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Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: demand reduction and related measures

Measures to protect children and young people from drug abuse

Report of the Executive Director

I. Introduction

1. In its resolution 53/10, entitled “Measures to protect children and young people from drug abuse”, the Commission on Narcotic Drugs encouraged Member States to implement various interventions for the prevention of drug use and the protection of children and young people; and requested the Executive Director of the United Nations Office on Drugs and Crime (UNODC) to report to the Commission at its fifty-fourth session on the measures taken and on progress achieved in the implementation of the resolution.

2. In order to enable the Executive Director to collect information on the issues raised in the resolution for inclusion in his report to the Commission, a note verbale was sent to Governments on 25 August 2010 inviting them to submit information to UNODC on their efforts to implement the resolution by completing and returning a questionnaire covering several key areas of drug prevention and treatment.

II. Findings

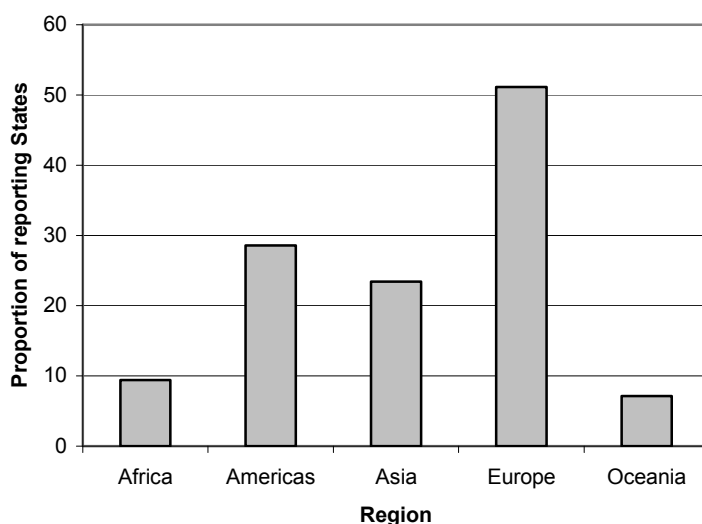
3. At the time of writing, a total of 50 Governments had responded to the note verbale.¹ Given the limited number of questionnaires returned, the analysis of the

* E/CN.7/2011/1.



results is presented mainly at the global level. In specific cases, analysis is presented by region. Europe was the continent where the response rate was the highest (over 50 per cent). In the Americas and Asia over 20 per cent of Member States responded, while in Africa and Oceania fewer than 10 per cent did so (see figure I).

Figure I
Questionnaire response rate, by region
 (Percentage)



III. Prevention of drug use

4. With regard to prevention, Member States were invited to report on whether they had been implementing interventions that are commonly included in comprehensive programmes for the prevention of drug use: dissemination of information about the danger of drugs; education in schools based on life skills; family and parenting skills training; workplace prevention programmes; alternative activities (sports, drama, music etc.); vocational training and income-generation support; media campaigns; and screening and brief interventions. In addition, Member States were asked to report on the promotion of two kinds of programmes mentioned specifically in resolution 53/10 — programmes in coordination with local governments and civil society, and programmes to prevent the use of children and young people in illicit production of and trafficking in drugs.

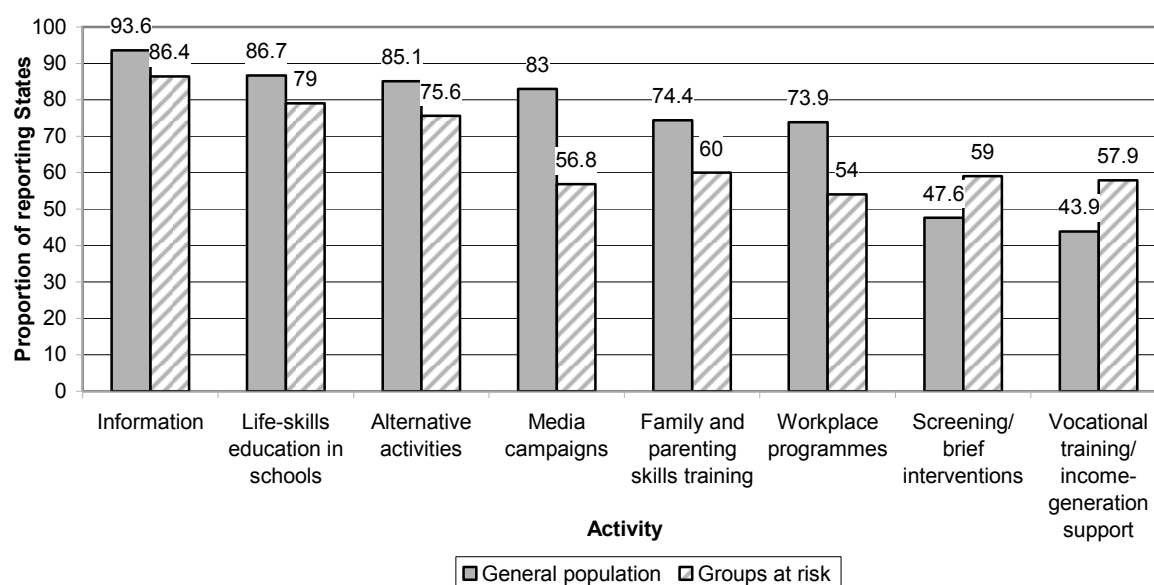
¹ Algeria, Andorra, Argentina, Armenia, Australia, Bahrain, Belarus, Bolivia (Plurinational State of), Canada, Chile, China, Colombia, Costa Rica, Croatia, Cyprus, Czech Republic, Ecuador, El Salvador, Estonia, Germany, Greece, Hungary, Ireland, Israel, Kyrgyzstan, Lebanon, Lithuania, Luxembourg, Malta, Mauritius, Mexico, Moldova, Myanmar, Nigeria, Norway, Pakistan, Philippines, Poland, Portugal, Republic of Korea, Republic of Romania, Singapore, South Africa, Spain, Sweden, Switzerland, Tunisia, Turkey, United Kingdom of Great Britain and Northern Ireland and Venezuela (Bolivarian Republic of).

5. Further, for each intervention, Member States were requested to report on whether it targeted the general population and/or at-risk groups, as well as to assess whether the intervention covered none, some, most or all of the targeted population and whether it had been or would be evaluated or not.

6. Figure II presents the percentages of Member States reporting globally on the implementation of the various prevention activities, in decreasing order of prevalence, both in the general population and among at-risk groups. The pattern is the same among both target groups: activities in decreasing order of implementation are information, life-skills education in schools, alternative activities, media campaigns, family and parenting skills training, workplace programmes, screening/brief interventions and, vocational training/income-generation support.

Figure II

All regions: implementation of various prevention activities in the general population and among at-risk groups
(Percentage)



7. The range in the percentages of Member States reporting the most and the least frequently implemented prevention activity in the general population (between 43.9 and 93.6 per cent) was substantially similar to the range among at-risk groups (between 54 and 86.4 per cent). Although these data mask wide variations across activities and regions, the figures should be considered encouraging. With the exception of screening and brief interventions and vocational training/income-generation support, all other prevention activities were reported as being implemented by the majority of Member States, which therefore appear to be implementing a wide range of prevention activities.

8. In particular, the very high rate of reporting about life-skills education in schools is heartening. When drug education in schools based on life skills is implemented according to the standards of scientific evidence, it is known to be

very effective, as it can prevent up to 20 per cent of new initiations. It is also efficient, saving nine dollars for every dollar spent.

9. The biennial reports questionnaire used by Member States to report on their drug demand reduction programmes up to 2008 did not request information about most of the evidence-based interventions surveyed in the present questionnaire used to gather data on the implementation of resolution 53/10. It is therefore particularly encouraging that two actions that have been proved to be effective and efficient by a large body of evidence, namely, family and parenting skills training and screening and brief interventions, were reported as being implemented on a large scale.

10. While the evidence concerning the effectiveness of media campaigns is more mixed, there is evidence that a carefully targeted media campaign, based on solid formative research and of significant duration and intensity, can effectively support a national prevention programme, for example, by suggesting simple behaviours to parents that are strongly protective of their children. In this area, as with all the interventions described in the present report, an analysis of the quality and content of actions would be helpful in gaining a full understanding of whether resources have been invested in the most efficient way.

11. Finally, with regard to screening and brief interventions, it should be noted that many more Member States reported the provision of such services in the context of drug dependence treatment and care. However, screening and brief interventions had also been successfully applied in school, workplace and primary health-care settings and had proved to be effective in reducing the use of drugs by individuals who had not yet developed dependence and/or had not been in contact with a drug dependence treatment and care service.

12. It should be noted, however, that implementation targeting the general population was still reported more commonly than implementation among at-risk groups. Six activities out of the eight listed in the questionnaire were reported as being implemented in the general population by more than 70 per cent of Member States. This was the case for only three activities targeting groups at risk and is a cause for concern, as prevention activities targeting and tailored to particularly vulnerable groups are generally considered to be more effective and efficient than activities targeting the general population, although both should be included in a comprehensive prevention programme.

13. Moreover, with regard to the coverage of this range of prevention activities, the situation was not as encouraging. In figure III, the percentage of Member States reporting coverage of none or some of the target groups is shown as reporting "poor" coverage. Conversely, Member States reporting coverage of most or all of the target groups are shown as reporting "good" coverage. It is apparent that, with the exception of information about drugs, life-skills education in schools and media campaigns, most Member States (more than 55 per cent in all cases) reported poor coverage of prevention activities. The percentage of those reporting poor coverage was the highest for workplace programmes and screening and brief interventions. Even in the case of life-skills education in schools and media campaigns a significant percentage of Member States (41 and 46 per cent, respectively) reported poor coverage.

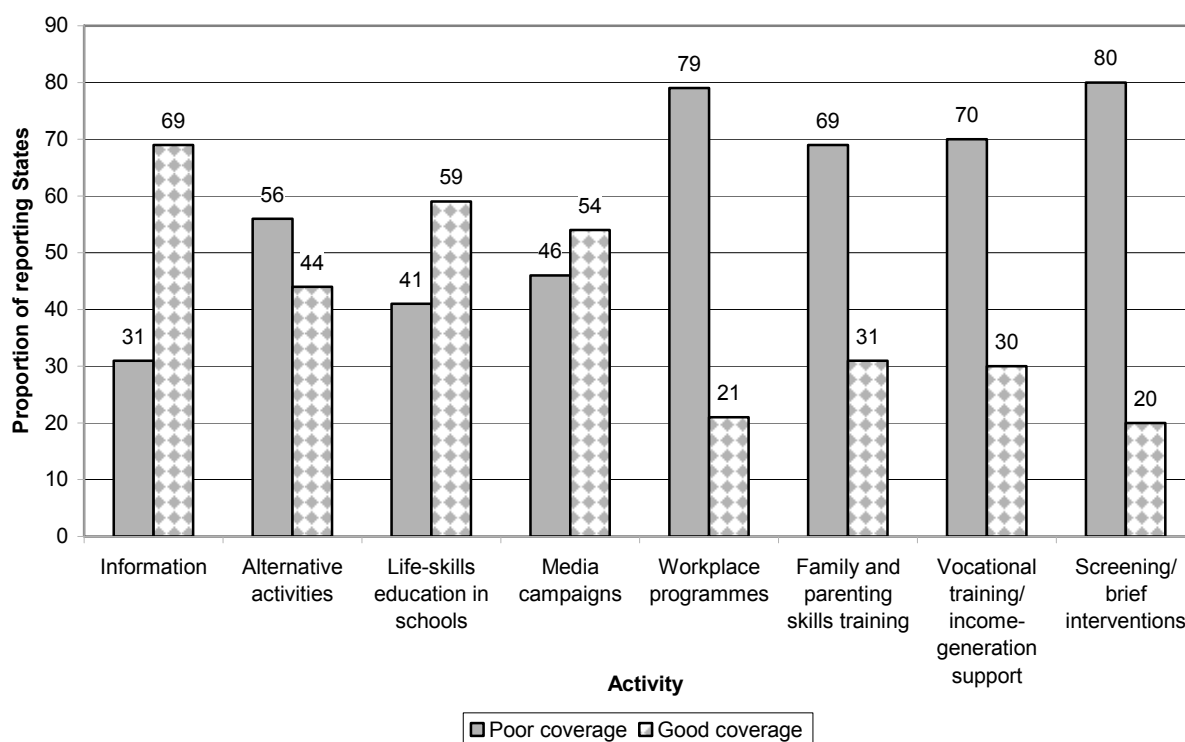
14. As mentioned above, evidence-based life-skills education in schools is an effective and efficient prevention activity, while with regard to media campaigns the

evidence of effectiveness is more mixed. In this respect, the relatively high percentage of Member States that reported good coverage of life-skills education in schools is a very positive development. Besides the concerns mentioned above as to the quality and content of the intervention, it should be noted that a good coverage of life-skills education in schools may not mean a good coverage of children and youth in general in Member States where the rate of children in schools is not high or with regard to at-risk groups who are more frequently out of school.

Figure III

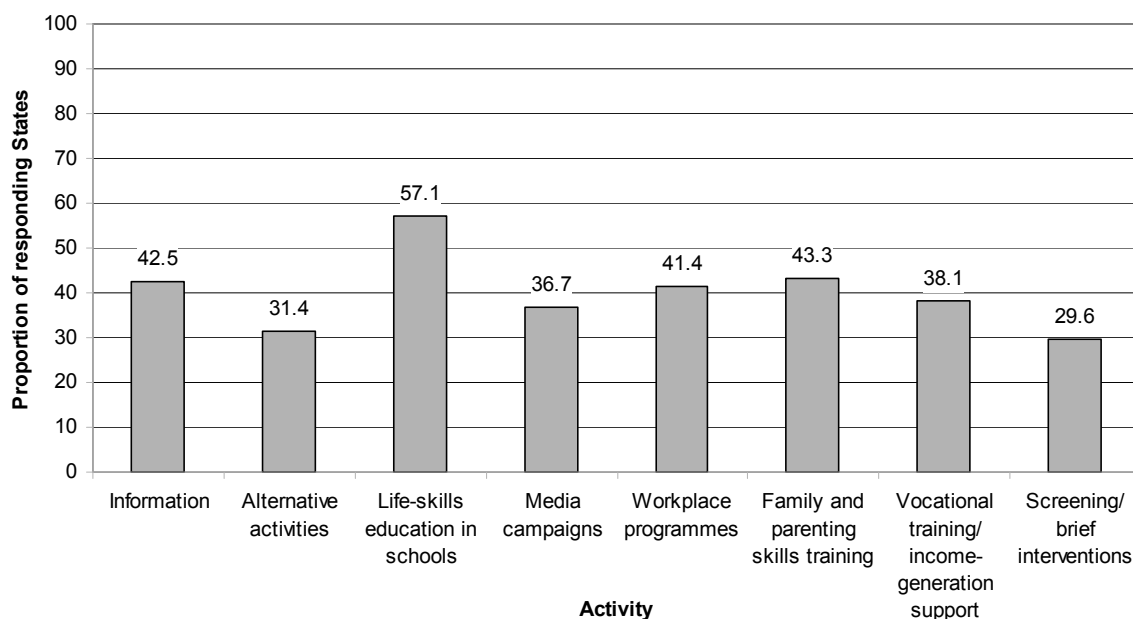
All regions: coverage of various prevention activities

(Percentage)



15. Figure IV shows the percentage of Member States reporting the evaluation of various prevention activities. In most cases (40 per cent or more), the implemented activities were not evaluated, revealing another cause for concern as regards the state of prevention activities worldwide.

Figure IV
All regions: evaluation of various prevention activities
 (Percentage)



16. Finally, almost all Member States reported that they implemented prevention programmes in coordination with local governments and civil society in the general population. This was reported for both the general population (96 per cent) and for at-risk groups (89 per cent), with minimal variations across continents. With regard to activities to prevent the involvement of children and young people in the illicit production of and trafficking of drugs, the situation reported was more varied. In general, fewer Member States reported having implemented such programmes, whether in the general population (53.6 per cent) or among at-risk groups (61.1 per cent).

IV. Drug dependence treatment and care

17. With regard to treatment, the questionnaire requested Member States to report on some basic characteristics of their treatment system, including whether it was based more on residential or outpatient settings, whether there was a compulsory or mandatory system or whether alternatives to criminal justice sanctions were provided for. Member States were asked whether they provided a range of drug dependence treatment and care services both in the community and in prison settings, as well as for an assessment of the respective level of coverage. Finally, Member States were invited to report on some basic indicators of the quality of the treatment services provided, such as the existence of standards of care.

18. More countries reported treatment and care services available for people suffering from drug dependence in the community than prevention activities. As

shown in figures V and VI, 19 out of the 19 services surveyed were reported as being provided by over 70 per cent of Member States. Thus, in terms of the availability of a comprehensive range of treatment and care services, the picture was even more encouraging than with regard to prevention activities. Services have been divided, purely for reasons of reporting, between drug dependence treatment and care services and services for the prevention, treatment and care of HIV and other infectious diseases. A recovery-oriented continuum of care would include the full range of services surveyed.

19. The responses received indicated a relative lower availability (below 80 per cent) of long-lasting pharmacological therapies and one particular psychosocial therapy, contingency management. Although the data concerning long-lasting pharmacological therapies may appear worrying, the results should be read in the context of either: (a) the current absence of medications clearly recognized for the treatment of dependence on stimulants; (b) the lack of the need to provide pharmacological therapy because opioid dependence is not a prevalent national problem; (c) the lack of appropriate legislation in the Member State to make the long-lasting pharmacological substances available; or (d) a combination of the above.

Figure V
All regions: provision of various drug dependence treatment and care services in the community
 (Percentage)

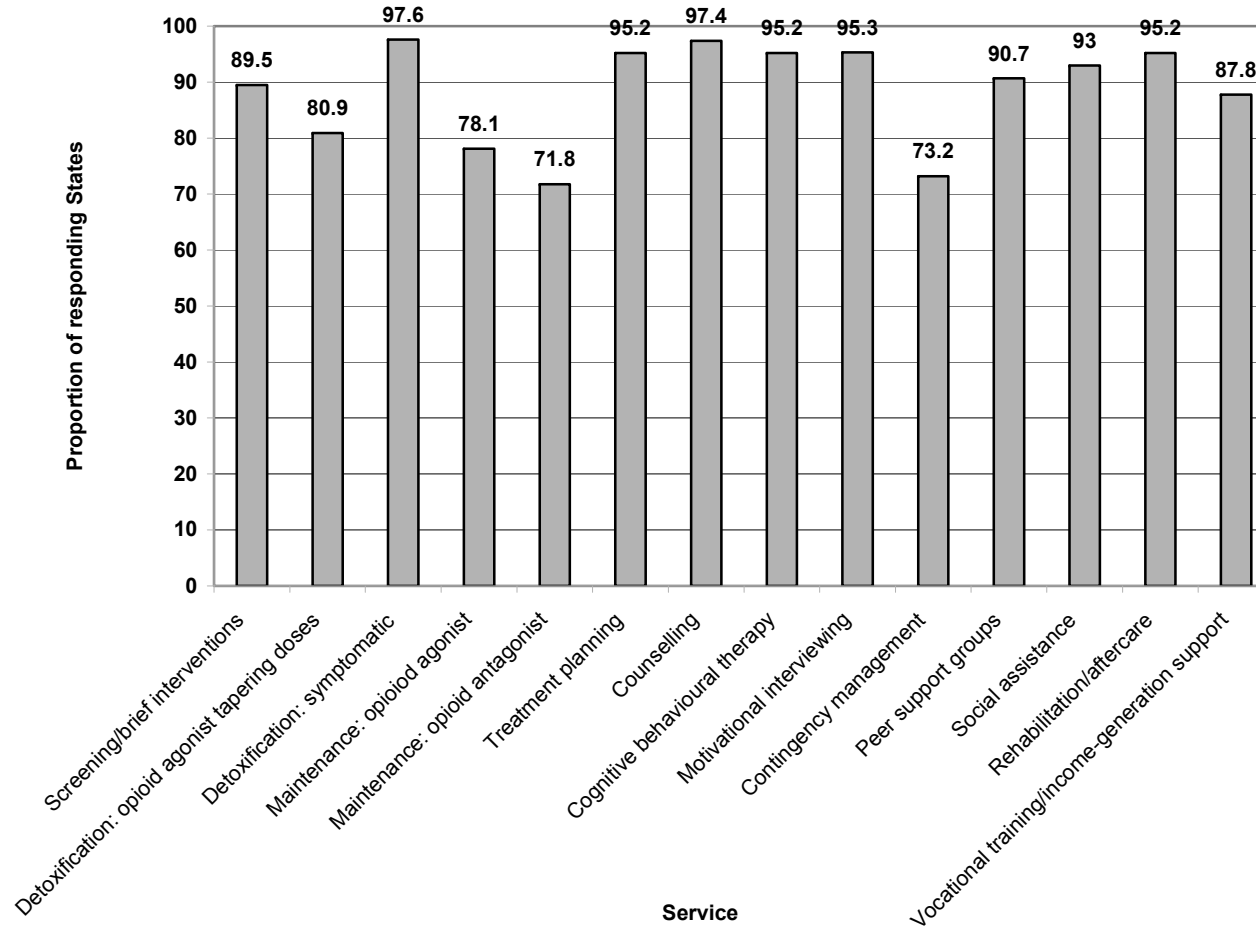
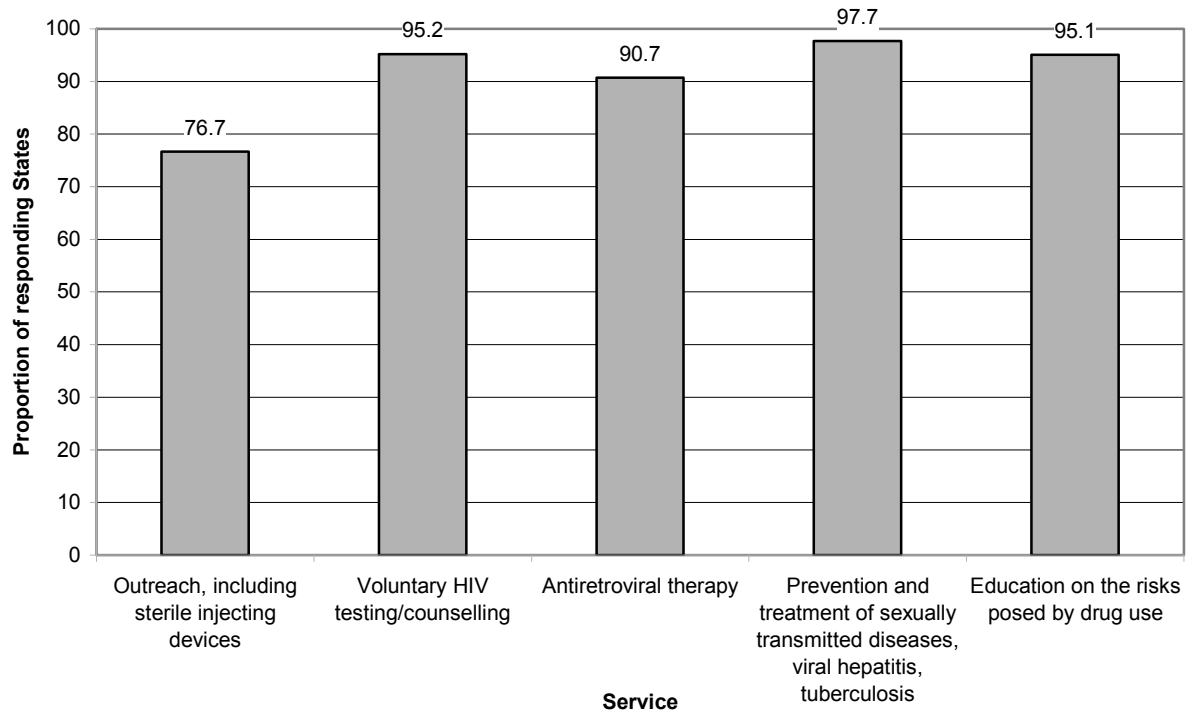


Figure VI
All regions: provision of various services for the prevention, treatment and care of HIV and other infections diseases among drug users in the community
 (Percentage)



20. Figures VII and VIII summarize the data reported with regard to the provision of drug treatment and care services in prison settings. It is evident that services were not provided in prison settings at the same level as in the community. The percentage of Member States reporting the provision of such services in prison settings was lower (only 13 of the 19 services were reported by 70 per cent or more of the Member States) and not as uniform as the percentage of States reporting the provision of such services in the community (with the prevalence of availability ranging between 33 and 95 per cent) The same weakness was noted with regard to pharmacologically assisted services, in addition to outreach work for drug users, including sterile injecting device programmes, which are still not implemented (or accepted) in many prisons.

Figure VII
All regions: provision of various drug dependence treatment and care services in prison settings
 (Percentage)

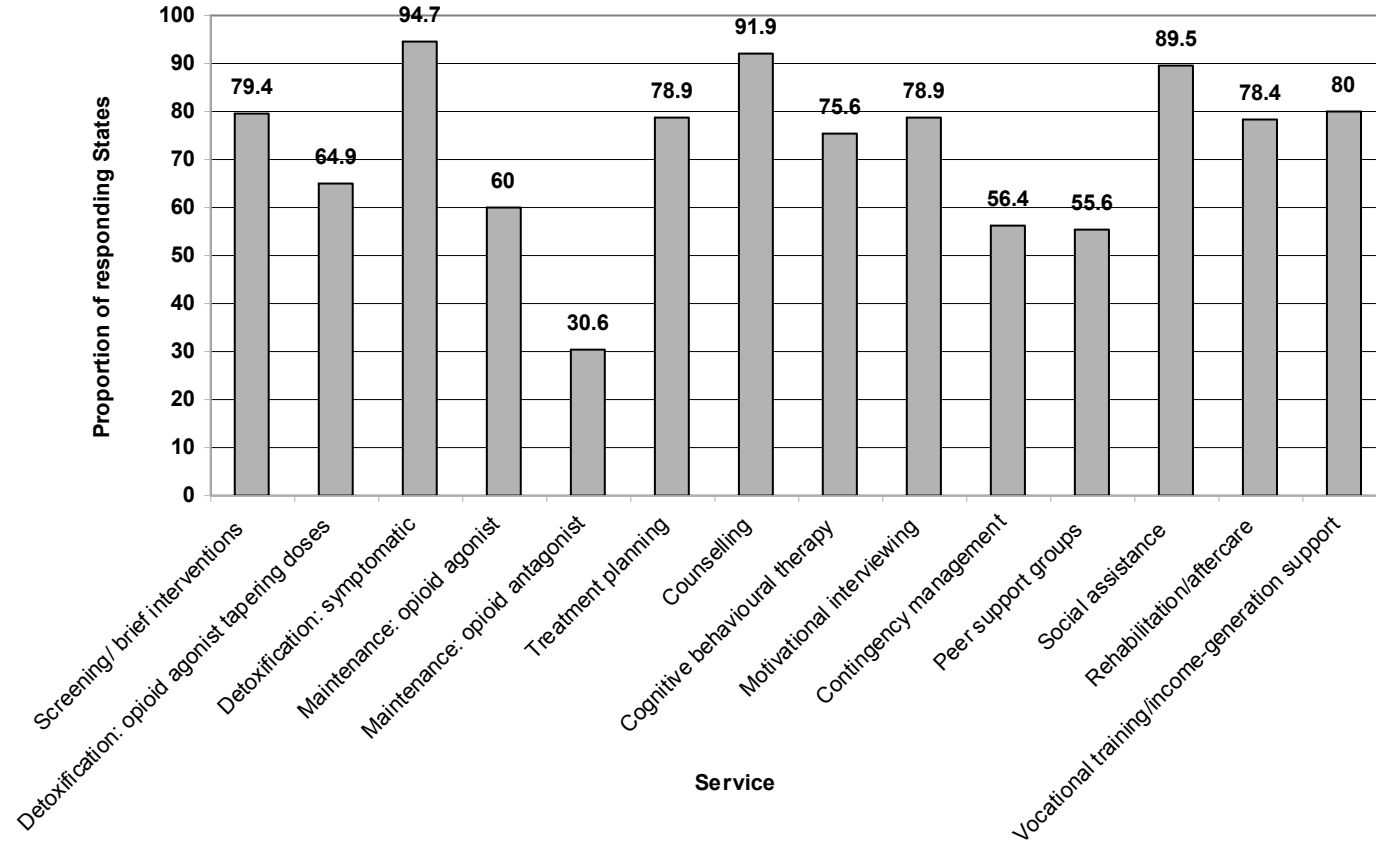
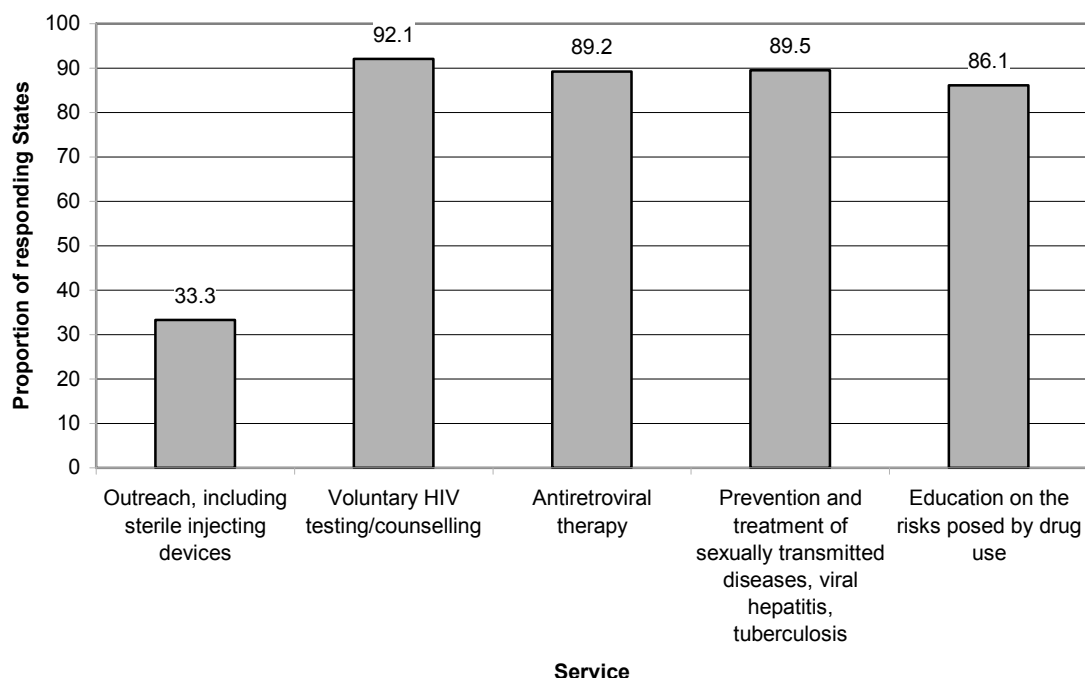


Figure VIII
All regions: provision of various services for the prevention, treatment and care of HIV and other infectious diseases among drug users in prison settings
 (Percentage)



21. The picture becomes more complex as regards the coverage of services. Figures IX and X show the percentage of Member States reporting low, medium and high coverage of their respective services in the community. It is striking that most services were reported as being provided with low to medium coverage, with only half of the services reported as having high coverage in around half the 50 Member States responding to the questionnaire. Between a quarter and half of States reported high coverage of their drug dependence treatment and care services, which is encouraging. For example, maintenance therapy using opioid agonists was reported as being provided with high coverage by 48 per cent of Member States, a new development. However, it should be borne in mind that such positive indications still meant that between 50 and 75 per cent of Member States were not able to provide specific services at high coverage, indicating that the road to universal access to drug dependence treatment and care is still long.

Figure IX
All regions: coverage levels of various drug dependence treatment and care services in the community
 (Percentage)

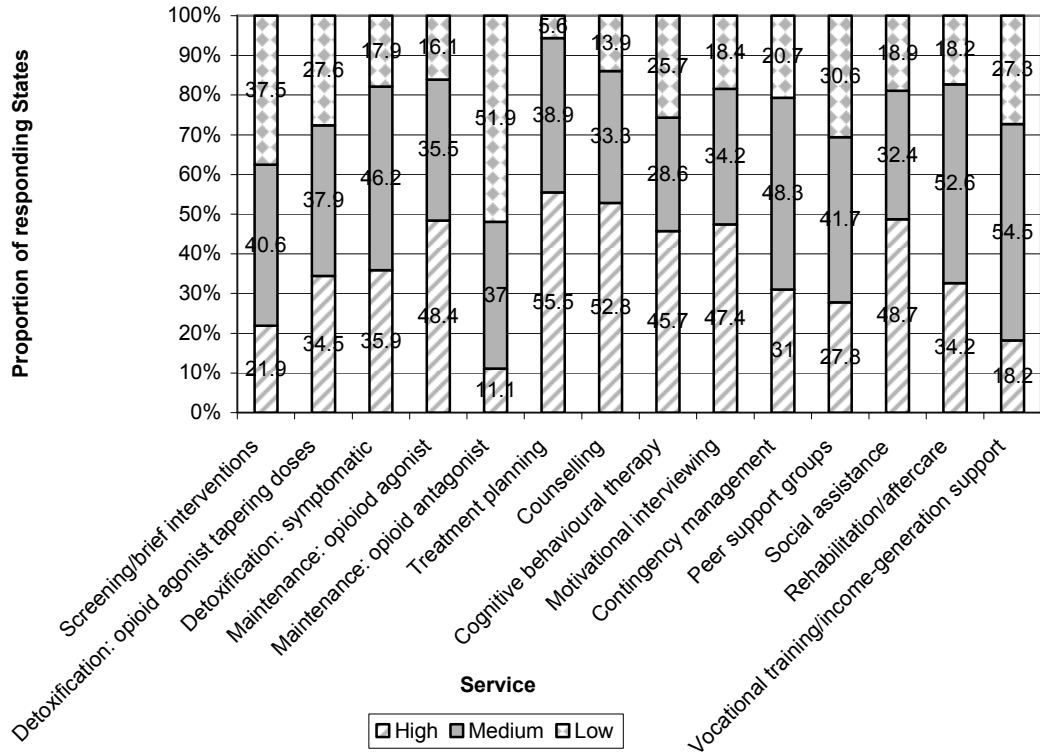
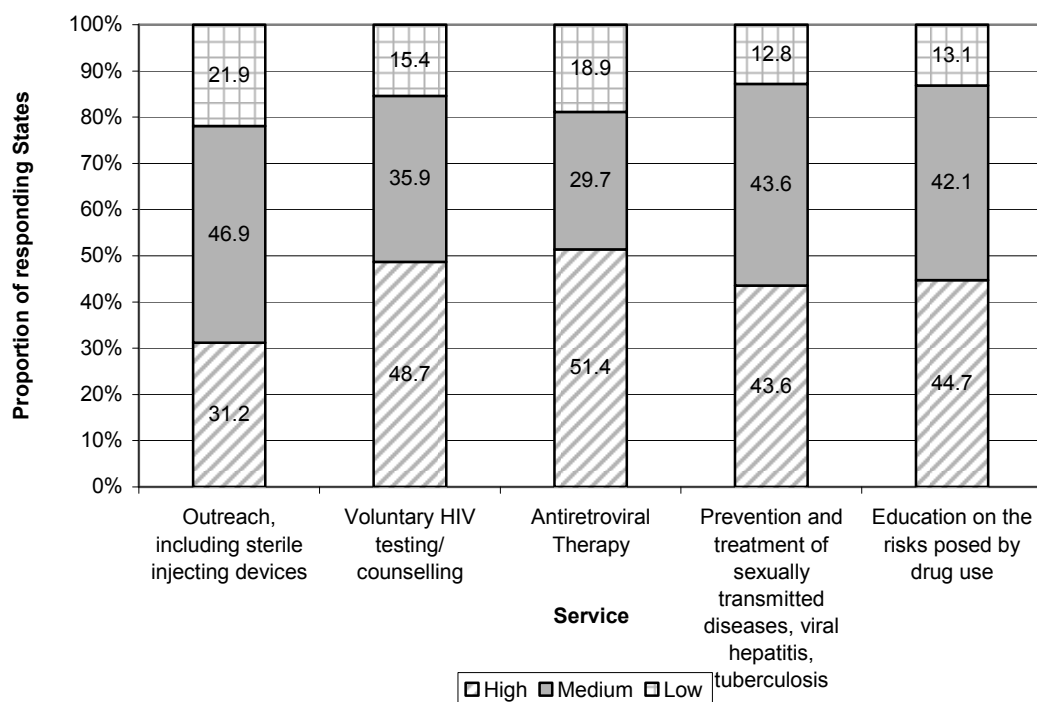


Figure X
All regions: coverage levels of various services for the prevention, treatment and care of HIV and other infections diseases among drug users in the community
 (Percentage)



22. Moreover, in prison settings (figures XI and XII), almost one in five Member States reported that they provided most drug dependence treatment and care services with low coverage and only between approximately 20 and 40 per cent reported that they provided the different services with a high coverage. Given that populations in prison settings are more likely to have poorer health, both physical and mental, including drug dependence, HIV/AIDS and tuberculosis, this is particularly worrying.

Figure XI
All regions: coverage levels of various drug dependence treatment and care services in prison settings
 (Percentage)

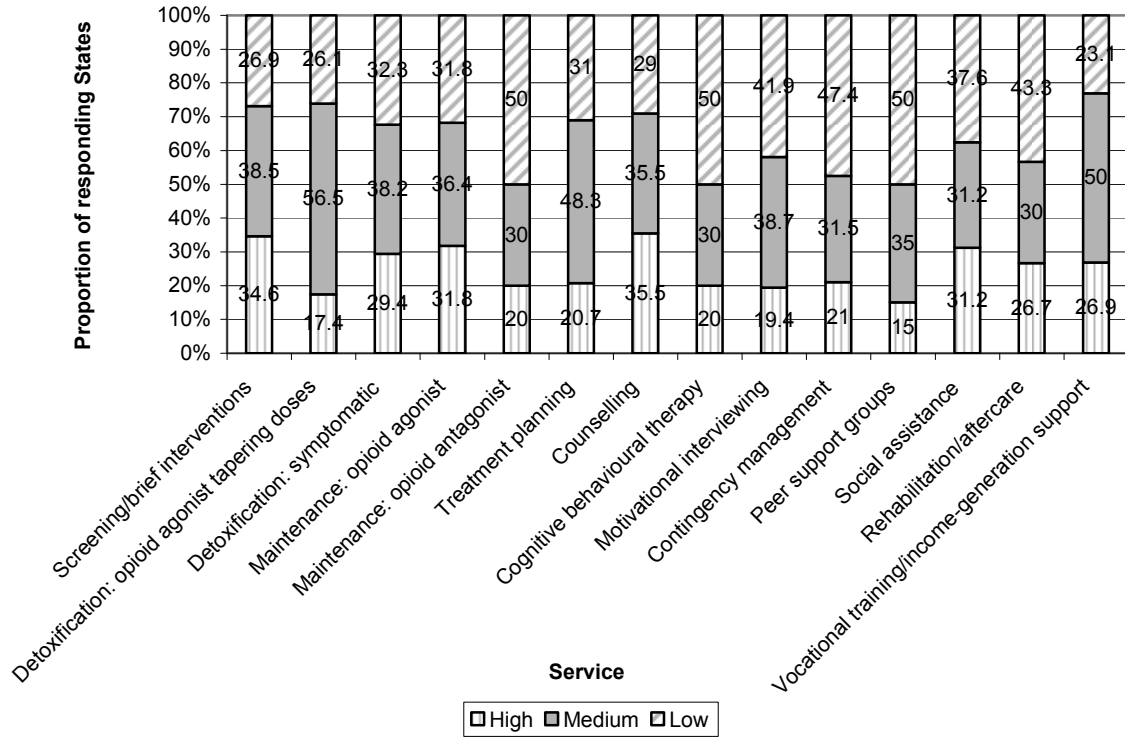
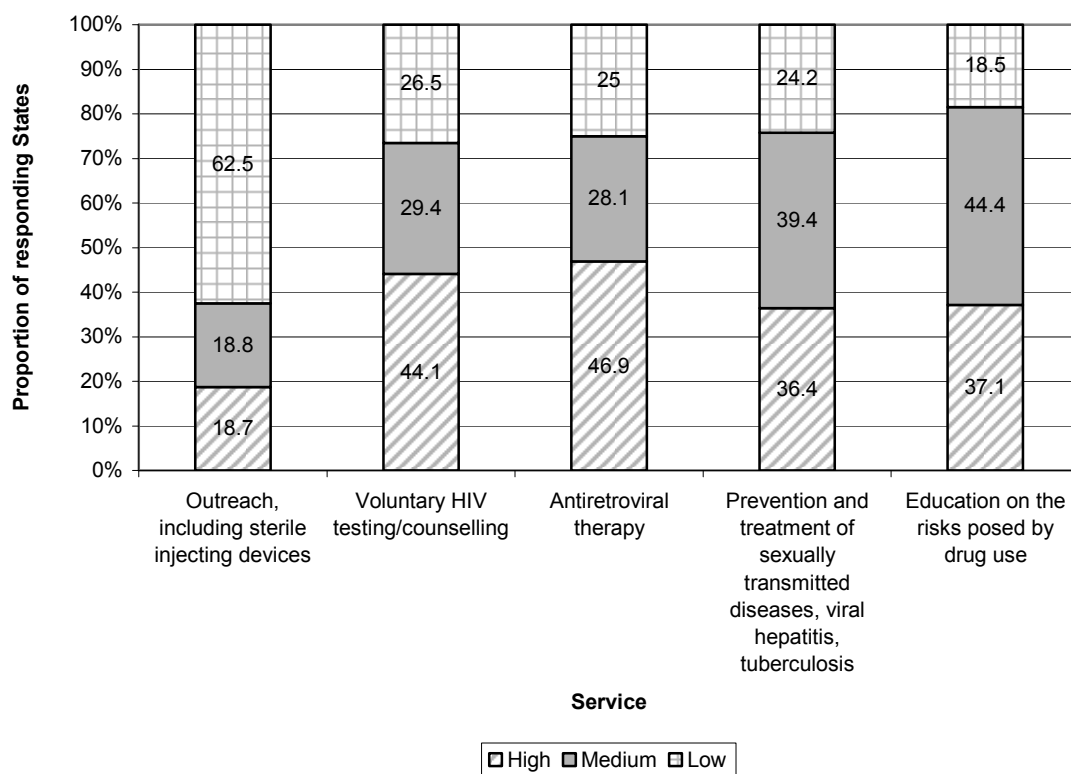


Figure XII
All regions: coverage levels of various services for the prevention, treatment and care of HIV and other infectious diseases among drug users in prison settings
 (Percentage)



23. With regard to the basic characteristics of the services provided, the quality of the data collected by the questionnaire was not as high as with regard to the issues discussed above. For example, 29 per cent of Member States responding to the questionnaire reported not having an estimate of the number of people in need of treatment. Although a global or continental estimate would not be statistically significant, given the relatively low response rate overall, this raises serious concerns as to the basis for the planning of the provision of treatment services in most countries in the world. In order to plan prevention and treatment systems, policymakers require an information system providing the appropriate data.

24. Almost 95 per cent of Member States reported that they provided services in the community in both residential and outpatient settings, with 50 per cent reporting that over 70 per cent of their treatment services were provided through residential programmes. Generally speaking, the provision of a majority of services through outpatient settings is a sign of a mature treatment system, so such data give cause for concern. In fact, this means that at least half of the Member States reporting provided drug dependence treatment services in the setting that is more expensive and less efficient. Moreover, it should be noted that residential treatment that is not

supported by strong outreach and outpatient services is generally not as effective as it can be, as drug dependent patients find it difficult to access.

25. More than half of Member States responding reported that they had a system of compulsory or mandatory treatment, while a large majority (82.2 per cent) provided drug dependence treatment as an alternative to incarceration. The latter figure is encouraging, since providing drug dependence treatment as an alternative to criminal justice sanctions has been found to be effective and efficient in lowering drug use and drug dependence rates, as well as their health and social consequences, including crime.² The data on compulsory and mandatory treatment were more worrying, in that, in accordance with ethical and medical standards, treatment should be provided only with the consent of the patient. However, the information provided should be interpreted with caution, given that many of the Member States offering treatment as an alternative to criminal justice sanctions may have reported such a system as a form of compulsory or mandatory treatment. As long as the choice between treatment and criminal justice sanctions still lies genuinely with the patient, this does not have to be the case. However, on the basis of the information provided, it is not possible at this stage to discuss the data further in a meaningful way.

26. Finally, a more encouraging picture emerges from the data on other basic indicators of the quality of treatment services. More than 75 per cent of the Member States responding reported positively on having written and approved standards and guidelines, as well as approved licensing regulations.

V. Work of the United Nations Office on Drugs and Crime in promoting measures to protect children and young people from drug abuse

27. UNODC has been assisting Member States to adapt evidence-based prevention programmes in schools, families and the workplace, as well as evidence-based and ethical drug dependence treatment and care services.³ In particular, during 2010, the Office provided training to almost 200 non-professional staff on how to deliver family skills training sessions to parents and their children in six countries in three regions. Most of these staff have already started to work directly with parents, who are testifying to the positive changes the work has brought about in their families and children. The programme currently reaches some 500 families and is due to

² United Nations Office on Drugs and Crime, "From coercion to cohesion: treating drug dependence through health care, not punishment", discussion paper based on a scientific workshop, Vienna, 28-30 October, 2009.

³ With regard to prevention of drug use, see the resources and documentation available from www.unodc.org/unodc/en/prevention/index.html, and in particular the UNODC publications: *Schools: School-Based Education for Drug Abuse Prevention* (United Nations publication, Sales No. E.04.XI.21); *Guide to Implementing Family Skills Training Programmes for Drug Abuse Prevention* (United Nations publication, Sales No. E.09.XI.8), supplemented by the *Compilation of Evidence-Based Family Skills Training Programmes* (2010); and *Workplace Prevention* (forthcoming). With regard to drug dependence treatment and care, the training materials and documentation of Treatnet and of the UNODC/World Health Organization joint programme on drug dependence treatment and care are available from www.unodc.org/treatment/en/index.html.

expand to six additional countries in 2011. However, it is clear that without further resources its beneficial reach can remain only very limited.

28. The UNODC international network of drug dependence treatment and rehabilitation resource centres, Treatnet, reached maturity in 2010, training 4,000 staff to deliver evidence-based, ethical and low-threshold services to people suffering from drug dependence. This groundbreaking work, currently being implemented in over 20 countries in five regions, is also being complemented by work to expand and improve the reach of the services themselves, aiming to assist at least 20,000 beneficiaries worldwide.

29. Moreover, UNODC is launching innovative initiatives aimed at children exposed to drug use at a very early age, the non-medical use of prescription drugs and access to controlled pain medications.

30. Substance use disorders are more problematic when the age of onset is low, given the increased damage that is produced in the underdeveloped brain. In most cases, the decision to experiment with psychoactive substances in children and adolescents is related to a combination of genetic and environmental factors contributing to psychobiological vulnerability and reduced resilience. UNODC promotes a worldwide coordinated response by public institutions and non-governmental organizations to assist children and adolescents at risk and/or affected by drug use, dependence and its health and social consequences. That response aims at reducing the risks of developing drug use disorders and at developing and providing appropriate treatment and social integration strategies tailored to respond to the specific needs of this age group.

VI. Conclusions

31. While specific conclusions are hampered by missing information from non-responding Member States, the general conclusions outlined below can be cautiously drawn from the data presented above.

32. Much remains to be done to ensure the protection of children and young people from drug abuse. This is particularly the case with regard to the provision of a comprehensive package of prevention activities that target with adequate coverage both the general population and groups particularly at risk. As is evident from the data collected, prevention activities are generally organized by fewer Member States than drug dependence treatment and care services, and this is especially the case with regard to particularly vulnerable groups.

33. In general, for both prevention and treatment, the availability of a range of services is of less concern than the actual coverage of the interventions. Most Member States indicated that they provided a range of prevention activities and drug dependence treatment and care services, even if less so for prevention than for treatment. Where the picture becomes problematic is in the coverage of the interventions, especially with high-risk groups with regard to prevention and to prison settings with regard to drug dependence treatment and care.

34. It is clear that much remains to be done to ensure that evidence-based and ethical interventions and services are universally accessible to those who need them.

35. As a first analysis and at a more general level, debate should be opened and an in-depth overview undertaken to examine the relative effectiveness and efficiency of different interventions so as to understand whether the limited resources available are being invested in the most appropriate way. There are some worrying signs in this respect with regard to both prevention and treatment. Family-based and brief interventions are backed by a much more solid base of scientific evidence and produce more positive and longer-lasting results than, for example, the provision of information and alternative activities, yet, they were being implemented by many fewer Member States. The case of outpatient versus residential treatment described above is a case in point with regard to drug dependence treatment and care.

36. The weak reporting with regard to the evaluation of prevention of drug use, as well as to the availability of estimates of numbers of people in need of treatment, points to a second general weakness to be addressed, that is, the availability of an appropriate data collection system capable of providing information that is useful in planning prevention and treatment programmes, as well as in assessing their implementation and effectiveness.

37. The worrying signs about coverage with regard to both prevention and treatment point to the need to identify among the wide range of evidence-based interventions minimum packages of a few low-cost interventions of proven effectiveness and the highest efficiency. Such packages should also be capable of being delivered by non-professional teams. This is not to say that fewer resources should be invested in training, to the contrary: adequate training and support of both professional and non-professional teams is key to the expansion of coverage while maintaining high-quality delivery and, thus, effectiveness and efficiency. Further, drug prevention interventions and services for drug dependence treatment and care must be mainstreamed in the normal delivery of health and education services of each country and should be universally accessible to the entire population, including prison inmates.

38. Finally, while there is a solid base of scientific evidence about the effectiveness and efficiency of many drug use prevention interventions and drug dependence treatment and care services, there are also many gaps, most notably with regard to prevention interventions that address individual risk factors at an early age and with regard to the pharmacological treatment of stimulant dependence. Member States should invest heavily in promoting scientific research to deepen understanding of the pathology of drug dependence, how to address its risk and protective factors, and how to treat and care for dependence on all substances. In this context, there is a need for initiatives that tackle the language and economic barriers that hamper the exchange of information between scientific communities.

VII. Recommendations

39. The discussion and conclusions above lead to the following recommendations, which are submitted for the consideration of the Commission on Narcotic Drugs:

(a) Member States should continue to strive to increase the range and above all the coverage of evidence-based and ethical interventions for both the prevention of drug use and the treatment and care of drug dependence, targeting the general population, but also groups particularly at risk and in prison settings;

(b) The Commission may wish to reinforce the mandate of and support to UNODC in assisting Member States in this endeavour by developing and disseminating the scientific base of evidence on the effectiveness of various interventions, as well as by providing technical assistance, as requested, in particular with regard to:

- (i) Emerging challenges, such as the problem of children exposed to drug use at a very early age and the non-medical use of prescription drugs, as well as access to controlled pain medications;
 - (ii) A package of low-cost, core and evidence-based interventions to be implemented in settings where resources are limited at maximum cost-effectiveness in the areas of both prevention of drug use and drug dependence treatment and care.
-