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Follow-up to the twentieth special session of the General Assembly: general overview and progress achieved by Governments in meeting the goals and targets for the years 2003 and 2008 set out in the Political Declaration adopted by the Assembly at its twentieth special session

General debate of the ministerial segment: assessment of the progress achieved and the difficulties encountered in meeting the goals and targets set out in the Political Declaration adopted by the General Assembly at its twentieth special session

Second biennial report on the implementation of the outcome of the twentieth special session of the General Assembly, devoted to countering the world drug problem together

Report of the Executive Director

Addendum

Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction

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Contents

Tables

I. Introduction

1. Section VIII of the biennial questionnaire on drug demand reduction consists of seven subsections. The subsections deal with political and strategic responses (commitment), information resources (assessing the problem), responses (tackling the problem), methods of working (forging partnerships), working with vulnerable or special populations (focusing on special needs), dissemination and education (sending the right message) and training and coordination issues (building on experience). In addition, a subsection is included on difficulties encountered by States when implementing the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution 54/132, annex).

II. The commitment

2. Questions dealing with the commitment of States explore their political and strategic responses to drug demand reduction. A national strategy for drug demand reduction is important in coordinating responses and ensuring good practice and a balanced approach to implementing the measures to reduce demand and supply enshrined in the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex). Such a strategy also provides a basis for promoting multisectoral and community-wide responses, as called for in the Declaration. Appropriately, in the first question in section VIII, States are asked whether they have a national strategy for demand reduction. In the overwhelming majority of cases, the reply to that question was positive. Of the 115 States replying in the reporting period 2000-2002, 86 per cent reported that they had a national strategy. Comparing the replies of States in the second reporting period (2000-2002) with those in the baseline (or first) reporting period (1998-2000) reveals that a larger proportion of States reported having a national strategy for demand reduction for the period 2000-2002 (89 per cent compared with 84 per cent for the period 1998-2000).

3. The majority (82 per cent) of States that had a national strategy also reported for the period 2000-2002, in a supplementary response, that that strategy incorporated the Guiding Principles of Drug Demand Reduction, which suggests that their national strategic planning took into account the agreed principles of good practice. A comparison of the responses of those States which replied to this question for both reporting periods shows that there has been a significant increase in the proportion of States reporting that their national strategy incorporated the Guiding Principles: 96 per cent in the period 2000-2002, compared with 68 per cent in the period 1998-2000. In addition, for the period 2000-2002, 85 per cent of the States reporting indicated that their national strategy incorporated areas relating to prevention, while 81 per cent, 69 per cent and 76 per cent of States, respectively, reported that their national strategies incorporated provision for treatment, measures to reduce health and social consequences of drug use and abuse, and data collection initiatives.

4. A further indicator of both the appropriateness of national strategies and the extent to which they are in accord with the Declaration on the Guiding Principles of Drug Demand Reduction (which stresses that demand reduction programmes should

be based on a regular assessment of the drug situation) was that the majority (79 per cent) of States that had national demand reduction strategies reported that the nature of the drug problem had been assessed before their strategies had been developed. A comparison of States' replies to this question in both reporting periods shows that there has been a significant increase in the proportion of States that have assessed the nature of their drug problem (84 per cent for the period 2000-2002, compared with 74 per cent for the period 1998-2000) before developing their national strategy.

5. In almost all States (84 per cent) with national demand reduction strategies, there was reported to be a central coordinating entity responsible for the implementation of the strategy; 89 per cent of the States also reported that a multisectoral approach had been adopted as part of that strategy. For those States which responded to those two questions for both reporting periods, a central coordinating entity responsible for implementation of the strategy was reported to be present in 84 per cent of the States in the period 1998-2000 and in 88 per cent in the period 2000-2002 and a multisectoral approach to drug demand reduction in the national strategy was reported to have been adopted in 87 per cent of the States in the period 1998-2000 and 92 per cent in the period 2000-2002.

6. Table 1 summarizes the data on the extent to which governmental, public and official agencies at the national and local levels, as well as civil society organizations, were involved in developing and implementing the national strategy for drug demand reduction in the period 2000-2002. It shows the percentage of all responding States that gave positive replies to those questions.

Table 1
Involvement of different sectors in developing and implementing a national strategy for drug demand reduction: proportion of all States submitting the biennial questionnaire for the period 2000-2002 that gave positive replies
(Percentage)

Sector	*Involvement at the national level*	*Involvement at the local level*	*Involvement of civil society*
Health	89	79	73
Social services	81	71	71
Education	84	77	68
Law enforcement	83	71	30
Justice	74	60	30
Employment	50	44	32
Other	30	22	19

7. There is evidence in the data of considerable multisectoral and multi-agency cooperation. Not surprisingly, at the national and local levels, health agencies are most commonly involved in formulating and implementing a national demand reduction strategy, as are education, law enforcement, social services and justice agencies. One half of all States reporting also noted that employment agencies were involved at the national level in the formulation and implementation of a demand reduction strategy. The involvement of civil society (non-governmental organizations etc.) was most often reported in the health, social service and education sectors. Such input is in accordance with the Declaration on the Guiding

Principles of Drug Demand Reduction, which refers to the importance of forging partnerships between governmental and non-governmental bodies.

8. When comparing responses of States that replied to the above-mentioned questions in both reporting cycles (see table 2), it is worth noting that, while at the national and local levels and in civil society, health agencies are most commonly reported as being involved in formulating and implementing a national demand reduction strategy, proportionately more States reported that to be the case at the local level and in civil society during the period 2000-2002. The increased involvement of civil society in particular in the social service sector and of organizations at the national and local levels and in civil society in the education sector in the period 2000-2002 is also noteworthy.

Table 2

Involvement of different sectors in developing and implementing a national strategy for drug demand reduction: comparison of the proportion of responding States that gave positive replies for the reporting periods 1998-2000 and 2000-2002

(Percentage)

	Involvement at the national level		*Involvement at the local level*		*Involvement of civil society*	
Sector	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Health	93	93	74	82	68	78
Social services	85	84	71	72	63	76
Education	86	89	73	79	61	73
Law enforcement	89	83	67	70	32	27
Justice	82	76	60	60	29	30
Employment	53	54	44	45	35	34
Other	46	33	27	24	19	23

9. In response to the question of whether the implementation of the national drug demand reduction strategy was supported by a dedicated budget, 68 per cent of States reported that that was the case. As to whether States with national strategies had a framework in place for assessing and reporting on the results achieved, 69 per cent of States replied that they had such a framework. When comparing the replies of States for the baseline (or first) reporting period (1998-2000) with the second reporting period (2000-2002), it is worth noting that, more States with national strategies reported allocating dedicated budgets for implementation in the period 2000-2002 (74 per cent) than in the period 1998-2000 (60 per cent). Given the emphasis placed in the Guiding Principles on assessment and on the adoption of an evidence-based approach, it is also noteworthy that the proportion of States with national strategies that reported having a framework in place for assessing and reporting on the results achieved, increased from 69 per cent in the baseline (or first) reporting period (1998-2000) to 75 per cent in the second reporting period (2000-2002).

III. Assessing the problem

10. In the biennial questionnaire, the topic of assessment covers availability, quality and coverage of national or regional research programmes and assessment mechanisms. In addition, States can indicate the areas causing difficulties in assessing the drug problem pursuant to the Action Plan. The availability of national or regional research programmes on drugs, drug dependence and drug demand reduction remained stable during both reporting periods. In both the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002), 62 per cent of the States reported having research programmes available. Eighty-two per cent of States indicated having a mechanism for continued surveillance available in the period 2000-2002, compared with 61 per cent in the period 1998-2000.

11. As for the elements involved in implementing the mechanism available for the assessment, over half of all 115 States responding in the second reporting period reported that prevalence estimates (65 per cent), school surveys (65 per cent) and treatment reporting systems (59 per cent) were being implemented as part of the assessment of drug abuse. Fifty-three per cent of the responding States reported the availability of surveillance of infection with the human immunodeficiency virus (HIV) and 47 per cent reported the availability of surveillance of drug-related deaths. As for the other elements mentioned, Greece and the Netherlands reported the implementation of general population surveys, while Austria and Ireland reported that they were planning to conduct such surveys soon. Italy reported that it had an early-warning system in place as a national control measure for rapidly tackling newly identified drugs. Mexico reported both qualitative and quantitative research among various subgroups at risk, such as women in prisons and street children. Drawing conclusions regarding trends concerning the availability of assessment mechanisms is not possible, as the question was added as part of the revision of the biennial questionnaire that was carried out after the baseline (or first) reporting cycle.

12. A question on assessing the quality of the national information available on drug patterns and trends was included in the revised biennial questionnaire. Slightly less than one-third (30 per cent) of all responding States estimated that the quality of the information was good and half of those States (51 per cent) considered the quality to be moderate. Only 12 per cent of the responding States reported that the quality of the information was poor. While nearly one fourth of the responding States in Africa and in the Americas gave the highest rating (23 and 24 per cent, respectively) for their national information on drug abuse, in Europe one half (50 per cent) of the responding States considered their national drug information to be of good quality. There were great differences among the responding States in their capacity to invest in research activities, in terms of both intensity and scale. In Australia, for example, the National Drug Strategy benefits from dedicated national research centres that provide opportunities for a core research programme, and research priorities are negotiated with each centre. Some other States, such as Cyprus, reported that the efforts for conducting research were limited and methodologically inadequate.

13. Trends regarding areas where research was carried out are presented in table 3. Analysis shows increases especially in those areas where many States reported

research activities already in the first reporting period, including the areas of prevention, treatment, epidemiology and sociology. The trend in frequency of activities conducted in other research areas remained rather stable in the second reporting cycle compared with the first reporting cycle. When all States responding in the second reporting cycle are included in the analysis, the main research areas basically remain the same. In addition, 39 per cent of all responding States reported research activities currently being conducted in the area of HIV prevention. That is encouraging, as such research should provide data necessary for designing and implementing effective interventions. However, as the area of HIV prevention was not included in the questionnaire for the baseline (or first) reporting period, no conclusions can be made regarding trends in that area.

Table 3

Areas in which research results were published or research was carried out during the reporting periods: proportion of responding States that gave positive replies for the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002); and proportion of those that had given replies for the baseline reporting period that gave positive replies for the second reporting period

(Percentage)

Area	*Proportion that gave positive replies for the baseline (or first) reporting period (1998-2000) (n=109)*	*Proportion that had given replies for the baseline reporting period that gave positive replies for the second reporting period (n=89)*	*Proportion that gave positive replies for the second reporting period (2000-2002) (n=115)*
Biochemistry	22	23	17
Pharmacology	32	30	25
Sociology	46	54	46
Epidemiology	58	63	55
Prevention	61	67	62
Treatment	58	66	58
General drug policy	43	42	38
Cost analysis	21	20	17
HIV prevention	[a]	[a]	39

[a] Area not included in the questionnaire for the baseline reporting period.

IV. Tackling the problem

A. Prevention interventions

14. In the biennial questionnaire, prevention activities are broken down into the following three general areas of work: information and education about drugs and drug abuse; life skills development; and providing alternatives to drug use. States are also asked to rate the extent of activities in various settings. The data suggest that most prevention work is occurring in schools and involves providing information. It should be kept in mind, however, that there is a tendency for both life skills development and alternatives to drug use to target particular populations considered to be at risk, rather than necessarily being seen as appropriate

approaches for the general population. They may also be more complex and costly to implement than activities that simply provide information. Those factors may partly account for the more extensive reporting of information and drug education work as prevention activities. Tables 4-6 present the trend analysis of prevention activities covering the first two reporting periods (1998-2000 and 2000-2002).

Table 4

Extent of coverage and programme execution of prevention activities in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): information and education about drugs and drug abuse

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Schools	27	15	68	70	33	32	43	38
Community-based action	34	24	51	50	33	26	39	30
Workplace	50	38	17	16	32	14	31	14
Correctional system	42	23	32	39	35	34	26	28
Health centres	32	18	40	51	34	30	38	30

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

Table 5

Extent of coverage and programme execution of prevention activities in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): development of life skills

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Schools	28	11	49	60	40	20	38	35
Community-based action	39	16	31	39	34	20	28	30
Workplace	37	16	10	12	41	12	25	24
Correctional system	30	12	27	33	37	30	24	33
Health centres	30	12	29	29	34	30	28	38

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

Table 6

Extent of coverage and programme execution of prevention activities in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): providing alternatives to drug use

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Schools	22	16	48	43	37	23	34	23
Community-based action	28	20	35	35	35	24	29	24
Workplace	31	10	9	12	27	18	25	23
Correctional system	28	16	23	25	43	33	29	25
Health centres	25	10	24	26	42	26	34	31

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

15. Sixty-six per cent of all States submitting replies to the questionnaire reported school-based drug education programmes with medium or high coverage of the target group. Other settings considered for the provision of information and education about drugs with a significant medium or high coverage were health centres (46 per cent) and community-based action (44 per cent). Relatively little interest was devoted to the correctional system (35 per cent) and the workplace (13 per cent). Those States which had submitted replies to the questionnaire for the baseline (or first) reporting period as well as for the second reporting period reported slightly increased rates for programmes with medium or high coverage for schools (from 68 to 70 per cent), health centres (from 40 to 51 per cent) and the correctional system (from 32 to 39 per cent). In line with the results of the first reporting period, about a third of all programmes (with the exception of the workplace setting) were reported as gender-sensitive, although the criteria on which that judgement is based remain unclear and may be a topic worthy of more detailed consideration and discussion in the future. School-based drug education programmes remained those which are most likely to be evaluated (37 per cent); however, in general, and especially in comparison with the previous reporting period, there was a notable decrease in the percentage of programmes being evaluated in all settings.

16. In this context, life skills development refers to a range of activities designed to strengthen social and coping abilities to enable an individual to avoid taking illicit drugs and developing drug problems. Programmes for the development of life skills were more commonly reported in school settings. Such work is sometimes considered particularly appropriate for high-risk or vulnerable populations. That is probably reflected in the fact that 30 per cent of all States submitting replies reported the implementation of extensive life skills programmes, particularly in prisons. The workplace was again the setting in which such work was least often conducted. Compared with the baseline reporting period (see table 5), there was a

significant increase in the number of States reporting in the second cycle extensive coverage in the school, community-based and correctional system settings. Gender-sensitive programmes were less common. Evaluation is more common and there has been some increase in comparison with the baseline (or first) reporting period. That is probably because of the fact that such programmes are more intensive and therefore more likely to have the human and financial resources to carry out evaluation. As shown in table 6, in the area of providing alternatives to drug use, there has been a slight increase in the coverage of programmes in the workplace, the correctional system and health centres. Such programmes encourage positive activities and training to displace the role that drug use might play in a person's life. It is also common for that approach to be regarded as particularly appropriate for young people or for those considered being at increased risk of developing drug problems.

B. Treatment and rehabilitation

17. The treatment and rehabilitation of drug abusers and people who are drug-dependent is clearly an important area of demand reduction work. Drug abuse treatment can and should be expected to improve the public health and social problems of patients; there are methods of organizing the structure and delivery of care to achieve those outcomes in a cost-effective manner. Amalgamating treatment and rehabilitation services is difficult because of the diversity of activities and settings found in countries. In the questionnaire, treatment and rehabilitation services are grouped under the following headings: detoxification; substitution therapy; non-pharmacological treatment; and social reintegration. The corresponding data are presented in tables 7-10 below.

18. Detoxification is among the most commonly used forms of intervention for drug abuse and drug dependency. On its own, detoxification is unlikely to be effective in helping patients achieve lasting recovery; this phase is better seen as a preparation for continued treatment aimed at maintaining abstinence and promoting rehabilitation. A wide range of procedures might fall under this heading, and they are likely to vary both by drug type and by country. It should not, therefore, be assumed that the responses given describe similar services. That is most probably true for the use of detoxification medicines, where practice varies considerably, ranging from herbal treatments to the use of opioid medication. In the second reporting period, detoxification was reported to be most commonly provided in specialized residential treatment institutions, general and psychiatric hospitals and specialized non-residential treatment institutions, in that order. About one out of two States reported medium or high coverage of residential detoxification services, while one in three reported relatively extensive coverage of non-residential detoxification services and one in four reported relatively extensive detoxification services in correctional institutions. Between one in three and one in four States reported gender sensitivity in detoxification services, the highest being in correctional services, social services and residential specialized addiction treatment service settings. Results of detoxification services had been evaluated in between one in three and one in five reporting States, depending on the setting, most frequently within social services or specialized addiction residential and non-residential services.

Table 7

Extent of coverage and programme execution in the areas of treatment and rehabilitation in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): detoxification

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
General and psychiatric hospitals	34	28	52	48	34	31	43	22
Primary care and other health facilities	47	23	18	25	30	27	31	27
Correctional institutions	39	19	20	28	38	37	20	28
Community institutions	25	7	17	18	38	26	29	22
Specialized addiction treatment (residential)	16	15	57	55	41	35	47	30
Specialized addiction treatment (non-residential)	29	16	43	38	35	29	43	29
Social services	25	7	18	12	32	42	28	26

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

Table 8

Extent of coverage and programme execution in the areas of treatment and rehabilitation in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): substitution treatment (therapy), excluding short-term detoxification

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
General and psychiatric hospitals	26	17	18	26	33	29	40	34
Primary care and other health facilities	19	8	18	20	34	23	41	31
Correctional institutions	17	6	14	25	41	33	24	44
Specialized addiction treatment (residential)	28	11	23	29	36	36	38	36
Specialized addiction treatment (non-residential)	17	10	42	31	33	33	48	49
Social services	9	3	15	9	50	58	38	42

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

Table 9

Extent of coverage and programme execution in the areas of treatment and rehabilitation in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): non-pharmacological treatment

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
General and psychiatric hospitals	28	21	27	23	27	23	42	25
Primary care and other health facilities	29	7	17	25	26	24	26	28
Correctional institutions	25	19	24	33	40	31	38	35

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Specialized addiction treatment (residential)	18	15	46	52	40	40	49	37
Specialized addiction treatment (non-residential)	21	11	46	45	32	37	48	42
Social services	24	11	16	18	27	30	32	23

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

Table 10

Extent of coverage and programme execution in the areas of treatment and rehabilitation in the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002): social reintegration

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
General and psychiatric hospitals	34	20	18	13	42	34	35	22
Primary care and other health facilities	35	15	8	13	34	37	26	22
Correctional institutions	33	15	24	30	31	31	27	18
Specialized addiction treatment (residential)	21	12	43	44	35	28	41	24
Specialized addiction treatment (non-residential)	26	17	37	36	41	19	50	33
Social services	27	10	27	33	34	23	31	23

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

19. Drug substitution therapy is widely used in the management of opioid dependence (opioid substitution treatment, opioid replacement therapy, opioid pharmacotherapy). For the sake of clarity, the question excludes short-term drug therapies intended for detoxification. Like the questionnaire for the baseline (or first) reporting period, the questionnaire for the second reporting period yielded data on the provision of substitution therapy that were broadly similar in pattern to those found for detoxification, though with somewhat lower coverage. Substitution treatment was reported to be, for the most part, extensively available in general and psychiatric hospitals and specialized residential and non-residential addiction treatment (in one in four reporting States), while its coverage within correctional institutions and primary-care facilities was medium or high in one in five reporting States. Once again, the services reported to be most gender-sensitive were those based on social services (50 per cent of the responding States), followed by those in specialized residential and non-residential treatment services (in about one in three reporting States). Social services, specialized non-residential treatment and services in correctional institutions were reported to have been evaluated in about one in two reporting States.

20. Non-pharmacological treatment and rehabilitation strategies have included such diverse elements as various forms of group and individual counselling and therapy sessions, Vedic medicine, acupuncture or participation in peer or help groups to provide continued support for abstinence (or any combination of those elements) administered both in residential and non-residential settings. Reports on the provision of non-pharmacological treatments present a slightly different pattern to detoxification and substitution therapy. Most forms of non-pharmacological treatment appear to be provided by specialist services on an in-patient or ambulatory basis (about two in five States), as well as in correctional institutions (about one in four States), but less frequently in hospitals or primary care. Several States (for example, Germany, Haiti, Mexico and Palau) referred to the contribution of self-help groups to the provision of such treatment. In addition, El Salvador noted the contribution of psychotherapy and group therapy, and Australia highlighted the comprehensive range of responses offered. Non-pharmacological treatment services in specialized residential settings were most frequently reported as being gender-sensitive (two in five States), while about one in three States reported that such services offered in specialized non-residential or correctional settings were gender-sensitive. The settings most frequently evaluated were reported to be those of specialized addiction services (both residential and non-residential) and correctional institutions (about two in five States).

21. The ultimate aim of treatment and rehabilitation is the eventual reintegration of the former drug abuser into society. Successful social reintegration requires efforts at all levels of society, in the family, community, workplace and schools (both formal and non-formal educational settings), supported by policy and legislation. Social reintegration was reported to be most commonly available in specialized residential and non-residential treatment services (about one in three States reported medium or high coverage), followed by social services and correctional settings (reported by about one in four States). Specific services highlighted by some States were: employment services (Austria and Greece), non-governmental organizations and youth associations (El Salvador and Mexico) and halfway houses (Singapore). While not a common setting for reintegration services, primary-care services were reported by two out of three States to provide gender-

sensitive reintegration; they were followed by community institutions and general hospitals (about one in three States). Availability of evaluation results of social reintegration services in different settings ranged from one in three States (for specialized non-residential services) to about one in six States (for community institutions).

22. A number of States mentioned additional services or settings not specifically mentioned in the questionnaire, such as brief population-based interventions (Australia), work with street children through community institutions (Chile), acupuncture, yoga and naturopathy (India), consultation services by narcotic control officers (Japan and Zambia), civil society and non-governmental organizations (Mozambique), community approaches (Myanmar), faith/religious assistance/therapy (Palau, Saudi Arabia, Thailand, the United States of America, and Venezuela), naltrexone (Singapore), outreach (Sri Lanka), health promotion (Swaziland), poison control centres (Tunisia) and private clinics (Uzbekistan).

23. Comparison of the overall availability of treatment and rehabilitation services as reported through the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002) seems to indicate an overall decrease in the proportion of States offering treatment services. However, there was an absolute increase in the proportion of States reporting availability of non-pharmacological treatment delivered by correctional institutions and by specialized residential treatment services. The apparent overall decrease in availability contrasted with the increase in the proportion of States reporting medium or high coverage of certain services, such as detoxification provided by primary health care and correctional and community institutions; substitution treatment administered by general and psychiatric hospitals, correctional institutions and specialized residential services; non-pharmacological treatment provided by primary health care, correctional, specialized residential and social services; and social reintegration provided by primary care, correctional institutions, specialized residential treatment services and social services. There also seems to be an overall decrease in gender sensitivity for all modalities in all settings, except for a trend towards increased gender sensitivity of social services. There was also an increase in the reported gender sensitivity of non-pharmacological treatment in specialized non-residential services and social reintegration provided by primary care. As for evaluation, there was an overall decrease in reporting the evaluation of results obtained by treatment services, except for an increasing trend with respect to different modalities offered by correctional institutions and substitution treatment in different settings.

C. Reducing the negative health and social consequences of drug abuse

24. The biennial questionnaire also addresses the extent to which provision is made to reduce the negative health and social consequences of drug abuse. Table 11 presents a trend analysis based on what States reported in the period 1998–2000 and the period 2000–2002. As for those States which returned the completed questionnaire in both reporting periods, there was a greater tendency to expand coverage of services from the “Low” category to the “Medium or high” category in the areas of overdose prevention programmes, needle and syringe programmes, provision of cleaning agents, testing programmes for infectious diseases and

condom distribution. There was also a trend towards less reporting of gender-sensitive programmes in all the service areas covered. A lower percentage of reporting States indicated that the results of their programmes were evaluated in the service areas of low-threshold interventions, outreach, needle and syringe exchange programmes, testing programmes for infectious diseases and vaccination. Programmes on emergency shelters were more evaluated in the reporting cycle 2000-2002, while the percentage of States that evaluated their programmes for overdose prevention, dissemination of information on safety procedures and provision of cleaning agents was fairly similar in the two reporting periods.

Table 11
Reducing the negative health and social consequences of drug abuse: comparison of the baseline (or first) reporting period (1998-2000) and the second reporting period (2000-2002)

	Coverage of target group				*Programme execution*			
	(Percentage of all responding States)				*(Percentage of States reporting activities)*			
	Low		*Medium or high*		*Gender-sensitive*		*Results evaluated*	
Setting	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*	*1998-2000*	*2000-2002*
Low-threshold interventions	36	21	27	26	32	21	38	26
Outreach	23	17	43	38	32	19	39	30
Emergency shelters	27	12	17	17	33	25	27	36
Overdose prevention programmes	17	11	11	18	23	14	29	28
Dissemination of information on safety procedures	20	12	35	33	23	13	23	24
Needle and syringe exchange programmes	22	11	20	29	24	18	46	26
Provision of cleaning agents	18	8	11	17	28	12	25	27
Testing programmes for infectious diseases	25	12	37	42	27	14	31	16
Vaccination	17	11	29	29	24	16	30	19
Condom distribution	30	12	34	40	30	18	23	18

Note: The category “Low” incorporates the baseline category “Isolated”. The category “Medium or high” incorporates the baseline category “Relatively extensive”.

25. In addition to the above-mentioned trend analysis, a closer look was taken at the responses of all the 115 States that replied in the reporting period 2000-2002 to the questions on the negative health and social consequences of drug abuse. While most programmes are implemented to address the problems of HIV and acquired immunodeficiency syndrome (AIDS), some were designed to address other issues, such as overdose prevention, provision of information and promotion of primary health-care services. Condom distribution was reported by 51 per cent of States, followed closely by outreach (50 per cent), testing programmes for infectious diseases (48 per cent) and dissemination of information on safety procedures (41 per cent). Over two thirds of all the programmes in those four service areas were categorized as belonging to "medium or high" coverage. The fairly high implementation rates found for the four service areas are not surprising, as they are the most globally advocated and best accepted programmes against HIV/AIDS. Next in frequency was the implementation of low-threshold services, needle and syringe exchange programmes and vaccination, each reported by 38 per cent of States. Implementation of gender-sensitive programmes was generally low, with a range of 13-25 per cent reported across the service areas. Similarly, evaluation of results of the services remained fairly low, rates of 18-36 per cent being reported across the programmes.

V. Forging partnerships

26. Section VIII, subsection D, of the questionnaire deals with the issues of facilitating partnerships through multisectoral structures at different levels. The existence of such structures in the second reporting period (2000-2002) did not differ substantially from that of the baseline (or first) reporting period (1998-2000). Of the States that responded in both reporting periods, there was a decrease in the proportion of States reporting the existence of multisectoral committees at both the national level (from 84 per cent in the period 1998-2000 to 78 per cent in the period 2000-2002) and at the regional level (from 59 per cent in the period 1998-2000 to 55 per cent in the period 2000-2002); at the same time, there was a slight increase in the number of multisectoral committees at the local level (from 62 to 64 per cent). Of all the States submitting the questionnaire for the second reporting cycle (2000-2002), 71 per cent reported the existence of multisectoral committees at the national level, 50 per cent reported their existence at the regional level and 59 per cent reported their existence at the local level. Approximately the same proportion of all States submitting the questionnaire (56 per cent) reported the existence of umbrella non-governmental organizations. Fifty-nine per cent of all responding States reported active collaboration or networking mechanisms at the local level in that period. Moreover, the proportion of States reporting that the collaboration or networking mechanisms had provisions for identifying and including new partners increased considerably, from 61 per cent in the baseline (or first) of reporting period (1998-2000) to 78 per cent in the second reporting period (2000-2002). Of all States responding in the second reporting cycle, 71 per cent reported that such provisions were being provided.

VI. Focusing on special needs

27. An important area of demand reduction work consists in identifying those populations which are especially vulnerable to drug problems. That can lead to better development and targeting of demand reduction programmes. It is important to ensure that interventions respect and are sensitive to cultural diversity, an issue specifically addressed in the Declaration on the Guiding Principles of Drug Demand Reduction. Guidelines can help to ensure that good practice is observed in that area. Many States responding to the questionnaire reported the existence of guidelines for prevention activities (65 per cent), treatment services (65 per cent) and rehabilitation services (57 per cent). Sixty per cent of States reported that such guidelines took into account cultural diversity and specific needs relating to gender, age and socially, culturally and geographically marginalized groups in the population. The developed guidelines included methadone maintenance in Bulgaria; a series of publications on best practices in Canada; manuals for drug abuse prevention education in Ethiopia; guidelines for research, coordination and action in France; gender-specific guidelines in Germany; guidelines for training, evaluation and monitoring in Mexico; protocols in the Netherlands; guidelines for outreach work in Sri Lanka; and guidelines for information and advice through helplines and reference centres in Venezuela.

28. Most States follow the principle of targeting those particularly vulnerable; in the second reporting cycle, 75 per cent of all States reported having special programmes for that purpose, a considerable increase from the 62 per cent reported in the baseline (or first) reporting period. The group most frequently targeted by such programmes was young people (more than two out of three States); it was followed by young offenders (one in two States) and drug injectors (almost one in two States) and other groups such as commercial sex workers, street children and the homeless. Groups considered vulnerable to drug problems were likely to vary from society to society. For example, countries such as Canada, Cyprus, the Czech Republic, Finland, Germany, Mexico and the United Kingdom of Great Britain and Northern Ireland have special programmes for indigenous and minority populations and migrants; and Bulgaria, Ireland, Italy and Portugal provide for pregnant and parenting drug users and their children. Other countries concentrate their efforts on special occupational groups, such as truck drivers and mine workers (India and Myanmar) or on recreational drug users (France, Greece and the Netherlands). Other groups identified as vulnerable include the economically marginalized, those denied access to schools and workers in the entertainment industry. According to the "good practice" principle, when developing programmes, the views of those who are the target of the demand reduction work should be taken into account. In the period 2000-2002, as in the period 1998-2000, two out of three responding States reported having involved young people in the development of programmes. Only two out of five responding States reported having involved groups other then the above-mentioned population groups in the period 2000-2002, a decrease from the figure of 58 per cent of the responding States for the period 1998-2000.

29. Prisoners and those in the criminal justice system are a particularly vulnerable group to drug problems. Results of the second reporting period indicate that, while demand reduction programmes designed for prisoners before release are relatively common (they were reported by two out of three responding States), those designed to reach prisoners after their release were less frequent (one out of three States

reported them). Programmes for drug offenders as an alternative to punishment and conviction were available in 45 per cent of all responding States. In the baseline (or first) reporting period, about one in two States reported demand reduction programmes in prisons, and about two in five offered alternatives to prison and conviction. However, it should be noted that the questionnaire refers only to the existence of such programmes, while there is no indication of their coverage.

VII. Sending the right message

30. Public information campaigns continued to be included in the national drug strategies of most of the States that sent replies for both reporting periods (83 per cent in the period 2000-2002, compared with 81 per cent in the period 1998-2000). In the period 2000-2002, 81 per cent of all the responding States reported such activities. In terms of the quality of the campaigns, it should be noted that, of those States which reported having implemented such campaigns, more based them on needs assessment (95 per cent in the period 2000-2002, compared with 79 per cent in the period 1998-2000). Of all responding States in the second reporting period, 88 per cent reported having conducted needs assessment for developing campaigns. Of the States that sent replies for both reporting periods, the proportion that reported that their public information campaigns had taken into account the social and cultural characteristics of the target population remained stable, though at a relatively high level: 89 per cent in the period 1998-2000, compared with 93 per cent in the period 2000-2002. (Of all the States responding in the second reporting period, 92 per cent reported that their public information campaigns had taken into account those characteristics.) There was a positive development in the evaluation of public information campaigns (from 53 per cent in the period 1998-2000 to 66 per cent in the period 2000-2002). The corresponding figure for all the States responding in the second reporting period was 58 per cent.) Finally, most States continued to provide training to social mediators in conveying demand reduction messages: the proportion of those States increased slightly, from 75 per cent in the period 1998-2000 to 80 per cent in the period 2000-2002. (Of all the States responding in the second reporting period, 76 per cent continued to provide such training to social mediators.)

VIII. Building on experience

31. Section VIII, subsection E, of the questionnaire deals with the issue of improving demand reduction programmes through training, monitoring and evaluation. With regard to training, less than one fourth of the States reported having provided initial training to specialized service providers. The availability of such services increased slightly, from 18 per cent in the period 1998-2000 to 21 per cent in the period 2000-2002. More than half of the States (58 per cent) provided "ongoing training" in the period 2000-2002, compared with 61 per cent in the period 1998-2000. (Of all the States responding in the second reporting period, 26 per cent provided initial training, while 53 per cent provided ongoing training.) About one third of the States provided initial training to non-specialized service providers (33 per cent in the baseline (or first) reporting period and 30 per cent in the second reporting period). The proportion of States providing ongoing training increased

considerably, from 28 per cent in the period 1998-2000 to 38 per cent in the period 2000-2002, but it was still less than half. (The corresponding figures for all States responding in the second reporting period were about the same: 31 per cent provided initial training and 33 per cent provided ongoing training.)

32. Of the States that sent replies for both reporting periods, the proportion that reported having programmes that were monitored and evaluated increased considerably, from 62 per cent in the baseline (or first) reporting period to 75 per cent in the second reporting period. (Of all the States responding in the second reporting period, the proportion reporting such programmes was 69 per cent.) Of the States that sent replies for both reporting periods, the proportion reporting having participated in international coordinating mechanisms decreased at both the bilateral level (from 74 per cent in the period 1998-2000 to 57 per cent in the period 2000-2002) and the regional level (from 80 per cent in the period 1998-2000 to 70 per cent in the period 2000-2002). At the same time, the proportion of States reporting their participation in coordinating mechanisms at the multilateral or other levels increased slightly (from 74 per cent in the period 1998-2000 to 76 per cent in the period 2000-2002). (The corresponding figures for all the States responding in the second reporting cycle were somewhat similar: participation in such coordinating mechanisms was reported at the bilateral level by 57 per cent, at the regional level by 69 per cent and at the multilateral level by 70 per cent.) The proportion of responding States that reported having maintained a database with information on drug demand reduction increased from 45 per cent in the period 1998-2000 to 57 per cent in the period 2000-2002. (The corresponding figure for all States responding in the second reporting period was 52 per cent.)

33. Of the States that sent replies for both reporting periods, the proportion reporting having available a national database on drug demand reduction that was linked to regional or other multilateral or global networks increased somewhat, from 24 per cent in the period 1998-2000 to 29 per cent in the period 2000-2002. (Of all States responding in the second reporting period, the proportion reporting having such databases available was slightly less (25 per cent).)

IX. Difficulties encountered in implementing activities involving drug demand reduction pursuant to the Action Plan

34. The revised biennial questionnaire addresses difficulties that States have experienced in implementing activities involving drug demand reduction pursuant to the Action Plan by asking about five potentially problematic areas. The reports on drug demand reduction that were received for the second reporting cycle, covering the period 2000-2002, show that the most outstanding area causing difficulties in that period was the financial constraints, followed by lack of appropriate systems and structures, technical expertise and coordination and multisectoral cooperation (see table 12). Existing national legislation was reported less often as an area causing problems than all of the other areas. In general, about 1-2 out of 10 States submitting the questionnaire reported national legislation to be a problematic area with regard to drug demand reduction. More than half of the responding States reported that financial constraints constitutes a problematic area. In approximately one third of the States that submitted the questionnaire, the other three areas (coordination and multisectoral cooperation; technical expertise; and lack of

appropriate systems and structures) were reported to have caused difficulties in implementing activities involving drug demand reduction pursuant to the Action Plan. As the question was added to the questionnaire after the baseline reporting period pursuant to a request by the Commission, no conclusions can be made regarding developments in this respect.

Table 12
Difficulties encountered in implementing activities involving drug demand reduction pursuant to the Action Plan in the second reporting period (2000-2002)
(Percentage of all responding States (n = 115)

Area	*Existing national legislation*	*Financial constraints*	*Coordination and multisectoral cooperation*	*Technical expertise*	*Lack of appropriate systems and structures*
Commitment	17	67	34	32	37
Assessing the problem	11	66	36	38	40
Tackling the problem: interventions for the purpose of prevention	13	59	30	29	26
Tackling the problem: interventions focused on treatment and rehabilitation	13	62	33	32	41
Reducing the negative health and social consequences of drug abuse	18	62	33	32	37
Forging partnerships	8	53	37	27	37
Focusing on special needs	17	58	34	30	42
Sending the right message	9	61	24	29	28
Building on experience	10	58	33	29	39