentry drug courts provide the same services to participants as drug courts, programs will often begin the treatment and rehabilitation processes while the offender is still

in the institution. Another critical function for their effectiveness is the critical coordination with the detention institution prior to the detainee's release regarding community services, to ensure the seamless transition to the reentry drug court once released. In many cases, this may require the reentry drug court to ensure that housing, treatment and other services are in place for the detainee upon release and a representative from the reentry drug court to physically transport the inmate from the detention institution to the community based facility.

Changing Role of Probation

Research results highlighting the chronic *disease* nature of addiction – which affects an estimated 80% of the criminal justice system population – and increasing responsibility of the justice system to provide meaningful responses that address this situation. This therapeutic rather than punitive focus has significantly changed the role of probation. At one time, the function of probation was considered more of a support function than solely one to ensure accountability as it subsequently developed in many locales. More recently, however, the role of probation has shifted to include its client service function in addition to providing monitoring and supervision services, and, in some instances, case management, drug testing and treatment services. Additional focus on community and restorative justice principles have introduced not only additional functions and roles of the traditional probation “agent,” but have expanded the orientation and operating philosophy of many probation departments and their relationships with offenders and the community.

One example of the application of therapeutic and restorative justice principles of current probation programs is “Project Hope” (Hawaii’s Opportunity Probation with Enforcement). Project HOPE is a program for probationers who are afforded drug and mental health counseling in addition to standard supervision services, with strict and swift brief jail sanctions applied for failing to report for random drug testing or missed supervision appointments. Program evaluations indicate

significant reductions in probation violations, drug usage, recidivism and time otherwise spent in prison.

Legislative Initiatives

In the U.S. there are significant legislative measures, both at federal and state levels, to reduce sentences for drug offenders. This movement includes downgrading offense classifications from felonies to misdemeanors, legalization of possession of small amounts of marijuana for personal use, consistent with statutory provisions in other countries, and reductions and/or elimination of sentences imposing “mandatory minimum” periods of incarceration for drug offenses, deferring, rather, to the sentencing judge.

The Smarter Sentencing Act of 2014 is an effort to reduce the size of the current U.S. prison population and associated costs. This legislation adjusts federal U.S. mandatory sentencing guidelines for various offenses, including drug crimes, and expands the ability of nonviolent offenders to reduce their sentences.

In California, voters passed Proposition 47, which downgraded previous specified nonviolent felony convictions to misdemeanors and provided for immediate resentencing of those previously convicted of these offenses, with options for expungement.

“Additional focus on community and restorative justice principles have introduced not only additional functions and roles of the traditional probation “agent,” but have expanded the orientation and operating philosophy of many probation departments and their relationships with offenders and the community.

Several other states in the U.S. have enacted legislative provisions permitting diversion or other alternative dispositions for drug using and other nonviolent offenders who are veterans, either through Veterans Treatment Courts or other justice system disposition mechanisms.¹⁴

In Costa Rica, Article 77, Law 9160, the Psychotropic Law, was amended to provide special provisions for women offenders, ameliorating previous provisions. The Amendment applied to women who transport drugs into prisons and are in a "situation of vulnerability," reducing the applicable prison term of 8 to 20 years to 3 to 8 years and permitting women charged under the statute who are "living in conditions of poverty, are heads of household living in conditions of vulnerability, or have custody of minor children, older adults or persons with some form of disability" to be sentenced to home arrest, supervised release, residence in a halfway house or be under electronic monitoring. The amendment was also provided for the release of women previously detained and provision to them of comprehensive socioeconomic services that address factors associated with their criminal involvement.

Conclusion

The wide range of alternatives to incarceration that are being undertaken, both systemically across all segments of the criminal justice system as well as by individual components, reflect the increasing broad-based awareness of drug addiction as a *disease* rather than simply a behavioral issue or a moral failing – a disease which has profound impact on individuals, families and communities worldwide. Countries across the globe are moving toward a new paradigm of criminal justice system functioning – built on the potential for its therapeutic rather than solely punitive role. Activating the courts as a vehicle for healing and rehabilitation instead of strictly punishment serves both offenders and communities in beneficial and restorative ways, and the multidisciplinary collaborative synergy of the legal and health systems creates powerful opportunities for comprehensive system reform, saving money and human lives, improving

public health and advancing the principles of international drug control conventions and human rights.

The international community has long asserted that human rights and dignity encompass the right to health.

Article 38 of The Single Convention on Narcotic Drugs, 1961 states: "The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, underlining the crucial role of health and social interventions."

This approach has been reinforced through The United Nations Resolution Adopted by the General Assembly, Fifty-fourth Session, 2000 and United Nations Office on Drugs and Crime (UNODC) and the Promotion and Protection of Human Rights Position Paper, 2012. Specifically, the UNODC stated: "There is an insufficient emphasis on human rights and dignity in the context of drug demand reduction efforts, in particular regarding access to the highest attainable standard of health services. There is also a need for an improved understanding of addiction and the growing recognition of it as a chronic but treatable multifactorial health disorder."

They entreated their member states to "Ensure that drug demand reduction measures respect human rights and the inherent dignity of all individuals and facilitate access for all drug users to prevention services and health-care and social services, with a view to social reintegration."

The June 7, 2013 "Declaration of Antigua, Guatemala" for a "Comprehensive Policy against the World Drug Problem in the Americas" at the forty-third regular session of the OAS general assembly exemplifies well this changing paradigm:

RECOGNIZING that the world drug problem, including its political, economic, social and environmental costs, has become an increasingly complex, dynamic, and multi-causal challenge that creates negative effects on health, social relations, citizen security, and on the integrity of democratic institutions, public

policies, development, and economic activities and that, under the principle of common and shared responsibility, which requires a comprehensive, balanced, multidisciplinary approach, built on a framework of full respect for human rights and fundamental freedoms;

DEEPLY MOVED by the large number of human lives lost and cut short, as well as the great suffering caused by the world drug problem; DEEPLY MOVED by the large number of human lives lost and cut short, as well as the great suffering caused by the world drug problem;

CONVINCED that policies to reduce illicit drug demand should focus on the welfare of individuals and their environments, so that from a multi-sectoral and multidisciplinary approach and using available scientific evidence and best practices, be based on approaches to mitigate the negative impact of drug abuse, reinforce the social fabric, and strengthen justice, human rights, health, development, social inclusion, citizen security, and the collective well-being;

REITERATING the need to strengthen State institutions and its public policies and strategies, particularly those related to education, health, and citizen security, in order to enhance prevention of drug abuse, violence and related crimes, with full respect for human rights and fundamental freedoms; REITERATING also the importance of greater allocation of public and private resources for the implementation of prevention, treatment, rehabilitation and social reintegration programs for the most vulnerable populations; MINDFUL of the need to reduce crime and violence associated with the activities of criminal organizations involved in illicit drug trafficking and related crimes, strengthening the role of the State as a guarantor of peace; DECLARE: That it is essential that the Hemisphere continue to advance in a coordinated manner in the search for effective solutions to the world drug problem with a comprehensive integrated, strengthened, balanced and multidisciplinary approach with full respect for human rights and fundamental freedoms that fully incorporates public health, education, and social inclusion, together with preventive actions to address transnational organized crime, and the strengthening of democratic institutions integrate diverse components of both the criminal justice

and health systems along with assistance of other available entities by providing more humane, cost effective and meaningful alternatives to criminal justice processing and incarceration. Collaborating together both the health and justice systems more efficiently provide consistent and qualitative assessments for proper placement, treatment monitoring, testing, supervision and accountability

Looking to the future, experience in augmenting the traditional law enforcement approach to drug control with strategies that also promote treatment and rehabilitation in appropriate situations provides useful guidance, including the following:

- Multi-faceted approaches to drug control are essential which take into account the situation presented by the drug user as well as the impact on the well-being and public safety of the community;
- Policies to reduce drug demand need to focus on the health and welfare of individuals and the community, drawing on public health, education, and other community resources, while policies to address drug supply must necessarily focus on the role of traditional law enforcement;
- The criminal justice system can be a major vehicle for facilitating these multi-faceted strategies, with a wide range of tools that can be used to attack drug demand and drug supply, by utilizing its authority to both punish and rehabilitate.

The social, economic, institutional and governmental costs of policies which promote over-incarceration of drug-related cases has reached a saturation point. Global communities are now actively considering alternatives which guard international human rights, the rule of law and vigilantly protect public safety while at the same time provide meaningful improvements to the lives of offenders. These strategies are laudable and will lead to a decrease in crime, victimization, and expenditures of resources while creating stronger, healthier and more robust citizens, families and communities.

Endnotes

1. Plea bargaining occurs when the prosecutor and defendant enter into an agreement whereby the defendant pleads guilty to some or all of the charges and the prosecutor in exchange, recommends to the court a particular sentence, agreement not to oppose the defendant's request for a particular sentence or some other concession.
2. Public Opinion on Sentencing and Corrections Policy in America, Public Opinion Strategies, The Mellman Group, 2012.
3. See www.therapeuticjurisprudence.org and TJ Blog at mainstreamtj.wordpress.com. The effort to 'mainstream' TJ is also reflected in two recent pieces, "New Wine in New Bottles" at <http://ssrn.com/abstract=2065454>, and "Moving Forward on Mainstreaming of TJ", at <http://ssrn.com/abstract=2564613> "
4. Drug court is a specialized court docket that targets substance-abusing offenders who commit crimes to support their dependency habits and are managed by a multidisciplinary team including judges, prosecutors, defense attorneys, community corrections, social workers and treatment service professionals providing comprehensive supervision, drug testing, treatment services and immediate behavior management.
5. *The Legalization of Marijuana in Colorado: The Impact*. Rocky Mountain High Intensity Drug Trafficking Area Volume 3, September 2015.
6. See, for example, Caroline S. Cooper, Brent Franklin, and Tiffany Mease. ***Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes***. (two volumes.)Justice Programs Office, School of Public Affairs, American University. Prepared for the *Drugs Summit: European, Latin American and Caribbean Mayors and Cities*. Organization of American States and the European Union. April 21 -23, 2010. Lugo, Spain; and Caroline S. Cooper, Chief Editor. *Drug Treatment Courts: An International Response to Drug-Dependent Offenders*. Justice Programs Office, School of Public Affairs, American University; Inter-American Drug Abuse Control Commission (CICAD), Secretariat for Multidimensional Security of the Organization of American States. September 2013.
7. *From coercion to cohesion. Treating drug dependence through health care, not punishment, Discussion paper*. United Nations Office on Drugs and Crime, New York, (2010).
8. Single Convention on Narcotic Drugs 1961 (Article 36b)
9. Approximately 80% of those arrested test positive for one or more of five drugs (including alcohol).
10. Naloxone is a medication used to reverse the effects of opioids especially in overdose situations. When injected it works within two – five minutes .The effects of naloxone last about half an hour to an hour. Multiple doses may be required as the duration of action of most opioids is greater than that of naloxone. Naloxone was patented in 1961 by Jack Fishman, Mozes J. Lewenstein, and the company Sankyo. The drug was approved for opioid overdose in the U.S. by the U.S. Food and Drug Administration in 1971. It is on the World Health Organization's List of Essential Medicines, the most important medications needed in a basic health system.
11. Goldstein, H., *Improving Policing: A Problem-Oriented Approach*. Crime and Delinquency 25:236–58. 1979
12. Rosenbaum, D.P., Schuck, A., Lawrence, D., Hartnett, S., with McDevitt, J., and Posick, C. *Community-based Indicators of Police*

- Performance: Introducing the Platform's Public Satisfaction Survey*. National Police Research Platform. 2011
13. *Handbook of basic principles and promising practices on Alternatives to Imprisonment*. United Nations Office on Drugs and Crime. New York. 2005
 14. Florida, Massachusetts, Minnesota, for example.

Chapter 9

Tackling International Drug Trafficking

“Tackling the world drug problem requires strong international collaboration. The current international drug control treaties establish an international framework to combat drug-related harm by reducing both drug supply and demand. However, more can be done to reduce any unintended consequences of the current regulatory regime and to ensure access to vital medical treatment and medications. We also believe that further international collaboration is needed to address the problems arising from the criminal drug markets, e.g. combating money laundering, corruption and international organized crime.”

No Shortcuts: Addressing Organized Crime and Drug Trafficking Through Institutional Development

Erik Leijonmarck

Secretary General, European Cities Action Network for Drug Free Societies

A Simplistic Discourse on Drug Policy Reform

The drug trade is, and has been for over hundred years, a truly global and transnational phenomenon which transcends national barriers. The core of international drug control are the three narcotic conventions from 1961, 1971 and 1988 which restricts use of narcotic drugs to medical and scientifically use only.

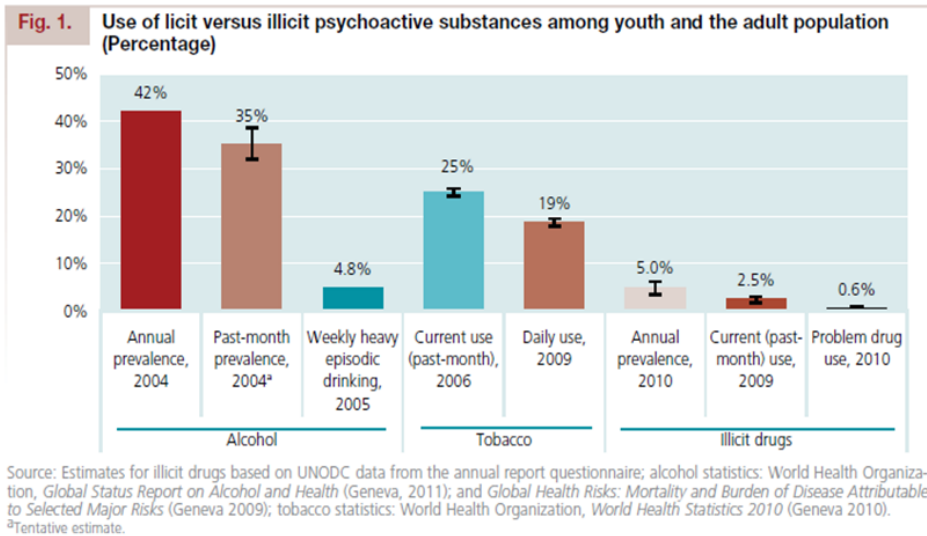
Seen in the light of consumption patterns of the two legal drugs, tobacco and alcohol, the drug control system has been remarkably successful in containing the world drug problem to a mere 5 % annual prevalence¹. There is no explosion in drug use and in this regard it is hard to consider the current drug control system as anything else but a stunning success.

There is however also a darker side to the picture. The demand for illicit drugs, though small in comparison to the demand for legal drugs, produces adverse effects on the security and development of countries which are plagued by illicit production, trafficking and

consumption. A global illicit market for drugs is partly fueling insecurity and corruption in the sense that it constitutes a mean of finance for illicit actors such as organized crime groups or terrorist groups seeking to challenge state authority. Violence and corruption are commonly associated with the drug trade.

Many arguments for drug policy reform, i.e. legalization, decriminalization or depenalization of illegal drugs, departs from the assumption that reforms in drug policy could de-incentivize criminal actors and make them less violent, less powerful and less detrimental to societies. If governments or legal businesses overtook the production and sale of narcotic drugs levels of violence, crimes and conflicts would be significantly reduced in affected countries, so the argument goes.

This line of thinking is becoming increasingly popular among advocates of drug policy reform who rarely fails to mention the adverse effect of drug control on countries that hosts production of illicit drugs or who are bypassed by drug trafficking on towards consumer markets in the US and in Europe. While



World Drug Report 2012

there are some merits in these arguments they are simplistic in the sense they fail to recognize that what is vaguely defined as organized crime:

- a) is a hydra with many heads of which drugs is just one.

Any type of regulation will create space for a criminal market which feeds on the demand for illicit goods and services. The smugglers and traffickers of yesterday exploited mercantilist regulations and trade barriers to enrich themselves or the states they served. Today's transnational organized crime groups and traffickers seek to profit from the trade in drugs just as they do with any type of service or commodity under regulation. Human traffickers and migrant smugglers profit from exclusive citizenship laws, prohibition of prostitution and strict labor laws. Traffickers in toxic waste exploit strict environmental laws to dump toxic waste in the oceans or in countries with less strict regulations or control. Sanctions and wars bring about artificially created scarcities which enable militias and organized crime to profit from trafficking in contrabands across borders. Taxes on legal drugs such as tobacco and alcohol create a black market which enriches organized crime who seeks to smuggle these goods to customers who are willing to pay a lower price or avoid age restrictions. Legal commodities such as medical drugs are being copied or forged to

escape costly patents, intellectual property are stolen to avoid paying copyrights, fake apparel are traded at a fraction of the development costs for the designers. The common denominator for this non-exclusive list of activities that organized crime profiteers from is that in each case there is a demand for illicit goods and services which enables the criminals to make money. Any discussion on drugs and drug policy in relation to organized crime must factor in that organized crime is often multi-criminal and can move between different criminal markets based on assessment of profitability and risk.

- b) has deep underlying root causes, specific to each society, which must be addressed if one is serious about undermining the power and legitimacy of organized crime. Shelf meters of academic literature have been produced trying to conceptualize and define what organized crime really is, why it exists and how to combat it. A number of definitions have been produced ranging from broad operational ones used by law enforcement agencies to more narrow definitions that will allow researchers to conceptualize exactly what differentiates activities of organized crime from mere "ordinary crime."

To add further confusion to this discussion post-cold war organized crime groups have become increasingly transnational and operate

or forge alliances across borders to get access to other markets or avoid law enforcement interdiction. Criminal proceeds are invested in legitimate businesses or end up in safe bank accounts as a result of global money laundering schemes run by strategic alliances between bankers, brokers and criminals.

The transnational element of organized crime has attracted the awareness of scholars from the field of international relations to study the impact of organized crime on international politics. By contributing to the fragmentation of nation states which in worst case scenarios results in failed states or areas of non-governance, organized crime is perceived as challenge to our Westphalian state centered international system and the security of regions.

The great paradox is that while there is ample of evidence of organized crime expanding across borders and connecting with foreign criminals, bankers and political elites organized crime groups have remained embedded in the local contexts in which they originated. They derive legitimacy and power from local socio-economic factors and specificities individual for each country. In areas plagued by conflict or war they can deliver some sense of order or provide public goods to populations whose governments have failed to do so.

The key to address organized crime systemic impact at the international level is to address its *raison d'être* in each specific country. The inability of governments to address organized crime in their own countries may translate into problems for their neighbors or even the international system in the sense that individual countries become failed states or safe havens for criminals. However, the fear of a worldwide crime conglomerate that operates across borders, avoids law enforcement which still mainly operates within domestic jurisdictions and challenges foreign nation states has not yet come into fruition and is unlikely to happen. Slogans and calls for simple solutions in the drug policy debate blurs sound analysis of the nature of the problem and consequently what to do about it. This chapter makes the following arguments:

- Smugglers, criminals and even

governments have profited from illicit markets long before the creation of modern drug control.

- Any type of market regulation creates room for actors to profit from illicit demand. Prohibition of drugs is in this regard not profoundly different from taxing cigarettes, protecting endangered animals or upholding copyrights. Our understanding of the drug trade should depart from how we understand other types of illicit markets from which organized crime profiteers from.
- Drug traffickers will outlive and adapt to changes in legal status of drugs, short of a complete legalization that is not followed by for example taxes or restrictions of use or limits in accessibility.
- Not all countries affected by drug trade have problems with drug related crime and corruption. Drug control in Latin America yields very different results from drug control in East Asia. The situational context of drug control i.e the institutional strength of countries shapes the outcome of drug control.
- Countries heavily negatively affected by drug trade have underlying problems which are aggravated by but not caused by the drug trade.
- Any sound discussion on drug policy should factor in how policies could improve development and security of nations while also ensuring that the demand for drugs and the negative health effects of drug consumption is kept at a minimum.
- A broad array of actions and policies are needed to improve the health and security of nations falling prey to drug trafficking and organized crime. These programs are viable within the current international system of drug control.
- Successful drug demand reduction programs in consumer countries could have beneficial long term effects on crime and violence assuming that the size of criminal drug markets diminishes and is not offset by an increase in demand in another illicit market.

The Origin of Drug Control

The international drug control system is based on the three UN conventions on narcotic drugs from 1961, 1971 and 1988. The conventions constitute an ambitious attempt to establish global control over the consumption and production of drugs and enjoys, with a few exceptions, almost universal adherence among states. The conventions originated out of necessity to treat the drug problem through strong international collaboration. This lesson was learnt from the experiences of the nineteenth century Chinese opium epidemic and the subsequent attempts in the first half of the twentieth century to counter drugs through unilateral and bilateral agreements between countries.

Before the seeds of our modern drug control system was sown in Shanghai in 1906 drug trafficking was not considered immoral but rather a legitimate source of revenue for the greater powers. European powers imported Chinaware, porcelain, tea and other commodities in large number from China in the 18th and 19th century and needed a commodity to export in return. Their solution was to export large quantities of opium which resulted in social costs for addiction that fell upon China which tried to install strict regulations on the trade. The British East India Company, a private company running under government license, cooperated with local criminal elements and enrolled smugglers to bypass Chinese regulations. Confrontations over the opium trade as well as other issues

“Before the seeds of our modern drug control system was sown in Shanghai in 1906 drug trafficking was not considered immoral but rather a legitimate source of revenue for the greater powers.”

led to that Britain went to war with China twice in what came to be called the Opium wars. In the second opium war between 1856 and 1860 China was forced to legalize the trade in opium under gunpoint.²

Imports of opium to China grew rapidly during all of the 19th century and peaked in 1880 when China decided to substitute some of the imports and encouraged domestic cultivation in order not to drain its national coffers. At peak production in 1906, China harvested 35,000 tons of opium and imported 4000 more to supply 13.5 million addicts, a level of mass addiction never equalled by any other nation before or after.³

The use of opium in China rose to gigantic proportion and spread to other countries through an expansion in trade and communication technology. The problem of addiction could no longer be contained to just one country and as opiate use became a global concern, opium dens started popping up in Britain, France and the US among other countries at the end of the 19th century.

Just as human rights groups had been successful in pointing out the immoralities of the slave trade which eventually ended slavery in the western world, the trade in drugs became recognized as an immoral way of profiteering on addiction in other countries. “That same century, Britain played the peculiar double role, on the one hand, of leading the campaign to prohibit and police the transatlantic slave trade, and, on the other hand, of aggressively promoting the East Asian opium trade.”⁴

Over the following decades the drug problem became recognized as a matter of transnational character which needed to be addressed through cooperation by different countries. Several international meetings were held about how to address the growing drug problem of opium and cocaine. The first international conference to discuss the world drug problem was held in Shanghai in 1909 and resulted in the establishment of the Opium Commission. The work of the commission laid the groundwork for the creation of the first international drug control treaty in Hague in 1912 which was followed by renewed efforts in 1925,

1931, 1936, 1946, 1948 and 1953 to strengthen international drug control. But it was not until after the Second World War when the UN was created that international drug control reached truly global dimensions. Almost all states adhere to the three narcotic conventions from 1961, 1971 and 1988 which have replaced previous agreements of drug control as the corner pillar of the global response to the drug problem.

Illicit Globalization and Modern Drug Control

The history of drug control tells the story of how rules and regulations on the drug trade set up by governments have been challenged by actors seeking new and innovative ways to profit from addiction. These actors range from individual farmers growing poppies or coca, to smugglers or armed groups profiting from the movement of drugs across borders and even to private or legal businesses operating under the willful eye of governments.

Actions are met by counteractions as rule makers and rule breakers adjust to each other's steps. The effectiveness of state controls varies based on the nature of demand and supply of the service or goods provided. Policing rarely eliminates the targeted activity but can nevertheless function as a market regulation by increasing the cost for supply and bringing down levels of demand. Corruption can also be seen as a form of market regulation in the sense that costs for bribing public officials will be internalized in the end price to consumers. So even during prohibition or other forms of state regulations economic laws still apply, at least to some degree, to illicit markets. This logic is true for drug trafficking and production but also equally applicable to any kind of illicit market transactions.

The interplay between rule makers and rule breakers in illicit markets is as ancient as history itself, but some scholars argue that the globalization of trade and technology that has taken pace after the end of the cold war has profoundly changed the way that these illicit markets connect with each other and impacts the rest of society.⁵ The same liberalizations

of capital markets and border controls which have facilitated increasing movement of goods, services and peoples between countries also enables illicit activities to flourish. The illicit side of globalization has opened up a golden opportunity for organized crime to mutate into transnational organized crime and thereby escape counter efforts from governments and law enforcement agencies which have remain confided within national jurisdictions.

UN agencies, state departments, scholars and many others have repeatedly voiced concerns over how "transnational crime has become a threat to peace and development, even to the sovereignty of nations."⁶ But how much merit has these alarmist statements? What raw data are they built upon and what actions should we take to minimize the harmful effects of transnational organized crime and drug trafficking?

The Impact of Drug Trafficking

Drug related violent crime and corruption is part of a cycle of state fragility, conflict and weak rule of law in which organized crime challenges both the security and development of states. It is becoming increasingly recognized in the literature that the concepts of security and development are interlinked. Both need to be strengthened for countries to develop and prosper. Unfortunately the drug trade often plays the exact opposite role by seeking



out countries that either lack in security or are underdeveloped or both and spearhead a race to the bottom in which governments' ability to provide basic security and development to its citizens are further undermined by the actions of traffickers.

Drugs and Violence

Drugs and violence are associated with each other. But the relationship between them is neither binary nor causal. The drug trade can be associated with extreme levels of violence in some countries, such as Mexico or Afghanistan, but the drug trade can also operate largely in peace as in many European countries or without creating severe adverse effects as in many East Asian countries.

Drugs and other illicit market activities are connected to violence in two ways:

1. In the absence of legal protection of property rights and agreements signed violence (or the threat thereof) becomes an enabler of illicit business transactions.
2. Illicit markets could also be the outcome or enabler of internal wars or armed conflicts.

Drug markets are often illustrated in media as violent confrontations between criminal gangs and or the police. A shooting makes big headlines and is, in the eyes of the public, a visible characteristic of a drug market. For a criminal point of view it makes sense having a reputation of violence to gain respect among peers and business partners. Violence is in this sense good for business. When organized in gangs criminals can use violence as a strategy to co-opt or intimidate the local population to adjust to their will or as a means of extortion or racketeering.

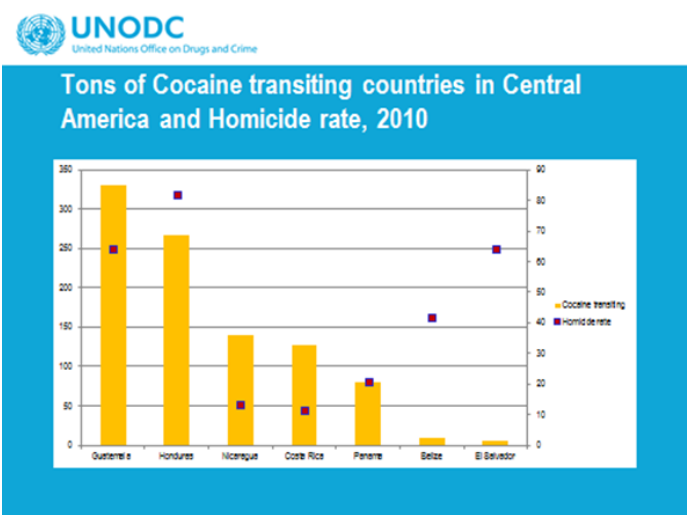
But despite what is commonly recognized, criminal markets are much less violent than one can think. Even drug markets are much less violent than what is commonly perceived. Violence is in fact, for a number of reasons, in most cases not the preferred modus operandi for making business. The use of stealth tactics or the settling of agreements over market shares is a more cost effective method than violence.

Even better is to bribe public officials to look the other way or corrupt law enforcement agencies not to interfere with business. And perhaps best is if crime could ensure passive or even active support from the political elite by striking alliances with governments or political movements.

The absence of violence doesn't automatically reflect absence of drug trafficking. It can be a reflection of an "established" high level trafficking, a pax mafiosa. This said, when informal systems of high level corruption break down or high level police interdiction successfully disrupts power relations among criminal groups the peace may fuel drug related market violence. Competition for leadership of a group can led to acts of violence within that group and when one group believes they have an opportunity to take over trade in another groups territory that might led to renewed acts of violence until a new informal power agreement settles.

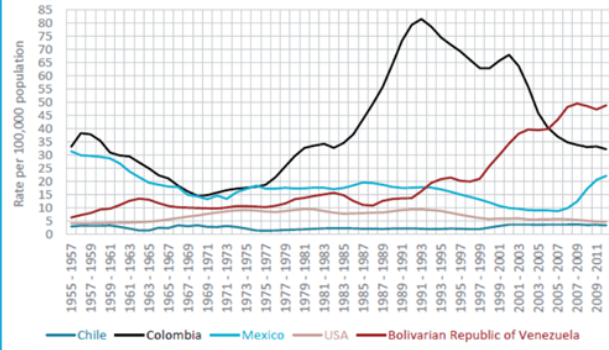
The actual volume of the drug trade is not proportionate to the level of violence in a society. Increase in violence has been associated with changes in drug trafficking (both increases and decreases).

Consider the differences in levels of trafficking and homicide rates in these Latin American countries.



Derived from presentation made by UNODC research director Angela Me

Homicide rates in selected countries of the Americas,
(1995-2012, three-year moving average)



Source: UNODC Homicide Statistics (2013) and WHO Mortality Database.

Source: UNODC, *Global Study on Homicide, 2013*.

Derived from presentation made by UNODC
research director Angela Me

It is easy to overstate the difficulties of addressing drug related violence and conclude that whatever governments do violence will prevail and criminals will outsmart law enforcement. But this is not always the case. Even in countries severely struck by violence, such as Colombia, the negative cycle of violence and under development can be turned around. The drug trade is also increasingly connected to armed conflicts and internal wars. And yet, there is no clear cut relation between armed conflicts and drug trafficking. Many transit countries for drugs are peaceful and stable states while others are plagued by armed conflict in which the trafficking of drugs, very much like the trafficking in wild endangered animals, blood diamonds or oil plays a role in prolonging conflicts. In Mexico, the large trade in cocaine and other drugs are disconnected from the country's small insurgencies. In Colombia the internal conflict outdates the country's production and trafficking of cocaine.

Escaping the Security and Development Dilemma

It is naïve to believe that a legalization of drugs would seriously undermine the power and wealth of organized crime. Latin America is perhaps the most well-known region where drugs play a large

role in the activity of organized crime groups. In Colombia and Mexico organized crime groups are even referred to as drug cartels. That very label implies that they would go away if their sourced of income was taken away.

Eliminating drug trafficking doesn't resolve the problem of OC and violence. Drugs is only one of the illicit markets managed by the Organized crime cartels in Central America and cartels have proven to adopt very quickly to the changing environment switching quickly to different markets if one proves to be less profitable or problematic. This is equally true in other parts of the world.

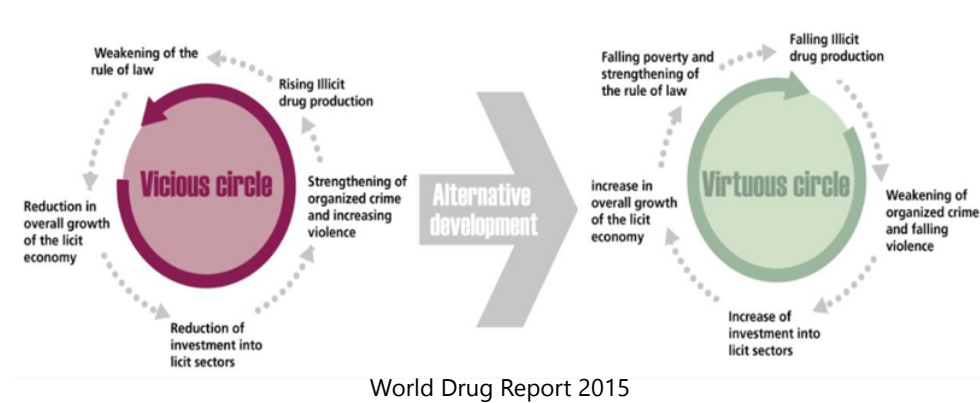
A good starting point for any discussions and subsequent actions to counteract drug trafficking and organized crime is to ask the question of how the vicious circle can be turned into a positive one where both security and development reinforces each other.

In a much cited world bank report from 2011 the role of strengthening rule of law and other institutions are emphasized to break circles of violence and underdevelopment: "The central message of the Report is that strengthening legitimate institutions and governance to provide citizens security, justice and jobs is crucial to break cycles of violence"⁷

Not all countries affected by insecurity and organized crime are doomed to continue to despair. There are countries, among them Georgia and Colombia to give a few examples, who have managed to break out of negative circles by addressing their root problems and strengthen important institutions. In this chapter, a case-study on how alternative development measures allowed Peru to escape its insecurity and under-development is presented.

Policy designs and evaluations should be broadly based and include considerations of national security, public safety, rule of law, economic development, public health and human rights. Root causes of state weakness should be addressed to indirectly target illicit drug production and organized crime.

The problem posed by drug traffickers must be answered through a twofold approach. In countries which primarily consume drugs we need to bring down demand and thereby



diminish the criminal market. In countries primarily producing drugs, the nation-building processes need to be assisted through the establishment of fair and effective institutions. Restore or build institutional legitimacy, restore public confidence in the justice system and governments, fight corruption and ensure that social programs provided for.

After all, the sky is not falling - states are not helplessly victimized by drug lords. Some countries are having severe problems but these have other root causes which should be addressed if one would really need to get to the heart of the problem. The problem of organized crime and its associated violence can be solved only if communities' vulnerabilities to organized crime are seriously addressed. There are no shortcuts.

Endnotes

1. United Nations Office on Drugs and Crime, World Drug Report 2014 (United Nations publication, Sales No. E.14.XI.7).
2. United Nations Office on Drugs and Crime (UNODC) World Drug Report 2009 World Drug Report 2009
3. Alfred W. McCoy FROM FREE TRADE TO PROHIBITION: A CRITICAL HISTORY OF THE MODERN ASIAN OPIUM TRADE accessible at <http://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=1804&context=ulj>
4. Andreas, Illicit Globalization: Myths, Misconceptions, and Historical Lessons, See for example Andreas, Illicit Globalization: Myths, Misconceptions, and Historical Lessons,
5. Quoted "in Organized Crime has Globalized and Turned into a Security Threat" United Nations Information Service, 17 June 2010.
6. Felbab-Brown, Trinkunas, UNGASS 2016 in Comparative Perspective: Improving the Prospects for Success
7. World Bank, World development Report 2011 accessible at http://siteresources.worldbank.org/INTWDRS/Resources/WDR2011_Full_Text.pdf

case study

Alternative Development in Coca-Growing Basins and Valleys of Peru

Alejandro Vassilaqui

Executive Director, CEDRO (Lima, Peru)

Deep in the Peruvian Jungle, in the region of San Martin, the alternative development program PIRDAIS was first implemented in 1999 by the organization CEDRO in cooperation with the Peruvian government and international donors and organizations.

Part of the name PIRDAIS implies “comprehensiveness” which means not only the implementation of coca leaf crop substitution but also to bring the state back in - Health, Education, Agriculture, Justice, Environmental Affairs, etc.

The purpose of PIRDAIS is to contribute towards a change in attitude and behavior among those populations involved in coca leaf production in the basins and valleys where it is grown. The aim is to ensure that these populations adopt or continue living a licit life without the influence of drug trafficking.

Under this strategy it is indispensable to work towards the eradication and reduction of coca leaf crops and to address the needs of the population through sustainable development. This means the application of a series of pro-

grams and actions by the state itself with the involvement of the civil society i.e. businesses and corporations, NGOs, churches, grass root organizations etc.

Local authorities were able to reduce coca leaf crops from 23,000 hectares to approximately 500 hectares in a 15 year period. This comprehensive action has managed to reduce the replanting of coca leaf by rapidly providing plausible alternatives to the population. The region of San Martin has been increasing its agricultural production of palm oil, cacao, coffee, palm hearts, and other products. By the end of 2013, this region had become the first exporter of coffee, cacao, palm oil and hearts and other products in the Amazon. San Martin is an example and has served as a “paradigm” for action in other coca-growing basins and valleys in Peru.

These developments were made possible thanks to the victories in the fight against the subversive groups that operated in the area. The capture of terrorist leaders from “Sendero Luminoso” and the “Revolutionary Movement Tupac Amaru” (MRTA) has contributed towards

the pacification and the development processes. This proves that the comprehensiveness of the actions is essential to achieve any change. This is accomplished and made sustainable since the community not only participates but also feels part of the transformation.

These building bricks are part of the successful PIDRAS activity in San Martin: crop eradication and crop substitution, involvement of the civil society such as businesses and corporations, adequate administration and political will, social awareness and connectivity programs, greater state presence, and international cooperation.

Today, San Martin is the first producer of cacao and the produce is harvested from areas that were formerly used almost exclusively for coca leaf growing and where the Alternative Development Program has been implemented.

In the year 2000, San Martin exported produce for a total of 11 million US Dollars. In the year 2012, the exports amounted to 113 million US Dollars. And in the year 2014, only cacao and coffee alone have brought in 150 million US Dollars. 15 years ago San Martin harvested two tons of coffee. The export figures for 2014 show that 14,580 tons of coffee has been harvested (SUNAT-UNAS).

43,754 hectares are being served by PIRDAIS and 55,068 families are involved in the program. It has also been recorded that 5,228 hectares have been reforested. As for crop eradication, between these basins and other valleys, a total of 23,407 hectares were eradicated reaching a historical figure concerning the reduction of coca growing space: 17.5% (UNODC – 2013).

Alternative Development in the Regions of Monzon and Huipoca

The regions of Monzon (Huanuco) and Huipoca (Ucayali) are special cases. In the first area the presence of the State had been practically non-existent for 40 years. The only presence was that of CEDRO as a private institution. The State entered Monzon and Huipoca in 2012 after negotiations between DEVIDA, the Peruvian governing body in matters related to drugs and the

main coca growing leaders and their families.

In the two aforementioned areas, intense PIRDAIS work was started with the introduction of fast-growing agricultural products (banana, beans, etc.) and the state and its different entities are brought into these areas. Different health, education and social programs were introduced in the regions. Money was given to parents provided they vaccinate and send their children to school, university scholarships were given to poor youngsters and retirement funds was delivered to people living in poor conditions without pension plans.

Successful negotiations were also entered into with existing local businesses to ensure the training of youngsters from the communities in trades that will enable them to rapidly obtain a job or provide services, like plumbing and electricity, and so cover the construction needs in the places where they live or close by.

As for crop substitution, which is a more long-term activity, it has been possible to grow coffee and cacao crops in over 2,359 hectares located in Monzon and Huipoca thanks to North American aid and government funds. This has been complemented with an enhancement and rehabilitation of community infrastructure such as trails and roads, bridges, etc. Furthermore, virtual connectivity is part of and should be added to the achievements of PIRDAIS. We should mention that CEDRO, since 2011, has been implementing a very successful program on information and communication technologies, which promotes an interaction between producers and markets, a licit and democratic lifestyle, and digital training.

With respect to Ucayali, this region has received and continues enjoying the benefits of PIRDAIS. Its exports during the last two years have grown: 63% in the areas of lumbering and paper; cacao production (77.2%), and palm oil. The region of Ucayali, which is also located in the Peruvian Jungle, has recently received a grant of eight million US Dollars from PIRDAIS (2015) and receives supplementary aid from the Ministry of Commerce and Tourism's and USAID which has been designed to promote lumbering and the production of camu-camu (a fruit with high citrus content). Ucayali is currently exporting goods for a value of 21.9 million US Dollars

(2014).

PIRDAIS (2012-2016) is implemented via training and technical assistance activities in connection with organizations and authorities. In 2013 a total of 195 programs and activities were undertaken in the coca-growing sectors where 51 entities from the federal, regional and local governments acted as operators.

At the beginning of 2013, the following figures were available regarding PIRDAIS results: 54,964 hectares of licit crops, with assistance; 284 rural roads were rehabilitated; 5,145 estates had title deeds.

The Comprehensive and Sustainable Alternative Development Program and its Rapid Impact Plan must have the Peruvian Government as its main operator and it should be nourished not only by the actions of the different sectors of the administration but also by the contributions of the private businesses, the civil society, the grass root organizations and any other institution that shares one same vision of sustainability and legality.

The Comprehensive and Sustainable Alternative Development Program has proven to be effective and efficient wherever it has been implemented and wherever it continues to develop actions. It is the obligation of the State and the communities to learn from its lessons and to scale out this program with resources from the State and the international and foreign cooperation to those areas where coca leaf is grown for illegal purposes to transform it into cocaine-based drugs.

PIRDAIS is a crucial component within a national strategy and constitutes a valuable tool in the global fight. Therefore, it should be the vision and mission of a country like Peru and it should be supported by all of its allies. PIRDAIS occurs within a shared responsibility approach to confront a real threat against humanity - drug trafficking.

Chapter 10

Conclusion

“

To promote public health and public safety it is essential that governments adhere to the three main drug control treaties of 1961, 1971, and 1988, as well as the Convention of the Rights of the Child. We believe that the UN drug treaties provide the best framework for reducing nonmedical drug use and its many negative consequences. We urge all member states to recognize that these treaties create a solid foundation on which to build future drug policy innovations.”

Progressing Drug Control into the 21th Century

The drug problem is complex. It touches many different aspects of the human condition. Why do some people start using drugs? Why does the use of some transgress into addiction? Why are some more vulnerable to drugs than others? How can drug use and abuse be prevented? How can we protect the most vulnerable? What does it mean to be addicted to drugs and how does one recover? When is one fully recovered from drug abuse? None of these questions has a clear answer.

Some seek answers in how our brains function and in medical science. Some seek answers from ourselves and ask what it means to be human, turning to behavioral science. Yet others ask what kind of societies would push people into drugs and turn to sociology for guidance.

Perhaps there is some truth to be found in all these fields. Perhaps this is a discussion which is likely to continue for a very long time. Drugs have the potential to unleash dramatic consequences for those who get addicted, their close ones and their communities. In some cases drugs are even a matter of life or death. What everyone agrees upon is that we need to do everything we can to protect ourselves from the harms of drugs.

Drug policy is complex. Added to the complexity is that whatever actions countries

take will have spillover effects for their neighbors. In a more globalized world these is felt more strongly than ever.

The international system of drug control has come a long way over the last 100 years. Based on the recognition that no country can solve its drug problems without the help of others, drug policy became an issue of global concern and cooperation early on. The rationale was, and still is, to protect the health of mankind by ensuring that narcotic drugs are restricted to solely medicinal or scientific purposes. The conventions stipulate that governments shall take all practicable measures for the prevention of drug abuse and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved. Closely linked to these stipulations is the Convention of the Rights of the Child, which obliges states to protect children from the illicit use of drugs.

Today's drug policy discussion is not profoundly different from how it was before. Yes, the world is smaller; we have more types of drugs and more ways to administer them. The population has grown substantially and yet the majority of us are financially better off than our parents and grandparents. In many senses we are even more interlinked to each other than

ever before in history. This requires each of us to share the burden of addressing the world drug problem and to be serious about fulfilling our individual commitments.

Things are far from perfect as they are, but those calling for an end to drug control – or those who would like to see the consensus achieved over the last hundred years replaced by a wider degree of freedom for each country to experiment in addressing their own problems – forgets that before international drug control our problems were larger.

Those blaming current policies for adverse consequences or failure in reaching the targets set should ask themselves – how can we better implement the spirit of the drug conventions? How should we better work to address our problems together? Prevention, treatment, rehabilitation and social reintegration remain central to tackling the drug problem. Any policy needs good implementation.

There is room for improvements and evolution of drug control. The conventions allow states enough room and flexibility to adjust their actions to local conditions and culture. But the foundation – the shared understanding of the problem and the recognition that we are all in this together, must be kept. The current foundation should be built upon and expanded – not discarded. Only thus can we advance drug control into the 21st century.

Recommendations

Drug policies should prevent initiation of drugs use. Prevention is one of the main components of a public health centered system and there is a growing evidence base for what works in drug prevention. The gaps that exist in science should make us cautious but not deter us from action. We have enough knowledge to tackle the challenge of doing the right things in the right way, even though more research and knowledge is needed.

DPF urges member states to put prevention of drug use as their top priority.

DPF urges member states to implement evidence-based prevention interventions in line with the UNODC's International Standard of Pre-

vention.

DPF urges member states to implement environmental prevention strategies that discourage drug use and reduce the availability of drugs.

Drug policies must respect human rights (for users and non-users alike) as well as the principle of proportionality. Human rights violations are present around the world. Examples include executions of offenders of drug crimes, arbitrary detentions and slave labor in drug treatment centers, as well as the militarization of anti-drug efforts and the attendant violations. They are abhorrent and should be condemned by the international community in the strongest way, including during the yearly CND meetings. However, there are no grounds to suggest that these violations take place because of the international drug control regime, as these breaches of human rights are systemic and widespread in areas beyond drug policy.

DPF urges UNODC to assist member states in the obligations under the three international drug control conventions by completing the review of the UNODC Model Legislative Provisions on Drug Control as an important tool and guidance in the implementation of drug control for member states.

DPF urges member states to take their human rights obligations for users and non-users alike into account when considering responses to drug use.

Drug policies should strike a balance of efforts to reduce both drug supply and drug demand or use. Policies to reduce drug demand need to focus on the health and welfare of individuals and the community, drawing on public health, education and other community resources, while policies to address drug supply must necessarily focus on the role of traditional law enforcement. The criminal justice system can be a major vehicle for facilitating these multi-faceted strategies, with a wide range of tools that can be used to attack drug demand and drug supply, by utilizing its authority to both punish and rehabilitate. Instead of being an obstacle to recovery, the criminal justice system should be-

come a powerful engine of recovery.

DPF urges member states to explore community policing models alongside more traditional approaches.

DPF urges member states to explore alternative sanctions for drug related crime.

Drug policies should protect children from drug use. Often overlooked in the debate on drug policy is the Convention on the Rights of the Child, one of the core international human rights conventions, which mentions the need for drug control. Article 33 in the convention states that states must “take all appropriate measures, including legislative, administrative, social and educational measures to protect children from the illicit use of narcotic drugs and psychotropic substance.”

DPF urges member states to implement article 33 in the Convention on the Rights of the Child in their legislation and in their work to implement the three drug conventions.

DPF urges member states and the international community to have a child-based approach when discussing the world drug problem. Drug policies should ensure access to medical help, treatment and recovery services.

Treatment for drug dependency should be accessible and affordable for people who are dependent on drugs. Treatment cannot be an end in itself, but needs to be seen as a route to recovery. Recovery should be considered as an achievable goal for treatment.

DPF urges member states to acknowledge that abstinence is a goal for many drug users seeking help.

DPF urges members states to strengthen the evidence base around recovery-based treatment, including the role of family and close friends.

DPF urges members states to recognize the potential of former users and (1) assist them in their way back to the society and (2) acknowledge their potential to help their peers.

Drug policies should ensure access to controlled drugs for legitimate scientific and medical purposes. Many people around the

globe lack access to controlled medicines today, but it is vital that the controlled medicines are available for scientific and medical use. Ensuring the adequate availability of controlled substances is one of the core objectives in the three international drug conventions.

DPF urges member states to strengthen the international cooperation to ensure access to essential medications for people around the world who need it, not only the rich ones.

DPF urges member states to better implement the three drug conventions to assure access to essential medication and at the same time avoid diversion of drugs from the licit to the illicit market.

Drug policies should ensure that medical and judicial responses are coordinated with the goal of reducing drug use and drug-related consequences. There is a need to develop a comprehensive drug policy and recognize that the drug problem is not only a health problem nor only a crime problem. A nation’s drug policy reflects a cultural set of values, beliefs and behavior and its associated laws result in normative actions on the part of its citizens. As shown in the examples of Japan and Sweden in Chapter 5, these are parameters that we can influence. The examples also show that it is vital for a drug policy to focus on the use of drugs to actually curb the drug problem.

DPF urges member states to develop methods and to focus drug policy on curbing the use of drugs.

DPF urges member states to find a balanced system of collaboration among sectors involved in the drug problem.

