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PREVENTION OF DRUG-RELATED CRIME REPORT

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Prevention of drug-related crime report

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| CCSA | Canadian Centre on Substance Abuse |
| CDT | Commissions for the Dissuasion of Drug Addiction |
| IGCD | Intergovernmental Committee on Drugs |
| ICPC | International Centre for the Prevention of Crime |
| SPF | Strategic Prevention Framework |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction |
| FDA | Food and Drug Administration |
| DSCIF | The Drug Strategy Community Initiatives Fund |
| RCMP | Royal Canadian Mounted Police |
| IDCP | International Drug Policy Consortium |
| OAS | Organization of American States |
| FOPH | Federal Office of Public Health FOPH (Switzerland) |
| NGO | Non-governmental organization |
| ONDCP | Office of National Drug Control Policy |
| UNODC | United Nations Office on Drugs and Crime |
| PNRCAD | <i>Plano Nacional Para a Redução Dos Comportamento Aditivos e Da Dependências</i> |
| UNDP | United Nations Development Programme |
| PORI | Operational Plan of Integrated Responses |
| PRI | Integrated Response Program |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SICAD | Direktorate General for Intervention on Addictive Behaviours and Dependencies |
| NADS | National Anti-Drug Strategy |
| NCPS | National Crime Prevention Strategy (Canada) |

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1. Core Issue

The core issue on which this report focusses is the ***prevention of youth crime committed under the influence of drugs or to acquire drugs***. To investigate this question, a comparative analysis was performed between seven national drug strategies, highlighting the differences and similarities in approaches.

The report is structured in four parts. The first part presents a **theoretical framework** and a literature review of the three central points of this report:

- The links between crime and drugs,
- The specific situation of young people in relation to this issue, and
- Effective prevention programs in this area.

The second part presents each of the **seven national strategies** identified, namely: Canada, Australia, the United States, the Netherlands, Portugal, the United Kingdom and Switzerland.

The third part consists of the above mentioned comparative analysis between the **seven national strategies** using established criteria.

Finally, the report concludes with a series of **recommendations** on drug-related strategies to prevent crime committed under the influence of or to acquire drugs.

1.1 Drug-Related Crime: Trends

a) *Psychotropic substances and crime: a causal link?*

There is a clear **correlation** between crime and drug use worldwide (Insulza, 2013). For example, in the United States, 60% of individuals arrested for most types of crime test positive for illegal drugs at the time of their arrest (National Association of Drug Court Professionals in The National Council on Alcoholism and Drug Dependence, n. d.), despite drug users comprising a mere 9.2% of the American population (National Institute on Drug Abuse, 2014)¹. In Canada, proportions are

¹ On a global level, the drug that is used most is cannabis (3.8%), followed by opioids and amphetamine-type stimulants (0.7% each), then Ecstasy (0.4%), cocaine (0.37%), and finally opiates (especially heroin) (0.35%) (United Nations Office on Drugs and Crime, 2014)-. Cannabis users may account for between 75% and 80% of all users of illegal drugs (Insulza, 2013).

similar: two-thirds of offenders in federal penitentiaries are drug-dependent (International Centre for the Prevention of Crime, 2012), while users of cannabis represent only 10.2% of the general population, and users of other drugs about 1% each (Health Canada, 2014). Drug users are therefore clearly over-represented among detainees.

However, while a correlation may have been established between crime and illicit drug use, the existence of a **causal link** between the taking of narcotics and the commission of offences is subject to greater debate (e.g., Sanfaçon, Barchechat, Lopez, & Valade, 2005). The fact that some inmates use illicit drugs does not prove that their offences were committed while under the influence of drugs or in order to acquire drugs (Insulza, 2013). Moreover, it should be noted that most drug users do not commit delinquent acts, and that in most cases drug use is not accompanied by criminal acts (MacCoun, Kilmer, & Reuter, 2003).

b) The influence of drugs on crime

Drugs can influence crime:

- **directly**: i.e., crime committed under the influence of a substance or to support an addiction: or
- **indirectly**: i.e., drugs may influence such things as the development of cognitive abilities, or associations with antisocial peers.

Drug use has a stronger causal relationship with property offenses.

In terms of the **direct** influence of drugs, there is a distinction to be made between:

- crimes committed to finance drug use; and
- crimes committed while under the influence of drugs.

Drug-related offences appear to have a much stronger causal relationship with property offences than with crimes against persons or assault. Indeed, the International Narcotics Control Board points out that:

Crime linked to consumption is mostly non-violent and often petty². Economic-compulsive crime to obtain drugs, such as theft and burglary, is more common than violent drug-induced assault. (International Centre for the Prevention of Crime, 2010, p. 74)

² INCB, Drugs, Crime and Violence: The Microlevel Impact.

Certain studies have concluded that there is no compelling evidence that drug use increases murder or violent crime rates; some even show a negative association instead (e.g. Resignato, 2000 in Markowitz, 2005; Corman & Mocan, 1996; and Gizzi & Gerkin, 2010). However, other studies claim the opposite³, especially one particular meta-analysis that establishes a strong correlation between drug use and aggression in intimate relationships (Moore et al., 2008).

As to the **indirect** influence of drugs, research has demonstrated that heavy drug use during adolescence may be detrimental to the development of the communication and interpersonal skills that are vital to establishing healthy relationships (Hussong, Curran, Moffitt, Caspi, & Carrig, 2004; Reyes et al., 2011 in McNaughton Reyes, Foshee, Bauer, & Ennett, 2014).

Drug use also influences the types of relationships a person develops and, consequently, even the lifestyle the person adopts. Hunt (1990) reports that "persons who abuse drugs, particularly expensive drugs such as heroin or cocaine, 'are more likely than nonusers to be involved in a lifestyle that includes a great variety of illegal activities' (p.159)" (Gizzi & Gerkin, 2010)

c) *Different drugs for different crimes*

It should be noted that neither psychotropic substances nor crime are amenable to analysis as homogeneous categories, as drug type influences the type of crime committed or lack thereof. Gizzi & Gerkin (2010) explain that

the logic is that different drugs will likely produce different effects on users and their likelihood of engaging in different types of crimes that compose the drug-crime nexus (pp. 931-932).

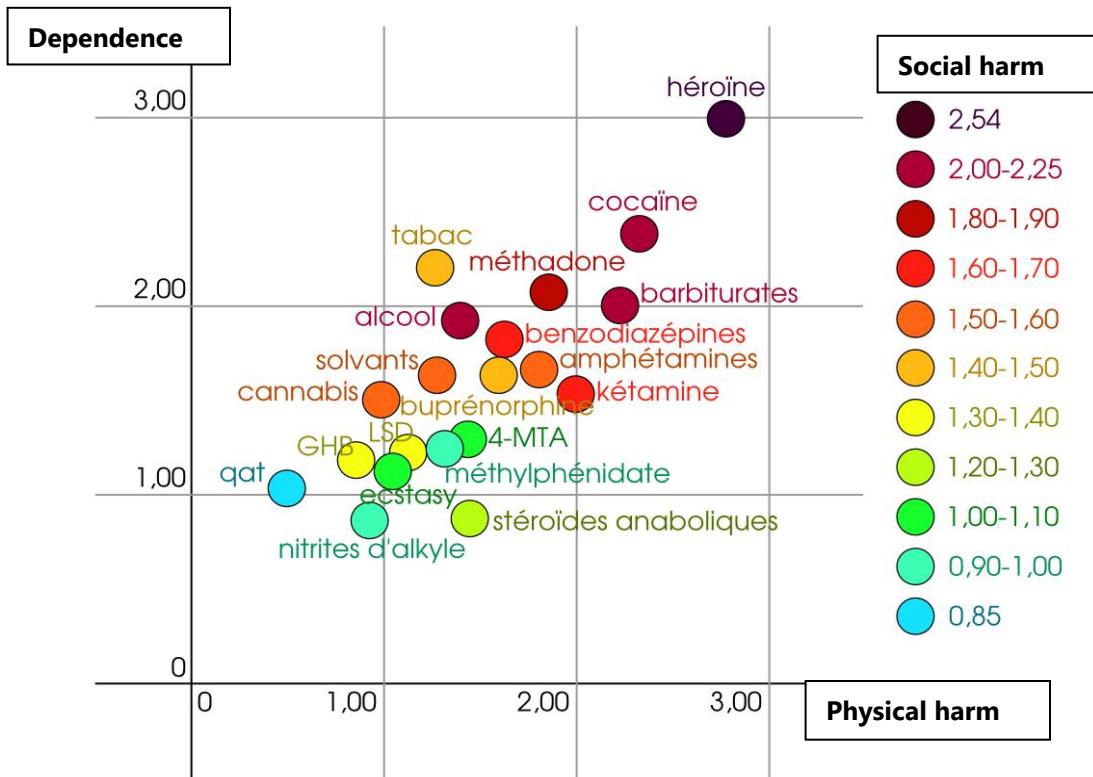
Drugs that have a high abuse potential and cause serious health damage generally are more highly correlated with crime than drugs that do not have such characteristics, but they rarely provoke violent behaviours (Insulza, 2013).

Lack of Research: A Considerable Major Challenge

The CLEEN Foundation, an ICPC member based in Nigeria, relates has collected anecdotes describing how insurgents involved in massacres in Nigeria committed their actions while under the influence of strong narcotics. However, no studies have been carried out on the impact of drugs on crime in Nigeria (CLEEN Foundation, 2015).

³ e.g. Inciardi, 1979; Manzoni, Brochu, Fischer, & Rehm, 2006; Martin, Maxwell, White, & Zang, 2004; Mendes, 2000 in Gizzi & Gerkin, 2010

In the graph below, various drugs are displayed according to their abuse potential as well as the physical and social harm⁴ they cause.



Heroin, cocaine, tobacco, methadone, alcohol; barbiturates, benzodiazepines, solvents, amphetamines, cannabis, ketamine, buprenorphine, LSD, khat, GHBé, 4-MTA. Methylphenidate, ecstasy, anabolic steroid.; nitrites -alkyl nitrates;

Figure 1. This graph is based on an article by Nutt, King, Saulsbury, & Blakemore (2007). Graphics by Castro (2014).

It should also be remembered that drugs may affect individuals differently depending on "drug potency, the size of the dose, body composition, personal drug tolerance, and the social context in which the drug is consumed". (Gizzi & Gerkin, 2010, p. 915)

The most common type of drug-related crime is **crime committed to support a drug habit**, generally associated with drugs with a high abuse potential.

⁴ Social harm refers to damage to one's family and social life, as well as costs related to the health care system, social institutions, and the police (Nutt, King, Saulsbury, & Blakemore, 2007).

A study conducted in the United Kingdom shows that between one third and half of the individuals involved in acquisitive crime are heroin, cocaine or crack users (Great Britain Home Office, 2010; see also Insulza, 2013). According to a Colorado study, methamphetamine users are also more likely to engage in certain types of property crime to finance their drug use (Gizzi & Gerkin, 2010).

The **psychopharmacological effect** of a drug may also influence criminal behaviour. An OAS study confirmed that stimulants induce violent behaviour (Insulza, 2013). Similarly, an Australian prison-based study revealed that a greater proportion of offenders having committed drug-related offences were under the influence of benzodiazepines at the time of their offence, a drug that would appear to induce uninhibited, aggressive and odd behaviour (Sutherland et al., 2015).

Research also indicates that methamphetamine-dependent individuals "report increased difficulty controlling anger and violent behaviour" (Zweben et al., 2004 in Sutherland et al., 2015). A study conducted in Los Angeles, USA, found that 35% of methamphetamine users aged 18 to 25 years had committed acts of violence while under the influence of the drug (Baskin-Sommers B, Sommers, 2006 in Atkinson et al., 2009).

Phencyclidine is also reputed to induce violent, aggressive and odd behaviour (Bey & Patel, 2007)

Finally, a study conducted with young people in Germany, Spain and England showed cocaine use during vacations tripled the odds of involvement in a brawl, while cannabis use doubled them (Hughes K et al., 2008, in Atkinson et al., 2009).

The degree of addiction also influences crime. The probability of an offence being committed has been observed to be greater when addiction is intense, with the probability decreasing when dependence is less (Insulza, 2013). Authors Baskin-Sommers and Sommers (2006) have noted that although low doses of methamphetamines do not increase aggressive behaviour, increasing dose and long-term use induce changes in users' social behaviours. Likewise, chronic use tends to reduce impulse control and induce exaggerated defensive behaviours. Moreover, high methamphetamine use combined with alcohol consumption appears to provoke frequent paranoia, resulting in aggressive and violent behaviour.

The South African experience of the NGO Khulisa

ICPC member organization Khulisa is involved in drug use prevention in South Africa. Testimony collected at its field offices has established the existence of different types of drug-related crime based on socio-economic context. It would seem that in the poorest neighborhoods, crimes are committed to finance drug use, while in neighbourhoods affected by the presence of street gangs, people tend to take drugs to increase their confidence and shed their inhibitions (Khulisa, 2015).

Withdrawal may also induce violent behaviour in some cases. Various studies suggest that withdrawal from long-term heroin and cannabis use may result in aggression⁵.

Finally, numerous studies have shown drug use also to increase the probability of being a victim of crime (Atkinson et al., 2009).

d) Findings

The examination of drug-related crime has resulted in a number of findings:

- Psychotropic substances may have crime-related consequences in the **short term** (while individuals are under the influence of drugs or to finance drug use) or the **long term** (in terms of brain development, or association with antisocial peers, for example).
- Drug-related crime is more prevalent in **property crime** than in offences against persons.
- **Drug type** influences behaviour in different ways: stimulants such as cocaine, amphetamines and methamphetamine are among those most likely to induce violent behaviour.
- Drug-related crime is especially dependent on the drug user's level of **addiction**
- **Withdrawal** can provoke violent behaviour.

1.2 Young People

a) Risk factors and protective factors in young people

This report focuses primarily on the prevention of drug-related crime **among young people**. Young people between the ages of 10 and 29 years are more likely to engage in interpersonal violence or to be the victims of such violence—especially gang-related or intimate partner violence—when levels of psychoactive substance use are higher (Atkinson et al., 2009). UNODC considers youth, in and of itself, a risk factor for drug use (United Nations Office on Drugs and Crime, 2003).

Furthermore, psychotropic drug use can have "a major impact on young people's education, their health, their families, and their long-term chances in life." (Great Britain Home Office, 2010, p. 7). The adolescent brain is still in the developmental phase; consequently, the earlier the initiation to drugs, the greater the probability of developing drug addiction issues (UNODC,

⁵ For more information, see studies cited by Atkinson et al., 2009, p. 5.

2013). It is therefore important that antidrug strategies take the specific needs of young people into account in the implementation of preventive approaches.

The objective of prevention programs is to strengthen protective factors and reduce risk factors.

Before designing any program aimed at preventing crime and/or illegal drug use, it is important to identify both **risk factors** and **protective factors**. [Translation]"The accumulation of a series of risk factors without the benefit of protective factors would constitute a so-called 'problem' behaviour syndrome" (Jessor and Jessor, 1977; Hawkins et al., 1992; Farrington, 1995, in Sanfaçon et al., 2005, p. 50). Thus,

the principal objectives of prevention programs must be to strengthen protective factors and to reduce risk factors.

Protective factors are characteristics that reduce the likelihood of an individual becoming involved in criminal or violent behaviour (see for example World Bank Institute, n.d.) or, in the present case, in illegal drug use.

Conversely, risk factors are "characteristics that increase the likelihood that an individual will become involved in crime and violence (either as a victim or a perpetrator)" (World Bank Institute, n. d.); or in this case, in the use of illicit drugs. Longitudinal studies have established that no one risk factor leads to delinquency, but rather that it is the accumulation of risk factors across multiple domains⁶ that is key (Wasserman et al., in Sanfaçon et al., 2005, p. 49). Thus, programs must address a variety of risk factors, as isolated initiatives are likely to have little impact.

Risk and protective factors may differ depending on whether they concern drug use or crime; however, there is considerable crossover. For example, a WHO study established drug use as a risk factor for crime (Krug EG et al., 2002, in Atkinson et al., 2009). Atkinson et al. (2009) have compiled a list of shared risk factors (see Figure 2. Shared risk factors for illicit drug use and crime (Atkinson et al., 2009)

⁶ Individual, family, social, etc.

| Individual (microlevel) | Relationship (mesolevel) |
|---|---|
| Stress/depression/anxiety | Parental substance abuse and deviance |
| Personality and behavioural problems including impulsivity, hyperactivity, sensation seeking and attention problems | Family interaction including low parental monitoring, poor supervision and discipline, family conflict, low parental expectations, parental rejection, low level of family cohesion |
| Agression | Family structure - single parents and divorce |
| Mental health problems | Peer behaviour (e.g. drug using peers) |
| Gender - males ⁷ | Community and societal (macrolevel) |
| Age - young people ⁸ | High drug availability |
| Education and school performance including absence, truancy, lack of formal support and low educational aspirations | Low socio-economic status |
| | Neighbourhood disorder |

Figure 2. Shared risk factors for illicit drug use and crime (Atkinson et al., 2009, p. 6)

There are also **protective** factors that need to be strengthened, and are the counterpart of risk factors. At the individual level, these are factors such as having self-esteem or a risk-avoidance personality (Insulza, 2013). With regard to family-related factors, Bry and Slechta (in press in Dusenbury, 2000) have shown that the following factors appear to protect children regardless of

Family influence is one of the most important risk and protective factors.

culture: a warm relationship with the parents, monitoring or supervision of children (especially adolescents), good communication, positive feedback from parents, family discipline that establishes a range of positive expectations and is enforced, parental involvement in children's activities, and

the seeking out of help and support for children. Family influence is recognized as one of the most important risk and protective factors in protecting adolescents from drug use (Vakalahi, 2001 in Lee, 2012, p. 407). Attachment to school and the influence of peers who are intolerant of drug use are also protective factors (Insulza, 2013). Finally, a community that provides a social support network and positive social status (e.g., public or private instruments designed to reduce social exclusion and inequalities) will also help keep youth from engaging in problem drug use (Insulza, 2013).

⁷ However, women are more at risk of becoming victims of certain types of violence such as sexual violence.

⁸ This does not include elder abuse.

However, further research is required into the connection between risk and protective factors for drug use and delinquency:

[Translation] Researchers have concluded that (a) the processes underlying the interaction of these various risk and protective factors remain unknown, and (b) in many cases, it is still unclear whether many of these factors are the causes or correlates of antisocial behaviour (Sanfaçon et al., 2005, p. 50). (Sanfaçon et al., 2005, p. 50).

The study of the causal factors of youth crime and drug use helps clarify why **prevention programs** do not necessarily address drug use directly (indeed, the topic may not be discussed at all with the young people in these programs), but instead **focus on reducing risk factors and increasing protective factors.**

b) Mental health

There is a clear association between mental health and drug use: individuals with mental illness are at greater risk of drug addiction, while the opposite has also been proven to be true. When a person suffers from both mental illness and addiction, we speak of *concurrent disorders* or *comorbidities*.

A study conducted in the United States revealed that:

- 30 per cent of people diagnosed with a mental health disorder will also have a substance abuse disorder at some time in their lives. This is close to twice the rate found in people who do not have a lifetime history of a mental health disorder.
- 53 per cent of people diagnosed with a substance use disorder (other than alcohol) will also have a mental health disorder at some point in their lives. This is close to four times the rate found in people who do not have a lifetime history of a substance use disorder (Reiger et al., 1990, in Skinner & Centre for Addiction and Mental Health, 2011, p. 2)

Concurrent disorders affect young people in particular as most mental illness starts before adulthood (Kessler RC, Berglund P, Demler O et al., 2005, and Kim-Cohen J et al., 2003, in Great Britain Home Office, 2010).

c) Promising youth programs

Shaw (2007, p. 8) has established a series of indicators of effective youth crime prevention programs, based on ECOSOC resolution 20002/13:

- (a) inclusive approaches which reduce youth marginalization;
- (b) participatory approaches;
- (c) integrated multisectoral strategies;

- (d) balanced strategies which include early intervention, social and educational programs, restorative approaches and crime control;
- (e) targeted and tailored strategies and programs to meet the needs of specific at-risk groups;
- (f) approaches which respect the rights of children and young people.

The importance of strengthening protective factors through prevention programs, including alternatives to incarceration, has also been stressed (Shaw & Travers, 2007).

These indicators will be used to assess the adequacy of the approaches to youth adopted in national strategies.

1.3 The prevention of drug-related crime

Criminology has borrowed the notion of three prevention categories—primary, secondary, and tertiary—from the health field. These categories are defined as follows (UNODC, 2011, p. 16):

- **Primary** prevention refers to programs or initiatives aimed at those who have never been involved in the criminal justice system, such as programs to educate or alert the general public or young people about domestic violence or bullying in schools.
- **Secondary** prevention refers to programs specifically targeted to children and young people who are identified by the social services, educational or justice systems as being at risk of involvement in crime.
- **Tertiary** prevention refers to programs for those who are in the criminal justice system and/or returning to the community, with the aim of preventing re-offending.

We have identified three types of preventive approaches for the prevention of drug-related crime:

- the prevention of illegal drug use
- harm reduction (the prevention of drug-related risk behaviors)
- the prevention of recidivism

a) Drug use prevention

Campaigns

Mass media campaigns are an interesting preventive tool as they make it possible to reach large numbers of people. They are primarily aimed at raising awareness of the harmful effects of drugs and discouraging their use.

A poorly designed campaign can have a negative impact and increase drug use.

Although numerous countries use such campaigns and large sums of money have been invested in producing them, media campaigns have not been sufficiently assessed to determine how effective they truly are (Wakefield, Loken, & Hornik, 2010). Indeed, research shows little evidence

for their ability to reduce drug use (see for example UNODC, 2013 and European Monitoring Centre for Drugs and Drug Addiction, 2013).

Moreover, UNODC notes that poorly designed campaigns can have a counter-productive effect making individuals dismissive of or resistant to other anti-drug initiatives (UNODC, 2013).

An evaluation of an American campaign in effect from 1998 to 2004 notes that, according to psychological reactance theory, young people who felt their freedom of choice was being threatened might adopt a proscribed behaviour to ensure that freedom, i.e. that "youths who were exposed to these antidrug messages [would have] reacted against them by expressing pro-drug sentiments⁹" (Hornik, Jacobsohn, Orwin, Piesse, & Kalton, 2008).

The evaluation presents an alternative theory as well: that antidrug campaigns convey the message that drug use is commonplace, thereby motivating young non-users to initiate use (Hornik et al., 2008)

Palmgreen and Donohew (2006) contend that, despite the lack of research on effective antidrug campaigns, the larger body of research regarding health-related behaviours is also applicable. They present a prevention approach based on sensation seeking theory. Sensation seeking is a personality trait that is correlated with drug use (the authors cite a number of studies to this effect). To prevent drug use, it is vital that preventive messages be tailored to sensation seeking: campaigns must be (1) novel, creative or unusual; (2) complex; (3) intense, emotionally powerful or physically arousing; (4) graphic or explicit; (5) somewhat ambiguous; (6) unconventional; (7) fast-paced; or (8) suspenseful (Donohew et al., 1991 in Palmgreen & Donohew, 2006).

In schools

In 2002, a UNODC study established that most government antidrug initiatives worldwide take place in schools (Botvin & Griffin, 2007). However, school-based programs do not necessarily produce conclusive results.

School-based prevention programs must be used in concert with other initiatives.

For example, the D.A.R.E. (Drug Abuse Resistance Education) program has been implemented in 50 states in the United States as well as 49 countries (D.A.R.E., n. d.), and constitutes a benchmark program in the domain. However, various studies show that D.A.R.E. has no long-term impact on the prevention of illegal drug use in young people (see for example Kanof, 2003).

Different data must be taken into account to determine the effectiveness of school-based programs. First, there are social and family risk factors for drug use: school-based prevention is generally ineffective when used alone (see for

⁹ The authors did not, however, find support for this theory.

example Botvin, 1999; Flay, 2000; Lloyd et al., 2000 in Ariza et al., 2013), and must therefore be combined with other initiatives. It is difficult for school-based prevention initiatives to address crucial issues such as families in conflict, family drug abuse, or exposure to drug use promotion (Hawthorne, 2001).

Second, there are a variety of drug use prevention models. The approach that has historically been used most is the **dissemination of information about the dangers of drug use and abuse** (Botvin & Griffin, 2007). However, evaluations have shown this approach neither modifies nor prevents drug use behaviours (e.g., Botvin and Botvin, 1992 in Botvin & Griffin, 2007 and Hawthorne, 2001). Similarly, fear-based approaches provide inconclusive results (UNODC, 2013).

Another approach is that of preventive programs focused on **social resistance skills training**. In this approach, young people are taught how to avoid situations in which they might encounter social pressure to take illegal drugs, as well as ways of refusing should they find nevertheless themselves in such a situation. Studies indicate this type of program can reduce marijuana use by 45% among regular smokers, while reducing by one third the proportion of young people who begin smoking (Ellickson and Bell, 1990; Shope and al., 1992, in Botvin & Griffin, 2007)—although success may not be maintained beyond three years after the end of such programs (Bell, Ellickson and Harrison, 1993; Ellickson, Bell and McGuigan, 1993; Flay et al., 1989; Murray, David-Hearn, Goldman, Pirie and Luepker, 1988; Shope, Copeland, Kamp and Lang, 1998, in Botvin & Griffin, 2007).

Based primarily on meta-analyses (Bangert-Drowns, 1998; Tobler, 1992; Tobler and Stratton, 1997), Botvin asserts that the most effective programs are:

delivered interactively and teach skills to help young people refuse drug offers, resist pro-drug influences, correct misperception that drug use is normative¹⁰, and enhance social and personal competence skills
(Botvin & Griffin, 2007, p. 613)

A study by Cuijpers (2002) corroborates the idea that initiatives should be interactive and foster the development of social skills to resist pressure to take drugs. It also stresses the importance of implementing evidence-based strategies, and strengthening young people's commitment and intention not to take drugs, and notes that community-based initiatives (with families, via media campaigns, and in the community) and the use of peer leaders strengthen the effect of school-based initiatives¹¹.

¹⁰ Correct the misperception that a large proportion of young people take illegal drugs.

¹¹ See also meta-analysis by Faggiano (2008 in Diamond et al., 2009)

In families

The family is the first and most important social context experienced by young people, and is an important arena for development. Consequently, family problems and dysfunctional parenting have been shown to be important early predictors of adolescent drug abuse (Sanders, 2000).

At the same time, some studies suggest that the three most important protective factors—for young people who do not consume drugs and do not have other behavioural problems in adolescence—are family-related, namely:

- positive parent-child relations,
- parental supervision and coherent discipline, and
- parental anti-drug use attitudes or values (Ary et al., 1999; CSAP, 2000; Dembo et al., 2000, in Kumpfer, Alvarado, & Whiteside, 2003)

It is therefore vital to consider family prevention when implementing strategies to combat drug abuse.

It is therefore vital to consider family prevention when implementing strategies to combat drug abuse. Moreover, various studies have shown combinations of youth- and family-centred preventive approaches to be far more effective than approaches focused solely on young people (see for example Kumpfer et al. , 2002 in Kumpfer et al., 2003).

Evaluations have established that certain programs are especially effective.

Prevention that focuses on the entire family, and includes training for parents, children, and the family as a whole, has been shown to have positive results in terms of the reduction of cannabis use among young people (Gates et al. , 2006 in European Monitoring Centre for Drugs and Drug addiction, 2013a).

Early intervention to provide support for families with high risk factors and low income, both before and after the birth of children, has been shown to be effective as a means of preventing drug use among adolescents 15 years later (Olds, 1997; Olds, Henderson, Cole, Eckenrode, Kitzman, Luckey, Pettit, Sidora, Morris and Powers, 1998 in Dusenbury, 2000).

Cognitive-behavioral programs have the highest success rates, with success being maintained over the long term (Kazdin, 1995; Sanders, 19996; Serketich and Dumas, 1996; Taylor and Biglan, 1998; Webster-Stratton and Taylor, 1998; 2002, in Kumpfer et al., 2003).

Kumpfer (2003) also stresses the importance of interactive training methods. He adds that it is important to implement ways of **involving and retaining hard-to-reach families**, and strengthening **protective factors**. He also argues that **the order in which training is given** is

important. The first sessions must be used to create a family environment, followed by the implementation of discipline.

UNODC standards add that programs must help strengthen family ties, and provide support for parents so the latter are able to take a more active role in their children's lives and be role models for their children (UNODC, 2013). Conversely, it is counter-productive to undermine the parents' authority, to use non-interactive methods, to provide information on drugs to parents for them to discuss with their children, to focus solely on children, or to have training given by personnel who have received minimal training themselves (UNODC, 2013).

In the community

The most effective strategies are those that target more than one risk factor, involve the entire community, and incorporate a coordinated set of activities through childhood and adolescence

Community intervention is defined as "a combined set of activities organized in a specific region or town, with the participation of residents" (Cuijpers, 2003, p. 7). Community-based youth drug prevention programs may be defined, more specifically, as "programs delivered outside of school which engage young people at risk of substance use in alternative activities" (Jones et al., 2006, p. 87). Typically, people living in the community play an important role in deciding which interventions will be developed and for whom (Bracht & Gleason, 1990, in Cuijpers, 2003). Indeed, participatory prevention programs that strengthen relations between young people and community organizations are better able to reduce behavioural problems such as drug use (UNODCCP, 2002, in Diamond et al., 2009).

In terms of drug use prevention, studies tend to show the most effective strategies are those that target more than one risk factor, involve the entire community, and incorporate a coordinated set of activities through childhood and adolescence (see Drug Info Clearinghouse, 2002, and Perry et al., 2006; Wood and al., 2006, in Diamond et al., 2009)¹².

A review of literature on the subject uncovered five recommendations that, when put into the practice, increase the efficacy of preventive efforts¹³.

The five recommendations are as follows:

- 1) a community must be ready for a prevention program, 2) effective community coalitions must be developed, 3) programming must fit the community, 4) program fidelity should be maintained, and 5) adequate resources, training,

¹² See also Cuijpers, 2003; Morsillo and Prilleltensky, 2007; and Pentz, 2003 in Diamond et al., 2009).

¹³ This research includes but is not limited to the prevention of drug use.

technical assistance and attention to evaluation are necessary (Stith et al., 2006, p. 599).

The authors indicate that a key element in determining whether a **community is ready to implement a prevention program** is whether the community recognizes that a problem exists. Sometimes the community is not sufficiently aware of the problem and it is necessary to begin by first conducting a public awareness campaign.

Next, **community coalitions** must include a wide range of stakeholders, have a positive internal climate fostering mutual trust, and have effective leadership. Community interventions also require **knowledge of the needs of the community** and be responsive to them. This means a needs assessment must be conducted prior to intervention.

Program fidelity refers to the fact that programs must be implemented as designed and as delivered in trials.

Finally, the authors point out that effective programs have **sufficient resources** in terms of funding, stable staff and organization, sufficient training, administrative support, technical assistance, and program evaluation¹⁴ (Stith et al., 2006).

There has been little assessment of community-based drug abuse prevention. However, in a literature review of 222 studies, it was established that community-based and family-based interventions had greater long-term effectiveness with regard to the reduction of marijuana use than short-term interventions (Jones et al., 2006). Moreover, although little research has been conducted on drug use among juvenile offenders, the *Multisystemic Family Therapy* program has been identified as especially beneficial. This program, which targets the interaction of individual, family, peer, school and environmental factors, is more effective than criminal justice services at reducing immediate drug use as well as criminal behaviours (Jones et al., 2006).

b) Harm reduction

Drug prevention is one means of addressing crime committed either under the influence of drugs or to obtain drugs. However, another is the harm reduction approach, which is not aimed directly at reducing drug use, but rather at reducing its negative societal effects (International Centre for the Prevention of Crime, 2010). Although primarily employed in the public health sector, the approach also focuses in part on the prevention of crime committed either under the influence of drugs or to acquire drugs.

¹⁴ (Backer, 2000; Biglan, Mrazek, Carnine, and Flay, 2003; Chinman et al. , 2005; Elliott and Mihalic, 2004; Galano et al. , 2001; Kellam and Langevin, 2003; Mihalic et al. , 2001; Morrissey et al. , 1997; Mulroy, 1997; Pentz, 2004; Rhatigan, Moore, and Street, 2005; Sanders et al. , 2002; Sandler et al. , 2005)

One harm reduction approach is **the dispensing of methadone, heroin, and cocaine under government medical supervision** primarily with the aim of reducing supply-related crime (ETHZ, 2007). Medical opiate prescription treatment programs have been implemented in Switzerland, the United Kingdom, the Netherlands, Germany and Denmark, with highly dependent heroin addicts for whom other forms of treatment have not proved successful¹⁵ (Nadelmann, 2015). Assessment of these initiatives has shown a significant decrease in crime rates, especially in Switzerland (Aebi, Ribeaud, & Killias, 1999), Germany¹⁶, the Netherlands (van den Brink et al., 2003), and England¹⁷. Moreover, a study in Switzerland showed reduced marginalization with improvements in housing and employment situations as well as decreased reliance on social assistance (Rehm et al., 2001).

Drug consumption rooms permit drug users to bring in illegally purchased drugs—typically heroin or cocaine—and take them under supervision (Home Office, 2014). The use of such rooms translates into improved public order, as drug users take their drugs in the location provided and not in public (Hedrich, Kerr, & Dubois-Arber, 2010).

Another option, adopted in Belgium, is that of differentiating among different **types of punishable consumption**, such as public nuisance, problem consumption, and drug use too near schools or too openly in public places (International Centre for the Prevention of Crime, 2010)¹⁸.

c) Recidivism prevention

Recidivism prevention is an approach used when a person has history of crime committed either under the influence of drugs or to acquire drugs. When an individual commits an offence under the influence of drugs, there are two possible approaches: repression, in which the individual is

¹⁵ Strang, J., Groshkova, T. & Metrebian, N. (2012). *New heroin-assisted treatment: Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond*. European Monitoring Centre for Drugs and Drug Addiction Insights. Luxembourg: Publications.

¹⁶ Bammer, G., van den Brink, W., Gschwend, P., et al. (2003). What can the Swiss and Dutch trials tell us about the potential risks associated with heroin prescribing? *Drug and Alcohol Review*, 22(3), 363-71; Dijkgraaf, M. G., van der Zanden, B. P., de Borgie, C.A., et al. (2005). Cost utility analysis of co-prescribed heroin compared with methadone maintenance treatment in heroin addicts in two randomised trials. *BMJ*, 330, 1297-1302 in Nadelmann, 2015.

¹⁷ See, e.g., van den Brink, W., Hendricks, V. M., Blanken, P., et al. (2003). Medical prescription of heroin to treatment resistant heroin addicts: two randomised controlled trials. *British Medical Journal*, 327, 310-316; Haasen, C., Verthein, U., Degkwitz, P., et al. (2007). Heroin-assisted treatment for opioid dependence. *British Journal of Psychiatry*, 191, 55-62; March, J. C., Oviedo-Joekes, E., Pereira-Milla, E., Carrasco, F. et al. (2006). Controlled trial of prescribed heroin in the treatment of opioid addiction. *Journal of Substance Abuse Treatment*, 31, 203-211; Oviedo-Joekes, E., Brissette, S., Marsh, D., et al. (2009). Diacetylmorphine versus methadone for the treatment of opiate addiction. *The New England Journal of Medicine*, 361, 777-786; Perneger, T. V., Giner, F., del Rio, M. & Mino, A. (1998). Randomised trial of heroin maintenance programme for addicts who fail in conventional drug treatments. *British Medical Journal* 317, 13-18; Strang, J., Metrebian, N., Lintzeris, N., et al. (2010). Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial. *Lancet*, 375, 1885-1895 in Nadelmann, 2015.

¹⁸ Based on the *Directrice commune de la ministre de la justice et du Collège des procureurs généraux relative à la constatation, l'enregistrement et la poursuite des infractions en matière de détention de cannabis*.

incarcerated, or a health-oriented approach. The health approach is based on the contention that drug dependence is a health disorder resulting from exposure to drugs in persons with pre-existing psycho-biological vulnerabilities, which would suggest that punishment is not an appropriate response (Chandler et al., 2009, Dackis and O'Brien, 2005, McLellan et al., 2000, in UNODC, 2010) The United Nations Office on Drugs and Crime concurs, stressing that a health-oriented approach is consistent with international drug control conventions as well as a large body of scientific evidence (UNODC, 2010).

Thus, **treatment can be a crime reduction tool**. Indeed, treatment has been shown to reduce crime more than incarceration (Gerstein and Harwood, 1990, Guydish et al., 2001, in UNODC, 2010). For example, longitudinal studies conducted in the United States on the treatment of drug addiction have shown treatment for cocaine addiction to reduce both drug use and crime (40% at the onset, 16% after one year, and 25% after 5 years) (Sanfaçon et al., 2005, p. 135). Having accessible treatment for individuals who wish to overcome addiction is therefore one of the cornerstones of crime reduction. It should be pointed out that such treatment must remain **voluntary**; to make it mandatory would represent a breach of human rights and medical standards (UNODC and WHO, 2008 in UNODC, 2010).

Treatment may also be proposed as an alternative to incarceration. **Drug treatment courts** permit the integration of the judicial system, social services, and treatment for drug users having committed non-violent offences. They are designed to address the underlying causes that led the individual to commit the offence. The Organization of American States points out that such courts "help reduce the crime rate, lower the number of relapses into drug use, reduce the size of the prison population, and lower incarceration costs" (Insulza, 2013, p. 100).

Another alternative measure is the **Dissuasion Commissions** that have been implemented in Portugal. When individuals possessing small amounts of drugs are arrested, they are brought before a non-judicial panel that relies on the services of psychologists and social workers. The aim is to free up the judicial system and steer offenders towards treatment¹⁹.

Another promising program is **Hawaii Opportunity Probation with Enforcement** (HOPE), for drug-involved probationers who have significant histories of drug use and are at high risk of returning to prison. Probationers are tested periodically to determine whether they are using. If the result is positive, they must return to prison immediately; if it is negative, they receive different types of rewards. The results are encouraging, with members of a HOPE group being 55% less likely to see their probation revoked than members of a control group (National Institute of Justice, n. d.)

¹⁹ For further details, consult the section in this report on Portugal's anti-drug strategy.

Insulza (2013) points out that initiatives such as the treatment of drug-dependent offenders in prison and the development of community courts and re-entry courts promote social integration and reduce recidivism. He notes that the involvement of local and community actors is critical to the success of such programs.

Finally, the importance of post-drug treatment **reintegration** programs in preventing recidivism should also be mentioned. In an interview, an official responsible for Britain's national drug strategy stressed the importance of such programs. Without such support, individuals who have recently overcome addiction run the risk of finding themselves back in their original environment and sinking back into addiction. A typical reintegration program includes support to help participants obtain housing, training, and a job (Sumnall & Brotherhood, 2012).

2. Methodology

The aim of this report is to **compare the preventive aspects** of six national drug-related strategies with that of Canada in order to feed the debate on the most effective approaches to preventing drug-related crime among young people.

Firstly a **literature review** was conducted to understand the links between crime and drug use, and to identify the characteristics of successful approaches in prevention. A list of criteria determining effective programs could then be established, which enabled us to construct analytical frameworks for observing the different national policies. In addition, this part has shown that strategies can prevent crime linked to drugs in three ways:

- The prevention of illegal drug consumption,
- Harm reduction (prevention of risky behavior related to consumption)
- The prevention of recidivism.

In order to study national drug related strategies, **government documents, as well as evaluations were consulted**. For further information, **interviews** were conducted with officials responsible for implementing each strategy, at both governmental and non-governmental levels. To start, in-depth interviews were conducted with those responsible for Canada's strategy in order to identify the central issues. On this basis, a semi-structured interview form was developed and used to collect information from strategy officials of comparison countries²⁰. Considering the realities of each country, the questions could vary from one interview to another, based on publicly available information.

Wherever possible, the ICPC tried to contact:

- The heads of strategy,
- The head of the prevention campaign,
- The head of the prevention component,
- The head for the treatment component and
- Non-governmental organizations involved in the implementation of the strategy.

In fact due to the inherent difficulty in arranging interviews (availability of these individuals, in particular) and the differing strategy structures, respondents were found to occupy different posts. Despite this difference, it was possible to contact officials of each national government. Here is a list of interviews conducted:

²⁰ In isolated cases, officials preferred to respond in writing.

Australia



- Social Research & Evaluation Pty
- National Drug and Alcohol Research Centre, University of New South Wales
- Drug and Alcohol Services, South Australia
- Asia Pacific Centre for the Prevention of Crime – APCPC

Canada



- Centre des jeunes l'Escale
- Acting Head, National Anti-Drug Strategy, Justice Canada
- École Amos
- Initiatives, Anti-Drug Strategy, Health Canada
- Canadian Centre on Substance Abuse
- Saskatchewan Council for International Cooperation
- Community Safety and Countering Crime Branch (CSCC) of Public Safety Canada
- Section of the Youth Justice and Strategic Initiatives, Department of Justice Canada (two)
- Velocity

United States



- Substance Abuse and Mental Health Services Administration - SAMHSA
- Office of National Drug Control Policy - ONDCP
- Reclaiming Future
- Justice Department
- Drug Policy Alliance

Netherlands



- Trimbos Institute
- Research and Documentation Centre, Department of Justice (WODC)
- Mainline – Drugs and Health

Portugal



- Directorate, Intervention services on addiction and substance abuse behaviours (Serviço de Intervenção nos Comportamentos Aditivos e nas-requis) (SICAD)
- Division of Prevention and Community Involvement, Intervention services on addiction and substance abuse behaviours (Serviço de Intervenção nos Comportamentos Aditivos e nas-requis) (SICAD)
- Projecto Homen

Switzerland



- Drugs section, Federal Office of Public Health (FOPH)
- Infodrog
- Addiction suisse
- Romand Group for the Study of Addictions (GREA)

United Kingdom



- Department of Health
- Home Office
- Public Health England

In the report, the interviews are cited by the first letter of the country, a number and a date. For example, an interview conducted on February 12 with a representative of Canada will appear as: C1, 12/02/2015.

The interviews helped to supplement the information gathered on the strategies and interpret it in order to support categorization.

Information was gathered firstly by consulting government documents on the national drug strategy. The information was classified into analytical grids, then completed using information obtained through interviews.

Once the information was collected, **each strategy was presented** according to predetermined criteria (see Understanding criteria for analysis).

Finally, the last part of the report consists of a **comparative analysis** of the seven strategies studied in order to highlight their similarities and differences in dealing with drug-related crime in young people. The comparative analysis is based on the following logic:

First, an overview of **structural decisions** behind drug strategies was made. This part facilitated an understanding of the basic choices underlying the drug strategies, their similarities and differences.

The second part provides an understanding of how different strategies address youth through pre-established criteria. These criteria were identified as suitable indicators of effective crime prevention programs for youth (see Overview of criteria for analysis).

Finally, the analysis compares how the prevention of drug-related crime is many by the various strategies in the following categories (see above):

- The prevention of illegal drug consumption,
- Harm reduction (prevention of risky behavior related to consumption)
- The prevention of recidivism.

The comparative analysis was performed based on the comparison grids and the interviews conducted.

1. Presentation of analysis criteria

National strategies are presented based on analysis criteria that was selected to make their comparison both possible and informative. This section discusses the logic behind the choice of criteria.

We will first present the key elements of each drug strategy in order to provide a good understanding of the strategy and its context.

We will then focus on the strategy's **preventive components** and their implementation, classifying them based on the primary, secondary and tertiary prevention trio. It should be noted that the strategies were not developed using this logic. However, we have employed this simple classification to highlight the strategies' preventive aspects, understand their logic and structure, and examine them as a comprehensive unit.

In our analysis, we will examine the primary, secondary and tertiary prevention of *drug use*. However, as the goal of this report is to study drug-related crime, we will also explore the impact of these types of drug use prevention on crime. Primary and secondary prevention are directly linked to crime reduction because if drug use is prevented at this stage, drug-related crime simply will not occur. In our examination of tertiary prevention, we have explored both the methods used to reduce drug use and the effect of this reduction on crime.

Finally, we have included a section on harm reduction, recognizing that in some instances it is also possible to reduce drug-related crime without actually reducing drug use.

The next question seeks to understand **how strategies take young people into account**. A number of criteria for establishing effective youth prevention programs were presented in the introduction to this report. The points in this section illustrate whether the strategies meet the criteria, i.e. whether they are inclusive and seek to reduce marginalization, whether they are participatory, whether there is an equitable distribution of resources between social programs and anti-crime measures and, finally, whether they offer targeted programs adapted to the specific needs of at-risk groups.

Next, the analysis of **initiatives undertaken to involve school staff, law enforcement authorities, and the communities** reveals how the strategies integrate these different intervention providers. It was explained in the introduction that the most effective interventions are those that involve community, family and school participation. This section also allows for a more detailed examination of how programs are selected under each strategy, whether they are evidence-based, and whether there are any implementation guidelines.

The connection between drugs and mental health is an important aspect of drug strategies targeting young people due to the strong link between the two phenomena. The aim here is to see how strategies foster collaboration between the two types of treatment.

Finally, we conclude the presentation of each national strategy with a brief overview of **an assessment of its impact on crime**.

2. Canada's Anti-Drug Strategy

In Canada, police-reported drug-related offences²¹ have increased over the past ten years (Statistique Canada, 2014). A study established that youth 15 to 24 years old are approximately five times more likely to report harm²² due to illicit drug use than adults aged 25 years and older (Health Canada, 2011 in Centre canadien de lutte contre les toxicomanies, 2013). In response to this, Canada's National Anti-Drug Strategy focuses primarily on young people.



2.1 Preventive aspects of the strategy and their implementation

The **National Anti-Drug Strategy** (NADS) is Canada's main strategy in the fight against narcotics and extends to 12 federal ministries and agencies.

Other national strategies also address the issue examined in this report, in particular the **National Crime Prevention Strategy** (NCPS) which:

"focuses on reducing those factors, including illicit drug use, that place certain populations of children and youth at risk (Sécurité publique canada, 2014)."

The NCPS is not a part of the NADS but has a related mandate. As a result, representatives of the NCPS and the other federal ministries frequently communicate and collaborate with one another (C5, 25.05.2015).

There is also the **Youth Gang Strategy**, which "focuses on preventing children and youth from joining gangs, and supporting the exiting of those in gangs" (Sécurité publique canada, 2014).

Finally, the Royal Canadian Mounted Police (RCMP) has established the first national strategy that targets a single class of drugs : the Synthetic Drug Initiative (GRC, 2010).

The following table presents the components and subcomponents of the NADS concerned with primary, secondary and tertiary prevention of illicit drug use.

²¹ Includes possession

²² Harms in the following areas: physical health; friendships and social life; financial position; home life or marriage; work, studies or employment opportunities; legal problems; difficulty learning; and housing problems

| COMPONENTS | SUB-COMPONENTS |
|------------------------|--|
| PREVENTION | The Drug Strategy Community Initiatives Fund (DSCIF) Public Engagement |
| TREATMENT | Drug Treatment Funding Program (DTFP) National Native Alcohol and Drug Abuse Program (NNADAP) Youth Justice Fund Drug Treatment Court Funding Program (DTCFP) Research on Drug Treatment Model |
| LAW ENFORCEMENT | As the <i>law enforcement</i> subcomponents are not part of the prevention framework, they will not be discussed. |

Figure 3. The components of Canada's anti-drug strategy (Ministry of Justice, 2015)

a) Primary prevention²³

From 2007 to 2012, the NADS included **a mass media campaign** called 'Drugsnot4me' (C5, 25.05.2015). Two additional campaigns were launched recently: one on the dangerous effects of marijuana on adolescent brain development and the other on the harmful effects of prescription drug abuse. The campaigns are being run by Health Canada but are not part of the NADS.

Through **Public Engagement**, the RCMP conducts prevention programs for young people to improve their understanding of the harmful societal and health effects of illicit drug use or abuse, as well as the connections between illicit drugs and serious crime and organized crime activities (*Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012*).

Public Safety Canada has funded primary prevention initiatives as part of the **NCPS**, notably the *Towards no Drugs* program, which was designed to raise awareness among secondary students in high risk areas (C1, 10.02.2015).

²³ The definition appears on page 19 of the current report.

b) Secondary prevention

The NCPS also includes a secondary prevention component targeting at-risk clienteles, especially young people (C1²⁴, 10.02.2015). The NCPS points out that even projects that do not address drug use directly are likely to influence young people not to use drugs. For example, a project designed to develop cognitive skills may change young people's attitudes, which may in turn reduce the risk of drug use (C1, 10.02.2015).

The **Drug Strategy Community Initiatives Fund** (DSCIF) also funds secondary prevention initiatives. Its funding priorities are determined primarily by information obtained from its scientific branch and from the Canadian Center on Substance Abuse (CCSA)²⁵ (C3, 03.02.2015).

NCPS and DSCIF initiatives are carried out in close collaboration with provincial and territorial partners and organizations, especially through NGOs (or action committees) or, in certain isolated cases, sub-levels of government. Projects are funded on the basis of calls for tender (C1, 10.02.2015 and C3, 02.03.2015).

c) Tertiary prevention

Tertiary prevention is included in the *treatment* component and aimed primarily at:

- improving funding for treatment, and
- directing individuals towards the appropriate social services (through Drug Treatment Courts (DTC), for example).

An evaluation of the strategy stresses that treatment makes possible the reduction of drug-related criminal recidivism (Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012).

These types of programs are implemented by the provinces, the territories, and non-governmental organizations.

d) Harm reduction

Canada's strategy does not contain any component specifically concerned with harm reduction. However, through the NCPS, *Public Safety Canada* has financed gang exit strategies aimed at reducing drug abuse among young people belonging to gangs or with a criminal record (C1, 10.02.2015).

²⁴ This notation refers to interviews.

²⁵ A national NGO primarily funded by Health Canada

2.2 Youth-related aspects of the strategy²⁶

As was noted earlier, the NADS adopted in 2007 concentrates on young people in particular (Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012). This decision is based on the premise that early prevention may steer a young person away from a delinquent trajectory or intervene before the individual has travelled too far along the trajectory (C1, 10.02.2015).

a) Is it inclusive and does it seek to reduce marginalization?

No component of the NADS focuses specifically on reducing marginalization. However, the **prevention** component includes numerous related objectives: attachment to the community, development of a sense of belonging to a neighbourhood or school, increased interaction with prosocial peers, reduced interaction with asocial peers (some of whom may be drug users), as well as referral of young people to pre-existing resources to prevent their marginalization and to permit them to develop networks around themselves (C1, 10.02.2015 et C3, 02.03.2015).

The **treatment** component of the strategy also indirectly includes approaches aimed at reducing marginalization. DTCs, for example, are designed for offenders incarcerated for drug-related offences who reoffend due to underlying drug dependency (Gouvernement du Canada, 2013), focusing especially on marginalized populations such as Aboriginal men and women and street prostitutes and providing them with alternatives to incarceration (Gouvernement du Canada, 2013).

b) Is it participatory?

The NCPS and DSCIF have adapted a participatory approach to the '**prevention**' component at all stages of the strategy's implementation²⁷. For all grants, applicant organizations must demonstrate that their projects are participatory (C3, 02.03.2015).

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

As we have seen, the NADS is built around three pillars: prevention (15% of funding), treatment (26%), and law enforcement (59%). The law enforcement component therefore clearly disposes of greater funding, almost four times that of the prevention component.

²⁶ The question choices in this section are explained in the introduction to the presentation of the national strategies on page 29.

²⁷ There are a few exceptions such as the *Strengthening Families* program which is a best practice but does not allow for youth participation.

d) *Does it provide targeted programs adapted to the specific needs of at-risk groups?*

Certain at-risk groups, such as aboriginal peoples, are specifically targeted in the strategy. The Drug Strategy Community Initiatives Fund has also launched calls for tenders concerning two groups with specific needs:

- **Youth disadvantaged by their living conditions:** young people whose parents use drugs, adolescents with mental health and substance use disorders, and other high risk youth.
- **Youth living in rural or remote communities:** youth who live in communities with limited access to programs and activities and who need a safe environment to reduce exposure and access to drugs (email C3, 30.03.2015).

2.3 Initiatives undertaken to involve school staff, law enforcement officials, and the community

The **NCPS** has produced a list of promising and model crime prevention programs, some of whose aims include the reduction of drug use, a significant factor in the fight against crime. The list is based on the findings of literature reviews and rigorous evaluations of prevention programs in Canada and elsewhere²⁸ (for more information, see National Crime Prevention Centre (Canada), 2008).

Organizations (mainly NGOs) present project proposals based on promising models inventoried by the NCPS (databank). Once projects are accepted, the organizations implement them while the NCPS provides tools, technical advice and support to facilitate the development, implementation, monitoring, and evaluation of the prevention programs (C2, 17.02.2015) (Public Safety Canada, 2008).²⁹

The DSCIF operates in a similar manner, the main difference being that organizations are not necessarily obliged to use inventoried good practices, but may also present innovative projects provided they are able to demonstrate why this is an appropriate choice (C3, 02.03.2015).

Along with these two approaches, the NADS has also resulted in the creation of the **Canadian Standards for Youth Substance Abuse Prevention** (henceforth, Canadian Standards). The objective of the latter is to explain "how best to plan, select, implement, monitor and evaluate [...]

²⁸ For example: *Blueprints for Violence Prevention* and *SAMHSA Model Programs*

²⁹ For more information, please see
http://www.securitepublique.gouv.qc.ca/fileadmin/Documents/police/prevention/colloque/2008/nouveau_positionnement_01.pdf (in French only)

prevention efforts with schools, communities and families" (CCLT, 2014a, p. 1). The standards stress the importance of adopting a multifaceted approach to prevention, involving media campaigns, and long-term school-, community-, and family-based initiatives.

a) School staff

Both the NCPS and the DSCIF may finance school-based projects. The Canadian Standards also allow for this type of intervention³⁰, encouraging institutions to integrate prevention efforts into daily activities rather than to treat them as separate, time-limited add-ons (CCLT, 2010). School-based programs may be designed to develop emotional awareness, problem-solving and social skills, and to improve peer relations, for example (National Crime Prevention Centre (Canada), 2008).

b) Law enforcement officials

As we have seen, the RCMP is responsible for the *public engagement* subcomponent including the synthetic drugs initiative aimed at raising public awareness of the dangers of drug use.

According to the persons interviewed for this report, law enforcement agencies also appear to collaborate on an ad hoc basis on different intervention projects. However, there is a noticeable reluctance to share data, making evaluation more difficult to carry out (C1, 10.02.2015 and C2, 17.02.2015).

c) Communities

The NADS provides funding to assist communities in implementing projects aimed at helping young people with illicit drug abuse problems (CIPC, 2012). Both the NCPS and the DSCIF support such initiatives. Canadian Standards³¹ also exist for community- and family-based intervention, providing intervention guidelines for workers.

2.4 Connections between drugs and mental health

Funds may include concurrent disorders among their priorities—as is the case for the DSCIF, for example—but they are not required to do so (C3, 02.03.2015).

The treatment component addresses concurrent disorders in a variety of ways. DTCs, for example, may enhance treatment outcomes by capitalizing on mental health partnerships at the level of the provincial government (Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012, p. 70). There has also been an effort made to improve mental

³⁰ "Building on Our Strengths: Canadian Standards for School-Based Youth Substance Abuse Prevention"

³¹"Stronger Together: Canadian Standards for Community-Based Youth Substance Abuse Prevention" and "Strengthening Our Skills: Canadian Guidelines for Youth Substance Abuse Prevention Family Skills Programs"

health services for aboriginal peoples. Funding for treatment programs for high risk groups, such as individuals with serious mental health issues, has also been provided by the *Drug Treatment Funding Program (DTFP)* (Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012).

Finally, the CCSA is working to ensure improved coordination through evidence-based systems planning (CCLT, 2014b)

2.5 Evaluation of the National Drug Strategy's impact on crime

Changes in attitudes as a result of NCPS and DSCIF programs will only become apparent over the long term, and could not therefore be measured at the time of the 2012 evaluation (Division de l'évaluation, Bureau de la gestion de la planification stratégique et du rendement, 2012).

However, the impact of substance abuse treatment was found to extend beyond the reduction of substance abuse to the reduction of crime, in particular (Evaluation Directorate & Health Canada and the Public Health Agency of Canada, 2013). The 2012 evaluation indicated that "*the Drug Treatment Court Funding Program (DTCFP) has contributed to reduced drug use behaviour and criminal recidivism compared to conventional justice system responses (...)*"

3. Australia's drug strategy

Since 1985, Australia has had a national antidrug strategy based on the principle of the minimization of harms caused by drug, alcohol and tobacco use at the individual, family and community level. The latest version of the strategy (2010-2015), entitled "A Framework for Action on Alcohol, Tobacco and Other Drugs", consists of three pillars: demand reduction, supply reduction, and harm reduction.

The two principal organizations that comprise the strategy's governance structure are the **Intergovernmental Committee on Drugs (IGCD)** and the **Australian National Advisory Council on Alcohol and Drugs** (A2, 05.02.2015). These organizations bring together experts from the health, justice and education sectors and are responsible for coordinating the strategy for the federal government. The strategy has a relatively flexible legislative framework at the federal level, allowing for the development of separate strategies, like the **2011-2016 South Australian Alcohol and Other Drug Strategy** (Drug and Alcohol Services South Australia, 2011), in each of the six states and two territories (Ministerial Council on Drug Strategy, 2011). Needs assessment and strategy implementation is left to the discretion of the Australian states and territories (A1 : 17.03.2015 ; McDonald, David, 2011).

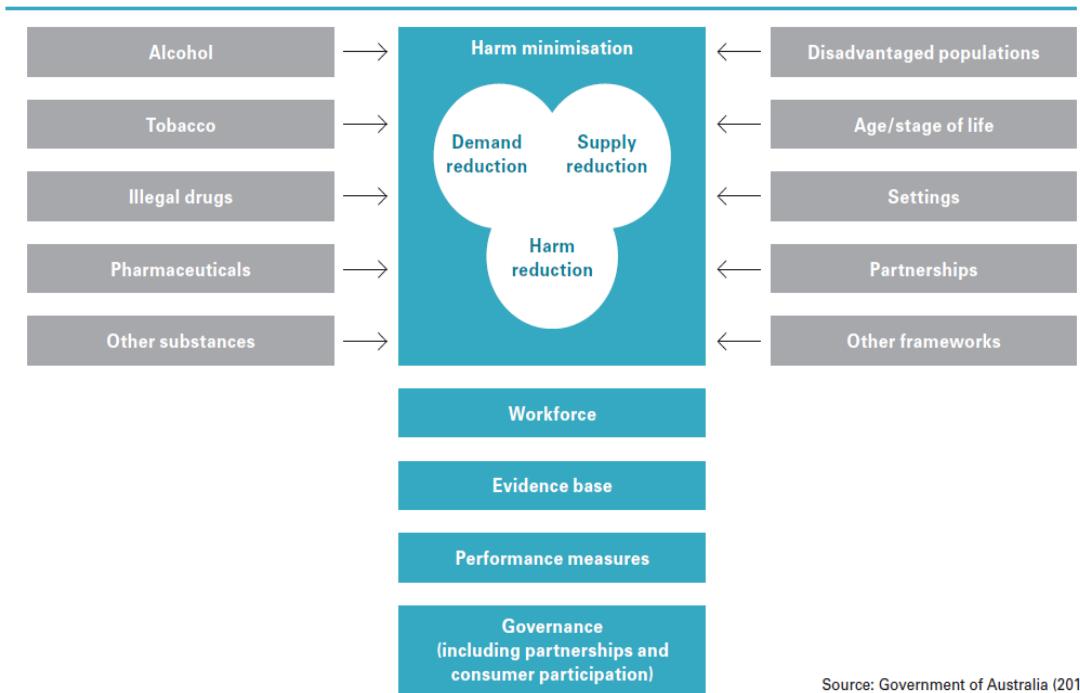
The strategy also recognizes the importance of evidence-based programs and policies, and relies on the scientific support of three specialized research centers: the National Drug and Alcohol Research Center, the National Drug Research Institute and the National Centre for Education on Training and Addiction (CIPC, 2012).

3.1 Preventive aspects of the strategy and their implementation

Drug use prevention is a cross-sectoral theme addressed by all three pillars of the Australian strategy (Ministerial Council on Drug Strategy, 2011). Drawing primarily on an evidence-based approach, it promotes an **integrated, multisectoral approach**.

The strategy, which is administered by the Department of Health and Aging, presents drug use prevention as a **public health issue** (Ritter, Alison, Lancaster, Kari, & Grech, Katrina, 2011). However, it also encourages collaboration with the Departments of Justice and Education, and is underpinned by a partnership structure involving community stakeholders, non-government organizations, and the private sector at the local level (Ritter, Alison et al., 2011). The approach adopted by the strategy considers **drug use prevention a precursor to the prevention of drug-related crime** (CIPC 2012).





Source: Government of Australia (2011).

Figure 4. Australian National Drug Strategy

a) *Primary prevention*

Supply reduction is underpinned by strategies and initiatives designed to prevent uptake or delay onset of drug use through public awareness campaigns and school-based educational programs (Ministerial Council on Drug Strategy, 2011). The **National Drugs Campaign** specifically targets young people aged 15 to 21 years and the parents of children aged 13 and 17 years. It emphasizes the risks associated with drug use and encourages parents to discuss them with their children, promotes alternatives to drug use, and provides access to support services. The campaign uses various media such as the internet (<http://www.drugs.health.gov.au/>) and social networking sites (Stancombe Research and Planning, 2012).

Education about drugs—including tobacco and alcohol—is **part of the regular academic curriculum** in all Australian schools, with content being adjusted to grade level (A4, 05.07.2015). Some whole-of-school prevention programs, such as **Climate Schools** and **The Gatehouse Project** (Lancaster, Ritter, Matthew-Simmons, 2013), have already proven their effectiveness in reducing drug use.

b) Secondary Prevention

The Australian strategy recognizes that approaches to prevention may vary by drug type. Thus, while whole-of-population prevention is more suitable for alcohol, tobacco and illegal drugs, it considers that targeted approaches should be used for at-risk groups and less commonly-used drugs. On a more general level, the strategy seeks to strengthen the resilience of individuals and communities by working with local governments and identifying risk factors for drug use (Ritter, Alison et al., 2011).

c) Tertiary prevention

The Australian strategy provides for a range of drug addiction treatment services—detoxification, pharmacological therapy (primarily methadone-based), and a variety of complementary forms of treatment (cognitive-behavioural approaches, motivational interviewing, support groups, mentoring programs, etc.)—to help addicts reintegrate with the community (Ministerial Council on Drug Strategy, 2011 ; Gowing, Ali, Dunlop, & Farrel, 2014). While the type of treatment may vary from one state to another, by and large pharmacological therapy is provided by the state whereas psychosocial treatment is the purview of state-funded NGOs (A3, 05.05.2015).

In particular, the National Guidelines for Medication-Assisted Treatment of Opioid Dependence are designed to provide a general strategic framework for treatment and to ensure national consistency in approach (Gowing et al., 2014). Moreover, youth drug courts exist in each state as part of different programs. For example, South Australia's Youth Court Assessment and Referral Drug Scheme targets young offenders appearing before the Court who misuse drugs or come from families with addiction issues (Office of Crime Statistics, 2007).

d) Harm reduction

Harm reduction initiatives are aimed at reducing the harm caused by drugs and drug use, without necessarily reducing the prevalence of drug use. While the government does not condone risk behaviours such as injecting drug use, it acknowledges that they exist: it is therefore the government's responsibility to develop and implement health measures aimed at reducing the harm such behaviours can cause to individuals, families and communities (Ministerial Council on Drug Strategy, 2004 ; Ministerial Council on Drug Strategy, 2011). In keeping with this principle, Needle Syringe Programs have been established aimed in part at encouraging drug addicts to use drugs in ways that are less harmful. In addition, Illicit Drug Diversion Initiatives redirect offenders away from the criminal justice system and towards a care and treatment system. The advantage of such "adapted justice" programs, found in every state and territory, is that they prevent the judicial system from becoming overwhelmed by minor offenses concerned with drug use or possession, while simultaneously reducing the risk of recidivism and increasing the individual's chances of recovery (A1, 03.17.2015).

3.2 Youth-related aspects of the strategy

The Australian approach focuses especially on vulnerable individuals who may be at greater risk of drug-related harm during transitional points in their lives (such as adolescence). Thus, young people are indirectly targeted.

a) Is it inclusive and does it attempt to reduce marginalization?

The strategy acknowledges and identifies a number of risk factors: unemployment, homelessness, poverty, physical handicaps and injury, family breakdown, and mental illness. As these can cause individuals to become socially isolated, the strategy advocates the development of socially inclusive communities (Ministerial Council on Drug Strategy, 2011). Attention is also paid to the fact that drug treatment is less accessible for certain marginalized groups, such as gay, lesbian, bisexual, transgender and intersex populations.

b) Is it participatory?

The strategy was designed "[...] through extensive consultation periods with a diversity of actors, which include communities, professional associations, academics, and government agencies" (ICPC, 2012, p. 109; Australian Government, 2011), while young people were consulted for the National Drugs Campaign. Moreover, there are ongoing qualitative and quantitative studies on young people's drug-related behaviours and attitudes. The studies examine young people's negative and positive views of drug use as well as motivating factors and barriers, identifying the most appropriate media for communicating with them (Australian Government Department of Health, 2014).

c) Are resources equitably distributed between social programs and anti-crime measures?

The budget is unevenly distributed among the strategy's three pillars: three quarters of the funding is allocated to the supply reduction pillar to the detriment of the demand reduction pillar (Douglas, Wodak, & McDonald, 2012). The bulk of resources go to the fight against drug trafficking (55 %) versus 23% for prevention and 17% for treatment (Ritter, Alison et al., 2011). Given that social support programs are found primarily in the latter two categories, it can be deduced that there is an inequitable distribution of resources between social programs and anti-crime measures. The supply reduction pillar attracts the lion's share of the financial resources (55% in 2008)(Miller et al., 2009), despite having the least evidence to support its budget.

d) Does it offer targeted programs specifically adapted to the needs of at-risk groups?

In an effort to create inclusive communities, the strategy provides for support programs designed specifically for at-risk populations such as young people, vulnerable families, marginalized communities, and Aboriginals. The strategy does not however impose any one program in

particular. Rather, states and territories implement the programs that best correspond to the specific characteristics of at-risk groups in their jurisdiction. That said, given Australia's sizeable Aboriginal population, the Australian strategy places a clear emphasis on this particular at-risk group, and several programs have been designed specifically to meet their needs (A3, 05.05.2015). For example, the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) Substance Misuse Service offers a range of treatments for Aboriginals living on or coming from APY lands, and who use drugs or abuse other legal substances through such practices as the inhalation of gas fumes, for example. (South Australia Health Services, n.d.)

3.3 Initiatives undertaken to involve school staff, law enforcement officials, and the community

a) School staff

School-based programs have been implemented since the 1970s to prevent the use of drugs (including tobacco and alcohol). Programs of this type ('Life Education', for example) focus on personal development and life skills training, adopting a holistic approach to prevention that involves all members of the school community (Lancaster, Ritter, Matthew-Simmons, 2013). Although the strategy is based on the law enforcement—health—education trio, education plays a secondary role.

b) Law enforcement officials

Police and justice services play an important role in the **Police Drug Diversion Initiative**. At the end of the 1990s, the Australian government established such programs as a complement to rigid drug-related legislation aimed at reducing drug use and its adverse effects on the population, especially young people. These programs permit the police to divert individuals charged with drug use or possession to treatment services instead of incarcerating them (Ritter, Alison et al., 2011 ; Police Drug Diversion Initiative (PDDI), n.d.).

c) Communities

The community is the key environment for problem drug use. The strategy therefore stresses the need to establish a whole of community approach involving all stakeholders in the community at different levels³². The development of inclusive communities helps targeted populations to avoid relapsing and to reconnect with their community.

3.4 Connections between drugs and mental health

In light of the close connection between drug addiction and mental health, the 2010-2015 strategy stresses the importance of continued efforts to improve coordination between the two

³² whole of community

sectors in order to provide support for people with concurrent disorders and for their families through an integrated, multisectoral approach. Integration of these sectors is based on the understanding that mental health is affected by factors outside the parameters of the health system (Australian Health Disaster Management Policy Committee, Australia, & Department of Health and Ageing, 2009, p. 10). The government has therefore adopted a comprehensive, whole³³ of government approach, interconnecting all government departments. The **Mental Health Strategy** (1992), for its part, concerns all individuals affected directly or indirectly by mental health issues (Australian Government, 2011).

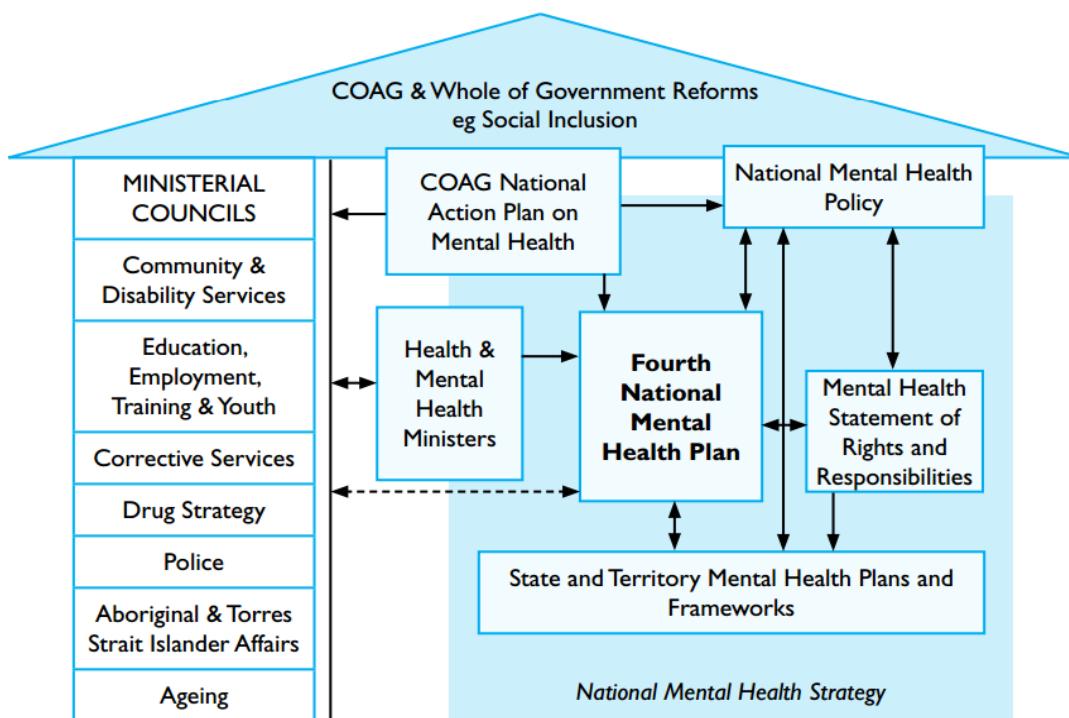


Figure 5. Fourth National Mental Health Plan and its relationship to the National Mental Health Strategy and a whole of government approach

3.5 Evaluation of the National Drug Strategy's impact on crime

As the strategy is revised every five years on average, the 2010-2015 drug strategy is currently undergoing assessment (Miller et al., 2009). Regarding the prevention of drug-related crime, supervised injecting centres have shown some degree of effectiveness with a reduction in drug-related criminal activities and the support of public opinion. For example, the prevalence of robbery in Sydney's Kings Cross neighbourhood has fallen since an injecting centre was opened

³³ Whole of government

there in 2011 (Fitzgerald, Burgess, & Snowball, 2010). Diversion programs have proven similarly effective in reducing recidivism among young people, unlike school-based programs and the National Campaign, whose impacts on drug use and benefits for the rest of the community are difficult to measure. (McDonald, 2011) Most offenders redirected to diversion programs do not either re-offend or return to the criminal justice system in the 12 to 18 months following diversion (Payne, Kwiatkowski, & Wundersitz, 2008).

The Australian strategy has the advantage of being sufficiently flexible to be adapted at the state and territorial level and to effectively meet the needs of local communities. However, it is sometimes considered too "vague" and not sufficiently binding (McDonald, David, 2011).

4. The United States' drug strategy

Generally speaking, illicit drug use has declined in the United States over the past 20 years. The *Monitoring the Future* study (2014), a survey on the drug use behaviours of American 8th, 10th and 12th graders, showed an overall rate of drug use of 27.2% for all three grades, a 6.9% decrease since 1997. (NIDA, 2014 ; Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2015).



The prevention of offences committed by young people either while under the influence of drugs or in order to acquire drugs is addressed through **a comprehensive vision that extends beyond the scope of the nation's drug strategy**. The American approach is holistic and highly integrated. The prevention of specific issues—such as drug use, violence, crime, and gang membership—is viewed as interconnected and therefore addressed simultaneously through multisectoral, interagency programs that target the different realities facing young people (E4, 05.28.2015). The path to crime prevention is seen to be through drug prevention and the adoption of healthy, drug-free behaviours (E1, 03.04.2015; E2, 03.19.2015).

The **National Drug Control Strategy** (2014) is the primary strategy in the fight against drugs in the United States, falling under the responsibility of the Office of National Drug Control Policy (ONDCP). The latter is a branch of the Executive Office of the President of the United States, created in 1989 following the adoption of the *Anti-Drug Abuse Act* (ONDCP, n.d.).

The Ministry of Justice's **Anti-Violence Strategy** is an initiative developed and steered by a network of U.S. Attorneys responsible for collaborating with states and local communities in order to devise place-based strategies in communities with serious issues of violence (Office of the United States Attorneys, 2014). The **National Prevention Strategy** is an interagency initiative, led by the Surgeon General under the Department of Health and Human Services, and aimed at improving the health and well-being of the nations' citizens by integrating recommendations and actions across multiple sectors of intervention, including health, justice and education. One of its priorities is preventing drug abuse and excessive alcohol use (Surgeon General, n.d.-a).

The American strategy adopts an evidence-based approach encompassing **prevention, early intervention, treatment, recovery support, criminal justice reform, effective law enforcement, and international cooperation** (ONDCP, 2014).

4.1 The strategy's preventive aspects and their implementation

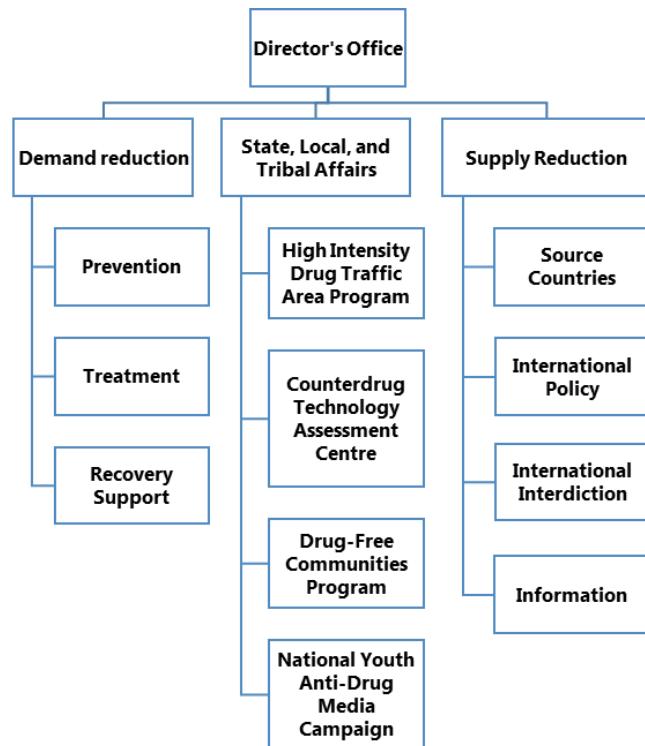


Figure 6. *Office of National Drug Control Policy*

The strategy serves as a series of guidelines for the different departments of the U.S. government implementing programs concerning the fight against drugs, the prevention of drug use, and the promotion of a healthy lifestyle for the nation's citizens (E2, 03.19.2015). It aims to reduce the use, manufacturing, and trafficking of illicit drugs; and drug-related crime, violence, and health consequences (Sacco & Finklea, 2014). The strategy addresses prevention primarily under the components of demand reduction—which encompasses prevention, drug treatment, and recovery (E2, 03.19.2015; ONDCP, n.d.b)—and state, local, and tribal affairs, through the implementation and funding of various programs.(see Figure 6. Office of National Drug Control Policy).

Most of the American Government's prevention efforts take the form of **federal grants to states, cities and townships, counties, federally-recognized tribal governments, public institutions, and community organizations** by various government departments, especially the Departments of Justice, Education, and Health and Human Services (E4, 28.05.2015; ONDCP, 2015).

a) Primary prevention

The strategy draws on the unique protective factors of individual communities. It encourages young people to make smart health choices, primarily by means of **healthy lifestyle programs** developed principally by the **Departments of Education** and **Health**, and calls for the mobilization of all members of the community, through mentoring, education, public awareness and leadership programs, for example. The idea is to provide holistic programs, primarily in schools, to prevent not only drug use and associated crime but the entire continuum of risk factors (E1, 04.03.2015; E4, 28.05.2015).

Above the Influence is a **national public awareness campaign** for young Americans that encourages them to "live above the influence" of drugs and alcohol and to reject the use of any substance that may be detrimental to their personal development (ONDCP, n.d.a). Although initially run by the ONDCP, its administration has now been taken on by an NGO³⁴ that provides toolkits to local communities to help them take ownership of the campaign and adapt it to their specific needs.

b) Secondary prevention

The strategy recognizes the importance of early intervention based on the triad of Screening, Brief Intervention, and Referral to Treatment (SBIRT), especially in the health care sector (SAMHSA, 2014). Health care providers use this approach to identify individuals—particularly young people—with risky substance use behaviours before they develop drug dependence issues. The strategy places special emphasis on at-risk youth, notably by encouraging them to participate in structured activities and to identify mentors who have a positive influence on their lives. One such program is The National Guard Youth ChalleNGe, which provides at-risk youth with training and guidance to help them become productive citizens.

c) Tertiary prevention

One of the strategy's objectives is to support the recovery of individuals with substance use disorders through the implementation of measures such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) Access to Recovery programs in various settings, such as prison facilities, recovery schools and recovery support centres (ONDCP, n.d.-g). The strategy acknowledges that treatment for substance use disorders must be an integral and accessible part of mainstream health care. The American government therefore encourages the use of medications approved by the Food and Drug Administration (FDA) for the treatment of opiate use disorders, i.e. methadone, buprenorphine and naltrexone. One of the strategy's other objectives is improve treatment for justice-involved youth with substance use disorders through the development and dissemination of more effective models of treatment for substance use

³⁴ The Partnership for Drug-Free Kids

disorders and mental health issues. It also promotes alternatives to incarceration by encouraging the use of diversion strategies, such as drug courts and other problem-solving courts, whenever appropriate (ONDCP, 2014, p.34).

The strategy stresses that recovery support is a crucial aspect of services for people with substance use disorders. It encourages the development of inclusive communities that provide support for the social reintegration of such individuals by offering recovery support services (such as housing, employment, and training) (ONDCP, 2014). Various departments provide grants to facilitate the integration or reintegration of young offenders with various issues (including substance use disorders) into the workforce, school and their community.

The ONDCP has also developed a national plan to promote and support the adoption of a recovery-oriented system of care approach by states, Native communities, and local governments.³⁵

d) Harm reduction

Although the *Consolidated Appropriations Act* (2012) prohibits most federal funding of needle exchange programs, 30 American states, the District of Columbia, Puerto Rico and several Indian Nations currently have sterile syringe exchange programs (ONDCP, 2014).

4.2 Youth-related aspects of the strategy

Every component of the American drug strategy is largely targeted at young people. One of the strategy's objectives is to prevent drug use before it begins, in order to avoid the consequences of youth drug use, especially crime (ONDCP, 2014, E4, 28.05.2015). In addition, most prevention funding is for school-age populations (Reles, 2011).

a) Is it inclusive and does it seek to reduce marginalization?

The reduction of marginalization is not presented as a component, per se, of the strategy. However, numerous initiatives aimed at ensuring the social inclusion of young people have been established, such as programs to improve employability or access to housing, and to prevent school dropout. The objectives of these initiatives include the reduction of the incidence of risk factors for drug use and associated crime (E4, 28.05.2015).

b) Is it participatory?

The strategy acknowledges the importance of involving communities and young people in the development and implementation of prevention programs. The Drug-Free Communities Program

³⁵ A coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk for substance use disorders

is a good example of this. Multisectoral community coalitions are trained and tasked with identifying the issues facing their communities, especially any issues concerning drug abuse and its prevention, so they may then implement appropriate programs with SAMHSA's financial support and expertise. Youth participation in these coalitions is mandatory, and a national program has been established to encourage young people to take a leadership role³⁶. Young representatives of each coalition in the country are mobilized, trained, and consulted on how to improve the strategy.

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

The United States' drug strategy is comprised of two key concepts: supply reduction (61.5% of funding) and demand reduction (38.5%). In 2014, a small share of the strategy's overall budget was awarded to prevention (5.1%), with the bulk of funds being allocated to treatment (31.3%) and law enforcement (50.7%). Seven percent (7.3%) of the budget was set aside for fighting international drug trafficking. The budget distribution reveals that prevention receives considerably less funding than other components (ONDCP, n.d.g).

d) Does it provide targeted programs adapted to the specific needs of at-risk groups?

The American strategy endorses an inclusive vision whereby all groups must receive the same services. Special attention is paid to Native Americans and Alaskan Natives, as addiction levels among these groups are higher than for any other demographic group in the United States (ONDCP, n.d.h). The strategy also provides support for programming and best practices concerning Drug Endangered Children (DEC) (ONDCP, n.d.i). Special tools have been developed to address the particular needs of DEC in American Indian and Alaskan Native communities. Moreover, Above the Influence has developed a public awareness campaign specifically for American Indian populations (ONDCP, n.d.j.). The strategy also considers high school dropouts to be a high-risk group (ONDCP, 2014).

³⁶ National Youth Leadership Institute

4.3 Initiatives undertaken to involve school staff, law enforcement officials, and the community

The drug prevention service providers who receive the most federal funding support are schools, law enforcement agencies and community organizations (ONDCP, n.d.k).

a) School staff

ONDCP grant programs are primarily intended for school-aged youth, and reach approximately 75,194,000 elementary school, high school, and college students (Reles, 2011). Nearly 140,000 schools introduce American children to messages promoting a healthy and safe lifestyle and opposed to drug use (ONDCP, n.d.k). In partnership with a myriad of other departments, the Department of Education has created an online portal³⁷ providing education professionals with various resources on illicit drug use (ONDCP, 2014, p.11).

b) Law enforcement officials

The strategy stresses the importance of collaboration between criminal justice agencies and prevention organizations. The involvement of law enforcement officials in prevention programs is seen as contributing to the strategy's effectiveness. Police officers are therefore encouraged to actively participate in community prevention programs involving schools, community coalitions, and civic and faith-based organizations (ONDCP, 2014).

c) Communities

The American government collaborates with States and communities to promote the crucial role of prevention partnerships and to underscore the importance of community involvement in the prevention of drug abuse. A prime example of this is the Strategic Prevention Framework (SPF) adopted in SAMHSA's Drug-Free Communities Program. This is a process whose effectiveness is based on both an understanding of the community's needs and the empowerment of the community. The framework is rooted in the participation of community members in all stages of the planning process. The long-term objective is to ensure the program is sustainable once SAMHSA funding comes to an end, which helps foster ownership and local autonomous management of the program (E1, 04.03.2015; E4, 28.05.2015).

4.4 Connections between drugs and mental health

Through the emphasis it places on health, the strategy acknowledges the links between mental health and substance use disorders. **SAMHSA** is the government organization responsible for improving the quality and accessibility of prevention, treatment and recovery support services with the aim of reducing illness, death, and societal costs resulting from mental illness and

³⁷ You for Youth (Y4Y) (www.y4y.ed.gov)

substance use disorders (E1, 04.03.2015). The institution requires community-based programs that receive grants from SAMHSA to employ effective approaches for screening for co-occurring disorders (ONDCP, 2014).

4.5 Evaluation of the National Drug Strategy's impact on crime

To monitor and assess the strategy's effectiveness, the ONDCP uses a Performance Reporting System, fostering government accountability to American taxpayers for drug-related programs and policies. One of the strategy's objectives for 2015 is to break the cycle of drug use, crime, delinquency, and incarceration by increasing by 5% the number of residential juvenile justice facilities offering substance abuse treatment, and increasing by 2.6% the number of treatment plans completed by individuals referred by the Criminal Justice System (ONDCP, 2012, p.18). Data provided by the White House shows sufficient progress to permit the first objective to be achieved in 2015. As for the second objective, the target has already been met, and progress should be maintained through 2015 (ONDCP, 2014b, p.19).

5. The Netherlands' approach to drugs

In 2013, 8.3% of police reports concerned Opium Act offences (Trimbos Instituut & WODC, 2015), for a total of 18,268 cases versus 22,269 in 2004 (Trimbos Instituut & WODC 2014). Similarly, between 2004 and 2013, the number of crimes committed by drug users³⁸ fell from 10,504 to 5,265. In 2013, the most frequent offences were "property crimes without violence" (57%), "other violence (against persons)" (28%), and "vandalism, disturbance of public order" (19%). Opium Act offences were in fourth position (14%). Despite a decrease in the number of crimes, their general representativeness remains similar from one year to the next (Trimbos Instituut & WODC, 2015).



The Dutch approach is underpinned by the **Opium Act** (1919) which, ever since it was amended in 1976, has made a distinction between soft drugs and hard drugs. Under the legislation, the trafficking, cultivation, manufacturing, dealing and possession of drugs (apart from marijuana in quantities of less than 5 grams) are considered crimes, but drug use itself is not illegal (Ministerie van Volksgezondheid, 2009 ; PB2, 11.05.2015)

"**The Dutch Drug Policy: Continuity and Change**" (1995) sets out the fundamental principles of country's anti-narcotics policy, which falls primarily under the purview of the **Ministry of Health, Welfare, and Sports**, responsible for demand reduction, and the **Ministry of Security and Justice**, responsible for law enforcement (Trimbos Instituut & WODC, 2015 ; PB2, 11.05.2015)

Its implementation has been updated through progress reports on specific issues, such as the fight against the production and trafficking of ecstasy (2001-2007), cocaine trafficking at Schiphol Airport (2002), restricting the use and professional production of cannabis (2004), as well as the prevention and reduction of drug use (which resulted in modifications to *coffee shop* regulations, limiting access to them) (2009) (Ministerie van Veiligheid en Justitie, 2008).

Another interesting document is the **Strategy Plan for Social Relief** aimed at improving living conditions for homeless people and reducing the disruption and crime frequently associated with their behaviour.

³⁸ In the Police Records System, "this designation is given to a suspect if he/she may constitute a danger to others due to his or her drug use, and/or if he/she indicates being a drug user and/or if he/she asks for methadone" (Trimbos Instituut & WODC, 2015, p. 99)

The "Drug Policy letter" (2011) established the two fundamental pillars of Dutch drug policy: protecting public health, and combating public nuisance and organized crime (*Trimbos Instituut, WODC, EMCDDA, 2013*).

5.1 The strategy's preventive aspects and their implementation

The strategy adopts **a pragmatic, control-oriented, public health approach** (van Ooyen-Houben, 2008) (Boekhout van Solinge, 2004). It concentrates on health protection and reducing the health risks of drug use (Ministerie van Veiligheid en Justitie, 2008). Abstinence is not an explicit goal for the strategy.

The policy sets out four objectives (Ministerie van Veiligheid en Justitie, 2008):

- 1) To prevent drug use and to treat and rehabilitate drug users
- 2) To reduce harm to users
- 3) To diminish public nuisance caused by drug users (the disturbance of public order and safety in the neighbourhood)
- 4) To combat the production and trafficking of drugs

The fundamental underlying premise is **that a large part of drug problems is caused by their illegal status**. The criminalization of drug users leads to their stigmatization, which in turn makes it more difficult for the government to provide them with the necessary services (Koopmans, 2011).

The Netherlands do not have a strategy document as such. The following table indicates the principal components of the Dutch approach to drugs.

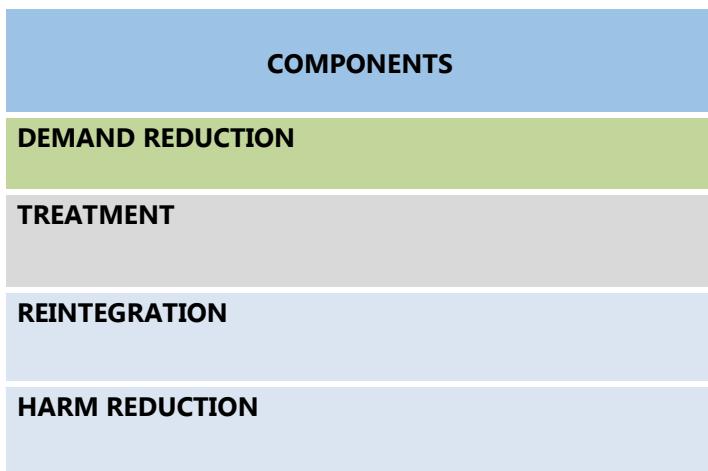


Figure 7. Principal components of the Dutch approach to drugs

a) Primary prevention

The "Healthy School and Drugs" program is aimed at reducing early and excessive substance use in adolescents (Malmberg et al., 2010). It employs several different types of intervention, focusing primarily on alcohol, tobacco, and cannabis use. The program is implemented at the local level by municipal health services and regional addiction care organizations, and is supported by the Trimbos Institute (van Ooyen-Houben, 2008 ; Ministerie van Veiligheid en Justitie, 2008). The program is currently being updated (PB2, 11.05.2015)

A national telephone hotline provides neutral and objective evidence-based information on drugs as well as free referral services via a range of electronic media (Twitter, Facebook, online forums, and a website: www.drugsinfo.nl).

The aim of the Safe and Healthy Nightlife and Events project is to support municipalities in the implementation of nightlife policies and to provide young people and their parents with information on the risks of drug use, in an effort to increase the safety of entertainment venues by reducing drug and alcohol consumption (Ministerie van Volksgezondheid, 2009 ; Ministerie van Veiligheid en Justitie, 2008).

Due to budget cuts, funding for media campaigns aimed at preventing the consumption of alcohol, tobacco, cannabis, and other drugs was terminated at the end of 2011 (Trimbos Instituut, WODC, EMCDDA, 2013).

b) Secondary prevention

Considerable emphasis is placed on secondary prevention in the Netherlands, although early detection of drug use and drug-related problems is often incorporated into comprehensive intervention programs. Secondary prevention programs conducted by NGOs in cooperation with government services mainly target young cannabis users, children of addicted parents, street youth, and young people from socio-economically disadvantaged neighbourhoods (Trimbos Instituut, WODC, EMCDDA, 2013).

In 2011, a new project targeting young consumers of cannabis with little motivation to stop their drug use was launched in 19 municipalities and via a web site. The program, based on an Australian initiative, uses a motivational enhancement technique to encourage participants to reassess their cannabis use practices.

c) Tertiary prevention

The reduction of recidivism in former drug addicts is one of the priorities of the government's Security Program, and the Strategy Plan for Social Relief.

At "Safety Houses", appropriate organizations (police, municipalities, youth services, youth probation services, addiction services, etc.) come together to work with young people at risk for drug problems, combining prevention and law enforcement.

Substitution treatment, psychosocial intervention, and rehabilitation treatment are emphasized as a means of meeting the specific needs of each individual drug addict, and are combined to ensure the long-term effectiveness of treatment, reduce relapses, and foster social reintegration.

The policy is encouraging increasing numbers of drug addicts having committed minor offences to take part in treatment programs as an alternative to incarceration. Part of their sentences may also be replaced with community service. In addition, the penitentiary system has Addiction Counselling Departments that encourage drug users to receive further treatment and take part in reintegration programs upon their release from prison (Trimbos Instituut & WODC, 2009).

Another concept is "Placement in an Institution for Prolific Offenders"; the majority of detainees in such institutions are hard drug users (Trimbos Instituut & WODC, 2009). Finally, the Forensic Addiction Clinic, overseen by the East Netherlands Institute for Addiction Care, provides care to problematic addicted offenders who have committed several crimes and undergone a number of unsuccessful clinical treatments.

The Dutch drug policy is thus based on the premise that a reduction in crimes committed by problem drug users can only be achieved if the latter receive help with their dependence (Trimbos Instituut & WODC, 2009).

d) Harm reduction

Harm reduction is one of the fundamental principles of the Dutch public health approach. However, it is difficult to define the difference between outreach, low threshold services, harm reduction activities, and social addiction care (Trimbos Instituut & WODC, 2009). In all instances, the objective is to make and maintain contact with difficult-to-reach drug users in order to prevent their personal or social circumstances from worsening (EMCDDA, n.d.-b).

The policy therefore incorporates methadone programs, a syringe exchange system found in most large cities, drug consumption rooms and heroin dispensing. Several programs are provided in outpatient care facilities (EMCDDA, n.d.-c).

A concerted effort is being made to combat social harms brought about by drug use, such as public nuisance, uncivil behaviour and petty crime. *Coffee shops* are seen as a means of regulating soft drug use while preventing users from coming into contact with hard drugs (EMCDDA, s.d.-b ; van Ooyen-Houben, 2008).

5.2 Youth-related aspects of the strategy

In 2007, the decision was made to include more youth prevention initiatives in the national drug policy (Ministerie van Veiligheid en Justitie, 2008). A survey of such programs (Oudejans and Spits, 2013) determined that there were 157 prevention products in the Netherlands, 37 of which were identified as being 'probably effective' or having a 'sound theoretical basis' by the Centre for Health Living (Centrum Gezond Leven).

a) Is it inclusive and does it seek to reduce marginalization?

The Dutch approach addresses the reduction of marginalization through the reintegration of young people via two components: support for reintegrating the community is provided to young drug addicts upon the completion of treatment or upon their release from prison. Treatment centres and prison facilities help young people return to daily life and provide them with assistance to find employment and housing (PB2, 11.05.2015).

b) Is it participatory?

The Ministry of Health organizes consultations with community organizations and frontline workers on an ad hoc basis to obtain their opinions and expertise on specific topics, and shape the government's approach. Some projects, such as ones to prevent drug use in nightlife settings, also involve young people in their development. Young people take part, primarily through focus groups, in the information gathering process, problem analysis, and the elaboration of solutions, (PB2, 11.05.2015).

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

In 2003, the drug-policy related budgets of the Dutch government's various ministries represented a total of 2,185 million euros divided among four functions: prevention (€42 million), treatment (€278 million), harm reduction (€220 million), and law enforcement (€1,646 million). Law enforcement represented the dominant expenditure (Rigter, 2006 ; Ministerie van Veiligheid en Justitie, 2008).

d) Does it provide targeted programs adapted to the specific needs of at-risk groups?

The program for children of parents with mental illness or addiction problems (KOPP/KVO in Dutch) provides courses and intervention through mental health services, as well as online support (www.kopopouders.nl) to parents with mental illness or addiction problems. Developed by the Trimbos Institute, the program is aimed both at preventing psychological and substance use disorders in children of preschool, primary and secondary school age, and at strengthening parenting skills (Trimbos Institute, 2003 ; Trimbos Institute, 2009).

Social reintegration of homeless people with addiction issues is another one of the Dutch policy's priorities. Supervised housing projects that frequently allow the use of drugs makes it easier to provide this population with support (Trimbos Instituut & WODC, 2015 ; PB4, 27.05.2015).

5.3 Initiatives undertaken to involve school staff, law enforcement officials and the community

a) School staff

Under the Primary Education Act, the promotion of healthy behaviours is mandatory for primary schools. Municipalities together with health and care services are responsible for implementing collective prevention measures regarding health risks for young people associated with drug use. The Basic Education Act for Secondary Education has laid the groundwork for a comprehensive, modern education that takes health promotion issues into account. The "Healthy Schools and Drugs" program was developed within this legal framework, providing professional development opportunities for teachers (EMCDDA, s.d.-a ; PB2, 11.05.2015).

b) Law enforcement officials

The Dutch approach is multisectoral, with police participation taking various forms. *At the local level, the mayor, the police commissioner and the public prosecutor take part in 'tripartite consultations', jointly shaping local drug policy* (Koopmans, 2011). In 'Safety Houses', the police are part of the multidisciplinary teams that work with the young offenders. In some cities, such as Rotterdam, several police stations offer needle and syringe exchange services (Trimbos Instituut & WODC, 2015).

c) Communities

In the Netherlands, prevention is the responsibility of the municipalities. The Ministry of Health, Welfare and Sport provides the guidelines for local policies and supervises the effective implementation of measures. Every four years, municipalities must draw up a public health strategy incorporating drug use prevention (PB2, 11.05.2015). The Healthy Municipality Guide, available at the website www.loketgezondleven.nl, helps municipalities work their way through every stage of the public health policy process, and is (PB2, 11.05.2015).

5.4 Connections between drugs and mental health

Thus, addiction care is considered to be a part of mental health care, falling under the responsibility of the Dutch Association of Mental Health and Addiction Care. Three echelons of comorbidity care are available (frontline support, primary and secondary mental health care), with treatment being adapted to the severity of the mental disorder (Trimbos Instituut & WODC, 2015). Over the past decade, the number of facilities for the treatment of comorbidity in mental health and addictions care institutions has increased (Trimbos Instituut & WODC, 2015). In 2009, a

National Expertise Centre on Dual Diagnoses was established, providing training and support for certain types of integrated treatment.

5.5 Evaluation of the National Drug Strategy's impact on crime

The Dutch strategy may be considered highly successful (Trimbos-Instituut & WODC, 2009). Numerous studies have shown the types of treatment offered in the Netherlands to have a better cost-benefit than incarceration (Prendergast, Podus, Chang, & Urada, 2002). Other studies have proven the relationship between abstinence-based or methadone treatments and reductions in crime in several countries, including the Netherlands (Stevens & al., 2005 ; Trimbos-Instituut & WODC, 2009). The Trimbos Institute's 2009 report shows a decrease in property crimes committed by drug users, explained in part by a decrease in crimes committed by problem opiate users.

6. Portugal's drug strategy

In November 2000, the Portuguese government approved the decriminalization of drug possession for personal use (P2, 03.11.2015). Prior to 2001, Portugal had 14,000 recorded drug-related offences. However, Decree Law 30/2000, which made the possession and acquisition of drugs an administrative offence, has resulted in an annual decrease of approximately 5,000 to 5,500 in the number of illicit-drug related offences, such as robbery, fraud and assault, since coming into force (Hughes & Stevens, 2010). According to a study by the Institute on Drugs and Drug Addiction (2009), crime committed either while under the influence of drugs or to acquire drugs decreased by 23% between 1991 and 2008 (Hughes & Stevens, 2010).



The **National Plan for the Reduction of Addictive Behaviours and Dependences³⁹** 2013-2020 (PNRCAD) is Portugal's main strategy for fighting drug use. The National Plan is overseen by the Directorate General for Intervention on Addictive Behaviours and Dependencies⁴⁰ (SICAD). The latter is a branch of the Ministry of Health, and subscribes to a continuous care model while also stressing the promotion of individual and collective health (SICAD, n.d.) PNRCAD 2013-2020 differs from the 2005-2012 strategy in that it also addresses other addiction-related behaviours such as doping and compulsive gambling.

Underpinned by scientific evidence, PNRCAD employs **prevention, dissuasion, harm reduction, treatment and reintegration** in an effort to reduce both the supply of illegal drugs and the demand, while adapting to the life stages of its individual citizens. The strategy is aimed at adopting a public health approach with the aim of providing preventive intervention (SICAD, 2013b).

Another national strategy of interest for this report is the **National Mental Health Plan⁴¹** administered by the Ministry of Health. It adopts a similar attitude towards psychiatric treatment to that adopted by PNRCAD.

³⁹ Plano Nacional Para a Redução Dos Comportamento Aditivos e Da Dependências

⁴⁰ Serviço Intervenção our Comportamentos Aditivos e nas Dependências

⁴¹ Plano Nacional de Saúde Mental 2007-2016

6.1 The strategy's preventive aspects and their implementation

The National Plan is guided by five fundamental objectives (EMCDDA, 2014):

- to prevent, deter, reduce and minimize the problems associated with the consumption of psychoactive substances, addictive behaviours and dependencies
- to reduce the availability of illicit drugs and new psychoactive substances;
- to ensure the availability, sale and consumption of legal psychoactive substances is safe and does not induce harmful use;
- to ensure legal gambling is safe and does not induce addictive behaviour; and
- to ensure the quality of services provided to citizens and the sustainability of policies and interventions.

The National Plan encompasses the dual pillars of **demand reduction** and **illicit-drug supply reduction**. It comprises two structural measures (the **Operational Plan of Integrated Responses** [PORI] and the **referral network**) and four cross-sectoral themes (information and research, training and communication, international relations and cooperation, and quality). For the demand reduction pillar, the strategy is conceptualized around the individual's life cycle and identifies critical times when drug use is more likely. Supply reduction focuses on reducing markets for illicit drugs and regulating legal gambling.

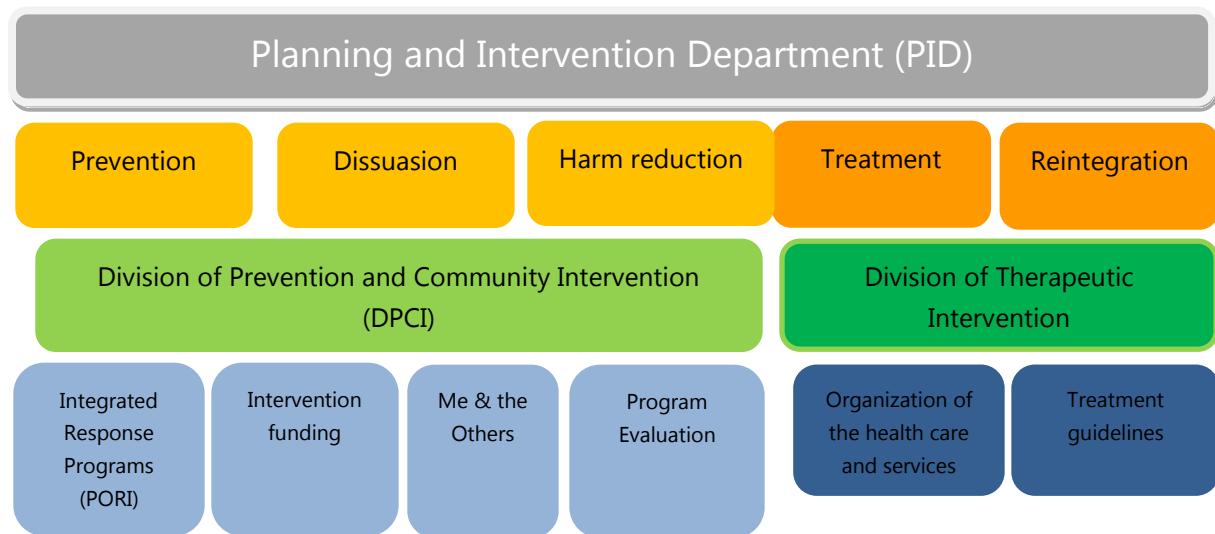


Figure 8. Organizational Chart for SICAD

a) Primary prevention

Prevention is the key concept in Portugal's strategy, which is implemented by SIDAC in cooperation with other government bodies such as the Ministry of Education and the police along with State-funded NGOs (Domoslawski, 2012, p.28).

SICAD has set up special telephone lines for young people and their parents, as well as "Tu-Alinhas", a website for young people, to provide objective information and advice on addictions.

SICAD also created **PORI**, a national program that funds NGOs mandated with establishing primary and secondary prevention programs (SICAD, 2013a, p. 98). Organizations must apply to obtain access to public funding and must respect the following selection criteria: propose systemic initiatives possessing a solid theoretical basis and fostering the development of partnerships, and take part in evaluations (SICAD, 2013a). **Me and the Others** is another national program set up by SICAD. It trains teachers as well as community and social workers working in public institutions to implement SICAD prevention services. Public institutions in the community thus receive the necessary resources to manage programs set up by SICAD.

b) Secondary Prevention

The **Commissions for the Dissuasion of Drug Addiction (CDT)** are the second line of intervention with regard to prevention. Each province has a commission composed of three people appointed by the government: a legal expert appointed by the Ministry of Justice and two people appointed by the Ministry of Health. When individuals are arrested with drugs, the police confiscate the illegal drugs and release the individuals on the condition that they appear before a CDT ((Domoslawski, 2012, p.29; P1.11.03.2015). If they do not appear, an administrative penalty may be imposed, such as a fine, the revocation of their driver's license or gun license, or community service. In light of the Portuguese government's public health approach, the strategy strives to reduce crime committed either under the effect of drugs or to acquire the drugs by reducing or preventing drug use by individuals.

c) Tertiary prevention

Drug addicts may receive treatment at medical centers specializing in drug-related treatment. For example, TAIPAS, a treatment centre in Lisbon, provides comprehensive care at different stages of treatment. TAIPAS has three teams of psychiatrists, psychologists and social workers, and provides consultation services, treatment, psychotherapy and methadone treatment (P2, 03.11.2015). In addition to specialized treatment, clients also have access to physiotherapy as well as art and computer courses (Domoslawski, 2012, p.34).

SICAD's multidisciplinary teams are responsible for the social reintegration of addicts and generally work in collaboration with treatment centers. They first prepare a diagnosis of the patient's condition, then work with the patient to establish an action plan that includes goals such as going back to school or to work. They also help patients find work or provide them with job-

seeking advice (Domoslawski, 2012, p. 34; P2, 03.11.2015). While safeguarding patient confidentiality, the teams also conduct public awareness outreach in the schools, businesses, and residential areas of patients' neighbourhoods, in an effort to combat prejudice against drug users, and thereby increase the chances of successful reintegration.

SICAD also collaborates with private companies to provide 9- to 24-month-long internships for patients being reintegrated (Domoslawski, 2012, p. 35). Finally, depending on the patient's family situation, SICAD may also provide available housing.

d) Harm reduction

Harm reduction initiatives in Portugal are based on the ethical conviction that, when it is impossible for individuals to overcome their addiction, the State should help people with addictions to reduce the harms their drug use causes to themselves, their loved ones, and their communities. To reduce drug-related risks, such as infectious diseases, social exclusion, and crime, a network of programs (needle exchanges, low-threshold substitution programs, etc.) and facilities (support centres, shelters, mobile centres) funded by the State and set up primarily by NGOs has been made available throughout the country in high drug use areas (Domosławski, 2012 ; EMCDDA, n.d.).

6.2 Youth-related aspects of the strategy

Young people constitute one of the age categories specifically targeted under Portugal's National Drug Plan, which employs a lifecycle approach based on the biopsychosocial development of the individual. The Portuguese strategy strives to identify critical times in an individual's life and stresses intervention focused on the individual's needs and strengths. Greater emphasis is placed on childhood and adolescence as they are key periods for the uptake of drug use.

a) Is it inclusive and does it seek to reduce marginalization?

Based on countrywide analysis, the strategy attempts to identify vulnerable areas where young people are more inclined to adopt addictive behaviors. Once intervention needs have been identified, the strategy seeks to help these young people be integrated into society and to minimize marginalization and exclusion through the Integrated Response Program (PRI) (SICAD, 2013a, p.53). The marginalization reduction approach does not however only target certain groups (based on socio-economic context). Rather, the strategy considers all individual as being at risk of marginalization, and aims to prevent drug use at critical life stages (SICAD, 2013a, p.53).

b) Is it participatory?

The National Council on Drug Addiction's coordinating bodies invite young people who are in school or on the National Council's committees—such as the *Committee of Working Youth*—to express their opinions on the strategy's various programs. This initiative makes it possible to establish adapted programs providing more effective intervention for drug, alcohol and gambling addictions (P1, 17.02.2015).

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

Unlike the 2005-2012 strategy, PNRCAD 2013-2020's budget has not been revealed to the public due to the large number of institutions involved in its development and implementation (P2, 03.11.2015). However, based on the various funding programs including PORI and Me and the Others, it is apparent that considerable emphasis is being placed on prevention, treatment, harm reduction, and social reintegration programs (P2, 11.03.2015).

d) Does it offer targeted programs adapted to the specific needs of at-risk groups?

As was previously mentioned, SICAD conducted a nationwide diagnosis in 2005 that enabled it to develop certain programs focused on high-risk groups (Domoslawski, 2012, p. 28). SICAD identified young people as being a high-risk group, especially young people who attend popular cultural events, as that is where they tend to initiate drug use. Outreach workers go to such events to talk to young people about the consequences of drug use, and to identify individuals who show signs of addiction, and encourage the latter to undergo treatment (Domoslawski, 2012).

6.3 Initiatives undertaken to involve school staff, law enforcement officials and the community

When setting up community-based intervention, PNRCAD takes the community into account in assessing and developing an understanding of the risks and needs of targeted populations, which is vital to program success and sustainability.

a) School staff

In elementary schools and secondary schools, cross-curricular learning about emotional, social and ethical behaviour is incorporated into the traditional curriculum. The Ministry of Internal Affairs and the Ministry of Education and Sciences created a national school program to create an environment conducive to healthy development. This collaborative initiative is designed to foster prevention and ensure the safety of schools and their surrounding areas, relying on a permanent police presence in close proximity to schools (SICAD, 2013a, p. 59; Policia Segurança Publica, n.d.).

The Me and the Others program is another school-based prevention initiative. It uses an integrated prevention approach that addresses various issues that may arise during adolescence including sexuality, violence, and illicit drug use (SICAD, telephone conversation, 11 March 2015). This government program is mandated to increase intervention by providing training and resources to teachers and social workers who act on behalf of SICAD.

b) Communities

PORI subsidizes Integrated Response Programs (PRI) that conduct interdisciplinary intervention at a local level. Thus, PORI allocates funds to NGOs which provide intervention addressing multidimensional issues such as illicit drug abuse. The NGOs are required to adopt an ecological perspective of human development, and an integrated, holistic vision (SICAD, 2013a, p. 57). They must also rigorously assess both the implementation and the impact of their initiatives in order to ensure the best possible results. If an initiative reveals any shortcomings, additional funding may be requested to meet the specific needs of a community.

c) Law enforcement officials

Portuguese police play an active role through the Safe Schools program. They undergo special training not only to increase security around schools, but also to identify and report at-risk situations—youth drug use—to the appropriate intervention services (Polícia Segurança Pública, n.d.) Moreover, the criminal justice system recognizes that it is essential for people with addiction issues to have access to multidisciplinary treatment and rehabilitation programs during incarceration in order to decrease potential recidivism. Information and education programs are provided to help such individuals develop a better understanding of the negative side effects of their dependence (SICAD, 2013, p. 62-63).

6.4 Connections between drugs and mental health

The Portuguese government's mental health program is independent of the PNRCAD strategy and is addressed in the **National Mental Health Plan 2007-2016**. Nevertheless, there is considerable crossover between the treatment of drug dependence and mental health, particularly in terms of the psychiatric treatment of concurrent disorders in referral network facilities. That being said, the priority for these clinics is addiction treatment, and as a result patients with mental health issues are referred to a different national network of care facilities (Barros, Machado & Simões, 2011; P2, 11.03.2015).

6.5 Evaluation of the National Drug Strategy's impact on crime

The 2013-2020 version of Portugal's strategy has not yet been evaluated to determine its impact on crime. However, the Open Society Foundation conducted an assessment of the 2005-2012 version and the results indicate that the new measures introduced at the time of decriminalization have had a **positive effects with regard to crime**. Decriminalization has inevitably resulted in a reduction in the number of people arrested and tried for drug-related offences since 2011 (Murkin, 2014). **The treatment and harm reduction programs have been successful**, in that they have made it possible to include greater numbers of marginalized people in government programs (P1, 02.17.2015; P2, 03.03.2015). According to Portuguese and international experts, the positive trends observed are the product of a drug policy that provides treatment to people with substance addictions, instead of treating them like criminals (Domoslawski, 2012).

7. The United Kingdom's drug strategy

The United Kingdom has one of the highest rates of youth cannabis use and binge drinking in Europe (HM Government, 2010). In England and Wales, 16% of young people aged 16 to 24 years have used drugs (EMCDDA, 2013). Alcohol abuse, which is often combined with the use of stimulants and other illicit drugs, can cause individuals to adopt violent criminal behaviours. The United Kingdom has estimated the social and economic costs of illicit drugs between 2010 and 2011 at £10.7 billion, of which over half (£5.8 billion) were crime-related (EMCDDA, 2013).



7.1 The strategy's preventive aspects and their implementation

In 2010, the United Kingdom adopted a new drug strategy advocating a whole-life approach, from early prevention (with young children) to addiction treatment (EMCDDA, 2013). The strategy's objective is to achieve abstinence among young people (HM Government, 2010).

Overseen by the Home Office, in partnership with the Departments for Education, Health, Work and Pensions, and Communities, together with the Ministry of Justice, the strategy provides a series of guidelines structured around three main pillars (HM Government, 2010):

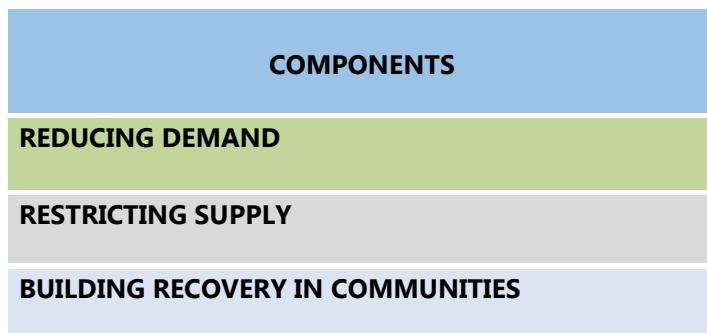


Figure 9. Components of the United Kingdom drug strategy

While the fight against drug trafficking falls under the exclusive purview of the United Kingdom, each nation⁴² has its own national anti-drug action plan specifying its responsibilities in terms of prevention and treatment (EMCDDA, 2013).

The strategy provides for the decentralization of power and accountability with regard to health care and prevention in England (HM Government, 2010). The national government⁴³ is not directly involved in developing local programs but plays an important support role through the allocation of funding, the building of local capacity, and the sharing of good evidence-based practices (RU3, 27.04.2015).

The strategy emphasizes the importance of multisectoral collaboration in dealing with dependency issues (HM Government, 2010).

a) Primary prevention

The United Kingdom has a public awareness **campaign** called "Talk to FRANK"⁴⁴ (HM Government, 2010), that incorporates tools such as a telephone helpline, an website on the harmful effects of drugs, and a live chat facility. 'Talk to FRANK' adopts a neutral, non-judgmental tone with the aim of dissuading young people between the ages of 11 and 18 years from using drugs (EMCDDA, 2015). The service provides young people with the necessary tools to resist peer pressure, understand social norms rationalizing drug use, and create a healthy environment in which they will be able to resist temptation (RU1, 26.02.2015). The FRANK program provides support for parents as it recognizes that young people coming from difficult family situations are often at greater risk of developing substance abuse issues (HM Government, 2010).

The "Rise Above"⁴⁵ program is an online resource designed specifically for adolescents and aimed at preventing risky behaviours, especially concerning drugs, by helping teenagers to develop their personal skills, social capital, and resilience (RU2, 09.04.2015).

Primary prevention also takes place via **schools**, as the strategy recognizes that they have a crucial role to play the prevention of drug abuse (HM Government, 2010). The information service known as ADEPIS⁴⁶ supplies practical advice, effective evidence-based prevention tools (primarily educational programs), and case studies to practitioners and educators working with youth (« ADEPIS », 2015).

⁴² England, Wales, Scotland and Northern Ireland

⁴³ It is also advised by the ACMD (Advisory Council on the Misuse of Drugs) which acts as an independent expert (HM Government, 2010).

⁴⁴ In Scotland, the "Know the Score" program employs the same model (telephone hotline and website) to provide information and advice to young people and their families.

⁴⁵ In Scotland, the educational "Choices of Life" program is built on a similar model, and deals exclusively with the prevention of drug, alcohol and tobacco use.

⁴⁶ *Alcohol and Drug Education and Prevention Information Service*

The strategy is also underpinned by the premise that young people living in a difficult family situation (abuse, neglect, trauma or poverty) are more likely to take drugs. Prevention must therefore begin as early as possible, especially in vulnerable **families**, to avoid the escalation of harm and to prevent young people from becoming substance-dependent adults (HM Government, 2010)⁴⁷.

The strategy encourages programs⁴⁸ that provide support for infants and their parents. Certain treatment programs designed specifically for parents with dependency issues work together with children services to create a healthy family environment (HM Government, 2010). Professionals in contact with young children and their parents are encouraged to undertake training so as to be able to intervene early to protect children from harm (HM Government, 2010).

b) Secondary Prevention

Early intervention⁴⁹ is the purview of local governments and community organizations. The national government provides financial support as well as evidence and advice on effective intervention. Family-based intervention is especially encouraged as having been shown to contribute to the reduction of crime, in particular (HM Government, 2010).⁵⁰

c) Tertiary prevention

Treatment is considered the most effective means of reducing crime, assisting the individual's reintegration with the community, and preventing recidivism (NTA-NHS, 2009). The strategy therefore seeks to reduce drug-related crime by providing comprehensive treatment services accessible to all (RU1, 26.01.2015).

If an individual commits an addiction-related offence, the police and judges have the ability to propose treatment to the individual as an alternative to incarceration⁵¹ (EMCDDA, 2013 and RU1, 26.01.2015).

Treatment is also available in prisons when incarceration is deemed necessary⁵² (NTA-NHS, 2009). Once the sentence has been served, the recommended approach to prevent recidivism is rehabilitating and reintegrating the individual with the community⁵³ through effective addiction treatment and social support (HM Government, 2010).

⁴⁷ Primary intervention with children who do not take drugs and secondary prevention if children are in the early stages of drug use.

⁴⁸ See for example 'Healthy Child', 'Troubled Families', 'Sure Start' and 'Family Nurse Partnerships'

⁴⁹ For example, '*Early Intervention Grant*', '*Choices*'

⁵⁰ See ref. 48.

⁵¹ All treatment in the United Kingdom is voluntary, except very exceptional mental health related cases (RU1, 26.01.2015).

⁵² *Integrated Drug Treatment System*

⁵³ *whole systems approach*

One program that bears mentioning is the 'Drug Interventions Programme'⁵⁴, which targets substance abuse and crime in especially problematic and hard-to-reach offenders (Home Office, 2011). Also of interest are the youth court 'liaison and diversion'⁵⁵ schemes that divert young offenders under the age of 18 years towards appropriate treatment services and away from the prison system (RU3, 27.04.2015).

d) Harm reduction

None of the component of the United Kingdom's strategy focuses specifically on harm reduction.

7.2 Youth-related aspects of the strategy

a) Is it inclusive and does it attempt to reduce marginalization?

The strategy provides for support programs for families in difficulty. Families receive social support to reduce marginalization and prevent drug use. Indeed, the strategy recognizes the influence of external factors, such as social factors, on youth drug use (HM Government, 2010).

The reduction of marginalization is a fundamental aspect of the '*Building Recovery in Communities*', as the strategy argues that recovery is not just about addressing the symptoms and causes of dependence, but also about enabling people to reintegrate into their communities (HM Government, 2010). If a person manages to overcome addiction, reintegration with society (employment, housing, etc.) is crucial to ensure the results are sustained over the long term (RU1, 26.01.2015).

b) Is it participatory?

For the Talk to FRANK campaign, messages are regularly reassessed with youth participation to ensure messages are targeted to the young people's needs (RU1, 26.02.2015) (RU3, 27.04.2015). The service's database is regularly updated to meet young people's emerging needs and stay in line with their social media habits (HM Government, 2015). The 'Rise Above' program also involves young people by creating opportunities for discussion and situational resources to encourage them to share their opinions (HM Government, 2015).

It is taken as a given that there is effective user involvement in all healthcare in the UK, in accordance with the principle "no decision on me, without me" (RU1, 01.26.2015).

⁵⁴ Drug Interventions Programme

⁵⁵ Liaison and Diversion Schemes

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

Of the estimated £2.5 billion in expenditures, slightly more than half is devoted to law enforcement. The remainder of the budget is divided among treatment (one fifth of the budget), early intervention programs (nearly 15%), education, non-rehabilitation (medical) related treatment activities (roughly 6%), and information campaigns (0.3%) (HM Government, 2013).

One of the unique facets of the United Kingdom's approach to funding is the establishment of eight pilot projects as part of the 'Payment by Results' system (Department of Health, 2014). The system seeks to attract private funding, with investors receiving a bonus if treatment outcomes are better than expected. A recent evaluation by the Department of Health showed some implementation challenges facing the system primarily due to unknown factors that may affect outcomes (Department of Health, 2014).⁵⁶

d) Does it provide targeted programs adapted to the specific needs of at-risk groups?

The 2010 strategy has established support programs for homeless people, among other specific groups, to prevent drug use or to help them overcome addiction (HM Government, 2010). The strategy states that housing assistance contributes to the prevention of drug-related crime, and is an effective complement to treatment services as it improves people's living conditions and social conditions (HM Government, 2010).

In England, the 'Positive Futures'⁵⁷ program, launched in 2012, targets young people ages 10 to 19 years who live in disadvantaged communities (EMCDDA, 2013). It establishes sports activities and creative workshops to divert young people from violence, drug use and crime (EMCDDA, 2013).

7.3 Initiatives undertaken to involve school staff, law enforcement officials, and the community

a) School staff

The strategy stresses the key role played by schools in preventing drug abuse. The government is committed to ensuring that school staff have the knowledge and capacity to supply pertinent information, address problem drug-related behaviours (such as trafficking) at school, and to work with organizations and the police to prevent drug abuse (HM Government, 2010)⁵⁸. School personnel have a certain amount of flexibility in the choice and content of such programs (RU3,

⁵⁶ The evaluation of these pilot projects will soon be soon completed and published (RU1, 26.02.2015).

⁵⁷ In Scotland, the 'CashBack for Communities' program reinvests funds in community programs, activities and facilities for at-risk youth.

⁵⁸ See for example 'Healthy Schools'

27.04.2015). The central government is committed to supporting them by sharing expertise, especially best practices. Special emphasis is placed, here as well, on children from disadvantaged backgrounds (HM Government, 2010).

b) Law enforcement officials

When the police believe an individual they have apprehended has committed an offence due to dependence issues, officers may conduct testing and divert the offender to treatment services rather than initiate judicial proceedings (RU1, 26.02.2015). Offenders may be released if they commit to undertaking treatment or doing community service work (RU1, 26.02.2015). The police and justice services have discretionary powers allowing them to make decisions based on what they deem to be best for society (RU1, 26.02.2015).

c) Communities

The strategy cites numerous social programs that address the issue of the drug use indirectly through such avenues as housing and employment (HM Government, 2010). Local organizations work together to help individuals build their personal skills and better (re)integrate with the community through mentoring programs such as 'Recovery Champions' (HM Government, 2010). Such networks are seen as a means of helping people overcome their addictions and serve as examples for their peers. Mutual aid networks and support from peers (community, family, loved ones) are known to be effective components of treatment (HM Government, 2010).

7.4 Connections between drugs and mental health

The strategy considers young people with mental health issues to be a particularly high risk population for drug use, and advocates intervention at the onset of the first symptoms (HM Government, 2010).

When young people develop a dependence on alcohol or drugs, they are diverted to the appropriate mental health services (Child and Adolescent Mental Health Service—CAMHS), while also being referred to other support services (housing, education, treatment, etc.) (HM Government, 2010). It is strongly recommended that the mental health component not be addressed in isolation from other social and environment factors of drug use (RU3, 27.04.2015).

Also, 'Liaison and Diversion' services work in collaboration with the judicial system to identify individuals—especially young people—suffering from mental health disorders, to provide them with support during incarceration or to divert them to specialized institutions if they are minors (HM Government, 2015).

7.5 Evaluation of the National Drug Strategy's impact on crime

As the strategy is recent (2010), it is relatively early to assess its impact. However, according to one interviewee, it would seem that the most effective programs are those that strengthen the

ability of participants to resist peer pressure (RU1, 26.02.2015). Targeted family interventions⁵⁹ have also proven economically viable, and effective at reducing drug-related risks including the risk of crime (Hamilton, 2010).

in accordance with the premise that the best way to reduce drug-related crime is to eliminate drug use itself, treatment—especially medical treatment in prisons—has been shown to be effective in reducing recidivism and crime (NTA-NHS, 2009).

⁵⁹ *Family Interventions*

8. Switzerland's four-pillar strategy

The number of drug addicts in Switzerland increased significantly towards the end of the 1980s, (FOPH, 2006) becoming a priority concern for a Swiss public exposed to scenes of open drug use (S1, 04.22.2015). The so-called four-pillar policy was developed gradually in response to the consequences of a problematic situation and the dominant position it had come to occupy in the public discourse (FOPH, 2006). Drug addiction is no longer a major issue for either the population or policy makers in Switzerland (S1, 04.22.2015).



8.1 The strategy's preventive aspects and their implementation

The Swiss policy is meant to be *pragmatic* (S1, 04.22.2015), based on the premise that the notion of an entirely narcotics-free society is a utopian ideal. It therefore does not consider abstinence an *a priori* objective, and instead takes drug users as they are, providing for measures designed to meet the needs of drug users wherever they may be on their drug-use trajectory (S1, 04.22.2015). This has resulted in the development of a four-pillar policy based on public health rather than exclusively on law enforcement. The four pillars are prevention, therapy, harm reduction and law enforcement. The desired impacts are:

- reduced drug consumption,
- reduced negative consequences for society⁶⁰, and
- reduced negative consequences for drug users (FOPH, 2012).

⁶⁰ Primarily in terms of drug use visibility (S4, 05.04.2015).

| CROSS-SECTORIAL TASKS | COMPONENTS | SUB-COMPONENTS |
|--|------------------------|--|
| I. COORDINATION II. QUALITY ENHANCEMENT/FURTHER TRAINING III. INNOVATION IV. IMPROVING SCIENTIFIC KNOWLEDGE | PREVENTION | School-based health promotion (holistic approach) Swiss education + health (e + h) network Early Intervention |
| | THERAPY | Prescription heroin treatment Prescription methadone or buprenorphine treatment Prison drug and rehabilitation treatment Hepatitis C campaign |
| | HARM REDUCTION | Development of concepts and provision of services Coordination and support |
| | LAW ENFORCEMENT | As the <i>law enforcement</i> subcomponents are not part of the prevention framework, they will not be discussed. |

Figure 10. Switzerland's four-pillar strategy (FOPH, 2012)

As Switzerland is a federal country in which cantons have a high degree of autonomy, preventive measures are largely left to the cantons' discretion, with the federal government playing more of a coordinating role⁶¹. As a result, implemented programs may differ considerably from one region

⁶¹ The **Federal Office of Public Health (FOPH)** in particular

of the country to another, depending both on the linguistic area and the organizational culture (S1, 04.22.2015).

However, an important aspect of the Swiss policy is collaboration between the four pillars. For example, law enforcement must take harm reduction into consideration: if the police confiscate clean needles (harm reduction), the results will be counterproductive (S4, 04.05.2015)

The policy is implemented in a way that incorporates NGOs, which frequently receive part of their funding from the cantons (S1, 04.22.2015).

a) Primary prevention

The FOPH's involvement in primary prevention occurs mainly at the school level via the *Education and Health* project (school network) and *Education 21* (producing teaching materials) (S1, 04.22.2015). Drug addiction prevention is integrated into the school curriculum (FOPH, n. d.-b), with school professionals receiving training to promote prevention and health at school (FOPH, n. d.-b). Implementation of these measures varies depending on the canton.

b) Secondary Prevention

Secondary prevention takes the form of early intervention⁶², consisting of support and counselling for vulnerable young people. There are four phases to the early intervention process: the creation of a favourable environment, identification, assessment, and provision of support (see *La démarche d'intervention précoce* (Al Kurdi, Carrasco, & Savary, 2010)

The first aim of early intervention is the *creation of a favourable environment*. This principle recognizes that society shares responsibility for illicit drug use when it fosters structural conditions that contribute to peoples' drug use (the pressure of productivity, living conditions, working conditions, etc.) (S4, 04.05.2015).

The second aim of early intervention is to train professionals who are in contact with young people so they are able to identify at-risk youth and convince the latter to accept help if necessary. Little by little, knowledge of addiction-related issues is integrated across all professions (teachers, social workers, community workers, police, etc.) that may be in contact with drug-dependent or at-risk individuals. Early intervention is at the junction between the Prevention and Therapy pillars (S1, 04.22.2015).

⁶² Early intervention is a component of the revised Narcotics Act.

It should be pointed out that primary and secondary prevention programs tend to be less and less drug-specific, and instead focus increasingly on shared risk factors for the use of drugs, alcohol, and violence, in particular (S1, 22.04.2015).

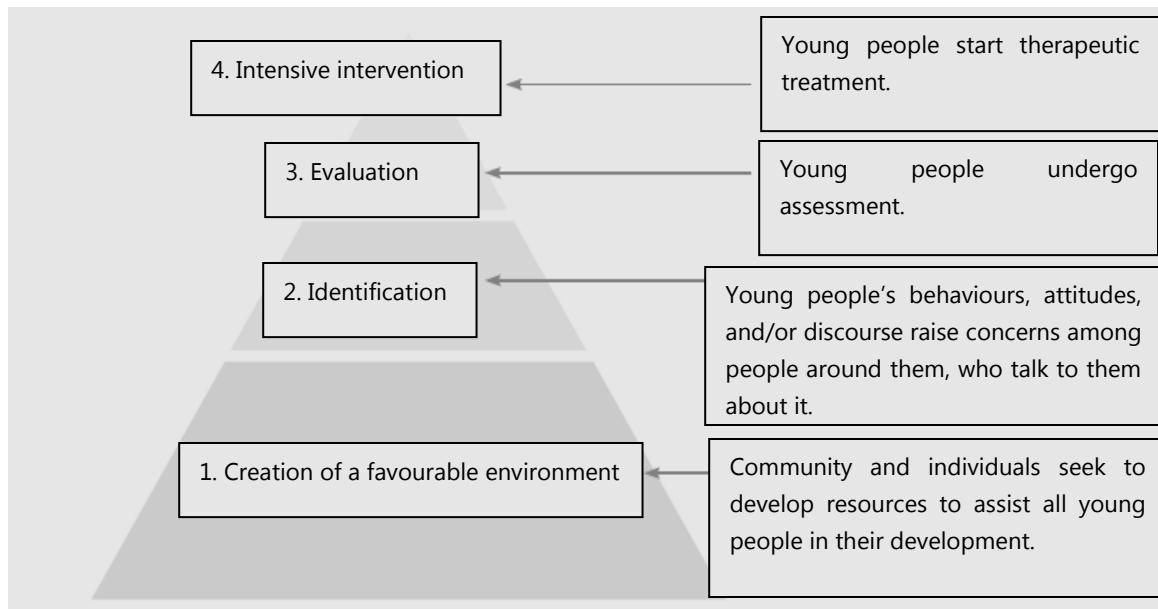


Figure 11. The early intervention process (Al Kurdi, Carrasco, & Savary, 2010)

c) Tertiary prevention

Tertiary prevention corresponds to the Therapy pillar of the Swiss model. The cantons provide a range of treatments, from ones based on the prescription of so-called substitutes (pharmaceutical heroine, methadone, buprenorphine or slow-release morphine) to residential abstinence-focused treatments. Access to substitution therapies has been made easier over the years, ensuring that most drug addicts are integrated into the health care system (S1, 22.04.2015).

Under the criminal code, judges may order one of these types of treatment instead of a prison sentence if the offender has committed an addiction-related crime or offence.

A national quality standard helps ensure the quality of care provided by treatment facilities (S1, 04.22.2015).

d) Harm reduction

The aim of harm reduction is to reduce the damage caused by drug use (FOPH, 2012). It is a [Translation] "safety net" to catch people who fall through the mesh of the prevention net or who have discontinued therapeutic care" (infodrog & GREA, 2009, p. 3). One of its attributes is the reduction of crime (infodrog & GREA, 2009).

Drug consumption rooms, where individuals are able to take drugs under hygienic conditions and to receive advice and care, are another Swiss harm reduction measure (S2, 04.23.2015). There are currently 12 such rooms across Switzerland (S2, 04.23.2015), and a quality standard has been established to ensure the quality of the services they provide (S1, 04.22.2015).

8.2 Youth-related aspects of the strategy

The prevention component of the Swiss action plan recognizes the importance of strengthening protective factors among young people (FOPH, 2012).

a) Is it inclusive and does it seek to reduce marginalization?

The reduction of marginalization is included in three of the pillars: *Prevention, Harm Reduction* and *Treatment* and is operationalized primarily through professional integration (or reintegration), along with integration into the health care system (S1, 04.22.2015 , FOPH, 2012, p. 5, S2, 04.23.2015 and infodrog & GREA, 2009).

Marginalization reduction thresholds vary depending on the individual's personal resources, ranging from professional reintegration to obtaining work as a day labourer depending on the individual's level of dependence. The Swiss approach acknowledges that certain individuals who are heavy users may have been socialized in such a way as to make full reintegration into the work force difficult, and that they need more flexible occupations (S1, 22.04.2015).

b) Is it participatory?

There is recognition at the federal level that a good prevention program must be participatory (see especially Addiction Suisse, 2013 and S1, 04.22.2015). However, as their autonomy allows cantons the freedom to choose the programs they implement, there is no guarantee that all programs are indeed participatory.

The participation of professionals who are in contact with vulnerable individuals is also considered desirable, as it is important that they adhere to and appropriate the process in order to intervene adequately. They are therefore actively involved in the development of addiction-related approaches (S1, 22.04.2015).

c) Is there an equitable distribution of resources between social programs and anti-crime measures?

Switzerland's drug policy is implemented at the federal, canton, and communal level, which makes calculating its budget extremely difficult (26 cantons, 2200 communes) (S4, 04.05.2015). However, according to one estimate, budget allocation among the four pillars would appear to strongly favour law enforcement, with this pillar receiving approximately 2/3 of the budget, therapy 1/4, and prevention and harm reduction 5% each (infodrog & GRE, 2009).

d) Does it provide targeted programs adapted to the specific needs of at-risk groups?

Programs targeting specific at-risk groups are rare in Switzerland (S1, 04.22.2015), although efforts are being made to integrate migration- and gender-related considerations, for example, into program development (S4, 05.04.2015 and FOPH, n. d.-a). However, the implementation of migrant protection is made difficult by a restrictive approach to migration, as foreigners sometimes having limited access to harm reduction services, for example (see especially Première Ligne, n.d., and S4, 04.05.2015).

Another example of a targeted program is the federal 'supra-f' project, which was implemented at the local level to meet the needs of at-risk groups (S3, 29.04.2015). It provided support to young people experiencing difficult situations to help them achieve a more stable school or job situation (infodrog, n. d.). Although it ended in 2009 (S3, 229.04.2015), the results of the program have been incorporated into the new early intervention program (S1, 22.04.2015).

8.3 Initiatives undertaken to involve school staff, law enforcement officials and the community

It should be pointed out that prevention initiatives are not systematically inventoried, as they fall under cantonal jurisdiction (S4, 05.04.2015).

a) School staff

As has been mentioned, school staff is heavily involved in primary and secondary prevention via the *Education and Health* and *Early Intervention* programs, and as school mediators in French-speaking Switzerland (S1, 22.04.2015). Professionals may be trained to identify risk situations, talk to the young people involved, and refer them to the appropriate individuals for assessment and support (S4, 05.04.2015).

b) Law enforcement officials

The four-pillar policy advocates less direct means of law enforcement (S4, 05.04.2015), encouraging collaboration between the police and harm reduction services (S1, 04.22.2015). This is reinforced by the Frankfurt Declaration—of which Switzerland is one of the adoptees—which stipulates "that prevention, harm reduction, treatment, and repression need to be balanced in a way that minimizes harm to individuals and society" (S4, 04.05.2015 and Frankfurt Principles on Drug Law Enforcement, 2013).

The police also play a preventive role through their interactions with young people. Police officers are taught how to intervene appropriately when engaging with young people in the street (S1, 04.22.2015).

Finally, in some cantons, youth justice officials and support centres work in collaboration to provide early intervention for young people smoking excessive amounts of cannabis, for example (S1, 04.22.2015).

c) Communities

Community projects are established at the commune level (S4, 05.04.2015). Multidimensional projects to fight addiction are implemented via a variety of forums such as school, the family, and the media (Addiction Suisse, 2013). These personalized measures are supported by RADIX, a national (private law) centre for the development and implementation of public health measures (RADIX, n. d.)

8.4 Connections between drugs and mental health

In Switzerland, treatment of concurrent disorders became possible when the approach towards addiction became more medicalized. It came to be realized that a link existed between drug dependence and mental health issues. For example, 75% of people in heroin treatment programs have psychiatric comorbidities (S1, 04.22.2015).

The Swiss government favours a comprehensive approach to this issue, both in the structures that provide care to individuals with addiction issues, and through close collaboration between these specialized structures and professionals in the field of psychiatry (S1, 04.22.2015).

Switzerland has also developed a quality standard known as QuaTheDA—Quality, Therapy, Drug, Alcohol—that includes criteria requiring professional collaboration not only with psychiatric professionals but also with all social and health care structures, in order to ensure integrated care for dependent individuals (S1, 22.04.2015)

8.5 Evaluation of the National Drug Strategy's impact on crime

The measures developed as part of the four-pillar policy have played a major role in reducing crime in Switzerland.

On the one hand, there has been a demonstrable decline in the crime rate due to the "Therapy" pillar and the lowering of the *threshold for access to treatment* (S1, 04.22.2015). It has been estimated that [Translation] "Swiss taxpayers save 420 million francs a year in crime-related costs simply by investing in (outpatient) substitution treatment" (Al Kurdi & Savary, s. d., p. 2).

Evaluation, beginning in 1994, of prescription heroin programs has clearly shown reduced crime (FOPH, n. d.-c) among patients. For example, in 1999, police files showed that the percentage of drug addicts receiving prescription heroin treatment who were involved in crime had decreased by 40%, and that the number of offences had decreased by 60% (Aebi, M. F., Ribeaud D., Killias, M., 1999, in Savary, 2007).

On the other, measures developed as part of the "Harm Reduction" pillar have also contributed to decreased crime, particularly the use of drug consumption rooms (Huber J. 2011/2012 in GREAS, s. d.-d).

The aim of this comparative analysis is to place the seven national strategies examined here in perspective so as to draw attention to the various aspects highlighting drug-related crime: both commonalities and the unique aspects of each strategies will be explored.

The first part will focus on the **structural decisions** underpinning each of the strategies, the choices that shape the different governments' approaches in dealing with drug use.

The second part will examine **the aspects of the strategies concerned with young people**, measuring their effectiveness via the indicators used to present each strategy (see Concurrent disorders affect young people in particular as most mental illness starts before adulthood (Kessler RC, Berglund P, Demler O et al., 2005, and Kim-Cohen J et al., 2003, in Great Britain Home Office, 2010).

, p. 20).

Finally, the comparative analysis will demonstrate how the various strategies use three approaches to **reduce drug-related crime**:

- prevention of illegal drug use;
- prevention of recidivism; and
- harm reduction (prevention of drug-related risk behaviors).

1. Structural decisions underpinning the drug strategies

The elaboration of a drug strategy presupposes structural decisions that serve as a blueprint for the policy. One part of these decisions is taken at the international level. States have agreed in international treaties on a common framework for addressing drug issues, a framework that has evolved over time.

Strategies also depend on **country-specific decisions** expressed through laws and approaches. A country may choose to adopt a repressive approach or a public health approach. It may also set itself the *objective* of creating an abstinent society or, on the contrary, it may consider abstinence an unrealistic goal and feel it is vital to concentrate instead on reducing the negative consequences of drug use.

Similarly, countries determine how integrated their strategies will be—both with other national policies, and amongst the strategy's various components. Moreover, strategies may be implemented at a national level, or the necessary powers may be delegated to local authorities.

Finally, countries have **different definitions of the term 'drug'**; they may choose to restrict its meaning to refer solely to illicit drugs or adopt a broader definition encompassing alcohol, gambling, and prescription drugs, for example.

It is therefore essential when comparing these seven strategies to keep in mind that approaches to drugs are, first and foremost, the product of societal choices.

1.1 The international context: limited latitude for states

In contextualizing the decisions made by these states regarding their drug strategies, it is important to remember the restrictions placed on national policies by the international treaties to which the countries are parties.

While the consumption of psychoactive substances is an age-old phenomenon, the international prohibition of certain substances is relatively recent. In fact, the first international drug control treaty was the *International Opium Convention* of 1912, which regulated opium, morphine, cocaine and heroin, and achieved virtually universal adherence as of 1919 (ONUDC, n. d.). The Convention was in response to humanitarian concerns regarding countries such as China that, despite numerous unsuccessful attempts to ban the use of opium⁶³, had seen their markets flooded by the colonial powers, especially the United Kingdom (United Nations & ONUDC, 2008). Controls on cannabis were first imposed in 1925 under the Geneva Convention (Sinha, 2001), which would be followed by a further six international conventions.

Currently, there are three conventions on narcotic drugs at the global level:

- The Single Convention on Narcotic Drugs, 1961;
- The Convention on Psychotropic Substances, 1971; and
- The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

These conventions have replaced the previous treaties **and limit** the use, possession, and manufacture of scheduled substances **exclusively to medical and scientific purposes**. The three Conventions enjoy quasi-universal adherence: Member states are legally bound by the Conventions, and their drug laws cannot, in theory, authorise the recreational use of scheduled drugs⁶⁴. The approach can therefore be qualified as prohibitionist.

⁶³ Some studies estimate that as many as 27% of Chinese adults were addicted to opium (International Opium Commission, 1909 in United Nations & ONUDC, 2008)

⁶⁴ All the countries whose strategies are examined in this report are members of these conventions.

However, treaty interpretation reveals a certain amount of latitude in how these obligations are understood. On the one hand, the Conventions do not oblige countries to impose criminal or administrative penalties for **consumption** per se. While the Conventions do oblige their parties to impose penalties when **possession** is for the purposes of trafficking, the **decriminalization**⁶⁵ of the possession of small amounts for personal use is consistent with the treaties. However, the treaties do seem to impose an obligation on their signatories to prohibit drug possession, at least by means of administrative sanctions, although the original scope of what was originally provided for under the treaties appears to have been expanded by state practices over time (Bewley-Taylor & Jelsma, 2012).

At the same time, negotiations are also taking place at the international level. The United Nations General Assembly convened a special session on drugs (UNGASS) in 1998. Another UNGASS was scheduled for 2019 but, due to a request by the presidents of Colombia, Guatemala and Mexico for a conference on drug policy reform, was moved forward to 2016 (IDCP, 2014), a reflection of the urgency of the need states feel to discuss the issue.

UNODC Executive Director, Yuri Fedotov, has encouraged Member States to use this session as an opportunity to discuss ways of rebalancing international drug control policies to focus on health and respect for human rights, and to address the stigma and discrimination that limits access to services by people who use drugs (UNODC, 2013 in UNDP, 2015).

For its part, the UNDP (2015) has recommended the adoption of a new system of metrics to assess the effects of drug strategies. The Program recommends replacing the practice of measuring success by "arrests and seizures"—which creates perverse incentives for law enforcement and may encourage the use of violence or other forms of abuse to achieve these goals—by other metrics such as:

- goals that address the root causes of supply and demand for drugs
- targets aimed at ensuring "the health and welfare of mankind" (through access to treatment and a reduction in disproportionate punishments, for example); and
- indicators related to the affected communities (level of social and economic development, inequality, etc.) to be measured with the communities' participation

⁶⁵ "Drug use and/or possession, production and cultivation for personal use are no longer dealt with through criminal sanctions, but drug trafficking offences remain a criminal offence. Under this legal regime, sanctions may be administrative or may be abolished completely" (IDPC, 2012b, p. 25). Indeed, UNODC (2014) stresses that such offences need not necessarily lead to punishment but may instead be addressed through more effective alternatives such as social protection, treatment, and reintegration into society.

The national policies of the countries studied in this report must therefore be understood in this context, in which it has been decided at an international level to adopt an approach to drugs that bans recreational drug use. This interpretation has caused a large number of countries to adopt a punitive approach. Currently, however, a number of debates are underway between states and international organizations, questioning the effectiveness of such approaches and highlighting their negative consequences for communities and individuals.

1.2 Repression versus public health: different approaches

Strategies are also influenced by **structural decisions** taken at the national level, which are primarily reflected in the laws in force in each country.

The **laws** governing drug use and possession in the countries studied adopt a prohibitionist approach and are therefore repressive to varying degrees. The United States adopts a relatively strict approach at the federal level that includes prison sentences even for first possession offences (Yeh, 2015). More than half of the inmates in American prisons have been convicted for drug-related offences (US Department of Justice, 2011 in (IDPC, 2012b)). Drug possession is a criminal offence (for all drugs) under Canadian and British laws as well (see [Figure 12.](#)).

However, even in the countries where regulations are repressive, there is a certain amount of leeway for tolerance. In the United States, several states have legalized the use and possession of limited quantities of cannabis for persons over the age of 21, while a significant number of other states have decriminalized it (Drug Policy Alliance, n. d.). In Canada, only 1 to 2% of people who consume illicit substances are arrested for the offence (Fischer et al., 2011). In the United Kingdom, authorities may exercise considerable discretion in implementing the law: police may choose not to arrest an individual for drug possession if they deem it to be in society's best interests not to do so.

Switzerland is in an intermediary position in that the use and possession of cannabis are punishable only by fine (Institut de Santé Globale de l'université de Genève, n. d.), although the possession of other drugs remains a criminal offence (L'Assemblée Fédérale de la Confédération Suisse, 1951).

Finally, Portugal and the Netherlands have the least punitive approaches. In the Netherlands, there is a certain latitude for tolerance regarding the possession of small quantities of hard and soft drugs: individuals will not generally be charged although the drugs will be seized and destroyed (EMCDDA, n. d.). The same room for manoeuvre applies to *Coffee Shops*: while they are technically committing an offence, in reality they are prosecuted only if they do not respect predetermined criteria (EMCDDA, n. d.). This type of tolerance is referred to as **de facto**

decriminalization⁶⁶, which consists of a government order not to apply a criminal law that nevertheless remains in force

The public health approach may be implemented to different degrees.

Portugal's legislation was the first to **decriminalize**⁶⁷ the use and possession of drugs⁶⁸ (Russoniello, 2012). Drug possession is still illegal, but sanctions are administrative, not criminal. The International Narcotics Control Board initially rejected this initiative in 1999 as non-compliant with international treaties.

However, in 2004, it acknowledged that the exemption of possession of small quantities was indeed consistent with the treaties, as the acquisition, possession and abuse of drugs remains illegal (International Narcotics Control Board, 2004 in Russoniello, 2012).

These laws influence the way drug-abuse issues are addressed. Traditionally, drug addiction has been perceived as either a criminal or a public health issue⁶⁹, which implies choosing between punishing or treating the individual.

One of this report's conclusions is that **the public health approach may be implemented to different degrees**. In fact, even though some countries, as we have seen, have particularly repressive approaches to drugs, all the strategies examined incorporate some public health elements. For example, they all allow for the possibility of proposing treatment in place of prison sentences for non-violent drug-related offences—. Similarly, all the laws we have looked at incorporate a measure of repression as even in the Netherlands—where the possession of small quantities is de facto decriminalized—larger quantities may result in prison sentences, and even Portugal provides for administrative penalties.

Switzerland has adopted an approach with a particularly strong public-health focus. Steps have been taken to make treatment accessible to all, resulting in most addicts being integrated into the health network. Similarly, the prescription of pharmaceutical heroin makes it possible to help severely heroin-dependent individuals for whom other therapies have proven ineffective (OFSP, s. d.-b). These two measures help ensure improved patient health, the reintegration of patients into the community, and the reduction of drug-related crime.

⁶⁶ "Drug use or possession for personal use remains illicit under the law but in practice, the person using that drug or in possession of it will not be arrested or prosecuted. (IDPC, 2012b, p. 24)

⁶⁷ "Drug use and/or possession, production and cultivation for personal use are no longer dealt with through criminal sanctions, but drug trafficking offences remain a criminal offence. Under this legal regime, sanctions may be administrative or may be abolished completely" (IDPC, 2012b, p. 25).

⁶⁸ When the amount does not exceed the quantity needed for ten days of individual consumption (Russoniello, 2012)

⁶⁹ As seen earlier in this report, the public health approach holds that drug dependence is a health issue resulting from exposure to drugs by a person with pre-existing psychobiological vulnerabilities, and that punishment is therefore not an appropriate response (Chandler et al., 2009, Dackis and O'Brien, 2005, McLellan et al., 2000, in UNODC, 2010)

In Portugal, the decision to decriminalize was driven by the realization that drug-related resources were being focused on repression, and that the attached stigma and fear of prosecution were barriers to treatment (Russoniello, 2012). Decriminalization has allowed for the adoption of an approach centred on public health, in which drug users are no longer considered offenders but rather persons requiring care. This vision is endorsed by UNODC which recognizes that drug prohibition has harmful consequences, especially as "the focus on law enforcement may have drawn away resources from health approaches to what, ultimately, is a public health problem" (UNODC, 2008 in ICPC, 2010, p. 76).

A second conclusion is that **the difficulty involved in implementing a public health approach varies depending on the laws in place**. Highly repressive approaches may make access to treatment more difficult for drug users. It is also evident that the non-imposition of criminal sanctions is no guarantee of a public health approach. Decriminalisation must be accompanied by specific health measures. In the Netherlands, possession of a small quantity of drugs does not result in the individual being arrested but rather in the drug being seized and the individual diverted to a treatment agency. However Portugal, which considers drug use an administrative offence, has established panels to determine the best way to assist the individual drug user in overcoming or avoiding drug dependence. This approach, although more punitive than that of the Netherlands (in that it involves the imposition of administrative penalties as opposed to no penalty at all), places greater emphasis on improving drug user health, due to a system that makes it possible to evaluate drug users' needs on a case-by-case basis, diverting individuals to the most appropriate form of treatment for them.

Finally, it would appear that **strategies have different objectives**. On the one hand, the strategies of Canada, the United Kingdom, and the United States are designed to produce **abstinent** societies. On the other hand, those of Australia, the Netherlands and Switzerland focus more on **reducing the harms** associated with drug use. For example, the Swiss strategy states that [Translation] "the most important outcomes are the decrease in deaths caused by drug use, the reduction of crime, the improved health of drug dependent individuals, and the disappearance of scenes of open drug use" (FOPH, n. d.-a). Achieving abstinence in society as a whole is not one of its objective as such.

| Country | Strategy's ⁷⁰ objective (for drug users) | Legislation (personal drug use) |
|--|---|---|
| Australia <i>A Framework for Action on Alcohol, Tobacco and Other Drugs</i> | Harm reduction | Criminal offence (decriminalisation of cannabis in some states) |
| Canada <i>National Anti-Drug Strategy</i> | Abstinence ⁷¹ | Criminal offence |
| United States <i>The National Drug Control Strategy</i> | Abstinence | Criminal offence (legalization and decriminalization of cannabis possession in some states) |
| Netherlands No policy. Different legal frameworks. | Reduction of drug use and its negative consequences for the individual and society | In general, there are no penalties for use, although drug use is prohibited in certain locations such as schools and public transportation Possession: Criminal offence ■ Petites quantités : Small quantities: <i>De facto</i> decriminalisation of possession ⁷² but drugs are confiscated and a treatment agency consulted. ■ Larger quantities: may involve prison sentences <i>Coffee Shops</i> technically represent an offence, but in reality are prosecuted only if they do not respect the 5 predetermined criteria (EMCDDA, n. d.). |
| Portugal <i>The National Plan for the Reduction of Addiction Behaviours and Dependencies</i> | Reduce the use of drugs among the population and their negative social and health consequences (Douglas, Wodak, & McDonald, 2012) | Decriminalization of drug use and possession ⁷³ |
| United Kingdom <i>Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life</i> | Abstinence | Criminal offence ⁷⁴ |
| Switzerland <i>The Four-Pillar Strategy</i> | Reduction of drug use and its negative consequences for the individual and society | Consumption and personal possession of cannabis is punishable by fine. Possession of other drugs: criminal offence |

Figure 12. Structural decisions associated with the different strategies

⁷⁰ These objectives are interpretations of the strategies.

⁷¹ The Canadian government seeks to eliminate the use of illicit drugs and the abuse of prescription drugs (C4, 07.04.2015)

⁷² Less than 0.5 grams of hard drugs and less than 5 grams of soft drugs

⁷³ When the amount corresponds to 10 days of individual consumption

⁷⁴ Consumption is not an offence (with the exception of opium use), but possession is.

1.3 Integrated strategies

All the strategies, and especially those of Canada and the United States, are linked to **separate policies** that are not part of the strategy. Canada's NADS is closely tied to its *National Crime Prevention Strategy* and *Youth Gang Strategy*, in recognition of the fact that illicit drug use is a risk factor for crime. Likewise, the government of the United States emphasizes that it considers the prevention of specific issues—drug use, violence, crime, and gang membership—to be interconnected and that these issues must be addressed simultaneously by multisectoral, interagency programs.

On the other hand, drug strategies sometimes conflict with other national policies. For example, one of the problem areas in Switzerland that was identified in the interviews concerns the fact that while migrants are one of the high risk groups that should receive special attention under the strategy, this is made difficult by a restrictive approach to migration that sometimes causes foreigners to have limited access to harm reduction services (see especially Première Ligne, n.d., and S4, 04.05.2015).

a) Horizontal integration

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Approaches may also be integrated **across the various components** of a strategy. Switzerland places special emphasis on collaboration between its four pillars, for example by encouraging coordination between law enforcement and harm reduction elements to avoid conflicting policies⁷⁵. The Swiss strategy also stresses the importance of multisectoral collaboration in addressing drug dependence issues. This collaboration was apparent in the interviews, with

⁷⁵ Such as distributing syringes (harm reduction) only to have them confiscated by the police (law enforcement) (see previous example).

officials presenting a comprehensive view of the strategy. In Portugal, the fact that the people who drafted the strategy are currently in key positions with regard to its implementation helps ensure the strategy's integrated vision is respected.

The interviews revealed that Canada's strategy is highly compartmentalized. The individuals responsible for each sub-component are specialists in their field and do not necessarily understand the strategy as a whole. Moreover, although the DSCIF and the NCPS engage in similar prevention activities, the methods they use to select programs for implementation and evaluate them are different.

Finally, in both Australia and the Netherlands, drug strategy is relatively ill-defined at the national level, precluding integration of the various components. Indeed, in the Netherlands, instead of a formal strategy, there is more of a philosophy that is applied via different legal frameworks. This prevents uniformity and impedes coordination.

b) Vertical integration

Strategies may be **centralized** or **decentralized**, resulting in greater latitude for local authorities (provincial governments, municipalities, etc.).

Portugal and the United States have largely **centralized** approaches. In Portugal, the strategy's planning and implementation is the purview of the national government. In the United States, the approach to prevention is determined at the national level, thereby ensuring that the same programs are found in every state.

In Canada, some aspects are centralized, and others decentralized. The federal government plays an important role in prevention, allocating funding, selecting projects, and overseeing implementation. However, provinces enjoy greater autonomy with regard to treatment.

The United Kingdom (particularly England), the Netherlands, Australia and Switzerland have more **decentralized** approaches.

In England⁷⁶ and the Netherlands, considerable powers are delegated to municipal governments. In the Netherlands, prevention is the responsibility of municipalities. Likewise, in Switzerland, the Confederation assumes a subsidiary role, with cantons playing a key role in areas such as drug policy. However, the strategy includes four cross-sectoral tasks to ensure approaches are harmonized: coordination; innovation; quality enhancement/further training; and improving scientific knowledge (FOPH, 2012).

⁷⁶ The other nations in the United Kingdom have not adopted a local approach, and the central government maintains a leadership role in this area (RU3, 27.04.2015).

According to the information gathered, Australia has a somewhat vague national strategy, leaving it up to states and territories to develop local strategies. The interviews revealed that the national vision of the Australian antidrug strategy is not very well defined. However, the local (state) governments appear to have adopted more comprehensive views for the strategy.

The *decentralized* approach may allow for a better understanding of local contexts, resulting in more targeted interventions. However, it may also produce a certain nationwide disparity in interventions and lack of coordination. For example, the Australian strategy is sometimes considered too "vague", and not sufficiently binding as it lacks an accountability mechanism for decision-makers (McDonald, David, 2011). It should be noted that whether a country is federal or not does not necessarily determine whether its drug policy is decentralized or not.

1.4 Substances considered to be drugs

All the countries include psychotropic substances under international control in their strategies, in accordance with the three conventions previously cited (OICS, 2014). Some have chosen to include only illicit drugs, while others also include legal drugs such as alcohol and tobacco.

Several studies (Golub & Johnson, 2001; Wagner & Anthony, 2002 ; Pudney, 2002; Kirby & Barry, 2012) indicate that the earlier an individual uses psychoactive substances, the more likely it is the person will develop a substance abuse disorder later in life. Also, according to the information collected from the interviews, due to the frequency of polydrug use among young people and the common risk factors for drug and alcohol use, it is difficult to treat drug addiction without including alcohol. **Due to all these reasons, as well as the close link between drug addiction and addictions to other substances, it is not surprising that some national strategies include substances other than illicit drugs in their approach.** This is true of Australia, the United States, Portugal and the United Kingdom, for example.

| COUNTRY | DRUGS | ALCOHOL | TOBACCO | PREScription DRUGS | NPS | OTHERS |
|----------------|---------------------------|---------|---------|--------------------|-----|----------------------------------|
| Australia | | | | | | |
| Canada | | | | | | |
| United States | | | | | | |
| Netherlands | Hard drugs vs. soft drugs | | | | | |
| Portugal | | | | | | Doping Compulsive gambling |
| United Kingdom | | | | | | |
| Switzerland | | | | | | |

Figure 13. Scope of national drug strategies

In the case of Portugal, the current strategy (2013-2020) differs from the previous one (2005-2012) in that, in addition to alcohol and other drugs, it also addresses two other addictive behaviours: **doping and gambling**. Some national strategies, notably those of the United States and—as of very recently—Canada, also address **prescription drug abuse** as an important youth issue (ONDCP, 2014; Minister of Justice - Government of Canada, 2015).

New psychoactive substances (NPS)—new substances not controlled by international conventions—are another issue that must be addressed by drug strategies (Evans-Brown et al., 2015). As updating the law after the discovery of a "new drug" is a relatively lengthy legal process, states are sometimes obliged to adopt alternative measures to ensure the law is effectively enforced. To accelerate legal processes, some countries, such as the United Kingdom for example, have introduced temporary control regimes that can be used while determining whether permanent controls are necessary (EMCDDA, 2015). Temporary Class Drug Orders (2011) permit the British Government to control a NPS for a period of one year when a substance is misused or likely to be misused and when there a possibility of harmful effects (Drugnet Europe, 2011). The United States has adopted an analogue approach permitting it to manage NPS under current legislation by modifying or extending existing laws. Similarities in pharmacological activity or in the chemical structure of NPS permit them to be regulated in the same way as controlled drugs (ONDCP, 2014; EMCDDA, 2015; HM Government, 2010). According to the information collected, the other strategies do not extend to NPS.

2. Youth-related aspects of the strategies

This section presents a comparative analysis of seven strategies and, in particular, of their approaches to young people. All the strategies analyzed recognize the importance of including youth into the strategy and developing initiatives in response to the specific needs of young people. Some strategies concentrate more on young people than others. This is especially true for the **Canadian and American strategies**, in which young people are at the core of each component, both strategies being underpinned by the observation that early prevention, if provided in time, can divert individuals from a delinquent trajectory.

While the strategies of Australia, the Netherlands, Portugal and Switzerland admittedly acknowledge the need to include young people in prevention programs, they do so more indirectly. The **Australian approach**, for example, focuses specifically on vulnerable individuals likely to experience greater exposure to drugs during transitional stages in their lives, such as adolescence. Young people are therefore considered an at-risk group and, as such, are targeted under the strategy. **Portugal's** lifecycle approach is along similar lines, with considerable importance being placed on childhood and adolescence as key periods for the onset of drug use, while Switzerland's strategy recognizes the importance of strengthening protective factors in young people.

According to the series of indicators presented earlier in this report for judging the effectiveness of youth prevention programs, effective programs incorporate (Shaw, 2007, p. 8):

- a. Inclusive approaches which reduce youth marginalization;
- b. Participatory approaches;
- c. Integrated multisectoral strategies;
- d. Balanced strategies which include early intervention, social and educational programs, restorative approaches and crime control;
- e. Targeted and tailored strategies and programs to meet the needs of specific at-risk groups;
- f. Approaches which respect the rights of children and young people⁷⁷.

The importance of strengthening protective factors through prevention programs, including alternatives to incarceration, has also been pointed out (Shaw & Travers, 2007).

In the following sections, we will examine how the different strategies meet these criteria.

⁷⁷We have not included a specific section to address this point as the strategies examined here have no significant problems on this level. It should be remembered however that treatment must be voluntary.

2.1 Approaches incorporating social inclusion and the reduction of marginalization

The tendency for substance abuse problems to be highly concentrated among a society's most marginalized groups appears to exist in all societies throughout the world. Marginalization is in fact associated with numerous risk factors (IDPC, 2012a).

The *International Drug Policy Consortium* notes that levels of poverty and inequality in a society have a greater long-term impact on drug use in any society than do specific drug policies (IDPC, 2012a). Thus, this component is crucial to preventing drug use.

All the strategies examined are aimed at reducing marginalization and social exclusion.

All the strategies examined are aimed, either **explicitly** or **implicitly**, at reducing marginalization and social exclusion. However, it should be noted that while this objective includes young people, it concerns the population as a whole and is not necessarily focused on young people per se.

The strategies that mention these aspects explicitly are those of Australia, Portugal and Switzerland. Australia has a broad, multisectoral vision of the importance of marginalization, and recognizes social integration as one of the elements that helps reduce the demand for drugs. Social integration is a multisectoral component of Portugal's prevention strategy as well⁷⁸. Meanwhile, the Swiss action plan explicitly mentions the importance of social integration in both its 'Therapy' and 'Harm Reduction' components.

Most of the other strategies do not specifically mention the reduction of marginalization as an objective. However, all the strategies include activities—such as job-seeking support, housing assistance, poverty reduction, and support for families—that implicitly correspond to the definition of this concept.

Examination of the strategies reveals that the reduction of marginalization—whether mentioned explicitly or not—is operationalized at three different stages: before an individual develops a substance use disorder, while the person is in the throes of addiction, and after the completion of treatment. The various countries studied concentrate on different aspects.

Reduction of marginalization **before a person develops a substance use disorder** is achieved in most of the policies studied via the creation of more inclusive communities, based on a recognition of the extent to which an individual's environment influences the development of substance use disorders. It receives particular attention under the Portuguese strategy, which comprises a vast program that makes it possible to identify the regions of the country where young people are most likely to adopt addictive behaviours, and is designed to help ensure these young people are integrated into the community.

⁷⁸ Portugal's strategy is based on a humanitarian principle recognizing the importance of social inclusion.

Similarly, although Canada and the United States do not specifically cite the reduction of marginalization as an objective in their strategies, they do incorporate it into their prevention programs, notably through efforts to increase school and neighbourhood attachment, and to foster relations with pro-social peers.

The United Kingdom's strategy places comparatively strong emphasis on families in difficulty, focusing on social support to reduce marginalization and prevent parental drug use. Young children receive special attention to ensure they do not develop drug dependence issues later on. Likewise, the strategies of the United States and the Netherlands specify that it is important to provide support to children whose parents have addiction problems in order to avoid the perpetuation of marginalization from one generation to the next.

Steps may also be taken to reduce marginalization **while a person is in the throes of addiction**, especially through employment support, reintegration into the health care system, and housing assistance. According to the information gathered, the strategies that concentrate most on this aspect are those of Switzerland and the Netherlands.

Under the Swiss policy, support is provided to people with drug addictions to help them be reintegrated into the health care system and obtain employment. It should be remembered that this is a flexible approach, ranging from professional reintegration to help obtaining work as a day labourer, depending on the individual's resources and level of drug dependence. The Netherlands' approach allows for housing to be provided to homeless people, with one of the stated aims being to reduce substance abuse.

Finally, the reduction of marginalization **after the completion of treatment** helps consolidate abstinence by providing individuals with the opportunity of (re)integrating fully into the community.

All the strategies specifically incorporate reintegration but to varying degrees. It is a cornerstone of the United Kingdom's strategy, which devotes an entire component—'Building Recovery in the Community'—to it. This component views reintegration as comprising three elements: access to housing; involvement in sustainable, stable activity; and the ability to form positive relationships (HM Government, 2010). These components are considered crucial to maintaining long-term abstinence. Reintegration also plays an important role in the strategies of Australia, the United States, Portugal and Switzerland. For example, in light of the fact that society often adopts a negative view of people with substance use disorders, Portugal, Australia and the United States have placed considerable emphasis on reducing this stigma in order to facilitate reintegration. According to the information collected, Canada places comparatively less emphasis on post-treatment reintegration than the other countries studied⁷⁹. Indeed, we were unable to identify any

⁷⁹ At the federal level, at least.

reintegration initiatives based on the interviews we conducted and our study of the federal strategy.

Finally, some policies may have actually increase social exclusion (IDPC, 2012b). As seen in the, Portugal decided to decriminalize possession for personal use precisely in order to avoid stigmatizing drug users and giving them a criminal record, as both make their reintegration, especially into the workforce, much more difficult.

2.2 Youth participation in prevention programs

UNODC states that the general objective of drug addiction prevention is much broader than avoiding or delaying the initiation of drug use among young people, or avoiding having them develop substance use disorders. Rather, "**it is the healthy and safe development of children and youth to realize their talents and potential becoming contributing members of their community and society**" (ONUDC, 2013b, p. 4). In order to achieve this, it is important not only to develop strategies targeting young people but also to involve youth via a participatory approach, whether in data and information collection, problem analysis, solution identification, or program implementation. Young people are therefore not only a beneficiary group of drug-related strategies; they also have an important role to play as contributors to the development and ongoing improvement of such strategies.

Youth participation in drug strategies and prevention programs results in positive outcomes such as decreased rates of substance abuse, lower crime rates, improved academic performance, and more meaningful connections between young people and their communities (Council on Drug Abuse, n.d.). It also helps ensure the development of strategies better suited to the unique needs of young people, and while their contributions serve to inform policies.

Youth program participation is exemplified by the United States' community coalitions and leadership programs⁸⁰, which help mobilize young people and make it possible to consult them in order to improve the drug strategy. Some Dutch projects, such as the ones aimed at preventing drug use in nightlife settings, also actively involve young people in their development. Young people take part in information gathering, problem analysis and solution identification, primarily through their participation in focus groups (PB2, 11.05.2015).

In the United Kingdom, young people's participation is regularly used to improve the Talk To FRANK campaign. Young people were also consulted in Australia on the development of the National Anti-Drug Campaign. Canada, meanwhile, has adopted a participatory approach at all stages of prevention program implementation. In Switzerland, although there is recognition at the

⁸⁰ National Youth Leadership Institute

federal level that good prevention programs must be participatory, due to cantonal autonomy it is impossible to guarantee that all programs are in fact participatory.

2.3 Integrated multisectoral approaches⁸¹

An integrated multisectoral approach makes it easier to ensure the same outcome objectives when approaching an issue from different angles, and thus to develop a more comprehensive response.

An integrated multisectoral approach to (primary and secondary) drug prevention is one in which programs are conducted in close collaboration and in an integrated manner with parents, police and the community (see, for example Shaw & Travers, 2007). As was pointed out in the first part of this report, the most effective prevention strategies are those that target more than one risk factor, involve the entire community, and incorporate coordinated activities throughout childhood and adolescence.

As was mentioned previously, our study of the seven strategies has highlighted the fact that implementation of drug prevention programs may be either *centralized* or *decentralized*. Implementation that is decentralized becomes the responsibility of local communities, making it impossible to determine at a national level whether approaches are multisectoral and integrated or not.

However, as Portugal, the United States and Canada have **centralized** approaches, it is possible to assess whether their strategies employ a multisectoral integrated approach at the national level.

The strategies of Portugal and the United States do indeed incorporate an **integrated multisectoral approach**. Portugal funds *integrated response programs* that are required to provide intervention addressing multidimensional issues, including illicit drug abuse. The same is true of the United States where, according to the information collected from the interviews, approaches must be multisectoral and integrated, addressing several issues simultaneously with the involvement of a myriad of partners.⁸²

Canada also advocates an integrated multisectoral approach, especially through its *Canadian Standards for Youth Substance Abuse Prevention* which ensure the implementation of programs that respect this criterion. Furthermore, the government has also made sure the DSCIF (under the National Anti-Drug Strategy) and the NCPS (National Crime Prevention Strategy) operate in concert, in recognition of the overlap in the issues they address. However, the two funds do not

⁸¹ The integrated multisectoral approach falls outside the scope of this section. The focus here is mainly on primary and secondary prevention programs targeting young people. Part 1.3 addresses strategy integration in the broader sense.

⁸² It should be pointed out that determining whether initiative implementation truly is multisectoral and integrated at the local level is beyond the scope of this report.

share the same program selection criteria, nor do they evaluate programs in the same way, which may detract from the comprehensive approach to prevention.

The countries with a **decentralized** approach are primarily England, the Netherlands, Australia and Switzerland. One of the consequences of decentralization is that **there is no integrated multisectoral vision at the national or federal level, but this does not exclude the possibility that such a vision exists at the local level**. However, according to the information collected, none of these strategies seem to place particular emphasis on this element. This is especially true of the Netherlands, which has no national strategy.

2.4 Resource allocation: balanced strategies

ECOSOC recommends that countries make certain when developing their drug strategies that their strategies are balanced, in order to ensure they will be effective.⁸³ A strategy must, on the one hand, **allocate its budget equitably** and, on the other, **use several different and complementary types of approaches**, including early intervention, social and educational programs, restorative approaches, and crime control.

It is clear that, from a financial perspective, **the countries analyzed in this study give a larger budget to law enforcement than to prevention**.⁸⁴ However, the percentage of the budget allotted to each component varies significantly from one country to the next. While prevention receives as little as 1.9% of the strategy's budget in the Netherlands and 5.1% in the United States, in Australia it receives 23%. Law enforcement and the fight against trafficking receive the majority of the budget for all the strategies: for example, 50.7% in the United States and 75.33% in the Netherlands. Most of the countries do not include harm reduction in their budgets, with the exception of the Netherlands (10.07%) and Switzerland (5%).

Even if a preventive strategy focuses on evidence-based initiatives, if the budget devoted to prevention is small, such initiatives will remain limited in scope. The United States' strategy (2014) is a good example of this: at first glance, it would appear that the United States advocates integrated holistic approaches that allow for high quality interventions, but when one takes a step back, one realizes that prevention interventions are not actually a priority, receiving a total of 5.1% of the entire budget.

Aside from the budgetary calculations regarding the various strategies, there are other findings worthy of note. We observe that while the **majority of interventions are family-based** in the United Kingdom, **communities are at the core of interventions** for all three kinds of prevention in the United States. Switzerland concentrates on identifying at-risk youth through individual

⁸³ Resolution 2002/13

⁸⁴ For various reasons, we were unable to obtain the budgets for Portugal and Switzerland, but our research nevertheless enabled us to identify budgetary priorities.

interventions rather than through programs as is done in other countries. According to the information collected, Canada places little importance at the federal level on reintegration, while in the Netherlands, Switzerland and the United Kingdom, it is a priority.

In sum, we note that, based on the allocation of funding, **prevention is not the main priority of any of the strategies**, despite UNODC's assertion that "the focus on law enforcement may have drawn away resources from health approaches to what, ultimately, is a public health problem" (UNODC, 2008 in (ICPC, 2010, p. 76).

2.5 The special needs of at-risk groups

The United Nations stresses the **importance of including vulnerable populations in the analysis of problems and the identification of solutions in order to better meet their special needs** (UNDCP, 1998). The *Declaration on the Guiding Principles of Drug Demand Reduction* states that attention must be paid to meeting the special needs of certain at-risk groups:

Demand reduction programs should be designed to address the needs of the population in general, as well as those of specific population groups, paying special attention to youth. Programs should be effective, relevant and accessible to those groups most at risk, taking into account differences in gender, culture and education.⁸⁵

Most of the countries in the study share a similar understanding of what comprises an at-risk group, i.e. a **specific subpopulation whose members' risk of developing substance use disorders, either in the short term or during their lifetime, is significantly higher than average**. This heightened vulnerability to drug use is often the product of social exclusion. UNODC has pointed out that the advantage of working with such at-risk groups is the fact that they have already been identified in part due to the contexts and places in which they find themselves: they live in certain areas (indigenous reservations, disadvantaged neighbourhoods, etc.) and engage in certain occupations (such as prostitution and pan-handling) (UNODC, 2004).

While this observation holds true from one country to the next, it is clear that **the at-risk groups that drug strategies need to take into consideration vary depending on the social or cultural context**. In terms of the strategies themselves, we note that certain countries identify targeted at-risk groups more clearly than others. This is the case, for example, for the United States, which explicitly targets Native communities; it is also true of the Netherlands, which places special emphasis on homeless populations. Both also consider children of drug-dependent parents an at-risk group. The Australian strategy, although decentralized at the provincial and territorial level, explicitly focuses on indigenous peoples.

⁸⁵ Resolution A/RES/54/132

Identification of the at-risk groups targeted under other strategies requires more research.

In the case of Canada, examination of the different programs and available funding as well as of the strategy's evaluation makes it possible to identify at-risk groups, such as Aboriginal peoples. In Switzerland, programs targeting specific at-risk groups are rare, although a number of programs have been established that focus especially on **migrants**.

Having identifying the at-risk groups targeted in each strategy, we are able to observe that **Aboriginal communities** are priority at-risk groups in Australia, Canada, and the United States. Obviously, the distinctive nature of this aspect of these three national strategies is due to the fact that this segment of the population exists in these countries and not in others.

From the information that was collected, it is apparent that **gender differences** are not taken into account in any of the strategies other than Switzerland's, which seems to do so on a purely theoretical level.⁸⁶

2.6 Alternatives to incarceration

Currently, there is an international trend towards **encouraging the use of alternatives to incarceration when diverting individuals from drugs** (IDPC, 2012). Given the inherent costs of incarceration and its lack of effectiveness as a deterrent, countries are tending to move away from an approach based on widespread arrests and severe penalties, and towards a public health approach. Under the latter, individuals struggling with addiction issues are not to be punished, but rather to be encouraged to enter evidence-based treatment programs, thereby making it possible to reduce pressure on criminal justice systems and achieve better health and social outcomes (IDPC, 2012). This is particularly true in the case of young people.

All countries analyzed include alternatives to incarceration in their strategies. We will come back to this in the section on tertiary prevention.

2.7 Connections between drugs and mental health

As mentioned in the first part of this report, there is a strong correlation between mental illness and addiction, with individuals suffering from one being more likely to suffer from the other as well. When both are present at the same time, they are called *concurrent disorders* or *comorbidities*.

Based on the information collected, all the strategies examined appear to reflect an awareness of the connection between addiction and mental health issues, as well as of the need to treat them

⁸⁶ It is nevertheless possible that many of the strategies' implementation programs may, in fact, include a gender component.

together. More specifically, we have identified four types of approaches used to address concurrent disorders:

- Addiction is treated as a mental health disorder,
- There is close collaboration between the treatment of addiction and the treatment of mental health disorders.
- People with concurrent disorders who are treated for drug addiction are referred to mental health facilities.
- Mental health issues are addressed in the strategy in an ad hoc manner.

At one end of the spectrum, the approach adopted by the Netherlands **views addiction as a mental health issue**, with addiction treatment being the responsibility of the *Dutch Association of Mental Health and Addiction Care*. The same is true of the United States where the agency responsible for matters pertaining to substance abuse is also responsible for overseeing the treatment of mental health disorders: the *Substance Abuse and Mental Health Services Administration* (SAMHSA). The Australian approaches to drugs and mental health are also highly integrated as the drug strategy is an integral part of the National Mental Health Plan. The government has adopted an integrated 'whole-of-government' approach by interconnecting different departments and levels of government.

Switzerland advocates joint treatment for concurrent disorders, whether through facilities that treat individuals with addiction issues (by integrating mental health care), or through **close collaboration** between specialized addiction facilities and psychiatric facilities. To ensure integrated care for dependent individuals, the QuaTheDA (Quality, Therapy, Drug, Alcohol) quality standard includes criteria requiring professional collaboration with psychiatry as well as with all social and health care agencies.

Other strategies do not address the issue of mental health directly, but favour collaboration with specialized services instead. This is the case in the United Kingdom and Portugal where, when patients with addiction issues are diagnosed with mental health disorders, they are **referred to another national care network**.

Finally, in Canada, according to the information collected, **mental health is addressed in an ad hoc manner** under the strategy. The decision is left to the discretion of the different programs: the DSCIF may include mental health care in its funding priorities, and DTCs may enhance treatment outcomes by leveraging their mental health partnerships, while the *Drug Treatment Funding Program* may provide funding for treatment programs for individuals with more serious mental health issues.

3. Prevention of drug-related crime

In the introduction to this report, we identified three ways of preventing crime committed either while under the influence of drugs or in order to acquire drugs:

- the prevention of illegal drug use;
- the prevention of recidivism; and
- harm reduction (prevention of drug-related risk behaviors).

Here, we will examine how the different national strategies address these three types of prevention.

3.1 Drug use prevention

The prevention of illegal drug use is an obvious way of preventing drug-related crime. It should be pointed out that, as was mentioned previously, drug use and crime have a number of risk and protective factors in common. Prevention programs may therefore have an effect on these common factors.

We will examine the prevention of illegal drug use in two parts: first, we will present a general overview of prevention (both primary and secondary), and second, we will discuss the various intervention agents employed: media campaigns and social media, school staff, law enforcement officials, and communities.

a) An overview of prevention

Primary prevention

The aim of primary prevention is to prevent drug use in the entire population. It is non-targeted intervention, aimed at raising drug awareness among all individuals, whether they are at risk for drug use or not.

The section on primary prevention will be divided into two parts: the first will examine it in terms of the target audience, the second in terms of the information strategy adopted.

Target audience

Our study of the seven strategies identified five ways of implementing primary prevention: through schools, through families, in the community, by focusing on a particular group, or by addressing a broader public through media campaigns.

First, it should be pointed out that all the strategies examined in this report include primary prevention in **schools**. This is not surprising given that, as we saw in the first part of this report, the majority of government implemented anti-drug initiatives worldwide are school-based. This can be explained by the considerable importance placed on youth prevention. This type of prevention can, for example, permit young people to be taught how to resist peer pressure to use drugs, or to learn the importance of a healthy lifestyle. However, it should be noted that, as seen

earlier in this report, evaluations of school-based initiatives tend to show that such intervention has little effect if carried out in isolation and that it is most effective when it used in tandem with other components of community-based prevention.

Second, primary prevention is carried out through **families**. More than any other country's strategy, the United Kingdom's places particular emphasis on providing support to vulnerable families and young children to avoid parental drug use resulting in later drug use by children. This is an evidence-based approach given that, as noted in the introduction to this report, family influence is one of the most important risk or protective factors for drug use.

Third, in Portugal especially, primary prevention is carried out through **community** interventions (such as PORI) aimed at addressing drug issues holistically.

Fourth, the Netherlands has implemented an intervention program targeting **a particular group**: the «Nightlife⁸⁷» program is aimed at educating young people and their parents about the harmful effects of drugs.

Finally, primary prevention is targets a broader audience through **media campaigns**⁸⁸. Four of the strategies⁸⁹ include national campaigns aimed at preventing drug use. Furthermore, all of the strategies involve the use of telephone hotlines, websites and/or social media to provide information to young people and answer their questions.

Information strategies

Strategies may address drug use prevention either by talking **specifically about drugs** or by adopting a **broader framework** not restricted to drugs. All the strategies studied would appear to recognize the importance of a holistic approach that addresses risk and protective factors for drug use. For example, the United States' strategy includes programs that promote a healthy lifestyle, while Portugal's PORI provides funding to organizations that implement systemic projects.

There are two main approaches to primary prevention which are sometimes combined. On the one hand, there are initiatives designed to **inform people of the dangers** of drugs and which use fear to discourage drug use, while on the other, there are initiatives designed to **develop social resistance skills**. It should be remembered that evaluations have tended to show that using fear with young people does not reduce drug use.

⁸⁷ Switzerland also has a "night life" program, but it focuses more on secondary prevention.

⁸⁸ School-based interventions, community-based interventions, and media campaigns will be discussed in greater detail later in this report.

⁸⁹ Those of Australia, Canada (indirectly), the United States, and the United Kingdom

Australia, Canada and the Netherlands⁹⁰ place particular emphasis on **presenting the risks** associated with drug use. In Australia, this information is transmitted primarily through media campaigns (via video, radio, and information materials) that focus on the devastating effects drugs have on the lives of individuals and their families. The Canadian government uses the Royal Canadian Mounted Police's 'Public Engagement' program as well as mass media campaigns on drugs⁹¹ to underscore the dangers of different drugs and the connections to serious offences and organized crime. Finally, in its 'Nightlife' program, the Netherlands focuses primarily on the dangers associated with drugs.

On the other hand, the strategies of the United Kingdom and the United States concentrate more on building **social resistance** skills for resisting peer pressure. Their campaigns—'Talk to FRANK' and 'Above the Influence', respectively—recognize the social pressure young people are under to use drugs, and present tools to help them resist it. The United States' campaign, in particular, concentrates on encouraging young people to make their own choices, rather than scaring them with the negative effects of drugs. According to interviewees, Switzerland also recognizes that school-based interventions need to focus on building young people's social resistance skills and that presentations on the risks associated with drugs are at best useless and at worst counterproductive. Portugal's strategy is likewise focused on systemic primary prevention that addresses the different risk and protective factors through efforts to reduce the first and reinforce the second.

Secondary Prevention

Secondary prevention targets children and young people identified as being at risk of drug use or having already begun occasional use.

Two distinct approaches are especially apparent in the strategies examined, the first being the use of school-, family- and community-based **intervention programs**, and the second being the **training of professionals** (e.g. school staff) who are in contact with young people to enable them to identify at-risk individuals and help the latter obtain the appropriate type of support.

Canada's strategy essentially reflects the first approach—the use of **intervention programs**. One advantage of such programs is that they can help identify and address the underlying social causes of drug use (IDPC, 2012a), such as low self-esteem or weak social skills. According to our information, Australia has also adopted such an approach, providing federal and state funding for this type of intervention. Such programs are generally normed and standardized, and amenable to evaluation.

⁹⁰ It should be pointed out that these different strategies incorporate the strengthening of social resistance skills, but more through secondary prevention.

⁹¹ It should be remembered that these campaigns are not part of the NADS, despite sharing common objectives.

The United Kingdom⁹² also advocates the use of intervention programs. The government leaves the choice of such programs up to local authorities, and provides financial support for the process while also supplying advice and evidence on effective intervention. The strategy repeatedly states that family-based interventions are especially effective both as a means of providing support to parents of young children (through primary prevention) and as a means of helping young people who already have addiction problems and their parents.

The other approach, found especially in the Swiss four-pillar policy, is to **train professionals** who are in contact with young people so that they are able to identify at-risk youth, reach out to them, and refer them if necessary to appropriate support services. No other strategy appears to place as much emphasis on this approach.

The United States has a **mixed** approach, incorporating both types of intervention. On the one hand, there are prevention programs, selected primarily from among 300 assessed programs. On the other, professionals in regular contact with young people are trained to identify those who are drug-involved and intervene appropriately. Portugal also has a mixed approach, with its PORI programs that fund systemic programs, and the 'Me and the Others' program focused on school-based intervention.

Under both approaches, interventions may focus specifically on drugs or more broadly on providing support to help reduce individual and community vulnerability. In other words, programs may **focus more on reducing risk factors and increasing protective factors than on addressing drug issues directly**. This tendency is apparent in all the strategies studied.

b) Prevention providers

This section explores different primary and secondary prevention initiatives involving school staff, law enforcement officials, and communities.

All the strategies assert that their implementation decisions regarding prevention initiatives are evidence-based. Such evidence may come from specialized centers whose work helps shape the strategy⁹³, a scientific branch of the government⁹⁴, or a specific component of the strategy⁹⁵. Canada has the distinction of having developed the *Canadian Standards for Youth Substance Abuse Prevention* to explain "how best to plan, select, implement and evaluate [...] prevention efforts with schools, communities and families" (CCLT, 2014). These standards informed the development of the UNODC's international standards on drug use prevention (ONUDC, 2013a).

⁹² Especially England.

⁹³ For example, in Australia, there is the National Drug and Alcohol Research Center, the National Drug Research Institute, and the National Centre for Education on Training and Addiction.

⁹⁴ Health Canada, for example.

⁹⁵ The cross-sectoral component of the Swiss strategy, "Improving Scientific Knowledge".

Media campaigns and social media

As mentioned earlier, media campaigns are widely used in drug prevention. However, policymakers and practitioners alike **debate the effectiveness of such campaigns to reduce young people's drug use or their intention to use** (EMCDDA, 2013).

As stated in the introduction, the promise of media campaigns lies in their ability to disseminate simple, targeted messages to a broad audience at a low cost per head (Wakefield et al., 2010). Such initiatives have been successfully used to change certain behaviours⁹⁶, but few campaigns on drug use have been formally evaluated. Most assessments focus exclusively on evaluating the understanding and reception of campaign messages. A meta-analysis evaluating the effectiveness of mass media campaigns to influence drug use—based on studies conducted between 1991 and 2011 involving more than 200,000 young people under 26 years of age in Australia, Canada and the United States—found no effect on reduction of use and weak correlation with the intention to use (EMCDDA, 2013).

These factors may explain why several of the strategies examined have **abandoned the use of media campaigns**. In the United States, responsibility for *Above the influence* has been turned over to an NGO, while the Swiss strategy contains no media campaign at all (S1, 22.04.2015).

Despite the arguments against such campaigns, some countries still choose to use this type of primary prevention mechanism. The Canadian 2007-2012 'Drugsnot4me' campaign, for example, has been followed by two other campaigns.⁹⁷

⁹⁶ For example, to reduce tobacco use, promote road safety, or promote healthy eating habits and physical activity.

⁹⁷ It should be remembered that media campaigns on drugs are not a direct part of the Canadian strategy

Other countries rely **on the use of social media** – including Facebook and Twitter—and several European countries encourage the **adoption of a less condemnatory tone** when discussing drugs with young people. One example of this is the United Kingdom's Talk to FRANK campaign. In the United States, the United Kingdom, the Netherlands and Portugal, neutral and objective prevention messages are designed to provide impartial information to help young people make their own decisions about drug use (Hornik, Jacobsohn, Orwin, Piesse, & Kalton, 2008).

School staff

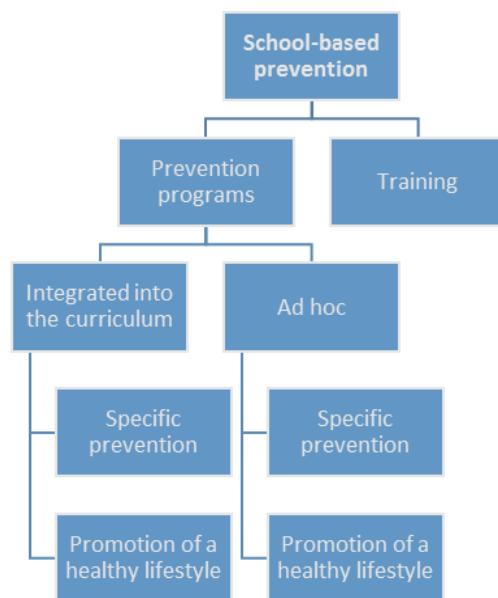


Figure 14. Prevention programs for students.

All the strategies examined include the involvement of school staff in drug prevention activities. We identified two main approaches to school-based prevention in the strategies: **training for school staff**, and **prevention programs** for students.

Training for school staff enables school personnel to incorporate prevention messages into their daily discourse, and to identify at-risk youth and refer them to the appropriate persons for assessment and support. Being in daily contact with young people provides an ideal opportunity for exercising a positive influence over them and intervening in a timely manner.

This is the main approach in Switzerland which, as has been mentioned, stresses the importance of training professionals who are in contact with young people so they are able to intervene when they detect a risky situation. The French-speaking part of Switzerland also has a program involving school mediators, who are trained to intervene to provide individualized support to at-risk youth.

The United States⁹⁸ and the United Kingdom are also committed to assisting teachers by supplying them with knowledge and information on good practices regarding the prevention of illicit drug use. The 'Healthy Schools and Drugs' program in the Netherlands and Portugal's 'Me and the Others' program both offer teachers professional development courses on intervention.

Next, there are the prevention **programs** that are implemented in schools. Such programs may concentrate on enhancing social skills and reducing school drop-out, or focus directly on reducing drug use.

The most notable example is probably D.A.R.E⁹⁹, a program taught in 49 countries (D.A.R.E., n. d.-b)—including the United States (in 75% of the country (D.A.R.E., n. d.-a)), Canada, the United Kingdom and Australia—and aimed at teaching students decision-making skills to help them lead healthy lives¹⁰⁰.

Programs may be **integrated** into the school curriculum nationwide, or **ad hoc** and left to the discretion of the region or school.

In the Netherlands, the inclusion of health promotion in primary and secondary school education is provided for by law, making this approach mandatory. As a result, it is **integrated** into the school curriculum, and applied uniformly nationwide. In Australia, Portugal and the United States, prevention programs are similarly incorporated into the school curriculum.

In Canada, projects are mainly financed through specific funds, making them **ad hoc** and transitory. However, as contradictory as it may seem, the Canadian Standards stress the importance of integrating prevention into daily activities and not restricting it to isolated and sporadic complimentary activities. It would therefore appear that, as a result of the evidence available to it, the government has adopted a stance advocating the integration of prevention programs into the school curriculum, although implementation has not yet occurred.

The fact that in the United Kingdom (especially England), prevention initiatives are left up to local communities, as was seen earlier, makes it impossible to obtain a comprehensive overview. The strategy does however stress the importance of school-based interventions.

Finally, such programs may focus **specifically on the prevention** of drug use, or more broadly on the **promotion of a healthy lifestyle** and on strengthening 'life skills' (the ability to make smart choices and to withstand peer pressure). None of the strategies examined focuses exclusively on the prevention of drug use. It emerged from the interviews with different government officials that there is widespread awareness of the fact that youth drug prevention efforts are ineffective

⁹⁸ SAMHSA has a Facebook page aimed at better equipping adults to intervene with young people.

⁹⁹ Drug Abuse Resistance Education

¹⁰⁰ It should however be remembered that, as seen in the first part of this report, various studies have shown D.A.R.E. to have no long-term impact on the prevention of the illicit drug use in young people (see for example Kanof, 2003)

when designed to inform young people of the harmful effects of different drugs in an effort to scare them, an approach that was frequently used in the past. Approaches that focus more on personal development are currently favoured.

Law enforcement officials

Law enforcement officials play an important role in the prevention of illegal drug use in the various strategies examined. Three ways of involving the police were observed: in **collaboration** with other prevention initiatives; through **specific prevention-related tasks**; and as part of the police's regular **street-level intervention**.

Police **collaboration** with the prevention sector is key to ensuring an integrated response to drug-related issues and avoiding counterproductive approaches (see Integrated multisectoral strategies;).

The Netherlands, Portugal, Scotland, Switzerland, the United Kingdom and the United States took part in the development of the *Frankfurt Principles on Drug Law Enforcement*. In particular, these principles recognize that it is important for law enforcement officials to:

"Cooperate and coordinate with stakeholders at various levels (e.g. public health, prosecutor's office, business, non-governmental organizations, affected communities etc.) for a genuinely collaborative approach to provide for public safety." ("Frankfurt Principles on Drug Law Enforcement", 2013)

Collaboration can occur on four different levels: in the **development** of the strategy, in the **implementation** of the strategy, in **prevention programs**, and in **health programs**.

The Netherlands places particular emphasis on collaboration in **strategy development** via 'tripartite consultations' (*involving the Mayor, the Police Commissioner, and the Public Prosecutor*) which permit the three participants to jointly shape local drug policy.

Collaboration may also be a part of policy implementation. Switzerland makes a concerted effort to ensure the law enforcement and the harm reduction pillars work in concert to avoid police punishment of harm reduction measures, such as the confiscation of sterile injection materials. In some cities, such as Rotterdam, several police stations even offer needle and syringe exchange services (Trimbos Instituut & WODC, 2015). In some regions of the United States, the police are trained by the Department of Health in the use of naloxone to counter the effects of an overdose (Office of National Drug Control Policy, 2014). Finally, Portugal has implemented a special program—the 'Safe Schools' program—to identify and report risky situations, such as youth drug use, to the appropriate intervention services (Polícia Segurança Pública, n.d.)

In the United States, police are encouraged to take part in **prevention programs**. In Canada, it would appear, based on the interviews that while there is occasional collaboration, there is also resistance to the sharing of data. However, police participation in prevention programs may be

crucial to ensuring an integrated response to drug addiction as the police play such a central role in this matter.

Finally, as seen earlier, law enforcement officials collaborate with **care services and social services** when individuals are arrested, by choosing to divert the latter to treatment for example. One such example is the 'Safety Houses' in the Netherlands.

The police may also undertake **specific tasks** concerning prevention. This approach is reflected in the Canadian strategy, in which the RCMP assumes responsibility for the *Public Engagement* subcomponent and the synthetic drugs initiative, aim at raising public awareness of the dangers of drug use. Based on the information gathered, it would appear that law enforcement officials do not play as important a role in prevention and public awareness efforts in the other strategies.

Finally, the police may also contribute to prevention **through their actions** at the street level. The police are called upon to interact with young drug users, and may steer them towards resources able to help them avoid or overcome drug dependence. Switzerland recognizes the importance of such an approach and trains police officers in appropriate ways of interacting with young people in the street. The United Kingdom also encourages this type of approach to prevention through the discretionary powers it gives police, as was mentioned earlier in this report.

Communities

Research has shown **community-based interventions to have promising results in terms of drug prevention** for a variety of reasons (IDPC, 2012) Drug strategies are aimed not only at changing individual behaviour, but also at generating change on a community level, stressing community empowerment and the strengthening of protective factors such as strong and positive family bonds, academic success, good social skills, and opportunities for employment. By involving communities in the solutions to drug-related problems, strategies achieve broader objectives and foster economic and social community development (IDPC, 2012).

It is therefore essential that a large set of community stakeholders be involved in the implementation of prevention programs. The inclusion of NGOs, youth groups, community groups, schools, law enforcement agencies, faith-based organizations and government allows for the adoption of a comprehensive approach to drug-related problems. Involving communities enables the latter to develop agency instead of simply viewing themselves as passive beneficiaries of prevention programs (IDCP, 2012).

All the strategies analyzed acknowledge the important role of communities in solving problems of drug use and drug-related crime. However, a number of important nuances were noted, with some strategies mentioning this role explicitly, while others did so implicitly.

Australia, Canada, the United States, the Netherlands and Portugal all place **considerable importance on communities**, as is reflected in their national strategies. The United States stresses the crucial role of prevention partnerships and the importance of community involvement

in drug abuse prevention via its Drug-Free Communities program. In Australia, greater focus is placed on the need for a 'whole-of-community' approach involving all stakeholders in the community at various levels. In Portugal, the government has stated that it is vital that the specific needs of each community be assessed before intervention is undertaken in order to ensure program success and sustainability. The government of the Netherlands, meanwhile, has given municipalities a central role in the implementation of community-based prevention measures, while in Switzerland, the communes are responsible for stimulating community participation. As the strategies of these last two countries are more centralized, we do not have the information necessary to determine the degree of importance attributed to communities.

3.2 Recidivism prevention (tertiary prevention)

Through tertiary prevention, we have explored the means employed in the different countries to prevent drug-use recidivism. Given that this report's main focus is on the prevention of crime committed under the influence of drugs or in order to acquire drugs, we have paid special attention to the impact of tertiary drug prevention on the reduction of drug-related crime. Indeed, individuals arrested for offences related to their personal drug use are highly likely to reoffend if their dependence issues go untreated.

The different strategies recognize the importance of **treatment** both as a means of preventing the recurrence of drug use and as a means of lowering drug-related crime rates. In this section, we will first examine how strategies conceive of tertiary prevention and implement it, then explore the ways in which strategies incorporate treatment as **an alternative to incarceration**, and finally, examine how **reintegration** contributes to lasting abstinence.

First, it is important to note that **all the strategies examined recognize, to varying degrees, the importance of treatment** in reducing drug use and associated crime. This is especially apparent in the Swiss and Portuguese approaches which, in recent years, have placed special emphasis on facilitating access to treatment so that all persons interested in obtaining treatment will be able to do so as quickly as possible.

Treatment encompasses detoxification programs and pharmacological therapy (including methadone treatment), as well as a variety of complementary forms of care and support (cognitive-behavioural approaches, motivational interviewing, mentoring programs, etc.). Switzerland, the Netherlands and, in isolated instances, the United Kingdom, also provide pharmaceutical heroin-assisted treatment. Heroin treatment has proven especially effective in reducing crime. Indeed, as heroin treatment involves supplying heroin as part of treatment, it may in fact eliminate the very cause of addiction-related offences committed to obtain heroin. Such treatment also makes it possible to reintegrate people who have been marginalized by their drug use, thereby giving them new incentive to respect social norms.

Second, treatment may be offered as an **alternative to incarceration**. It should be pointed out that access to treatment is partly dependent on the *laws in force* in each country, and on whether

drug use is a criminal or an administrative offence. Depending on local laws, drug use may be an imprisonable offence although, as has been mentioned previously, there is a growing tendency at the international level to consider prison sentences not necessarily to be the most effective means of steering individuals away from drugs (IDPC, 2012b). UNODC stresses that incarceration should only be considered when an important societal aim cannot be achieved by less restrictive means (2008). Indeed, to do otherwise would make the custodial sentence counter to the right to individual freedom, one of the most basic human rights recognized by international instruments and national constitutions. Furthermore, research shows that sanctions have little effect on drug use, particularly that of drug-dependent users (IDPC, 2012b).

As seen earlier in this report, the repressiveness of drug laws varies depending on the strategy. However, all these strategies provide for the possibility of offering individuals arrested for drug possession or a non-violent addiction-related offence the opportunity to avoid incarceration by diversion **to treatment**. This decision may be made by police at the time of arrest or at a later point by a judge. The United Kingdom is unique in that it provides for discretionary powers at both stages so that law enforcement officers may decide what they believe would be best for society as a whole.

Two types of courts may decide on alternative sentences to incarceration¹⁰¹ for addiction-related offences: ordinary courts and specialized drug courts (IDPC, 2012b). The aim of the latter is to treat the underlying causes that lead individuals to commit non-violent offences by integrating the judicial system, social services and treatment resources (see p. 27). Canada and the United States have especially highly developed drug treatment court (DTC) programs. The evaluation of Canada's strategy highlighted the fact that DTCs have a greater impact on the reduction of drug abuse and criminal recidivism than traditional justice system approaches. The United Kingdom has both types of courts (IDPC, 2012b).

Australia has established specialized drug courts for Aboriginals, while Canada has introduced an addiction-related restorative justice program for its own Aboriginal populations.

Drug treatment courts are not alone in seeking to integrate the judicial system, social services and treatment. In the Netherlands, 'Safety Houses' were born out of the recognition that issues involving drug-related crime cannot be resolved by the criminal justice system alone. The government encourages cooperation between the justice system, care facilities, and municipalities to coordinate their efforts. The goal of 'Safety Houses' is to enable the different partners to come together to address specific cases in a coherent and holistic manner in order to prevent individuals from reoffending (FESU, 2014).

¹⁰¹ Treatment, community service, etc.

The situation in Portugal is unique because possession for personal drug use is an administrative, not a criminal, offence. When individuals are arrested, they are brought before a *Commission for the Dissuasion of Drug Addiction*—consisting of a social worker, a legal adviser and a health professional—which seeks to discourage occasional drug users from using drugs and to encourage drug-dependent individuals to receive treatment. Proposed solutions depend on the individual case, and range from administrative sanctions to community service to referral to treatment or education programs.

With regard to young people, a number of special programs have been implemented as alternatives to their incarceration. In Canada, the *Youth Criminal Justice Act*, which also addresses drug-related offences, encourages provinces to employ extrajudicial measures in dealing with adolescents (C4, 14.03.2015 and Minister of Justice, 2002). The United States' strategy focuses on alternatives to incarceration as well as improvements to treatment systems in the juvenile justice system. The United Kingdom also encourages treatment for young people in place of the deprivation of liberty.

Finally, strategies include **reintegration after treatment** to varying extents. One interviewee stressed that treatment has little chance of success if the individual does not receive reintegration support in the form of job-seeking support, housing assistance, and reintegration with the community. The United States, Portugal, the United Kingdom, Switzerland and the Netherlands all place considerable emphasis on reintegration in their strategies. However, according to the information collected, Canada places little importance on reintegration.

3.3 Harm reduction

According to the International Drug Policy Consortium, "simply pursuing the long-term objective of a 'drug-free society' is no longer a sustainable policy" (IDPC, 2012). The harm reduction approach is therefore not directly aimed at reducing drug use, but rather at minimizing its negative effects on the individual and society (ICPC, 2010). Harm reduction encompasses **all interventions that contribute to the reduction of the health and safety risks associated with drug use**, regardless of whether they are aimed at decreasing drug use or not (IDPC, 2012). It should be remembered that while such initiatives are primarily the responsibility of the public health sector, they are also aimed at preventing crime committed either under the influence of drugs or in order to acquire drugs (ICPC, 2010).

| COUNTRY | Drug consumption rooms | ¹⁰² Heroin dispensing | Opioid Substitution Therapy (OST) | Nightlife measures | Community reintegration |
|------------------------------|------------------------|----------------------------------|-----------------------------------|--------------------|-------------------------|
| Australia | | | | | |
| Canada | | | | | |
| United States ¹⁰³ | | | | | |
| Netherlands | | | | | |
| Portugal | | | | | |
| United Kingdom | | | | | |
| Switzerland | | | | | |

Figure 15. Types of harm reduction initiatives included in strategies

It is recommended that the concept of harm reduction be applied to all aspects of drug policy (IDCP, 2012). Policy makers should be explicit in articulating the specific harms they aim to reduce through their drug policies, design programs that have a reasonable evidence base for reducing these harms, provide the necessary resources for their implementation, and evaluate these programs to ensure they achieve the desired outcomes (IDPC, 2012). It is also recommended that harm reduction initiatives be complementary and mutually reinforce one another to maximize effectiveness in protecting drug user health and safety (IDPC, 2012). The objective, in all instances, is **to make and maintain contact with difficult-to-reach drug users** so as to prevent their personal or social circumstances from worsening (EMCDDA, n.d.-b). It should be noted that **the success of harm reduction programs depends on a wide range of factors** such as drug user involvement in service design and implementation; accessibility and breadth of coverage; adaptability of the service to local drug use patterns; engagement with law-enforcement services not to interfere with available services; and negotiation and consultation with the wider community (IDPC, 2012).

¹⁰² In this report, we consider heroin treatment to be a harm reduction measure as it helps reduce crime associated with the drug without necessarily reducing the use of the drug in the same proportions.

¹⁰³ Syringe exchange programs are available in roughly thirty states. However, as this type of initiative is aimed at reducing health risks, it is not included in our analysis.

The majority of the countries studied in this report include a harm reduction component in their national drug strategies. This is true of Australia, the Netherlands, Portugal and Switzerland. Where these nations differ is in the nature of the initiatives put forward to reduce harms. Some countries, especially the Netherlands, Portugal and the Switzerland, offer a wide range of programs and infrastructures aimed at harm reduction. Harm reduction is a key priority in their strategies, based on the conviction that, where it is impossible for individuals to overcome their addictions, the State should help them reduce the harms their drug use may cause to themselves, their loved ones, and their communities.

The Netherlands, in particular, considers **community reintegration** an important harm reduction tool. By focusing on providing housing for homeless individuals (where they can live and take drugs), the Netherlands has successfully reduced the disorderly conduct and insecurity caused by public drug use. Providing these drug users with support via the housing programs has made it possible to mitigate the consequences of their drug use through social reintegration rather than through the repression of their behaviours. The United Kingdom's strategy adopts a similar tack, with its "Building Recovery in the Community" pillar.

Other countries, including Canada, the United States and the United Kingdom, do **not have any components in their strategies that specifically focus on harm reduction**. However, that does not prevent numerous isolated initiatives from existing in these countries. For example, needle exchange programs are available in all three countries. Moreover, there have been supervised injection services in Vancouver, Canada since 2003 and discussions are currently underway to implement the same concept in Montreal (Portail Santé Montréal, n.d.).

Dispensing heroin under government medical supervision in the Netherlands, the United Kingdom and Switzerland contributes to the reduction of supply-related crime, in particular (ETHZ, 2007). The strategies of both the Netherlands and Switzerland include **nightlife management** programs aimed at mitigating the crime and insecurity resulting from the use of drugs in bars, nightclubs and other entertainment venues and the surrounding areas. In the Netherlands, this policy extends to *coffees shops* as well.

Based on this comparison, we find harm reduction to be a far more prominent part of the national strategies of Australia, the Netherlands, Portugal, Switzerland, and the United Kingdom, which employ a broad range of harm reduction initiatives, but absent from the strategies of the other countries studied (Canada and United States).

On the strategy

- Strategies should have a holistic approach that includes addiction as a problem to be addressed along with other frequently interrelated problems, e.g. crime, belonging to street gangs and mental health disorders. In addition, drug-related strategy must recognize that it fits into a broader context and strive to be consistent with all government programs across all departments.
- Strategies both channel the combined efforts of various ministries and also include different components to address illicit substance-related problems. Therefore, it is important to promote synergies between the different interventions and to avoid counterproductive initiatives. Consequently, note that mechanisms should be implemented to facilitate collaboration and information sharing.
- In order to implement an effective integrated multi-sectoral approach, it is essential to raise awareness among various stakeholders of the need for collaboration, for example between mental health professionals and those working in substance abuse care, or between police and harm reduction initiative workers.
- A preventive approach resulting from an evidence-based strategy is not in itself a guarantee of meaningful results if the budget remains marginal. Therefore, care should be taken that the repressive component does not monopolize funding for non-evidence-based use.
- Also note that strategies must promote a supportive social environment. Indeed, society bears a share of the responsibility for illicit drug use when it promotes living conditions that make people vulnerable to consumption (the pressure of productivity, working conditions, etc.).
- **Strategies should recognize that abstinence cannot be a goal for all individuals with addiction issues and thus should include a harm reduction approach.**
- Strategies to prevent drug-related crime should incorporate marginalization reduction measures, recognizing the link between social exclusion and addictive disorders.

The approach to addiction issues

- For individuals suffering from drug addiction, drugs were originally the solution to the problem before they became the problem itself. Therefore, strategies should consider addiction as the result of multiple factors and should work towards decreasing risk factors and increasing protective factors.
- Considering the various steps leading to addiction, strategies should take into account the different types of consumption: recreational or problematic. Indeed, individuals may continue using drugs for different reasons than those that led them to first start using.
- Strategies should address substance abuse issues through a public health approach where repression is carried out in line with preventive and harm reduction approaches.
- Strategies must not only recognize the existence of concurrent disorders but must also implement coherent solutions for dealing with mental health problems related to substance abuse issues.
- Decriminalization and de facto decriminalization tend to support a public health approach. However, they alone are not enough to guarantee such an approach. Therefore it is imperative that in all cases, strategies incorporate a system to better guide an individual suffering from addiction to appropriate treatment systems.
- Strategies must recognize the close link between the use of legal drugs (alcohol and tobacco) and illicit drugs, especially the shared risk and protection factors.

Crime reduction-related recommendations

- It is important that strategies acknowledge that different types of drugs will cause different types of crime. Therefore, interventions must be adjusted accordingly.
- Considering that treatment significantly helps reduce drug-related crime, strategies should consider facilitating access to treatment for all addicts.
- Considering the strong link between drug-related crime and the dependency of individual, strategies should include alternatives to imprisonment that address the underlying causes of the offense.
- Since research indicates that treatment for heroin addiction has a significant positive impact on the reduction of drug-related crime, strategies should consider including this type of treatment.

- Similarly, supervised injecting rooms can significantly reduce the sense of insecurity and disruption of public order in areas where they are set up.

For the prevention of consumption

Bearing in mind that prevention of consumption helps reduce drug-related crime, strategies should focus in particular on:

- Interventions by and for communities. Indeed, community interventions enable a systemic and holistic change in factors influencing consumption.
- Interventions with families, especially those with young children. As highlighted in this report, the family is one of the most important risk and protective factors regarding illicit substance abuse.
- School interventions integrated into a broader framework. Consequently, a school-based intervention should be undertaken in collaboration with other interventions (such as community, with parents, law enforcement). Indeed, a school intervention only focuses on the individual and pays little attention to the environment, consequently limiting its scope.

For youth

- We recommend the application of the youth-related criteria mentioned in this report, with successful programs that include:
 - inclusive approaches to reduce the marginalization of young people,
 - participatory approaches,
 - integrated multi-sectoral strategies,
 - balanced strategies including early intervention, social, educational programs, restorative approaches and crime control,
 - strategies and programs tailored to the specific needs of at-risk groups,
 - approaches that respect the rights of children and youth [free interpretation].
- Strategies that promote the participation of young people not only in the implementation of initiatives but also in the development of the strategy itself.
- Strategies that consider the importance of training all professionals in contact with youth in their daily work (not only teachers but also the rest of the school personnel, medical personnel, police, etc.) to identify a risk situation and be able to respond to it adequately.

- Interventions that provide neutral information without judgment so that youth can make informed decisions. In parallel, programs to strengthen the social skills of young people, for example resistance to peer pressure, should be implemented.

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