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Thematic debate: in the context of a balanced approach to reducing drug demand and supply, measures to enhance awareness of the different aspects of the world drug problem, including by improving understanding of how to tackle the problem: (a) Effective means of raising awareness about the risks of abusing drugs, including cannabis, giving special attention to addressing in a comprehensive manner the specific needs of women, men, youth and children; (b) Measures to improve the understanding of drug addiction as a chronic but treatable multifactorial health disorder; (c) Regional and interregional cooperation; (d) Importance of research and the collection, reporting and analysis of data for raising awareness about the world drug problem

New challenges, strategies and programmes in demand reduction**

Summary

The 2009 Political Declaration and the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem invites Member States and international organizations to intensify efforts in the area of drug demand reduction, as a primary way to deal with the severe challenges related to drug use. Six challenges related to drug use and dependence should be considered as most problematic undermining security, development, health and social cohesion: (i) drug use and dependence and crime; (ii) violence related to drug use and dependence; (iii) car accidents related to drug use and dependence; (iv) workplace problems and accidents related to drug use and dependence; (v) HIV,
Hepatitis, TB related to drug use and dependence; and (vi) mental health diseases related to drug use and dependence. Information provided by international organizations, regional agencies and expert bodies has enabled the Secretariat to obtain data about these main challenges and the ongoing development of the services for prevention of drug use, treatment of drug dependence and prevention of the health and social consequences of drug use and dependence. The full implementation of these services would constitute the main effective response to these drug related challenges. On the basis of a quick review of evidence available, the document summarizes the evidence describing the major challenges, provides examples of global responses by Member States and international and regional organizations, as well as of responses lead by UNODC.
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Introduction

1. The Political Declaration and the Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem adopted at the fifty-second session of the Commission on Narcotic Drugs on 12 March 2009 and subsequently by the General Assembly in its resolution 64/182 of 18 December 2009 invites Member States and international organizations to intensify efforts in the area of drug demand reduction, as a primary way to deal with the severe challenges related to drug use. The Declaration specifically mentions the “commitment to promote, develop, review or strengthen effective, comprehensive, integrated drug demand reduction programmes, based on scientific evidence and covering a range of measures, including primary prevention, early intervention, treatment, care, rehabilitation, social reintegration and related support services, aimed at promoting health and social well-being among individuals, families and communities and reducing the adverse consequences of drug abuse for individuals and society as a whole, taking into account the particular challenges posed by high-risk drug users...”.¹

2. Recent years have been characterized by an ever-increasing sensitivity to this issue, due to the growing body of evidence that supply reduction activities are not fully effective when carried out without a close connection with prevention of drug use, treatment of drug dependence and all the necessary health, care and social support measures. For this reason, the Member States in the Political Declaration committed themselves “to investing increased resources in ensuring access to those interventions (prevention and treatment) on a non-discriminatory basis, including in detention facilities, bearing in mind that those interventions should also consider vulnerabilities that undermine human development, such as poverty and social marginalization...”.²

3. Aware of the dangerous consequences of drug use, Member States reaffirmed “their determination, within the framework of national, regional and international strategies, to counter the world drug problem and to take effective measures to emphasize and facilitate healthy, productive and fulfilling alternatives to the illicit consumption of drugs, which must not become accepted as a way of life...”.³

4. Among the significant challenges related to drug use and dependence, which undermine security, development, health and social cohesion, the following six should be considered as the most problematic in particular, justifying the necessity of immediate action on both demand reduction and related specific areas:

   • Drug use and dependence and crime
   • Violence related to drug use and dependence
   • Car accidents related to drug use and dependence
   • Workplace problems and accidents related to drug use and dependence
   • HIV, Hepatitis, TB related to drug use and dependence

¹ A/64/92, para. 21.
² Id.
³ Ibid., para. 22.
• Mental health diseases related to drug use and dependence

5. Information provided by international organizations, regional agencies and expert bodies has enabled the Secretariat to obtain data about the main challenges related to drug use and dependence emerging in recent years and the ongoing development of the services for prevention of drug use, treatment of drug dependence and prevention of the health and social consequences of drug use and dependence. The full implementation of these services would constitute the main effective response to these drug related challenges. This document summarizes this evidence, describes the major challenges, provides examples of global responses by Member States and international and regional organizations, as well as of responses lead by UNODC. It should be stressed that this document is by no means exhaustive and is based on a relatively rapid review of the latest research. Moreover, the presentation had to be kept relatively succinct, focusing for each topic on few key examples. Yet, it is believed that such challenges and responses as discussed below emerge clearly even from such a rapid review and succinct presentation.

I. Main challenges related to drug use

A. Drug use and dependence and crime

6. The drug-crime nexus has been widely investigated and the relationship between the two is so complex that an in-depth discussion of all the relevant facets would be beyond the scope of this paper. However, there are interesting indications that the way drug use and dependence relate to crime at the community level means that drug use prevention and drug dependence treatment are effective strategies to prevent crime at the community level.

7. On the one hand, specific temperaments and personality traits, personality disorders, neglect and/or abuse in the family, socio-economic marginalization and deprivation constitute a common vulnerability pattern for both substance abuse and the proneness to violating the law. On the other hand, the effects of drugs on behaviour and the need to obtain the money for buying drugs, as well as the affiliation to criminal organizations dealing drugs, could explain some of the connection between drug use and dependence and crime.

8. The proportions of this relationship are significant. During an investigation of the prevalence of recent drug use among persons arrested by the police in South Africa, 45 per cent was found testing positive for at least one drug (mainly cannabis or “Mandrax”). Similarly, the prevalence of recent drug use among police detainees in Australia was found to be very high: around three-quarters tested positive to at least one drug and around one-third tested positive to multiple drug use. A study examining illegal drug use prior to arrest among incarcerated women in the same country evidenced that regular use of drugs in the 6 months prior to arrest was

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reported by 62 per cent of offenders and 39 per cent reported multiple drug use.\textsuperscript{6} The rate of the offenders residing in federal correctional institutions and living in the community on conditional release in Canada who were using one or more illicit drugs was 27.2 per cent.\textsuperscript{7} Moreover, a longitudinal study in Norway demonstrated that cannabis use in adolescence and early adulthood may be associated with subsequent involvement in criminal activity.\textsuperscript{8} Finally, a more extensive criminal activity has been evidenced in methamphetamine users, particularly among injecting drug users in Australia.\textsuperscript{9}

9. The dimensions of the problem clearly indicate that effective interventions on prevention of drug use and treatment of drug dependence, together with health and social support services for drug users, reducing the rate of population actively using illicit drugs, could result in significant benefits in security and reduce the significant costs to the criminal justice system. In particular, evidence-based prevention of drug use has been shown to be preventive of a range of risky behaviours, including the use of drugs and involvement in bullying, delinquency, violence and crime. Alternatives to prison, replacing sanctions with treatment, care and education, could also contribute to improve social security and cost saving.

B. Drug use and violence

10. A strong relationship has been also demonstrated between the use of illicit drugs and susceptibility to violent behaviour. Some psychotropic agents such as alcohol and illicit substances have been suggested to play a role in the occurrence of major behavioural disorders, mainly due to the suppression of psychomotor inhibition. The behavioural disinhibition induced by drugs involves the loss of restraint over certain types of social behaviour and may increase the risk of auto or hetero-aggression and acting out. The increased use of psychotropic agents in recent years and the occurrence of unwanted effects including violence are extremely worrying.

11. Research evidence obtained in the United Kingdom and the United States of America, indicate that intimate partner violence is a widespread problem and that substance abuse is one of the factors contributing to this type of abuse.\textsuperscript{10} In Thailand, intimate partner violence was commonly found in slum communities (27 per cent) and strongly related to the socio-economic status, personality characteristics and substance abuse of the couples.\textsuperscript{11} In Uganda, the prevalence of lifetime intimate partner violence was 54 per cent and physical violence in the past

\textsuperscript{10} Home Office (2004), Alcohol and intimate partner violence: key findings from the research, Findings 216, Home Office, United Kingdom.
year was 14 per cent, and multiple partners and substance abuse were major reasons for intimate partner violence.\textsuperscript{12} Similarly, in India, a study found a lifetime prevalence of 18 per cent of moderate to severe physical violence during pregnancy, with substance abuse being one of the four main causal factors.\textsuperscript{13} Finally, a small study on exposure to violence and violence-related activities (i.e., crime and drug use) in children whose mothers were addicted to alcohol or other drugs reported that exposure to violence was relatively common for these children, with many exposed to repeated violence in both the home and community and with the levels of violence exposure being also higher when mothers reported more severe drug use in the recent past.\textsuperscript{14}

12. Inward related aggressiveness, as expressed by suicide, has also been evidenced to be significantly related to consumption of illicit drugs other than cannabis (e.g. in Mexico).\textsuperscript{15}

13. Taking into account the link between drugs and violence, the role played by drugs in premature death extends far beyond overdose and disease, with illicit drugs associated strongly with homicide. A screening-research in Australia, including a large number of cases of violent death, comprising homicide and non-substance toxicity suicide, detected psychotropic substances in 65.5 per cent of cases, and multiple substances in 25.8 per cent.\textsuperscript{16} Illicit drugs were detected in 23.9 per cent of cases. In particular, the chronic use of cocaine has been reported to induce “a limbic dyscontrol syndrome” based on the altered activity of limbic structures in the brain, underlying behavioural disinhibition and possible violent reactivity.\textsuperscript{17} Also in the case of methamphetamine, psychological harms have been reported to include psychosis, depression, suicide ideation, anxiety and violent behaviours.\textsuperscript{18}

14. It should be made clear that people using or dependent are not necessarily violent, however, it has to be noted that, among people who do commit violent crimes, there is a preponderance of people using drugs. In this context, scientific evidence shows that, while people committing crimes, especially violent crimes, should be sanctioned, the root cause of the criminal behaviour, i.e. their drug use and/or dependence, will not be solved by criminal sanctions, but by evidence-based

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prevention and treatment, which improve social cohesion, reduce conflict and physical abuse, improve family relationships and protect social security.

C. Drug use and car accidents

15. Most recent statistics reveal that more than 40,000 people die on European roads each year, while a further 1.7 million are injured. No less than a quarter of these deaths, some 10,000 per year, are estimated to be caused by drink-driving. Although alcohol is by far the most prevalent and well-documented psychoactive substance affecting drivers, concerns have been mounting about increasing reports of road deaths linked to illicit or medicinal drugs.19

16. The results of experimental studies indicated that several illicit drugs can have an influence on driving performance, while some drugs show effects that are dose-dependent. Cannabis can impair some cognitive and psychomotor skills that are necessary to drive. MDMA exhibits both negative and positive effects on performance, while studies investigating the effects of a combination of alcohol and illicit drugs found that, in such cases, some illicit drugs (for example, cannabis) can cause additional, synergistic impairment. The chronic use of all illicit drugs is associated with some cognitive and/or psychomotor impairment, and can lead to a decrease in driving performance even when the subject is no longer intoxicated.20

17. Among the drivers suspected of driving under the influence of drugs studies show a large variation in the number of drug-positive samples found on suspicion (55 per cent to 99 per cent),21 but in any case the rate of drug use appears very high.

18. Considering drivers killed in traffic accidents, alcohol was the most frequently detected psychoactive substance. However, drugs were also frequently detected, at a higher prevalence rate than in the general driving population. The combination of alcohol and drugs was also prevalent in a substantial number of samples, ranging from 2.5 per cent to 17 per cent. In five studies, cannabis was the most prevalent drug, with a maximal value of about 29 per cent in the study in France. In this study, however, only drivers younger than 30 years were included, which may partially explain the high number of cannabis-positive samples.22

19. Drugs and/or alcohol were frequently detected in injured drivers, more frequently than in the general driving population. This is particularly shown by the results of a study conducted in the United States.23 More than 50 per cent of the injured drivers in this study tested positive for drugs other than alcohol. In Iran, it has been estimated that 14.4 per cent of by truck and bus drivers use opioids.24

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20 Ibid.
21 Ibid.
22 Ibid.
D. Drug use and workplace problems

20. Research evidence showed that two-thirds of significant problems among companies’ employees in the workplace are linked to alcohol abuse and illicit drug use. High levels of stress, both at work and at home, can push workers to cope with these problems through smoking, drinking, and drug use. In some cases in low and middle income countries, workers have turned to the use of amphetamine-type stimulants to cope with extremely long working hours in factories and call centres. Problematic levels of substance abuse most certainly have an effect on work performance and results in safety and security concerns in the workplace. Moreover, studies show that when compared with non-substance abusers, substance-abusing employees are more likely to: (i) change jobs frequently; (ii) be late to or absent from work; (iii) be less productive employees; and (iv) be involved in a workplace accident.25

21. Nearly 75 per cent of all adult illicit drug users are employed, as are most binge and heavy alcohol users. Although rates of drug use are generally higher among the unemployed, the absolute number of employed drug users is greater than the number of unemployed drug users. In the U.S., for example, the 2007 rate of current drug use among unemployed adults (18.3 per cent) was significantly higher than it was for adults who were employed full time (8.4 per cent), or part-time (10.1 per cent). However, of the estimated 17.8 million current drug users in the U.S., 13.1 million (75.3 per cent) were employed either full or part-time.26 Given

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that such a large number of drug users might be reached through workplace organizational structures, workplace prevention is a particularly promising approach for the effective delivery of drug prevention initiatives.

22. In summary, alcohol and drugs at work have a negative impact on workers’ physical and mental health and on workplaces’ safety and productivity. In particular, they affect safety through a false sense of confidence, poor concentration and judgment, impaired vision and hearing, drowsiness, slowed reaction time and impaired coordination and reflexes. For the worker, they represent a higher risk of accident, increased family or social problems, stigmatization and discrimination, deteriorating physical or mental health, pain, distress, and disability. In addition, workplace drug and alcohol abuse is associated with the following costs: increased health-care costs, increased number of accidents, poorer work relations, impaired performance, increased replacement costs, poor morale, increased absenteeism and turnover, and, reduced profits or services or competitiveness. In this context, workplace prevention programmes have been found to be effective in saving significant amounts of financial resources.27

E. Drug use and HIV, Hepatitis, TB

23. Illicit drug use is one of top twenty risk factors to health worldwide and among top ten in developed countries.28 Drug use disorders are associated with increased risk of development of many other diseases and health conditions, including HIV and AIDS, hepatitis and tuberculosis.

24. Injecting drug use is a major route of HIV and hepatitis transmission in many regions, including Eastern Europe, Central, South and South East Asia and some countries in Latin America. Injecting drug use was documented in 148 countries and worldwide about 3 million people who inject drugs might be HIV positive.29 Up to 10 per cent of global HIV infections are due to injection drug use. If Sub-Saharan Africa is excluded, up to 30 per cent of global HIV infections are due to injecting drug use.30

25. HIV epidemics among injecting drug users are characterized by notable regional and in-country variations. Nevertheless, once the virus is introduced into an injecting drug user community, prevalence can rise up to 40-90 per cent in a matter of months.31 UNODC data from 2007 show that at least 15 million people use

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opiates, at least 16 million people use cocaine, and at least 16 million use amphetamine-type stimulants. These very conservative estimates add up to a reservoir of at least 47 million people who, if they start injecting drugs and use contaminated injection equipment, face a significant risk of being infected with HIV.

26. By helping people reduce or stop injecting drugs, substance abuse treatment reduces the transmission of blood-borne diseases, such as HIV and hepatitis B and C. Treatment needs to take into account the special needs of vulnerable groups, including people living with HIV and AIDS.

27. Evidence has been accumulating that also certain types of non-injecting drug use has a significant role in fuelling the HIV and AIDS epidemics, while deprivation, marginalization and poverty exacerbate the risks for both. By altering judgement and inhibition, the use of certain drugs and alcohol increases the likelihood of high risk sexual practices (e.g. unprotected sex, multiple partners) or “transactional” sex (e.g. trading sex for money or drugs).

28. Among runaway, homeless or street children, those children who used heroin, methamphetamine or cocaine have been reported to display more risky sexual behaviours than their non-substance using peers. Accordingly, in Latin America, drug consumption was found associated with high-risk sexual behaviours and


related infections among young adults after controlling for alcohol consumption level. More significantly, research on the use of amphetamine-type stimulants (ATS), in particular methamphetamine, shows that there is a clear increase in the number of sexual contacts, partners as well as risky sexual behaviours (e.g. reduced condom use) while using ATS, including among men who have sex with men.

Similarly, a study on crack smokers reported that this subgroup of users were far more likely to have unprotected, high-risk sex than IDUs who did not use crack. They also reported more days of alcohol consumption. This was in turn independently associated with unprotected sex, as well as high rates of Sexually Transmitted Diseases (STDs).  

29. This body of evidence is particularly significant as classic HIV prevention interventions such as needle syringe programmes would clearly not be useful in the context of non-injecting users while long-acting opioid maintenance therapy would not be useful in the context of stimulant users. It becomes evident therefore that the response to the HIV epidemics needs to take into account both injecting and certain types of non-injecting drug and alcohol users.

30. Other groups for which deprivation, marginalization and poverty interact with different socio-economic variables are women drug users, drug users, whether women or men, in prison settings and drug users on the move, in particular migrant drug users and people who have been trafficked. Women drug users, both injecting and non-injecting, are more likely to be stigmatized by society than male drug users, they often have a male sexual partner who also uses drugs and may have introduced them to using and/or injecting. In such situations, the vulnerability of women to HIV is much higher due to the higher biological vulnerability of women and gender roles that make it difficult if not impossible to negotiate safe injecting and/or safe sex. Moreover, women drug users may be or become pregnant and further they appear on average to have dependent children, but fewer resources, and to have experienced trauma as well as higher rates of concurrent psychiatric problems. Finally, transactional sex, be it in exchange for cash or drugs, is often a common activity for some female drug users, which puts them, their partners, clients and their children at increased risk of HIV.


42 UNODC (2004), Substance abuse treatment and care for women, United Nations Office on Drugs and Crime, Vienna, Austria.
31. Prisoners often originate from the most vulnerable sectors of society — low socio-economic level, low level of education, poor health conditions, the mentally ill, those dependent on alcohol or drugs or involved in sex work. These groups already have an increased risk of diseases before entering prison, such as drug dependence, TB, HIV and STI. Various studies estimate that the percentage of individuals reporting problematic substance misuse is comparatively higher in prisons than in the community. Different studies have indicated that the percentage of people in prison who have a drug problem ranges from 40 to 80 per cent. Some level of continued drug use often occurs in prison and is usually associated with high risk of HIV transmission due to sharing/reusing injecting equipment and drug solution. In fact, in countries where there are high rates of HIV infection among injecting drug users, high rates of HIV infection in prisons are related primarily to sharing of injecting equipment outside and inside prison. Hepatitis C Virus (HCV) seroprevalence rates in prisons are even higher than HIV rates, while TB rates are also often higher than in the general population. Within prison population, rates of drug use, HIV and HCV infection among women tend to be higher than among men. These women frequently come from deprived backgrounds and experience problems related to mental health disorders, alcohol and drug dependences, infectious diseases, reproductive diseases and histories of physical and sexual abuse. Similarly, migrant drug users and those who have been trafficked have very high risk for drug use related HIV infection, while having very low, and in many countries, practically no access to even basic health services.

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43 UNODC (2009, unpublished report), Addressing Health And Human Development Vulnerabilities In The Context Of Drugs And Crime, Thematic Programme, United Nations Office on Drugs and Crime, Austria.
F. Drug use and psychiatric disorders

32. The studies investigating the rates of psychiatric co-morbidity (coexistence of substance abuse and mental health diagnoses) revealed a co-morbidity rate of 45 per cent and significant relationships between co-morbidity and socio-demographic variables.51 If personality disorders (Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis II) and major psychiatric disorders (DSM Axis I) are considered together, this rate, including around 50 per cent of the patients affected by drug use disorders, has been confirmed by many other findings. This high number of patients with both addictive and mental health disorders can be explained by different factors contributing to the coexistence of psychiatric symptoms and drug/alcohol use.

33. On one hand, the use of most of the illicit psychotropic drugs and the abuse of alcohol are able to induce psychiatric symptoms and cognitive impairment, or to facilitate the clinical expression of mental health disorders in vulnerable individuals.52 A large body of evidence indicates that cannabis, particularly in heavy smokers at high dosage, may induce psychosis and that cocaine and amphetamines are able to induce depression, aggressive and violent behaviour, paranoid thinking and psychotic symptoms.

34. On the other hand, many personality disorders and Diagnostic Statistical Manual of Mental Health Disorders Axis I psychiatric diseases may pre-exist to substance abuse, playing a role in the psychobiological vulnerability to addictive disorders. Finally, mental health disorders and drug abuse/dependence may present also concomitant onset. In many cases, it is difficult to establish a causal relationship between the two concomitant disorders.

35. Depression and anxiety were the most common disorders, and more than a third of individuals entering outpatient substance abuse treatment clinics in the United States had two or more probable disorders. Levels of mental health functioning were lower than the 25th percentile of the population norms.53

36. Coexisting psychiatric disorder was the rule and not the exception in a sample of alcohol and drug users in New Zealand.54 Seventy-four per cent of the sample had a current non-substance or gambling axis I disorder, with a lifetime rate of 90 per cent. The most commonly diagnosed of these coexisting psychiatric disorders were major depressive episode (34 per cent), social phobia (31 per cent) and post-traumatic stress disorder (31 per cent). Another study reported, among the most

common co-morbid disorders, psychotic disorders, affective disorders, anxiety disorders, personality disorders and attention-deficit/hyperactivity disorder.  

37. Different life-time rates of coexisting psychiatric disorders among heroin addicts in different settings were found in Taiwan; 83 per cent of hospital subjects and 66 per cent of incarcerated subjects were diagnosed as having at least one coexisting Axis I or II disorder, again confirming that the majority of substance abusers also had a mental health problem.  

38. In agreement with previous data, the prevalence of psychiatric co-morbidity in a population of young heroin users recruited from outside of the health-care context in Spain was reported to be around two-thirds (67.1 per cent, 95 per cent CI: 59.6-74.7 per cent) of the sample. Anti-social personality and mood disorders were found to be the most frequent conditions (33 per cent and 26 per cent, respectively). Mood, anxiety and eating disorders were more common among women than men. Similarly, in a sample of 700 drug users in the United States, 64 per cent evidenced co-morbidity (i.e., coexisting substance use and psychiatric disorders). Robust relationships between the presence of co-morbidity and increased levels of risk behaviour, such as needle sharing and trading sex for money, were revealed.  

39. A study in Australia demonstrated that irrespective of treatment received, drug user clients who had recently withdrawn from treatment were at the highest risk of a psychiatric admission, experiencing seven times the hazard of admission compared with those who did not access drug treatment. Amphetamine users had at least three times the hazard of psychiatric admission compared with opioid users. In conclusion, drug use disorder patients presenting at a drug treatment service should be screened for mental health diagnoses at their initial assessment so that appropriate treatment strategies can be offered to these dually diagnosed clients, together with addiction treatment.  

40. Co-morbidity presents challenges to treatment providers, not only because individuals with multiple diagnoses require different treatment approaches but also because such individuals engage in increased risk-taking behaviours. Risks associated with co-morbidity have been addressed in recent research of the general population, mental health treatment samples, and substance abuse treatment samples. Findings indicate that clients with co-morbidity tend to have fewer and less adequate relationships and social support networks. They also often have unstable housing, employment, and income histories and tend to be younger and less  

educated. These clients are more likely to have criminal or other legal problems, and they tend to have poorer overall functional skills, such as more problems with family relationships, more restricted social networks, and difficulty in maintaining employment. Given these challenges, clients with co-morbidity often have more difficulty gaining access to treatment, have a poorer course of treatment, have less successful treatment outcomes, and incur more treatment costs than clients with only mental health or substance abuse symptoms.60

II. Developing prevention responses

A. Prevention activities: family skills

41. To prevent children and adolescents from engaging in drug use, delinquency and risky sexual behaviours, families can act both as powerful risk and protective factors for the healthy child and youth development. In all the models attempting to explain the path that may lead children and youth to start using drugs, family factors have a central position together with peer influence. While peer influence is often the major reason adolescents initiate negative behaviours, a positive family environment is the primary reason youth do not engage in these behaviours, including alcohol and drug use, delinquency, and early or unprotected sex.61

42. Relationships between children and parents characterized by indifference, non-responsiveness, emotional insecurity; poor management of children’s behaviour and discipline; lack of opportunities to learn social skills; a chaotic home environment and lack of structure in family life are all characteristics that increase the risk of children and youth to initiate drug use or other risky behaviours.62


43. Conversely, families can be one of the most powerful protective forces in the lives of children and youth. Secure and healthy parent/child attachment; parental supervision, monitoring, and effective discipline; communication of pro-social family values; parental involvement in child’s life; supportive parenting; and, a cohesive and organized family environment are the characteristics of the family that help to protect children from drug use and contribute to their capacity to overcome adverse situations and achieve positive outcomes.

44. Supporting parents in taking better care of their children by offering family skills training programmes has been proven an effective strategy to prevent drug use and a range of risky and problematic behaviours and thus promote the health of young people. Skills training is based on interactive and practical methods in order to produce enduring behavioural changes in parents and children. A review comparing the effectiveness of these family skills training programmes has found them to be on average four times as effective as drug education programmes targeting youth only in school.

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45. Family skills training programmes have also been found cost-effective returning a saving of approximately US$ 10 in the long term for every dollar spent to implement the programme as well as producing other positive outcomes besides decreased drug use. These include: increased child attachment to school and academic performance, decreased child depression and aggression, increased child social competence and pro-social behaviour, and decreased family conflict (OJJDP, 2001). These, in turn, act as additional protective factors in the lives of children and youth.

46. Family skills training programmes target a number of families at the time, thus allowing children and above all parents to overcome barriers of social isolation and strengthen aggregation and solidarity in the community. Well implemented programmes have been known to reach an 80 per cent attendance rate. Such programmes generally pay a lot of attention recruitment and make it easy and attractive for parents to attend.

47. Family skills training programmes have been successfully implemented in high- and middle-income countries (e.g. Islamic Republic of Iran, Philippines, Peru, Russian Federation, El Salvador, Thailand), including in very marginalized and deprived situations, such as immigrants in high-income countries, First Nation communities in North America, Aboriginal communities in Australia. Moreover, recent reviews of family-based programmes undertaken by WHO and by UNODC report that isolated activities have been implemented in low-income countries.

48. Some Central American countries (e.g. El Salvador) and Latin American countries (Peru) developed evidence-based prevention programmes, utilizing family skills methods. The Programme “Strong Families: Love and Limits” is based on “The Strengthening Families Programme” of the University of Iowa and was adapted for Latin America by the Pan-American Health Organization (PAHO). The PAHO and the German Cooperation Agency (GTZ) started the application of the Programme in coordination with four Municipalities in the province of Lima.

49. The Programme in Peru is oriented towards preventing the emergence of risky behaviours associated with drug consumption and violence within the families and therefore, as most programmes of this kind, it requires the participation of the families as a whole (parents and children). The main objectives are to: (i) improve the relationship among parents or tutors and children through the promotion of clear and effective dialogue; (ii) establish, with clarity, relations of affection; (iii) promote discipline; (iv) help children to develop empathy and respect for their parents; and, (v) teach children how to phase stress and group pressure.

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UNODC (2009), Guide To Implementing Family Skills Training Programmes For Drug Abuse Prevention, United Nations Office on Drugs and Crime, Vienna, Austria.

50. The Programme has sessions for parents only (love and limits: ways of raising children; establish rules; encourage good behaviour; punishment; establish bonds; protect against risky behaviours; connect with the community), for children only (have objectives and dreams; appreciate parents; how to face stress; obey rules; how to face group pressure?; group pressure and good friends; help the community), and for parents and children together (support objectives and dreams; promote communication within the family; appreciate other family members; use family meetings; understand family principles; families and group pressure; summary).

51. During 2007, PAHO and GTZ reported that 96 per cent of participants improved their support, their family relations, family proximity and happiness spending time with the family; 97 per cent increased the quantity and quality of time spent in family activities; 98 per cent improved their levels and exigency for the fulfilment of family rules; 95 per cent experienced an improvement in the relations between adolescent children and other family members; and 98 per cent of the parents diminished their negative attitudes towards the raising of their children.

52. Thailand adapted a family skill programme (SFP) originally developed by the Department of Health Promotion of the University of Utah in the USA. The particularity of this adaptation of an evidence-based family programme is that it followed a very careful and rigorous process. SFP-Thailand maintains the structure and core concepts of the original SFP. However, to make the Programme more cultural appropriate, it introduced minor changes with regard to graphics, songs etc. SFP-Thailand covers 14 sessions including children, parents and family groups. The recruitment of the families involved in the Programme was done through schools and communities on voluntary basis and their participation facilitated through incentives such as meals and transportation. The feedbacks from parents and children were very positive. The Programme is also undergoing a rigorous evaluation and measures concerning outcomes will be available in 2010.

53. Prevention programmes in Iran include a significant component on family-based prevention, particularly targeting the parents. A parent training package was divided in 8 sessions covering a range of parenting issues such as: adolescent behaviour, particularly high-risk behaviour and the role of parents in shaping it; showing your love and supporting the dreams and goals of youth; results of different styles of parenting; house responsibilities and how to deal with small and big problems; motivating and supporting youth in schools; anger, anger management, how to meet the basic needs of adolescents; monitoring teens and listening with empathy; and, how to solve conflicts.

B. Prevention activities: drug education in schools based on life skills

54. School based programmes are very frequent world-wide. However, the quality of such programmes varies greatly and in general only a minority of students have access to evidence-based drug education based on life skills, as shown by the following estimates based on information collected from UNODC from key countries.
55. Still, evidence-based drug education programmes in schools based on life skills have been implemented in many countries (e.g. United States, Canada, Europe). More recently, a consortium of researchers and practitioners (EUDAP) has developed and trialled a curriculum (called “Unplugged”) in seven countries in Europe. “Unplugged” is a drug education programme for students between the ages of 12 and 14 and, consisting of 12 interactive lessons to be led by trained teachers. The programme is based on the Comprehensive Social Influence Model, integrating life skills elements (critical thinking, decision-making, creative thinking, effective communication, relationship skills, self-awareness, empathy, and coping with emotions) and normative beliefs (young people tend to have exaggerated beliefs concerning the attitude of older teenagers (e.g. almost everybody smokes hash at 16) and this belief becomes their norm and influences their behaviour. Addressing normative beliefs, or normative education, means correcting normative expectations and attempting to create or reinforce conservative beliefs about prevalence and acceptability of drug use). The programme was evaluated in nine sites in seven countries in Europe (Belgium, Germany, Spain, Greece, Italy, Austria, and Sweden) and the pupils who participated in the “Unplugged” school curriculum had a 30 per cent lower probability to have smoked cigarettes (daily), to have experienced intoxication drinking, and a 23 per cent lower probability to have used cannabis in the past month, compared to students who followed the usual educational curricula. Besides the original countries, a NGO is implementing EUDAP in some countries in Eastern Europe (including Lithuania, Russia and Kyrgyzstan).

C. Prevention activities: workplace prevention

56. Workplace programmes are also quite widespread (for example in North America and Europe, as well as, among others, Argentina, Brazil, Chile, India, Mexico and Viet Nam).

57. In Chile, this is a programme of the organization dealing with the prevention of accidents and occupational diseases in companies, and all the factors directly or indirectly associated to them, including alcohol and drug prevention. The organization mostly offers a 10-month assistance programme. It works with committees comprised of workers of the same company. An initial diagnosis to collect information about alcohol and drug consumption habits as well as a socio-cultural diagnosis are performed. An alcohol and drug prevention policy is then
developed. Monitoring teams are trained and a programme of activities intended to improve the indexes obtained in the initial diagnosis is carried out. Lastly, an ex-post diagnosis is performed, and recommendations are made in accordance with the results of the evaluation.

58. Following the initial assistance, the programme is maintained by the teams trained for that purpose. It becomes a permanent programme inserted in the health promotion programmes or in those for improving people’s quality life. The organization has been working since 2000 and is currently working with 50 companies, covering 50,000 workers plus their respective families. The organization has also been assessing those companies that have finished their programmes and their performance can be evaluated as excellent, good, and fair, depending on the company.

59. The ILO has been active in this field for a long time. Indeed, UNODC’s experiences in Brazil and in India originate from old projects lead together with the ILO. Presently, based on the principle that “Decent Work must be Safe Work”, the Programme on Safety and Health at Work and the Environment (SAFEWORK) aims to create worldwide awareness of the dimensions and consequences of work-related accidents and diseases; to place occupational safety and health (OSH) on the international and national agendas; and to provide support to the national efforts for the improvement of national OSH systems and programmes in line with relevant international labour standards.

60. The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS), through its Expert Group of Demand Reduction, has been working on workplace prevention during the last two years and has developed “CICAD’s Hemispheric Guidelines on Workplace Prevention”. These Guidelines provide for the development of comprehensive policies at the universal (the entire firm), selective (groups at high-risk of use) and indicated (users and their families) levels.

D. Prevention activities: media campaigns

61. In the period 1998-2008 media campaigns were the most implemented drug prevention strategy. At the beginning of the decade, 72 per cent of countries in all regions were implementing these activities, while this figure had risen to 92 per cent by the end of the decade. Anecdotal evidence indicates that many such campaigns are ongoing; these are organized by both governmental agencies and non-governmental organizations, sometimes through innovative media such as Internet and mobile telecommunications, targeting specific target groups (teens, parents, minorities, etc.).

62. In particular, the United States of America has been implementing a very large campaign, including a website for teens (“above the influence”), one for parents (“the anti-drug”), one in Spanish, one devoted to methamphetamines, and a very strong evaluation component, while Canada has just started a new campaign.

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63. In Europe, in the United Kingdom, the Government has supported a wide-ranging campaign called “Talk to Frank” for several years. “Talk to Frank” aims to ensure that young people understand the risks and dangers of drugs and their use and know where to go for advice or help; parents have the confidence and knowledge to talk to their children about drugs; and that professionals who work with young people, especially vulnerable groups, are supported. “Talk to Frank” uses a variety of channels to achieve these aims including advertising, PR, resources, local campaigns, a helpline and a website. Spain has been reporting on yearly campaigns. The Exchange on Drug Demand Reduction Action (EDDRA) database of the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal, classifies at least 35 programmes under “mass media campaign” in 12 countries (Austria, Belgium, Denmark, Finland, Germany, Ireland, Italy, Lithuania, Netherlands, Norway, Spain, United Kingdom), in addition to those led by the European Commission. They all include at least a formal process evaluation and they cover a range of target groups (e.g. not only the general population, but also youth or parents) and settings (schools, internet, entertainment venues, sport venues, etc.).

64. In Southeast Asia, Indonesia, Japan, Malaysia, and Singapore have been producing well targeted materials for youth for many years. In Oceania, Australia has launched recently a new campaign, including a website. The campaign aims to reduce the uptake of methamphetamines and other illicit drugs among young Australians, by raising awareness of the harms associated with illegal drug use and encouraging and supporting decisions not to use. It also encourages young people using methamphetamines to reconsider their use and direct them to relevant support, counselling and treatment services. The campaign utilizes advertising, public relations, online activities and information resources.

65. The evidence supporting the implementation of media campaigns to prevent the use of illicit drugs is not strong, given that many campaigns do not include a strong evaluation component. Moreover, there are contrasting indications as to their actual effectiveness. On the basis of the experiences that have been positively evaluated, it can be argued that, to be effective, a media campaign should: (i) not happen in isolation; (ii) support other prevention, treatment and rehabilitation programmes; (iii) clearly identify a specific target group and realistic goals to be achieved; (iv) be based on strong formative research (pilot testing of messages, media and materials); (v) reach the target group with frequent messages from different media over a period of time; and (vi) include a strong monitoring and evaluation component.71

E. UNODC response in the field of drug prevention

66. UNODC has developed a programme on family-based prevention of drug use, building on existing activities and systematically adapting successful existing programmes to support parents and families in the difficult socio-economic situations including, for example: poor economic prospects and social exclusion in

71 UNODC (2008), Together We Can Make A Difference, How to deliver an integrated media training workshop for TV, radio and newspaper participants on reporting about drugs, United Nations Office on Drugs and Crime, Vienna, Austria.
the context of rapidly developing economies; disconnect between parents’ and children’s values; migration; post-conflict situations; marginalised, economically depressed and insecure communities.

67. This programme will implement evidence-based family skills training programmes to directly strengthen the protective factors of families, starting in 5 countries in 3 regions: Central America, Central Asia and South-eastern Europe.

68. With regard to drug education in schools based on life skills, UNODC is supporting the dissemination of EUDAP to several Middle-Eastern countries and is planning to expand the dissemination of this and other evidence-based drug education programmes based on life skills as funding will become available. UNODC is also participating in the last activities of the Focusing Resources on Effective School Health (FRESH) initiative, inter-agency partnership including all major players on health in the school sector (WHO, UNESCO, UNICEF, the World Bank, as well as other international organizations and NGOs). The last leg of this 10-year initiative is the development of a common framework to evaluate health promotion programmes. UNODC was identified as the lead agency in developing the indicators on substance use, as well as an interested agency in the development of indicators for mental health and emotional learning, violence, and HIV/AIDS.

69. With regard to workplace prevention, UNODC is building on the activities of its Regional Office for Brazil and the Southern Cone, that has been promoting drug prevention in the workplace by means of structured projects in partnership with the Social Service of the Industries of Rio Grande do Sul (SESI/RS) since 1994. UNODC convened a Technical Consultation on “Workplace Prevention: Promoting Health and Preventing Substance Abuse”. The consultation included a global representation of researchers, programme developers, policy makers and practitioners, as well as representatives from ILO and CICAD, and developed guidelines that will be published in the course of 2010 on how to develop effective workplace prevention programme. The draft guidelines take very much into account the “CICAD’s Hemispheric Guidelines on Workplace Prevention”.

70. UNODC leads a global campaign on the occasion of the International Day Against Drug Abuse And Illicit Trafficking (World Drug Day). Promisingly, the theme of World Drug Day has been focusing on messages putting the protection of health at the heart of the drug phenomenon, with activities and documentation on e.g. Brazil, Bulgaria, Colombia, India, Kenya, Lao PDR, Myanmar, Nigeria, Pakistan, Senegal, South Africa, Thailand, Viet Nam.

III. Developing treatment and health-care responses

71. Many governmental and non-governmental stakeholders are engaged in drug dependence treatment and care, but the accessibility and the quality of treatment services remain a challenge. In 2006, of the estimated 26 million problem drug users only 4.9 million were actually in treatment.\footnote{United Nations Office on Drugs and Crime. (2009). World Drug Report 2009 Executive Summary. United Nations Office on Drugs and Crime: Vienna.} Data from selected key countries collected from UNODC in 2009 illustrates the alarming discrepancy between variety of services available in a country and the coverage of these services. Often
the only specialized treatment facilities are only available in the capital, can only serve a limited number of persons, sometimes even for high fees.

72. Different national and international, governmental and non-governmental stakeholders are addressing drug use and drug dependence treatment in low-resource countries. Presented below is a snapshot of the work some national institutes, development agencies, NGOs and international organizations are doing in the field of drug dependence treatment and care.

73. The Central Asia Drug Action Programme (CADAP) is financed by the European Union and mostly implemented by UNDP. It started in 2003 and its current fourth phase is ongoing since 2008. The Programme is active in the five Central Asian Republics. CADAP covers supply and demand reduction. The current phase puts its main focus on regionalization and the cooperation between governmental and non-governmental actors. The goals of the project in the area of demand reduction include drug epidemiology (based on EMCDDA guidelines), treatment and rehabilitation services in prisons, and prevention media campaign informing about the health risks of drug use including HIV. CADAP and UNODC project Treatnet II (see below) have agreed on close cooperation of their respective activities and a CADAP expert was present at the Treatnet II Training of Trainers in Central Asia.

74. The Department for International Development (DFID) of the United Kingdom messages on World AIDS Day (December 2009) highlighted the need to work with vulnerable groups. DFID is for example supporting a centre in Delhi, India that provides food, maintenance treatment, basic medical help and counselling to approximately 200 drug users on a daily basis, many of those have migrated from rural areas to urban Delhi.

75. Germany’s Gesellschaft für Technische Zusammenarbeit (GTZ) recently published a report on its work on reducing injecting drug use and HIV. Highlighted are projects in Bangladesh (development of drug policy and detoxification services for female drug users), Nepal (public private partnership to offer maintenance treatment), Pakistan (services for street children and in prison), Ukraine (maintenance treatment for female drug users), Viet Nam (advocacy and HIV prevention services).

76. The HIV/AIDS Asia Regional Programme (HAARP) is funded by the Australian Government, AusAID working on the implementation of harm reduction strategies to reduce drug-related HIV harm in the South-East Asia region. HHARP
is working in Cambodia, China, Lao PDR, Myanmar, Philippines, and Viet Nam. HAARP coordinators were present at the Launching Meeting of UNODC’s Treatnet II project in South East Asia. Methadone maintenance treatment is part of the HAARP activities.

77. The Drug Advisory Programme (DAP) of the Colombo Plan focuses on the development of human resources in member countries, particularly for those involved in the treatment and rehabilitation of persons dependent on drugs in the public sector, NGOs and the community and in drug demand reduction activities. In line with this goal, the Colombo Plan DAP established a Training Arm, in February 2009, consisting of a pool of experts in the field of training and rehabilitation, who will be responsible to prepare and implement the Certification Programme process for addiction professionals in the Asia-Pacific region. In addition, the special programme in Afghanistan which has been in place since 2003 continues (treatment centres, outreach/drop-in-centres, transit shelter for women, the mobilization of religious leaders against drug abuse, counter narcotics public information campaign, women treatment centres in Kabul and Balkh).

78. Supported by CICAD (OAS) and the European Commission, the EU-LAC Drug Treatment City Partnerships initiative contributes to improve policy decisions at the city level on the quality and coverage of drug treatment, rehabilitation and harm reduction for diverse populations in the European Union and Latin America and the Caribbean to ensure that the care provided to them is appropriate. Specific objectives include the creation of a learning partnership among programmes in different cities, the development of drug policies that incorporate treatment and rehabilitation into local health-care systems, an exchange network of twin cities in Latin America, the Caribbean and the European Union for mutual reinforcement of skills and experience to serve problematic drug users, sensitizing prosecutors and judges to drug treatment as an alternative to incarceration for petty drug offences.

79. The National Institute on Drug Abuse (NIDA) in the United States of America supports the Clinical Trials Network (CNT) to ensure the transfer of scientific knowledge into clinical practice. In the CTN framework researchers and community-based treatment service providers cooperate closely to develop, validate, refine and deliver new treatment approaches for patients at the community level. Studies conducted focus on behavioural, pharmacological, and integrated behavioural and pharmacological treatment interventions, which are being researched in multisite clinical trials with diverse populations.

80. NIATx is a collaborative that works with nearly 1000 drug treatment service providers across the United States. Using a simple process model originally developed for the industrial world to improve access to and retention in treatment of clients. The focus is on a reduction of waiting times, the reduction of no-shows, increased admission and increased continuation in treatment. The NIATx approach could prove around 34 per cent reduction in waiting times, 33 per cent reduction in no-shows, 21 per cent increases in admission and 22 per cent increases in treatment continuation.

81. The Centre for Addiction and Mental Health (CAMH) in Toronto, Canada is involved in training and research in 20 countries in Latin America and the Caribbean in collaboration with CICAD, as well as in South Asia.
82. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) through its database EDDRA provides access to information on evaluated practices from Europe by type of intervention, including drug dependence treatment and care (social reintegration, care). Described practices can be sorted by country, intervention type, type of evaluation, target group and finally by quality level. The project with the highest quality rating in the EDDRA treatment database was to adapt, develop and test a standardized treatment approach based on the combination of the Community Reinforcement Approach and Vouchers (CRA + Vouchers) for cocaine-dependent patients in five treatment centres in the Netherlands (2005-2007).

A. Pharmacological treatment, in particular methadone maintenance treatment

83. Treatment with long acting opioid agonists (LAOA), especially methadone, is an evidence-based treatment for opioid dependence,\(^{73}\) which is successfully implemented in many countries. Recent studies prove that methadone treatment is also effective in low-resource countries and that drug dependence treatment is an effective method for HIV prevention among injecting drug users.

84. In a WHO Collaborative Study on Substitution Therapy of Opioid Dependence and HIV/AIDS, 730 participants from 8 countries (Australia, China, Indonesia, Iran, Lithuania, Poland, Thailand and Ukraine) were recruited from dedicated drug treatment centres or drug clinics attached to other primary health care or emergency care facilities, staffed by medically qualified personnel who were authorized to treat drug dependent patients and prescribe appropriate medications. Maintenance treatment at the Chinese, Indonesian, Iranian and Ukrainian study sites had only first become available between 2001 and 2004, whereas at the other countries’ study sites Maintenance Treatment had been available for at least seven years. All countries had opiate substitution treatment available at sites additional to the study sites prior to the commencement of the study. All patients were treated with methadone, except the Ukraine which used buprenorphine. There were significant reductions in heroin use in all countries and excellent retention in treatment in all countries (with the possible exception of Australia), demonstrating that Maintenance Treatment can be successfully conducted in a range of developing and emerging economies with results similar or better to those in developed countries. Not one person contracted HIV.

85. A study published in AIDS (2008) evaluated the effectiveness of the first phase of eight methadone maintenance treatment (MMT) clinics in China.\(^{74}\) Three surveys were carried out with clients attending the first phase of eight MMT clinics at entry, and 6 and 12 months after enrolment. Drug using behaviours, drug-related criminal activity, and relationships with families were compared for the three periods. Blood specimens were collected and tested for HIV for each client at entry, and HIV-

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\(^{74}\) Pang, Lin; Hao, Yang; Mi, Guodong; Wang, Changhe; Luo, Wei; Rou, Keming; Li, Jianhua; Wu, Zunyou AIDS: December 2007 - vol. 21 - Issue - p. S103-S107 doi: 10.1097/01.aids.0000304704.71917.64 Original papers.
negative clients were re-tested after 12 months. A total of 585, 609 and 468 clients participated in the first, second and third surveys, respectively. The proportion of clients who injected drugs reduced from 69.1 per cent to 8.9 per cent and 8.8 per cent, and the frequency of injection in the past month had reduced from 90 times per month to twice per month, employment increased from 22.9 per cent to 43.2 per cent and 40.6 per cent, and self-reported criminal behaviours reduced from 20.7 per cent to 3.6 per cent and 3.8 per cent in the three surveys. By the third survey, 65.8 per cent of clients reported a harmonious relationship with families, an increase from 46.8 per cent at entry, and 95.9 per cent of clients were satisfied with MMT services. Eight HIV seroconversions were found among 1,153 clients during 12 months. In conclusion, the study demonstrated that the first phase MMT contributed to a reduction in drug use, drug injecting behaviours, drug-related criminal behaviours, HIV infections, and improved relationships within families among heroin users who participated in the MMT programme. MMT needs to be scaled up nationwide rapidly with improved services.

B. Psychosocial treatment

86. The past three decades have been marked by tremendous progress in behavioural therapies for drug abuse and dependence, as well as advances in the conceptualization of approaches to development of behavioural therapies.75 Cognitive behaviour therapy, contingency management, couples and family therapy, and a variety of other types of behavioural treatment have been shown to be potent interventions for several forms of drug addiction, and scientific progress has also been greatly facilitated by the articulation of a systematic approach to the development, evaluation, and dissemination of behavioural therapies. The findings of research on behavioural treatments have been positive, but there is still a great deal more to be done. Even the most powerful behavioural therapies are not universally effective, nor do all individuals who benefit from these treatments improve as quickly or as completely as desired. Basic neuroscience and basic research on behavioural, cognitive, affective, and social factors offer rich and relatively untapped sources of information on behaviour and behaviour change.

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75 Kathleen M. Carroll, Ph.D., Lisa S. Onken, Ph.D.
With the development of new technologies of brain imaging, behavioural treatments based on a new understanding of the brain could be on the horizon. Currently underutilized strategies for investigating mechanisms of action include: (a) evaluating novel combinations of behavioural therapies or psychotherapy/pharmacotherapy combinations, both to enhance treatment efficacy and to offset weaknesses of a single approach; (b) investigating individual differences in treatment response and in treatment moderators by using novel methods that may in the near future include sub-typing and predictor analyses involving neuroimaging, stress-response paradigms, and genetics; and (c) developing strategies to investigate sequenced interventions, in which treatments or treatment components are delivered on the basis of the individual drug user’s characteristics, including previous treatment response, neurocognitive functioning, and family history. Greater emphasis is also needed on enhancing adherence and response to existing behavioural and pharmacological approaches. Finally, promising strategies include evaluation of the means by which efficacious treatments can be reduced in duration, complexity, and cost. For example, individual treatments could be transformed into group-based approaches that would have wider acceptability in clinical practice. Simplified training procedures should be developed for treatments that are difficult for practitioners to learn. New information technologies should be considered, both as a means to improve treatment efficacy and as a way to make treatments more readily available and easier for patients and practitioners to use. In summary, the level of progress in the behavioural treatment of drug abuse in recent years has exceeded what many researchers and practitioners had believed possible. Efficacious behavioural treatments exist, and conditions for which efficacious medications exist can be treated with combinations of behavioural and pharmacological treatments that have even greater potency than either type of treatment alone. More work can be done to improve effect sizes in research on behavioural treatments and to develop strategies to help drug users who do not respond to existing treatments. Work on the mechanisms of action of behavioural treatments, in addition to translational efforts to link basic science and neuroscience with treatment development, promises to yield new insights that will help to make drug abuse not only treatable but treated.

87. A range of family-based psychosocial therapies have been developed and applied also for drug dependence treatment, most of them in the United States (for example MDFT — Multidimensional Family Therapy, MST — Multisystemic Treatment, BSFT — Brief Strategic Family Therapy). However, they have been applied also internationally, for example BSFT in Latin America, while the International Cannabis Need of Treatment (INCANT) Study on Multidimensional Family Therapy (MDFT) is a research a multi-site, trans-national randomized controlled trial (RCT), based on the Five-Countries Action Plan for Cannabis Research, adopted in April 2003 by representatives of, or on behalf, of the Ministries of Health of Belgium, France, Germany, the Netherlands, and Switzerland to test an outpatient treatment of cannabis use disorders in troubled youth. Multidimensional Family Therapy (MDFT) was developed by researchers from the University of Miami. Applying the rules of evidence-based practice, MDFT emerged as best supported treatment in the adolescent cannabis treatment literature, with strong evidence of efficacy and effectiveness in U.S. treatment settings. So far the five countries mentioned have carried out a successful Pilot Study to assess the feasibility of a trial of MDFT in Western Europe and have now
started the so-called INCANT Main Study. Cannabis is the most often used illegal drug in the general population in the Western world. Adolescents are quite sensitive to the development of cannabis disorders. In youth, these disorders are not easily overcome without treatment. Cannabis abusing and dependent youth show high rates of concurrent psychiatric co-morbidity (e.g., anxiety, depression, conduct disorder), alcohol disorders and psychosocial problems. MDFT acknowledges that treatment should focus on this multiplicity of problems rather than on cannabis alone.

88. The INCANT Main Study will compare MDFT to treatment as usual (TAU) in Belgium, France, Germany, the Netherlands, and Switzerland both at the local (national) level and across these five countries, with a cost-effectiveness component to be included in one or two of these countries. The trial will be implementation-oriented, i.e., it will focus on transportability of MDFT to (varying) European context. MDFT is a family based and developmentally oriented outpatient treatment for adolescent substance use disorders and associated or related problems. Data from the INCANT study suggest that MDFT can be implemented in European practice, though not without effort or change of routine. Current European treatment practice often boils down to a therapist conducting sessions with an adolescent or sometimes family that are limited in setting (the therapist's office) and focus, and widely spaced in time. In contrast, MDFT is outreaching, with the therapist paying home visits and conducting sessions in the community whenever needed, and contacting and visiting school and sometimes juvenile court, speaking to peers, and bringing material from one source into other sessions and vice versa in frequently scheduled sessions. MDFT has been shown in U.S. based trials among adolescents to engage and retain clients and their families in treatment, to reduce cannabis and other substance use, to diminish hanging out with drug using peers, to improve family and school functioning, and to reduce delinquency and symptoms of internalizing (anxiety, depression) and externalizing (disruptive conduct) behaviours more than comparison treatments. Adolescents, families and therapists alike are generally quite appreciative of MDFT. MDFT is not necessarily or overly long in duration for the kind of clients considered, but is quite intense and focused. The effort may pay off in favourable cost-effectiveness ratios according to U.S. based MDFT research, to be confirmed in Europe.

89. Cannabis use disorder is the most common illicit substance use disorder in the general population. Despite that, only a minority seek assistance from a health professional, but the demand for treatment is now increasing internationally. Trials of treatment have been published but not systematically reviewed. To evaluate the efficacy of psychosocial interventions for cannabis abuse or dependence a search was conducted using different scientific databases such as Cochrane and Medline. Also researchers in the field were contacted. Six trials involving 1,297 people were included. The six included studies suggested that counselling approaches might have beneficial effects for the treatment of cannabis dependence. The six studies included in this review show that cannabis dependence was not easily treated by psychotherapies in outpatient settings. Cognitive-behavioural (CB) both in

individual or group sessions, motivational enhancement in individual sessions have been demonstrated to be effective in reducing cannabis use. The most recent, best quality and largest controlled trial, found extended individual CBT to be more effective than brief individual motivational therapy. The two studies on contingency-management treatments concluded that this may enhance outcomes combined with CBT or motivational enhancement.

90. Dependence on or problematic use of prescription drugs (PD) is estimated to be between 1 per cent and 2 per cent in the general population. In contrast, the proportion of substance-specific treatment in PD use disorders at 0.5 per cent is comparatively low. With an estimated prevalence of 4.7 per cent, PD-specific disorders are widespread in general hospitals compared to the general population. Brief interventions delivered in general hospitals might be useful to promote discontinuation or reduction of problematic prescription drug use. One hundred and twenty-six patients fulfilling criteria for either regular use of PD (more than 60 days within the last 3 months) or dependence on or abuse of PD, respectively, were allocated randomly to two conditions. They were recruited from internal, surgical and gynaecological wards of a general and a university hospital. Participants received two counselling sessions based on Motivational Interviewing plus an individualized written feedback (intervention group, IG) or a booklet on health behaviour (control group, CG). After 3 months, more participants in the IG reduced their daily dosages compared to the participants in the CG (51.8 per cent versus 30 per cent). In the IG 17.9 per cent, in the CG 8.6 per cent discontinued use of PD. It can be concluded that Brief intervention based on Motivational Interviewing is effective in reducing PD intake in non-treatment-seeking patients.

C. Drug dependence treatment and HIV/AIDS

91. For those who are using drugs, providing accessible, evidence-based, treatment for drug users and drug dependent individuals has been found to reduce individual and social harm. The option of drug-free oriented treatment, or at least the possibility to reduce illicit drug use, as well as retention in treatment with continuous contacts with health-care providers, have proved effective in reducing overdoses, infections, car accidents, legal problems, criminal behaviour, psychiatric hospitalizations and suicide rates. This has been demonstrated for both pharmacologically assisted treatment (long acting opioid-agonists and use of antagonists) and drug-free oriented treatments. Evidence-based and specialized treatment should be part of any group of services provided to female drug users, including when pregnant and with children, to prevent HIV and other health and social consequence to themselves and/or their children.

78 UNODC (2008), Reducing adverse health and social consequences of drug abuse: A comprehensive approach, United Nations Office on Drugs and Crime, Vienna, Austria.
92. Numerous studies have now documented that significantly lower rates of drug use and related risk behaviours are practiced by injecting drug users (IDUs) who are in treatment. Importantly, these behavioural differences, based primarily on self-report, are consistent with studies that have examined HIV seroprevalence and seroincidence among drug users. The underlying mechanism of action suggested by the collective findings of the available literature is rather simple: individuals who enter and remain in treatment reduce their drug use, which leads to fewer instances of drug-related risk behaviour. This lower rate of exposure results in fewer infections with HIV.80 Properly dosed, long-term methadone treatment was found to be a central protective factor in preventing HIV infection from the earliest days of the epidemic in New York City.81

93. A review of the scientific literature from 1981 to 2005 has shown that, although recent trends indicate a decline in the proportion of newly diagnosed HIV infections associated with injection drug use, drug-use behaviours overall still account for 32 per cent of new HIV diagnoses. Factors in addition to syringe sharing contributing to HIV transmission among IDUs were: risky sexual behaviours, sharing of drug preparation equipment and drug solutions, and contextual and social factors. The review concluded that promising approaches for HIV prevention included rapid HIV testing, office-based substance abuse treatment, behavioural interventions, improved communication about syringe exchange programmes, and case management, thus underscoring once again the importance of drug dependence treatment in responding to the HIV and AIDS epidemics.82

94. To increase the complexity of the problem, concomitant mental illness affecting a large portion of drug users has been found to increase the risk of HIV infection and reduce the rate of individuals engaged in risk-reduction behaviours, such as using a needle exchange, to rates as low as 2 per cent.83 In fact, scientific evidence suggests that the harm reduction effects of needle exchange programmes can be significantly enhanced through the referral of participants to programmes that treat substance use and/or other psychiatric disorders.84 This might be particularly relevant in the context of prison settings, and among women drug users (both in the community and in prison settings), where, as described above, rates of drug dependence and mental disorders in general are generally higher than in the general population.

95. Moreover, it has been noted with regard to the treatment and care of AIDS that one of the challenges for patients treated with Highly Active Anti Retroviral Therapy (HAART) is adhering to the medication routine needed for maximum benefit from this therapy. Treatment of AIDS with highly active antiretroviral treatment appears to be less effective in drug users than in other patient groups, because of a variety of factors such as delayed access to effective treatment, lower adherence to care and treatment regimens, continuation of illicit drug use, depression and negative life events. This is compounded by the fact that drug use and drug dependence can also worsen the progression of HIV and vice versa. In animal studies, methamphetamine increased HIV viral replication; in human methamphetamine abusers, HIV caused greater neuronal injury and cognitive impairment compared with non drug-users. The available evidence strongly suggests the need for a large-scale implementation of comprehensive treatment and care strategies for IDUs that include both treatment of drug dependence and antiretroviral treatment.

96. Finally, providing evidence-based drug dependence treatment and care as an alternative to incarceration and penal sanctions is not only the of the basic principles of effectively and cost-effectively addressing drug dependence, but should also accompany and be an integral part of any HIV prevention accompany — and be seen as an integral component of — a comprehensive strategy to prevent HIV transmission in prisons, to improve prison health care, and to improve prison conditions.

D. UNODC response in the field of drug dependence treatment and HIV/AIDS

97. In line with the evidence presented above, UNODC is implementing projects in the field of drug dependence treatment that are guided by scientific evidence and good practice from around the world. The response is articulated through a series of global and regional programmes and projects, with activities complementing each other.

98. The goal of UNODC project Treatnet II is to prevent HIV and AIDS as it relates to drug use and provide care to those affected through increased access to quality, affordable drug dependence treatment services in project countries. The project will contribute to reducing or halting the HIV/AIDS epidemic in targeted

90 UNODC (2006), HIV/AIDS Prevention, Care, Treatment and Support, A Framework for an Effective National Response, United Nations Office on Drugs and Crime, Austria.
countries and improve the well-being of and social integration of project beneficiaries.

99. The strategy to achieve this goal includes three lines of action: (i) systematic advocacy to promote a sound understanding of drug dependence treatment and care (including HIV/AIDS prevention) and the recognition of drug dependence as a health disorder; (ii) capacity building for service providers (Training of Trainers approach); (iii) support for the development and strengthening of sustainable drug dependence treatment services. Countries currently involved in the Treatnet II project are: Côte d’Ivoire, Kenya, Mozambique, Nigeria, Sierra Leone, United Republic of Tanzania, Zambia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan, Brazil, Colombia, Haiti, Nicaragua, Peru, Cambodia, Myanmar and Viet Nam. Implementation in 2009 focused on the training component with regional trainings of trainers in all project regions and the initiation of national trainings. It is expected that by the end of the project more than 10,000 practitioners will have been trained as part of the Treatnet II project on psychosocial and pharmacological drug dependence treatment as well as on assessment and brief interventions.

100. The UNODC Treatnet II project is closely coordinated with the UNODC-WHO Programme on Drug Dependence Treatment and Care, which was launched in March 2009 by UNODC and WHO. The overall aim of the Programme is to promote and support worldwide, with a particular focus on low- and middle-income countries, evidence-based and ethical treatment policies, strategies and interventions to reduce the health and social burden caused by drug use and dependence. UNODC and WHO are organizations with complementary mandates, experience, competencies and networks. Through this Programme, UNODC and WHO will strengthen their collaboration on drug dependence treatment and care at the global, regional and country levels, sharing their networks of intervention and interacting with Member States and the other intergovernmental organizations on a common basis. In particular, this Programme will permit to start or facilitate a dialogue with the Member States through their Ministry of Health, National Drug Secretariat, Ministry of Interior, Ministry of Justice and other relevant ministries.

101. The Programme has two main expected outcomes: i) the improved ability of health and social systems to address effectively treatment of drug use disorders in populations, thereby improving effectiveness, impact, human collective and individual security, and enhancing social development; and ii) the expected increase of the coverage of evidence-based drug dependence treatment and HIV prevention interventions in targeted countries by at least 30 per cent by 2013. Consequently, the implementation of the Programme between 2009-2013 envisages two stages. Stage I (2009-2010) would include: advocacy and engagement of partners, development of programme models and technical tools, dissemination of good practices, capacity building and piloting of programme activities in selected countries, as described below. Following a mid-term evaluation of Stage I, Stage II envisages the full implementation of all components, including the activities in an increased number of countries, with increasing support from the envisaged global and regional activities and consolidated and strengthened international collaboration on demand reduction. An external evaluation of the Programme will form an important part of Stage II. Stage I will start implementation in Serbia, Albania and Haiti in early 2010.
102. At the regional level, UNODC project XNAJ58 entitled “Promoting good practices and networking for reducing demand for and harm from drugs (Africa and Middle East region)” started in 2007 and aims at empowering regional capacities to cover a wide spectrum of activities aiming at reducing demand (prevention, treatment) for as well as harm from drugs. This is being undertaken through the expansion and adaptation of successful national best practice models to a regional level. This facilitates bridging local NGO/resource institution expertise with those of best practice within the European Community. The treatment component of the project follows the established methodology and tools of UNODC project Treatnet II.

103. In Central America, UNODC project CAMH90 entitled “Establishment of a treatment, rehabilitation and social reintegration network in Central America” has been ongoing since 2004 with the objective to create a treatment, rehabilitation and social reinsertion network in the region, including Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panamá, in order to promote progressively the improvement and modalities of integral attention through the different services available for persons in use or abuse of drugs. The first three phases allowed for the establishment of the institutional bases in each country, which has resulted in a valuable experience. It is now required to institutionalize the network as an instrument of public policy at a national and regional levels with sustainable mechanisms. The project will develop four mechanisms to strengthen the technical resources and infrastructure for the network members so that they can progressively achieve and promote the treatment minimum standards and actively take part in the development of drug prevention public policies. Reciprocal coordination and communication among different institutions and sectors will be crucial to support continuous education, research and an efficient and effective use of social capital. Training activities are closely coordinated and linked with those of UNODC project Treatnet II.

104. UNODC, a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), is the lead agency in the UNAIDS family for HIV and AIDS prevention and care among drug users, especially injecting drug users and in prison settings. UNODC is also responsible for facilitating the development of a United Nations response to HIV and AIDS associated with human trafficking. The focus of the work of UNODC in these areas is to assist States in implementing large-scale and wide-ranging interventions to prevent HIV infections and in providing care and support to people living with HIV and AIDS. One of the most important lessons learned from two decades of work on HIV and AIDS is that prevention and care interventions need to be comprehensive and multisectoral to address the needs of often very diverse vulnerable populations. Projects using single and stand-alone interventions have little impact. UNODC has more than 60 staff members in 28 countries working on HIV-related issues. A team based at UNODC headquarters in Vienna supports the work of advisers posted in countries in Eastern Europe, Central Asia, South and South-East Asia, Africa and Latin America and the Caribbean. UNODC is mainstreaming HIV and AIDS prevention into its activities at the national, regional and global levels, and is helping States and civil society organizations to develop and implement comprehensive HIV and AIDS prevention and care programmes for injecting drug users.