MODULE 3

Effective drug prevention and treatment

Aim of Module 3

To define, understand and analyse the objectives and desired results of evidence-based drug prevention and drug dependence treatment, as part of a comprehensive health-based approach to drug use.

Learning objectives

Participants will be able to:

- Understand the principles and potential results of drug prevention, and assess evidence for effectiveness
- Understand the objectives of different forms of drug dependence treatment
- Assess the cost-effectiveness of prevention and treatment interventions in resource poor settings.

Introduction

As drug use is increasing in West Africa (see Session 3.1 below), it is becoming urgent that governments establish evidence-based policies to respond to this phenomenon. Despite growing concerns, however, few countries in West Africa have a national drug policy that covers treatment and prevention, nor one which outlines clear and measurable goals and strategies. In the region, drug policies have tended to focus predominantly on law enforcement, in some cases with severe punitive measures towards all people involved in the drug trade, including people who use drugs. As discussed in previous modules, harsh punishments and the implementation of punitive drug laws have been ineffective at curbing the levels of drug use and have led to a number of serious health and social consequences for people who use drugs.

A number of politicians, NGOs, academics and UN agencies are now calling for drug use to be considered as a health issue, rather than a criminal one, and that consumption issues be tackled through a comprehensive health-centred strategy. Indeed, the West Africa Commission on Drugs, in its "Not just in transit" report, called on governments in the region to: "Treat drug use as a public health issue with socio-economic causes and consequences, rather than a criminal justice matter".[1] Such a strategy encompasses three main components – drug prevention and drug dependence treatment (which will be the focus of this Module), and harm reduction (which is discussed in Module 4).

A myriad of interventions have been developed over the years in the fields of drug prevention and treatment. But not all have been effective, and some have even been counter-productive and unable to reduce the health and social harms related to drug use. This module aims to capture the key objectives, characteristics and outcomes of evidence-based prevention and treatment interventions, and how these can be adapted to the context of West Africa.

MODULE 3

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Activity: Key elements of an effective drug dependence treatment programme

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Activity: Referrals to treatment: The limits of coercion

1. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

MODULE 3

Session 3.1

Presentation: Setting the scene: Drug use in West Africa

15 min

Aim – To offer the latest data around patterns of drug use in West Africa

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Explain to the participants that the first half of this module will focus on drug prevention, and the second on drug dependence treatment (with the next session focusing on defining these two concepts).

Information to cover in this presentation:

There is much concern today about illicit drug use in West Africa; but the problem is not a new one. As far back as the late 1950s there was already clear evidence that cannabis was being grown and consumed in several West African countries.[1] According to estimates by the United Nations Office on Drugs and Crime (UNODC), between 22 and 72 million adults use drugs in the region, with a prevalence rate in the range of 3.8 and 12.5%.

The pattern of illicit drug use in the region is characterised by a high prevalence of cannabis use, and low but increasing rates of cocaine, heroin and amphetamine use.[2, 3] In 2010, around 12.4% of adults in West Africa (aged 15-64) had used cannabis. Cocaine and heroin are newcomers in the illicit drug scene in West Africa, and were relatively unknown before the early 1980s. Although there is a lack of data related to the use of these drugs, many small surveys of heroin and cocaine use have been conducted in several West African countries. These studies show an estimated all-African average of 0.4% - but of 0.7% in West Africa, which is equal to the global average.[4] As for amphetamine-type stimulants (ATS), in particular methamphetamine, it has become a popular drug among traffickers in West Africa, and local production has increased in the region. Although ATS use has been recorded in the region for many years, the effects of these drugs are only now beginning to be felt.[5]

Studies conducted in several West African countries show that the numbers of people who inject drugs vary from a few hundred to several thousands.[6] As far back as 1998, injecting drug use was reported in five countries in the region, namely Nigeria, Cote D'Ivoire, Gabon, Ghana and Senegal.[7] Three rounds of UNODC-funded rapid assessments in Nigeria show that out of the 1,147 street-based people who use drugs recruited into the survey, 90 (8%) were current injectors, while 145 (13%) had injected at least once in the past.[8] The drugs most injected are heroin, cocaine, pentazocine[9] and speedball.[10,11]

Prevalence of drug use in different regions of Africa (adults 15-64, 2011)[12]

Region	Cannabis	Opioids (synthetic narcotics)	Opiates (naturally occurring narcotic)	Cocaine	ATS
East Africa	4.1	0.17	0.2	-	-
North Africa	4.4	0.25	0.3	0.02	0.6
South Africa	5	0.41	0.3	0.8	0.7
West/Central Africa	12.4	0.44	0.4	0.7	-
Africa	7.5	0.33	0.3	0.4	0.9
Global	3.9	0.7	0.4	0.4	0.7

Source: UNODC World Drug Report 2013

1. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
2. Lim, S.S. (2012), 'A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010', The Lancet, 380: 2224-2260
3. World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)
4. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
5. Ibid
6. Harm Reduction International (2014), 'Sub-Saharan Africa', *The global state of harm reduction*, www.ihra.net
7. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
8. Adelekan, M., & Lawal, R. (2006), 'Drug use and HIV infection in Nigeria: a review of recent findings'. African Journal of Drug and Alcohol Studies, 5(2): 118-129; http://www.sahealthinfo.org/admodule/afrjour/afrjour-drug2006.pdf
9. Pentazocine is a synthetically-prepared prototypical mixed agonist–antagonist narcotic (opioid analgesic) drug of the benzomorphan class of opioids used to treat moderate to moderately severe pain
10. Speedball refers to heroin and cocaine used together in a cocktail
11. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
12. Table drawn from: Asare, J.B. & Obot, I.S. (2013), *Treatment policy for substance dependence in West Africa, WACD Background Paper No. 8* (West Africa Commission on Drugs & Kofi Annan Foundation)

MODULE 3

Session 3.2
Activity: Objectives of drug prevention

20 min

Aim – To understand what the objectives of drug prevention interventions are

1. Introduce the aim of the session.
2. Ask the participants to brainstorm around a definition and the objectives of drug prevention and note the responses on a flipchart.

Example of what participants may come up with

- Reducing the overall prevalence of drug use

1. Reducing drug use among certain groups (e.g. young people, pregnant women, etc.)

- Reducing the levels of problematic drug use and dependence
- Reducing the frequency and/or quantity of use

3. Present the information below (present slides), adding up to what has already been said during the brainstorming session.

Information to cover in this presentation:

Drug prevention is an activity aimed at preventing, delaying or reducing drug use and/or its negative consequences in the general population or sub-populations. Prevention interventions can be realised in different settings and with different methods and contents. The duration can vary between one-off activities and long-term projects running for several months or more.

Some form of drug prevention interventions have been developed in most West African countries.[1] The challenge to policy makers and professionals is to develop and implement prevention programmes that are based on evidence of effectiveness, and that respond to the specificities of local needs. But the first challenge, before measuring effectiveness, is to define what the objectives of these interventions are – what are we trying to achieve?

The primary objective of drug prevention is to help people to avoid or delay the initiation of drug use (or, if they have started already, to avoid their drug use becoming problematic). However, the general aim of an effective, holistic prevention programme is broader than this: it contributes to the positive engagement of children, young people and adults with their families, schools,

workplace and community, and seeks to build important life skills and personal capacity in individuals.

One common misconception about drug prevention is that it consists merely of informing (generally warning) young people about the effects (most commonly the dangers) of drug use. Prevention is then often equated with scare tactics and mass media campaigns. However, there is currently no evidence to suggest that this approach has an impact on drug use behaviours, or that mass media campaigns are cost-effective. In reality, the challenge of prevention lies in helping people **to adjust their behaviour, capacities, and wellbeing** in fields of multiple influences such as social norms, interaction with peers, living conditions, and their own personality traits.[2]

Prevention science in the last 20 years has made enormous advances. As a result, practitioners in the field and policy makers have a more complete understanding about:

- What makes people more vulnerable to experiencing problems with drug use – the so-called "**risk factors**" – at both the individual and environmental levels. The evidence points to the following powerful risk factors: biological processes, personality traits, mental health problems, family neglect and abuse, poor attachment to school and the community, favourable social norms and conducive environments, and growing up in marginalised and deprived communities.
- What makes people less vulnerable to experiencing problems with drug use – the so-called "**protective factors**" – include psychological and emotional well-being, personal and social competence, a strong attachment to caring families, and schools and communities that are well resourced and organised. [3]

Some of the factors that make people vulnerable (or, in contrast, more resistant) to starting drug use, differ according to age – with risk and protective factors evolving through infancy, childhood and early adolescence (e.g. family ties, peer pressure, etc.). At later stages of the age continuum, schools, workplaces, entertainment venues and the media are all settings that may contribute to make individuals more or less vulnerable to drug use and other risky behaviours. Needless to say, marginalised youth in vulnerable communities with little or no family support and limited access to education in school, are especially at risk. So are children, individuals and communities torn by war or natural disasters.

Therefore, if governments invest in prevention activities expecting to achieve a **reduction in the overall level of drug use** in society, they are likely to be disappointed as very few prevention programmes evaluated so far have been able to show such impacts. If, however, the objective is to **delay the onset of drug use, strengthening individuals' ability to avoid drug problems, or increasing their knowledge of risks**, then some prevention programmes can achieve the desired results.

1. See: World Health Organization (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)
2. European Monitoring Centre on Drugs and Drug Addiction (2011), European Drug Prevention Quality Standards, http://www.emcdda.europa.eu/publications/manuals/prevention-standards
3. United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, http://www.unodc.org/documents/prevention/prevention_standards.pdf

MODULE 3

Session 3.3

Presentation: Defining the different types of drug prevention

30 min

Aim – To understand the various models and components of drug prevention programmes

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Distribute the "The drug prevention cards" previously cut from the handout and ask the participants to sort them out in the following categories:
   a. Universal prevention
   b. Selective prevention
   c. Indicative prevention
   d. Environmental prevention
4. Distribute the handout "The different types of drug prevention" and ask the participants if they have any more questions.

Information to cover in this presentation:

In order to strengthen protective factors and mitigate risk factors at the different stages of an individual's life, drug prevention activities need to be carefully designed and targeted – both in terms of who the target audience is, and what setting is best to use to reach that audience. Prevention practitioners usually categorise prevention interventions into four broad groups:[1]

1. **Universal prevention – i.e. intervening on *populations:*** this is the broadest approach to prevention, targeting the general public without any prior screening for their risk of drug use – these interventions assume that all members of the population are at equal risk of initiating use. Universal prevention interventions target skills development and interaction with peers and social life and can be implemented in schools, whole communities, or workplaces. Available evidence shows that these interventions have not been effective at reducing levels of use, and at times, have even proved to be counter-productive. We will turn back to effectiveness later in this session.
2. **Selective prevention – i.e. intervening on (vulnerable) *groups:*** these interventions target specific sub-populations whose risk of developing drug use or problematic drug use is significantly higher than average. Often, this higher vulnerability to drug use stems from social exclusion (e.g. young offenders, school drop-outs, marginalised ethnic minorities, etc.). Selective interventions therefore usually target the social risk factors (that is, the living and social conditions) that make this specific group more vulnerable to drug use.
3. **Indicated prevention – i.e. intervening on (vulnerable) *individuals:*** these programmes target high-risk individuals who are identified as having minimal

but detectable signs or symptoms that may put them at greater risk of experiencing problems with drug use (e.g. mental illness, social failure, antisocial behaviour, hyperactivity, etc.). The aim of indicated prevention is not necessarily to prevent initiation of drug use, but rather to prevent the (fast) development of dependence or problematic use.

4. **Environmental prevention – i.e. intervening on *societies and systems:*** these programmes are aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use. This perspective takes into account the fact that individuals do not become involved with drugs solely on the basis of personal characteristics, but rather that they are influenced by a complex set of factors in the environment, what is expected or accepted in the communities in which they live, national rules or regulations and taxes, the publicity messages to which they are exposed, and availability of drugs.

1. O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.) (2009), *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*, National Research Council and Institute of Medicine of the National Academies (Washington, D.C.: The National Academic Press)

MODULE 3

Session 3.4
Presentation: Minimum quality standards for drug prevention

15 min

Aim – To present and discuss the minimum quality standards set out in the region and beyond

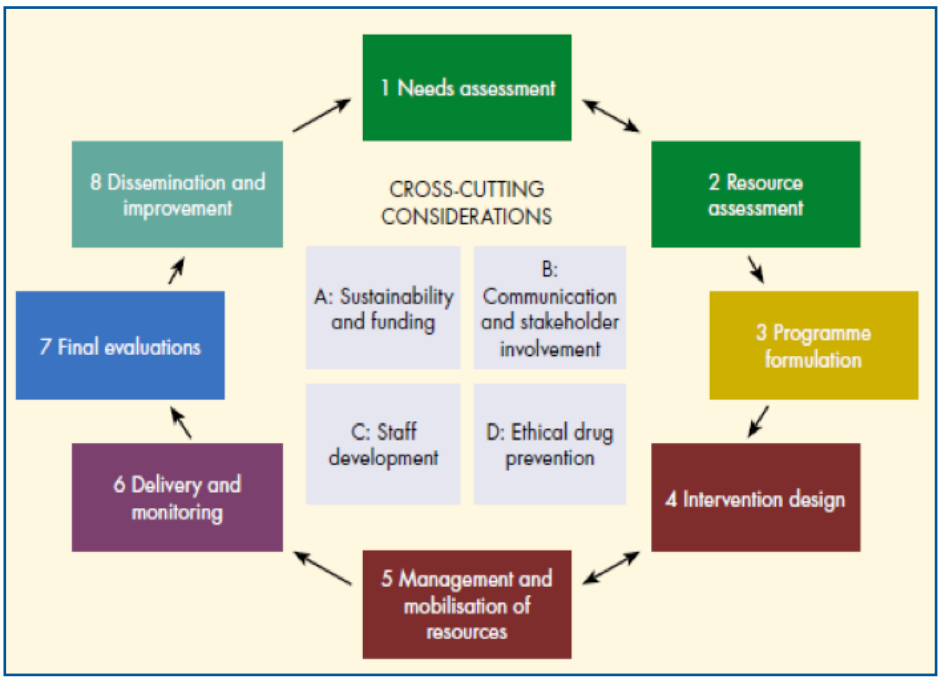
1. Introduce the aim of the session.
2. Present the information below (present slides). Ask the participants if they have any questions and whether their country has similar quality standards in the field of prevention.

Information to cover in this presentation:

There are several documents made available by the United Nations (UN) and other bodies that provide minimum quality standards in the field of drug prevention. Among those, the "Minimum quality standards in drug prevention" adopted by UNODC in 2013 provides useful information about how prevention interventions and policies should be developed and implemented, based on available evidence.[1] According to the report, "An effective national drug prevention system delivers an integrated range of interventions and policies based on scientific evidence, in multiple settings, targeting relevant ages and levels of risks", which include:

- A supportive policy and legal framework
- Scientific evidence and research
- Coordination of multiple sectors and levels (national, sub-national and municipal/local) involved
- Training of policy makers and practitioners
- A commitment to provide adequate resources and to sustain the system in the long term.

The EMCDDA Minimum Quality Standards on Drug Prevention manual also offers a set of tools on prevention interventions, based on the following prevention project cycle:[2]



The first step for an intervention to meet the quality standards is a **needs assessment** – that is, an assessment of drug use and community needs. This includes a thorough understanding of the targeted population or group (i.e. a mapping of the risks and protective factors in that particular group). While the needs assessment indicates what the programme should aim to achieve, the **resource assessment** offers important information on whether and how these aims can be achieved – this second step therefore provides a realistic understanding of the desirable type and scope of the programme. The **programme formulation** outlines the programme content and structure and provides the necessary foundation to allow for detailed, coherent and realistic planning. In the next stage, "**intervention design**", the contents of the intervention will be developed to ensure quality and effectiveness, as well as activities tailored towards the target population, taking into account evaluation requirements. A drug prevention programme consists not only of the actual intervention, but also requires good **management and mobilisation of resources** to ensure that it is feasible. At the stage of **delivery and monitoring**, the plans developed are put into practice; where there needs to be a balance between fidelity toward the original project plan, and flexibility to respond to emerging new developments. After the intervention has been completed, **final evaluations** assess outcomes and processes of delivery of the intervention. These evaluations will form the basis for **dissemination** of current results and **improvement** of our interventions for future prevention programmes.

Issues to consider in designing prevention strategies

There are a series of issues that need to be considered when designing an effective prevention strategy, some of which have already been mentioned above:

- What are the **objectives** of the drug prevention strategy? It is important not to be too ambitious – prevention programmes on their own cannot bring down overall levels of drug use significantly, but they can change the behaviours of some young people by delaying or preventing drug use, improving decision making and resistance, preventing problematic use, and encouraging safer choices.
- What is the **target group** for prevention programmes? While it is easier to reach the largest number of young people with mass campaigns through the media or schools, the delivery of simple information and messages about risks to a mass audience does not seem to have a big impact on behaviour. Planners also have to be clear on what age group they are targeting – interventions before the average age of initiation will focus on information, protective factors and resistance skills; while prevention in later years will focus more on minimising risky behaviour.

- What is the best **setting** for prevention messages to be delivered? This will depend very much on the age and breadth of the target group, but there are a number of options. Prevention interventions can be organised through families, community or religious networks, or health and social services structures. Two key factors need to be considered in deciding the setting for prevention – the extent to which the target group will engage with and trust the information provided and, particularly in resource-poor environments, the relative cost of any initiative (prevention programmes, depending on the design, can be very cheap or very expensive).
- What will be the best prevention intervention based on **available resources**? In resource-poor environments, it is important to avoid rushing into eye-catching campaigns that show immediate action, but will have little short- or long-term impact.
- Does the general **policy and regulatory framework** have an impact on my prevention interventions? Drug prevention is but one of the fundamental components of a health-centred system, alongside evidence-based drug dependence treatment and harm reduction. In this respect, an effective national system would be: 1- Embedded in a comprehensive and health-centred system of drug control focused on providing treatment, care and rehabilitation of drug dependence, and, preventing the health and social consequences of drug use (e.g. HIV/AIDS, hepatitis C, overdoses, etc.); 2- Based on the understanding of drug dependence as a complex health condition with a mix of biological, psychological and social causes; 3- Linked to a comprehensive national public health strategy; 4- Mandated and supported at the national level by appropriate regulation, including national standards for policies, interventions and practitioners; as well as requirements for schools, workplaces and health and social agencies to implement relevant prevention interventions; and 5- Supported by a local and national monitoring and evaluation systems to identify emerging substance use patterns and inform prevention strategies.
- Is the prevention intervention based on **scientific evidence and research**? Interventions and policies should be chosen on the basis of an accurate understanding of the situation. To this effect, a data collection system should be in place to provide information on drug use prevalence, drug use initiation and vulnerabilities. A formal mechanism should regularly feed the data generated by the information system into a systemic planning process. This data should be used to prioritise evidence-based programmes and carefully adapt our interventions without necessarily modifying the core components of the programme, but by making it more relevant to the new socio-economic/cultural context.
- Finally, the **effectiveness and cost-effectiveness** of delivered interventions and policies should be evaluated – programmes need to include a scientific monitoring and evaluation component to assess whether interventions result in the desired outcome.

1. United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, http://www.unodc.org/documents/prevention/prevention_standards.pd
2. European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, http://www.emcdda.europa.eu/publications/manuals/prevention-standards

MODULE 3

Session 3.5

Activity: The effectiveness and appropriateness of prevention interventions

1 h

Facilitators' note

The handout "Examples of drug prevention interventions" includes two copies of each intervention – one to be distributed to the group of participants and that only includes a photo/snapshot of the intervention, and a second copy to be kept by the facilitator and includes key information about each intervention to feed into the discussions during the exercise.

Aim - The effectiveness and appropriateness of prevention interventions

1. Introduce the aim of the session.
2. Explain to the participants that they will work in groups of 4-5 people (each group will need to nominate a note taker and a rapporteur). Give each group an example of a drug prevention programme – either as a handout (see the handout "Examples of drug prevention interventions"), or on pre-prepared slides. Based on what has already been discussed during this module, each group will respond to the questions below:
   a. What type of prevention programme is this? What do you think were its primary objectives?
   b. Do you think that the prevention programme was effective? Why?
   c. Would this programme be effective in your country? Would it be practically possible to implement it in your country?
3. Ask each group to present their case study and their findings to the rest of the participants (if possible, display the prevention interventions on PPT slides). Leave time for the participants to discuss each case study with the rest of the group.
4. Present the information below (present slides).
5. Ask the participants if they have any questions, explaining that this is the last session on drug prevention, and that the rest of the module will discuss drug dependence treatment.

Information to cover in this presentation:

A review of effectiveness

Major reviews[1] of drug prevention programmes have led to the following evidence-based conclusions:

- Mass media strategies are generally not effective except if delivered in coordination with community involvement interventions
- School-based prevention programmes that teach social and coping skills have a slight positive effect by delaying initiation when compared to provision of information about drugs and their effect
- Interventions that seek to change the school environment and classroom management are better than trying to change individual behaviour because factors that predict drug use also predict school failure

- Reducing criminal penalties for some drugs does not seem to increase drug use, but instead significantly reduces the health and social costs related to criminal penalties, especially incarceration.[2]

Therefore, the interventions that are the most effective have two main characteristics:

1. they focus on early intervention with their close social environment (i.e. family, classroom), and
2. they address issues other than drugs by focusing on social and behavioural development. [3]

A review of cost-effectiveness

Investing in evidence-informed drug prevention not only reduces the harms associated with drug abuse experienced by individuals, their families and communities, but it can also greatly reduce costs to society. A growing body of evidence over the last 20 years demonstrates that prevention can have significant cost-benefit savings. It has been shown that, for every dollar spent, good programmes for the prevention of drug use among youth can save up to 10 dollars.[4]

1. Hawks, D., Scott, K., & McBride, M. (2002), *Prevention of psychoactive substance use: a selected review of what works in the area of prevention* (Geneva: WHO)
2. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs & Kofi Annan Foundation), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
3. Babor, T., Caulkins, J., Edwards, G. et al. (2010), Drug policy and the public good (Oxford: Oxford University Press)
4. United Nations Office on Drugs and Crime (UNODC), "Prevention" http://www.unodc.org/unodc/en/prevention/; Canadian Centre on Substance Abuse, "A Case for Investing in Youth Substance Abuse Prevention", 2013 http://www.ccsa.ca/Resource%20Library/2012-ccsa-Investing-in-youth-substance abuse-prevention-en.pdf; Miller, T., & Hendrie, D. "Substance abuse prevention dollars and cents: a cost-benefit analysis," Center for Substance Abuse Prevention, SAMHSA (2009) http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf; Lee, S., Drake, E., Pennucci, A., Miller, M. & Anderson, L. "Return on investment: Evidence-based options to improve statewide outcomes". Olympia: Washington State Institute for Public Policy, 2012

MODULE 3

Session 3.6

Activity: The availability of drug dependence treatment in West Africa

20 min

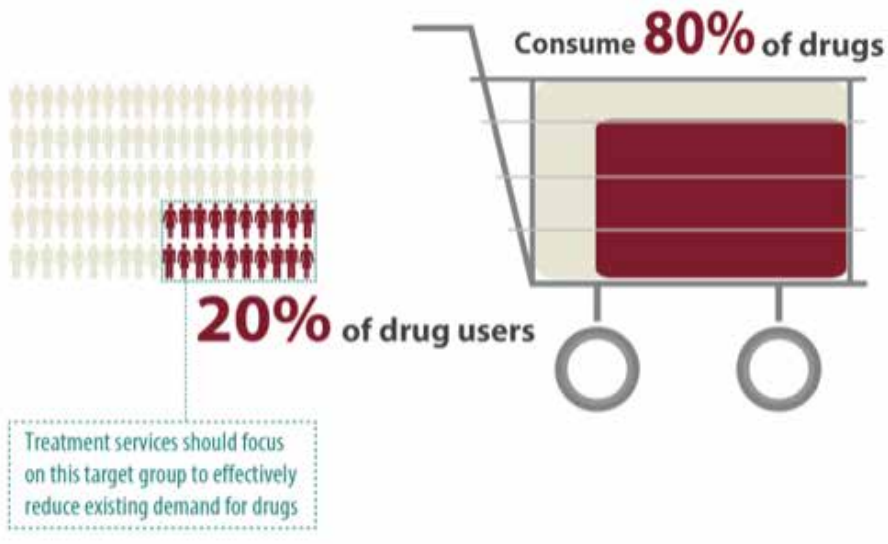
Aim – To establish the availability of treatment services in the region

1. Introduce the aim of the session.
2. Reiterate that the rest of this module will now focus on drug dependence treatment.
3. Ask the participants what kinds of drug treatment are available in their country/region, and whether they think these are appropriate.
4. Present the information below (present slides) and distribute the handout "Data on the availability of drug treatment services in 14 West African nations".

Information to cover in this presentation:

Drug dependence treatment refers to a wide range of support services (such as opioid substitution therapy [for more information about OST, please refer to Module 4 on harm reduction], psychosocial support, mutual aid support groups, abstinence-based treatment, etc.) for individuals experiencing serious problems related to their drug use. It is important to understand that treatment interventions are appropriate only for those who are diagnosed as dependent, or whose drug use is causing significant risks to themselves or others. Too often, scarce treatment resources have been directed at people who do not experience significant problems. This is a wasteful use of scarce resources, but also unnecessarily stigmatises a large number of people who use drugs as being incapable of looking after themselves.

Figure: The 20/80 rule of thumb



Source: Kleiman, Caulkins and Hawkins, 2011. Drawn from: http://www.wacommissionondrugs.org/report/

The gap between drug dependence and the availability of treatment services is significant and expanding as the prevalence and diversification of drug use increases in different countries across West Africa. A recent global survey of treatment resources shows a general lack of resources (facilities, personnel, training, etc.) for treating people with drug dependence across the world, but much more so in Africa, and particularly in West Africa.[1]

Across the region, most services are provided in psychiatric hospitals and traditional faith-based facilities which tend to be overcrowded and characterised by abuses of the rights of the clients seeking treatment. Those facilities also tend to be poorly funded, and lack personnel, skills and experience in the field of evidence-based treatment. This situation is caused, in part, by the lack of treatment policies that regulate the delivery of services in these facilities, but also by the fact that people who use drugs are often heavily stigmatised and are deemed as not deserving the expenditure of state resources. A snapshot of the availability of drug dependence treatment services across the region is available on the table below:

Country	SA Policy exists	Govt. Unit for SUD	Budget Line	Financing Method	Usual Treatment Setting	Medical detox for DUD	SMT available	Specialized Tx available	3 Most important professionals	National data collection
Benin	Drugs	Y	Y, drugs	Tax-based	Gen health	Y	N	N	Psych, GPs, Nurses	**Y**
Burkina Faso	N	Y, alcohol	N	Out-of-pocket	Gen health	N	Y	N	_	**N**
Chad	N	Y	N	Out-of-pocket	MH service	Y	N	N	Psych, Nurses, GPs	**N**
Cape Verde	N	MH	N	Insurance	MH service	Y	N	N	GPs, Psych, Psy	**N**
Cote d'Ivoire	Y/MH	MH	N	Out-of-pocket	MH service	N	N	N	Psych, GPs, Nurses	**N**
The Gambia	N	Y	N	Tax-based	Gen health	Y	N	N	Nurses, PHC workers	**N**
Ghana	N	MH	N	Insurance	MH service	Y	N	N	Psych, Counsellors, GPs	**N**
Guinea	Y/MH	N	N	Out-of-pocket	MH service	Y	N	N	Psych, GPs, Psy	**N**
Mali	N	MH	N	_	MH service	Y	N	N	Psych, Psy, Nurses	**N**
Niger	N	MH	N	External grant	MH service	Y	N	N	Addictologists, Psych, Nurses	**N**
Nigeria	N	Y	Y/MH	Tax-based	MH	Y	N	Y	_	**N**
Senegal	N	MH	N	_	MH	_	_	N	_	**N**
Sierra Leone	Y	MH	Y	NGOs	MH	N	N	N	Psych, Nurses, PHC	**Y**
Togo	N	Y	Y/MH	Out-of-pocket	MH	Y	N	N	GPs, PHC, Psych	**N**

Notes:
Y = Yes, available N = No, not available
MH = mental health Psy = psychologists Psych = psychiatrists PHC = primary health care workers GPs = general practitioners
SMT = Substitution maintenance therapy

Source: World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)

1. See: World Health Organisation (2010), ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders (Geneva: WHO)

MODULE 3

Session 3.7

Activity: Defining the objectives of drug dependence treatment

30 min

Aim – To understand who treatment is for, and what the expected outcomes of effective treatment should be

1. Introduce the aim of the session.
2. Ask the participants to brainstorm on what the objectives of drug dependence treatment should be. Note the responses on a flipchart.

Example of what participants may come up with

- Becoming abstinent
- Reducing levels/quantity of drug use
- Achieving a stable life
- Obtaining a job or continuing one's studies/training
- Reductions in petty crimes committed by people dependent on drugs to purchase drugs
- Reductions in public health threats

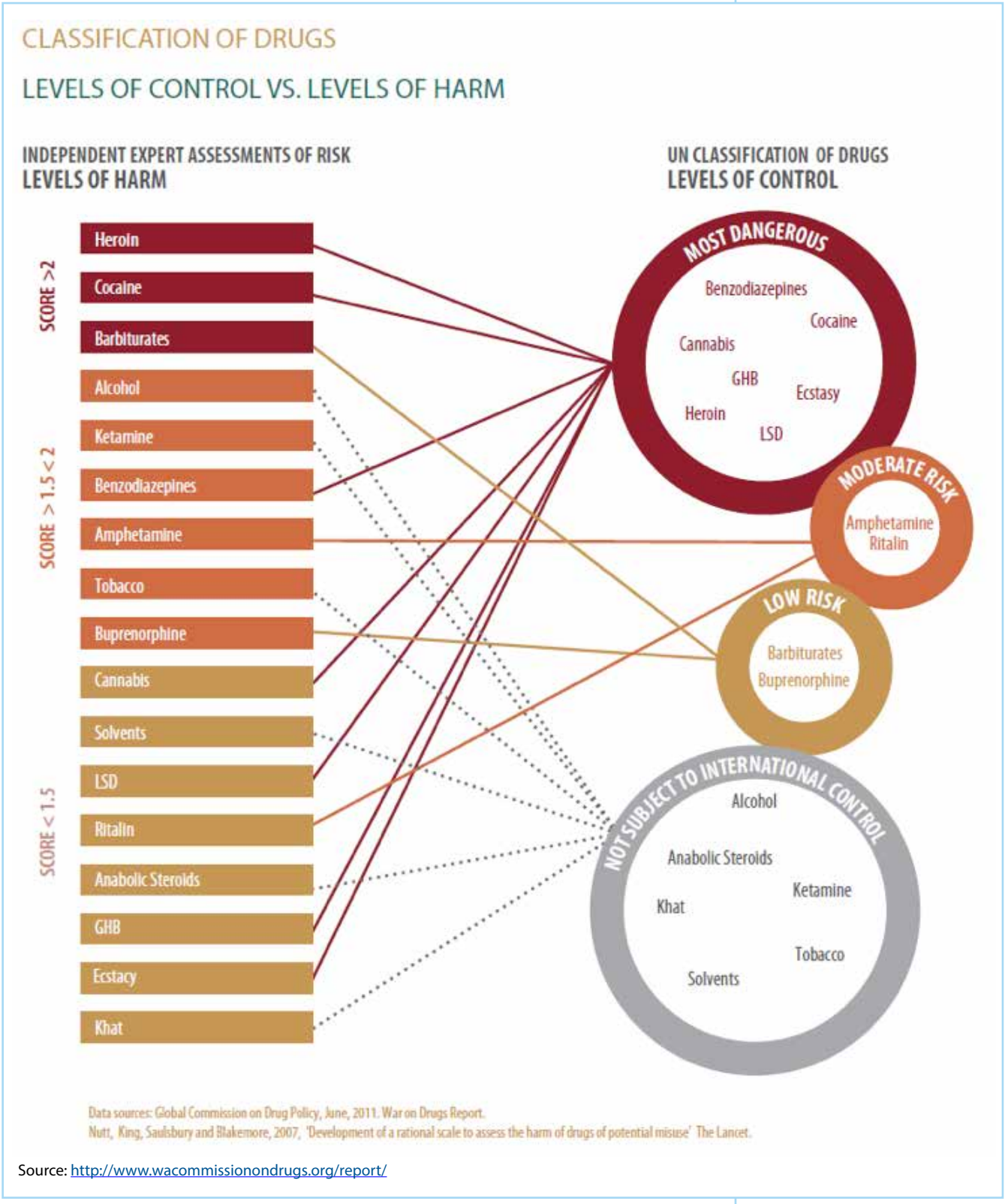
3. Reflect on what the participants have said, presenting the information below (present slides).

Information to cover in summary presentation:

It is important to remember that people who use drugs are a heterogeneous population, most of whom do not experience problems with their drug use. Only a minority will experience multiple and complex difficulties. It is therefore important to focus treatment interventions on those who are experiencing the greatest problems and have the greatest need. Forcing treatment on all people who use drugs (irrespective of the nature of their use) has led to a misdirection of resources, as well as the development of models of treatment that are ineffective and that breach the human rights of the patients.

Most young people who experiment with drug use do not become frequent users, and most who become frequent users do not become dependent. For example, it has been estimated that approximately 32% of people who use tobacco will become dependent, with a prevalence of 15% for alcohol, 23%for heroin, 15-16% for cocaine, 11% for amphetamines and 8% for cannabis.[1] Based on these numbers, it seems clear that there is no correlation between the addictive nature of a substance and whether it is legal or illegal. In fact, significant research has shown that international (and national) scheduling and control are scarcely

based on evidence. This graph displays the levels of harms caused by a substance compared to its levels of control to illustrate this point.



Source: http://www.wacommissionondrugs.org/report/

The key elements of dependence are the loss of control over use, and continued use despite awareness of problems caused or exacerbated by the using behaviour. The high risk of harm to individual users and the community of dependent and problematic use make this population the legitimate focus for treatment services. Because of its nature as a chronic relapsing health disorder, drug dependence requires long-term treatment and care.

The objectives of drug dependence treatment can therefore be categorised on three levels:

1. For the **individual**, the objective is the achievement and maintenance of physical, psychological and social well-being. This may be through reducing the risk-taking associated with drug use, through reducing levels of drug use, or through complete abstinence from drug use – dependent on the individual. Because of the chronic relapsing nature of drug dependence, and the need to address social and psychological dimensions, achieving abstinence is often a lengthy and difficult (or even undesirable) goal for some people. The provision of "stepping stones" or "stabilising strategies" in the form of more achievable interim goals helps to define and structure progress and also to reduce drug-related harms.[2]
2. For the **family or community**, the most important objective is that the person dependent on drugs is able to integrate and interact positively with those around them.
3. For the **wider society**, treatment aims to reduce health and social problems, including rates of early and accidental death, public health concerns such as HIV or hepatitis infection, or drug dependence-related crime. At a national level, many countries have reported falling crime rates, reduced levels of overdose deaths, and averted HIV epidemics, that can be attributed to drug dependence treatment strategies.[3] As will be shown below, all of these objectives can be successfully achieved through well designed and delivered treatment and harm reduction interventions (see Module 4).

When setting up a drug dependence treatment programme, policy makers must address three key questions. These will be further discussed during the rest of this training:

- **Who the treatment is for?** An assessment needs to be made of the current (and possible future) populations of users in a country and, critically, which subsets of these users are most problematic and in need of treatment. Care should be taken not to target or impose treatment or controls on individuals who are causing no social problems, as this would be a waste of limited resources. Mechanisms for identifying, making contact with, and motivating individuals to want to accept treatment need therefore to be carefully designed – although care should be taken to avoid unnecessarily coercive measures.
- **What the treatment is aimed at achieving?** In any given setting, the objectives of a treatment system will be a mixture of maximising recovery from dependence, and minimising the related crime, health and social problems. In practice, there will be different priorities which drive the need to develop or expand treatment, but a well-designed system and evidence-based interventions have been shown to achieve positive outcomes in all of these domains.
- **What mix of interventions and services are provided?** We have described above how research has shown that several treatment methods are particularly effective. Treatment planners need to offer a "menu" of services and settings, as no single model can be suitable for a group of patients using different drugs in different ways, with different emotional and psychological challenges, and in a variety of socio-economic and cultural contexts.

1. For more information, see: Wagner, F.A. & Anthony, J.C. (2012), 'From first drug use to drug dependence; developmental periods of risk of dependence upon marijuana, cocaine, and alcohol', *Neuropsychopharmacology*, **26**(4): 497-88, http://www.ncbi.nlm.nih.gov/pubmed/11927172; National Institute on Drug Abuse (October 2014), *Drugfacts*: Heroin, http://www.drugabuse.gov/publications/drugfacts/heroin; Anthony, J.C. & Echeagaray-Wagner, F. (2000), 'Epidemiologic analysis of alcohol and tobacco use', *Alcohol Research and Health*, **24**(4), http://pubs.niaaa.nih.gov/publications/arh24-4/201-208.pdf; World Health Organisation Western Pacific Region (2011), *Harm reduction and brief interventions for ATS users*, http://www.who.int/hiv/pub/idu/ats_brief2.pdf
2. World Health Organisation (2006), *Evidence for action: Effectiveness of drug dependence treatment in preventing HIV among injecting drug users"*, http://www.who.int/hiv/pub/idu/drugdependence_final.pdf?ua=1
3. International Drug Policy Consortium (2012), ' Chapter 3.3: Drug dependence treatment', *Drug Policy Guide,* http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition

MODULE 3

Session 3.8

Presentation: Minimum quality standards for drug dependence treatment

30 min

Aim – To understanding and compare what the minimum quality standards for drug dependence treatment are in Africa, and elsewhere.

1. Introduce the aim of the session.
2. Present the information below (present slides).
3. Ask the participants whether the treatment programmes in their country/region

Information to cover in this presentation:

As for drug prevention, a wide range of quality standards have been developed in the field of drug dependence treatment to ensure the effectiveness of available programmes.

According to the African Union (AU) *Continental minimum quality standards for treatment of drug dependence,*[1] drug dependence treatment should respond to the following standards and principles:

- Addiction is complex but treatable. It affects brain function and behaviour.
- Treatment needs to be readily available. Forcing someone who needs addiction treatment to wait for it when he or she is ready for it may mean losing that person to care.
- Matching treatment settings, interventions, and services to an individual's particular problems and needs is essential to the end-result and recovery.
- Effective treatment attends to several needs of the individual, not just drug use. To be effective, treatment must address the individual's drug use and any related medical, psychological, social, vocational, and legal problems. Treatment must also be tailored to age, gender, and culture.
- Recovery from drug addiction is a long-term route and frequently requires multiple instalments of treatment. Therefore, remaining in treatment for a sufficient period of time is critical, as is allowing patients to have as many rounds of treatment as necessary.
- Counselling and other social therapies are the most universally used forms of drug use treatment. Participation in group therapy and other support programmes during and following treatment assists abstinence.
- Medications are often a core element of treatment, in particular when linked with counselling and other social therapies. Treatment of opiate addiction using methadone, for example, even over a long period, is highly effective for many patients.
- Individual treatment plans must be evaluated frequently and adapted as required.

- Accessible and affordable treatment for mental disorders may be crucial to ensure effectiveness of treatment for drug dependence.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Patients should be encouraged to continue drug treatment following detoxification. Ongoing support, motivation and encouragement must also be included.
- While the voluntary nature of treatment is a central principle, family, friends and colleagues can often help by urging and encouraging entry into treatment.
- Drug use during treatment must be monitored to prevent lapses.
- Treatment programmes should assess patients for infectious diseases and provide support and counselling to help patients modify activities that place them at further risk.
- Treatment and rehabilitation services should play a key role in reducing the social stigma and discrimination against drug users and supporting their reintegration into society as healthy and productive members of the community.

In Europe, the European Union has worked on developing minimum quality standards on demand reduction.[2] Those related to treatment include the following standards:

- accessibility
- physical environment (adequate spacing, separate rooms for individual counselling, safety)
- indication criteria (i.e. diagnosis)
- staff education and composition (multi-disciplinary)
- assessment procedures (drug use and treatment history, somatic and social status, psychiatric status)
- individualised treatment planning
- informed consent
- written client records (e.g. assessment results)
- confidentiality of client data
- routine cooperation with other agencies.

1. African Union (2012), *Proposed continental minimum quality standards for treatment of drug dependence*
2. Uchtenhagen, A. & Schaub, M. (2012), Minimum quality standards in drug demand reduction EQUS, http://www.emcdda.europa.eu/attachements.cfm/att_231087_EN_INT09_EQUS_2012.pdf

MODULE 3

Session 3.9

Activity: Key elements of an effective drug dependence treatment programme

1:15h

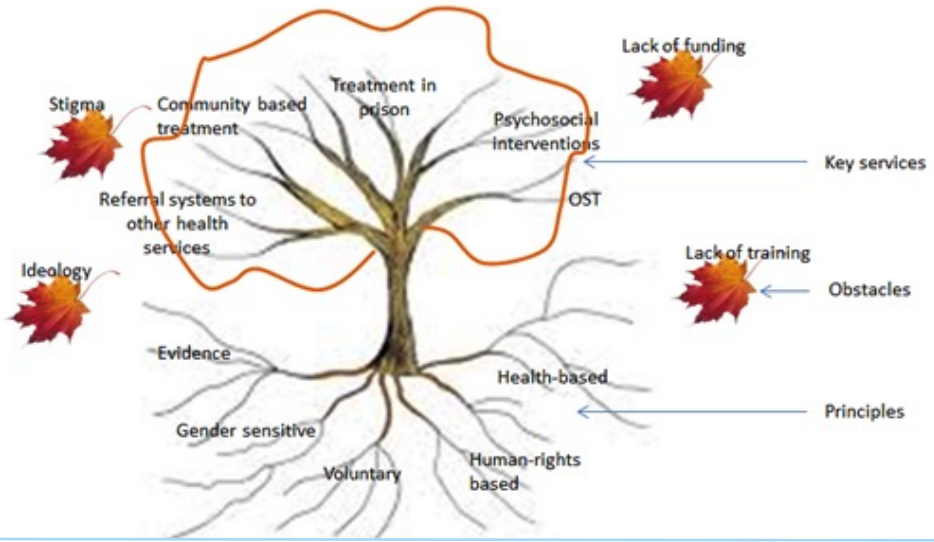
Aim – To understand and discuss the key aspects that constitute an effective and evidence-based drug dependence treatment programme

1. Introduce the aim of the session.
2. Divide the participants into four groups (each group will nominate a note taker and a rapporteur), give them a flipchart and marker pens.
3. Explain to the participants that they will produce a "tree of effective drug treatment".
4. Ask the participants to draw a trunk with roots and branches.
   a. Ask the participants to think of the basic underlining principles of drug dependence treatment, and note them along each root of the tree (can include evidence, human rights, gender-based, voluntary, etc.).
   b. Ask the participants to think of the key services that need to be offered as part of a comprehensive drug treatment programme (can include setting such as community, residential and prison, forms of treatment such as OST, psychosocial interventions, etc.).
   c. Ask each participant to use falling leaves (see Annex 5) to characterise the obstacles to evidence-based treatment.

Facilitators' note

This exercise is similar to those proposed in Sessions 1.5 and 2.2. To avoid repetitions, we advise the facilitator to use this exercise only once, either here or in Modules 1 and/or 2

Example of tree of effective drug dependence treatment



5. Ask each group to present their tree to the rest of the group. Leave time for the participants to comment on other groups' trees.
6. Present the information below (present slides), and distribute the handout "Key resources on drug prevention and treatment"

Information to cover in this presentation:

Treatment for drug dependence can come in different forms: specialised services, psychiatric care, the general medical care system, criminal justice/ prisons, social welfare system and the voluntary or NGO sector. In addition, treatment can also take place in traditional and religious healing sites – the latter accounts for a high proportion of people who seek treatment in Africa.[1] It is therefore important to consider the key aspects that characterise what is an effective drug dependence treatment strategy.

Treatment methods

The complexity of drug dependence is such that the response, setting and intensity of the treatment need to be tailored to each person. A menu of services should therefore be made available to suit the differing characteristics, needs and circumstances of each person. Below is a list of the most common methods used for drug dependence treatment – these are often used in combination and along other health and social services, whenever appropriate:

- Detoxification: defined by WHO as "the process by which an individual is withdrawn from the effects of a psychoactive substance" and "as a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimised". Detoxification is therefore the first stage of drug dependence treatment, and often needs to be followed by longer-term treatment to keep individuals from using drugs.
- Opioid substitution therapy: the prescription of a substitute drug for which cross-dependence and cross-tolerance exist, and used to minimise the effects of withdrawal or move the patient from a particular means of administration. There is significant evidence from around the globe that shows the effectiveness of OST. The most common drug substitutes include methadone, buprenorphine and naltrexone. In West Africa, OST is not widely used, mainly because opioid use is not common in the region. But consultations with experts in the region also suggest that there is a fear among health practitioners that OST would simply "substitute one addiction with another". Currently, OST is available in two West African countries – Burkina Faso and Senegal.
- Psychosocial treatment: counselling – individual or in groups – and other behavioural therapies including peer support. These activities vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, improving problem solving skills, facilitating better interpersonal relationships, etc. There is good evidence that these approaches, especially cognitive behavioural therapy (in particular motivational interviewing, contingency management and multidimensional family therapy), are associated with reduced drug use, as well as a decrease in drug-related problems, criminal activity and infections.
- Rehabilitation: aims to help people adjust to society and to overcome the many social problems associated with their drug use. It is important to manage family life, impart social skills and satisfy educational needs, as well as help solve employment and accommodation problems. Rehabilitation programmes ensure continued involvement of the client with treatment systems and should be viewed as an integral part of service delivery.[2]

Treatment settings

As well as offering a range of interventions, an effective treatment system should also deliver interventions in a range of environments. These can be broadly categorised as street-based (e.g. outreach, drop-in centres), community-based (e.g. regular attendance at a clinic, counselling, etc.) and residential.

In resource-poor settings, residential treatment programmes are often expensive and sometimes use unnecessary or unacceptable practices – they might, for instance, apply overly rigid treatment pathways to all clients irrespective of their individual

needs, use coercive or abusive practices, expect the clients to pursue particular sets of religious or community beliefs or isolate the clients from their families or friends. On the contrary, community-based treatment centres are generally more cost-effective, they usually have more capacity to deal with more patients, can be better integrated with other health and social support services, and can make better use of family and community support. The individual's recovery is also likely to be more robust if achieved in the community, as opposed to the rather artificial setting of a remote residential centre.

As many people who use drugs end up in prison (either because drug use continues to be heavily criminalised, or because the consumer has committed a crime), the rates of drug dependence amongst the prison population are high – and often significantly higher than among the general population. Prisons are therefore an important setting for drug treatment. Many of the principles of effective treatment in the community also apply in prison – the need for a range of services, incorporating clear assessment of need, motivational work, the availability of general health and specific harm reduction services, and voluntary access into both substitution and abstinence-based treatment pathways – but services need to be designed to fit in with the realities of prison conditions, ensuring that security is protected, taking into account the varying sentence lengths of participants, and working with the restrictions on movement of prisoners. Notwithstanding these restrictions, well designed and delivered prison-based treatment services can go a long way to protecting the health of prisoners, and preventing a return to drug dependence, risks of overdose deaths and crime after release.

Respecting human rights and the principle of individual choice

No matter what treatment method or setting is being used, treatment programmes must be respectful of human rights and the principle of individual choice to enter a treatment programme or not, and whether to comply and continue with it. This not only fulfils human rights obligations, but also ensures the effectiveness of the programme. Evidence shows that long-term behaviour change only comes about when individuals decide to change of their own free will. Treatment systems therefore need to be organised so that they encourage individuals to accept treatment and lay down the rules and expectations for programme compliance, but do not cross the line into coercion. We will examine the issue of coercion in the next session. Treatment programmes that use torture, cruel and inhuman punishment, humiliation, sleep and food deprivation, forced labour and other such practices also violate human rights and are ineffective strategies.

Ensuring cost-effectiveness

Drug dependence treatment is less expensive than alternatives, such as not treating or simply incarcerating people dependent on drugs. According to several conservative estimates, every $1 invested in evidence-based drug dependence treatment programmes yields a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1.[3] According to several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. OST has been shown to decrease criminal behaviour by as much as 50 percent amongst the patients. Research also shows that OST reduces risks of overdose deaths, as well as the risk of HIV infection – this form of treatment is much less costly than that of treating HIV-related illnesses. Finally, treatment can improve the prospects for employment.[4]

1. Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs & Kofi Annan Foundation), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf
2. Ibid
3. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (July 2014), *The funding crisis for harm reduction*, http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction
4. National Institute on Drug Abuse (2007). *Understanding drug abuse and addiction: What science says. Section IV.6*, http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment

MODULE 3

Session 3.10

Activity: Referrals to treatment: The limits of coercion

45 min

Aim – To assess what are acceptable levels of coercion into treatment

1. Introduce the aim of the session.
2. Explain to the participants that many governments across the world, but also in the region, have relied on some form of coercion to push people to enter treatment.
3. Divide the participants into four groups and distribute flipchart paper and marker pens to each group.
4. Ask the participants to divide the flipchart paper into two, in the length of the page. The left column will be entitled "Acceptable referrals/pressure", the right "Inacceptable referrals/pressure", and ask them to list all the methods they can think of that have been used to refer/push dependent users to a treatment programme.

Example of what participants may come up with

Acceptable referrals/pressure	Inacceptable referrals/pressure
Informed orientation of a person arrested by the police to a health facility	Police raids to arrest people who use drugs and send them to compulsory detention/treatment
Referral by an administrative body that has the health and social skills to do so	Referral by community members without the consent of the person
Drug courts	
Informed referral via a doctor or other health professionals	Mandatory drug testing
Self-referral	Referral by family member without the consent of the person
Voluntary access to treatment in prison	

5. In plenary, ask the participants to present their work to the rest of the group and explain why they categorised each method in a certain column.
6. Present the information below (present slides).

Information to cover in this presentation:

Another challenge is to be able to identify people who use drugs and encourage them to engage with social and healthcare services. As this population is often hidden, useful gateways can be established through which they can approach these services. However, these need to be careful not to fall into the "coercion into treatment" trap.

There are a number of routes through which people can access treatment:

- **Self-referral by the individual** – people who use drugs should therefore be aware of the types of treatment programmes available and how to reach them without fear of arrest. This can be facilitated through outreach services, in particular peer outreach programmes (see below)
- **Identification through general health and social service structures** – this necessitates that health professionals are adequately trained on issues related to drug dependence (often a challenge in some West African countries) and are aware of existing treatment facilities. It also requires a certain level of trust between the healthcare professional and the client, without fear of stigma and discrimination
- **Identification through specialist drug advice centres and outreach services** – these services can offer a range of services ranging from food, temporary housing, harm reduction services, etc. The existence of drop-in centres with a flexible and informal approach is a useful tool to provide a gateway for those caught up in drug dependence
- **Identification through the criminal justice system** – as mentioned before, people who use drugs regularly come into contact with the criminal justice system. The justice system can therefore play an important role in identifying dependent users and motivate them to access treatment. Treatment may then be offered as an alternative to arrest (in the UK, for example), or incarceration during court proceedings. In Nigeria and Mali, drug laws state that a person can be referred to treatment upon judgement, instead of conviction or punishment (in Nigeria, this is only for minors – for adults, treatment can be offered in addition to punishment). Although this has not been used in practice, it is a move away from a punishment-based approach to drug dependence. But, the question remains – what level of coercion is deemed to be acceptable?
    - In Asia, the practice of compulsory detention of people who use drugs has been condemned by many governments, UN agencies and NGOs. The practice involves arresting any person using drugs and coercing them to attend and stay in treatment programmes that often rely on physical and psychological abuse, rather than healthcare and support. This is an unacceptable practice.
    - The use of drug courts is also being extensively discussed worldwide, including in Nigeria and Mali in West Africa. Although this may be a useful way to refer people into treatment, there are a set of guidelines that should be respected to ensure that the mechanism works adequately: ensuring that those sent to treatment are dependent, that the assessment is done by trained medical professionals, that the individual has a choice to enter treatment or not, that those sent to the drug courts are not there for simple drug use (drug use itself should not be punished by criminal sanctions) but are people dependent on drugs who have committed other crimes, etc. Such a system is also fundamentally flawed by the fact that relapse into drug use constitutes an infraction leading to a prison sentence – this is against the scientific position that drug dependence is a chronic relapsing condition.

› Less extreme forms of compulsion have been applied in many countries, such as the use of mandatory drug testing as a measure of compliance into treatment.[34] Such a mechanism has, in practice, often resulted in mistrust between patient and treatment service provider, while not having a deterrent effect in levels of relapse, and should therefore be avoided.

It is very important, in designing assessment and treatment systems, that any external pressures and conditions applied to drug dependent individuals are justified by established criminal justice principles of due process and proportionality, and do not undermine the principle of self-determination.

1. For a full discussion on drug courts, see: Guzman, D. (2012), Drug courts: Scope and challenges of an alternative to incarceration (London: International Drug Policy Consortium), http://idpc.net/publications/2012/07/idpc-briefing-paper-drug-courts

Handout: The drug prevention cards

UNIVERSAL PREVENTION	SELECTIVE PREVENTION	INDICATED PREVENTION	ENVIRONMENTAL PREVENTION
Mass information campaigns	Prevention education children in foster care	Brief intervention for a child diagnosed with hyperactivity	Taxation of alcohol
School-based interventions	Peer support groups for children whose parents have a drug problem	Training for parents of a child with disruptive behavioural disorders	Publicity ban on tobacco
Education targeted at physicians on illicit use of prescription drugs	Skills training for unemployed people	Skills building programme for a teenager diagnosed with a mental illness	Ban on pentazocine by the national government

MODULE 3

Handout: The different types of drug prevention

	Universal	Selective	Indicated	Environmental
Developmental	Social/life-skills programmes to provide young people with skills to cope with social influences, classroom behavioural management to socialise children	Family/parenting programmes with families among vulnerable communities in a city/region/country	Individual counselling programmes with young male teenagers with impulse control problems	Legislation to prohibit drug use, suppression of international supply routes, taxation policies on certain substances
Informational	Mass media campaigns to raise awareness of the risks of drug use	Informational interventions targeted at young males in vulnerable communities with strong gang cultures	Normative feedback interventions for individuals who screen positive for drug use	Publicity bans, information on where substances can/ cannot be used (for tobacco, alcohol & cannabis in USA/ Uruguay)

Handout: Examples of drug prevention interventions

Prevention campaign against the use of new psychoactive substances in Romania

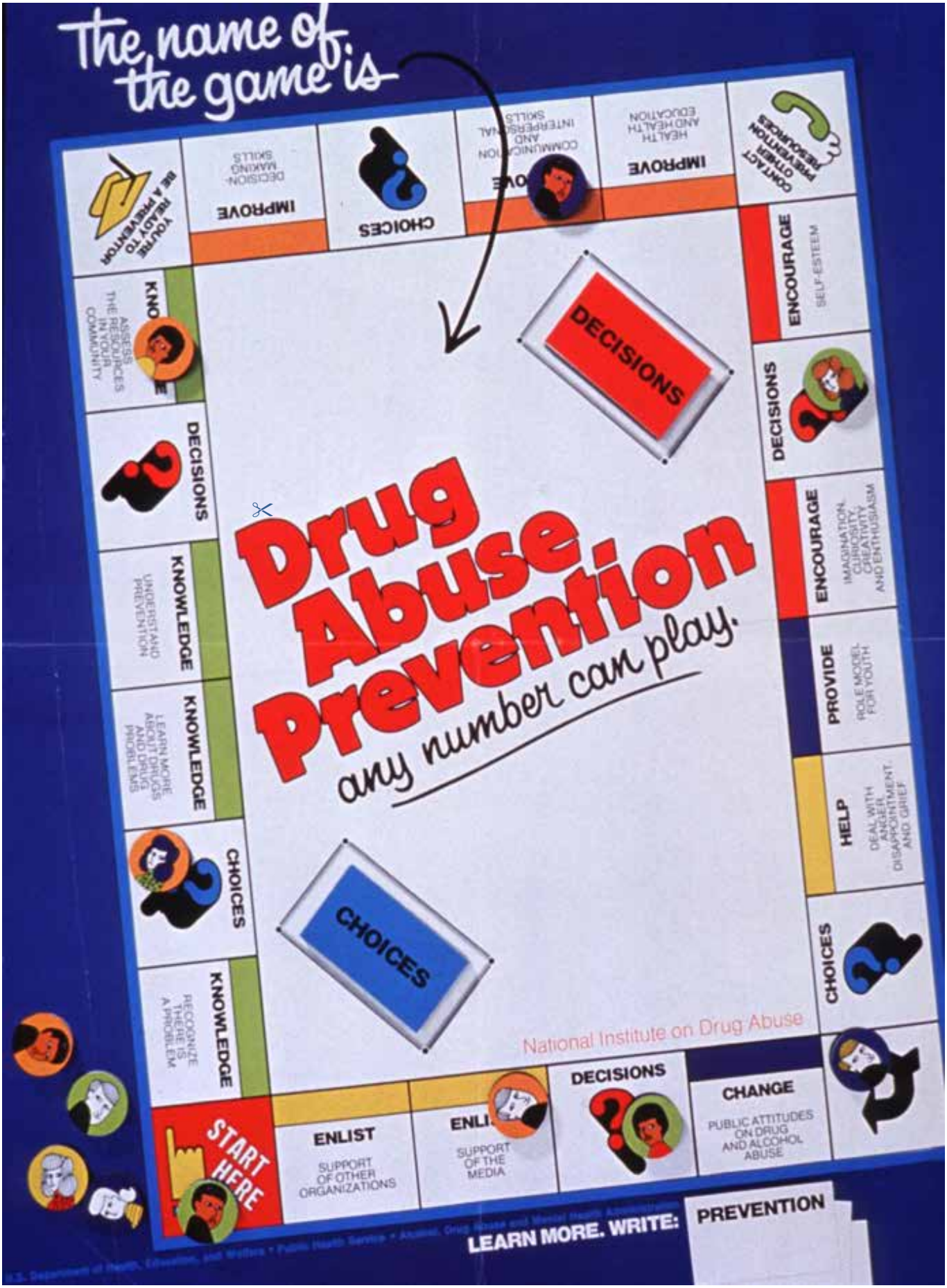
"The difference between a user of illicit plants and a cow is that the cow knows what it uses. Drug use kills!"

Prevention campaign against the use of new psychoactive substances in Romania:

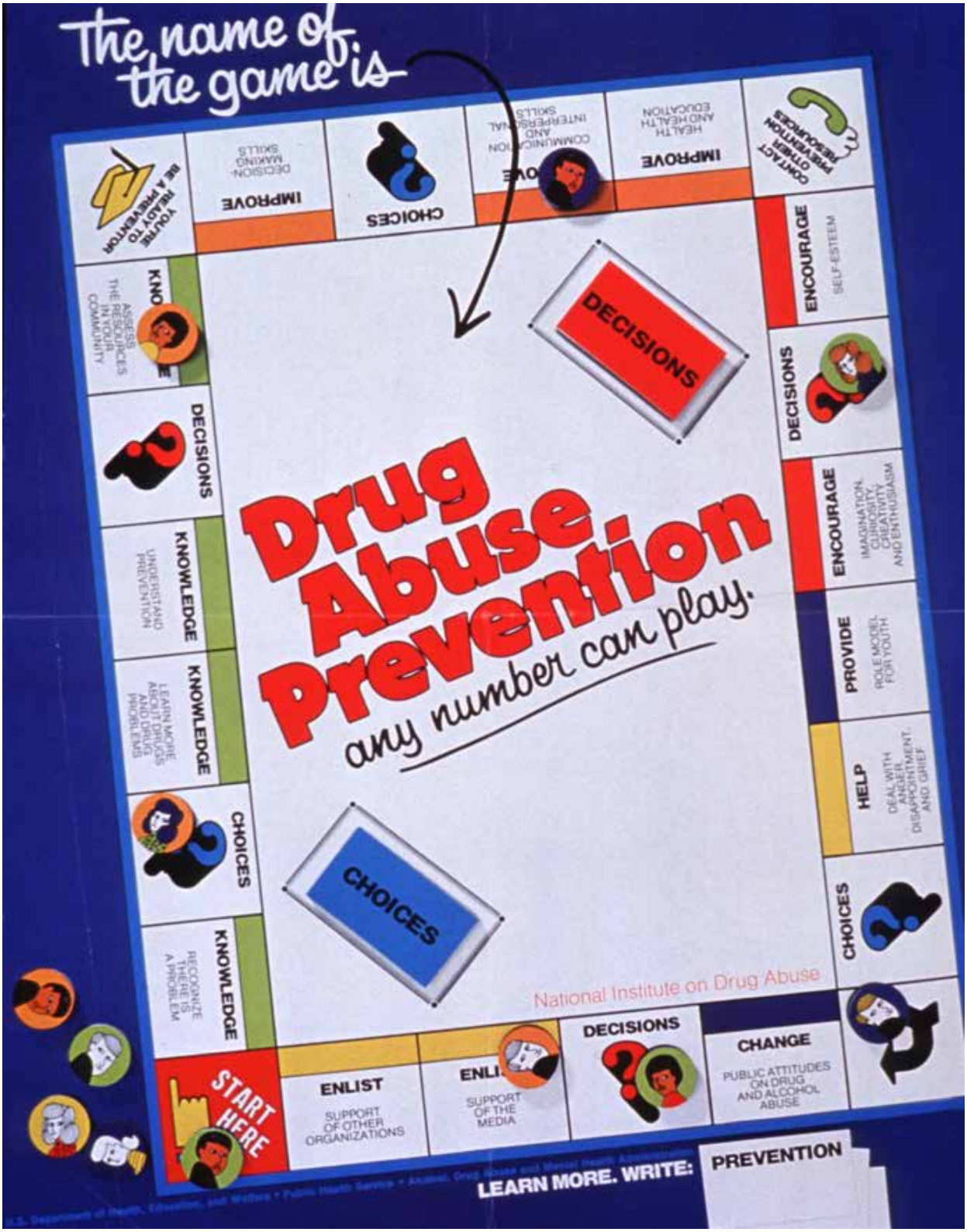
"The difference between a user of illicit plants and a cow is that the cow knows what it uses. Drug use kills!"

Recently, Romania has experienced a fast increase in injecting new psychoactive substances (see: http://www.emaramures.ro/stiri/55999/CAMPANIE-ETNOBOTANICE-Ministerul-de-Interne-raspunde-care-este-diferenta-dintre-un-consumator-de-etnobotanice-si-o-vaca-VIDEO-).
This has happened in parallel with the economic crisis, which has led many harm reduction services to close down – leading to a fast growing HIV epidemic among people who inject drugs. Instead of adopting a public health approach to the problem, the government has conducted bans on local stores selling NPS and has produced numerous drug prevention campaigns in the same spirit as this photo. In a country where drug use is particularly stigmatised, such campaigns can be more harmful than beneficial and can deter people who use drugs from accessing the health, harm reduction and treatment services they need.

Prevention campaign developed by the National Institute on Drug Abuse in US schools:



Prevention campaign developed by the National Institute on Drug Abuse in US schools



Prevention programmes are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills (Botvin et al. 1995). This game was developed by the National Institute on Drug Abuse to use in US schools. Instead of only focusing on a "just-say-no" message, the programme aimed at engaging children in meaningful conversations about drug use, possible harms, as well as the protective and risk factors related to drug use.

UNODC video released on the International Day against Drug Abuse and Illicit Trafficking in 2013 (international)

Video available at: https://www.youtube.com/watch?v=jJGw_d5nqi4

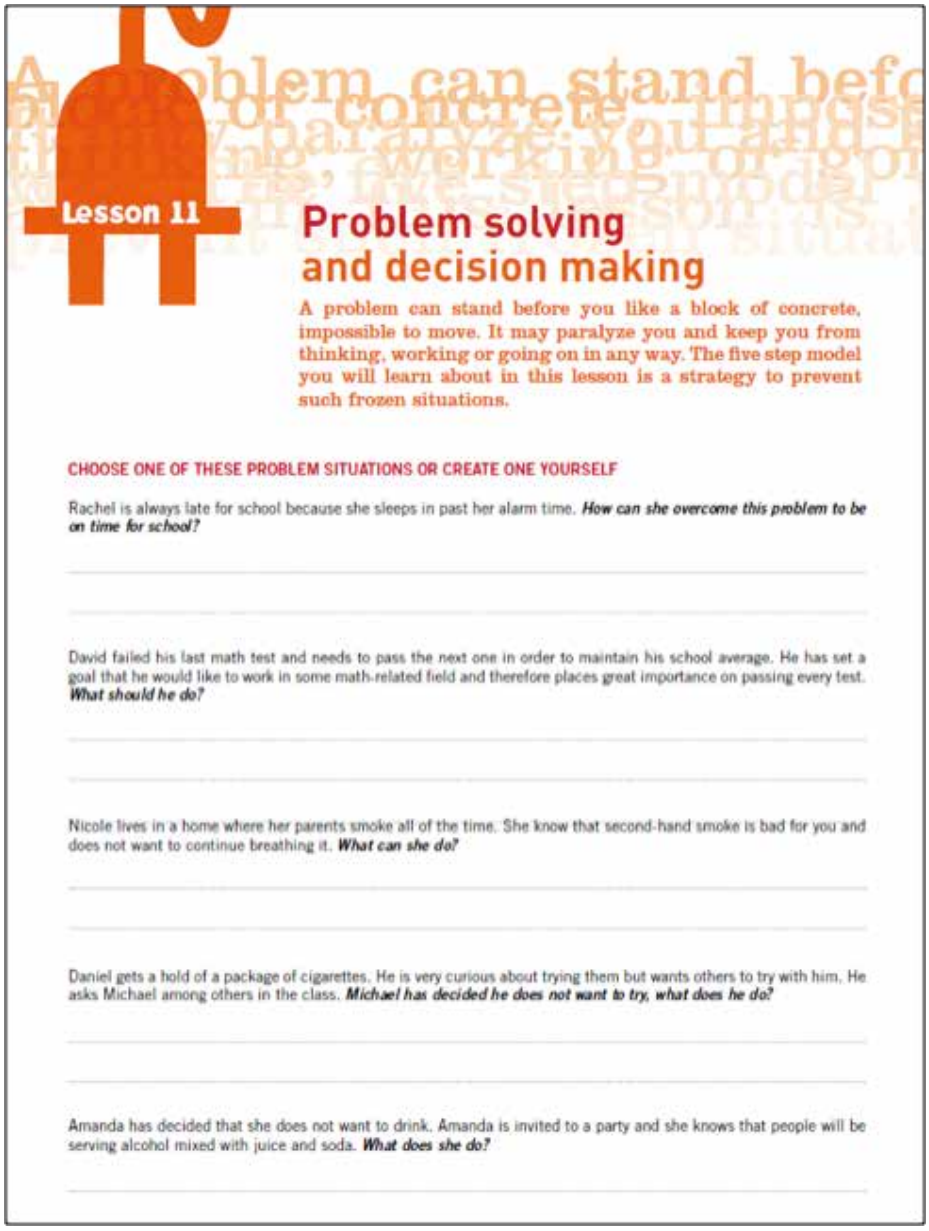
UNODC video released on the International Day against Drug Abuse and Illicit Trafficking in 2013 (international)

Video available at: https://www.youtube.com/watch?v=jJGw_d5nqi4

These mass media campaigns are very frequent across the world. A recent systematic review of all scientific evaluations of anti-drug public service announcements has found that these interventions had been largely ineffective, and may in fact encourage drug use and exacerbate the social stigma associated with drug use.

See: Werb, D., Mills, E.J., DeBerk, K., Montaner, J.S.G. & Wood, E. (2011), 'The effectiveness of anti-illicit-drug public-service announcements: A systematic review and meta-analysis', *Journal of Epidemiology & Community Health*, 65(10): 834-840

Unplugged prevention programme in schools (international)


Lesson 11

Problem solving and decision making

A problem can stand before you like a block of concrete, impossible to move. It may paralyze you and keep you from thinking, working or going on in any way. The five step model you will learn about in this lesson is a strategy to prevent such frozen situations.

CHOOSE ONE OF THESE PROBLEM SITUATIONS OR CREATE ONE YOURSELF

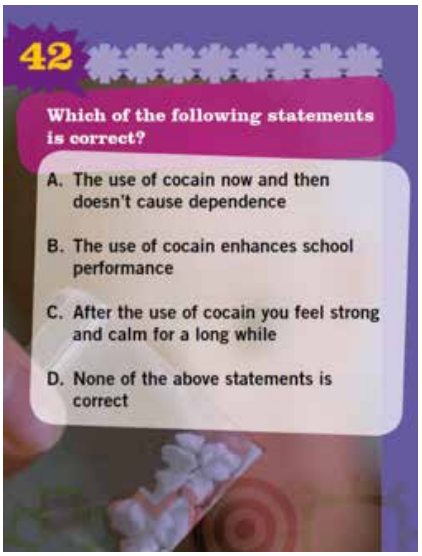
Rachel is always late for school because she sleeps in past her alarm time. ***How can she overcome this problem to be on time for school?***

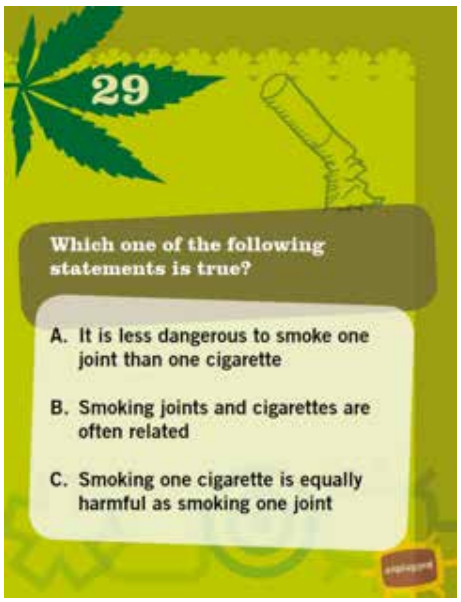
David failed his last math test and needs to pass the next one in order to maintain his school average. He has set a goal that he would like to work in some math-related field and therefore places great importance on passing every test. ***What should he do?***

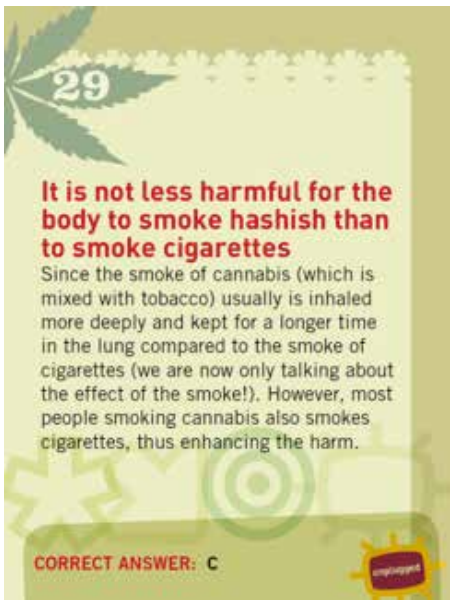
Nicole lives in a home where her parents smoke all of the time. She know that second-hand smoke is bad for you and does not want to continue breathing it. ***What can she do?***

Daniel gets a hold of a package of cigarettes. He is very curious about trying them but wants others to try with him. He asks Michael among others in the class. ***Michael has decided he does not want to try, what does he do?***

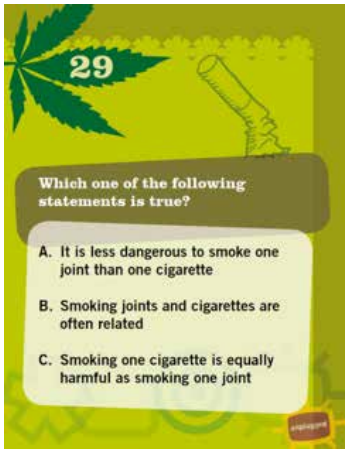
Amanda has decided that she does not want to drink. Amanda is invited to a party and she knows that people will be serving alcohol mixed with juice and soda. ***What does she do?***

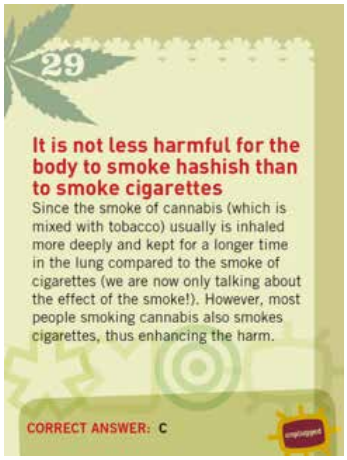


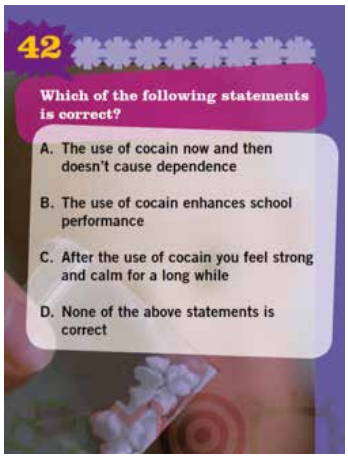


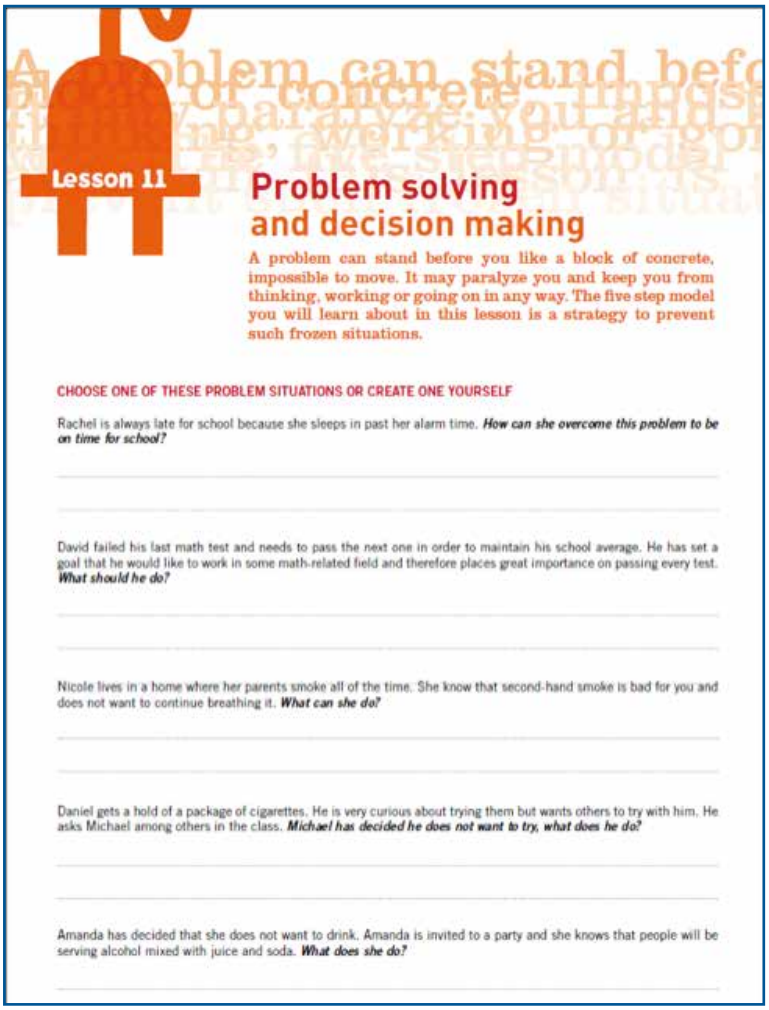


Unplugged prevention programme in schools (international)









Unplugged is the first school-based prevention programme developed in an international collaboration in Europe and evaluated in a multi-centre cluster randomised controlled trial. It is based on the comprehensive social influence approach, and includes training of personal and social skills with a specific focus on normative beliefs. Unplugged was developed by a European expert group as a standardised package and includes the following components: social skills, personal skills, knowledge and normative education. The core programme consists of 12 1-hour sessions to be delivered weekly by class teachers who previously attended a 3-day training course.

It is a strongly interactive programme and follows a standardised package programme. The programme has been evaluated in the EU-Dap study, a large European collaborative study conducted between September 2004 and May 2007 in seven European countries: Austria, Belgium, Germany, Greece, Italy, Spain and Sweden, and involving 143 schools, 345 classes and 7 079 students. The evaluation showed that Unplugged reduced the use of tobacco and cannabis, and the episodes of drunkenness among pupils receiving the programme versus pupils of the usual curriculum control group.

At post-test, significant intervention effects were detected for daily use of cigarettes, frequent and sporadic drunkenness episodes and cannabis use. The effect on drunkenness episodes and cannabis use was maintained at 18 months follow–up. In a second phase of the EU-Dap project, the teacher handbook was largely revised, mainly based on teacher feedback information. Moreover, to complement the new teacher's handbook, a student's workbook was developed, intended as a personal workbook of the student, and containing activities that students are to work through during the Unplugged units.[1]

[1] EMCDDA Best Practice Examples Database, http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=IT&tab=overview; http://www.eudap.net/Research_Pubblications.aspx

Handout: Data on the availability of drug treatment services in 14 West African nations*

Country	SA Policy exists	Govt. Unit for SUD	Budget Line	Financing Method	Usual Treatment Setting	Medical detox for DUD	SMT available	Specialized Tx available	3 Most important professionals	National data collection
Benin	Drugs	Y	Y, drugs	Tax-based	Gen health	Y	N	N	Psych, GPs, Nurses	**Y**
Burkina Faso	N	Y, alcohol	N	Out-of-pocket	Gen health	N	Y	N	–	**N**
Chad	N	Y	N	Out-of-pocket	MH service	Y	N	N	Psych, Nurses, GPs	**N**
Cape Verde	N	MH	N	Insurance	MH service	Y	N	N	GPs, Psych, Psy	**N**
Cote d'Ivoire	Y/MH	MH	N	Out-of-pocket	MH service	N	N	N	Psych, GPs, Nurses	**N**
The Gambia	N	Y	N	Tax-based	Gen health	Y	N	N	Nurses, PHC workers	**N**
Ghana	N	MH	N	Insurance	MH service	Y	N	N	Psych, Counsellors, GPs	**N**
Guinea	Y/MH	N	N	Out-of-pocket	MH service	Y	N	N	Psych, GPs, Psy	**N**
Mali	N	MH	N	–	MH service	Y	N	N	Psych, Psy, Nurses	**N**
Niger	N	MH	N	External grant	MH service	Y	N	N	Addictologists, Psych, Nurses	**N**
Nigeria	N	Y	Y/MH	Tax-based	MH	Y	N	Y	–	**N**
Senegal	N	MH	N	–	MH	–	–	N	–	**N**
Sierra Leone	Y	MH	Y	NGOs	MH	N	N	N	Psych, Nurses, PHC	**Y**
Togo	N	Y	Y/MH	Out-of-pocket	MH	Y	N	N	GPs, PHC, Psych	**N**

Notes:
Y = Yes, available N = No, not available
MH = mental health Psy = psychologists Psych = psychiatrists PHC = primary health care workers GPs = general practitioners
SMT = Substitution maintenance therapy

* World Health Organisation (2010), *ATLAS on substance use 2010: Resources for the prevention and treatment of substance use disorders* (Geneva: WHO)

MODULE 3

Handout: Key resources on drug prevention and treatment

Prevention

United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, http://www.unodc.org/unodc/en/prevention/prevention-standards.html

World Health Organisation (WHO), *Prevention publications*, http://www.who.int/substance_abuse/publications/prevention/en /

Obot, I.S. (2013), *Prevention and treatment of drug dependence in West Africa, WACD Background Paper No. 2* (West Africa Commission on Drugs & Kofi Annan Foundation), http://www.wacommissionondrugs.org/wp-content/uploads/2013/05/Prevention-Treatment-of-Drug-Dependency-in-West-Africa-2013-04-03.pdf

European Monitoring Centre on Drugs and Drug Addiction, *Prevention of drug use*, http://www.emcdda.europa.eu/topics/prevention

European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, http://www.emcdda.europa.eu/publications/manuals/prevention-standards

National Institute on Drug Abuse (2003), *Preventing drug use among children and adolescents: A research-based guide for parents, educators and community leaders*, www.drugabuse.gov/pdf/prevention/redbook.pdf

Treatment

European Monitoring Centre on Drugs and Drug Addiction, *Best practice in drug interventions*, http://www.emcdda.europa.eu/best-practice

Asare, J.B. & Obot, I.S. (2013), *Treatment policy for substance dependence in West Africa, WACD Background Paper No. 8* (West Africa Commission on Drugs & Kofi Annan Foundation)

European Monitoring Centre on Drugs and Drug Addiction (2011), *Guidelines for the treatment of drug dependence: a European perspective*, http://www.emcdda.europa.eu/publications/selected-issues/treatment-guidelines

European Monitoring Centre on Drugs and Drug Addiction (2014), *Treatment for cocaine dependence - Reviewing current evidence, http://www.emcdda.europa.eu/topics/pods/treatment-for-cocaine-dependence*

United Nations Office on Drugs and Crime (2012), Treatnet. Quality standards for drug dependence treatment and care services, http://www.unodc.org/docs/treatment/treatnet_quality_standards.pdf

United Nations Office on Drugs and Crime (2014), *Community based treatment and care for drug use and dependence – Information brief for Southeast Asia*, http://www.unodc.org/documents/southeastasiaandpacific//cbtx/cbtx_brief_EN.pdf

United Nations Office on Drugs and Crime & World Health Organisation (2009), *Principles of drug dependence treatment and care. Discussion paper*, http://www.unodc.org/docs/treatment/Principles_of_Drug_Dependence_Treatment_and_Care.pdf