DIANOVA INTERNATIONAL

CONSUMPTION PATTERNS AND HEALTHCARE RESPONSE

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THE UNITED STATES

LATIN AMERICA

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FOR THE NEW CENTURY

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A NEW THERAPEUTIC COMMUNITY FOR THE NEW CENTURY

In recent years **Dianova International** has played a leading role in a transformation process that has taken it from the place created by self-help groups in the "social movement against drugs" in the 1970s to a very different place today. A place now also inhabited by the public and private mechanisms developed later, under the umbrella of processes of institutionalisation and professionalisation of assistance for drug addicts, which emerged during the second half of the 1980s in most parts of the world. Undeniably the Dianova experience has been especially exciting, not least because, first of all, it emerged from the heart of a pre-existing organisation that was one of the most important and representative (in Southern Europe but also in Latin America and Canada) within that "social movement against drugs" that characterised the toughest stage of the heroin epidemic.

Its history, the story of *Le Patriarche* and the later creation of Dianova, which is still unwritten, would resolve many of the questions that we are still asking and that relate to that period of social, political and cultural upheaval. The response to the drugs problem characterised, in a better way than many other social processes, the profound changes experienced by the developed world between the end of the 1960s and the beginning of the 1990s. After this, over the last ten years, the waters have calmed, and it seems that we are experiencing a more stable period, with less changes. But now we are in another historical era, perhaps another civilisation, after twenty-odd years of labour pains, during which we lost many young people and friends, as illustrated by Allen Ginsberg's poem "Howl", but where nobody, neither those who were lost nor those who survived, nor those of us who were observing, was completely aware of what was happening, beyond the omnipresence of intravenous heroin.

But in addition, and this is the second reason of interest, Dianova's transformation has not been superficial, but has involved a radical commitment to evolve, in a short space of time, from a complete and self-sufficient group that lived in its own personal "apartheid", to an organisation that seeks to adapt to new realities and furthermore include a perspective of quality in the services it offers. A change that means putting its history of conflicts with the institutions behind it, in order to search for agreements, exchanges and possible cooperation, with a view to offering the best care services, in a renewed Therapeutic Community that is open to the demands and needs that the 21st century is already putting forward for this type of institution.

This is saying everything whilst saying very little, because the transformation undergone by Dianova not only relates to its philosophy, its global mission, but to each little aspect that governs **daily life in the Therapeutic Community**. It is not just a case of the educator, the monitor, the psychologist or the doctor responding to a different type of logic (scientifically compared bases for intervention, permanent assessment and guidance towards social reinsertion), or of incorporating an entire string of new professionals, whose presence is becoming increasingly evident; it is also a case of the therapeutic programme being able, on a specific and immediate basis, in the day-to-day life of an assistance centre, to give a response to the new problems that drugs are causing to different people in different parts of the world.

Undoubtedly the objective is an ambitious one, but we should also remain clear that in order to provide this response, Therapeutic Communities continue to represent one of the most effective methodological contributions. Clearly we are talking of a new type of Therapeutic Community, that shuns old fundamentalist theories and that proposes, above all else, to help people overcome their dependence problems. So the question is: how can this be done given the new set of circumstances? Well, in a wide variety of ways. Sometimes via behavioural therapy, sometimes through education, either with the family's help or without, with the help of prescription drugs or using more natural techniques, in a residential or semi-residential system, using long-duration treatments or short-term stays, with maximum objectives or with low threshold programmes. Everything is possible,

everything is right, if what is done is suited to the addict's needs and possibilities. In addition, all this can be thought up, designed and carried out from the Therapeutic Community, which facilitates both intensive and extensive techniques, and of course, any combination of these.

I have presented this series of images, in other words, firstly the processes of change that have taken place in the world, and not just in the sphere of drug addiction, in the quarter century that began at the end of the 1960s, secondly the emergence of Dianova in the second half of the 1990s, and thirdly the role reserved for the Therapeutic Community in the new century, so that we can understand the meaning and significance of the text that follows. In methodological terms, it is a **review of secondary documentation**, whose original objective is to offer the entire Dianova sphere a more or less complete view of the drugs situation, from supply to demand, from consumption and needs for aid to the institutional response, from prevention to reinsertion, in order to finally define what the Therapeutic Community really stands for and what its new components will be. In addition, it is a document whose primary objective, which is maintained in the definitive text, it to encourage internal debate amongst the professionals of Dianova.

With this background information it could be supposed that this is a document whose usefulness is limited, that can only interest those people who, within Dianova, play a role in the transformation mentioned. But whilst true, this is not the whole picture, because in addition to being useful for Dianova it also manages to offer considerable interest to all people working in the drugs sphere, especially Therapeutic Community professionals, because it is basically a synthesis, a “state of the issue” of a general nature, which allows anyone to delve into and debate what is occurring all over the world in drugs-related matters.

In fact, one of the problems usually faced by professionals working in the drug abuse sphere, especially those in assistance and even more so those who work in Therapeutic Communities, is related to the loss of meaning of the social and historical context. A context that was so necessary at the time when they “started” to work in this sphere, because without this global view they would not have been capable of understanding what

they were doing, but which progressively becomes part of routine with their day to day work. A book which is now out of date, like nearly everything on this subject, was written by Nick Maining and published by Routledge in 1989, on assistance centres in Australia. Even back then it revealed the risk for Therapeutic Communities. It showed, with empirical evidence obtained in that far-off land, that between charisma and routine it is sometimes difficult to find a happy medium. Perhaps for Dianova, this glance at the world serves for mulling over the certainties of a discourse that at its time was too charismatic. However, for other professionals, other Therapeutic Communities, it will help them to distance themselves from an excess of routine that blots out reality. These are two different forms of opacity, but each is as dangerous as the other.

Therefore the text prepared by Benjamín López offers a fresh, new and innocent approach by someone who has lived in the context of a particular experience in terms of the drugs assistance response and who suddenly steps through the looking-glass and finds himself on the other side. Then, he becomes rather like the "noble savages" touring Europe, those stars of 18th century stories for the learned. They gradually discovered the real state of things, a reality that the courtesans themselves, too tied to the formalities of etiquette, could not even see, but that the view of the "other", of the innocent outsider, helped them to glimpse. Thus, on the one hand they could laugh at themselves and on the other, become aware of their own, occasionally serious, errors. This view, the view of drugs that appears in this text, will enable "long-standing professionals" to take on board matters that they had left to one side.

But we have already said that we are not dealing with a reflection but with a documentary compilation of indirect sources. In other words of a type of research that all social sciences manuals have unanimously identified as a valid research method for some time now. However it is rarely used, perhaps because it is unfairly viewed as a somewhat poor methodological strategy and the majority of authors tend to work with other research techniques that allow contribution of their own brilliant or original ideas. Clearly, as a consequence of this attitude, we have at our disposal an unapproachable set of beautiful species of trees (qualitative poplars, quantitative oaks, sample pines, delphi cedars, and even exotic "participating observation" ceibas planted around the popular "objectives,

material, method, discussion" species) but we can't see the wood for the trees, and perhaps, taking advantage of all the foliage, Little Red Riding Hood is eating the wolf. In fact, research based on secondary documentation should be one of our priorities, as important as national surveys, case records or programme evaluations, but it seems that nobody really has the gumption for it.

In this case, a base of seventy-odd documents has been used, which were selected after an intensive search, and we all know that this is not easy. In fact, I myself am working on another study, and I am trying to locate Spanish articles that are scientific, rather than institutional, regarding drugs policies in this country. I find myself faced with the difficulty of their practical non-existence. Thus, having reviewed the entire records of the Annual Conference of the Socio-drugs-alcohol Association, with over a score of volumes and nearly eight hundred articles, only in five cases can one speak of approaches that provide a global view of the subject from the perspective of the needs for planning and the definition of policies. Most of the papers refer to the presentation and/ or evaluation of very specific interventions, where the larger part of the bibliographies cited have nothing to do with Spanish contributions on the subject, but are exclusively references, also specific, from the English-speaking sphere. The most striking thing of all is that in whilst in this collection of records, over the years, different contributions appear on individual subjects - for example let's say there are thirty fairly correct and adequate articles on preventing relapses - the thirty-first article does not make a single reference to any of those thirty, and only cites North American authors.

Obviously this is not science because one condition of scientific work is the accumulation of knowledge, whilst the ignorance displayed, on both the subject itself and on the home country, is not only non-scientific but scandalous.

This process is surely repeated in all the surrounding countries (although with nuances in France) and of course all of Latin America, and the only countries to escape, logically, are the United Kingdom, and in a very special way, the United States. The latter does the same thing, it just so happens that all the experiences compared are from the home country. This

allows them to put forward the meta-evaluations and overall views that are so scarce in our own places of origin. Not due to any lack of material, or of documentation, as in any of our countries there are sufficient bibliographies and research, but because it seems more important, for the reasons outlined above, to compare the retention rate of a specific mechanism with six rates from six unknown North American mechanisms, rather than find out what changes have taken place and what new needs addicts may have in a determined territory when it comes to taking decisions on the most appropriate aid policy.

The great advantage of the text that follows is that this overall view is its main objective, or at least that is the intention. It is intended for the people of Dianova, but on the rebound it offers an overall view for everybody, especially for the professionals of Therapeutic Communities who are “cut off” (more so than the users themselves at times), and don't know where to go to answer the questions: what's happening in the outside world? and: how might it be affecting us?

The text which, due to its own functionality sometimes may appear to lack coherent order, touches upon an entire series of subjects, whose coherence needs to be explained according to the author's intentions. The idea is not to offer a systematic view, following academic criteria on the subject of drugs and the response to them, but to contribute elements to the interdisciplinary team working in assistance and particularly in the Therapeutic Community. The coherence of the text is, then, that of a determined view, and its lack of order a reflection of “those subjects that may be of interest” to these professionals, which do not necessarily correspond with the format of political or academic priorities. This is a different agenda, but it is a discourse that must be heard, because it reflects on what is truly of interest “from below” to those who are working in the assistance network on a daily basis.

In this sense the text has two differentiated parts. The first, to try and describe it in some way, corresponds rather well with Dianova's territorial logic, because it offers a balance of the subject in four **major geographical areas** that coincide with those where Dianova has some presence, i.e. first the European Union, then the former Eastern Bloc Countries, to follow with the United States and Canada and finally Latin America. The second part is

more subject-related, with questions raised regardless of geographical areas, although they end up attaching themselves to one of these.

The most significant aspect of each of these chapters lies in the fact that in each, the subject is treated differently, largely reflecting what happens in the different geographical areas, and also treated from the perspective needed by those who have to work on the basis of a Therapeutic Community. Thus, for example, for the **European Union** area, the first issue discussed involves the levels and characteristics of consumption through comparison of the different countries, which reflects the priority given by the Drugs Observatories (that of the EU in Lisbon as well as different national focus points and some regional observatories) to this type of data. Only a vague outline can be given in terms of a European drugs strategy, but on the other hand it is possible to devote a long section to harm reduction policies and to introduce the subject of pharmaceutical treatments, specifically methadone, naltrexone and buprenorphine. This is logical, despite the fact that we Europeans may not like it much, because in fact it is in Europe and not in the USA where these things are spoken about most and where there are most people in favour of the omnipotent fantasy that drugs are purely a medical matter that will be resolved with the current and foreseeable future prescription drugs. The rest of the network, closed up in its cubicles and dedicated to defending them, and safeguarding precariousness have not even caught on that this is now Europe.

Then there is a short section on **Eastern Europe** which deals only with consumption. This is an alert on the situation being experienced in these countries, worse than that experienced in Western Europe twenty years ago. At least here the "social movement against drugs" demanded answers and got them in a few years. In contrast, in the former Eastern Bloc countries, which have now been affected by the epidemic for over ten years, their very economic, social and cultural crisis prevents them from setting up any type of social movement and on top of that, aid from the European Union appears to be cut due to a response to a very different situation. Our attitude towards the drugs problem in Eastern Countries is reminiscent of that cruel story about a European tourist travelling through Ethiopia who asks why the children are so thin and when told that it is "*because they don't eat*" he sternly addresses the children with the reprimand "*you really must eat*".

In the case of the **United States** the report firstly presents the main consumption trends. It is true to say that the NIDA, on this subject, has been offering very consistent information for the past two decades, to the point that this information is normally used, under the uncertain emblem of "*what happens in the United States ends up happening in other countries*" to try to explain world trends in drugs consumption. After this report it goes on to explain what is happening with certain groups, identified by age, gender or ethnic background, as well as specific programmes aimed at such groups and especially at women. This clearly reveals the American obsession with defining and working on social fractions, in part explained by the role played in this country by self-help groups, which are never generic as in Europe, but which belong to each of these social fractions.

Finally **Latin America** appears, with a detailed review by country, especially, although not exclusively, those where some type of Dianova mechanism exists, and in each the subject is dealt with from the perspective of the information available. Logically, the subject of drugs trafficking is an important issue in many Latin American countries, and in nearly all of them, so is the subject of prevention, although there are only real institutional prevention policies in a few. In fact the Latin American problem with drugs is made clear in the report. It is a case of an excess of seduction by foreign models and a great lack of analysis of their own reality. This seems highly contradictory with the trends in project systemisation, community work and psychosocial analysis that are so dominant in this part of the continent. But, equally, all this may be no more than words to hide the true reality, both Creole and indigenous realities alike.

As we have already said, another part of the report deals with **subjects of a general nature**. The first, short but substantial, refers to the **worldwide demand for drugs**. From here we can draw two ideas, the first is perhaps already commonplace for many professionals, but for Dianova, too accustomed until quite recently to rigidly proposing the same programme, without allowing the slightest deviation, in very different contexts, it is very important: different drugs are consumed, with different habits and producing different consequences in different places around the world.

Secondly we are offered the idea, for the first time - though nowadays different United Nations heads are beginning to insinuate it, yet it is true to say that it enjoys little public credibility due to the U.N.'s excessive involvement in the most repressive proposals - that the international model of drugs trafficking is starting to show the first symptoms of a crisis and that we may even be witnessing its definitive breakdown.

In fact, with drugs, a situation is starting that is similar to the last phase of the slave trade. We have moved on from a model of generalised drugs trafficking, with numerous sources of production and a wide diversity of suppliers, to a model in which the sources and suppliers are decreasing and becoming more isolated, basically due to many traditional producer countries beginning processes of development and industrialisation that are incompatible with a social and economic structure that allows for the production of natural illegal drugs. Those countries that remain in extreme poverty are too poor and lack any social network to facilitate drugs production. Only Colombia maintains an ideal drugs trafficking model: a country with a fairly well-developed social structure but whose social and political conditions, especially a non-existent State in a large part of the country, facilitates the formation of a society that can produce, process and distribute cocaine.

But in addition the demand for the type of illicit drugs produced and distributed by this international drugs trafficking model is decreasing (except perhaps, in a very paradoxical manner, in the United States, where it remains stable), despite both the emergence of new markets in some developing countries and social crisis in some of the former Eastern Bloc Countries. In fact another model is opening up, where addiction is increasingly less linked to international drugs trafficking and more related to the legal market and local chemical production. Also the triumph of economic liberalism is associated to a growing hegemony of positions more inclined towards legalisation, although obviously this will not be able to apply to the current natural illegal drugs (except perhaps Cannabis), until the international drugs trafficking market sinks deeper into the mire, and, at the same time, the new model of chemical drugs, legal and illegal alike, dominates the panorama.

Different factors have intervened in the process, without doubt the most important being the finalisation of the cycle of social and cultural changes that presided over the decades of the 1970s, 1980s and 1990s, following the unexpected or harmful consequences that arose from all this - especially AIDS - which were unimportant when the great objective was social change, but that in the current period of stability are becoming unacceptable for society. Mention should also be made of the new system of social stratification, in which a new consumer-oriented middle class maintains, especially in the more developed countries, a clear level of hegemony. Finally the technological changes, that lead natural drugs (and combinations of them) towards the image of a world that is seedy, antiquated and obsolete, in the face of new and modern chemical drugs, apparently less dangerous, less addictive, and more discriminating, although also lighter, in their effects.

It is also true that all this includes a certain measure of fantasy, because natural illegal drugs will continue to exist, because intravenous use will continue, because the majority of addicts will be more than ever polydrugs consumers, and because this ideal of the "controlled consumer" who every weekend chooses one or several different substances from all those available, according to their "plan" for that weekend, is a long way from reality. But this is what society believes, and if I have learned one thing in my life, it is that reality is worth very little when society and the media think otherwise. Although clearly from time to time reality takes its revenge.

In summary, on this sugar cane estate that is our world, the system of slavery, in other words, drugs trafficking, is now much less profitable, which means that it is preferable to rely on free workers, in other words pharmaceutical drugs, where one can pay peanuts and at the same time offer sensations that will supposedly preserve liberty. For this reason we can no longer dedicate ourselves to liberating anybody, but rather to try to defend the rights of the workers and improve their quality of life. Of course another option would be to burn down the plantation, but that's another subject.

Another subject dealt with individually in the text is the question of **prevention**, or demand reduction as it is called nowadays. It is interesting, first of all, to see how the situation is

only considered in relation to two large areas. The first is the United States, with its institutional "prevention" policies that boast so much prestige but so little success and the second is Latin America, easy to talk about because so much is said about prevention in the numerous meetings that are held relating to this subject. Europe is not included in the analysis and this could be considered an error, because for many specialists it is precisely in Europe where prevention is achieving, in the community sphere and contrary to the closed programmes model of North American origin, a spectacular take-off. Yet the author overlooks this, perhaps he should not have done so, but this can also be viewed as a symptom.

It is possible that the time has come to consider that prevention in Europe demands a global review, beyond the mere totting up of programmes in databases. There are thousands of programmes in Europe, hundreds of tried and supposedly effective materials, but: what is prevention in Europe? The answer is a complex confusion where only experts can find their way, with North American material that is completely out of context coming in to land on top. There is no European prevention strategy, and the very documents proposed by the EU, are mere generalisations on the diverse and contradictory things that are being done. For example, in Europe, the majority of experts consider that TV advertising campaigns lack effectiveness and even work against prevention, however a very large part of expenditure is assigned to media campaigns. On the other hand in the United States they think that they aid prevention and so run them, but if in Europe there is a lack of agreement, why not debate the subject? We may think that the text does not touch the subject of prevention in Europe because it is difficult to say something coherent, but in fact the problem is a different one.

I believe, and this is the first time that I have said this, and I have never heard it come from anybody else, that prevention in the USA is a "scientific task" which incorporates a great deal of pressure group policy, whilst in Europe, prevention is a confused amalgam of "community interventions" that the institutions try to substitute with the North American model of successful scientific programmes. What is being done in the USA can be explained, on the contrary it is difficult to explain what is being done in Europe (that is why

there are so many databases, so many lists, on prevention programmes), and from a positivist scientific perspective, what is being done in Europe appears to be incoherent. But whilst more than thirty years of successful scientific programmes have not managed to reduce the drugs consumption rates in the USA, in a little over fifteen years, in half that time, in Europe, a series of not very coherent initiatives, but social initiatives at the end of the day, have managed to modify the consumption panorama.

The other main monographic section is related to **reinsertion** and here, again, the geographical factor is the most important, because nearly all references are made to the European Union and the subject of employment, in other words social and labour market insertion. Again, this is the state of things, because it is in Europe and almost only in Europe where the subject of reinsertion is truly considered, in a context, in addition to large transnational policies related to youth unemployment. The general programmes of the European Union are cited, along with national policies in Spain, Italy, and Greece (the countries most affected by unemployment) as well as the Dianova experience in Portugal.

It is possible that there is something lacking in this review, for example policies on minors or the alcohol issue, but these are questions that are important in their own right and that allow us to leave tasks pending for the future and that, with the same intention and the same methodology, both Dianova and others can try to tackle in the same way, in order to debate them later.

I have left everything relating to the **Therapeutic Community** for the end, partly because it is the last chapter and partly because it seems to be the weakest, amongst other reasons because the documentation managed, part of which is mine, is somewhat obsolete. In fact, most of the literature on Therapeutic Communities for Drug Addicts was produced in the 1980s, in the full swing, both in the charismatic and the professional sphere, of hegemony of the total and absolutist model of Therapeutic Community and later all that have appeared have been repetitions of what was established in that phase. The shortages that can be seen in this latter part reflect this reality and invite us to continue with our research. They ask us

to once more take up reflection on a subject that came to a halt around a decade ago, when the self-sufficient Therapeutic Community myth went into crisis.

For this reason I feel obliged, albeit briefly, to launch a proposal on what I believe the Therapeutic Community of the 21st century should be, taking advantage of a text that provides us with a series of pointers. The most important, undoubtedly, is that we are left with no other option than to undertake the task of designing a new Therapeutic Community if we want to preserve this institution. This is because we have learned that the Therapeutic Community is necessary, is effective, is useful, it can be adapted to changing conditions, although it is currently in crisis because we have kept it immobilised for such a long time.

To a certain extent the Therapeutic Community for drug addicts is rather like an exquisite cake: sweet, pretty and tasty. Somebody put it on the table a quarter of a century back using the traditional old recipe by Maxwell Jones, and since then the guests have been looking at it but nobody has sunk their teeth into it because everybody is admiring, even ecstatic, before such perfection and so afraid of destroying it. As a consequence, over twenty five years, it has become rather dried out and is now inedible. But we can add syrup (and right now even a modest drop of liqueur) to make it recover its texture. Of course, if we do this, it will be in order to really make use of it, to eat it, leaving the aesthetic ecstasy for the next cake, which will most certainly be put on the table once no crumbs remain of this one. In this case, we will also admire it, but only for a short while, because cakes are made to be eaten.

The main idea, the syrup and the liqueur, refer to the need to open the Therapeutic Community to new needs and demands, giving priority in this sense to two main ideas. First, the loss of relevance of single drug addictions, of which heroin is a good example, and second, the possibility of introducing prescription drugs into Therapeutic Community work. In other words the TC will no longer be identified as a drugs-free space, but as an intensive work methodology that admits all types of aid strategies. Obviously not all of them in the same place and at the same time, but all of them will be under the Therapeutic Community umbrella. In other words, some Communities will be able to admit only cases

in methadone maintenance, others will not admit them, and others will work in a mixed way. Also, they will be able to work with a reduced or a broad group of substances, with only adults, with minors, with a single gender or with both, with a predetermined duration or a variable one, etc. What really matters is that a complete design overhaul be carried out, where the contents of each mechanism are chosen (yes to this and no to that) and that at the end it responds to the Therapeutic Community methodology.

Obviously some may then put forward the question; what will remain of the Therapeutic Community if it can become anything at all?, but this is a badly formulated question that mixes up substantive elements (the Therapeutic Community as an intensive programme of re-socialisation), with factual elements (the classic version of drugs-free programmes). Does this mean that the Therapeutic Community can no longer propose drugs-free programmes? Absolutely not, because the Therapeutic Community is a good mechanism for this type of programme. But it can be good for other types too.

Therefore, from my own point of view, the flexibility of the design should be accompanied by greater methodological rigour, because what really identifies a Therapeutic Community is this rigour in its assistance programme. In other words, the Therapeutic Community may have the best methadone maintenance programme, it may use prescription drugs better than anyone, it may work with socially integrated addicts who only attend on weekends, or it may help to resolve the family problems of alcoholics, because it is a mechanism of a higher quality, a place for intensive treatment, that improves, for many addicts, the conditions offered by other programmes and mechanisms. But of course, it is necessary to set up this optimum Therapeutic Community model.

Following on with the metaphor of the sugar cane plantation mentioned in previous paragraphs, it is clear that the future Therapeutic Community client is no longer a slave-like addict of a substance or a series or substances, but a free worker, whose life may perhaps be worse than that of a slave, but supposedly he can do what he wants within the context of a diversified and accessible range on offer. It is perfectly possible to believe that he is even worse off than the slave whose life, at least, had certain securities, or certainties. In contrast

the new addict is a free man who lives in insecurity. He neither can nor wants to accept (why should he?) a single dimension alternative, he does not believe that he needs to "free himself" because he considers himself a free being, but he asks for help to overcome his problems. We have to give him that help, we have to have a diversified offering and in the interim we may be able, perhaps, to tell him that he is not a free man because the low salary of a la carte drugs is also a form of slavery.

In this context the Therapeutic Community becomes more necessary than ever, at least for two reasons, firstly because other aid offerings form part of this new drugs contract of the free worker, and although we cannot reject them, we can improve them and complement them. The second reason is related to human rights, the right to a dignified and healthy life, to employment and social participation, rights which can best be rebuilt in an intensive space that we can identify with the Therapeutic Community.

Obviously there remains much to be done and this is only the beginning, but the next decade may once more be the decade of the Therapeutic Community, if we just make that little extra effort.

INTRODUCTION

- Drugs consumption
- The distribution of drugs
- Drugs production

It was in the 1970s that the current international system of production, distribution and consumption of psychoactive substances from natural and synthetic origins first appeared on the scene. The 1980s was a decade that saw its growth and expansion, and the 1990s were marked by the stabilisation of this system made up of four illicit dealable drug groups: cannabis (marihuana and hashish), ATS[1], cocaine and opiates.

Although it is not easy to establish linear relationships between contextual factors and the increase in demand for psychoactive drugs, we can initially consider two approaches to tackling this possible relationship: one is to base ourselves on drugs consumption surveys and complement the information they offer with statistics provided by public and private institutions with useful and regular records (healthcare and policing bodies, interdisciplinary groups on drug dependence, care services for minors, educational services, etc.), and the second approach involves an analytical focus that tries to link, at least conjecturally, the growth in consumption with sociocultural dynamics.

The first approach relates drugs consumption with variables that influence it, to a greater or lesser extent. These variables range from the most basic, such as gender and age, to other more subtle variables such as subjects' relationships with their families or their degree of integration in the productive sphere. Thus, for example, we find a range of information from the most recurring statements (drug consumption is greatest amongst males aged between 19 and 35 years), to other much more subtle breakdowns (greater consumption amongst the unmarried and widows, amongst those

[1] Amphetamine-type-stimulant (Amphetamine, methamphetamine, “ecstasy”...)

hospitalised due to emotional problems, amongst those without a solid family unit, amongst those who neither work nor study, those who live in cities with over 500,000 inhabitants, those who began sexual relations before the age of 12, those who declare that over half of their friends take drugs and others). These details are interesting and quite useful when it comes to designing prevention policies.

The second focus, of an interdisciplinary nature, searches cultural, sociological and demographic phenomena for elements and clues that allow an understanding of why, from a certain moment in history onwards, the demand for drugs starts to grow. In this sense, the words of Francisco Thoumi are interesting: "Given that the set of genes and the distribution of individual personalities does not change significantly from one generation to the next, explanations for great changes in the use of psychoactive drugs by a society should be based on the social changes experienced by that society (...) the social characteristics of each group within a society determine its degree of vulnerability and the probabilities of its members becoming addicts". He adds later: "Any strategy designed to control addiction must identify the most vulnerable social groups and the variables that determine their vulnerability (...) the most effective policies for controlling drugs should be considered based on the knowledge of factors that determine their use and abuse. To consider drugs usage and trafficking as a criminal act is not necessarily the best policy in terms of cost effectiveness to reduce drugs consumption". (Thoumi, 1994).

Obviously, within the range of drugs-related services, the most relevant information on the context of drug addicts can be obtained by those people who participate from the perspective of the "professional therapeutic community" as this is where there is greatest contact with the user and the therapeutic team. This is because its aims are rehabilitation and social reinsertion, rather than merely palliative aims as is the case in other forms of intervention in drug addiction.

Another factor that can aid us in profiling the context is to check in what way consumption can be categorised. The most common way is to categorise consumption for preventive effects in a linear way. A distinction is made between occasional consumption, regular consumption, and compulsive consumption (addiction); or otherwise between softer or harder drugs users, or with variable correlated effects. These classifications are more frequent because they are easily drawn up from the information sources available: surveys, clinical statistics and criminal statistics. But if we only depend on these, we run the risk of overlooking the motivations, processes, and sociocultural contexts that surround drugs consumption.

In a more comprehensive and better broken down categorisation we find groups of users that are linked in different ways to productivity and sociability. The following examples, offered by Martín Hopenhayn, are useful for illustrating some contrasts:

"**1**. Use of cocaine and amphetamines in higher class business and financial circles or in show business, motivated by their properties that offer resistance to stress and tiredness or a loss of inhibitions, considered convenient by users;

2. consumption of volatile substances, heroin and cocaine sulphate amongst marginal urban groups, where these groups affirm their isolation and dysfunctional nature - both on a productive and social scale - through drugs use;

3. occasional consumption for fun in all sectors of society and involving all types of psychoactive substances;

4. ritual consumption, whether amongst ethnic minorities or diverse groups for experimental purposes;

5. habitual consumption as part of a productive and nutritious diet, as is the case of the coca leaf in Andean society;

6. consumption to stimulate creativity amongst those working in the arts;

7. consumption in the most competitive sectors of sport to increase physical performance". (Martín Hopenhayn, 1997).

Such differentiations do not abound in the public drugs debate. But they are important for creating educational and communicational strategies that allow the establishment of more specific bridges with the diversity presented by the problems surrounding drugs use.

We should like to say that, if we do not have access to good explanations of the contexts that lie behind consumption, and a more refined categorisation of usage patterns, we are missing out on valuable data that would help to understand one of the basic elements in the preventive campaigns and even in those interventions whose aims are rehabilitation and social reinsertion. We are referring to the process by which a vulnerable group moves from "zero consumption" to experimental consumption, from the latter to recurring consumption and from recurring consumption to the compulsive consumption of illicit drugs.

- Drugs consumption

The main characteristic of drugs consumption in this decade is that it remains constant, with slow growth, greater for cannabis, ATS and heroin (consumption of which has been increasing constantly since 1985) and lesser for cocaine (for which the increase is almost stagnant, but showing no signs of diminishing). It could be said that consumption grows in line with the growth of the population and its capacity for consumption, which proves that the *utility function* that psychoactive drugs have for considerable segments of the world's population has not varied. This means that natural and synthetic psychoactive substances maintain their capacity to satisfy specific needs for those sectors of the population that use them.

The above indicates that all endeavours to prevent the misuse of drugs have failed, because they have been unable to offer other products or services that satisfy these needs. "Here it is clear that a prevention strategy based solely on promoting abstinence offers nothing to satisfy the desires and needs of important sectors of the population"[2] Studies on the utility function of drugs could be a great help in reconsidering policies, strategies and control actions related to demand.

The strategies for controlling drugs demand (consumption) that are based on denying their utility and their capacity for satisfying certain needs are bound to fail. The need for psychoactive substances cannot be denied, as they are used in medicine to treat mental health problems. In addition, "the proper use of psychoactive substances is related with an improvement in quality of life, in other words, with the elimination of depressive states, over-excitement, anxiety, anguish and pain".[3] What we want to say is that to intervene in drug addictions it is necessary to analyse the reasons underlying drug use, the starting point of the entire process. Denying their importance would be to base ourselves on false and biased positions. It is necessary to study in depth the utility function sought and found in drugs by their user, the experimenter, the drug addict, as this is the key to understanding and clarifying in order to propose useful intervention strategies, so that the 141 million cannabis users, 30 million ATS users, 13 million cocaine users and 8 million heroin users[4], cease to be a piece of statistical data and become a centre for analysis, generating a meeting point between Science and Experience; in other words, between the "world of Ideas" (researchers, healthcare workers, chemists, etc.) and the "world of praxis" (users who know why they took drugs; what effects psychoactive substances produce in

[2] DE REMENTERÍA, Ibán. Ex advisor to the United Nations Programme for International Drugs Supervision (UNPIDF) and the United Nations Development Programme (UNDP), currently advisor to the Social Development Division of the Economic Commission for Latin America and the Caribbean (CEPAL) "Grieta de las drogas: Desintegración Social y Políticas Públicas en América Latina/ The Drugs Crack: Social Disintegration and Public Policies in Latin America" United Nations Pub., New York, 1997.
[3] Ibid.

their bodies and minds and what the absence of these same substances means for them.

- The distribution of drugs

In the sphere of drugs distribution, in other words, drugs trafficking, the main characteristic during the last decade has been the constant fall of prices on the international market. This indicates two things. In economic terms, the maturity and stability of the system, as happens with any agricultural product, means that as time passes, prices come closer to the costs of production and dealing. In criminal terms, the fall in prices indicates an increase in impunity for these illicit activities, as some of the greatest costs involved are expenditure on protecting them through the use of legal tricks, corruption and violence.

As regards the final aim of organised crime (responsible for generating the offer of drugs on a worldwide scale), the obtaining of extraordinary income, current deregulation and banking, financial and investment techniques make it impossible to detect monetary flows that accompany the different national and international transactions involved in drugs trafficking, as well as the legalisation of the substantial profits produced by such illicit activities. The few known cases and non-significant amounts involved in money laundering processes, whether in producing countries or those used involved in the transit and consumption of drugs (especially in the latter, where 90% of the final added value of this illicit activity is produced) speak for themselves. In the specific field of controlling drugs trafficking, this shows up an impunity that is symmetrically opposed to the toughness of political statements, as well as the rigour and weight of the penal norms created for its punishment.

Another feature of great importance in drugs distribution is the "democratisation" of its retail sellers. This activity is no longer carried out

[4] UNITED NATIONS OFFICE FOR DRUG CONTROL AND CRIME PREVENTION (UNODCCP)"Global Illicit Drug Trends" UN, New York, 1999.

by specialised gangs of common delinquents that act on a neighbourhood scale, or regular users who use their social and work relations to "supply" drugs and thus finance their own personal habit. "Now these are members of diverse social categories, such as small business owners, traders and industrialists, professionals, employees, manual workers, housewives and even agents of law enforcement, who supplement their income, resolve their household crises, finance their unemployment or occupy their free time in the exercise of this activity."[5]

In the case of the international distribution of cocaine, the successful repression measures taken against the two main drug cartels, Medellín and Cali (whom it is said controlled between 60 and 80% of the international market for this drug), with their main leaders being eliminated and the rest handed over to the law, is a well-known victory against crime. But at the same time, this success has put an end to the imposing of very high wholesale prices or "cartelisation" (which was a characteristic feature of this market after the 1983 crisis), and has unleashed the active participation of old and new agents in free competition. This phenomenon has made prices drop in the different segments of this illegal market and at consumer level. Which means it has achieved exactly the opposite of its objective of repressing drugs trafficking, which involves squeezing supply and raising prices to consumers in order to reduce their demand. From this it is inferred that, despite certain statements without foundations, in drugs, also, supply is price-sensitive. (Nowadays teenagers can find a gram of cocaine with 20-40% purity for 40$, or 6,000 pesetas, when a few years ago the price, with a lesser degree of purity, was moving between 80 and 100$, or 12,000 and 16,000 pesetas). Evidently this evolution does not help to reduce demand (consumption).

[5] DE REMENTERÍA, Ibán

- Drugs production

In the illicit production of psychoactive substances, those of natural origins continue to predominate, since the economic risks involved in illegal production of synthetic psychoactive substances are high due to the technical need to centralise production and investment. However, a considerable production capacity of psychotropic drugs and their "precursors" in the ex-socialist countries and some developing countries, where political circumstances have relaxed control systems, have been detected. Nonetheless, the predominant note is the commercial subordination of peasant farmers and settlers to illicit cultivation for drugs trafficking. This subordination is upheld due to the traditional failure of lawful agriculture. In summary, natural drugs and peasant farmer production continue to be the main characteristics of international dealing in psychoactive substances.

During this decade, the production of natural drugs has been characterised mainly by the continual expansion of the agricultural area under cultivation and by the stagnation of the volume of production of raw materials from which psychoactive alkaloids are extracted. This is due to the constant fall in prices paid to producers for their illicit crops, and also to the rise in the cost of agricultural technology, as a consequence of adjustment policies in the agricultural sector. All this has led to illicit agriculture processes becoming less technical in order to reduce costs and retain profit margins, with a strong reduction in yield per hectare.

However, this phenomenon, which could have been beneficial in making lawful agriculture competitive, has not reached its objective because legal crops continue to show negative profitability, whilst drugs trafficking pays for illegal harvests at least sufficient to cover production costs - otherwise it would not be able to offer its irreplaceable supply on the world market. In contrast, the world market has turned its back on the legal agriculture of developing countries.

In addition, the "naturalisation" of illicit agriculture, as a response to the fall in prices and the rise in costs, causes, in a similar way to what has happened in recent decades with legal agriculture, a new predatory impact on the natural resources and environment of the region.

Another noticeable trend during the 1990s has been a shift in the illicit production of coca from Peru, and to a certain extent from Bolivia, towards Colombia. This shift has been caused by the strong rise in agricultural costs, especially in Peru, in addition to the general agricultural crisis being suffered by Colombia. The effect of this crisis has not only meant an expansion of illicit peasant farming in Colombia, but also, and for the first time since coca cultivation has been subject to the application of penal control, an illicit business agriculture has appeared in the region, which in criminal terms is another indicator of the impunity which this illegal activity enjoys.

The transfer of production is no new phenomenon in the field of illicit drugs trafficking. In the 1970s the withdrawal of the United States from Southeast Asia transferred poppy cultivation from that region to Mexico, Guatemala, and now Colombia. At the same time and during the last decade, the lax attitude towards marihuana cultivation in the United States and its repression in Mexico, Colombia and Jamaica, meant a transfer from these countries to the territory of the largest consumer country (the USA).

To finish, we would like to propose, in a conjectural way, some factors that we find worthy of consideration in an attempt to comprehend the current phenomenon of consumption, and above all of consumption understood in its most pernicious forms or those with the greatest personal and social costs.

First of all, we want to make mention of a phenomenon that we will define as **"exogenisation" of the sources of personal interior balance.** In other words, people today tend to increasingly condition their sources of self-regulation to exogenous elements. The exponential increase in the

consumption of tranquillisers, sleeping pills and anti-depressants, like the search for euphoric or extreme experiences in risk sports, are all part of the same set of symptoms. Vitality, rest and ecstasy are taken away from the individual and then offered back in the form of tablets, "powders" or trips at high-speed. The explosive increase in illicit drugs use is set within the same dynamics.

In the shifts made from occasional users to recurring users, or recurring users to addicts, a decisive role is played by this growing incapacity to create desirable moods in an endogenous way, such as: festive enthusiasm, introspection, euphoria, distension, inspiration, expressiveness, communicational capacity and many more. The more an individual resorts to drugs due to difficulties in internal self-regulation, the greater the risk of the usage pattern becoming addictive and forming an essential part of the individual's life. If this is true, then a strategic element for a communicational campaign would be the challenge to people to recover their endogenous capacity to generate desirable moods (the basis of rehabilitation in "Therapeutic Communities").

A second factor is related with the frustration of expectations and conditions of exclusion typical of precisely those groups who are considered to be at risk (groups who not only have a tendency towards using drugs, but towards doing so with a greater risk of harmful consequences for their own lives). We are referring here in a general way to working class urban youths. This is the segment most influenced by the promises and aspirations promoted by the mass media, schools and politics, but that does not have access to the social mobility and consumption possibilities contained therein. Thus, these young people suffer the effects of an explosive combination: they have greater difficulties in gaining a foothold in the jobs market that reflects their level of education; they experience a prior process of education and culturisation where they take on board the economic potential of their own education, and this is then contradicted when they find

themselves with few possibilities in the jobs market; they have greater access to education and stimuli to consume new and varied goods and services to which they have no access and which, in turn, become symbols of social mobility; they have a clear perception of how others gain access to these goods within a general game plan that affords them neither fairness nor equality; and all this occurs at a moment in history, on a worldwide scale, where the "rules of fair play" to gain access to the benefits of progress are far from clear.

This frustration of expectations favours their willingness to make use of the vast range of drugs on offer. Drugs use may seem like a spurious way (a handy substitute) to compensate for the experience of a young person as someone who is excluded or isolated from access to social mobility, political participation or cultural exchange.

A third contextual factor that may be considered, in a view in line with cultural anthropology, is the lack of rituals of belonging, of communion and of passage in society as the latter becomes more modern and secular. Within this framework, the consumption of psychoactive substances can be understood as a ritual of belonging to groups or "urban tribes", which affirm their identity through opposition to the established norms (opposition to the law, to adult life, to morals, to discipline); as a "rite of rest" from the hassles of work and daily life, especially when productivity demands tend to be on the increase: as a rite of communion, closely related with the expansive effects that are typical of some psychoactive drugs, substituting other traditional rites of communion that tend to weaken in a secularised culture; or also as a rite of passage in which a young person identifies their experience with drugs as a "leap" or "transformation" in their own subjectivity.

A fourth and final factor that we would like to mention, is the consumer society trend towards the immediate obtaining of pleasure. We are not inferring here that pleasure is a bad thing. Rather, we are referring here to a

specific type of value given to pleasure, that is tending to become an imposition in advertising, in messages from the media, in the window displays of shopping centres, in the show business world, in conversations between successful professional people and also between financially disadvantaged young people. This specific valuation of pleasure proposes a seductive image of a life filled with a sequence of pleasurable sensations. In the words of Martín Hopenhayn: "a life where pleasure must continually increase, where the present must offer increasingly intense vibrations, where sensory perception must access a progressive excitability. A life in which the same hyperkinesis that operates in the world of work and money must also make its appearance in the sphere of leisure, relaxation and recreation. And there is nothing like psychoactive drugs to give an immediate response to pleasure when the latter has become a permanent demand" (Martín Hopenhayn, 1997).

Once situated in the context of the drugs cycle, we will enjoy a better perspective for approaching the details on prevailing trends in use and the wide range of interventions implemented by Institutions and Social Organisations in general, in different regions of the World, in order to reduce damage caused or to prevent addiction or rehabilitate and reinsert drug addicts: the European Union, Eastern Europe, North America and Latin America. We will also consider health and legal indicators related with drugs use and demand for treatment on a worldwide scale.

THE DEMAND FOR PSYCHOACTIVE SUBSTANCES

1. Consumption on a worldwide scale
2. Tendencies and patterns of consumption on a worldwide scale
3. The worldwide extension of drug abuse
4. Drugs use amongst young people (15-24 years)
5. The cost and consequences of drugs abuse

THE DEMAND FOR PSYCHOACTIVE SUBSTANCES

1. Consumption on a worldwide scale

1.1 Cannabis

The estimates presented by the *World Drug Report* show **cannabis** as the most widely consumed drug in the world, with approximately 141 million consumers[6]. This represents 2.5% of the world population. Consumption is particularly high in the West of Africa, in Central America, North America and some European countries.

Many young people experiment with cannabis. The percentage of school age and young people who have consumed **cannabis** during the year prior to the sample, reaches 37% in some countries, and the percentage of consumption in the last month varies between 10 and 25%. This indicates that cannabis is a drug that is accepted with a fair degree of normality and is not exclusive to small marginal groups.

These trends show a clear increase in **cannabis** consumption in the last ten years in all regions of the world, especially in the European market, but also in Africa, Asia and the Americas. This increase has accelerated during the 1990s. For example, in Germany, the number of people aged between 18 and 39 years who had consumed **cannabis** in 1990 accounted for 4% and in 1997 they had increased to 7%. In the UK, the percentage of cannabis consumers aged between 16 and 59 years represented 5% of the population

[6] UNODCCP "Global Illicit Drug Trends" New York, 1999.

in 1991, growing to 9% in 1996. Similar increases can be found in the other countries of Western Europe.

This increase has also taken place in the Americas, and very few countries have shown a stabilised tendency. **Cannabis** abuse seems to have been especially high in the South and Southeast of Asia (notably in India, the Democratic Republic of Laos, Malaysia, Indonesia and the Philippines), whilst Pakistan reported a sharp decrease in 1997. This information seems to be related with the decrease in seizures of cannabis destined for the markets of Western Europe from Afghanistan and Pakistan, and the increase of those originating from Southeast Asia.

On a clinical level, studies coincide in diagnosing a syndrome of dependence, characterised by incapacity or lack of control in the use of the substance (dose), cognitive and emotional disorders, interference in professional occupations and other problems related with low self-esteem and depression, particularly in long-term users. This is aggravated in the face of the reality of finding ourselves in America and Europe, so this drug is the third most frequently behind requests for treatment, after cocaine and heroin, respectively). In the same way, we find that it is the second most common drug to cause treatment to be started in many countries in Asia (after opiates, which predominate in treatment requests in this area, except for in the Far East, where amphetamine derivatives are in first place).

1.2. Amphetamine Derivatives

The second most widely extended drugs in the world are amphetamine derivatives, with their level of consumption varying a great deal between regions and countries. UNDCP estimates show that consumption of synthetic drugs, particularly “amphetamine-type stimulants” (**ATS**), is widespread and increasingly quickly. UNDCP estimates calculate that around 30 million people consume **ATS** (annual prevalence of 0.52% for the world population).

Their advance was relatively slow in the 1980s, but consumption increased rapidly in the 1990s.In Europe this increase has been especially strong, and this is also an important producer region. Synthetic drugs have gained protagonism, especially amongst teenagers and young people, who have made them part of their way of having fun, usually combining them with cannabis. **MDMA**[7] (Ecstasy) is the *protagonist* in the industrialised world, especially in Europe, and there are indicators of very rapid growth in Southeast Asia.

In Australia and Europe, **ATS** are the second most widely extended drugs after cannabis. However, in Asia the situation is not so even. In many capitals, **ATS** represent the main drugs causing requests for treatment, and this is the case in Seoul, Tokyo and Manila, whilst they are the second cause in Bangkok. There has also been an increase in the number of countries in Asia and Europe showing an increase in the number of **ATS** taken intravenously.

1.3. Cocaine

In general, **cocaine**, in its various presentations (powder or base), is the second most widely extended drug in America after cannabis. **Cocaine** in powder form (**cocaine-type**) is the drug that causes most requests for treatment. The same occurs in many Latin American countries, where there is increased use of "**bazuco**" (coca paste). An approximate estimate would situate consumption of **cocaine-type** at around 2% of the population aged over 11 years in the United States.

In accordance with UNDCP estimates, around 13 million people (0.23%) are calculated to take **cocaine** around the world. Consumption of **cocaine** increased throughout the 1980s in a constant way, but in the 1990s its

[7] Methylenedioxymethamphetamine. Problems: psychological difficulties, including confusion, depression, sleep disorders, a vehement desire to take drugs, severe anxiety and paranoia whilst taking MDMA and sometimes several weeks after taking it (some psychotic episodes have even been notified). Increase in heartbeat and blood pressure, a particular risk for people with circulatory or heart problems.

consumption experienced complex changes. For example, **cocaine** abuse was especially heavy in the mid-1980s, then at the beginning of the 1990s consumption dropped steeply and in the mid-1990s it began to increase again with notable vigour, with a great influence on the production and export markets for this substance. Towards the end of the 1990s, consumption began to stabilise in the North American market (which represents the largest **cocaine** market in the world), and in the same period a very strong increase began in Andean countries, as well as in their neighbouring countries, the main players on the trafficking routes of this substance towards North America and Europe (where its consumption amongst young people is increasing).

In any case, the greatest increase in consumption and extension of the phenomenon, in recent years in Europe, has been related to ATS. Although it is also true to say that in Western Europe the use of cocaine has continued to increase, but levels continue to remain lower than those reached in the United States.

1.4. Heroin

Compared with the consumption of other drugs, the abuse of **heroin** and other opiates show lesser prevalence. In relation with UNDCP estimates, around 8 million people consume **heroin** or other opiates in the world (0.14% of the world's population), with the largest percentages being found in Southeast and Southwest Asia. In these regions the percentage of consumption rises to 2% of the population, increasing even further in traditional areas of opium cultivation. For example, in the Democratic Republic of Laos, the percentage ascends to 6%.

The use of **opium**, whether smoked or ingested, has a long tradition in some parts of Asia. Diverse factors underlie the elevated prevalence of its use, but one of them is the level of acceptance of its consumption in these regions. For example, prevalence in the agricultural areas in the Republic of Laos

and Thailand rises to 10 or 12%. In urban areas, the consumption of **heroin** is increasing rapidly. And the growth in the number of people injecting over the last five years is becoming a real cause for concern.

Even though Europe has the largest **heroin** market in the world in economic terms, prevalence of consumption is lower than that of ATS and cocaine. In Europe, prevalence in the consumption of **heroin** is much greater than that of **opium** and it is estimated in between 0.2 and 0.4% for the population aged over 15 years.

The consumption of **heroin** in the Americas is less of a problem, except in the United States, where there has been an increase in recent years. In Europe, however, expansion is blocked in general terms. In Africa the consumption of **heroin** is starting to appear with significant data in some countries, although the proportion is not a major cause for concern.

Although prevalence of heroin consumption continues to be lower than for other drugs, it continues to be the drug that leads to most **treatment** requests in Europe and Asia. On average around 70% of treatments in Europe correspond to the consumption of opiates, fundamentally heroin. In Asia, the use of opiates represents around 60% of requests for **treatment**.

1.5. HIV/AIDS

At the beginning of 1998 there were 30 million people in the world infected with the **HIV/AIDS** virus, according to UNAIDS data. Of these, a total of 3.3 million are intravenous drugs users, representing 11% of the total. During the period between 1996 and 1998, the countries reported that the number of injectors had increased by 9%, whilst the number of injectors who had been infected with **HIV** had increased by 37%; this means that transmission amongst injectors is increasing at an alarming rate, thus an infected person who enters into contact with a community of injectors that is not infected can extend the virus through the community at a very high speed.

1.6. Methods of consumption

In terms of the **ways** in which drugs are consumed, intravenous drug taking has become less common, with the possible exception of cocaine. In Europe and Asia, country reports indicate that there are currently less **injectors** of cocaine than there were at the start of the decade, however in America there has been no reduction, and this is the region where this substance is consumed most. In addition, the number of ATS injectors has increased in Asia and in Europe, whilst the number of heroin **injectors** has increased in Africa and Asia.

Polydrug consumption and the diversification of substances and **methods** of consumption seems to be the key. The introduction of new drugs is not leading to any reduction in consumption of classic drugs. In turn, the introduction of new methods of use does not imply the abandonment of classic consumption methods. The new drugs are added to those already in existence and new uses increase traditional uses.

1.7. Conclusions

The UNDCP reports that out of 68 countries have given their data, by answering the Annual Reports Questionnaire (ARQ), there is a net increase in the consumption of **cannabis** in 31 of these, a net increase of **amphetamine-type-stimulants** (ATS) in 26 countries; **heroin** in 21 countries, **cocaine** in 18 countries, **hallucinogens** in 12 countries, **volatile substances** in 12 countries and **benzodiazepines** in 9 countries. As regards **opium**, what is happening is that in the countries where this was consumed traditionally, its consumption is being swapped for heroin consumption.

Although cannabis has the highest consumption levels, the most dynamic increase during the 1990s has been that of ATS. In 1997, four times more countries than in 1990 reported on an increase in their territory in ATS consumption, double the amount of countries reported an increase in

cannabis consumption, a further half in heroin consumption and the number of countries reporting an increase in the use of cocaine has not changed.

The data indicate that the consumption of heroin and cocaine have continued growing during the 1990s; with greater intensity in countries that had not been affected until now, but in any case their expansion was slower than that of ATS.

In regional terms, the increase seems to have been especially strong in Europe. European countries report an increase in ATS, cannabis, opiates and cocaine.

In economic terms the largest drugs markets are North America and Western Europe. In each, an increase in the consumption of heroin and cocaine can be observed. With North America being the region where the greatest levels of cocaine consumption are reported, what is increasing now is the consumption of heroin. Meanwhile in Europe, traditional stronghold of heroin consumption, what is continuing to grow is the consumption of cocaine. In these two regions there is also heavy consumption of ATS and cannabis.

2. Tendencies and patterns of consumption on a worldwide scale

2.1. Cannabis

Changes of attitude have been detected in consumption, especially in young people who use cannabis together with synthetic drugs in leisure areas: acid house parties, raves, discos, etc. This great demand for cannabis has meant that, together with the crops situated in traditional exporting regions such as Africa and Asia, more and more plantations are appearing in North America, Europe and Australia, with the aim of satisfying the huge demand.

In comparison with the previous decade, clear growth in cannabis use has taken place, especially in Europe, but also in Africa and Asia.

As we said previously, the increase in Europe has been strong, but always lower than the increase in consumption levels in the United States, always three or four points higher. For example, the annual prevalence in 1997 was 9% (population aged over 12 years) for the United States and 5.5% of the population aged over 15 years in the European Union.

In the Americas, and especially in the United States, during the past two decades prevalence here has been suffering a constant increase, according to the report by the National Epidemiology Network, United States Department of State and United Drug Enforcement Agency (INCB). With respect to South America, it is important to highlight the 1997 reports, in which Brazil, Argentina and Chile showed an especially high increase in cannabis consumption, as did Central America and the Andean area in general. However, it is in the United States where we find the greatest problem over the last two decades. In the early 1980s, the largest number of consumers ever was calculated, 30 million in 1982, equal to 15% of the population aged over 12 years); later, at the beginning of the 1990s, consumption had dropped to 16 million (1992, 7.9%), only to rise once more to reach 20 million in 1997 (9.0%).

The problem in Western Europe, although somewhat smaller, is still very serious, due to the increase in the use and abuse of cannabis in the last two decades. For example, in Germany, the population aged between 18 and 39 years showed an annual prevalence of 4.1% in 1990, rising to 7.2% in 1997, equivalent to the high rate of 4.1% for the general population (18-59 years). In the UK, the number of consumers rose from 5% in 1991 to 9% in 1996, for the population aged between 16 and 59 years, according to British Crime Survey data. It is also true to say that in 1997, some countries such as the United Kingdom itself, Ireland, France, Switzerland, Spain and Portugal, reported that prevalence had stabilised (not amongst young people).

In Central and Eastern Europe, together with the Russian federation, the countries report a stabilisation or light reduction in consumption, but this is

supported by their recent political history and the lack of porosity experienced by their borders until the beginning of *democratisation*, since in recent years a strong increase has been observed in the consumption of all the drugs used in Western Europe.

2.2. Amphetamine Derivatives (ATS)

As we have already pointed out, the abuse of this substance shows the greatest increase in recent years. In Europe, the phenomenon is turning out to be especially prominent as it has become closely linked with the way in which many young people spend their leisure time: techno parties, raves and the general "dance scene". In countries where musical phenomena such as dance or acid house have traditionally developed, a large increase in the use of these substances has been experienced, much higher than that of heroin or cocaine base, fundamentally extended through lower or isolated social classes, whereas ATS consumption may be found amongst all social classes. There is also notable consumption in some professions, such as truck drivers, fishermen or professionals in the sex for sale world, to counteract fatigue or a lack of communication.

The countries that reported the greatest increase throughout the 1990s have been European countries, followed by those from Asia and the Americas.

In the period between 1995 and 97, the greatest increase seen in the consumption of ATS corresponds to Europe. The majority of Western European countries, including France, Italy, Switzerland, Germany, Spain and the Nordic countries have presented reports on this alarming increase in the consumption of ATS; as have the majority of countries from Eastern Europe, above all amphetamines and MDMA. The only countries reporting a decrease in consumption were Turkey, Greece and Lapland.

In the majority of European countries the increase in consumption is even greater than that of cannabis, which is, as we indicated, the drug most

commonly consumed. For example, in Holland, in the period between 1992 and 1996, for the population aged between 12 and 18 years the prevalence in consumption increased for cannabis by 40%, whilst the prevalence in consumption of ATS in the same period was more than double, increasing from 1.0% to 2.2%. We find the same in western Germany, where during the period 1991 to 1997 the increase in the consumption of cannabis (population 18-39) was 60%, whilst in the same period and for the same sector of the population the increase in the consumption of ATS was double: 1.7% for the consumption of ecstasy, 0.9% for the consumption of amphetamines, and lower, 1.2% being the increase in cocaine consumption and 0.3% in heroin consumption. With small numerical differences, the same can be applied to the United Kingdom. According to British Crime Survey data, during the period 1991-1996 (population aged between 16 and 29), the increase in the consumption of amphetamines doubled, rising from 4% to 8%. Meanwhile the increase in the consumption of heroin and cocaine remained at 0.5% and 1%, respectively.

An increase in the prevalence of consumption is also true of the United States and Mexico, in addition to many countries in South America, above all for methamphetamine and to a lesser extent ecstasy.

2.3. Cocaine

The increase in cocaine consumption experienced a steady rise during the entire decade of the 1980s. Measuring consumption of this substance became more complicated during the 1990s, as different rates were experienced. In the period between 1990 and 1995 the increase gradually reduced its pace, then a sharp acceleration began in 1996 which continued throughout that year, with a new reduction in the pace in 1997, on a global level, although in certain regions the pace has continued to show a strong increase.

In regional terms, we find strong expansion in the Americas during the mid-1980s; the rate decelerates at the beginning of the 1990s and is then reactivated once more in the mid-1990s, having continued with a more moderate increase over the last five years.

In any case, even though the Americas is the region where most coca is consumed in the world, the strongest rise in use is to be found in Western Europe, with the exception of the Nordic countries where the increase in consumption of ATS eclipses the increase in cocaine consumption. The increase in Eastern Europe is lower. There are now more countries in Europe than in the Americas reporting an increase in cocaine consumption. However, the increase in cocaine consumption, in general, has been less than that of ATS, and in Eastern Europe its consumption is still low.

In the United States and Canada, the period between 1995 and 1997 was a period of stabilisation in consumption; although this represents the largest cocaine market in the world, together with the constant increase in countries in the Andean area and their neighbours: Brazil, Paraguay and Venezuela, along with the countries of Central America (Mexico and some countries in the Caribbean) crossed by the cocaine trafficking route as it makes its way towards the United States and Canada.

In summary, cocaine is a serious consumption problem in the United States and Western Europe, although in the latter prevalence is less than in the USA. As relevant data, we can say that 0.7% of the population aged over 15 years consumes cocaine in Europe, as compared to 1.9% of the population aged over 12 years in the United States.

In recent years a light decrease has been appreciated in some countries in Latin America, such as Chile and Argentina.

2.4. Opiates

The most critical problem, on a global scale, continues to be presented by opiates, fundamentally heroin. The data available show how heroin has experienced a gradual expansion around the planet over the last decade. Although this expansion has been gradual, it experienced a strong rise at the end of the 80s, at the beginning of the 90s, and during the period 1994 to 1996, to then continue with its slow advance.

For Europe, it was in the 1980s that the most accelerated pace occurred in the expansion of heroin; however, in the decade of the 1990s it was the Americas, above all in the North, that experienced the fastest rate of expansion. Linked to this, in Latin America domestic cultivation of heroin has begun to prosper and has remained so far, in the main part, within the area's borders.

Western Europe, where it is estimated that there are a million heroin addicts, has been stabilised since the 1995-97 period. Except for the United Kingdom, Ireland and the Nordic countries, which have experienced a considerable increase, together with the countries of Eastern Europe, especially the regions close to the Balkan routes.

In the Americas a mild increase in heroin consumption has been contemplated since 1995, increasing in recent years. This fact is reported by the following countries: United States, Canada, Mexico, Colombia, Venezuela and Ecuador.

Along these lines, since the 1995-97 period, an increase has been witnessed in consumption prevalence in the United States, with an increase from approximately 300,000 heroin addicts in 1991 to 600,000 in 1997. We also find, as already indicated, a strong increase in Canada, the United Kingdom, Ireland and Australia.

3. The worldwide extension of drug abuse

3.1. Conclusions

The exact number of drug users in the world cannot be ascertained. But it is estimated that it may range between 3.3% and 4% of the worldwide population, and this includes alcohol and tobacco.

According to World Health Organisation (WHO) estimates, at the beginning of the 1990s around 1100 million people were smokers, around 47% of men and 12% of women. It is also estimated that in 1998 the use of tobacco cost the lives of 3.5 million people, and if the current rate of consumption continues, in 2030 around 10 million people could die due to tobacco abuse in all its forms.

With regard to alcohol consumption, the data show rates near to 100% of users for a population aged over 15 years in countries where alcohol has traditionally been consumed. For example in Canada 80% of the population segment indicated consumes alcohol, in Italy 81%, in Western Germany 91% and in the Nordic countries the percentage varies between 82% and 96% (Lifetime prevalence, the annual prevalence is reduced by a few percentage points).

With respect to cannabis, fundamentally marihuana and hashish, in 1997 we had 141 million consumers representing 2.5% of the world population.

After the above, we come to the drugs that cause the highest levels of mortality, social problems and requests for treatment in the world: cocaine and heroin. As we already saw previously, there are around 13 million cocaine consumers (0.2%) and around 8 million heroin users (0.1%).

As for the use of synthetic drugs (ATS), as we already mentioned these drugs have experienced the greatest degree of growth, above all amongst the

younger population. It is estimated that there are around 30 million consumers in the world, representing 0.5% of the world population.

4. Drugs use amongst young people (15-24 years)

Drugs use amongst young people represents one of the factors that most influences the increase or difficult elimination of unemployment, negligence, violence and sexual abuse. At the same time there is heavy drugs use amongst socially integrated young people: middle and upper classes, mainly in the most developed industrialised areas in the world. Under consideration as one of the possible reasons is the high level of social tolerance in these regions towards drugs use.

The use of **cannabis** (marihuana, hashish) amongst young people remains high in many regions of the world (13.5%) and continues to increase. It is linked with the consumption of **ATS** (methamphetamine, MDMA) whose consumption has stabilised at a high level in many countries in Western Europe and continues increasing in other regions. The average for **ecstasy** is, approximately, 2.6%. As regards **cocaine** there are large differences, but an increase is reported amongst young people in the United States. In Eastern Europe the number of **heroin** injectors is increasing; whilst in Western Europe and the United States we are seeing an increase in **heroin** smokers. In any case, heroin and cocaine continue to be secondary drugs for young people, representing 1.9% for cocaine and 1.0% for heroin. The subject of volatile substances is a more serious problem for the younger sector (representing 7.8%).

Alcohol, although it is a legally and socially accepted drug, is causing devastation amongst teenagers and young people, with high prevalence being found. For example, in the United States in 1996 (16-17 years) the prevalence (lifetime) was 80%. And in Ghana, Kenya and Zambia, 70 to

80% of students consumed alcohol (1996), it being considered that between 10-14% were already alcoholics.

4.1. Cannabis

Data with prevalence of consumption, in some regions of the world, approaching 37% (consumed throughout the entire life) and from 10 to 25% (consumed within the last month), show that this consumption is not limited to marginal sectors of the population, but rather that it is extended to all social levels.

A large quantity of countries inform that prevalence (lifetime) for the consumption of cannabis gives the highest percentages (25% on average) in Australia, Canada, Germany, Ireland, Spain, Switzerland, the United Kingdom and the United States. In Western Europe, the data only inform on minor prevalences (lifetime): Austria, Finland, Portugal and Sweden with an average of 10%.

In the majority of countries in Central and Eastern Europe consumption is lower than in Western Europe, although the increase has been steady throughout the decade of the 1990s, above all amongst young people.

In Latin America and the Caribbean, the data show a high prevalence (lifetime), above all in Chile (22.7% age 12-25), Jamaica (13-19 years) and Bahamas (16-29 years) giving around 17%. Brazil contributes a lower percentage (7.6%) but this lower number may be due to the fact that the population segment chosen for the prevalence of consumption (lifetime) is 10-19 years. Other countries in the area offer an average percentage of 5%.

4.2. Ecstasy

As we have already pointed out, synthetic drugs consumption, mainly of ATS, has experienced the greatest increase, with the number of consumers of these drugs being estimated at around 30 million people (0.5% of the

world population). The most widely used ATS in the world is methamphetamine, finding the highest levels of consumption in the United States, the Far East and Southeast Asia.

Out of a large number of ATS drugs, the most notable expansion has been enjoyed by MDMA (Ecstasy), fundamentally in the industrialised areas of Western Europe; although there are data that show a rapid expansion in other regions. In Western Europe, prevalence (lifetime) in ecstasy consumption ranges from 9% (Ireland) to 0.2% (Finland). The average prevalence (lifetime) found amongst young people in Austria, Belgium, Germany, Italy, Holland Spain and the United Kingdom is 3%.

Ecstasy consumption in the Untied States (3.1%) and Australia (3.6%) is at lower levels than many countries in Western Europe. Rapid expansion can be observed through Central and Eastern Europe, linked with the expansion of mass “dance” and “house” parties, “raves”, etc. In the South of Africa and Southeast Asia (Indonesia, Singapore and Thailand) a strong expansion in consumption can be observed. As regards Latin America, we do not yet have clear information concerning ecstasy consumption.

4.3. Cocaine

The percentage of prevalence (lifetime) of cocaine consumption by young people varies greatly from some regions to others, from a very high 6.3% (Bahamas, 16-29 years), to a very low 0.2% in Finland. In general, the countries that offer the highest levels of cannabis consumption also offer those of cocaine: Australia, United States and the majority of Western European countries, with the odd exception such as Finland.

4.4. Heroin

Heroin and cocaine, as we have been saying, are not the main drugs consumed by teenagers and young people. However, their consumption amongst this age group is growing in many countries, as is the increase in

the number of intravenous users, thus increasing the risk of AIDS infection, as teenagers and young people do not take excessive prevention measures to avoid infection.

The highest percentages in the prevalence (lifetime) of consumption can be found in Europe: Germany, Greece, Ireland and Italy (Population 15-16 years, 2%). There are data that indicate a considerable increase in consumption through the lungs (smoking) of heroin in some countries in Western Europe. In Eastern Europe intravenous use of heroin has been increasing and this tendency has reached younger people. One of the countries with the greatest percentage is Slovakia with prevalence (lifetime) of 1.9% (15-16 years). In general a sizeable increase can be observed around the world, of young people that smoke heroin, with a high probability of them becoming injectors in the future.

4.5. Volatile substances

The problem represented by these substances, regarding which many countries report that they have teenage users, are their low price and the fact that they are easy to buy. In addition they are the threshold which many young people will cross to access other illegal drugs.

After cannabis, volatile substances (glues, etc.) are the most highly consumed substances amongst adolescents. Thus, we find ourselves with very high prevalence (lifetime) levels in many countries: 25% (Australia); between 10 and 20%: Brazil, Croatia, Kenya, Lithuania, Malta, Switzerland, United Kingdom, United States, Zimbabwe.

5. The cost and consequences of drugs abuse

5.1. Demand for treatment

In the Americas the drug which causes the greatest demand for treatment is cocaine; in Europe and Asia it is heroin. Following ATS, in Asia cannabis is the third drug that causes demand for treatment.

In the majority of European cities, and across all of Europe, overall, the drugs that cause the most demand for treatment are opiates, and fundamentally heroin.

According to a study carried out by the International Epidemiology Work Group (1998), in 29 European cities, 70% of the demand for treatment in Europe is caused by heroin addiction; 9% by cannabis, 7% by ATS (especially amphetamine) and 3% by cocaine abuse. The Western European cities that show the greatest levels of demand for treatment for opiate addiction are Madrid and Rome, and in Eastern Europe, Sofia, Bratislava and St. Petersburg.

The Republic of Czechoslovakia is the only European country where the greatest proportion of demand for treatment corresponds to ATS abuse, 50% in Prague. Opiate abuse is relatively low. In other Eastern European cities such as Budapest and Bucharest, benzodiazepines and barbiturates represent a greater problem than opiates. In the Nordic countries (Finland, Sweden) the consumption of amphetamines accounts for a high percentage of demand, 20% for Sweden and 40% in the case of Finland (1996).

In comparison with other cities in Western Europe, Amsterdam reports a low percentage for opiates (50%) with a high percentage of demand due to cocaine use (30%), one of the highest in Europe, and also a relatively high percentage for cannabis (15%). Holland, however, may represent the average demand for treatment in Europe with 66% for opiates, 16% for cocaine and 11% for cannabis; even so, we should remember that Holland is

one of the countries with the highest percentages in demand due to cocaine use. As regards treatment demand for ATS, the European average is 5%, although there are countries with higher percentages, for example Belgium, where in 1996, 24% of its patients in treatment were being treated for abuse of this substance.

In Asia, the situation is very similar to that in Europe: a study carried out in 15 Asian cities shows 80% on average in demand for treatment due to opiates, with a change being observed in the use of traditional opium to heroin. Cannabis represents a high percentage, especially in Southeast Asia, with 70% for heroin and 15% for cannabis.

It is curious, and worth highlighting that in the Asian Far East, two thirds of patients request treatment for consumption of ATS (amphetamines), with opiates lying in second place in terms of causing treatment.

In contrast with Europe and Asia, in the Americas the greatest percentage is caused by cocaine (powder cocaine, crack and bazuco) in all countries. As an average for North and South America, 60% of patients are cocaine users (19 countries), next comes the percentage for cannabis (13%) followed by volatile substances (5%), then heroin (2%), and finally ATS (1%).

In some countries the percentage due to cocaine is relatively low: Mexico, Brazil and the United States with an average 30%. In the case of the United States the percentage varies considerably from State to State. For example, as regards cocaine: Atlanta, 47%, Miami, St. Louis, Detroit, Washington D.C., Texas, Illinois, New York City and Philadelphia an average 40%. In Los Angeles, however, we find that heroin, with a large increase in recent years, accounted for 60% of demands for treatment in 1997; or San Diego, where ATS caused 43% and cocaine was relatively low (14%).

The United States and Mexico are the only countries that report a significant number of treatment demands due to heroin consumption (26% and 7% respectively).

With respect to ATS consumption, the United States reports one of the highest percentages (6%), followed by Argentina with 4% and Colombia with 3%.

The percentage of demand for treatment due to cocaine is especially high in countries in the Andean region, with an average of 60%; it is also high in some Central American and Caribbean countries, their problem is growing due to the fact that they are countries on the cocaine trafficking route; we find an average percentage of 64%. In cocaine exporting countries, the main demand for treatment is due to the abuse of this drug; in Peru we find 70% (always excluding alcohol). The form of consumption par excellence is bazuco (smoked coca paste), with a similar percentage in numbers per consumption method in Bolivia, Chile, Ecuador, Colombia, Trinidad and Tobago and to a lesser extent, but still in a high proportion, in Panama, Costa Rica, Mexico and Argentina. The most common form of cocaine consumption is crack. Crack represents the main form of consumption in Costa Rica, 68%, the Dominican Republic, 67%; Barbados and Jamaica, 50%.

The use of volatile substances is another drugs issue with a strong impact in the Americas, where in some countries percentages are very high, (Nicaragua, 29%; Bolivia, 24%; Guatemala, 11%); at the same time, Guatemala reports a very high level in tranquillisers, (14%).

Cannabis consumption causes a high number of treatment demands, above all in the countries of Central America and those of the Caribbean (Jamaica 50%; Barbados 28%, Nicaragua 20%); also, Chile reports 20% and the United States 19%.

5.2. Dangers posed to health

5.2.1. Cannabis

We will describe the effects of marihuana. Researchers have found that THC (delta-9-tetrahydrocannabinol) changes the way in which sensory information arrives and is processes by the hippocampus. The hippocampus is a component of the limbic system which is crucial for memory and learning, and the integration of sensory experience such as emotions and motivations. Research has demonstrated that the neurones of the information processing system of the hippocampus and activity levels in nervous fibres are repressed by THC. Also, researchers have found a deterioration of the behaviour patterns learned, also dependent on the hippocampus.

5.2.2. Crack and Cocaine

Cocaine is a strong stimulant of the central nervous system that hinders the process of re-absorption of dopamine, a chemical messenger that is related with pleasure and movement. The dopamine is released as part of the brains system of compensation and is related with the stimulus that is characteristic of cocaine consumption.

High doses or prolonged use of cocaine or both at once may cause paranoia. Smoking crack cocaine may produce a paranoid conduct that is particularly aggressive in users. When drug addicts stop using cocaine, they often get depressed. This may also lead to greater use of cocaine in order to alleviate depression. Prolonged inhalation of cocaine can cause ulceration of the mucous membrane in the nose and damage the bone inside the nose to the point where it causes a collapse. Deaths related with the use of cocaine are often due to cardiac arrest or respiratory failure.

5.2.3. Heroin

The long-term effects of heroin appear after the drug has been used repeatedly for some period of time. A chronic user may suffer vein collapse, infection of the endocardium and the heart valves, abscesses, cellulite and liver disease. There may be lung complications, including various types of pneumonia, as a result of the poor health of the heroin addict, as well as due to the depressor effect of heroin on the respiratory apparatus.

In addition to the effects of the drug itself, heroin sold on the street may contain additives that do not dissolve easily and thus obstruct the blood vessels that go to the lungs, the liver, the kidneys or the brain. This can cause infection or even the death of small groups of cells in these vital organs.

5.2.4. Amphetamine Derivatives

Methamphetamine releases high levels of the neurotransmitter called dopamine, which stimulates the brain cells and improves mood and body movements. It also appears to have a neurotoxic effect, as it damages the brain cells that contain dopamine and serotonin, another neurotransmitter. With time, methamphetamine can reduce the levels of dopamine, which can result in symptoms similar to Parkinson's Disease, a very serious nervous disorder.

Some research carried out on animals over more than 20 years shows that high doses of methamphetamine damage the endings of neurones. The neurones that contain dopamine and serotonin do not die after the use of the methamphetamine, but the nerve endings are cut back and it seems that the regrowth process is limited.

In addition, methamphetamine increases heartbeat rate and blood pressure and may cause irreversible damage to blood vessels in the brain, thus producing brain haemorrhage. Other effects include breathing problems,

heartbeat irregularity and extreme anorexia. Its use can lead to a cardiovascular collapse and death.

5.2.5. Ecstasy

MDA, the base drug in MDMA, is very much like amphetamine, with a similar chemical structure. Research has shown that MDA destroys the neurones that produce serotonin, which directly regulate aggression, mood, sexual activity, sleep and sensitivity to pain. It is probable that this effect on the serotonin production system gives MDA its supposed properties that cause intensification of sexual experience, calmness and sociability.

MDMA's structure and effects are also related to those of methamphetamine, which has been shown to be a cause of degeneration of the neurones that contain the neurotransmitter substance dopamine. Damage to these neurones is the basic cause of the motor alterations observed in Parkinson's Disease.

In laboratory experiments, a single exposure to methamphetamine at high doses or prolonged use at low doses destroys up to 50% of the brain cells that use dopamine. Although this damage may not be apparent immediately, scientists believe that with age or exposure to other toxic agents, symptoms of Parkinson's Disease may appear over time. These begin with a lack of coordination and shaking and in the long term may cause a form of paralysis.

5.2.6. Volatile substances

Inhaling very concentrated quantities of chemical substances that contain solvents or aerosols may be a direct cause of heart failure and death. This is very common with fluorocarbons abuse and the abuse of gases similar to butane. High concentrations of volatile substances also cause death due to asphyxia as they displace oxygen from the lungs and the central nervous system, which leads to breathing failure. Other irreversible effects caused by solvent inhalation are as follows:

- Loss of hearing: toluene (aerosol paint, adhesive substances and wax removers) and trichloroethylene (cleaning and correcting fluids).

- Peripheral neuropathy or spasms in the extremities: hexane (adhesive substances and petrol) and nitrous oxide (whipped cream in aerosol and gas cylinders)

- Damage to the central nervous system or the brain (aerosol paints, adhesive substances and wax removers).

- Damage to bone marrow: benzene (petrol).

Amongst the effects that are serious, but possibly reversible, we could mention:

- Liver and kidney damage: substances that contain toluene and chlorated hydrocarbons (dry cleaning and correction fluids).

- Exhaustion of oxygen in the blood: organic nitrates (popularly known in America by the names “poppers”, “bold” and “rush”) and methylene chloride (varnish remover and paint thinners).

5.2.7. HIV/AIDS and intravenous drugs users

The first case of infection through injecting drug use (IDU), was diagnosed in New York in 1981. Since then the figure has risen to 3.3 million in the world, representing 11% of the total people infected. 54% represent heterosexuals, 26% homosexuals, 6% transfusions or infection due to contact with infected blood and 3% are babies infected by their mothers.

According to UNDCP reports in 1996 and 1998, the number of IDU infected with HIV has grown by 9%. The number of countries reporting data on IDU infected by HIV has grown by 36%. This is due to the fact that a considerable increase has been reflected in the world of heroin, cocaine and ATS users. The numbers have grown in the United States and in Eastern

Europe, but above all in Africa and Asia, in the latter above all from ATS, the greatest increase IDU of amphetamines is reported by Asia.

In terms of the extension of the epidemic, in the United States and in Western Europe, where the epidemic began, we find 23% of HIV cases related with IDU. In the East and Southeast of Asia an average of 20%, in Eastern Europe 19%, in South America 11% and in the Middle East around 6%.

The great endeavours made in terms of prevention has contained the expansion of the epidemic in the United States and Western Europe, but in other regions of the world infection continues to increase at an alarming rate amongst IDU, as is the case in Latin American and China, where this phenomenon is associated to the increase in the percentage of IDU.

Here are some further data: in the Ukraine, 64% of those infected, around 25,000, are drug addicts; many countries report that the greatest percentage of infections of AIDS is due to IDU, this is the case in China, Georgia, Italy, Malaysia, Poland, Republic of Moldavia, Spain, Vietnam and Yugoslavia, countries in which the average is around 50%. There are many countries that report high percentages of infected IDU: Argentina, Brazil and Uruguay, as well as the United States, report between 25% and 42%.

2

CONSUMPTION PATTERNS AND HEALTHCARE RESPONSE IN THE EUROPEAN UNION

1. Study by substances
2. Consumption prevalence in the EU
3. Demand for Treatment
4. Infectious diseases associated with drugs
5. Addictions and their consequences on neonatal health
6. Drugs-related deaths
7. Healthcare Response

CONSUMPTION PATTERNS

AND HEALTHCARE RESPONSE IN THE EUROPEAN UNION

1. Study by substances

1.1. Cannabis

Considerable differences continue to exist between different countries regarding the level of cannabis consumption, but there are indications of convergence in levels of prevalence (countries with a traditionally high prevalence: following the increases of the 1990s, the level of consumption is tending to stabilise or even to fall; countries with a lower prevalence: the level of consumption has increased during recent years).

Recent surveys suggest that in the EU over 40 million people have consumed cannabis (around 16% of the population aged between 16 and 64 years of age) and that at least 12 million have consumed cannabis during the last twelve months (around 5% of people aged between 15 and 64 years). It could be said from a bolder perspective that the latter are potential habitual consumers.

These percentages are higher amongst young people. On average, around one in five teenagers between 15 and 16 years affirm that they have consumed cannabis, and this number increases to one in three young people aged around 25 years.

In some countries, an increase in the demand for treatment for cannabis addiction has been observed, especially between younger consumers.

In the majority of countries, cannabis is the most habitual drug involved in police arrests for drug-related crimes, mainly related more with possession for own use than with trafficking.

The quantity of cannabis seized each year is stable, although the number of seizures is increasing constantly. Availability remains high in almost the entire EU and the cannabis market seems to be well established, with prices for the most part remaining stable.

In many parts of the EU, cannabis consumption is not linked to a specific social group, but rather it is extended across all social groups.

1.2. Amphetamines, ecstasy and LSD

Public concern regarding "synthetic drugs" grew during the decade of the nineties in response to the generalised consumption of ecstasy and similar drugs in a culture based around leisure and music for the masses, known as "rave", "techno" and "dance" events, attended mainly by young people of all types. The most recent developments appear to show diversification in the drugs consumed and the contexts and methods of consumption.

The predominant tendency, maintained in recent years, is a lasting and constant increase in availability and consumption of amphetamines. In the wider context of youth leisure culture, amphetamines are consumed in most cases through the nose (in powder) or orally (in pills or mixed with drinks).

As regards ecstasy (MDMA), this is used not only in entertainment contexts such as dances and parties, but also in private contexts, with important differences between countries. In some countries there are indications of a stabilisation or even a fall in the level of consumption (seizures of the drug also reflect a generalised decrease), as well as a certain level of disenchantment with tablets sold as ecstasy. The analysis of ecstasy tablets shows that, they increasingly contain less MDMA and more amphetamines.

It is difficult to define in a precise way the trends in diversification of consumption. Several reports point towards greater interest in stimulant drugs, such as, for example, amphetamines and cocaine in some cases, and in hallucinogens such as LSD or magic mushrooms in others.

An increase in the consumption of drugs with sedative effects such as heroin or benzodiazepines has also been found, especially amongst heavy users of ecstasy or amphetamines.

Other trends found in this context and reflected, especially, on the Internet, include consumption or experimentation with different substances, including aphrodisiacs and drugs that develop physical and mental capacities, as well as the consumption of substances that induce psychological alterations.

In the Nordic countries, amphetamines have been and continue to be used (often intravenously) by chronic and problematic consumers in situations of greater social isolation, usually unrelated to the general context of young drugs consumers.

It should be pointed out that the increases in the consumption of amphetamines and ecstasy are not strongly reflected in indicators such as demand for treatment.

1.2.1. Situation by country

We do not have data of a continental nature, but we do have national data that show a rapid growth of prevalence of consumption amongst young people aged between 13 and 18 years. Surveys show an ascending spiral of consumption from adolescence to youth, with an increase in the consumption of psychoactive substances joining the increase in consumption of tobacco and alcohol.

Illustrating the above, in 1996 a survey was carried out in Brussels among 2909 students from different European countries. The results were, for

young people aged between 17 and 18 years, 8% for boys and 5.7% for girls, these percentages are undoubtedly a cause for major concern.

- Austria

We cannot find data on national surveys, but details are available for specific areas that are representative of the national tendency. According to drugs experts in the country, the growth in the prevalence of consumption of ATS has been increasing over the last five years. For example, in Vienna, in a survey carried out amongst young people aged between 13 and 18 years, it turned out that 1515 of them (4%) had consumed ecstasy, this figure was only exceeded by cannabis (22% lifetime prevalence). In the 13-14 years age group, 5.6% had consumed, which indicates an alarming increase in the prevalence of consumption. This tendency is closely related to the spiralling upwards consumption of tobacco and alcohol.

- Denmark, Finland and Sweden

The Scandinavian countries share a legendary history of using and abusing amphetamines. During the Second World War it is calculated that some 200,000 people regularly consumed amphetamine derivatives; 3% of the entire adult population of Sweden. Today the epidemic continues, although with a level of consumption at a much lower percentage. It is calculated that today some 17,000 people show addiction to psychoactive substances, of which more than 14% suffer this problem due to consumption of amphetamines.

As in other European countries, new design drugs like ecstasy have penetrated society, together with the "house music" culture. But in reality they have not had a great influence the young people of these countries. It should be highlighted that the group showing highest MDMA consumption

levels is the Swedish army, with the greatest increase in consumption prevalence, rising from 0. 9% in 1995 to 1.4% in 1997.[8]

As regards Denmark, we find ourselves in a parallel situation to that shown by the Scandinavian countries as a whole. Following the strong epidemic of amphetamines consumption during the 1960s, a result of the impressive level of consumption that took place during the 1940s and 1950s, the percentages have dropped, but they have remained high. It is calculated that around 4% of the total population of Denmark consumed amphetamines at some time in 1997. But in reality the consumption of ecstasy remains low. In a representative survey amongst 2,571 students of between 15 and 16 years of age, somewhat reassuring results were obtained: 0.7% for boys and 0.3% for girls.

In Finland we observe the same chronic consumption of amphetamines as shown by the other two countries studied, and a slow but constant penetration of MDMA is maintained.

- France

Expansion in France finds its origins in the 1990s, where we find the first police intervention in a rave party in 1991. And the first legal measures directed at repressing the phenomenon appeared in 1996. According to a report by the French Observatory on Drugs and Drug Addictions, in March 1997 there were some 50,000 people in France who occasionally or habitually consumed “ecstasy” and the majority were men aged between 18 and 25 years, connected to the world of Techno, raves, etc. A high level of users is to be found amongst professionals working in this sector.

The situation in France with respect to the population in general of ages between 18 and 75 years in 1997, according to the EMCDDA, showed a prevalence (lifetime) of ecstasy consumption of 0.7%, dropping to 0.3% for those who had consumed in the year prior to the survey.

[8] E.M.C.D.D.A “Annual report on the state of the drugs problem in the European Union” 1998.

When we analyse the situation amongst young people, the numbers rise once more, and in 1993 a survey on a national scale for the school-aged population between 11 and 19 years, showed a prevalence of consumption of amphetamines of 2.8% for boys and 1.3% for girls. These are very high percentages, especially if we bear in mind that the prevalence of consumption has increased considerably in recent years, despite the fact that we are talking only of teenagers and young students.

- Germany

The problem of amphetamines consumption during the Second World War and the years that followed it, were the main problem that needed to be tackled by the country as far as addictions are concerned, but that use is not related to the use made of amphetamines today, related with leisure and the techno dance culture, with the reference drug in these contexts being MDMA. The consumption of ecstasy, other amphetamine derivatives and LSD has been growing in Germany in recent years. More so in Western Germany than in the East (where the increase is more obvious in opiates consumption). A representative survey carried out by the Ministry of Health in 1995 gave the following data: the sample was made up of 6305 people aged between 18 and 59 years, for whom a prevalence (lifetime) of ecstasy consumption was obtained of 1.6%, descending to 0.5% for those who had consumed it in the month prior to the survey. For amphetamines, in the same period, prevalences were: 2.8% and 0.3% respectively; and 2.1% and 0.2% for LSD. In any case, it can be said that many more people have consumed amphetamines or LSD during their lives than ecstasy, this is no doubt due to the, more or less recent appearance of the latter. This can be observed quickly when the study focuses on the population of teenagers and young people, as percentages shoot up. If we select young people aged between 18 and 20, we find ourselves before a lifetime prevalence of ecstasy consumption of around 6.9%; amongst young people aged between 21 and 24 years, of 5%, and amongst those who are aged between 25 and 29 years

of 3.1%. This clearly illustrates the age segment where the consumption of this drug is most intense.

It can be said, with no fear of mistake, that the greatest concentration of consumers occurs amongst fans and professionals from house, dance, and rave scenarios, etc. In two surveys carried out in 1997, one of 1647 people who went to techno discos and raves in Berlin (Tossmann and Heckman, 1997), and another study (Kröger and Künzel, 1997) of 447 people in Munich, offered the following results: around half had consumed ecstasy at some stage in their lives, and approximately the same number in the last year. Between 69% (Berlin) and 79% (Munich) had used cannabis at some stage, around 45% had used amphetamines, around 40% had used hallucinogens and around 35% cocaine; as regards those declaring themselves as new consumers of cocaine, the sample indicated 6% in Berlin and 9% in Munich. The year before, the percentages had been 4% and 5% respectively. In Berlin, as in the majority of cities where ecstasy is consumed, its use is accompanied by that of other drugs such as cannabis and others derived from amphetamines, and on less occasions by the consumption of cocaine and hallucinogens.

- Greece

At the moment the use of ecstasy or other types of designer drugs is not very widely extended. In the survey carried out by the Psychiatric Studies University in 1993, the use of ecstasy as an independent drug was not reflected. As regards amphetamines consumption, the lifetime prevalence, in other words, people who have consumed them at least once, was of 1% (1.2% for women and 0.7% for men; the greatest prevalence for women was found in the 25 to 35 age group, with 2.2%). As happens in all countries, when the focus zooms in on the school population, the percentages shoot up, thus we find 4.4% of young people who had consumed at least once; men showed more consumption than women (EMCDDA, 1997)

- Ireland

The European School Survey Project on Alcohol and Drugs (ESPAD) carried out a survey in this country in 1997. It was estimated that there are some 150,000 people using ecstasy every weekend.

Another survey carried out in Dublin amongst the school population gave the alarming piece of data that "one in every four pupils consume drugs" (O'Keefe, 1996).

From the most recent studies it can be inferred that approximately one million tablets (MDMA) are consumed each weekend, with around 750,000 people having consumed at some stage, and around 100,000 being regular users (Ministry of the Special Unit for the Reduction in Drugs Demand, 1997).

- Italy

As a representative sample of what happens in this country, with respect to this substance, we find a survey carried out amongst 343 young people in five discos in the Veneto Region in the summer season (Schifano et al. 1996). The following percentages were obtained: 47% admitted having consumed ecstasy recently, and of these 86% had done so along with other drugs (alcohol 60%, cannabis 59%, poppers 33%, cocaine 31%, amphetamines 9.9%;) In general, the majority had jobs or were students. It is interesting to note that around 6% indicated that they consumed in football stadiums.

- Luxembourg

In 1992 a school survey was carried out, which found a lifetime prevalence of consumption of 1.2% for ecstasy, 2.1% for LSD, and 9.9% for amphetamines (EMCDDA, 1997).

In 1997, a survey was carried out (Meisch, 1997) amongst 660 students aged between 13 and 22 years, students of the European Network of Health Schools (indicative but, obviously, not representative of all the students in

the country; for whom it should be supposed that the prevalence of consumption would increase) the following percentages were obtained: for this first age group around 2.12%, rising to 4.2% for the 18-22 years age segment, with a similar proportion between boys and girls, with use anywhere between once per month to once per week.

- Holland

The use of ecstasy was monitored for the first time in 1992, obtaining a prevalence for the month prior to the survey of 1%; in 1996 (from Zwart et al. 1997) 2.2% was obtained for the same prevalence (consumption in the last month); 2.9% for boys, 1.5% for girls. And lifetime prevalence was 5.6%. The rise in consumption prevalences can clearly be appreciated.

The population of Amsterdam is studied most often. One of the most recent studies (Sandwijk et al. 1995), a home survey carried out on the population aged over 12 in Amsterdam, 1994, and conducted by the University of Amsterdam showed a lifetime prevalence of around 3.2% of approximately 4,308 people surveyed, and a consumption prevalence for the month prior to the survey of 0.6%.

It seems that ecstasy is a drug that has not been deeply introduced into different age groups, not in the way that other drugs such as cocaine, cannabis or heroin have done. The greatest increase in the prevalence of consumption, throughout the nineties, is to be found in groups aged between 20 and 34 years.

A recent study (van de Wijngaart et al. 1997) on the use of ecstasy amongst young people who frequent raves or techno raves, directed by the Utrecht University Addiction Research Institute, came up with a lifetime prevalence of 81% and consumption for the night prior to the survey of 64%, confirming the close relationship between this leisure-time activity and the consumption of MDMA. Use is usually restricted to leisure time, the sample

presenting only 6% who used ecstasy in a continual way. Only 34% drink alcohol at raves and a similar proportion take amphetamines, rising to 41% of subjects taking cannabis.

- Portugal

The European School Survey Project on Alcohol and other Drugs (ESPAD), carried out a sampling throughout 1995 of 9,774 students which has recently been published. A prevalence of ecstasy consumption of 0.54% was found, a lower rate than that of amphetamines, 1.97%. As regards ecstasy, we find a prevalence amongst males of 0.8% and females of 0.34%.

Recent studies, such as that carried out in the city of Coimbra on 300 young people, show the same tendency as in other European cities, the emerging use of MDMA in the techno and rave culture environment, etc.

- Spain

Spain, together with the United Kingdom and Holland, shows the largest consumption of MDMA and other designer drugs, of all European countries. The growth in consumption of these substances has been especially rapid since 1992, with the phenomenon stemming back to the Ibiza style parties of the mid-1980s. The new phenomenon was related with house music, mega-parties and discotheques and the exodus of young Spanish people from one place to another at weekends.

In 1996, the Survey on Drugs Use in the School Population (National Drugs Plan, 1997) carried out a survey amongst students aged between 14 end 18 years; 5.10% had consumed ecstasy or similar drugs at some stage in their life, whilst 3.9% had done so in the past 12 months and 2.2% in the past month. Differentiating between the consumption of MDMA and other designer drugs is difficult, as in the so-called “tablets”, there is usually a mixture of different drugs. In 1994, the lifetime prevalence of consumption was of 3.5%, in the preceding year of 3% and in the preceding month 2%.

Other substances, such as amphetamines, were used by students in that same period (1994-1996) in a variable percentage of between 3.3% and 4.15% and between 4% and 5.3% for hallucinogens.

In this same period a strong increase was observed in the consumption of cannabis, hallucinogens, ecstasy, amphetamines, cocaine and tobacco amongst Spanish students, which according to new reports are now showing a tendency to stabilise.

In a home survey of the population in general in 1995, with a sample of 9,984 people aged over 15 years (National Drugs Plan, 1997), a lifetime prevalence was shown of 1.6%, for the preceding year of 1.1% and the previous month of 0.3%.

If we analyse this sample by age groups, for the 15-18 age group we have a lifetime prevalence of 2.4%; for the 19-24 age group a lifetime prevalence of 4.9%; and amongst the 25-39 age group, 2..3%. The majority of users are men (70.1%), aged between 20 and 29 years (61.7%), single (77.4%) and living with their birth families (59.6%). Most have primary or secondary education and come from a middle-class background.

As we have already mentioned, the use of MDMA is usually accompanied by other drugs. This same group of users consumed alcohol (90%), cannabis (76%), cocaine (47.3%), amphetamines (30.5%) hallucinogens (29.8%), heroin (19.9%) and tranquillisers and hypnotics (18.6%).

29.3% have used ecstasy more than ten times in their life; 20.3% have taken more than three tablets in a single session.

- United Kingdom

The first reference to MDMA in the United Kingdom was an article published in “The Face” in 1984. The article made reference to consumption by a restricted group of people who worked, mainly, in the media, pop

music and the world of fashion. They would travel to the United States on work assignments and return with small quantities of tablets for their own personal use, not for selling (McDermott and Matthews, 1997).

Over the last three years, the presence of MDMA has grown slowly but constantly. British disk jockeys and other dance scene personalities began to travel to Ibiza and other tourist destinations in the Mediterranean, giving rise to what was known at the end of the eighties as the "Balearic beat". From that moment, the consumption of ecstasy began to extend from the elite of the British music scene towards other layers of British music subculture.

After 1988, the year in which the first death due to ecstasy consumption was reported, controversy started raging between different sectors of society, as to how dangerous the new rave, techno parties etc. might be.

The results of a survey carried out on the population in general aged between 16 and 59 years of age (Ramsey and Percy, 1996), with a representative sample of 14,520 people surveyed, were the following: a lifetime prevalence of 2%, increasing up to 6% in the segment aged between 16 to 29 years, with a prevalence of consumption in the previous month of 1%.

Another survey (Health Education Authority, 1996), carried out in 1995 with a sample of 5,020 people aged between 11 and 35 years gave results of 28% who had been offered ecstasy; a lifetime prevalence of 7% (9% men and 7% women), and a prevalence for the previous month of 1%. Use had taken place in discos (65%) at raves (51%) and at private parties 43%.

Another sample that sheds some light on the level of consumption by European students is the study carried out by the Pompidou Group (Miller and Plant, 1996). The sample covered 7,722 students from different countries in Europe, the results for the segment aged between 15 and 16 were conclusive: a prevalence of lifetime consumption of 9.2% for boys and 7.3% for girls.

1.3. Opiates

The level of consumption or of problematic drug addiction[9] concerning opiates (mainly heroin) seems to be relatively stable in the entire EU. The average age of known consumers continues to increase slowly, although this may also be due to the development of substitution treatments.

It is calculated that the number of problematic opiates consumers amounts, approximately, to 1.5 million people (4 in every 1000) in the EU, and it is calculated that around 1 million (2.7 in every 1000) comply with the "addicts" profile.

As we will see later, as regards the prevalence of consumption, differences between countries are notable and related to numerous factors, including social exclusion. A strong level of consumption continues to be the case in peripheral areas of the main European cities.

Several countries continue to register an increase in heroin consumption, especially smoked heroin, amongst different groups (including young people who are ATS consumers). Recent studies suggest that young people take longer to start treatment[10], therefore this tendency is not clearly observed in the different indicators that exist.

1.4. Cocaine

The prevalence of cocaine consumption is lower than that of amphetamines or ecstasy (ATS), but higher than that of heroin.

Growing cocaine seizures and supply indicators point to continued growth in the cocaine market throughout the EU.

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[9] "The problematic consumption of drugs" is defined as the consumption of drugs in a way that it increases the risk of serious physical, psychological or social consequences, that are of an adverse nature for the consumer. (OEDT, 1999 Report)

[10] There seems to be an inverse relationship between age when consumption starts and age when treatment starts.

In some countries the demand for treatment due to cocaine consumption has risen, with it generally appearing as a secondary drug taken by heroin addicts.

As for "crack", a certain expansion has taken place, exceeding the previously limited number of areas where this substance was consumed (strong consumption amongst patients in PMM).

Multiple drugs consumption

There are an increasing number of cases of multiple consumption of different medicines and/or alcohol, both amongst problematic drugs consumers and in occasional consumption contexts.

2. Consumption prevalence in the EU.

2.1. Consumption of drugs amongst the general population

Despite the differences between countries and different information methods, some models are profiled.

The consumption of **cannabis** amongst adults fluctuates between 10% in Finland and 20-30% in Denmark, Spain and the United Kingdom. In the case of young adults, the rates are higher: between 16 and 17% in Finland and Sweden and among 35 and 40% in Denmark, Spain and the United Kingdom.

Life-long consumption of **amphetamines** (ATS), generally the second most frequent substance, is situated between 1 and 4% of all adults and between 1 and 5% of young adults in the EU. Between 0.5 and 3% of all European adults have tried ecstasy as have between 1 and 5% of young adults. AST consumption rates are noticeably higher in the United Kingdom.

Between 1 and 3% of all adults and between 1 and 5% of young adults in Europe have tried **cocaine**. In Spain and France, cocaine consumption figures are higher than those for ATS.

In general, the prevalence of opiates consumption, mainly heroin, is the lowest in the EU. The lowest levels of consumption can be found in Germany, Austria, Finland and Sweden, and the highest levels in Italy, Luxembourg and the United Kingdom. In countries with an intermediate prevalence, estimates lie between three and five consumers (CVI) per thousand inhabitants.

3. Demand for Treatment

The majority (between 70 and 95%) of admissions for treatment are due to opiates consumption (mainly heroin), although in the Flemish Community of Belgium, Finland and Sweden, opiates related cases represent less than 40% of admissions.

In most countries, cocaine features as the main drug in less than 10% of admissions for treatment, although the percentage rises to 15% in Luxembourg and 18% in the Netherlands. Heroin consumers often point out that they consume cocaine as a second drug.

Cannabis generally appears as the main drug in between 2 and 10% of patients in treatment, although percentages are higher (13 to 22%) in Belgium, Germany and Finland.

Amphetamines, amphetamine type stimulants (ATS) and hallucinogens are the main drug, approximately, for less than 1 or 2% of the cases in treatment. However, the proportion is higher in the Flemish Community of Belgium (19%), Finland (48%), Sweden (20%) and the United Kingdom (9%)

The prevalence of intravenous drugs consumption is more common amongst users of opiates and ranges from around 14% (Netherlands) to over 80% (Greece and Luxembourg). Consumption of amphetamines (ATS) frequently occurs in the Scandinavian countries and the United Kingdom, although this is not a common pattern in most countries.

In all EU member states, males account for between 70 and 85% of patients admitted for treatment. The average age is between 25 and 35 years in the majority of cases. Some countries have recorded in increase in this figure.

A slight drop is observed in numbers admitted for opiates addiction and an increase in those presenting cocaine or ATS as their main consumption drug; an increase amongst cannabis consumers in demand for treatment has also been observed, above all amongst those in treatment for the first time.

4. Infectious diseases associated with drugs

Infectious diseases, such as HIV and Hepatitis B and C, have reached a high prevalence amongst intravenous drugs users (IDU). Rates of prevalence with respect to HIV infection show, however, important differences between countries, ranging from 1% in England, Ireland and Wales to 32% in Spain.

It seems that the prevalence is slowly diminishing in some countries (France, Italy), but not in others (Spain). Even in countries where prevalence remains stable, HIV transmission continues amongst IDU. The HIV epidemic has now entered into a stable (endemic) phase in most Western European countries.

5. Addictions and their consequences on neonatal health

In cases where women consume addictive substances and continue to do so during pregnancy, it is important to pay attention to the implications that such consumption has on the newborn baby.

A consensus exists between researchers investigating the negative effects of different addictive substances on foetal and neonatal health.

Acquired harmful habits such as a poor diet, or the consumption of alcohol, tobacco and illegal drugs have an influence on numerous pathologies in newborn babies and imply a lesser use of prenatal care.

The use of psychoactive substances deserves special consideration due to their influence in avoidable infant deaths.

5.1. Alcohol: Greater frequency of abortions, retarded prenatal and postnatal growth (average birth weight of 2000g), facial deformities and neurological disorders, microcephaly, mental handicap and alteration of neurobehavioural development (Foetal alcohol syndrome).

Alcoholism is a more frequent cause of mental disability than Down's Syndrome and cerebral palsy.

5.2. Cocaine: Greater frequency of abortion, detached placenta (15%), genitourinary and neurological malformations, irregular interaction behaviour in the child, neurobehavioural alterations (hyperactivity, shaking, learning difficulties). Premature birth (31%), LBW (low birth weight) (19%). If consumption is suspended in the first three months, the frequency of premature birth and placenta detachment persist, but foetal growth is normalised. There are also cases of isolated Atresia and skeletal defects. Effects caused by vasoconstriction with foetal hypoxia through bradykinin. Rebound vasodilation may favour the massive absorption of otherwise

inoffensive substances (dangerous in polydrug addict mothers). The effects mentioned have even been reported in cases of sporadic consumption.

5.3. Cannabis: Associated to a deficit in neurological behaviour of the newborn baby, congenital abnormalities and retarded growth.

5.4. Heroin: Associated with menstrual abnormalities linked to maternal malnutrition, hepatitis, pelvic infections.

Polydrug abuse syndrome: Intravenous addicts usually present anaemia, cellulitis, bacteraemia, endocarditis, hepatitis, phlebitis, pneumonia, tetanus, AIDS and other sexually transmitted diseases.

6. Drugs-related deaths

Since the heavy increases that occurred at the end of the 1980s and the beginning of the 1990s in many EU member States, the number of drugs-related deaths has stabilised or even diminished However, increases were maintained in some countries until recently.

Most deaths owing to acute intoxication are caused by opiates, although often there is evidence of the consumption of alcohol and benzodiazepines.

Deaths owing to acute intoxication and related exclusively to the consumption of cocaine or amphetamines are relatively infrequent.

Despite being paid a great deal of attention by the media, deaths related with ecstasy or similar substances are not numerous.

7. Healthcare Response

7.1. Harm minimisation

It would seem clear that this is the posture most vigorously defended by the Institutions. Having been sidelined for years in many countries, harm minimisation is increasingly being recognised as an important tool in national and local policies related to drugs. Now the debate is centred mainly on scientific evidence. Projects aim to obtain legal, professional or political recognition for a range of activities such as needle exchanges, areas where addicts can inject, or substitution treatments that aim to reduce both the harm to health and the social harm caused by drug addiction.

Definition: Reducing risks is understood as a philosophy of health and educational action without any real prior evaluation on determined conduct. It is an aid policy that organises and encompasses the practice of a set of health, social and community-related actions, in relation to the harmful effects of drugs consumption.

This strategy encompasses all those medical or social programmes and services, whether individual or collective, designed to minimise the negative effects associated with drugs consumption.

In consequence, the objective of these policies is not abstinence.

Their **objectives** in the short, medium and long term are:

In the short term:

- Establish contact between existing social and healthcare networks and the greatest number of drugs users possible.

- Reduce to the minimum the biological, psychological and social risks associated with active drugs consumption.

- Reduce the risk of transmission of infections amongst and outside the group of active drugs consumers.

- Detect needs

- Alleviate social shortages

- Promote early diagnosis and prevention against opportunist infections and treat associated pathologies.

In the medium and long term:

- Facilitate access towards other resources for those who request it.

- Promote maintained contact, facilitating their participation as personal health agents and in promoting healthier behaviour amongst their fellow users.

- Integrate their participation to adjust resources to the needs that exist, applying their knowledge to the reality of the situation.

- Intervening so that they give up or reduce the use of any psychoactive substance.

This process of intervention by stages, with priority objectives that do not aim for abandonment of consumption, but rather a progressive transformation of the same, from more to less dangerous, where abstinence lies at the end of a process that may be long or never-ending, comes to form a final aim that is legitimised from a Public Health perspective.

7.2. General classification of treatments

Within the variety of Centres that offer treatment for drug addicts, a classification of four main groups[11] can be made, valid for Western Europe and North America.

[11] COMAS, Domingo "Los estudios de seguimiento" ("*Studies on monitoring*") Ed. GID Madrid.

- DETOXIFICATION, nearly always with admission of the patient into a Centre, it may be effected either with or without the help of medicines. This is a mode of treatment of a short duration, that precedes other types of treatment.

- SUBSTITUTION TREATMENT, mostly for opiates addicts, this often functions as a non-residential regime with complementary services that vary according to each centre.

- THERAPEUTIC COMMUNITY or drug-free residences, in which the therapeutic process places emphasis on group interaction, developing realistic self-perception and self-control.

EXTERNAL DRUGS FREE TREATMENT, can be used for groups and individuals alike, frequently including vocational, occupational and family counselling programmes and services, etc.; and covering a broad variety of different modalities.

This classification, when broken down, shows the following alternatives (Cole and Watterson).[12]

Substitution Treatment – Oriented towards change.

Substitution Treatment – Adaptive/palliative/harm minimisation.

External drugs-free treatments – Oriented towards change.

External drugs-free treatments – Adaptive.

Therapeutic Community – Traditional.

Therapeutic Community – Modified.

[12] DART programme. This can be considered as the first systematic endeavour to objectively evaluate the effectiveness of different types of treatments for drug addiction amongst a numerous and widely spread population. It was financed by the National Institute of Mental Health (USA) and developed by the Institute of Behavioral Research, at the Christian Texas University.

Therapeutic Community – Short duration.

Detoxification – Internal patients.

Detoxification – External patients.

- Concept of effectiveness of a treatment

The measures adopted by a treatment should be based on objectives that conceptually represent the expectations of society on the effectiveness of the rehabilitation of drug addicts.

We could summarise these as a set of expectations that involve behavioural changes in aspects such as productivity, non-deviation, non-dependency, life in a non-supervised community, and that includes an increasing improvement in employment, in abstinence with respect to illegal drugs, moderation in alcohol consumption, a stable way of living and stable family life, and a reduction in criminal conduct and activities that may lead to arrest or prison.

The most spectacular changes in conduct have been achieved with maintenance treatments using methadone, and with older patients. It seems that the best successes are achieved with patients aged over 25 years; this brings into play the age variable, as something to bear in mind when aiming to achieve an effective treatment.

The major problem with methadone is that it is also an opiate and also creates addiction. This means that one of its most controversial aspects is whether it is necessary to achieve that finally patients also give up methadone.

7.2.1. Rapid Antagonising of Opiates

Detoxification treatment in patients addicted to opiates, when administered in a General Hospital, often use a pharmacological procedure aimed at the

patient experiencing as few as possible of the typical symptoms of Opioid Withdrawal Syndrome (OWS) and favouring contact between doctor and patient, as it is considered that this will increase the possibilities of completing the detoxification process and establish the bases for embarking upon later psycho-therapeutic treatment.

Specific techniques have been developed that combine medicines such as clonidine, naltrexone, naloxone and others that include general anaesthetic and/ or sedation. These pharmacological protocols frequently use adrenergics due to the importance of noradrenergic hyperactivity in pathogenesis of OWS. The effectiveness of clonidine to reduce or suppress OWS symptoms is well established, even for blocking OWS precipitated by naloxone. A good number of studies exist that advocate the combined use of clonidine and naltrexone, proposing this a safe, effective and rapid method for hospital and outpatient detoxification of opiate dependent patients (E. Elizagárate and M. Gutiérrez Fraile, 1996)[13]

A review of the literature leads to the deduction that the clonidine-naltrexone combination works well, and that patients present an OWS of medium intensity, showing that this combination offers a net shortening in the time taken to achieve abstinence without intensifying symptoms.

These models, commonly known as **short cures** for opioids detoxification tend to equalise completion rates in outpatient and hospital treatment and facilitate the transition towards rules for treatment with antagonists.

Following these short cures for opiates detoxification, studies have been carried out on other combinations of medicines. Some of these studies try to determine wither opioid withdrawal symptoms induced via antagonists are blocked by barbiturates such as methohexital, midazolam, ondasetron, etc.

[13] Elizagárate, E. and Gutiérrez Fraile, M. "Antagonización rápida de opiáceos. Eficacia en una muestra de 91 pacientes" (*Rapid Opiates Antagonisation. Effectiveness in a sample of 91 patients"*) Hospital Santiago Apostol. Vitoria, 1996

The average hospital stay for opiates detoxification is 12 days and the rate of retention in treatment reaches an average of 65%.

A technique used quite often as short detoxification involves, **firstly**, effecting the ultra-short detoxification of opiates with the early use of antagonists, administered almost exclusively orally. **Secondly**, in avoiding hospitalisation by using a day hospital regime and finally checking that the application of this treatment means an improvement in technical and perceived quality.

In this type of clinical tests the aim is to ensure: 1. The ultra-short opiate detoxification treatment with the use of orally administered psychotropic drugs reduces the OWS in the same way as other pharmacological protocols that exist; 2. the prior stabilisation of the patient with opiate antagonists at constant dosage allows greater quality of the protocol due to a better adjustment of the dosages of agonists (methadone, buprenorphine) and antagonists (naltrexone, naloxone); and 3. the retention rate achieved with this protocol is greater than that achieved with classic protocols.

As an example of this type of detoxification we will take that carried out in the Santiago Apostol Hospital in Vitoria-Gasteiz (Basque Country)[14]

7.2.1.1. Materials and method

Selection of patients: All the subjects treated were heroin dependent through either intravenous or inhalatory use, and were detoxified between September 1995 and February 1996 in the day hospital (non-psychiatric) mentioned above. The patients were sent by specific aid centres for drug addicts located in the Basque Country and belonging to the Basque Health Service (Osakidetza) or sent from a Mental Health Centre from a bordering province.

[14] "Adicciones" (*Addictions*) Magazine, Vol.X.No.6, 1998.

The time that transpired between the request for treatment in the outpatient centre and the hospital treatment was one week. Upon admission, patients had to not have eaten that day, have abstained from opiates for several hours prior to admission, and be accompanied by family members during the treatment, who remained for 12 hours in the same room as the patient. All the patients signed an informed consent form that explained treatment risks and the explanation of the basis of the same. The exclusion criteria were: 1) structured psychiatric pathology (schizophrenia, toxic psychosis history, severe mood disorders, structured suicidal tendencies), 2) somatic disorders (severe lung, liver or kidney failure). 3) concomitant active infections (active hepatitis with hepatic enzymes >300 U/I, AIDS with a CD4 count <300). Also excluded were those patients who presented other addictions excluding nicotine (especially alcohol, benzodiazepines and psychostimulants). Sporadic consumption of benzodiazepines or psychostimulants no more than once per week was accepted.

Protocol applied: a mixed pharmacological technique was applied, that consisted of using clonidine, midazolam and ondasetron administered orally and simultaneously at the start of the treatment, followed by firstly antagonising using naltrexone administered orally and secondly antagonising using naloxone administered subcutaneously. The treatment was carried out under partial hospitalisation during a 12 hour period. In some cases, patients were stabilised prior to admission for 3-4 days with opiate agonists (methadone or buprenorphine) in the referring centres. On the day of admission (towards 9 a.m.) the patient was given midazolam as a medicine for sedation (oral) and clonidine (orally administered adrenergic agonist). At 9.30 the patient was given a first antagonisation with naltrexone (oral) and a few minutes later (9.45) a second antagonisation with naloxone (subcutaneous). At 12 o'clock the patient was given ondasetron and naltrexone once more. Concomitant medication was given when necessary due to symptoms, for example, metoclopramide I.M. for controlling vomiting; antispasmodics (hyoscine bromide type) for diarrhoeas and intestinal spasms. In the odd case

it was necessary to administer clonidine around the halfway stage (some 6 hours after the antagonists were administered) to control withdrawal symptoms. Safety measures implemented included the recording of oxygen saturation, breathing rate, pulse and blood pressure at 15 minute intervals. Also, oxygen and suction were available. In accordance with Ethical Norms, the protocol was accepted by the Hospital's Ethics Committee.

7.2.2. Substitution Treatments

For opiate dependency these treatments are becoming widely extended, often with the participation of general practitioners. It is estimated that around 300,000 personas in the EU are receiving substitution treatment, mainly using **methadone**[15]. In the European Union, perhaps 20% of all problematic opiates consumers receive substitution treatment.

7.2.2.1. Methadone

Methadone is, by far, the most common substitution medicine used in the EU and there is now substantial agreement regarding the benefits of its maintenance. Maintenance using methadone has shown successes in parameters such as the consumption of drugs, reduction in criminality, reduction of morbidity-mortality rates (especially linked to HIV/AIDS) and an increase in work-related activity, all related with a retention in treatment level that is much higher than in other methods. Even so, some studies show how patients in MMP present an increase in the consumption of illegal substances other than heroin, above all a proven increase in consumption of cocaine and alcohol.

[15] **Methadone** is a synthetic opiate medicine that blocks the effects of heroin for 24 hours. It has a history of proven success when prescribed in concentrations high enough for heroin addicts. **LAAM**, which is also an synthetic opiate medicine for treating heroin addiction may prevent the effects of heroin for up to 72 hours. Other approved products are naloxone, used to treat overdose cases and naltrexone, which obstructs the effects of morphine, heroin and other opiates. Other medicines are being studied for use in treatment programmes against heroin addiction.

The effectiveness of MMPs is ensured, nowadays, by dozens of studies (Simpson, 1982; Yancovitz, 1991; Bobes J, Cervera S. 1996; D'Aunno T, Vaughm C. 1992; Caplehorn JR, Bell J, Kleimbaum DG, Gebski VJ. 1993, etc.). In general, except for the differences between them due to the multitude of variables that require analysis (from retention in treatment to the user's quality of life), we can say that the **profile of the user** treated using an MMP is that of a heroin addict with a long history, with medical complications and low social and labour adaptation, that has tried treatment on previous occasions

- Results

Studies show how the situation of the group of users analysed, after several years of treatment (in many cases we are talking about 4 years) improves with respect to that offered when they started treatment, both in terms of their consumption of drugs in general (drastic reduction in heroin consumption, important reduction in cocaine consumption and less striking but definite changes towards lesser use of extra-therapeutic benzodiazepines and large quantities of alcohol) as well as their social reinsertion (important reduction in legal problems and more moderate increase in employment, highly conditioned by the employment context of the area of residence). Also, high-risk practices associated with consumption are almost non-existent, with seroconversion during treatment being very low. Finally, the patients show a moderate degree of satisfaction with their state.

These changes can be related, reasonably, with permanence in the MMP, although it is evident that to affirm this, it would be necessary to carry out a study using a "control group" going without treatment, which is quite obviously unfeasible for ethical reasons.

With respect to the achievements obtained during treatment using methadone, there have been several studies on the variables that could influence the manifest effectiveness of MMPs. Those most related with a

poor prognosis are the consumption of cocaine or other drugs, psychiatric comorbidity, inappropriate methadone dose, a length of time in treatment (retention) of less than one year and a lack of aid available (waiting lists).

- Quality of life

As we can see, the MMP evaluations have concentrated on measuring "hard" variables (consumption of drugs, morbidity-mortality, criminality, employment, etc.) but have not paused to find out about the quality of life obtained by patients in treatment, in other words their subjective perception. Although the term "quality of life" is questioned and it is difficult to be precise, an agreement exists on the theoretical conception of health as a global evaluation of the individual's condition, "taking wellbeing as the definition of the same, and the need to calculate the effects, both positive and negative, of healthcare interventions on the patient's living conditions and not only on the symptoms of the illness" (Bobes J. 1996).

There are now numerous works on the quality of life related to other pathologies, and several attempts have been made to achieve a reliable measuring instrument. Notable amongst these is the SF-36 Health Survey (recently adapted for Spain).[16] Its seems impossible, therefore, to avoid measuring a parameter that is constantly cited as a final objective in treatments with substitutes: the improvement in the addict's quality of life.[17]

Research into the quality of life of addicts shows that it undergoes a notable improvement after a time in the MMP. It is striking that there are so few studies on this aspect, especially considering that, as we have already commented, one of the MMP's objectives is a general improvement in the addict's quality of life, which in most cases seems to be measured only with "hard" variables.

[16] ALONSO J, Prieto L, Antó JM. "La versión española del SF-36 Health Survey (Cuestionario de Salud SF-36): un instrumento para la medida de los resultados clínicos" ("*The Spanish version o f the SF-36 Health Survey: an instrument for measuring clinical results*"). Med Clin (Barcelona) 1995, 104:771-776.

The two most recent experiments that evaluate quality of life in these patients are one in Australia, which shows how addicts who begin treatment with methadone have a much worse quality of life than the general population and even such poor physical and mental health that it is similar to that of groups with serious chronic illnesses (both somatic and psychiatric). And closer, one in Barcelona, which confirms a notable improvement in quality of life after one year spent in an MMP, but which can already be observed in the first month, although it continues to be poorer than that of the general population of the city; and the improvement is less, especially, in consumers of high doses of heroin.

It is necessary to underline the fact that the quality of life in MMP addicts is very much conditioned, as could be expected, by HIV infection, and also by the presence of psychopathology (anxiety, and especially depression), which may undermine it considerably.

- Evaluation

The global results obtained by the MMPs can be considered as very positive, as they sufficiently achieve the majority of the objectives assigned to these types of programmes: reduction in the consumption of illegal drugs, prevention of physical deterioration and of legal problems, and in general, better social integration (questioned in the case of consumption of crack)

"From the viewpoint of individual patients, an acceptable qualification of their situation is shown, with a moderate quality of life according to the SF-36."[18]

As regards the variables related with evolution, it is necessary to underline the need to detect and treat as soon as possible any associated

[17] World Health Organisation. "Option for the use of methadone in the treatment of drug dependence" WHO Division of Mental Health. Geneva, 1999.
[18] FERNANDEZ Miranda, JJ; et al "Calidad de vida y severidad de la adicción en heroinómanos en mantenimiento prolongado con metadona" ("*Quality of life and severity of addiction in heroin addicts in prolonged maintenance with methadone*") Adicciones (*Addictions Magazine)*, Vol., 11 No.1, p.43/42. 1999.

psychopathology (depression and anxiety), as these are conditioning factors of poorer evolution with polyconsumption (of illegal drugs and alcohol) and lesser quality of life. The relation of psychopathology with HIV infection is probable in many cases, therefore an increase in psychological and social support for these patients becomes very necessary.

An improvement in the effectiveness of the programme would require, therefore, greater attention to patients' mental health problems, in addition to tackling the dependence on heroin and other substances itself.

- Functional characteristics of treatments using methadone

Origin of patients

With respect to the flow of patients between services it was observed that a high proportion of patients went to the centres requesting treatment on their own initiative. Methadone is, in itself, very attractive to opiate addicts and although we do not know if the significance of this origin has been interpreted correctly, the gradient observed according to location of the MMP indicates that probably a high proportion of patients ask for treatment themselves. This may also indicate that the specific aid network for drug addicts is well consolidated, and as it is well recognised by users, they attend directly. It is also important to highlight the increase in the presence of penitentiary centres, as they send patients to other centres.

Another feature to highlight is that a high percentage (between 33 and 50%) of the dispensing centres have a waiting list, and it seems that year after year, the number of centres reporting this problem and requesting more places increases. In centres with no waiting list, patients have to wait around 8 days and where a waiting list exists, between two and three months.

It is important that any waiting time should be as short as possible because there is no justification from a therapeutic viewpoint and it may even be counter-productive to make patients wait. “It has been shown that obstacles

and delays between the moment that the MMT[19] is indicated and its commencement not only does nothing to facilitate patient motivation, but furthermore it is associated with more MMT dropouts and expulsions and with more heroin consumption in the first 6 months of treatment, when compared with patients who are admitted into the programme quickly." (Bell et al., 1994)

- Methadone treatment inclusion and expulsion criteria

It appears that a certain consensus exists in considering some **inclusion** criteria for patients in MMT, with suffering a serious organic pathology, having AIDS and being pregnant being considered as the most important for including a patient in a MMP. These were the initial criteria when methadone began to be prescribed. In contrast, other criteria, such as being HIV negative or patients themselves requesting MMT, were evaluated with a low score in a high proportion of centres. "Although there has been a certain improvement in comparison to years ago, this suggests that in the inclusion of addicts in MMPs, priority continues to be given to palliative treatment, aimed at patients in a worse state of health, and not adopting an infection prevention objective in patients not yet infected." (Institut Municipal d'Investigació Médica/ *Municipal Medical Research Institute*. Barcelona, 1999)

With respect to criteria for **expulsion** from MMT, at least 50% of the centres consider that an important criterion for expelling patients in MMT, is the consumption of illegal drugs and continued consumption of opiates. A low number of centres, around 10%, reduce the methadone dose if they detect opiates in urine samples. Although this attitude should be qualified according to the frequency of positive urine samples and other conditioning factors for expulsion, it seems to suggest a restrictive attitude, more oriented towards abstinence from drugs than harm minimisation. Even when it is

[19] Methadone maintenance treatment.

described “that, although MMT favours the reduction in drugs consumption, total abstinence from heroin and other drugs is an unattainable goal for the majority of addicts in this type of centre” (Ball, 1991). It has also been reported that even in the most effective programmes, a quarter of patients will continue injecting methadone, although with less frequency (Wolk et al., 1990). Although it is true that this reduction in intravenous administration means a step forward in the reduction of the risk of diseases transmitted through the blood.

Other criteria such as causing violence in the centre, consuming or trafficking with drugs in the centre, trafficking with methadone or forging prescriptions are valued by most centres as criteria for expulsion.

As regards monitoring of patients after they have received medical discharge from MMT, this is carried out in a large number of centres, although the reality is that generally the only patients who report to the centre are those that require monitoring for medical or psychiatric problems.

- Dose

Today the relationship between methadone doses and the illegal consumption of opiates is fully accepted. From the studies carried out it can be established that the minimum effective dose of methadone is 60 mg (Hartel et al., 1988; Kreek, 1992; Ball, 1991; Farrell et al., 1994). The average dose for the majority of centres is 70 mg, above the dose considered as a turning point. Reality has shown that the greater the dose of methadone, the less heroin consumption that takes place. This is a reality that should be borne in mind, knowing that “methadone programmes as a tool for the prevention of HIV transmission, involves understanding retention in treatment as one of the priorities” (Klee, 1991). In this sense, an important aspect of the methadone dose administered, is its fundamental role in achieving that patients remain in treatment as long as necessary. There is a direct relationship between the methadone dose and retention in treatment,

in such a way that doses above 80 mg are those that achieve the greatest retention (Ball, 1991; Caplehorn and Bell, 1991; Caplehorn et al., 1993). Later studies indicate that the greatest effectiveness is obtained with doses higher than 120 mg (Caplehorn et al., 1994). These studies have confirmed this in Spain (Torrens, Castillo and Pérez-Solá, 1996), with this country being of special relevance due to the high number of people infected with HIV following intravenous consumption of heroin. "Thus then, it would be recommendable that the doses were adjusted for each individual case, without theoretical or subjective limits, with the aim of reducing the illegal consumption of opiates and favouring the retention time"[20].

- Types and duration of treatments

MMT coexists with other types of treatment. In turn, and within the MMT centres we find the offer of different types of treatment: detoxification programmes of less than 21 days, short-term MMT (less than 6 months) and long-term MMT (over 6 months). It should be pointed out that the majority of centres run long term MMT.

The objective of most centres is palliative (harm minimisation). Although due to the accumulation of users, in many centres special emphasis is being placed on reduction of numbers, proposing the completion of treatment to the patient. In this sense it must be remembered that the teams that are carrying out these MMT are made up of professionals who, on many occasions, have had to alter their focus in terms of the treatments for opiates addiction that they offered before the development of MMT. This meant a change from abstinence-oriented treatments to palliative treatments with opiates substitutes. In the first, the addict had to give up drugs, whilst in the second, the patient's difficulty in giving up drugs use is accepted, and aspects related to improving the patient's quality of life are considered as priorities.

[20] National Drugs Plan (PND) "Características de los centros con tratamientos de metadona en España" ("*Characteristics of centres offering methadone treatment in Spain*)" Ministry of the Interior, 1997.

- Methods of methadone administration and "Take-home"

Methadone is most frequently presented as a liquid, although in some cases, a minority, it is supplied in the form of tablets. The liquid form seems to be preferable as it better ensures that the patient really does take the right dose.

Allowing the patient to take doses of methadone home has often been considered as a prize for the good evolution of the patient under treatment and an indicator of the success of that treatment (Ball, 1991). In the majority of existing centres "take-home" is given as a privilege. The most important criteria for being awarded this "take-home" privilege are: achieving therapeutic objectives, urine testing negative to opiates and social and work improvement. Take-home doses are also given when the centre is closed or because patients are suffering from a serious illness, or because access to the centre is difficult. One aspect to be pointed out is the role of support and control played by family members or people responsible for the patient, especially when the take-home doses are not a privilege. A large proportion of centres give 100% of take-home doses to a family member.

Some key definitions differentiate the function of different centres: Indication Centre (IC), Prescription Centre (PC), Dispensing Centre (DC) or Prescription and Dispensing Centre (PDC).

Indication: evaluation of a patient's state of health and decision regarding suitability of Methadone Treatment.

Prescription: Assignation of a specific norm of administration of the Methadone Treatment indicated (initial dose and modification of doses of Methadone, beginning, follow-up and completion of treatment, etc.).

Dispensing: Supply, administering of the Methadone.

- Incidence of the consumption of cocaine derivatives in patients included on MMPs.

A study of the consumption of cocaine[21] and its different forms of presentation has been carried out on 759 patients (589 men and 140 women) who are including in the Methadone Maintenance Programme of the centres of the San Miguel Juvenile Cooperation Association. Out of the group of patients, it was shown that 333 consumed cocaine (45.7% of the total). A sub-set of 105 patients was chosen based on their toxicological history, in order to gather from them, amongst other data, data relating to the type of drugs consumed, method of consumption, how they obtained it, physical and pathological effects, addiction and dangerousness. It was seen that a progressive increase in frequency and quantities of cocaine hydrochloride and derivatives exists, consumed by this type of patient in recent years, with similar consumption percentages being observed in women (43.6%) and men (46.2%). It can be highlighted that the majority (70%) of those surveyed show a greater consumption of these substances at present, of which around 90% indicate consumption of crack. As regards the predominant effects produced by the consumption of cocaine base, these include, loss of appetite (88.5%), weight loss (84.5%), palpitations (84.5%), dilated pupils (76.28%), mood swings (84.5%), loss of memory (59.7%), lack of concentration (78.3%), irritability (71.13%) and fits (56.7%).

7.2.2.2. **Naltrexone**

- Habit-breaking programmes with naltrexone

Although, traditionally, the treatment of opiates addiction was considered as not very hopeful, the use of therapeutic measures is absolutely vital. The controversy surrounding the possible effectiveness of treatments for addictions cannot be sustained at the current time. Different theoretical

[21] San Miguel Juvenile Cooperation Association and Pharmacy Faculty of the University of La Laguna.

conceptions have led to the development of different therapeutic methods that have greatly improved the pessimistic view of this problem.

Addicts who complete a therapeutic programme present a better evolution as regards work, family, legal problems and substance consumption than those who do not. In addition, treatment significantly reduces the high mortality risk faced by heroin addicts.[22] In studies carried out on the general population, a mortality rate of 2% per year has been found for opiate addicts[23] and for addicts in treatment the annual mortality rate is 13.5 per 1000.[24] These deaths are due mainly to overdoses, suicides, medical illnesses and violence. Despite this, these disorders must be considered as chronic illnesses with a bad prognosis, where relapses are a central feature in the picture.

Favourable evolution of addicts depends on their permanence or retention in treatment, which is the most widely accepted evaluation criterion used by therapeutic programmes.

Methadone maintenance programmes began the approach to the problem from the medical model of illness. These programmes were initially based on the metabolic model, by which dependence on heroin would be due to an abnormality in the endogenous opioid system and methadone would correct such an alteration. Maintenance programmes that use naltrexone (NMP) follow this model. This treatment aims to achieve abstinence from opiates and situates the addict in ideal conditions for modifying adverse consequences on a social and family level caused by the addiction. However, the different therapeutic methods cannot be considered as mutually exclusive. The psychological and therapeutic techniques developed

[22] GRÖNBLADH, L; Öhlund LS, Gunne LM. "Mortality in heroin addiction: impact of methadone treatment" Acta Psychiar Scand 1990; 82: 223-227.
[23] VAILLANT, GE "Outcome research in narcotic addiction-problems an perspectives" Am J Drug Alcohol Abuse 1974; 1: 25-26.
[24] SÁNCHEZ-Carbonell, J., Brigos B, Camí, J. "Evolución de una muestra de heroinómanos dos años después del inicio del tratamiento" ("*Evolution of a sample of heroin addicts two years after starting treatment*") (EMETYST project). Med Clin (Barc.) 1989, 92: 135-139.

must be used in a complementary way with opioid antagonists. Nor can methadone programmes be considered as antagonistic. It should be borne in mind that the doctor's attitudes and expectations with a determined treatment may not match those of the patient and to avoid an unfavourable evolution, the attitudes of addicts must be considered. Possibly it may be necessary to refer them to a therapeutic community or other type of programme.

- Historical development of maintenance programmes using naltrexone

The first reports on opiate antagonists appeared in 1915. Pohl showed that pre-treatment with N-allyl-norcodeine prevented the respiratory depression caused by morphine or heroin. In 1942, following the synthesis of nalorphine, it was observed that the latter blocked some of the effects of morphine and it was used for clinical purposes in opiates overdoses and in the detection of dependence, although its agonist properties were responsible for a certain dysphoria and physical dependence and a mild withdrawal syndrome was described.[25] The possible utility of antagonists in the treatment of dependence was suggested in 1965.

Naloxone was synthesised in 1960. This substance is a virtually pure antagonist and does not produce physical dependence, but the low power and short duration of its effects are serious drawbacks for its clinical use.

Naltrexone was synthesised in 1963 by Blumberg and Dayton, fulfilling the requirements of a powerful and active orally administered antagonist.

Some factors and situations exist associated with drugs use that can produce withdrawal symptoms despite the individual having been abstinent for a long time, these factors unleash the craving and may lead to a relapse. If the individual takes opiate antagonists s/he will not experience the high in response to the use of opiates, and, with the repeated lack of effect, this leads to an extinction of drug searching conduct. In addition, naltrexone prevents

relapse due to conditioned withdrawal syndrome. Thus, naltrexone blocks the effects of opiates, extinguishes the conditioned withdrawal syndrome in response to the stimuli associated with the use of drugs and searching conduct by blocking the euphoria and reinforcement produced by self-administering of opiates. The clinical use of naltrexone was approved by the Food and Drugs Administration (FDA) in 1984. In Spain, antagonists have been used in a controlled way since 1986 and naltrexone was first marketed in 1989.

- Pharmodynamic properties

Around 50 mg of naltrexone block the effects of 25 mg of intravenous heroin for 24 hours and 125-200 mg block the effects for 72 hours. Long term tolerance to its antagonist properties does not exist, it presents little potential for abuse and no withdrawal symptoms appear once the treatment is discontinued.

- Side effects

With the use of naltrexone in addicts, few side effects have been described and these are limited to the induction phase. The majority of complaints decrease in the first weeks of treatment, even at a dose of 80 mg per day. Adverse effects are more frequent in addicts who have previously followed methadone programmes, therefore the majority of effects related may be withdrawal symptoms that can be attributed to the methadone, including those caused by precipitating abstinence by the antagonist.

As regards the capacity of retention on naltrexone programmes, we find large differences between its administration to users in an indiscriminate way and its administration to selected and especially motivated users. In the first case, results include an average number of dropouts in the first three months of between 42 and 60%, with between 12 and 17% remaining more than 6 months; therefore retention is low. In contrast, with selected patients

[25] ARIAS Horcajadas, F. and Ochoa Mangado, E. “Programas de deshabituación con Naltrexone” ("*Habit-*

the results are more favourable. “Thus, in health professionals a retention is obtained of 53% at 6 months and 74% at one year, and in executives a retention of 61% at 6 months, to which one has to add 20% of dropouts who were abstinent, with 64% remaining abstinent at 18 months.” (F. Arias and E. Ochoa, 1998).

- Retention on a programme of naltrexone and transformation of the areas affected by the addiction.

The problems facing opiate addicts are multidimensional. If the treatment objective is limited to the consumption of drugs, the favourable evolution of this consumption may not lead necessarily to an improvement in other areas of psychosocial functioning. Inversely, other areas apart from abstinence may improve without abstinence being fully achieved.

In any case, permanence in treatment for the addiction is related with abstinence and this is closely linked to an improvement on a social, legal, and medical level and in the consumption of other substances, with these changes reverting if there is a relapse into consumption. During the opioid block, addicts experience a reduction in their impulse to consume and in their searching behaviour that allows the development of a lifestyle with the normalisation of family, social, recreational and vocational activities.

- Evolution of cocaine consumption.

The consumption of cocaine during treatment programmes with naltrexone tends to fall together with that of heroin. When comparing different types of treatments, there are more positive urine tests for cocaine in methadone programmes that in naltrexone or drugs-free programmes. Cocaine abstinence seems to be related to opiates abstinence.

Naloxone and naltrexone are effective in reducing self-administering of cocaine in laboratory animals, possibly because they mitigate the effects of

cocaine in reinforcement processes involving the opioid and dopaminergic system.

- Evolution of alcohol consumption

One of the main problems in using antagonists seems to be the increase in alcohol consumption during treatment. A review refers to the fact that consumption of alcohol drops during heroin addiction, and in some patients, it could substitute heroin to obtain euphoria-producing effects. In the majority of addicts in a sample, the use of alcohol preceded the consumption of other drugs, intensified at the beginning of other consumptions, decreased with the consumption of heroin, and increased after treatment with methadone, in the search for its euphoria-producing capacity.

When addicts begin a treatment it is common to find an increase in the use of alcohol, both in methadone maintenance programmes and with naltrexone, although a decrease can be observed in therapeutic communities and drugs-free programmes.

- Treatment Plan

The type of treatment selected is going to contribute to the treatment's success. A suitable dose of naltrexone will be important for the treatment's success, as when addicts being treated with naltrexone observe pleasant effects with the consumption of heroin, evolution is poorer. From the first studies carried out it was shown that it could be administered at doses of 125-150 mg per taking on a Monday-Wednesday-Friday basis. On comparing three different ways of administering 350 mg of naltrexone per week, in 2, 3 and 5 times a week, few differences were observed, although side effects were less frequent in the three weekly takings.

Patients may receive 50 mg a day or 150 mg on Mondays and 200 mg on Thursdays, but the majority of programmes have used the regime of 100 mg on Monday, 100 mg on Wednesdays and 150 mg on Fridays.

- Induction

The induction phase lasts some two weeks, and includes symptoms of withdrawal and a gradual increase in the dose of naltrexone. Prior to introducing naltrexone, detoxification is carried out, with 5 to 14 days of abstinence being recommended, depending on the addict's consumption level.

It is preferable to carry out detoxification with the use of alpha-2-adrenergic agonists, and opiate agonists should be avoided. Afterwards a test is carried out with 0.8 a 1.2 mg of subcutaneous or intravenous naloxone and if this is negative, in other words, abstinence symptoms do not appear, the naltrexone can be administered, however if it is positive, the first dose of naltrexone has to be delayed for 24 hours. If the naltrexone test is negative, 25 mg of naltrexone can be administered an hour later, and 50 mg on the following day.

Induction is the most problematic phase of the treatment due to the large number of dropouts. A hospital regime does not seem to offer better results. Patients coming from methadone programmes are those who drop out most often, due to the prolonged withdrawal syndrome and because a longer prior abstinence period is required, during which they may suffer a relapse.

- Stabilisation

The stabilisation phase includes the first month after induction, where the treatment guidelines are selected. During this month there are still high drop-out rates due, amongst other factors, to prolonged withdrawal syndrome and the craving. After this phase the craving usually decreases in a significant way for the majority of addicts. Complementary psychotherapeutic methods should be aimed at encouraging permanence in treatment during this phase. Family involvement will be essential.

- Maintenance

This phase, in general, should be no lower than six months and should be complemented with other psychotherapeutic measures and a programme of psychosocial rehabilitation. Visits to the centre can be progressively spaced further apart. In this period a change in the patient's lifestyle with regards to work, friends and family should take place. This phase also includes monitoring after the suppression of the naltrexone dose, during which the family must get involved in monitoring the changes that may appear in the addict and restoring the naltrexone dose should urine tests be positive.

- Duration of treatment

The duration of treatment with naltrexone is variable and should be adjusted individually, from a few months for those who, having spent a long time in abstinence suffer a brief relapse, up to years for individuals with frequent relapses and easy access to opiates.

In general, a minimum of 6 months is recommended, as it is observed that in this way the later evolution is more favourable and this period is also required for the psychosocial changes necessary to take place in order to maintain abstinence.

- Indications

It has been pointed out that the use of naltrexone is especially useful in highly motivated patients. The most favourable results have been in health professionals and executives. In groups of non-selected patients the best results have been in those from prison or from therapeutic communities who were already abstinent rather than active addicts who have not come from a therapeutic programme or from methadone treatment. Poor results in individuals coming from methadone programmes, with high dropout levels especially at the beginning, are attributed to problems in detoxification, with

better results being obtained with those coming from programmes with a low methadone dose than high doses.

7.2.2.3. Buprenorphine

Substitution treatments using buprenorphine

- Historical background

Buprenorphine is a partial opiates agonist, it has been on sale in France to supply drug addicts under the name Subutex since 1996. In France, it is the most widely accepted medicine used in heroin substitution treatments.

According to research by the National Committee on Substitution Treatments by the Association National des Interveants en Toxicomanie (ANIT), the first articles that make reference to the interest of buprenorphine in the treatment of opiates dependence date back to the early 1980s, notably an article by Nancy K. Mello[26]. At that time, buprenorphine was assured to have qualities that later tests rejected, such as: "Buprenorphine is much safer than methadone on two counts: it does not create physical dependence and the risk of overdose is ruled out because due to its opiate blocking properties". This affirmation made through two different channels, was contradicted by later studies. The same team from the University of Harvard (Massachusetts-USA) produced a new report with less daring affirmations: "Given that heroin addiction is a complex behavioural disorder that is produced due to multiple causes, it is quite logical to foresee that buprenorphine and other drug-based therapies that follow, will manage to attenuate consumption of this drug, but never suppress it entirely". (1984)

The interest in and viability of substitution treatments using buprenorphine were later confirmed by other North American researchers. We will cite

[26] MELLO, Nancy K. Et al "Análisis sobre los efectos de la buprenorfina en los heroinómanos" ("*Analysis on the effects of buprenorphine in heroin addicts"*) The Journal of Pharmacology and Experimental Therapies, vol. 233 no. 1, p.30-39. 1982.

Thomas R. Kosten,[27] Richard B. Resnik[28] (the author suggests that treatment with buprenorphine will be better accepted than that using methadone, as some drug addicts consider the latter as "just another drug" and refuse to enter substitution programmes that use it"). And, amongst more recent studies, that of Walter Ling,[29] which concludes with the need to implement a suitable dosage so that buprenorphine may be a useful complement in pharmacotherapy; and Mary Jane Kreek[30] (the great American methadone specialist) who, with relation to future perspectives that exist in treatment for opiates addiction, affirms that "methadone, LAAM and buprenorphine are three agonists that allow physiological and behavioural normalisation".

In Europe, it appears that the first article advocating buprenorphine in treatment for heroin dependence was published by the Belgian doctor Marc Reisinger (1985). This line of research was followed by other medical specialists in his country (Binot, Jacques and Vnderveken, cited by O. Lex)[31] who in 1989 wrote: "under a medical form that excludes all risk of it being injected, this molecule could be used in Belgium as a substitution product, taking into account the absence of euphoria-producing effects in those individuals used to consuming opiates and the reversibility of the treatment."

In France, although in approximately the same era, Temgesic started being prescribed to drug addicts to substitute opiates, it was fundamentally in the

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[27] KOSTEN, Thomas R. and others "Síntomas Depresivos de los Adictos a los Opiáceos durante el Tratamiento de Sustitución a base de Buprenorfina" (*Depressive symptoms in Opiates Addicts during Buprenorphine-based Substitution Treatment"*) Journal of Substance Abuse Treatment, vol.7, pp. 51-54. 1990

[28] RESNICK, R.B. and others "Buprenorfina: un tratamiento alternativo a la metadona para los heroinómanos" ("*Buprenorphine: an alternative treatment to methadone for heroin addicts"*) Psychopharmacology Bulletin, Vol.28. nº1, pp.109-113. 1992

[29] LING, W & others "Mantenimiento de la buprenorfina en el tratamiento de los pacientes adictos a los opiáceos: un ensayo clínico múlticéntrico y aleatorio" ("*Maintenance of buprenorphine in the treatment of patients addicted to opiates: a multi-centre and random clinical trial"*) Adicciones (Addictions magazine), Vol.233 no. 1, pp.475-486. 1998.

[30] KREEK, MJ "Estados Unidos y Europa: perspectivas para el futuro tratamiento de las adicciones a los opiáceos (...)" (*"United States and Europe: perspectives for the future treatment of opiates addictions"*) Lyon Méditerranée Médical –Medicine du Sud-Est, Vol. XXXIV no. 1. 1998.

[31] LEX, O. "Estudio de los tratamientos a base de medicamentos para los heroinómanos" ("*Study of treatments based on medication for heroin addicts*") Cahiers de la Dépendence, 15, p. 33-51, Belgium. 1991.

early 1990s that its use became a source of controversy. This medication was suddenly at the centre of two problems that led to intense debates, both on a professional and a political level: on the one hand, the way in which the struggle against the Aids epidemic had been organised, and on the other, the fact that in the country there was an almost generalised opposition to the use of substitution treatments. (Coppel A. 1996; Morel A. 1998)

Within this context, marked by ideological controversy, several French authors published clinical works on the use of buprenorphine. They included Auriacombe & others (1994)[32]

- Buprenorphine as an aid in giving up opiates consumption

Amongst the articles published on this subject, we would highlight that carried out by Bickel and colleagues,[33] who affirm that buprenorphine, a partial morphinic agonist "possesses an agonist activity that is sufficient for it to be as effective as methadone in the detoxification of patients who are heroin addicts, without being superior to methadone: the percentage of individuals who finish the treatment is fairly similar and the consumption of drugs is equivalent in the two groups". The authors point out that, in general, the results of this study have been negative for both groups, and that buprenorphine may possibly be more effective after a period without consuming drugs, when the first withdrawal symptoms appear.

However, other studies showed that stopping use of buprenorphine caused a syndrome that was "generally not very intense", weaker than that of heroin and methadone.

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[32] AURIACOMBE, M. & others (1994) "Tratamiento de sustitución a base de metadona y buprenorfina para las adicciones a la heroína" ("*Substitution Treatment based on methadone and buprenorphine for heroin addiction*") Debate on Drug Addictions, Saint-Tropez, 1993.
Auricombe M. (1996) "Por qué razón la buprenorfina es una molécula original en el tratamiento de la farmacodependencia a los opiáceos" ("*Why buprenorphine is an original molecule in the treatment of opiates dependence*") Debate on Drug Addictions, Cannes, 1995.

[33] BICKEL & others "Un ensayo clínico con buprenorfina: comparación con la metadona en la desintoxicación de heroinómanos" ("*A clinical trial with buprenorphine: comparison with methadone in the detoxification of heroin addicts*") Clin. Pharmacol. Therap. 43, p. 72-78. 1988.

Nonetheless, although it is pointed out that buprenorphine is more effective when taken daily, and that it should be given up progressively, it is also observed that the need to take opiates is much more intense for patients who have taken buprenorphine on a daily basis, than for those who have only taken it every two days (Fudala P.J., 1990). Thus, it appears improbable that it would generate a mild withdrawal syndrome, when it produces a strong addiction.

We should clarify that, according to the "Committee on Substitution" of the ANIT (French Association of Professionals on Drug Abuse), these studies should be viewed with prudence, since they are based on very small groups and relatively short periods of time. In addition, they have almost always eliminated the most problematic cases (psychiatric problems and ill subjects) and have often chosen the most motivated patients in terms of their attitude towards detoxification. The buprenorphine doses mentioned are also lower (2 to 8 mg) than the norm (11/12 mg).

- Buprenorphine and cocaine

In the USA work is being carried out to see how buprenorphine can be used to help cocaine addicts to kick their addiction. Experiments are being carried out using human subjects (disulfiram together with buprenorphine).

Some clinical trials appear to show that buprenorphine does not act on the cardiovascular effects and the fever that follow a single dose of 30 mg of cocaine. The authors show that the results could be different if cocaine consumption is chronic, but they do not conclude that buprenorphine can be used in polydrug addictions (a very high number of heroin addicts and patients in methadone treatment often consume cocaine as a second drug, apart from psychotropic substances, alcohol and cannabis).

- Buprenorphine and risks of overdose

The existence of a "ceiling effect" linked to the dual agonist and antagonist action of buprenorphine has been maintained by the majority of authors to explain a minimisation of the risks of breathing problems that could turn out to be fatal, unlike the pure agonists (heroin, morphine, methadone, etc.) It is true that no cases of fatal overdose have been published in France before 1996, which is when its high dose presentation was marketed. This apparent safety has been, in addition, one of the arguments most brandished by the public powers to justify their decision (in 1995) to facilitate as far as possible the prescription of buprenorphine as a substitution medicine.

In an article by A. Tracqui, of the Institute of Legal Medicine of Strasbourg,[34] it is shown that the reality is not so simple, and it confirms the fears of the clinics[35] regarding the risks linked to its injection and its association with benzodiazepines.

Tracqui and the other members of his team studied a series of 29 cases of acute intoxication, following the ingestion of high doses of buprenorphine, and another series of 20 fatal cases recorded at the Legal Institution of Strasbourg. First of all, they confirmed that the twenty deceased individuals had presented at autopsy an asphyxia syndrome identical to that found in all overdoses caused by any central nervous system depressor. Secondly, they exposed the two risk factors in this type of intoxication:

First of all, **associations**: only in one of twenty fatal cases was no type of association able to be found. In the rest, associations were observed, mainly with certain benzodiazepines, above all Tranxene and Rohypnol) and with

[34] TRACQUI & others "Intoxicaciones aguadas debidas al tratamiento sustitutivo a base de elevadas dosis de buprenorfina, 29 observaciones – 20 casos mortales" ("*Acute intoxication due to substitution treatment using high doses of buprenorphine, 29 observations - 20 fatal cases*") Presse Med., 27 p. 557-561. 1998.
[35] HUTEFEUILLE, M. "El temgésic: nuevo producto, vieja ilusión" ("*The Temgesic: a new product, an old hope*") in "Therapeutic Options, Political Options: individual suffering and social fears" talks given at the 12th National Conference of the AINIT, Interventions, no. 30-31, p. 27-29. 1991.
Hautefeuille M; Polomeni, P. "El resistible desarrollo de una droga legal" ("*The irresistible development of a legal drug*") Journal du Sida, nº35. 1992.

alcohol. They comment: “These results suggest the existence of an increase in the central depressor effects of buprenorphine caused by certain benzodiazepines”. Effects that are also found in other opiates such as methadone.

The second risk factor would be **intravenous injection.** “This incorrect use is perfectly documented clinically, as it leads to a series of specific locoregional complications (inflamed nodules, abscesses, cutaneous necrosis, etc.) Intravenous use has led to observation of respiratory problems (forcing assisted breathing) (...) a single 8 mg tablet crushed on a spoon and injected provides a buprenorphine dose that is 10 to 50 times greater...”.

As a conclusion to their study, the authors propose a review leading to the restriction of the legal framework for prescribing and distributing buprenorphine, with the aim of providing greater safety in these treatments.

According to the ANIT, unfortunately the calls for attention made by the press (more than by experts on the subject) have only made reference to buprenorphine, and not to the misuse made of it when taken accompanied by other drugs. Even worse conclusions could have been obtained in relation with the cited benzodiazepines (fundamentally Tranxene and Rohypnol) and with the dangerous practice of prescription in France. In addition, it would have doubtless been positive to put on one side of the scales the 20 fatal cases and on the other, the 50,000 people that are currently benefiting from buprenorphine. However, this is one of the first studies that clearly show the vital risks involved in the abuse of a molecule that until very recently was considered "extremely safe”.

- Buprenorphine and hepatic toxicity

Bibliographic references on this subject cannot be found, which according to the ANIT, implies a great deal of thoughtlessness as insufficient importance is attached to dealing with this problem.

The Subutex prospectus contains a contraindication against treatment in the case of severe liver failure and states that this medicine may possibly modify the hepatic metabolism. This notion of hepatic toxicity is based on the descriptions made in drugs surveillance on modifications of the biological balance due to an increase in hepatic enzymes.

According to the drugs surveillance centre that we have contacted, these biological problems may be attributed to other causes of liver damage (viruses, alcohol) and the treatment has never been interrupted for this reason: in some cases the same dose is maintained and in others it is reduced to half. Evolution has always been favourable, with biological balance becoming stable once more.

This means it is necessary to carry out active drugs surveillance towards this medicine that is prescribed so often to young individuals, whose history presupposes hepatic damage that is much greater than the norm for their age; for this reason, as has already been said, this is a matter not to be dealt with light-heartedly.

- Buprenorphine and dependency

As has occurred on all the occasions in which a new opiate derivative has been discovered (codeine, heroin, etc.), the potential for induction into a physical dependence through buprenorphine was initially minimised and even denied: “Buprenorphine does not induce any significant physical dependence”, wrote Nancy K. Mello in 1982. However, the observations carried out in different countries soon began to contradict this affirmation. In 1983, several cases of buprenorphine abuse and addiction occurred in New Zealand and Germany. Shortly afterwards, in Australia, Scotland and Ireland, and later still, in Spain.[36] The same phenomenon could be observed

[36] SAN, L. & others “Valoración y manejo del síndrome de abstinencia en los individuos adictos a la buprenorfina” ("*Evaluation and management of withdrawal symptoms in individuals addicted to buprenorphine*") British Journal of Addiction, 87, p. 55-62. This article came from the Drug Addictions centre of the Hospital del Mar in Barcelona, 1992.

in France at the end of the 1980s. In 1989, in their report no. XXV, the group of experts in drug addictions from the WHO, recommended the inscription of buprenorphine in class III of psychotropic substances. All this forced a reconsideration of the molecule's capacity to stimulate abuse and cause physical dependence.

In 1992, Resnick emphasised the fact that all the studies that had spoken of low intensity of the withdrawal syndrome after several weeks of administration of high doses of buprenorphine (Jasinski, 1992; Fudala, 1990; Mello, 1990), had been done with internal patients; in other words, who did not have to function in real life. Resnick's research was based on 85 patients treated on an outpatient (external) basis and showed how the progressive reduction in the doses of buprenorphine caused a withdrawal syndrome whose main symptom, as well as the main reason for their relapses, according to the words of the individuals involved, was a loss of energy. “This was a problem, fundamentally, for the people who worked. Loss of energy is a symptom that frequently may be ignored by people in a hospital centre setting” – he relates. But the symptoms produced by withdrawal are not limited to loss of energy, since, according to the same study, when the dose of buprenorphine is reduced, it is followed by, in order of frequency, intense states of impatience (agitation, insomnia, anorexia, muscular pains, diarrhoea, tears and yawns).

- Buprenorphine and pregnancy

There is nothing established yet regarding specific risks and numerous women have continued to take Subutex during pregnancy and birth, without us being aware of any problem. This is another field where it is necessary to shed all ambiguity, even if only for the responsibility that has to be shouldered by those who prescribe this medication.

The only article located that talks about this subject is that by Reisinger,[37] published in a reduced circulation and distributed by the laboratory Reckitt& Colman. The study concludes affirming that buprenorphine is very safe to be taken during pregnancy. Only one case of agitation was observed amongst the newborn babies, thirteen days after birth, which could be related with withdrawal syndrome. The author goes as far as suggesting that pregnant women who take methadone should change this drug for buprenorphine, in order to reduce the risk of newborn babies suffering from withdrawal syndrome.

However, this study is only based on four cases (...) And it was presented for a seminar organised in Great Britain by the laboratory Reckitt & Colman, which is the laboratory that holds the rights of this molecule in the country, and whose desire is to achieve the same development that the Schering Plough laboratories have achieved in France (...).

7.3. Low threshold services

Currently low threshold services exist in all the member States of the EU, but they differ in terms of the availability and type of services. In general, they offer individual help and medical, psychological and social attention mainly to very underprivileged consumers, especially older consumers with a long history of drug addictions. In all countries there are needle and syringe exchanges, although to different degrees. In some countries, chemists supply free or cheap needles. A controversial service available in some member States is the offer of areas for injecting drugs.

It should be pointed out that the low threshold methadone programmes are more effective in this sense, with their fundamental strategy being to prevent the risk of contracting and transmitting AIDS between intravenous heroin dependant patients. Their success depends on their rate of retention and the

[37] REISINGER, M. “Uso de la buprenorfina durante el embarazo” ("*Use of buprenorphine during pregnancy*") Research and Clinical Forum, vol.19, no. 2, pp.43-45. 1997.

majority usually show high rates at 21 months of treatment, around 70%, with doses of over 80 mg per day. 50% of drop outs usually take place in the first 3 months of treatment, when the patients are taking very low doses of methadone.

7.3.1. Controlled prescription of heroin

The Experimental Narcotics Prescription Programme (PEPS) is a treatment experiment with drug addicts, within the context of the Swiss federal policy of Minimising Harm in problems related with the abuse and dependence on drugs, which includes in the therapeutic offering the prescription of diacetylmorphine (heroin) under medical supervision.

It is aimed at drug addicts that have failed in the classic aid programmes and who are sinking into social isolation. The idea is to attract them to the Public Health System and integrate them in a process of change that improves their quality of living.

Until 1986, the official Swiss policy of aid to drug addicts was based on abstinence. In Geneva, methadone was prescribed by private doctors with official authorisation from the end of the 1970s. In 1991 new services appeared, such as the "AIDS-prevention-bus" and public methadone programmes[38]. It was in 1995 that the experimental prescribing of heroin began.

The therapeutic policies of minimising harm in Geneva, at the end of the 1990s (of which the prescription of heroin constitutes a minority aspect that is indivisible from the rest), brought the first positive results and proof of their effectiveness and viability. However, a severely affected population of drug addicts is recorded, which eludes classic aid programmes. The Geneva PEPS programme is aimed at that population, and it took in its first patients in September 1995 (the first Swiss experimental programmes had begun in 1994).

[38] In September 1991, The State Council in Geneva approved Risk Minimisation as the basis for its policy on drug addictions. Ratified in June 1995.

Today, the PEPS is made up of an injected heroin programme and another oral heroin programme, the latter aimed at heroin smokers and all those injectors who presented a level of vein and muscle deterioration such, that intravenous or intramuscular injection is impossible.

In September 1999, the PEPS had 42 patients; only 12 (28%) were taking exclusively heroin. The rest were taking a combined opiates treatment: 18 (44%) with methadone, and the remaining 28%, another 12 patients, were combining it with morphine. The average dose of opiates was equivalent to 500 mg of heroin (900mg/day, the maximum dose, and 10 mg/day, the minimum dose). (Marset, M. 1999).

The psychosocial profile of the patients was:

- The majority were male.

- Average age: 35 years.

- Average duration of intravenous drug addiction: 16 years.

- On average they have failed in 3 detoxification treatments and 4 maintenance with methadone treatments.

- Their social problems, at the start of treatment, were very significant: **1**. The majority had no work nor home. **2**. Their physical and mental health was very precarious. **3**. 28% were HIV positive (Geneva average 10%). **4**. 73% suffer from Hepatitis C (Geneva average 44%). **5**. 69% have severe personality disorders, only 8 patients (20%) do not have psychiatric problems.

The results reported by the PEPS, following four years of treatment, appear to be satisfactory (although the evaluation of the project has not yet been completed). Retention in the programme is at 74%, causing a retention in the aid network, public or private, of 98%. Since the start of the programme 55 patients have been treated in the PEPS, all reported to have experienced a significant improvement in their general state and quality of life. The

consumption of cocaine descends, as does that of illegal heroin and that of non-medical consumption of benzodiazepines. A decrease has also been recorded in criminal trials, earnings arising from drugs trafficking and criminal acts (possession and consumption of drugs, robberies, etc.).

However, what seems to work well in Switzerland encounters resistance in other European countries, as is the case with Spain where in 1999 the Medication Agency refused authorisation for a clinical trial with heroin proposed by the Government of Andalusia. Other Autonomous Regions, such as Catalonia, are trying to obtain authorisation to set up the programme.

7.4. Drugs consumers and the criminal justice system

Between 15 and 50% or more of prisoners in the EU have, or have had, problems with drugs consumption. Several member States report that prison overcrowding often hinders progress towards suitable attention for drugs consumers. Needle exchange exists in some prisons in Germany and Spain, and in the United Kingdom inmates who inject have recently been allowed access to sterilisation tablets. Another problem is the lack of training of prison staff.

In all member States several options exist as alternatives to prison, ranging from postponing or exempting of criminal responsibility to parole.

Only the Netherlands and Sweden report on compulsory attention, although the choice of terminology may hide the fact that there is more or less compulsory attention in the majority of EU member States when addicts can or have to choose between the alternatives of imprisonment or treatment.

An increasing number of countries have adopted the principle of therapy instead of punishment in the general directives of drugs-related policies. Some member States have consolidated the social and medical support given to drug addict delinquents who enter into contact with judicial authorities for the first time as an access gateway to treatment and counselling services.

THE SITUATION IN CENTRAL AND EASTERN EUROPE

1. Historical and current consumption patterns
2. Specific drugs and tendencies
3. The legal response
4. Reduction in drugs demand
5. Synthetic Drugs

THE SITUATION IN CENTRAL AND EASTERN EUROPE

The countries in question are: Albania, Bosnia-Herzegovina, Bulgaria, Czech Republic, Estonia, the Former Yugoslav Republic of Macedonia, Hungary, Latvia, Lithuania, Poland, Rumania, the Slovak Republic and Slovenia.

The ESPAD[39] analysis, carried out in 1995 under the auspices of the Pompidou Group of the Council of Europe, included seven CEECs (Czech Republic, Estonia, Hungary, Lithuania, Poland, Slovak Republic and Slovenia) and provided valuable information on the drugs consumption amongst students aged 15 to 16 years in these countries.

Country	Sample	Boys	Girls
Czech Rep.	2962	25%	18%
Estonia	3118	10%	5%
Hungary	2571	5%	4%
Lithuania	3196	2%	1%
Poland	8940	2%	5%
Slovak Rep.	2376	12%	6%
Slovenia	3306	4%	12%

[39] European School-Survey Project

1. Historical and current consumption patterns

The consumption of illegal drugs in the CEECs was not a cause for concern until after the political changes at the beginning of the 1990s. However, some countries, (Poland, Hungary, Slovenia and former Czechoslovakia) had recognised prior to this that the consumption of illegal drugs was a problem and they developed suitable research and treatment strategies.

At the end of the 1970s, in some CEECs, (Czechoslovakia, Poland, Lithuania, Latvia, Bulgaria and Hungary) intravenous consumption of home-made drugs was recorded. In this same period, pharmaceutical drug abuse in Hungary, former Czechoslovakia, Poland and, to a lesser extent, Bulgaria, was commonplace. More recently, this has also become a problem in Albania, Bosnia-Herzegovina and the Former Yugoslav Republic of Macedonia. The political changes that took place in the region at the start of the 1990s have brought with them not only an increase in drugs trafficking through many CEECs, but also an increase in the interior use of imported drugs.

2. Specific drugs and tendencies

In the ESPAD 1995 analysis, cannabis stood out as the drug most frequently consumed amongst teenagers and the youngest group of adults in the seven participating CEECs.

According to the same survey, solvents are the second most prevalent substance abused. Since the beginning of the 1990s, in many CEEC, heroin consumption has increased (Bulgaria, Czech Republic, the Former Yugoslav Republic of Macedonia, Hungary, The Slovak Republic and Slovenia). More recent tendencies reflect a gradual change towards injection of imported heroin. The consumption of pharmaceutical drugs combined with illegal drugs has become a common practice in recent years in Bulgaria, Bosnia-

Herzegovina, the Former Yugoslav Republic of Macedonia, Hungary, the Slovak Republic and Slovenia. Cocaine consumption levels remain low, although seizures reflect an increase in traffic in Poland, the Czech Republic, Hungary and Rumania.

3. The legal response

The CEECs are endeavouring to adapt their legislation to comply with EU norms in legislative affairs. All have approved a new legislation in the field of drugs dependence (the majority since 1996). The production and trafficking of drugs carries a penalty in all countries, but this is not the case, generally, for the consumption of illegal drugs. All the countries, except for Albania, have signed the three UN Agreements on narcotics, psychotropic substances and illegal trafficking, and have ratified them, with the exception of Estonia, which has not yet ratified the 1998 Agreement.

4. Reduction in drugs demand

The history of the reduction in the demand for drugs varies throughout the region. It has been applied for over two decades in Poland and only for a few years in Rumania. In general the reduction in the demand for drugs continues to have little importance in the majority of the CEECs, which mainly assign most resources to repression (reducing supply).

Treatment in hospital settings by psychiatrists and other health professionals is predominant. In most CEEC countries, only in the largest cities are treatment services available. Today, in nearly all of these countries, drug-free treatments for outpatients and long term treatments for hospital patients are being rapidly developed.

Prevention is a fundamental priority in nearly all the national strategies and programmes, which include health and educational promotion in schools.

In recent years, services such as exterior projection and harm minimisation have been added to demand reduction strategies. The availability of substitution programmes (maintenance with methadone) and needle exchanges have increased in the entire region. Despite the increase, the availability of these harm minimisation options continues to be scarce, even in major cities.

Non-governmental organisation in nearly all regions continue to be underused and have poor fund provisions. The key needs are to strengthen capacity and performance, increase funds and improve communication and cooperation with official organisations.

5. Synthetic Drugs

Nearly all the countries are recording an increase in seizures, but reports on consumption to a large extent continue to be anecdotal.

THE SITUATION IN THE UNITED STATES

1. National Trends
2. Consumption patterns amongst Secondary students
3. Treatment Trends
4. Social costs
5. Therapeutic medications
6. The consequences of drug use for women

THE SITUATION IN THE UNITED STATES[40]

According to the preliminary results of the National Household Survey on Drug Abuse (NHSDA)[41] the current number of illicit drugs users has not changed significantly in recent years: 1995 (12.8 million) and 1996 (13 million).

1. National Trends

1.1 Marihuana

It is estimated that 2.4 million people began using marihuana in 1995. This re-emergence of the use of marihuana continues, especially amongst teenagers: it is increasingly mentioned in the emergency services, and the percentage of people admitted to treatment programmes has also been increasing. Two factors could be contributing to this spectacular leap in marihuana consumption: a higher potency of the drug and the use of marihuana mixed or in combination with other illegal drugs. Marihuana cigarettes or "blunts" often include crack, a combination that is known by various names on the street, such as "3750", "diablitos", "primo", "oolies" and "woolies". Often, these cigarettes and "blunts" are dipped in Phencyclidine (PCP)[42] and are known on the street as "happy sticks",

[40] We base ourselves on data published by the National Institute on Drug Abuse (NIDA) in October 1999.
[41] This is an annual survey carried out by the Substance Abuse and Mental Health Services Administration.
[42] PCP (phencyclidine) started to be produced in the 1950s as an intravenous anaesthetic. The use of PCP in humans was discontinued in 1965 as it was discovered that patients often became agitated, delirious and irrational whilst they were recovering from its anaesthetic effects. PCP is produced illegally in laboratories and sold on the street with such names as angel dust, ozone, wack and rocket fuel. Killer joints and crystal supergrass, are common names referring to the combination of PCP and marihuana.

"wicky sticks", "illies", "love boat", "Wet" or "tical". Combinations of these two types have been observed in Boston, Chicago and New York; the combination of marihuana and PCP has been seen in Philadelphia and parts of Texas. Marihuana cigarettes are also sometimes dipped in embalming fluid, this has been seen in Boston (where they are known as "shermans") and in parts of Texas.

1.2. Cocaine

Crack cocaine continues to dominate the problem of the nation's illicit drugs. The current total number of cocaine users did not change significantly between 1995 and 1996 (1.45 million in 1995 and 1.75 million in 1996). This means a reduction when compared with the peak of 5.7 million in 1985. However, it is still estimated that 652,000 Americans used cocaine for the first time in 1995. There continues to be an abundant supply of drugs in nearly all cities. The data indicate a stabilisation in many urban areas: deaths due to cocaine remained stable or increased slightly in 9 out of 10 areas where data was collected regarding this. The percentage of new users admitted into treatment due to problems primarily related to cocaine decreased slightly or remained stable in the majority of areas.

Although demographic data continue to show that the majority of users of cocaine are adults, addicted to crack cocaine, and living in city centres, isolated reports from the field indicate that there are new groups of users. Amongst these new groups we can mention teenagers who, in some cities, smoke crack together with marihuana in the form of "blunts" (cigarettes with the tobacco removed and filled with marihuana, often in combination with another drug); in Texas, Hispanic crack users, and in the Atlanta area, cocaine hydrochloride users in middle class suburbs, and women in their thirties who use crack without having any prior history of drugs consumption.

1.3. Heroin

Since 1992 there has been a growing trend of new heroin users and it is estimated that there were 141,000 new heroin users in 1995. It is estimated that the number of people who used heroin in the month prior to the survey increased from 68,000 in 1993 to 216,000 in 1996. Of these recent new users, a large proportion smoked, snorted or inhaled heroin, and the majority were aged under 26 years. Other quantitative indicators and reports from the field continue to suggest that there is an increasing incidence of new users (who snort the drug) amongst younger age groups, and often amongst women. In some regions, such as San Francisco, recent beginners include more middle class members. In Boston and Newark, heroin users can also be found amongst the suburban population. One concern is that young people who snort heroin may start injecting, due to greater tolerance, pain in the nose, or drugs that are less pure or whose purity is unreliable. The use of injectable heroin would expose them to greater risks of acquiring HIV. In fact, the purity of the drug has been deteriorating or is inconstant in several cities, such as Atlanta, Boston and New York. However, in the East and in some cities in the centre of the country, especially in Chicago and Detroit, the purity of the drug remains high, as does its intranasal use. In some cities such as Boston, Detroit and New York, aggressive sales techniques and price cutting have intensified. Frequently, heroin distributors sell other drugs too, as is the case in Miami, Minneapolis/St. Paul, St. Louis and some Atlanta neighbourhoods. Recent death rates have increased or remain stable at high levels in 5 out of 10 cities with data available. The rate of mention of the drug in hospital emergency departments has increased in 8 of 19 cities consulted and the percentage of people in treatment that say they use heroin has increased in 8 out of 14 areas.

1.4. Amphetamine Derivatives (ATS)

Methamphetamine[43]

In several cities in the west and centre of the country, methamphetamine indicators, that had been increasing regularly for several years, seem to be starting to show variations. All indicators suggest increases in San Francisco and Seattle, whilst in San Diego and Los Angeles they show a tendency to stabilise of a slight reduction. But everything seems to indicate that the consumption peak has not yet been reached. The greater availability of methamphetamine and the increase in its use has been sporadically observed in several regions of the country, especially in rural areas, and this has caused concern regarding its propagation outside of areas of endemic use (the West Coast). Most methamphetamine comes from large-scale operations in Mexico. Recent seizures in Florida have included cocaine powder, heroin and flunitrazepam[44] in the same shipment with methamphetamine. In addition, local laboratories are still common, which has produced an increase in the seizures carried out in areas such as Seattle, Arizona and rural regions in Georgia, Michigan and Missouri. The four ways of using drugs, injecting, inhaling, smoking ("chasing the dragon" in San Francisco), and oral ingestion, are used nowadays, but vary from one city to the next. In Honolulu, reports of violence associated with methamphetamine consumption persist and there are also reports now from Seattle.

Other stimulants

Abuse of methylphenidate (Ritalin)[45] continues amongst heroin users in Chicago and teenagers in Detroit. Products based on ephedrine, sold in fast-moving consumer goods stores, at truck stops and in naturalist shops, are

[43] Methamphetamine hydrochloride consists of transparent crystals in stones that look like ice, that can be inhaled by smoking and are called "ice, crystal and glass".
[44] Rohypnol is the commercial name for flunitrazepam.
[45] Ritalin, the commercial name for methylphenidate, is a medication prescribed for children that show an abnormally high level of activity or who suffer from attention deficit and hyperactivity disorder (ADHD). In 1996 its use was detected for purposes related with drug addiction, mixed with heroin and with cocaine.

commonly used amongst teenagers in Atlanta, Detroit, Minneapolis/St. Paul and Texas. The state of New York recently banned the sale of this type of products, trying to contain growing abuse of them by teenagers. The use of methylenedioxymethamphetamine (MDMA or "ecstasy") has been observed more frequently amongst young adults and teenagers at night clubs, raves and rock & roll concerts in Atlanta, Miami, St. Louis, Seattle and parts of Texas. In 1996, a study carried out by the MTF[46] gathered data on the use of MDMA by secondary school pupils. Usage rates remained relatively high between 1996 and 1997. 1n 1997, 6.9% of final year secondary students; 5.7% of those in 10th grade, and 3.2% of those in 8th grade had used MDMA at least once in their lifetime.

2. Consumption patterns amongst Secondary students and other young people

Since 1975, the Monitoring the Future Study has determined each year the proportions of drug abuse by final year secondary students. The survey was broadened in 1991 to include students from 8th and 10th grades. Financed by the NIDA, the survey is carried out by the Institute for Research into Social Matters attached to the University of Michigan.

In the class of 1997, 54.3% of students had used some illicit drug before reaching the last year of secondary school, this continued to mark a rising tendency in relation with the sum of 40.7% recorded in 1992, but still a long way below the maximum figure of 65.6% recorded 1981.

After having increased significantly between 1992 and 1996, the use of illicit drugs by adolescents was stabilised for the majority of drugs in 1997. Amongst 8th grade students, it remained stable or decreased for some

[46] Annual survey on drugs and related attitudes of teenagers in the United States.

substances. Amongst 10th and 12th grade students the use of illicit drugs remained stable, but their lifetime prevalence increased for some substances.

The use of all illicit drugs in the last year (annual use) by students in the group mentioned increased from 27.1% in 1992 to 42.4% in 1997, after decreasing constantly with respect to a maximum figure of 54.2% recorded in 1979. The percentage of final year secondary students that had used an illicit drug in the last month (current use) increased from 14.4% in 1992 to 26.2% in 1997.

2.1. Consumption by substance

Lifetime prevalence.

	8th grade	10th grade	12th grade
Marihuana	**22.6%**	**42.3%**	**49%**
Cocaine	**4.4%**	**7.1%**	**8.7%**
Inhalants	**4.7%**	**18.3%**	**16.1%**
LSD	**4.7%**	**9.5%**	**13.6%**
Heroin	**2.1%**	**2.1%**	**2.1%**
Stimulants	**12.3%**	**17%**	**16.5%**
Alcohol	**53.8%**	**72%**	**81.7%**

A clear increase in lifetime prevalence of consumption, in marihuana, cocaine, LSD, stimulants and alcohol; with heroin use appearing to be stable and decreasing use of inhalants as age increases.

2.1.1. Marihuana

The increase in the last year and lifetime use of marihuana by students in the 8th grade (14-15 years) that was observed between 1992 and 1996, stabilised in 1997. Between 1992 and 1997, however, the use of this drug during

lifetime increased from 11.2% to 22.6%; last year use from 7.2% to 17.7% and current use (in the last month) from 3.7% to 10.2%.

Between 1992 and 1997 the use of marihuana during their lifetime in students in the 10th grade (16 years) increased from 21.4% to 42.3%; annual use from 15.2% to 34.8% and current use from 8.1% to 20.5%.

In 1997, 49.6% of final year secondary students (17-18 years) had used marihuana at least once in their lives, a figure that represents an increase in relation to the 32.6% recorded in 1992. The annual use of marihuana for final year secondary students reached a maximum value of 50.8% in 1979, and decreased constantly until it reached 21.9% in 1992 then increasing to 38.5% in 1997. Current use increased from 11.9% in 1992 to 23.7% in 1997.

2.1.2. Cocaine

The use of cocaine amongst 8th and 10th grade students remained at the same level between 1996 and 1997. However, the lifetime usage for 12th grade students increased from 7.1 in 1996 to 8.7% in 1997, the highest rate since 1990.

The use of crack cocaine during their lifetime of 12th grade students increased from 3.3% in 1996 to 3.9% in 1997. Its use for 8th and 10th grade students remained equal between 1996 and 1997. The survey results showed that 2.7% of 8th grade students and 3.6% of 10th grade students had used crack at least once in their life; 1.7% of 8th graders and 2.2% of 10th graders had used it in the year preceding the survey and 0.7% of 8th graders and 0.9% of 10th graders had used it in the preceding month.

2.1.3. LSD

In 1997, the use of LSD during their lifetime for final year secondary students was 13.6% and last year use of 8.4%, figures that exceed the corresponding levels of the maximum annual usage of the mid 1970's.

Annual use of LSD for 8th grade students was 3.2% in 1997 (an increase in relation to the figure of 2.4% recorded in 1994). Annual use for 10th graders increased from 5.2% in 1994 to 6.7% in 1997.

2.1.4. Inhalants

Inhalants are the substances most abused by 8th graders after alcohol, tobacco and marihuana. The use rate amongst 8th grade students is higher than that of 10th and 12th graders.

In 1997, more than one in five 8th grade students (21%) had used inhalants, adhesive substances, aerosols and solvents at least once in their life and 11.8% had used them during the preceding year.

2.1.5. Alcohol

In 1997, daily use of alcohol by final year secondary students was 3.9%; for 10th graders 1.7% and for 8th graders, 0.8%.

In 1997, 31.3% of all the final year secondary students and 25.1% of the 10th graders declared that they had been drunk (non-stop consumption of five drinks or more. The sum corresponding to 8th grade students was 14.5% in 1997.

The percentage of 8th grade students that said that they had been drunk in the last 30 days, decreased from 9.6% in 1996 to 8.2% in 1997. But the percentage of 10th grade students that said that they had got drunk on a daily basis increased from 0.4% in 1996 to 0.6% in 1997. Amongst the 12th grade students, alcohol consumption over the last year increased from 72.5% in 1996 to 74.8% in 1997. The lifetime use of alcohol for final year secondary students also increased.

3. Treatment Trends

During the 1995 financial year, approximately 1.9 million people were admitted into state-subsidised treatment.

- Of these, around 54% began treatment against alcoholism; and nearly 46% underwent treatment for illicit drugs abuse.

- Approximately 70% of these individuals were male and 30% female.

- 56% where white, followed in number by Afro-Americans (26%), Hispanics (7.7%), American Indians (2.2%) and Asians and Pacific Islanders (0.6%).

- The greatest number of people who went into treatment for the use of illicit drugs, did so because of the following drugs: cocaine (38.3%), heroin (25.5%) and marihuana (19.1%).

- 60% of these people underwent treatment in an outpatient setting.

3.1. Treatment

3.1.1. Crack and Cocaine

According to the state profile of alcohol and drugs abuse, in the 1995 financial year, in the United States, 333,359 patients underwent treatment mainly for cocaine abuse in state subsidised programmes, which represented almost 38.3% of those admitted for treatment.

The NIDA's top priority in research matters is to find a medication that prevents or notably reduces the effects of cocaine, to use it as part of an integral treatment programme. Research is being carried out to study medicines that help to relieve the great anxiety involved in the need to consume drugs often suffered by people who are in treatment for cocaine

addiction. Currently various products are being studied in order to check their effectiveness and harmlessness for treating cocaine addiction.

In addition to pharmacological treatments, interventions for modifying behaviour, especially cognitive behavioural therapy, may be effective in reducing the use of drugs in patients treated due to cocaine abuse. Providing therapeutic services in an optimal combination for each person is of critical importance for the success of treatment results.

3.1.2. Heroin

There are a great variety of therapeutic options available for heroin, including medications and behaviour therapy. According to the NIDA, science has demonstrated that combining medication based treatment with other support services for the patient makes it possible for the drug addict to stop using heroin (or other opiates) and return to a more stable and productive lifestyle.

In November 1997, the National Institutes of Health (NIH) brought together a Consensus Group on Effective Medical Treatment for Drug Addiction. This group of experts from the entire nation (USA) concluded that opiate addictions are illnesses of the brain and medical disorders that, in reality, can be treated effectively. The group strongly recommended: 1. Greater access to methadone maintenance treatment programmes for people addicted to heroin and other opiates; and 2. The elimination of federal and state rules, in addition to other barriers, that prevent access to these programmes.

The group also underlined the importance of offering psychological counselling against substance abuse, psychosocial therapies and other patient support services, to encourage retention and the success of methadone maintenance treatment programmes.

Apart from methadone (24h), LAAM (72h), naloxone (excessive doses) and naltrexone, other medications are being studied for use in methadone maintenance programmes.

There are many behaviour therapies that are effective against heroin addiction. These may include residential and outpatient methods. Several new behaviour therapies are turning out to be especially promising against this type of addiction. These include:

Contingency Management which uses a system based on a voucher concept, where the patient is rewarded with "points" when drugs analysis test give negative results, and may exchange these for articles that encourage a healthy lifestyle.

Cognitive behavioural intervention has been designed to help modify the thinking, hopes and behaviour of patients and to increase their ability in tackling various factors that cause stress in life.

In 1995, heroin abuse occupied second place amongst the causes that led people to request treatment in state subsidised anti-drugs programmes. In Puerto Rico, California, Connecticut, Maryland, Massachusetts, New Jersey, Rhode Island and Washington, it was the main abused drug mentioned by new patients who underwent treatment for drug addiction in programmes subsidised by the state. This goes to ratify the increase in heroin consumption being experienced in the entire nation for some years.

3.2. Types of treatment programmes

The final goal of all treatment for drug abuse is to help the patient achieve lasting abstinence, but the immediate goals are to reduce the use of drugs, to improve the patient's ability to function, and minimise the medical and social complications resulting from drug abuse.

There are several types of treatment programmes for drug abuse. Short-term methods last for less than 6 months and include residential therapy, therapy with medication and outpatient therapy without medication. Long-term methods may include, for example, outpatient methadone maintenance treatment for opiates addicts and residential therapeutic community treatment.

In maintenance treatment for heroin addicts, the person in treatment receives an oral dose of a synthetic opiate, generally methadone hydrochloride or levo-alpha-acetyl methadol (LAAM), administered in a sufficient dose to block the effects of heroin and produce a stable state, without euphoria, and free of the physiological anxiety involved in opiates consumption. In this stable state, the patient may disconnect from drug-searching conduct that is related with crime, and through counselling and suitable social services, become a productive member of the community

Outpatient drugs-free treatment does not involve medication and includes a wide variety of programmes for patients who visit a clinic at regular intervals.

Most of these programmes include individual or group psychological counselling.

Patients who enter these programmes abuse other, non-opiate drugs or abuse opiates but maintenance therapy is not recommended for them, as they have a stable life and a short history of drug addiction.

Therapeutic communities (CT) are highly structured programmes in which the patient remains in residence, normally from 6 to 12 months. Patients in a therapeutic community usually correspond to the profile of drug addicts with relatively long histories of drug addiction, participation in serious criminal activities and seriously deteriorated social functioning. The focus of CT is the re-education of the patient who will try to become integrated in a drug-free and crime-free lifestyle.

Short-term residential programmes, often referred to as chemical dependency programmes, are often based on the "Minnesota Model" for the treatment of alcoholism. These programmes include an in-residence phase of treatment lasting 3 to 6 weeks followed by extensive therapy on an outpatient basis or in 12 step self-help groups such as Narcotics Anonymous or Cocaine Anonymous. Chemical dependency programmes began in the private sector in the mid 1980s with insured drug addicts who abused alcohol or cocaine as the main patients. Nowadays, as private provider benefits decline, more programmes are extending their services to publicly funded patients.

Methadone based maintenance programmes generally have more success in maintaining clients who are opiates addicts than do therapeutic communities, which, in turn, have greater success than outpatient programmes that offer psychological counselling and psychotherapy. Amongst the various methadone programmes, those that offer the highest doses of methadone (generally a minimum of 60 mg per day) and also, those who give other services, such as psychological counselling, therapy and medical care, together with the methadone, generally have better results than the programmes that offer minimum services.

Treatment programmes for drugs in prisons may be successful in preventing the patient from returning to criminal behaviour, particularly when linked to community programmes where treatment will continue when the client is released from prison.

Some of the most successful programmes have reduced the re-arrest rate by a quarter or up to a half. For example, the "Delaware Model", a study in progress on the comprehensive treatment of prisoners addicted to drugs, shows that treatment in prison that includes a therapeutic community atmosphere, a work-release therapeutic community and community-based medical care reduces the probability of a patient being arrested again by 57% and the probability of a patient returning to drug use by 37%.

4. Social costs

Drug abuse has a major economic impact on society; estimates put the sum at around $67,000 million per year (10 billion pesetas). This figure includes costs related with crime, medical care, treatment for drug abuse, social welfare programmes and work absenteeism. Treatment for drug abuse can reduce these costs. Studies have shown that a saving is made of between $4 and $5 for each dollar spent on treatment. It costs approximately $3,600 (600,000 pesetas) per month to leave a drug addict in the community without treatment, and the cost of imprisonment is approximately $3,300 per month. In contrast, methadone based maintenance therapy costs around $290 (46,000 pesetas) per month.

5. Therapeutic medications

Treatment for people who abuse drugs but do not yet show a severe addiction profile, frequently consists of behaviour therapies, such as psychotherapy, psychological counselling, support groups or family therapy.

However treatment for drug addicts commonly involves a combination of medication and behaviour therapy.

The primary method of medically assisted withdrawal consists in switching the patient to another comparable drug that produces a milder withdrawal syndrome and in later gradually reducing the amount of the substitute medicine until it is completely eliminated. For opiates withdrawal treatment, the medication most commonly used is methadone, which is taken by mouth once a day. Patients begin by taking the lowest dose that avoids the severest withdrawal symptoms and then the dose is gradually reduced.

Substitutes can also be used to assist in withdrawal from sedatives. The patient is given another sedative with long-lasting action, such as diazepam or phenobarbital, and then this is gradually reduced.

Once the patient has gone through withdrawal, a considerable risk of relapse still exists. The patient may take drugs again even though s/he is no longer suffering physical withdrawal symptoms. A great deal of research is taking place to find medications that can block the craving to consume drugs and a return to drugs taking.

Patients who cannot continue to abstain from opiates are given maintenance therapy, nearly always using methadone. The methadone maintenance dose, generally higher than that used for medically assisted withdrawal, avoids both withdrawal symptoms and the craving to consume heroin. It also prevents the drug addict experiencing the heroin high, and as a result, the individual stops using it. Research has shown, as we indicated previously, that maintenance therapy reduces the spread of AIDS through the treated population, whilst it also reduces the overall death rate and all kinds of social costs.

Another drug, already mentioned, for use in maintenance treatments is LAAM (levo-alpha-acetyl methadol), which is administered three times per week rather than daily, as is the case with methadone. As we have seen, the drug naltrexone is also used to prevent relapses. Like methadone, LAAM and naltrexone prevent the drug addict from experiencing the high provided by heroin. However, naltrexone does not eliminate the craving to consume the drug, so it has not been very popular amongst drug addicts. Naltrexone works better with patients who are highly motivated and want to kick their drugs habit.

There are currently no medications approved by the Food and Drugs Administration (FDA) to treat addiction to cocaine, LSD, PCP, marihuana, stimulants, inhalants nor anabolic steroids. There are medications, however,

that treat the adverse affects on health produced by these drugs, such as seizures or psychotic reactions, and for opiates overdoses.

One of the priority objectives of the National Institute on Drug Abuse (NIDA) is to develop a medication that is useful in treating cocaine addiction.

6. The consequences of drug use for women

Women of all races and socio-economic status fall victim to the grave illness of drug addiction.

Many women that use drugs have faced serious challenges to their wellbeing during their lives. For example, research indicates that around 70% of women that say that they have taken drugs, also say that they were sexually abused before the age of 16 years, and the father or mother of over 80% were alcoholic or addicted to other illicit drugs.

A large number of women that use drugs do not look for treatment because they are afraid. They are afraid that they will not be able to look after their children or maintain them, they are afraid of reprisals from their spouses or boyfriends, and they are afraid of punishment from authorities in the community.

A significant percentage of women report that their companions initiated them into drugs use and then sabotaged their efforts to stop using them.

6.1. Risks associated with drugs abuse

Specifically, health risks associated with drug abuse in women are:

- Poor nutrition and below average weight.

- Low self-esteem

- Depression

- Physical abuse

- If pregnant, preterm labour or premature birth

- Serious medical and infectious diseases (for example, higher blood pressure and heart rate, STDs, AIDS)

6.2. Drug abuse and AIDS

AIDS is now the fourth most important cause of death in women of child-bearing age in the United States. Between 1993 and 1994, the number of new AIDS cases amongst women decreased by 17%. Even so, in January 1997, the Centres for Disease Control and Prevention had documented nearly 85,000 cases of AIDS amongst adult and teenage women in the United States. Of these cases:

Around 62% were related with the fact that the woman was injecting drugs or had had sex with an injecting drug user.

37% of the cases were related to heterosexual contact, and almost half of the women acquired AIDS by having sex with an intravenous drugs user.

6.3. Treatment for women

Around 4 million women need treatment for drug abuse in the United States. Unfortunately, as has been mentioned previously, there are several important reasons for which women do not seek help. Research shows that women benefit most from treatment programmes for drug addition that offer comprehensive services to meet their basic needs, including access to the following:

- Food, clothing and shelter

- Transport

- Legal assistance

- Literacy training and educational opportunities

- Parenting Training

- Family therapy

- Psychological counselling for couples

- Medical care

- Child care

- Social Services

- Social support

- Psychological assessment and mental health care

- Assertiveness training.

- Family planning services.

It is possible that traditional drugs treatment oriented towards men are not appropriate for women, because they perhaps do not offer the services mentioned above. Research also indicates that, for women in particular, an important factor is that through treatment, they can have a continued relationship with a treatment provider. It is expected that any individual may have lapses and relapses, and these steps from part of the process of treatment or recovery.

During these periods, women, especially, need the support of their community and encouragement from those closest to them. After completing a drugs treatment programme, women also require services that help them to sustain their recovery and rejoin the community.

6.4. Extent of use

The National Household Survey on Drug Abuse (NHSDA)[47] provides yearly estimates of drug use prevalence for several demographic groups in the United States. The data are derived from a national sample of household members aged 12 years or over.

In 1996, 29.9% of women in the United States (females aged over 12 years) had used illicit drugs at least once in their lives: 33.3 million out of a total of 111.1 million women.

Over 4.7 million women had used illicit drugs, at least once during the month preceding the survey (potentially addicts).

The survey showed that 30.5 million women had used marihuana at least once in their lifetime. Some 603,000 women had used cocaine in the previous month; 240,000 had used crack cocaine. Approximately 547,000 women had used hallucinogens (including LSD and PCP) during the previous month.

In 1996, 56,000 women had used a needle to inject drugs and 856,000 had done so at some point in their lives.

In 1996, nearly 1.2 million women aged 12 years or over had taken, during the previous month, prescription drugs (sedatives, tranquillisers or analgesics) for non-medical purposes.

In the month prior to the survey, more than 26 million women had smoked cigarettes and over 48.5 million had consumed alcohol.

[47] The National Household Survey on Drug Abuse (NHSDA) is an annual survey carried out by the Substance Abuse and Mental Health Services Administration.

THE SITUATION IN LATIN AMERICA

1. Consumption, production and aid policies
2. HIV/AIDS in the Americas
3. Harm Reduction
4. Situation by countries

THE SITUATION IN LATIN AMERICA

1. Consumption, production and aid policies

Latin American has traditionally been considered as one of the main regions of supply and a transit area for drugs for the whole world. But in recent years it has experienced a rapid transition, no longer being merely a producer region, but also a consumer region.

After legal drugs (alcohol, tobacco and psychotropic medicines) marihuana is the most commonly consumed illegal substance, followed by cocaine hydrochloride, base paste and, in a proportion that is not yet highly significant, opiates. However, consumption is increasing quickly.

Within the forms of consumption, the administration of psychoactive substances administered intravenously is not a very frequent custom in the northern half of Latin America but has spread to a certain extent in countries such as Brazil, Argentina and the South of Chile, where HIV/AIDS is largely related to this type of consumption.

In Latin America the discourse that has steered the drugs issue has been based fundamentally on diagnoses that emerged, to a large extent, through interpretations by the USA government. To a greater or lesser degree, all the Latin American countries have taken on board a similar diagnosis: zero tolerance of consumption, lack of comprehension towards consumers and a precarious aid network.

The prevention and rehabilitation of people suffering from addiction have been set within a framework of a prevention model based on explaining the

effects of drugs and learning to say no, and on Therapeutic Community treatments with high thresholds of requirements.

In terms of consumption, the execution of different actions, generally guided by North American policies, has been reproduced mechanically in most South American countries without any weighing up of the situation nor any objective evaluation of their real results.

"We have been moving constantly, but nearly always *in the dark. (...)* Diverse initiatives with different ascending degrees of repressive intensity against consumers, based on the discourse proposed by the USA regarding the drugs phenomenon, have been implemented with very little success." (Castaño, G.A. 1999)[48]

In fact, in the last 30 years in Latin American it has been a case of "more of the same" without very positive results to date. Despite the prevention campaigns that have run, a pointed transition has been witnessed, from mere producer countries to consumer countries. In other words, the drugs business continues to be successful.

At the same time drugs production and trafficking in Latin America has been exacerbated. "However we could point out, that under the administration of the current U.S. president, Bill Clinton, an important modification has taken place in the policy, without any basic change in the paradigm; a necessary modification in the actions taken has been proposed, in order to put into perspective the separation of producer/consumer countries, this being a modification where Colombia played a starring role."(Castaño, 1999).

1.1. Drugs Consumption in Latin America

To give general statistical data on drugs consumption in Latin America is difficult and imprecise, since there are few countries that carry out

systematic epidemiological studies. But we can generally say that the most important problem in America, as is the case in all regions in the world, is made up of the group of legal drugs: alcohol, tobacco and psychopharmaceutical drugs.

As regards illegal drugs, it can be said that the main drugs abused in Latin America, in order of frequency, are: marihuana, cocaine hydrochloride, cocaine base paste, synthetic drugs and heroin.

In the opinion of Augusto Pérez Gómez[49], the visible head of the fight against drugs in Colombia, there is a possible classification in Latin America: "from the consumption point of view we have in first place Colombia, Peru, parts of Brazil (especially the large cities such as Sao Paulo and Rio de Janeiro), and Panama. In the second group we find Venezuela, Ecuador and some Central American countries. In the third group are Mexico, El Salvador and Bolivia. And in the fourth and final group, the southernmost countries: Uruguay, Paraguay, Argentina and Chile, as the countries with the lowest consumption.

Although as we already noted, the data we are dealing with come from sources that may haveused dubious methodology, we will now give a general situation of consumption in Latin America, and later, the specific situation of some of the southernmost countries and Central America.

In **Colombia**, the latest study carried out by the National Narcotics Board (Dirección Nacional de Estupefacientes[50]), a governmental organism that deals with drug policies in the country, reported a global consumption for illegal psychoactive substances (marihuana, cocaine, bazuco and opiates) of

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[48] CASTAÑO Pérez, G.A. "Drogas en América Latina y los programas de reducción del daño" (*Drugs in Latin America and Harm Reduction Programmes)* Adicciones (*Addictions*) Magazine. Vol.11, no.4, p.387/393.

[49] PEREZ Gómez, A. "Consumo de Cocaína en América Latina" (*Cocaine Consumption in Latin America*) In: International Symposium on Coca and Cocaine. Santafé de Bogotá. October 1995.

[50] "II Estudio de Consumo de Sustancias Psicoactivas en Colombia" (*2nd Study on Consumption of Psychoactive Substances in Colombia*). Fundación Santafé de Bogotá. National Narcotics Board. 1996.

6.5% of the Colombian population, which means approximately 1,674,510 people, of which 1,299,224 are men aged mainly between 18 and 44 years.

In this study, opiates consumption in Colombia gave very low values, since 12,566 people had consumed it at some stage in their lives. However, following this study and as a consequence of the greater availability of heroin on the street, there are an increasing number of young polydrug consumers who include heroin on their menu. With respect to this, different reports point towards an alarming increase in heroin injectors, both in North America and Latin America.

In **Peru**, data supplied by CEDRO (cited by Pérez Gómez, A.,1995), a non-governmental organisation, with a very important presence in the prevention activities implemented in this country, show the following consumption figures for the year 1992: marihuana 8.4%, base paste 4.4% and cocaine hydrochloride 2.7%. There are no data on the consumption of heroin or opiates (this is normal if we take the date into account) and considerable consumption of hallucinogens is also reported, at 2.5%.

As regards consumption prevalences in **Ecuador**, we can find information published in 1999[51]; the following percentages are reported: marihuana 4.1%; coca base 1.0%; inhalants 0.9%; cocaine hydrochloride 0,9%; injectable drugs. These results come from the "Second National Survey on Drugs Consumption CON-SEVIP-NAS"(1995).

The Narcotics Investigation Department in **Brazil** (DENARC)[52] reports an important increase in cases, in the number of people treated regarding drugs problems between the years 1991 and 1996. In the year 1991, the number of people treated due to drugs consumption in the division of Prevention and Education of the DENARC was 740. In the year 1996 this figure rose to 10,804 people, equivalent to an increase of 1,465%. Of these, 915 depended

[51] Project Document: "Fortalecimiento de las Estrategias de Reducción de la Demanda en Colombia, Ecuador y Venezuela" (*Strengthening of Demand Reduction Strategies in Colombia*). CEV. 1999.

on some psychoactive substance; 97 of them, or 10.6% were women, and 818 (84.9%) were men. The drug of choice for men is crack and cocaine hydrochloride, (47% dependent on crack and 14.9% dependent on cocaine hydrochloride); 27% were polydrug addicts and 7.4% marihuana consumers.

Of the women, 36.1% consumed crack, 17.5% cocaine hydrochloride, 18,6% marihuana and 22.7% were polydrug consumers.

In **Venezuela**, some epidemiological studies can give us an idea of consumption in this country. A first study refers to the consumption of drugs by students, and was carried out by the Fundación Venezuela Libre de Drogas (Drugs Free Venezuela Foundation)[53], amongst students from seventh grade primary education to third year higher education, with ages between 11 and 25 years in the eight main municipalities of the metropolitan area of Caracas and where 1730 interviews were held.

In this study the prevalence of consumption of illegal substances such as marihuana, cocaine hydrochloride and base paste were found to be less than 5%. Of the individuals who stated that they were active consumers, it was found that the substance most consumed was marihuana, both in men and women, followed by cocaine hydrochloride and base paste.

Another epidemiological study of the consumption of psychoactive studies in a Venezuelan University[54], with a sample of 2014 people including students, teachers, employees and manual workers attached to the University, reported prevalences for cocaine hydrochloride of 2.0%; inhalable 1.4%; base paste 1.0%; hallucinogens 0.8%; heroin and opiates 0.3%.

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[52] "Annual Report" Department of Narcotics Investigation (DENARC) Sao Paulo.1996.
[53] "Estudio sobre consumo de drogas en Estudiantes" (*Study on Drugs Consumption in Students*) Drugs Free Venezuela Foundation. In: "Grupo Interinstitucional para la Investigación del Consumo de Drogas en Venezuela. Algunas investigaciones 1985-1995" (*Inter-institutional Group for Research intro Drugs Consumption in Venezuela. Some investigations 1985-1995*). Caracas. Empresa el Cojo. 1995.
[54] Salazar, M. Et al. "Diagnóstico Epidemiológico de Consumo de Sustancias Psicoactivas en una Universidad Venezolana" (*Epidemiological Diagnosis of Psychoactive Substances Consumption in a Venezuelan University*) CEPRODUC, University of Carabobo, 1994.

In this same study the results for prevalence of consumption indicated that out of every one hundred people, 7 consumed amphetamines; 3 cocaine hydrochloride; 2 marihuana and 1 base paste, inhalants and hallucinogens.

In **Chile**, according to the Third National Study of Drugs Consumption,[55] it is highlighted that 17% of the general population (12-64 years), have consumed at some stage in their lifetime one of the three illicit drugs most used in this country: marihuana (16.77%), cocaine hydrochloride (4.02%) and base paste (2,27%).

Consumption in the last year of any of these drugs was 5.3%, strongly influenced by the consumption of marihuana, which in accordance with all the studies on the general and specific populations, is by far the most consumed drug in Chile.

Those who had consumed at least one of the three illicit drugs mentioned in the month prior to the survey made up a total of 2.23% of the general population.

Bolivia, judging by the data available[56], seems to have one of the lowest consumptions in Latin America, even though it reports an elevated consumption of inhalants.

Argentina and **Uruguay** we will look at below; as for other countries such as **Paraguay**, we have not had access to systematic studies, but with the data that we do have available we believe we can offer a global view of the situation in Latin America.

[55] Tercer Estudio Nacional de Consumo de Drogas en Chile" (*Third National Study on Drugs Consumption in Chile*). Executive Secretariat of CONACE, 1999

[56] ROTH, E.; Jung, JE "Panorama Actual de la Prevención del Consumo de Drogas en Bolivia" (*Current Panorama of the Prevention of Drugs Consumption in Bolivia*) La Paz. CIEC/Development Associates. 1995.

1.2. Aid policies

In Latin America it is clear that a decisive factor is greater concern for aspects related to production or trafficking, prioritising repression as a response (we will analyse this question in more detail later.)

As regards the aid available, the hegemonic model is that based on abstinence, with "Drugs Free Programmes" (CT) as the only real services offered.

With a great many social and political difficulties, Harm Reduction programmes began towards the end of the 1980s and under the focus promoted by the World Health Organisation on Risk Minimisation and associated above all with the prevention of HIV/AIDS in intravenous users.

Intravenous use is low in Latin America. More frequent consumption can be observed in the southernmost countries, especially Brazil, Argentina and the South of Chile, where there are reports of worrying consumption of cocaine hydrochloride.

2. HIV/AIDS in the Americas

Epidemics of HIV/AIDS infection continue to pose a grave problem for public health in the Americas. The Pan-American Health Organisation (OPS), calculates that 1.6 million people are living with the infection in Latin America and the Caribbean, and around one million in North America.[57]

In 1998, the rates of prevalence in adults were estimated at around 0.57% in Latin Americana and 1.96% in the Caribbean, this latter figure only being exceeded by those of sub-Saharan Africa, which is the most severely affected region in the world.

[57] "Sida e infecciones de Transmisión Sexual en las Américas" (*AIDS and Sexually Transmitted Diseases In the Americas*). Rev. Panamericana de Salud Pública *(Pan-American Public Health Magazine*).. Vol.6, no. 3. Sep. 1999.

As regards the number of people infected according to the bulletin on AIDS Surveillance in the Americas[58], Brazil has 550,000 cases, Mexico 200,000 and Argentina 14,974 cases.

In the different countries, the AIDS epidemic has evolved at different speeds, in accordance with the transmission mode. In the case of **Argentina** between the years 1987 and 1997, the cases with intravenous drugs use as a risk factor multiplied by 64[59].

In **Chile** a slow but progressive increase has been observed in recent years, both of AIDS and HIV cases. In the period 1985-1990, intravenous drug addiction was responsible for 36% of blood-borne infection cases, whilst in the years 1991-1997 this figure reached 83%[60].

Colombia reports a very low number of infections due to intravenous use of psychoactive substances, 15 cases on record[61] In general the use of intravenous drugs in countries that occupy the northern part of Latin America is still very low; with the exception of **Panama, Puerto Rico** and **Mexico** which have adopted this pattern of consumption thus facilitating the spread of the HIV/AIDS epidemic.

In countries such as Ecuador, Peru and Colombia it is cocaine base paste that is causing the most serious biological and social deterioration. In this type of user, the severe addiction and high level of social exclusion and self-isolation that this substance produces, linked to a high incidence of sexually transmitted diseases and tuberculosis, are leading some experts to think about the possibility of developing harm reduction strategies, in contexts other than heroin consumption and the transmission of HIV/AIDS through intravenous drugs users.

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[58] CALENTANO, A. Et al. "Mujer, Prostitución y VIH/SIDA" (*Women, Prostitution and HIV/AIDS*) Political Sciences Faculty. University of Rosario,1999.
[59] "Perfil Epidemiológico en la R. Argentina. 1988-1998" (*Epidemiological Profile in the Republic of Argentina*) Boletín sobre SIDA (*AIDS Bulletin*). Ministry of Health and Social Affairs. Buenos Aires, 1998.

3. Harm Reduction

The development of harm reduction in Latin America, despite having been considerable, is limited by the severe social problems and those relating to the distribution of incomes and wealth experienced by the region.

In spite of this situation, preventive efforts have been made and there has been in increase in the launch of harm reduction strategies in Latin America. The first experiences of harm reduction were developed in **Brazil**, in Santos in 1989. In 1993, the Institute of AIDS Studies and Research in Santos (IEPAS) began the first programme distributing sodium hypochlorite and the first street outreach work in the country.

There are currently 14 harm reduction programmes running in Brazil, concentrated in 7 priority states, and they include needle exchanges and other services. In March 1998 in the state of San Paulo, the first Latin American law was passed regulating needle exchange programmes as an HIV/AIDS prevention measure. In 1997, the Brazilian Outreach Workers Association (ABORDA) was founded, followed in October 1998 by the Brazilian Network for Harm Reduction.

In 1995 the first needle exchange programme began in **Salvador**, in the state of Bahía.

In **Argentina**, a programme was begun in 1993 for the prevention of AIDS amongst drugs users, developed by the team that founded the Exchange Association in 1995. Since 1998, this NGO has been pushing forwards with a programme based in pharmacies and interventions in harm reduction for drugs users in Buenos Aires, with the support of the Ministry of Health and of **UNAIDS** respectively. Harm reduction activities are also being developed in the city of Rosario.

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[60] "Boletín epidemiológico trimestral" (*Quarterly Epidemiological Bulletin*) CONASIDA. Ministry of Health of Chile. Sep. 1997.
[61] "Programa VIH/SIDA" (*HIV/AIDS Programme*). Ministry of Health. Colombia, June 1998.

UNAIDS has supported three research projects which include perspectives for harm reduction, carried out in Argentina, Paraguay and Uruguay[62] and it is about to start a regional project "Prevention of HIV infection in injectable drugs users in southern South America".

In August 1998, the **Bolivian** Harm Reduction Network was created, supported by the "Coca Museum" in La Paz.

The Resolution of the City of Medellín is a document that was signed in **Colombia** in 1996, following the First International Summit on "Major Cities and Plans regarding Drugs". This was the first time that harm reduction was discussed.

In June 1998, a Resolution issued by the Colombian Health Ministry and through which the National Mental Health Policy was determined (Resolution 2358 of June 1998) included Health proposals for Risk Reduction. In this same country, the Santa Teresa Community Farms Foundation in the city of Medellín, has, since 1998, been running harm reduction activities amongst drugs users that live on the streets.

In Mexico, the NGO "Compañeros"; carries out work on the street and distributes education and prevention materials.

In January 1998, representatives of governmental and non-governmental organisations from Argentina, Brazil, Colombia, Chile, Paraguay and Uruguay met in the city of San Paulo and decided to create the Latin American Harm Reduction Network (RELARD).

RELARD's aim is to promote harm reduction activities related with drugs use, with priority given to preventing the transmission of HIV/AIDS, within

[62] "Investigación sobre la Prevención del SIDA en Usuarios de Drogas" (*Research on AIDS Prevention in Drugs Users*) Theme Group, UNAIDS Argentina; "Reducción del Riesgo de Transmisión del VIH en Poblaciones Vulnerables" (*Reduction of HIV Transmission Risks in Vulnerable Groups*) Theme Group UNAIDS Paraguay; "Relación SIDA y Drogas: Diagnóstico y propuestas" (*Relationship between AIDS and Drugs: Diagnosis and Proposals*) Theme Group UNAIDS Uruguay.

a proposal based within the frameworks of Public Health, Human Rights and Citizenship in Latin America.

Since its creation RELARD has encouraged links between research and intervention and has promoted cooperation in the region and with other regions. It has disseminated useful information for researchers and field workers through its bulletin, published in three languages (Spanish, Portuguese and English).[63]

In March 1998, the city of San Paulo in Brazil played host to the 9th International Harm Reduction Conference, the first held on Latin American territory. This important event gave significant impetus to the debate on this subject in the region.

4. Situation by countries

4.1. Argentina

As a reference we will take the Province of Buenos Aires (15,000,000 inhabitants, 45% of the population of Argentina)[64]

The Province is in a high risk situation due to:

- The situation of Argentina surrounded by drug producing countries (Bolivia, Paraguay, Brazil), in close contact with other producer countries (Peru, Colombia, Ecuador, Mexico); all this is made more serious by a wide land border measuring over 3,000 Km and a broad riverbank that communicates with the majority of producing countries and a long coastline with deep water posts that make it a transit country as well as a consumer country.

[63] Its Web site (www.irha.net/relard)
[64] "Entrevista a Juan Alberto Yaría" (*An interview with Juan Alberto Yaría*) "Intercambio" Magazine. FAD. No. 4. June 1999.

- The peculiar geographical construction of the Province, with 9,000,000 of its 15,000,000 inhabitants concentrated into a small perimeter known as the urban perimeter, containing 25 municipalities of the 134 that make up the province of Buenos Aires.

4.1.1. Consumption

In a study made of a population of some 10,000,000 (aged over 14 years) the results are as follows:

Marihuana

Contact: **1997** (9.9%) **1999** (12.36%) **Increases**

Consumption: **1997** (1.40%) **1999** (2.37%) **Increases**

Inhalants

Contact: **1997** (2.20%) **1999** (3.03%) **Increases**

Consumption: **1997** (0.40%) **1999** (0.63%) **Increases**

Tranquillisers

Contact: **1997** (9.80%) **1999** (5.67) **Decreases**

Consumption: **1997** (1.70%) **1999** (1.20%) **Decreases**

Cocaine

Contact: **1997** (4.30%) **1999** (4.90%) **Increases**

Consumption: **1997** (0.70%) **1999** (1.19%) **Increases**

Hallucinogens

Contact: **1997** (1.60%) **1999** (1.45%) **Decreases**

Consumption: **1997** (0.20%) **1999** (0.28%) **Decreases**

Heroin

Contact: **1997** (0.40%) **1999** (0.52%) **Increases**

Consumption: **1997** (0.10%) **1999** (0.12%) **Increases**

Ecstasy

Contact: **1997** (0.60%) **1999** (0.60%) **Stable**

Consumption: **1997** (0.10%) **1999** (0.10%) **Stable**

4.1.2. Intravenous use of cocaine in Argentina

The evolution of consumption, up to intravenous use, goes through certain levels of initiation or a spiral of consumption. In Argentina, as in the majority of regions in the world, on the **first level** alcohol is used as a psychoactive substance. Manipulation, due to alcohol, of mood and behaviour, is presented as a model of social adaptation that is based on reducing or cancelling the emotional expression of conflicts.

"This situation, from the individual viewpoint and the cultural environment, has found reinforcement from the alcoholic drinks market itself with abundant explicit references to the younger age group as a defined economic segment within the beer market by advertising agencies working for producers and distributors" (Hugo A. Míguez, 1998)[65]

These details are significant is we consider that in relation to intravenous drug abuse, no references were found of cases that had reached use of injectable drugs without having first passed through a stage of alcohol abuse.

[65] MIGUEZ, H.A. "Uso intravenoso de la cocaine en Argentina" (*Intravenous Use of Cocaine in Argentina*) Acta Psiquiát Psicol Am lat (*Lat. Am. Psychiatry and Psychology Documents*). 44 (1) 41-49.1998

On a **second level,** evidence can be found of initiation with psychopharmaceutical drugs mixed with alcohol, the use of glue and the appearance of the first illegal substances, as is the case of marihuana and cocaine.

A neighbour from the Province of Santa Fe comments: "*The kids begin at 9 years old with the glue bag and then continue at 14 with marihuana. Also with cocaine. They mix it with beer or wine. You can see them in the morning, in the afternoon, at any time of day. It's as though the neighbourhood closed in on itself and no longer sees them. Before it was a small group and everybody protested, but now there are loads of them and nobody says anything. The neighbourhood no longer reacts to this*" [66]

On this level, nearly the totality of intravenous drug addicts questioned,[67] adopted snorted cocaine as the base drug around which the others would revolve. This consumption is related with an important illegal market that in some poor areas constitutes one of the few alternatives for income, giving rise to an important network of local users and sellers.

On a **third level**, we find ourselves before the fact that all those interviewed, evaluated intravenous use as a definitive change, offering no return to previous levels of consumption. Their start is explained as a search for greater sensations and as a leap towards what is visualised as the "harder" groups in drugs terms. Once the first "flash" sensation has been experienced, the young person's search was reduced exclusively to the unstoppable compulsion to experience it again.

"*...The flash is an explosion in your head, an electricity that is stronger than you. I think that at some stage I thought that I felt it like orgasms. It was like*

[66] Ibid.
[67] "Patrones socioculturales del abuso de drogas intravenoso" (*Socio-cultural patterns of intravenous drugs abuse*) research carried out by the Fundación Proyecto de Vida (*Life Project Foundation*) with a subsidy from the Prevention Project of the HIV/AIDS Programme run by the European Community and the German Technical Cooperation Agency Deutsche Gesellschaft für technische Zusammenarbeit GTZ Gmbh.

masturbating, something that gave me pleasure, me with myself, with my arms, my veins, was pure pleasure...'[68]

Thus sexuality disappears and couples, if they stay together, become an association that fulfils the task of helping each other, in injecting or in controlling risk situations.

In the majority of cases, alcohol was a facilitator in their initiation, helping those interviewed to overcome their fear of injecting themselves, and also being the substance for controlling the stimulant effects of cocaine.

The use of multiple substances is usually misunderstood as an indiscriminate polydrug addiction when in reality there is always an elected substance (in this case cocaine) and the rest have a function of alleviating the discomfort caused by deprivation, or, of continuing or increasing its effects.

4.1.3. HIV/AIDS

Although from the first level HIV infection risks begin, as is the case of situations of alcohol abuse and sexual exchanges, it is on this level where the problem of transmission due to exchanging injection equipment is presented. This is not only as a result of uncontrolled situations during injection but also due to the difficulty in obtaining needles and syringes.

"*...the thing is it's a problem trying to get hold of a syringe, because they don't want to sell you them at the chemist's. So we went there (to the square where the older boys injected) and we found one they'd thrown away. We went to clean it and I think that that was when I became infected.'*[69]

The urban estates of poverty with intricate corridors and labyrinth-like passageways, with waves of children and teenagers spilling out onto the streets due to overcrowding, with high levels of unemployment and violence, are frequently used as a refuge for intravenous use as they are not

[68] Ibid.

easily controlled by police surveillance which is limited to mass sporadic procedures that are easy to foresee.

A complex network protects the groups that participate in sale and consumption in the illegal economy, ranging from those that recruit people for public events to sports groups that do it to deal in the stadiums and on the street.

4.2. Chile[70]

In Chile, concern has been caused by the figures related to consumption rather than other dimensions of the problem. There has been a great deal of controversy after the publication, from studies carried out by state organisations, of the fact that approximately 800,000 people have at some stage tried psychoactive substances (marihuana, cocaine hydrochloride and base paste), and that a sum close to 50,000 were dependent on consumption.

However, according to Oviedo[71], drug consumption continues to be a taboo subject in Chilean society, or even, a subject that is treated with fear, it is disturbing and this leads to repression or total complacency.

4.2.1. Production as a rural problem and distribution and consumption as an urban problem

Drugs are produced in rural scenarios (once could mention their heavy ecological impact), but the social conflicts and delinquent violence, caused by distribution and consumption, belong to urban scenarios. In fact, it is in the cities where the drugs problem acquires greatest importance. This is hardly surprising, as whilst in 1950 only 41% of the population of Latin American lived in the cities, in 1990 this figure had increased to 72%. It is

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[69] Ibid.
[70] HOPENHAYN, M. "Grieta de las drogas: Factores de contexto en el consumo (...)" (*The Drugs Crack. Context Factors in Consumption*) United Nations. Economic Commission for Latin American and the Caribbean (CEPAL). United Nations, New York, 1997.
[71] OVIEDO, Enrique "Grieta de las drogas: Alteración de la sociabilidad por efecto (...)" (*The Drugs Crack: Alteration of Sociability due to the effects*) United Nations, New York, 1997

expected to reach 77% in the year 2000. With this, the largest level of urbanisation in the world will be reached.

In Chile, the effects of drugs in the city can be seen all around the country. The quantities distributed are important in towns near to the borders of Peru and Bolivia (Arica, Iquique), but drugs also have a significant impact in large and developed cities (Santiago), as well as in tourist spots (La Serena and Temuco)

4.2.2. Consumption

We will use the data obtained by the Second and Third National Studies of Drug Consumption in Chile, carried out in 1995 and 1998-99 respectively, by the Executive Secretariat of the National Narcotics Council (CONACE) attached to the Ministry of the Interior.

The use of drugs has become generalised in all social strata. However, whilst base paste is consumed by the lower strata, in higher strata powder cocaine (hydrochloride) is consumed.

Drugs jeopardise people of different ages and professions. In some social groups the consumption of drugs is a socially accepted behavior.

The age for starting consumption has dropped brusquely, with cases being recorded of children from basic primary education, consuming base paste and cocaine.

There has been an increase in the number of organised gangs linked to drugs, given the high profitability they provide. Drugs have become established as an economic solution for many families and a sign of economic prosperity, but paradoxically they have also led to the breaking up of, or losses in families, above all amongst the younger members. The following statement regarding this comes from a trafficker:

"I am 50 years old and I have spent 20 years of my life in prison, serving different sentences, and in the end you start to get angry, to get tired, you start getting old, you get stronger and you don't have the same desire and heart to do so many mad things" This man sees trafficking as a quieter alternative, an alternative... he talks of his tranquillity, he talks of his family; it is very interesting to see his expectations: "I think that my greatest contribution has been my family, especially my wife; when we have problems, the kids also do the right thing and try to help in what they can. I want them to study, I want them to have a career, I don't want them to suffer like I have, but it seems that history repeats itself; because my kids are the same, in the shit, the oldest has a criminal record, he's screwed up on base paste, I think that that's my punishment for selling, I know the harm I'm doing to somebody else and every day I ask God to forgive me, every Sunday we go and light candles in the church and ask God to forgive us, ask him to understand us, he will be the one to judge us at the end, but I have faith in that he can't be that bad, at the end of the day it was our lot"[72]

The 1995 study reports that 13.4% of the Chilean population living in cities of 50,000 inhabitants or more have consumed drugs at some time in their life[73], and 4.5% have done so in the last year, considering any of the three illegal drugs that are consumed in the country (marihuana, base paste and cocaine hydrochloride). These global consumption figures include the incidence of consumption of marihuana (2.2%), of base paste (0.5%) and of cocaine hydrochloride (0.6%), which represent 135,000, 33,200 and 36,000 new cases of consumption in the last year. They also include 44,600 people who have developed dependence on marihuana, 9,900 dependent on base paste and 7,500 who are dependent on cocaine hydrochloride, in accordance with international criteria for the diagnosis of illness.

[72] Quote from an interview from an unpublished study on drugs, intervention of an attendant at the Postgraduate seminar of SUR, Social Studies and Education Centre, Santiago, 1999.
[73] A survey carried out by the Executive Secretariat of the National Council for Narcotics Control (CONACE) in 1995. The universe studied was composed of 8,271 individuals aged between 12 and 64 years which represent 6,186,528 (80%) Chileans of both sexes who live in urban areas.

The same sample offers a lifetime prevalence of 0.7%, of 0.18% in the past year and of 0.006% in the last month of consumption of volatile solvents, a prevalence of alcohol consumption in the last month of 40% (and 24% of "problem drinkers").

The consumption of tranquillisers observed in the last year reached 6.2%, and 2.88% in the last month. This was greater than the consumption of amphetamines, with a lifetime prevalence of 4.7%, with an incidence of 0.23% in the last month.

Drugs consumption in Chile is more common in males (three times greater in the case of any of the three illegal drugs consumed in this country), aged between 19 and 34 years (43% of these having consumed marihuana, base paste or cocaine hydrochloride at some stage in their lives), and amongst those of a high socio-economic level (for these same illegal drugs consumed as lifetime prevalence). The consumption over the last year, appears to be associated more strongly with single and widowed people; those who have studied in higher education; those who have been hospitalised due to emotional problems and who have been in treatment for those problems; those who have been arrested by the police; those who have a small family (up to two people); those who have a family of an "average quality" (according to AGPAR family evaluation scores); to those who know a few or many people where they study or work that consume drugs; and those who have family members that consume drugs.

In the 1998-99 study we can observe how consumption prevalences have shot up for the three basic drugs, especially for marihuana consumption.

With respect to the population in general, we see a rise from 13.4% in 1995 to 17% of Chileans who in 1998-99 had consumed one of the three illicit drugs that are most widely used in the country: marihuana consumption rises to (16.77%); base paste consumption up to (2.27%) and that of cocaine hydrochloride increases to (4.02%).

Consumption in the last year of any of these drugs was 5.3%, strongly influenced by the consumption of marihuana, which according to all the studies of the general and specific parts of the population, is by far the most frequently consumed illicit drug in Chile.

Those who had consumed at least one of the three illicit drugs studied during the month prior to the survey reached 2.23%; in other words, 2 out of every hundred Chileans.

4.2.2.1. Specific Groups

Those surveyed show a high level of awareness regarding the negative consequences of drugs consumption; they consider that a drugs consumer is a person that is ill, irresponsible, disordered, violent, indifferent or a rebel and a delinquent; they declare that it is relatively easy to get hold of drugs; that the results of prevention campaigns run are good or very good; and that police action against drugs trafficking is good or very good.

The consumption of any of the three illegal drugs used in Chile, considering those that consumed during the last year, is greater amongst those that neither work nor study (but belong to the wealthier class); that work part-time or sporadically or that study (and amongst those with higher studies); in the geographical areas of Norte Chico and Metropolitana and in cities with more than 500,000 inhabitants, in those who began sexual relations before the age of 12 years and in those who have had the largest number of partners in the last year and in those who declare that half or more of their friends consume drugs.

The use of volatile solvents in the last month is greater in females aged under 12 years and in males aged between 12 and 18 years.

The consumption of tranquillisers is greater in the upper and middle-upper socio-economic classes.

The age for starting base paste consumption is highest between 19 and 25 years for women and men. Between 19 and 25 years in men and 12 and 18 years in women for cocaine consumption; and between 12 and 18 years in the case of marihuana consumption; between 12 and 18 years in the case of tobacco and alcohol consumption (across all socio-economic levels); and between 26 and 64 years in the case of tranquilliser consumption.

From these data, we can deduce that, except for the consumption of tranquillisers, women start consuming and give it up before men.

- Prevalence of lifetime consumption of the three main illegal drugs (marihuana, base paste and cocaine) according to gender (%) (1995)

GENDER	PEOPLE	%
MEN	594,308	20.63
WOMEN	235,940	7.14
TOTAL	830,249	13.42

According to these data it can be said that one in every eight Chileans aged between 12 and 64 years of age has consumed one or more of the drugs indicated.

- Prevalence of lifetime consumption of the three illegal drugs according to age (age groups) (1995)

Age group	People	%
12-18	100,677	9.43
19-25	274,471	22.23
26-34	289,016	20.85
35-44	124,488	11.64
45-64	41,596	2.91
TOTAL	830,248	13.42

The data suggest that the preventive efforts should be oriented towards the first age sector considered (12-18 years) and even younger, with the aim of eliminating (or at least postponing) the first consumption of these illegal drugs.

The greatest frequencies in terms of lifetime prevalence for the illegal drugs considered, can be observed in the 19-25 and 26-34 years age groups; with percentages of 21.31 and 19.93% for marihuana; 3.17 and 3.54%, for base paste; and 4.88 and 3.73% for cocaine.

- Lifetime prevalence of consumption according to gender and type of drugs (1995)

DRUG	MEN	WOMEN
MARIHUANA	20.04	6.59
BASE PASTE	3.27	0.86
COCAINE	4.35	0.66

- Prevalence of lifetime consumption of the main illegal drugs according to socio-economic level (1995)

Socio-economic Level	People	%
HIGH	68,461	21.11
MIDDLE HIGH	150,620	15.35
MIDDLE	311,030	13.10
MIDDLE LOW	271,334	12.00
LOW	28,803	11.73
TOTAL	830,248	13.42

Considering the lifetime prevalence of the three main illegal drugs overall, it can be observed that, in terms of the proportion of the consumer population,

a direct relationship exists between socio-economic level and consumption. The percentage of the consuming population increases systematically as we move up the scale of social strata. The frequencies of this "at some stage in one's lifetime" consumption of marihuana, base paste or cocaine gradually decrease from 21.11% at the "high" socio-economic level to 15.35% at the "middle-high" level and slightly, to 11.73% at the "low" socio-economic level.

The data reveal that lifetime prevalence for these illegal drugs crosses all socio-economic groups in the country's population, at the same time that they attack the belief that attributes the drugs problem to more underprivileged groups of the population.

- Type of drug consumed according to socio-economic level (1995)

In the case of **marihuana** consumption increases as we move up the scale of socio-economic level; from **21.11%** of the "**High**" to **10.09%** of the **"Low"**. In the case of **cocaine** the trend is similar, greater consumption percentages can be observed in the higher strata than in the lower, **3.24%** at the "**High**", level to **0.94%** at the "**Low**" level. With **base paste**, the following happens, the greatest percentages of consumption are observed in the "**Low**" and "**Middle-low**" groups with **3.16** and **2.26%** respectively, as against **2.11%** of the "**High**" level.

It is interesting to see that when we observe the prevalence of the last month prior to the survey; in other words, potentially addictive consumption, we find the greatest level of consumption in the "Low" level, followed by the "High" level, with all the middle levels of society appearing as those who develop the least problematic consumption. **"High" (3.16%)**, "Middle-high" (1.98%), "Middle" (2.44%), "Middle Low" (1.17%), **"Low" (4.48%)**.

- Lifetime prevalence of consumption of volatile solvents according to age groups. (1995)

Age groups	%
12-18	1.18
19-25	1.12
26-34	1.06
35-44	0.27
45-64	0.10
TOTAL	0.73

With respect to the prevalence of consumption of volatile solvents according to age, it can be observed that this is greater in the 12 to 18 years age group. This confirms other reports where the same trend is noted. Reiterating those mentioned previously, it seems necessary to tackle the problem of solvents consumption specifically amongst the child population, which includes age groups below those considered in the maximum consumption group. As regards their use and the relation between this and socio-economic level, we find that a greater percentage of consumption is reflected for the more underprivileged levels.

4.3. Uruguay

Uruguay presents the following characteristics that explain the economy and the consumption of illicit drugs on its territory.[74]

It possesses a relatively small consumption market due to the fact that its total population amounts to only 3,150,000 inhabitants.

[74] CEPAL. Rafael Bayce, Doctor in Sociology from the University of Chicago, professor at the Universidad de la República, Montevideo, Uruguay.

This resident population is not only small, but it also only grew by 7% between 1985 and 1996 (a little over 0.5% year on year)

In that resident population, relatively small and hardly growing, there are increasingly less people aged under 60 years and the ageing of the population pyramid is growing, as is the proportion of women in the population. Remember that in all national statistics on drugs consumption the elderly and female population show rates below the average.

The urban concentration of the population accounts for over 85% and the country's capital (Montevideo), brings together 42% of the same.

From 1985 to 1996 the travelling or visiting population increased by 210% as against 7% growth in the resident population (30 times greater).

These factors combine to make Uruguay a country which in drugs terms presents the following features:

It is more a country of transit than of trafficking and consumption of fine products, intermediate products, chemical “precursors” and raw materials. Recently the use of Uruguayan airports and ports seems to have added incentives as an alternative route (whether circumstantial or not) for the transit of illicit drugs in their final product form.

Dealing and end consumption involve the following substances: inhalants, marihuana and cocaine, a certain amount of hashish and lysergic acid (LSD) in small quantities in the Costa Sur region, and some “ecstasy”, in summer, on the East Coast.

In financial terms, rather than for financing crops, industrialisation and substance dealing, the country seems to be suitable for laundering money that comes from illicit activities related to drugs dealing.

In Uruguay there has been no detection of organised cartels, nor notorious Mafia types, nor clandestine armies, nor “narco-guerrillas”, nor “narco-

counterinsurgency", nor criminality linked to some phase of the substances cycle, nor linked to ethnic groups, races, religious or political groups.

According to Doctor Rafael Bayce, the country has a noticeable consumption of illicit drugs, although this is magnified and dramatised by the institutions.

All in all, the influence of the illicit drugs cycle is not basically a determining factor in the frequency and rates of mortality or accidents. "Narcotics" are the reason behind 0.42% of police interventions involving people (1994); 3.68% of those put on trial (1994), and approximately 5.5% of the prison population (1995). The consumption of illicit drugs is estimated to be 200 times less than that of alcohol and tobacco. Uruguay is the seventh highest ranking country in the world in the consumption of psychotropic substances under medical prescription and the fourth in consumption per capita of tranquillisers under prescription.

In synthesis, except due to phenomena linked to transit and money laundering, Uruguay does not present any severe expansion of illicit drugs, nor of their effects and consequences.

4.3.1. The prohibition and increase of consumption in Uruguay

According to Rafael Bayce, the special Law on narcotics that has been in force since 1974, becomes a reality in a police persecution with a certain judicial backing.

The first consequence that can be considered is the increase in consumption that can be expected. Prohibition, in many cases, works as an added attraction, especially amongst young people, teenagers and pre-teenagers. Rigid prohibition and persecution make illicit drugs and all that is criticised by child sociologists a possible object of desire. The magnificent stories on the danger, risks and death wrapped up in the social mythology on the subject, work as a further attraction in this leisure and pleasure seeking

romanticism that dominates the evaluation scenario of the urban consuming society of Uruguay.

This functioning is even clearer in the case of people isolated from levels of income, power, prestige and consumption, that culturally determine the objects of desire that people make theirs. Then, people increasingly feel their heteronomous nature and also perceive a growing gap between their realities and the possibility of achieving their personal ideals, and so seek other systems of values as frameworks of reference to build up their self-esteem. When they find themselves once more rejected inside the groups to which they belong, they build up their coexistence by moving away from those groups and their values, seeking new groups to belong to, and other role models.

Adherence to that which is banned, and to risk, thus acquires a prestige typical of alternative systems of values, a semantic code of reference, origin of alternative groups to which to belong, encouraging conversion of subculture in itself to counterculture, and a channel of individual and social mobility, within this internal micro-world as compared with the unreachable and hostile external macro-world.

Prohibition then, turns out to be an ideal form of articulation for the rebel spirit inherent in the childhood and teenage process of identity construction, within the westernised urban consumer society of Uruguay. “An effective contribution is made to this by all the publications on the value of the substances, the volume of seizures and cinema and television fiction about police fighting against consumers, traffickers, and distributors-sellers, in which the “bad guys” are presented in an epic and hedonistic way, surrounded by great luxury, pleasures and frenetic daily activity”.(R. Bayce, 1997)

Thus, the “war against drugs”, the “struggle against the scourge”, the objective of “eradication”, end up providing a sophisticated marketing tool

for drugs within the structure of the process of socialisation in today's urban centres that were immersed late into capitalism.

The probable increase in consumption, resulting from the boomerang effect of the struggle against the scourge, not only acts as an efficient marketing tool amongst urban pre-teen, teenage and young people, but it spreads to the rural worlds in exodus. It also reaches the adult population, as the consumerist and hedonist society inverts the attractions of different "ages", placing what is young, teenage and pre-teenage on a throne as an aesthetic ideal, with capacity for enjoyment and freedom of expression. It is no longer the young who want to be adults, but the exact opposite, adults want to be young. Actresses, models, musicians, show business personalities, current Uruguay top sports competitors, all aspire to reduce their age through the effect of role models.

From this reality we can deduce, it seems, that as long as illicit drugs are a fashion and a generational cultural symbol, as well as a channel for economic and social mobility, demand and supply are assured; and any attempts to repress them will be condemned to an increasingly expensive and explosive failure.

Bayce proposes that only pragmatic policies that minimise the harm caused by consumption and prohibition, with a strong progressive action that releases drugs from their stigmatisation, criminal characterisation, penalisation and therapeutic institutionalisation, can possibly reduce consumption and the harm caused by the same, and reduce the damage that is derived from prohibition in the form of police and judicial persecution.

For this author, the above has political repercussions:

The struggles against "scourges", which are known to be exaggerated, sterile and corrupt, end up legitimising the adoption of tougher legislative, judicial and police measures that violate human rights, constitutional guarantees and

civil rights (intimacy, privacy, freedom of speech, etc.), and that "exacerbate" social repression and control without providing solutions. From all this, the only beneficiaries are certain political ideologies, the professionals of those struggles, some elements from the cultural field who are full of prejudice, and many intermediaries.

These struggles constitute one of the mechanisms of "perverse re-legitimisation of the states and governments in late arrivals to capitalism", not reducing but rather increasing such epidemics as Aids, delinquency, youth and child crime, accidents and natural catastrophes, and warlike fascination as an aesthetic and "adrenaline-filled" show.

Corruption increases, as it does with all radical prohibition, but with aggravating circumstances: it reveals the hypocrisy and irrationality that lies behind these policies that corrode the "aura" of the world of politics.

The margins of political and cultural sovereignty are reduced in countries in the face of the prohibitionist model, which conditions loans and credits to a criterion of confrontation that magnifies problems and fails in its objectives.

They could be qualified, as stated by Alain Joxe, as disguised attempts of neo-imperial intervention, through which ghosts are built that cause low intensity conflicts to: legitimise "holy" interventions, exorcise own demand by attributing it to outside supply, and displacing persecution from the original laundering –from the places where demand is most abundant - towards the places of "secondary laundering" (Uruguay being one of these).

"Culturally, they reduce the level of rationality of the debate, converting a problem strictly of public policies and civil solidarity into an object of manipulation of ethical radicalism, and in a contribution to the confrontation between small psychotic groups and "saints", which are potentially lethal." (Bayce, 1997)

For this author, the prohibitionist model in force in Uruguay is turning out to be increasingly costly, ineffective and unfair, and the consequences of its application are devastating, with the cure turning out to be worse than the illness. For this reason, it is more necessary than ever to consider the substitution of this prohibitionist model, of a radical ethic, that penalises the drugs cycle, and that constitutes direct imperialist intervention.

"Alternative formulas exist such as those attempted in Spain, in some North American states, in cities such as Liverpool, Amsterdam and Zurich, and currently in Germany" (Bayce, 1997).

4.4. Venezuela

For the Brigadier General of the Anti-drugs Command of the National Guard, Orangel Oliveros, Venezuela is currently affected by drugs in many areas, not just in consumption,. Due to its strategic position, it is a bridging country, neighbour of the largest cocaine producer in the world and handy for money laundering. "When we see abandoned children and the fact that, in the hills, leisure is king, our immediate thought is that the population has a clear tendency towards vice and the organisations that traffic with drugs are perfectly aware of this, and they give children these substances so that they will become addicts and then they will be the ones to do whatever is necessary to pay for drugs and be able to consume them"[75]

4.4.1. Consumption

In the year 1998 the Drugs Free Venezuela Foundation reported an increase in drugs consumption amongst the younger population, children aged 11-12 years. All social strata are reflected, with one of the most highly consumed drugs being crack.

As regards trafficking and distribution, concern is oriented towards the influence on this that may originate from the country's precarious social and

economic situation, in that an important sector of the population may get involved in trafficking and distribution as an alternative for earning fast economic resources, which in any other way would be almost impossible to obtain.

4.4.2. Prevention

In the opinion of Evelyn Guiralt[76] (vice-president of the Drugs Free Venezuela Foundation), meetings are being encouraged in the country between Governmental and Non-Governmental organisations that work in this area, with the sole aim of reaching agreements that allow more integrated inter-sectorial work.

The result of these meetings has been the agreement reached in considering the comprehensive prevention focus as the best approach, understanding comprehensive as the development of specific and direct actions on determined problems, the promotion of the development of individual, family, educational, work and community alternatives.

For E. Guiralt, prevention must contemplate the launching of a set of strategies that generate positive conditions for personal development and harmonious social coexistence. This involves understanding the actions that must be developed on the level of each person, school, society, family and community, with the aim of creating the opportune skills. For this reason it is necessary to go beyond individual information and training strategies and to consider processes of social intervention.

The model of action most applied in recent years has been the community model, developing alternative social practices and creating valid and real actions oriented towards varying the factors that make possible the emergence and strengthening of a problem that weakens both the individual and society.

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[75] Gral. Hernández "www.cyberven.com/alianza/sumario.html

The Drugs Free Venezuela Foundation runs programmes that deal with family, community, educational and work spheres. Its objectives are to develop permanent, educational and simple programmes, to inform and prevent on the effects of drugs trafficking and consumption. The target population, would be those forming the work, educational, family and community spheres.

4.5. Colombia

From the 1990s onwards Colombia has been characterised by a diversified illegal economy, that is generated and made dynamic by the presence of the production, transformation and trafficking of coca, poppy and marihuana. Throughout the 1970s, Colombia was known worldwide as a marihuana producing and exporting country. At the end of that decade, and during the 1980s, the Colombian image moved towards the status of a cocaine processing country, and above all, a country that was headquarters to the main drugs trafficking organisations with export capacity to the consumer markets of the United States and Europe. During this period, the official figures on coca production in Colombia were between 16,000 and 35,000 hectares, which led the country to becoming the main importer of coca base from Bolivia and Peru, in order to satisfy a constantly growing international demand.

4.5.1. Changes within the world drugs circuit

Whilst the cocaine market in the United States experienced, towards the end of the 1980s, a saturation of supply that contributed to a reduction in prices, reaching 14,000 dollars per kilo in 1990, the European market reached, from that period onwards, and in the wholesale cocaine market, prices situated at between 50,000 and 60,000 dollars per kilo.

[76] "INTERCAMBIO" Ed. FAD. No. 3; p.20-21. December 1998.

"Throughout the current decade supply has been stimulated by the European market that has been significantly influencing the size of coca cultivation in Colombia. In turn, the trend in the reduction of prices in the United States are tending towards a reversion, with stable recovery that situate them on average at around 20,000 dollars per kilo" (Ricardo Vargas M[77]. 1998)

Towards September 1995, with the arrest of the leaders of the Cali drugs cartel in Colombia, the region of Alto Huallaga (Peru) suffered the worst fall in prices ever, given its high level of dependence on the traffickers of the capital of the Cauca Valley. This led to situations of famine in the area, which caused displacement of peasant farmers to other regions. Also, this fall in prices in Alto Huallaga led to the increase in prices of base coca in Colombia, which the low salaries and conditions of production in Peru had previously helped to keep down. In effect, since the end of 1995, the producer areas of Colombia experienced an increase in the price of coca base that was maintained until June 1996, when it had reached around 1200 dollars per kilo, whilst in 1995 it had been at an average price of 600 dollars per kilo.

In the case of Peruvian coca, on top of biological diseases there are the dissuasive effects on Colombian traffickers of the prohibitive measures implemented by the Peruvian government against the movement of aircraft along the Colombia-Peru border, with orders to shoot against unidentified aircraft.

One detail to be highlighted, is the appearance of a demand for heroin in the interior of the United States with characteristics that are different to those for intravenous consumption (heroin for smoking and inhaling). This generates a transformation in the rituals of consumption, which contributes to this drug circulating around channels typical of cocaine, influencing the consequential loss of the "perception of danger" traditionally linked to the syringe and possible transmission of HIV. This variant of consumption broke with the

[77] Researcher from the Centre for Research and Popular Education (CINEP), Bogotá, Colombia.

stabilisation of the number of heroin addicts, calculated at 500,000 for decades. Today heroin is one of the illegal drugs that is experiencing the greatest growth, in terms of internal demand. These characteristics of the new increase in heroin demand contributed to Colombian narcotraffickers having access to a portion of the North American opiates market. The increase in poppy cultivation in Colombia is related to this phenomenon.

4.5.2. Rural poverty: increase in illicit cultivation

The agricultural sector is in the midst of a severe crisis, which is expressed through a lack of new technologies, low yields of the main products, limited capacity for access to loans by rural farmers, and a heavy fall in coffee prices at the beginning of the 1990s.

In the opinion of Ricardo Vargas, these factors were aggravated by internationalisation policies regarding the economy, which generated low capacity and competence in the sector in the face of legal and illegal imports, all of which was translated into a great social insecurity reflected in an increase in absolute poverty in the countryside.

Rural poverty increased from 26 to 31 percent, between 1991 and 1992. The decrease in employment explains the intensification of rural poverty.

4.5.3. Social violence

A seriously violent situation is being experienced, both derived from the internal warring conflict and from social violence that reflects the levels of impunity in the country, which fluctuate between 97 and 99 percent. In the case of a single region, the Putumayo, social violence has reached figures of 425 violent deaths per hundred thousand inhabitants, compared with highly conflictive areas such as Urabá, which gives a figure of 350 per hundred thousand; Colombia itself as a whole represents a rate of 77 violent deaths in every hundred thousand, whilst countries such as France or Switzerland report a rate of 5 per hundred thousand.

It is also interesting to mention here, the silent restructuring of the Medellín group, which, according to R. Vargas, is today participating in the relative reduction of the Cali group's monopoly of the drugs trade, together with regional groups from the Atlantic coast, those from Santander, the centre of the country, the centre and north of the Cauca Valley, Huila-Tolina, the Eastern Plains and others. Mexican groups are also participating in this process of new re-accommodation, and are beginning to have an influence as importers of raw materials produced in Peru and Bolivia.

The relative loss of space by the Cali group has been accompanied by acts of violence against the families of the Rodríguez Orejuela traffickers, and against their allies, in what seems to have been a rebellion and emergence of new heads in the north of the Cauca Valley who are struggling for leadership in controlling the illegal drugs circuit.

4.5.4. Poppy Cultivation

The convergence of these internal and external phenomena has contributed to an unprecedented increase in poppy cultivation in Colombia, located in the Andean area (at a height of between 1800 and 3000 metres), which is seriously affecting the jungle areas where the main rivers are born. It is calculated that this affects an extension of land of between 15000 and 20000 hectares of this opioid.

4.5.5. Export capacity

Towards the United States market, 300 tonnes, with an average wholesale price of 20,000 dollars per kilo, giving an income of 6000 million dollars.

Towards the European market, 100 tonnes with an average wholesale price of 50,000 dollars per kilo, providing an income of 5000 million dollars.

Towards other markets (Africa, Asia), 50 tonnes with an average wholesale price of 35000 dollars per kilo, which gives an income of 1750 million dollars.

With respect to the heroin market, this refers basically to the demand in the United States, since there is not yet any realistic proof that Colombian heroin is being exported to Europe (which contrasts with the seizures made of opiates flows between different points of Asia and toward eastern and central Europe).

On a calculation of 15,000 hectares of poppies in Colombia, and taking into account that each hectare produces 6 kilos of latex, and acknowledging two harvests per year, we would have 12 kilos per hectare, which would produce 18,000 kilos per year. The relationship of conversion to heroin is calculated in 10 kilos of latex to produce one kilo of heroin, which generates a productive potential of 18 tonnes of heroin. The wholesale price of heroin is calculated in 50,000 dollars per kilo which would finally lead to an income of 900 million dollars.

Adding together income from cocaine, calculated at 12,750 million dollars per year, and income from heroin, at 900 million, there would be a movement of 13,650 million dollars. Finally, with the contribution of marihuana calculated at 250 million, we would reach a total of 13,900 million dollars, from which we must deduct costs of around 20 per cent (2,700 million dollars), which represents a net income of 11,200 million dollars. However, it is known that not all this sum returns to the Colombian economy, since this market can only allow for the return of sums whose calculation is not clearly established, and which in general is situated between 2,500 and 4, 000 million dollars.

4.5.6. Anti-drugs Commitments

The security forces have opted for a “war against drugs” strategy with its target being another scenario: the regions with illicit crops; in other words, the Amazonian region, especially Guaviare, Caquetá and Putumayo.

In the Colombian Amazon, the agrarian colonisation of the 1950s took place, as a result of the model of the *Latifundista* (large estate owner) which became consolidated with the violent expulsion of masses of rural peasants towards the forests of the South. Forgotten by the State and following continual failures in consolidating sustainable crops, the settlers found in coca the only profitable and easy-to-sell product in the region. From the 1990s onwards, the Colombian surface area dedicated to coca reaches figures that the inhabitants of these regions put at around 150,000 hectares, which leads to a calculation of 300,000 people directly depending on this economy.

At the same time, these areas have been under the control of the guerrillas, who receive important income through taxes imposed upon medium sized growers, on base cocaine intermediaries, on dealers and above all on crystallisation laboratories and on the clandestine cocaine loading strips. This money is used to strengthen their logistics and communications capacity for the war.

In this sense, the Army perceives the coca grower as a direct collaborator of the guerrilla. According to Vargas, the decision to focus the drugs struggle combating cultivation, based on the theory of the "narco-guerrilla", has resulted in a set of actions against the peasant farmers that inhabit these areas, with serious human rights violations (such as the burning down of homes and their violent expulsion from these territories, as has been happening in Guaviare since mid 1996).

These areas are targeted by decrees 900 and 717, which create "special zones" where the civil authorities are deprived of their constitutional attributions and the regions come under the control of the State security forces. This area has been the scenario of mobilisations of over 200,000 settlers and farmers since August 1996, due to the running down of rural workers and the decision to put a radical finish to the only product that allows surpluses of utilities to the settlers of the Amazonian region.

According to the same author, the Department of State itself acknowledged, in its report on human rights from 1996, that "in the resulting confrontations the government forces, in general, and obeying orders, did not employ deadly force. However, there were deaths between the demonstrators caused by the soldiers and some abuses were mentioned. Investigators sent by a consortium of NGOs attributed 13 deaths to the army, one to the police and four to the guerrilla. They immediately warned that the number of deaths could be greater" (Department of State, 1997).

4.5.7. Presidential programme of Colombia to tackle drugs consumption[78]

The Presidential Programme of Colombia to tackle drugs consumption, the name of which is "Rumbos" (*Directions*), was officially created on 26 October 1998. The programme seeks to give an answer to the concerns identified amongst citizens by the President of the Republic with regard to the growing consumption of drugs, which led them to considering this subject as a priority and to include it amongst the 10 essential points of the government programme.

4.5.8. Treatment

With respect to this question, a National Directory will be produced with all the remission centres, noting their characteristics: location, number of places, costs, etc. All institutions in the country that work in the area of treatment will be called upon to create networks. A telephone hotline will be made available to offer immediate counselling (a 9800 line).

According to reports by Augusto Pérez Gómez (Director of "Rumbos") The State will give support to treatment centres in terms of the number of places available, with the condition that they accept controls and implement evaluation and monitoring systems. The 50 most solid institutions will offer

[78] INTERCAMBIO. Nº4. Junio 1999.

permanent advice and information to parents whose children are consumers in order to help them tackle the situation. For this they will receive an annual payment. The users of this service will assess it constantly.

The Health Social Services and the Health Secretariats will assume the responsibility of assuring control over the functioning of the Institutions and will provide half-yearly reports on the "Rumbos" programme.

4.6. Bolivia

4.6.1. The coca economy in Bolivia

In Bolivia, coca is produced by small peasant farmers whose activity relies mainly upon the availability of the family work force, and who dedicate no more than half of their land to the production of the basic raw ingredients of cocaine. Most of these lands, if not all, are located in lands that were settled recently; in other words, in areas of expansion of the agricultural border. All these producers cultivate coca as part of a strategy of production and labour diversification which includes a large variety of products, especially food, such as rice, yucca (manioc), banana, avocado, pineapple and other varieties of fruits.

It is important to bear in mind that coca is just another product amongst several, in order to understand the logic of its production as part of a strategy of diversification, often resorted to by small-scale rural farmers.

4.6.2. Why do they produce coca?

In the opinion of Roberto Laserna[79] the first answer, which is immediate, is the most common answer: because it is more profitable, because the prices are high and allow for a high utility, greater than that of other agricultural products. This is only partially true, as shown by the fact that the fall in prices that occurred in recent years (of base paste) has not displaced the economic activity of the rural farmers towards other products. It has even

been observed that, in some cases, the reduction in the prices of coca was followed by an increased response in the productive effort. In effect, although some people did drop cultivation, many continued to produce coca and even increased the area covered by this crop. "This means that the rural farmers, when they grow coca, are not only searching for utilities or a marginal profit from that production, they are also searching for a certain regularity in their income flow" (R. Laserna, 1997).

What makes coca important as a source of a more or less stable flow of money, is firstly the fact that it is a permanent crop; in other words, once it is planted it can be made use of economically for at least ten to thirteen years. In agricultural terms it is, then, a very advantageous crop, since it requires a large initial effort, then it only requires maintenance of the crop and the periodical harvesting of the leaves.

Secondly, coca is a plant that is highly resistant to plagues; for this reason it requires much less care, for example than coffee or tea.

Thirdly, as the final biological product, which is the fruit, is not used, but rather an intermediate product, which are the leaves, the plant can be harvested several times a year (in some cases up to four times, although the normal frequency is between two and three times a year). Thus, this allows a farmer who manages his crop properly to harvest a little coca every month, every fifteen or twenty days, and thus maintain constant contact with the market.

As, in addition, the dry leaf is used, it is easier to conserve and to store than the majority of products that a farmer in a jungle area can grow. And as it has a high value in relation to its weight, it is also a very suitable produce in areas with a lack of infrastructures for access. In other words, it is much easier to carry one hundred Bolivian pesos worth of coca on your back than to carry one hundred pesos worth of oranges or pineapples. In fact, the latter

[79] LASERNA, R. "La grieta de las drogas: La economía de la coca en Bolivia (...)" (*The Drugs Crack: The coca economy in Bolivia*) U.N. New York, 1997.

would be impossible if they did not have a lorry, whilst for coca all that is needed is a bicycle or a person's own back.

Finally it is a product that has and has always had a relatively guaranteed market. It is evident that at this moment in time, such a market is strongly marked by the demand of drugs producers, but even before the coca boom- before the 1980s- it was already a highly valued product that was in demand.

4.6.3. Impacts of the coca economy

On a microeconomic level, it is enough to simply remember that this economy represents opportunities for income for the peasant farmers, who without coca would have a much more precarious and unstable footing with the market economy. Linked to the illegal phase of production and trafficking of the products derived from coca, it offers tempting opportunities to thousands of traders, carriers, crafts workers and unemployed people. However, due to the high level of uncertainty that surrounds these activities, they have not been able to sustain investments in the medium and long term, in such a way that their impact on economic growth is almost negligible.

On a macroeconomic scale, the production and export of illegal drugs allows the national economy to rely on an important flow of foreign exchange that is freely available; this, for the main part, finances imports; relieving the pressure of demand on the resources managed by the official system of exchange.

It must be admitted that, for Bolivia, the coca economy has been a lever for international negotiation, which has allowed it access to preferential treatment in some fields. In truth, it has been the only possibility that was available to the Bolivian governments to make themselves visible and to earn some importance in their relations with the United States and the European Union.

4.6.4. Impact of the anti-drugs struggle

The connection of the coca leaf economy, to the international cocaine circuit, has increased Bolivia's political vulnerability, placing governments in a position subject to manipulation and international pressures.

International narcotics fighting policies have also entered Bolivia, in a legislation that spreads judicial insecurity by placing in doubt, with the pretext of the struggle against drugs, fundamental citizen's rights. Suspicion has the strength of proof, and citizens live with the threat of having to demonstrate their innocence from the prisons which, as can be imagined, are chock full of prisoners without any sentence and who are quite frequently not guilty.

4.7. Nicaragua

During the last five years of the decade of the 1980s, the economic and social conditions of Nicaragua were characterised by the stagnation of economic activity, the negative growth of the gross national product, the vertiginous fall in real salaries, an increase in unemployment, a drop in productive capacity and consequently the dramatic growth of poverty.

The economic crisis and the erosion caused by the war had a generalised impact on the living conditions of the entire population, with the poorest sectors being those who have suffered with the greatest force the effects of the economic recession.

Nicaragua has, and will have until the start of the year 2000, a very young population structure, in other words, 40% or more of the population will be aged around 15 years. It is estimated that currently 46% of Nicaraguans are aged between 0 and 14 years of age and the average age of the population is 16 years.

In recent years there has been an increase in the number of children and youngsters (5 to 18 years) who are habitual drugs consumers. These groups show destructive conduct, both towards themselves and society, there being no viable alternatives that counter what has been mentioned above (there are no real policies or strategies aimed at this type of project). In theory, there is a legal framework for tackling the problem, but the reality is that the social situation does not allow the necessary resources to be destined in order to apply it.

In 1992 the National Assembly of the Republic of Nicaragua passed legislation on the subject of illicit activities related to the cultivation, supply, acquisition and export of narcotics, psychotropic and controlled substances.

The Ministry of Education indicates that within the academic curriculum, information should be included on risk factors and prevention in drugs and other social problems.

The Ministry of Health has general control over the different drugs that produce dependence and that are distributed in national territory.

In this context we find the intervention, in terms of prevention, of the FENIX Foundation (Nicaragua) and the FAD Foundation (Spain) with the following work:

Project[80]

Community development based on work in preventing drug addiction with the young population of the city of Managua.

Period of execution

Twenty-four months.

Description of the Project

[80] INTERCAMBIO. Ed. FAD. No. 2. June 1998.

Creation of a work team for the prevention of drug addiction to attend to the young population of Managua based on the extension of seven preventive programmes (six based on community intervention and one on school prevention), and in parallel, support to students in professional training that belong to marginal urban neighbourhoods through the setting up of a pilot programme of sustained development of micro-businesses.

The preventive work proposed is a result of the identification of risk factors for consumption, that give as a result a Community Development Project with special importance being attached to the component dedicated to the struggle against youth exclusion, based on the development of viable self-employment proposals.

The mission is made up of

Creation of a "Central Operation" to set up the functioning of the experiment, based on the infrastructure of the FENIX Foundation.

Location and preparation for preventive work, of resources for the participation platforms that exist in the six selected neighbourhoods.

Connection of preventive programmes with existing resources in matters of professional training, for the preventive preparation of teachers, and the creation of four pilot experiments of sustainable development micro-businesses, based on:

- Implementing professional qualifications and the management capacity of a group of two hundred students belonging to four professional families (carpentry, mechanics, commerce and computers).

- Selecting twenty students for the creation of four micro-companies, based on the concession of micro-credit grants, and supported with accompanying activities to ensure their viability.

In return a collaboration agreement will be signed between the beneficiaries and FENIX, for their participation in future training activities.

Strategic objectives

- Cooperate in the creation of preventive activities in Managua, based on the professional and institutional development of the FENIX Foundation.

- Make possible, from the start of the Project, the sustained development of the actions undertaken once external financing has been exhausted.

- Create a debate and reflection network to support and make viable the continuity of the action undertaken within the framework of the Project.

The expected result is the production of preventive information aimed at the young, marginal urban population of Managua, based on the use of the "neighbourhood association network", in connection with formal resources.

PREVENTION

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2. Materials
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PREVENTION

1. Conceptual Approach

According to Dr. Domingo Comas[81], the following are requirements for setting up any prevention programme for drug addiction: a) a specific budget, b) a group of professionals with a fair degree of experience, even if in general care, c) more or less established drugs education materials and d) a possible institutional or social sphere of action for which responsibility has been transferred to us, that has been abandoned, or for which the institutional bodies responsible have requested our services.

2. Materials

The materials normally used in most countries are, firstly informational materials, and secondly materials that combine theoretical and methodological education with information on drugs. The latter usually devote more space to "specific and well delimited practices" than to theoretical education.

It seems clear, in the light of the confusion regarding interventions in the field, methodology, results of sociological research oriented towards macro scenarios and evaluations made by university departments, that, "in such conditions *prevention of drug addiction* neither is nor can be a closed, definitive or finished methodology. On the contrary, it can only ever be a

research programme, one that is indisputably necessary, but that will always be recent, immature and offer few results for comparison" (Domingo Comas, 1998).

In the light of these affirmations, action for prevention means accepting that one is forming part of a search process, of the construction of a theory and of an explanation that has not yet been found.

In practice, we use the term drug abuse prevention programmes in reference to numerous actions, many implemented by professionals with public support "who prefer to yield to the operative demands and indications of those in charge of the institutions, overlooking the fact that they are working in the Drug Abuse Prevention research programme" (Comas, 1998).

In this author's opinion, such ignorance acquires special importance when the programme's objectives include social revitalisation, the development of social networks and the launching of community initiatives, which so badly need both the presence of a professional to design, organise, incite, coordinate and evaluate, and the effective participation of groups of citizens who, having received adequate training, will act with a large degree of independence within the programme.

3. Basic characteristics of Prevention

In the opinion of the experts and researchers from the Fundación de Ayuda contra la Drogadicción (Foundation for Aid against Drug Addiction - FAD), Prevention should offer at least some of the following characteristics:

- It must be alive: and in step with changes in the social context.

[81] COMAS, D., doctor in Political Sciences and Sociology from the Universidad Complutense in Madrid, is President of the Interdisciplinary Group on Drugs (GID) and Secretary of the European Association of Professionals Working with Drug Abuse (ITACA).

- It must be continual: and not be based on isolated actions.

- It must be comprehensive: involving different social groups and agents.

- It must have a technical basis: and not involve arbitrary actions.

- **It must be able to be evaluated:** to check its effectiveness and scope.

4. Operational definition of terms

With the objective of achieving a certain degree of standardisation and without any claim to offer absolutely agreed definitions, we offer below a list of terms that frequently appear when dealing with Drug Abuse Prevention.

The terms are listed in alphabetical order.

Activity organisers: people who act as mediators for a programme, facilitating participation by the target group through social or recreational activities.

Centre in charge: Institution, organisation, or public or private centre, charged with implementing the programme.

Drugs consumers: people who repeatedly self-administer psychoactive substances.

Experimental drugs consumers: people who use one or several psychoactive substances in a first phase of consumption. The term sometimes refers to people displaying infrequent or non-persistent consumption.

Detoxification: A therapeutic procedure designed to eliminate psychoactive substances or their metabolites from the drug addict's body and to control withdrawal symptoms.

Evaluation: Scientific and systematic gathering, processing and analysis of data relating to the implementation of the programme, in order to evaluate its effectiveness and efficiency.

Evaluation of the programme planning: This is the phase of planning and design. The evaluation in this phase begins, at the latest, once the idea of beginning the intervention has been specified. This is the moment when objectives and methods are selected. The evaluation of programme planning reflects the process of definition of the problem, the need for intervention, the target population and objectives. It also includes the evaluation of resources available and ends with the decision on planning for forthcoming evaluations.

Process evaluation (formative): evaluates the implementation of the intervention and its effects on the different participants. Questions asked include where and how the intervention took place, if it was implemented in accordance with its design, and whether it reached the target group. Process evaluation helps to explain the results and improve future interventions.

Summary Evaluation (results and impact): evaluation of the programme's final results in relation to the established objectives. Includes the description of the sample, of the time period measured, of the methods and tools used, as well as the results and a discussion of the evaluation.

Protection factors: those factors that reduce the possibility of drugs being used.

Risk factors: those factors that increase the possibility of drugs being used.

Self-help Group: a group of people affected by the drugs problem who organise themselves in order to provide mutual support and to be better informed on subjects related to drugs (groups of former addicts, associations of family members, ex-alcoholics, etc.).

Strategic target group / agents of change: the intermediary population used to reach the final target group and therefore achieve the general objective.

Target group/ population: the population in which it is aimed to achieve the change(s) defined in the general objective.

Evaluation indicators: measurable elements related with the objectives and expressed in numbers that allow control of the evaluation of the changes expected in relation with the initial situation.

Insertion or reinsertion: activities designed to incorporate former drug addicts into the social and jobs network, in order to ensure that they may live their lives within a social network, in a psychologically stable way and support themselves financially.

Evaluation tools: technical resources and specific instruments used to carry out the evaluation.

Intervention in early childhood: actions aimed at promoting healthy lifestyles in the family or school (nursery), increasing the child's emotional and physical health as an early way of preventing drugs consumption.

Evaluation methods: methodology / focus used in the evaluation process. Includes both quantitative and qualitative methods.

Specific objective: intermediary results necessary for achieving the general objective.

General objective: final results related with the solution or modification of the established problem or situation. Its definition must include a brief description of the change expected, a quantified measurement of the result in relation to the population and an estimate of the moment in which it is expected that the change will occur.

Organisations involved: Institutions, organisations or centres that support or cooperate in any way in the programme's development, financing, implementation or evaluation.

Contact person, department or service: reference person who can provide information on programmes or activities.

People involved: individuals who work in implementing the programme and belong to the team of professionals or the voluntary sector.

Basic principles: the theoretical concepts that guide the choice of methodology to achieve the programme objectives. These are examples in the theoretical framework: lifestyle models, alternatives models, drugs substitution models, behavioural models, social learning theory, etc. The strategies chosen may originate from pre-existing models or be completely new. If so, a brief explanation of the hypothesis underlying the focus will be needed.

Programme

Set of coordinated activities for which resources are available. A programme tries to cover general objectives related to drugs.

Community Programme: activities carried out at community level that encourage participation by community representatives or institutions (schools, youth centres, neighbourhood community associations, etc.) in order to work on the immediate environment of those concerned and facilitate active participation in the social setting.

Justice system programme: any activity aimed at drugs consumers with some type of relationship with the Justice System, for example when arrested, when appearing in court, when in prison, or when released from prison.

Harm reduction/minimisation programme: any activity aimed at stopping harmful consumption practices, or reducing the social and health problems related with drugs, or death. Its objective is not for the consumer to achieve total abstinence or reintegration.

School programme: a coordinated set of activities and resources designed for schoolchildren. Often, prevention of drugs consumption is part of the curricular health education programme. Characteristic features of this type of programme are specific materials for teachers, teacher training regarding drugs and the reorganisation of the school's daily programme encouraging active participation of pupils and parents.

Extra-curricular youth programme: activities aimed at young people outside the school setting, ranging from leisure time activities to specific work with those who drop out of the school system (cultural events, video productions, peer group activities, sporting events, etc.)

Opiates substitution or maintenance programmes: coordinated activities and resources aimed at helping drugs consumers to use alternative drugs, generally methadone, under medical supervision in such a way as to produce less harm both socially and to health, reducing the risk of HIV infection. The substitution of drugs may be prescribed as part of a short or medium term treatment with the objective of abstinence or of maintenance in the long term.

Evaluation Resources: human and financial resources used for evaluation.

Low threshold services: services that aid drug addicts with their daily needs, avoiding greater deterioration. Such services do not require a high degree of motivation on the part of the drugs user, and offer basic attention such as shelter, hygiene and food. Their goal is to establish or re-establish

social relationships and maintain contact with hidden groups of drugs users (outreach services or units, emergency drop-in centres, etc).

General health service: assistance in controlling the health consequences of drugs consumption which mean that greater medical care is required than for the normal needs of the corresponding age group in the general population (public health focuses, training for doctors, etc.).

Initial situation: description of the situation before beginning the implementation of an action or programme in terms of the different variables of the population related to drugs, and the socio-economic and demographic situation. It also includes the availability of data and their sources, social perception and the public debate regarding the situation.

Helpline: telephone services with an extended timetable that provide information on drugs, as well as information or counselling on prevention and treatment centres for parents, teachers, young people and drugs users.

Outreach work: activities at community level that aim to make contact with people who do not attend the existing therapeutic services. A key element for this type of orientation is active contact with risk groups in an atmosphere where they feel at ease, maintaining a close relationship with them instead of waiting for them to go to the centres. This focus includes preventive action for healthcare and advice for drugs consumers not in treatment.

Outpatient treatment: a broad and flexible set of services of care and treatment for drug addicts and their families in the social environment in which they live. It includes psychosocial aid, intervention in crisis situations and social and educational support given by professionals.

Residential Treatment: care and treatment services for drug addicts in a clinical environment where patients remain 24 hours a day, receiving multidisciplinary treatment within the mental health care system, in general or specialised hospitals, or in therapeutic communities.

5. Some answers

- ¿What is the etiology behind drugs consumption?

There is no single cause. Otherwise giving up drugs wouldn't be so difficult. Those who aim to simplify this put forward intransigent proposals and consider themselves carriers of a kind of infallible *magic wand* that will do away with drugs. Those who are more prudent cannot avoid admitting their difficulty in answering this question.

In brief synthesis, the causes behind drugs consumption would be the following:

Genetic:

1. Family history of substance abuse. 2. Neurobiological disorders.

Psychological:

1. Personality. 2. Conditioned reflexes.

Environmental:

1. Drug addiction-prone family structure. 2. Social exclusion. 3. Lack of information on the subject. 4. Availability of drugs. 5. Unemployment (non-marginal)

- Do all those people who try drugs become addicts?

No; drugs will cause devastation only amongst those people with a certain degree of vulnerability (predisposition). That said, any person who tries drugs is running a large risk.

Notable personality factors that most facilitate addiction include: psychological immaturity, insecurity, emotional instability, introversion and shyness.

Abusive consumption of drugs is also facilitated by the presence of some mental illnesses such as anxiety, depression, psychosis, and impulse control disorders.

- Is drug addiction an illness?

All the national and supranational organisations, including the World Health Organisation, consider drug addicts as people who are ill, both in terms of their rights and their responsibilities.

It is also true that they are patients of a peculiar type, different, with certain nuances that are sometimes difficult to understand, above all for those who have never had any experienced drug addiction themselves or in their family.

"Drug addicts are a very difficult type of patient to manage, uncomfortable, manipulative and aggressive, even for the very doctors who want help them. But it is important to have clear ideas and avoid any ambiguities. The drug addict is, above all, a person who is ill and in need of help and understanding" (J. Cabrera Forneiro[82], 1999)

- Are designer drugs something new?

Not at all, the majority are old substances that have long been used in medicine. What is new is the way in which their molecules are altered, in order to achieve variations in their initial effects, or strengthen those that they already had (a la carte drugs).

Nearly all designer drugs are stimulants derived from amphetamines, made in simple laboratories. Thus we have the popular Ecstasy (methylenedioxymethamphetamine), the first European seizure of which took place on the island of Ibiza, the no less famous Love Drug

[82] Doctor of Medicine and Surgery from the Universidad Complutense of Madrid. Managing Director of the Anti-drugs Agency of the Community of Madrid and Spanish representative at the European Drugs Observatory in Lisbon, and also member of the Technical Committee of the Spanish Drugs Observatory.

(methylenedioxyamphetamine) and the equally well-known Eva (methylenedioxyethylamphetamine).

The main social and health problems being caused by these drugs are, firstly, the mistaken belief that they are not very dangerous drugs, and secondly, the legal difficulty in persecuting them, as the slightest modification of their molecules leaves the substance legally undefined and thus the trafficker enjoys impunity.

The majority of designer drugs are derived from substances that have existed in medicine for a long time, derivatives of amphetamine, of Fentanyl, of Pethidine, of Arylhexylamines and of Methaqualone.

6. Prevention in Western Europe

School continues to be the main setting for prevention activities and is probably one of the best ways for reaching most children. Teacher training and parent participation are crucial and are being promoted in the entire EU, although the family's role, and especially that of parents, varies.

6.1. Drugs consumption amongst school pupils

The majority of EU member States have carried out national surveys in schools in recent years, some as part of the *European School Project on Alcohol and Drugs Consumption* (ESPAD).

In most EU member states, cannabis is the most widely consumed illegal substance. Consumption by adolescents aged between 15 and 16 years ranges between approximately 5% (Portugal and Finland) and 40% (Ireland and the United Kingdom).

Generally, solvents are the second most common substance consumed amongst young people aged between 15 and 16 years of age, and the number

varies between 3-4% (Belgian Flemish Community, Spain and Luxembourg) and 20% (United Kingdom). In Greece and Sweden, solvent consumption is higher than that of cannabis.

The consumption of amphetamines varies between 1 and 13% of teenagers aged between 15 and 16 years (2-8% in most cases), ecstasy between 1 and 9% and LSD and other hallucinogens between 1 and 10% (2-5% in the majority of cases). Ireland, the Netherlands and the United Kingdom show comparatively higher figures for consumption of amphetamines, hallucinogens and ecstasy than other countries.

Between 1 and 3% of students have consumed cocaine and less than 1% have consumed heroin, although the percentage rises to 2% in Denmark, Ireland, Italy and the United Kingdom.

In general, in recent years the upwards trend in cannabis consumption amongst young people has continued, and the same goes for amphetamines and ecstasy, although with lower levels. In Finland and the United Kingdom, however, cannabis consumption has stabilised.

6.2. European Policy in Drugs Prevention

The European Plan for the Fight against Drugs that the European Communities Commission has sent to the European Council for the 2000-2004 period, includes an abundance of material aimed at promoting and coordinating the work that Member States carry out related to the prevention of drug abuse.

The Plan, in accordance with the information gathered in order to produce it, establishes two constants regarding the current situation in terms of demand reduction:

A general trend is observed towards **diversification** in the field of prevention, with a call for a strategy on two levels: a great effort in health

promotion and health education aimed at the general public, and specific actions aimed at vulnerable and risk groups.

Help for drugs users in Europe is increasingly taking the form of differentiated services oriented towards the individual, seeking simultaneous coordination with existing services and the improvement of cooperation structures.

In terms of **prevention**, a trend is observed towards running education programmes at an early stage, as a way of introducing dissuasive factors for the later consumption of drugs.

Although no evaluation exists on campaigns in the **mass media**, certain signs indicate that they may have an effect in increasing awareness.

The **Internet** is increasingly used to provide information. In this respect, the EU must play a crucial role in providing services on the net to programmes and players working in the field of experience exchange and evaluation.

In early intervention and risk groups, the Plan votes to continue with the determined efforts to alert young people to the risks of ecstasy and other associated substances.

Prevention of contagious diseases: The important preventive measures applied in this field have had a strong influence in terms of a reduction in the appearance of new HIV/AIDS cases, but not on new cases of Hepatitis C, which have increased at an alarming rate.

As regards the information that is published by the **European Drugs and Addictions Observatory** (EDO) in its 1999 Report, we find the nature of the aforementioned Plan ratified. Preventing drugs consumption is a matter that has been given priority in the EU work programme, and it receives impetus, year after year, at the meeting known as **European Drug Abuse Prevention Week**.

In the 1998 event, the last on which information was available at the time of writing this Report, the main objective was to reinforce cooperation at European level in the health aspects of the drug consumption phenomenon, to underline long-term prevention activities in the member States and raise public awareness regarding the problem.

The 1998 Week was the first organised and held within the context of the EU Action Programme for the Prevention of Drug Addiction (1996-2000).

- Some strategies designed during The Week

A community-wide campaign "*Talking is the first step*", underlined the importance of dialogue in the prevention of drugs consumption. The campaign was directed at adults in constant contact with young people, including parents, teachers, social and educational monitors, instructors and sports coaches.

The **media** campaign consisted of a television advertisement in 18 languages, a radio advertisement in 6 languages, a poster presented in 19 language versions, a prospectus in 13 languages, a press advertisement in 12 languages and a press release in 18 languages.

As regards its effects on an **economic level**, more than 1000 initiatives were launched in the EU by member states, as well as on a national, regional and local scale, with a contribution by the Commission of 950,000 Euros.

Some member States identified new target groups in the community prevention texts, such as ethnic minorities and young children. For example, in Austria, during the "Summer '98 Sessions", Austrian, German and Hungarian experts examined a series of possibilities for prevention of drugs consumption amongst children aged between three to six years, and the Prevention Information Centre in Vienna organised a conference on drugs prevention programmes in nurseries.

Each State rose to the challenge by strengthening cooperation and the interdisciplinary focus in different ways. For example, the Netherlands created a national steering committee, made up of Government and NGO representatives, responsible for the prevention of drugs consumption and for producing and applying national programmes in accordance with European Community Directives. Other Member State initiatives tried to highlight to a greater extent drugs prevention efforts by addressing those working with young people, those structures already active in drugs prevention and the public in general, promoting cooperation between these three.

- Monitoring

The EU action programme for the prevention of drug addiction (1996-2000), is evaluated in a global manner with the support of the "Association of Schools of Public Health in the European Region" (ASPHER).

The evaluation methodology is designed to ensure that the member States report on the Week in a coordinated way. For this, the Commission supplied all the *national coordinators* with an information questionnaire produced by the OEDT for the exchange of opinions on the information system relating to the actions on drug demand reduction (EDDRA).

6.3. The role of the EU in Public Health: the Maastricht Treaty

The role of the European Community in the public health sphere has increased in importance over time, especially since the ratification of the Maastricht Treaty, which gave the Community a specific role in promoting the healthcare and the prevention of illness. To comply with this task, eight different programmes relating to health matters were created, and other activities have also been organised, ranging from programmes against cancer, AIDS and the fight against drug addiction to the production of reports on the health status of the European Union and of recommendations on blood safety.

- Legal Basis

Until the Maastricht Treaty and its new stipulations on public health matters, the Community had not had the opportunity of developing a coherent strategy in this area. **Letter o) of article 3** puts the new objective of contributing towards the "achievement of a high level of health protection" in the hands of the Community and it is applied to all community policies. Thus, then, **Article 129 of the Treaty** establishes a new framework for public health activities in order to achieve this objective.

The main stipulations of this Article are as follows:

The Community will contribute towards achieving a high level of protection of human health (...)

Community action in health protection matters will be aimed at illness prevention.

Community activities in the public health sphere will focus, especially, on *more serious and widespread illnesses, including drug addiction*.

- The development of Community public health activities since Maastricht.

Action programmes

On the basis of the analysis carried out in its 1993 Communiqué, the Commission proposed the running of eight public health action programmes. Of these, five have been adopted. Action programmes on AIDS and other transmitted diseases, cancer, drug addiction and health promotion have been developed since 1996. The Fifth Programme on health surveillance was adopted in June 1997. **The Programme on the prevention of Drug Addiction is linked to other political and legislative measures, including the creation of the European Drugs and Drug Addiction Observatory.** The member States have approved a coordinated focus to fight against

supply and demand of drugs, which has resulted in the European Union action plan on anti-drugs matters (the current one, already published, is for the period 2000-2004).

7. Prevention in North America

7.1. Canada

The Office of Alcohol, Drugs, and Dependency Issues, attached to the Minister of Public Works and Government Services, reports that Prevention in Canada is based on protecting and training *minors* to protect their own health, as this strategy is seen to be the key to ensuring that minors manage to lead a drugs free life.

Within the enormous range of interventions, we can highlight some as initiatives that contribute valuable information for parents who have to approach the problem of drugs consumption with young children; they are advised on how to talk with their children about this subject.

Other initiatives are oriented towards parents who have themselves had problems with alcohol or other drugs, encouraging them to promote prevention with their children, as these are considered to be a risk group. These programmes find their extension and numerous ramifications towards maximum risk groups through socio-economic characteristics.

There is also promotion of programmes run by the government, non-governmental organisations and the private sector (including the alcoholic drinks industry itself) to raise awareness amongst young people of the enormous problems that can be caused by alcohol abuse and the potentially lethal effects of driving under the influence of psychoactive substances.

Other initiatives, in thousands of schools, are aimed at raising awareness amongst young people who begin to show promise in the world of sport,

regarding the problems that arise with the use of substances to improve their physical capacity, i.e. “anti-doping” campaigns.

HIV transmission amongst young injectors is another great concern for the prevention strategy of Canadian drug addiction professionals, as they report on a continued and alarming growth in transmission of the virus amongst young intravenous drugs users.

We also find numerous preventive activities in the prisons sector, above all aimed at harm reduction and preventing HIV transmission.

Of course we also find the traditional prevention campaigns in the mass media.

7.2. United States

The National Institute on Drug Abuse (NIDA), based on two decades of research into drug abuse, has identified important principles for prevention programmes in the family, school and community. These principles have been tested in programmes for long-term drug abuse prevention programmes and have been found to be effective.

7.2.1. Prevention research teachings

- Prevention programmes should be designed to improve protection factors and reverse or reduce known risk factors. Prevention factors are those that reduce the possibility of drugs being used. Risk factors are those that increase the possibility of drugs being used.

- Protection factors include strong and positive bonds within a prosocial family: parents keeping a watchful eye, clear rules of conduct constantly applied within the family, parental participation in the lives of their children; success at school; strong links with prosocial institutions such as school and religious organisations and adoption of the conventional norms on drugs abuse.

- Risk factors include chaotic home atmospheres, especially those where there is substance abuse by parents or they suffer from mental illness; ineffective child-raising, especially with children with a difficult temperament or behavioural disorders; a lack of mutual fondness and affection; timid or aggressive non-suitable behaviour at school; failure at school; insufficient practical knowledge to face society; affiliation with fellow students who have gone astray or who display deviant behaviour; and perception that within the family, work, school, colleagues and community settings, behaviour related to drugs use is met with approval.

- Prevention programmes may be oriented towards a variety of drugs that can be abused, such as tobacco, alcohol, inhalants or marihuana, or they may be oriented towards a single aspect of drug abuse, such as the misuse use of medications sold with or without a prescription.

- Prevention programmes should include the development of life skills and techniques for resisting drugs when they are offered, reinforcing personal attitudes and commitments against drugs use, and increasing social ability (i.e. in communication, relations with peers, personal effectiveness and self-assertion).

- Prevention programmes for children and teenagers should include interactive methods that are adapted to the subject's age, such as discussion groups between classmates and group problem solving and decision making, instead of offering purely instructional teaching techniques.

- Prevention programmes should include components where parents or people caring for children reinforce what the children are learning on drugs and their harmful effects, and open opportunities to hold family discussions on the use of legal and illegal substances and the family's position regarding their use.

7.2.2. Prevention Strategies: long-term programmes

According to research by NIDA, prevention programmes should be long-term (throughout the entire school career), with repeated interventions to reinforce the original preventive goals. For example, school activities oriented towards middle and primary school students should include support sessions to help with the critical transition from middle school to secondary school.

7.2.3. Total Prevention

- Family-based prevention activities have a greater impact than strategies aimed only at parents or only at children.

- Community programmes that include media campaigns and modification of policies, such as new regulations restricting access to alcohol, tobacco and other drugs, are more effective when accompanied by school and family interventions.

- Community programmes need to reinforce norms against drugs use in all drugs prevention atmospheres, such as the family, school, work and the community.

- Schools offer the opportunity to reach all populations and in addition, they serve as an important environment for specific sub-populations that run the risk of falling into drugs abuse, such as children with behaviour problems or with learning difficulties and all those who could possibly drop out of school.

- The prevention programme should be adapted to attend to the specific nature of the drug abuse problem in the local community.

- The higher the risk level of the target population, the more intense the prevention effort must be and the earlier it needs to start.

- Prevention programmes must be oriented towards specific age groups and be appropriate for their stage of development and sensitive to cultural differences.

7.2.4. Prevention: effectiveness and social savings

Effective prevention programmes are cost effective. For each $1 spent on drug abuse prevention, the community may save $4 or $5 on the cost that would be involved in psychological counselling and treatment against drugs abuse.

7.2.5. Designing Prevention programmes

Critical aspects that should be taken into account when designing a prevention programme:

Family relationships

Prevention programmes can teach parents of small children techniques that aid improved communication between family members, in maintaining better discipline and in making firm and permanent rules. Research also shows how parents need to take a more active role in the life of their children, including talking with them about drugs, keeping a watchful eye on their activities, knowing their friends and understanding their personal problems and concerns.

Relations with the peer group

Prevention programmes focus on the relationship of an individual with his or her peer group. These programmes develop ideal social practical skills, that imply better communication, strengthening positive relationships with peers, intensification of positive social behaviour, and resistance techniques for refusing offers of drugs.

The school environment

Prevention programmes are also centred on the improvement of academic achievements and reinforcing the bond between student and school, giving them a sense of identity and achievement and reducing the possibility of

them dropping out. The majority of study programmes include support for positive relations with fellow students and an element of normative education designed to correct the mistaken idea that the majority of students use drugs. Research has also found out that children try not to start using drugs when they understand their negative effects (physical, psychological and social) and when they perceive that their parents and friends do not approve of drugs use.

The community environment

On a community level, prevention programmes function with civic, religious, judicial, police and governmental organisations. These programmes are designed to underline anti-drugs norms and prosocial behaviour via modifications of policies or regulations, activities in the media and community awareness-raising programmes. Community programmes could include new laws and their application, advertising restrictions and drugs-free school areas; all of which are designed to provide a cleaner, safer, drugs-free environment.

8. Prevention in Latin America

Due to the cultural differences between the countries that form Central and South America, we find it appropriate to tackle the subject of Prevention from the "Prevention according to population type" perspective, basing ourselves on the Prevention slogan: "*each social context requires understanding of the problem and creation of solutions".* This means that, beyond the images mainly published by the media, it is necessary to identify and make explicit, from individual, family and group subjectivity, all those elements that allow us to understand the individual meanings in relation with drugs, so that in this way, we can throw light on the relationships that exists between a number of events.

This type of approach to the reality of each group involves researching, in other words, observing, putting forward hypotheses, checking, comparing.

From this perspective, each group, based on the construction and understanding of its problem, makes possible the construction of a suitable and coherent type of prevention.

Although there are principles, components or even prevention strategies that can be common to different groups or communities, particular elements exist that define different types of prevention beyond the classifications made from the Public Health or other Social Organisations.

From this viewpoint we consider it opportune to show the work done in Prevention in Latin America, as a set of specific programmes that are carried out in the different countries making up the region, contributing a clear idea of what is being done in this sub-continent.

8.1. Ibero-American Meeting

Before beginning with the sample of programmes we believe it is necessary to highlight the **IBERO-AMERICAN MEETING**[83] that took place from 1 to 5 February 1999 at the **Fundación de Ayuda contra la Drogadicción** (Aid against Drug Addiction Foundation - FAD), attended by representatives of 11 NGOs that work in the prevention of drug addiction in the different countries of Latin America (Colombia, Peru, Bolivia, Nicaragua, Venezuela and Ecuador), as well as prevention experts from the FAD.

8.1.1. Educational Sphere

It was established that school enjoys a privileged environment for carrying out preventive action, as it offers the following advantages:

[83] "INTERCAMBIO" Ed. FAD. No. 4, June 1999.

- Children and teenagers are at an age where they are forming values, attitudes and habits for their personal and social development.

- It allows training and information on the drugs phenomenon to be given in a way that is structured, systematic and suitable for each age group.

- It can offer an action that is intentional, specific and planned with the possibility of evaluation and continuity over time.

- Not only can one work with students, but also together with teachers and parents towards a common objective.

In summary, some of the basic aspects in relation to the distinguishing features of the shared model were highlighted:

- The professional in charge of prevention within the school environment should be the same person that is responsible for the rest of the daily tasks.

- To work in prevention in the school environment, specific spaces are not required, but rather this is a task that crosses the entire school curriculum and should impregnate general educational activity.

- For school prevention to be effective, it needs a written programme to be produced according to each centre's individual characteristics.

- The programme should include educational and informative actions, and alternative proposals for leisure and free time, with the link being the identification of protection factors.

- Prevention in the school environment has to be understood as being part of the preventive actions of a community.

- Teacher training

All participants agree that there are a series of steps prior to the implementation of training processes which, if not contemplated, may have a

negative influence on the final results or make prevention actions that are to be run later unfeasible. These steps include:

- Being aware of the profile of the teacher group and whether teachers are able and willing to devote time to the subject.

- Raising awareness and involving the management teams of schools.

- Involving governmental organisations in the work carried out, in order to add visibility and more impetus to the action.

8.1.2. Programmes Management

It was highlighted that prevention of drugs use is linked to the concept of social management, understood as an ordering of the different living and healthy forces of society. In this sense, actions should consider the participation of the target group in the design of actions, as well as the real possibilities of a future snowball effect. Within this conceptualisation, both interdisciplinary action and a shared vision is vital.

In turn, it was highlighted that, taking into account as a starting point social management, the management of programmes will have to bear in mind aspects related with modernity and globalisation, but always take into account the particular singularity imposed by cultural identity.

- Community environment

- It was agreed that currently it is difficult to find a profile of a **social mediator** that moulds itself, without major training requirements, to the different programmes of a social nature that are launched in each community. In connection with this idea, the importance of the social mediator getting involved in projects from their birth was pointed out as important for favouring a change in knowledge and attitude when the time comes to tackle the new problems that will be found when the social mediator carries out his or her task.

There was also discussion regarding the need to contact with and train "community leaders" for preventive work as, in a difficult environment, it seems that the training of members of the community itself in order to tackle prevention challenges from within is an appropriate strategy.

To improve achievement of programme objectives, a process of monitoring and refresher activities is established as necessary in order to ensure that the mediator has adapted correctly to his task, and thus to give a response to the needs for which the mediator was trained.

8.1.3. Promotion with associations

It was established that it was necessary to see the problem from a structural focus, contemplating support actions, designed to maintain communication channels open and to maintain an active presence throughout the entire running of those preventive projects launched.

It was highlighted that development has to be both collective and individual, that action must be taken in the social sphere in line with a **total prevention** focus, and that community mobilisation has to be a **process that extends into the long term** over time, with the main concern being to find a methodological proposal that is suitable for each different real situation and that will encourage participation of the target group.

- Structural framework

The analysis concentrated on the need to coordinate social practices already set up by NGOs from outside the drugs sector and that, although in appearance they could be considered as bearing no relationship to the consumption problem, in their final aim, they do bear relation and respond perfectly to the model of intervention proposed. In this sense, the need to use a preventive focus to train monitors who work in such institutions and who can involve the subject of prevention in a transversal way, in their current work.

The **basic action principles**, as regards **work with associations**, are proposed based on:

- First of all, taking into account that each locality has its own characteristics, therefore the actions have to be adapted to the peculiarities of the community in question.

- Secondly, the importance of working with local resources, because, if people from the community get involved in the project, they will see it as something that is of their own creation, where they have invested great effort and they will then have more interest in it making progress.

- In third place, making use of human resources with basic skills to resolve local problems, as this has a synergetic value of importance for the community.

- In fourth place, creating strategic alliances on a local level with bodies that already exist, such as schools, official bodies, neighbourhood associations, etc...

- Finally, being aware that community intervention is a process that develops over time and becomes long term, it is not a short-lived happening or event.

8.1.4. Child workers from and on the street

This population group has a singular set of problems that require special consideration, with great importance attached to aspects such as child labour and child abuse.

It was pointed out that the consumption of inhalants and alcohol by children is one of the negative consequences of working on the streets, with the causes of this problem being the tough conditions, whether physical (cold, hunger) or social (social exclusion, poverty) which children try to evade by using these substances.

Consideration was given to the role of schools, which are often a long way from an integration philosophy, with reactions to the problem being suspension or expulsion in cases where drugs use is detected.

Three objectives concerning work with street children were established, consisting of:

- Reducing the risk situation of street children and teenagers, but at the same time being aware that the risks of living on the street are always going to exist and that these children are alive thanks to the street.

- Improving the model of socialisation of the children, both from the viewpoint of society and that of the child in question.

- Favouring the community integration of these children and adolescents taking their families as a starting point, even when one is aware that they are usually families with problems, therefore there is a requirement for creating community spaces that facilitate integration.

- Community violence

This is a real situation with a strong presence in families in difficult circumstances, with special virulence in urban-marginal environments, and a multiplying effect that feeds back into the same society that generated it, causing a perverse vicious circle where there is a significant presence of drugs consumption, including alcohol consumption.

It was underlined that one of the most important causes in terms of factors that generate violence is sexual abuse within the home, because when children fall victim to this type of violence, often their pain is kept locked away inside and may come to light when they in turn become violent towards those weaker than themselves.

It was proposed that the best solution for eradicating, where possible, such outbreaks of violence, is the promotion of settings favourable to affection and social justice.

8.1.5. Training and materials

To get a clearer view of the features and contents that should be included in the materials, an analysis was begun of training needs. Starting with the knowledge of what the future educators are willing to do (want), it is aimed to find out what skills and availability are necessary for them to carry out their task (ability) and end up converting these into training needs (know how).

- Training of trainers

In the task of preparing the materials that are going to be used in the **training of trainers**, it was established that the first thing must be included is a selection and ordering of general prevention contents, so that the person being trained may become thoroughly familiar with the terminology that must be shared in the educational processes that the trainer will lead in the future.

Another fundamental part of the training of trainers is the study of the characteristics and singularities of teaching-learning processes, as well as training in teaching skills. Also salvaged from the experience of NGOs that took part in the meeting, the need to connect the training materials with the launch and execution of preventive programmes that will later be run by the future social mediators. In this sense, the future importance was highlighted of the preventive agents in relation to sustainability, viability, visibility and the snowball effect of the actions carried out..

- Training of mediators

Three aspects were proposed to be taken into account when designing materials for the **training of mediators**:

The need to know, before designing the materials, the scope that they will have in educational processes and whether they will then be used for the starting up of preventive tasks.

Ensuring that the materials produced are constantly updated, based on changes that take place in the real situation where they intend to intervene.

Analysing the possibility of involving future users of the materials in their design and updating.

- Target population of the preventive programmes

The importance was highlighted of not overlooking the issue of the cultural diversity that often exists in a single country and that necessarily means that a prior study needs to be carried out in order to adapt materials to the different target groups. It was also recognised as appropriate to devise different strategies for publicising materials, used according to the characteristics of the target population of the preventive task, as well as periodically evaluating the impact of these.

8.2. Situation by country

8.2.1. Argentina

The "**Promoters of Total Teenage Health**" Institutional Project organised by Dr. Jorge Jozami.

We use this experience as an example, as we consider that the same work that is carried out by the Casa del Joven (Youth House), could be carried out by a Therapeutic Community using its Prevention professionals.

Conceptual framework

The programme designers consider that, if there is a real desire to offer guidelines for life, modify habits and develop greater aptitudes, then the

cultural ways of the target population should be known, in order to achieve effective action in preventing illnesses (drug addiction) or stopping their evolution, preventing lasting damage, prolonging life, promoting health, physical and mental efficiency through the combined effort of health teams, educational and recreational institutions and the community in general.

The team makes it clear that they do not believe in sporadic prevention, with no continuity and no participation. They consider as fundamental the training of health promoters whose purpose is to organise group activities with projection in the community where they live, generating strategies that facilitate educational processes in health prevention and promotion.

They consider it important to encourage dynamic activities that favour personal development in order to achieve self care. And for this, to mobilise the resources belonging to both the institutions and the community together, that allow spaces to be creatively sought in order to develop interests and aptitudes for meetings with "others".

An important priority is being able to work from "a thinking about health" perspective; in other words, reinforcing the protection factors of a community. Thus, prevention should play a fundamental role in health sector strategies, with inter-sectorial and inter-jurisdictional breadth. Being able to work in an interdisciplinary manner with defined roles, bringing together the resources that exist in the community: non governmental and religious, community leaders, etc.

Systematisation of the experience

History of Demand:

The programme is registered in the area of research-action, it is the result of a systematisation of actions effected in two different stages. The first, corresponds with the organisation and launch of the Institutional work of the

School, and the second with the Recruitment of Promoters including evaluation and monitoring of the same.

These interventions were carried out in the framework of a request made by a School Institution to the Prevention area of the Casa del Joven. The origin of this concern appeared at the end of the year 1996 with the request for "assistance", made by a tutor for some pupils who presented difficulties due to *alcohol consumption*.

This situation led to the institutions coming together to join forces, with people starting to think about the possibility of carrying out Prevention activities at the School, and the first stage began, of *diagnosis*. In this way, a deeper and more detailed monitoring of the request was created and the Prevention Area proposed that the personal interest of the tutor should be transferred to the higher authorities, with the aim of creating and formalising a work space with the School and some of teaching staff interested in accompanying that work.

As a result of this exchange, it was proposed hold a workshop with teachers from the School; it was decided to include the following activities:

1) From the Casa del Joven, the training of "Health Promoters", elected by votes from the different classes; a call for voluntary teaching staff, in the role of guide teachers.

2) From the school, meetings were held between teachers, tutors and students, where information on the project was given and an anonymous survey drawn up for the selection of the contents to be developed in the workshops.

The *second Stage* was developed when the Programme of Training of Health Promoters began.

Work methodology

This is established based on the workshop as a time and space for "experience and reflection" and for "conceptualisation" as a synthesis of thinking, feeling and doing: as the place for participation, learning and the systematisation of knowledge.

The workshop as an operational modality that requires work in groups. The construction and consolidation of the groups requires a process that enables and prepares participants to experiment and take awareness of their reality together with that of others.

The main *objective* of the group dynamics, is to help in the process of personalisation, where the change is made from *plurality to unification*, the support team is prepared to encourage the organised participation in the real school subjects.

Development

The professionals from the Casa del Joven attended to the request of the Tutor, transferred to the Headmistress and voluntary teaching staff, with the aim of achieving a common space for diagnosis and producing work proposals. The conclusion that came out of this first meeting was to implement a Health Promoters Project for the Institution, consisting of:

Voluntary Teaching Staff for the different disciplines, committed to working transversally, from the subjects tackled by the professionals from the Casa del Joven.

Guide Teachers, are those committed to the drafting and specific execution of the Project with the pupils.

Voluntary Health Promoter Students, are the pupils that were voluntarily elected through voting by their classmates from different courses and academic years, committed to attend monthly training in the Casa del Joven and to work in a continued way on these subjects at the School and in its

environment, supported by the guide teachers and professionals from the Casa Del Joven.

The **School Institution** established, together with the educational psychology office and the committed body of staff, to accompany the voluntary students and to *carry out a survey* at the school in order to collect information on the systematic needs of their fellow students.

This survey was carried out amongst 600 pupils at the School. The ***subjects*** selected as priorities were: ***addictions-violence-sexuality***.

The workshops at the Casa del Joven ***were held over a one year period on a monthly basis and with fortnightly guidance*** for the activities run by student promoters at the School; these activities were:

- Presentation of the Group of Promoters

- Talks for each academic year

- Showing of videos on prevention

- Organisation of sporting events

- Competitions on ideas for prevention

- Production of a file with the subjects dealt with at each meeting

Evaluation and close

The indicators considered for the final evaluation were:

Attendance: **a) Student Promoters**, this was measured in terms of the number of registrations, a total of 32 pupils, with the number of females remaining the same and the number of males decreasing from 20 to 10. **b) Teachers**, this was measured in terms of the number of registrations, a total of 16; volunteers who worked from the subjects angle and guide teachers. Of

the latter, seven remained who made up the group of guide teachers (it is important to highlight that they were all females).

***Commitment**:* of the promoter students to their role. This was evaluated in terms of the activities that they planned to run at the school and those that were eventually run.

Of the proposed activities the following eventually ran:

- They established a weekly work space, where they gradually consolidated the group and the activities proposed.

- They remained in contact with the Casa del Joven

- They worked as a group in the preparation of a logo for promoters that would identify them.

- Presentation of files related to the subjects dealt with.

- Preparation of a folder on the subjects dealt with.

- Organisation of recreational activities and end of year closure programme.

Evaluation of each Workshop

Work was done in groups and individually, through anonymous questions referring to: thematic content of the professionals, technique used for the development of the workshop and individual and group participation by students, in terms of acquiring knowledge.

- Federation of Non-Governmental Organisations in Argentina for the Prevention and Treatment of Drug Addiction (FONGA)

This Federation is made up of 44 Institutions dedicated to the prevention and assistance of addicts. The assistance programmes include Therapeutic Communities and Outpatient Treatment Programmes.

FONGA's objective is to network the different institutions in the development of complementary policies for training, resources integration, common prevention and research projects, proposing at the same time the formalisation of agreements before the public powers, and acting as the advising body for governmental structures.

In September 1993 it signed a Framework Agreement for Technical Cooperation with the Ministry of Health and Social Action of the Nation.

In 1994 it signed a Framework Agreement with the Secretariat of Prevention and Assistance for Addictions in the Province of Buenos Aires that allowed it to progress with three projects: 1. **Fondroga,** a 24 hour free service for the community: information, counselling and referral for people and families with problems due to the misuse of drugs. 2. **Education in therapeutic communities,** under the assistantship modality. 3. **Training courses on the problems of addiction,** aimed at magistrates, civil servants, and staff from the Judicial Department.

In 1996 a Travelling Conference was organised; Drugs and Addictions: Prevention and Treatment", set up within the framework of the **CONOSUR PROGRAMME**, subsidised by the European Union.

FONGA has constituted the Network of Institutions Offering Assistance for Drug Addiction (**RIPAD**) made up of representatives from the FONGA institutions.

8.2.2. Chile

The National Council for the Control of Narcotics (CONACE) reports on different initiatives for the Prevention of Drug Addiction:

Creation and development of a National Drugs Information System

This System includes the performing of regular diagnoses, through national surveys, qualitative studies or studies in specific populations, carried out by the Executive Secretary of CONACE.

Prevention Coordinating Committee

This has been in operation since 1992. It comprises all the Ministries represented in the National Council. This committee has been established to coordinate all the action that covers the public response to this matter, therefore it is analysing a total of eleven programmes, projects and actions, mostly with a national scope, whose responsibility lies with one, two, or even three State Secretaries. This Committee has prepared a project with financing from the German Government, that intends to strengthen both the CONACE corporate image and the set of activities, sectorial networks and the public response in general, with the strategic mainstay being the drafting, production and application of support prevention materials and direct actions with the population groups that they target.

Coordination with Non-Governmental Organisations

From 1995 onwards permanent coordination began to be established with Non-Governmental Organisations that organise activities in prevention, treatment, research and other areas, related with drugs consumption on both a regional and national scale. This coordination takes the form of:

- Bilateral or multilateral monthly meetings designed for exchanging viewpoints on specific subjects and exchanging experiences in the specific work that is being carried out.

- Participation in the organisation, planning and holding of seminars and events according to the needs that arise.

During 1996 a Seminar was held: “Drugs: A View of the State and Civil Society”, which offered a space for reflection regarding the relationship that should exist between the state and non-governmental organisations. In addition the first travelling seminar took place, the **CONOSUR** programme, which in Chile was dependent upon the **“Diego Portales” University**, and dedicated to the training of social and health workers in the field of drugs

demand. Its aim was to facilitate the contribution of analysis of experiences in the countries of Argentina, Paraguay and Chile, and of some countries in the European Community.

- Frequency of risk behaviour amongst adolescents whose parents are heavy drinkers

The Faculty of Medicine of the University of Chile, with the aim of preventing addiction amongst minors, conducted a study based on analysing how far parental drinking determines risk behaviour in children, this being understood as behaviour that increases the possibility of a person having health problems in the future.

To this end, a survey was held amongst 1904 students from basic seventh to middle fourth grade in the city of Santiago, selected by clusters, in three-stage and stratified segments, with a sampling error of 2.5% and a reliability level of 95%. The students were given a version of the "Minnesota Adolescent Health Survey" that had been modified and tested in Chile, where they were asked about consumption of chemical substances (tobacco, alcohol, marihuana, cocaine, inhalants, amphetamines and other drugs), antisocial attitudes (vandalism, individual and group aggression and robbery) and about the presence of emotional symptoms.

As a result, a statistically significant difference was found between the children of occasional drinkers and the group under study, in the sense of the latter presenting a greater frequency of consumption of chemical substances, of antisocial attitudes and of emotional symptoms. It was concluded that being the child of an alcoholic or heavy drinker constitutes a vulnerability factor for the presence of greater consumption of chemical substances and other risk behaviour in adolescence.

Frequent alcohol consumption by the father or mother is directly related to the consumption of alcohol or other chemical substances by adolescent children, as shown by the study statistics.

Also, antisocial behaviour such as vandalism, and individual or group aggression, are more frequent amongst adolescents whose parents are heavy drinkers.

The results are statistically significant regarding the correlation of heavy drinking amongst parents and the appearance of risk behaviour in their children.

The impact of alcohol consumption by the mother was especially striking, and can be explained on several levels: it corroborates the importance of the mother-child link, as well as the fact that alcoholism in women is more severe and has a more solid genetic basis.

These data are of interest in the consideration of preventive activities, both on a primary and secondary prevention level. The multi-causality of these problems requires interventions to be tackled in a comprehensive way and from a systemic perspective, that covers both adolescents and their environments, especially the family environment.

- Prenatal prevention: consumption and pregnancy

The alarming number of pregnant women consuming base paste means that a programme aimed at this group is urgently needed.

Since 1994 in the Health Service of Metropolitan South East (SSMSO), 110 children have been diagnosed as children of consumers of base paste and cocaine hydrochloride, either alone or associated with alcohol and other drugs. 70 children were studied, of which 34% presented low birth weight, and 20 % being small for their gestation age. They also presented an increased frequency of congenital heart disorders (10%), convulsions (10%), apnoeas (14%), a sudden death syndrome rate of 23 in every thousand, in

addition to hyperactivity, sleep disorders and aggressiveness. They are hospitalised more frequently, for more severe causes and with longer stays; generally they require protection measures and they go to different institutions. All of which means physical, intellectual and social limitations for these minors and an enormous social cost in terms of health, education, justice, etc. For this reason, foetal drug addiction urgently needs prevention.

Foetal Drug Addiction

Drug abuse during pregnancy, especially of base paste, is widespread in the Metropolitan South East Area (AMSO) of Santiago, with many neighbourhoods being affected. This area has a population of 1,200,000 inhabitants and has the worst socio-economic problems in the entire Metropolitan Area.

Due to the difficulty in obtaining a drug addiction history, in the maternity ward of the Hospital Sótero del Río just a third or quarter of the pregnant women who consume base paste are detected and also amongst pregnant teenagers that are controlled by the Adolescent Health Unit of the Paediatrics Service.

During recent years more than 110 children of base paste consumers have been diagnosed. The histories of 70 have been analysed due to the lack of adherence of these mothers to the Health Service. Of these, 41% are controlled in a more or less regular way and they coincide in being those who are being looked after by other family members or people outside the family nucleus; the rest, 59%, only occasionally attend check-ups, or they never return.

The characteristics of pregnant base paste consumers are as follows:

25% are teenagers, 51% single, more than 34% in an irregular legal situation; these make up 85%, which makes this an immense social and

economic problem for their children and a considerable and unsuspected social burden for the state.

Conclusions

It can be concluded that during pregnancy drugs consumption produces numerous important and definitive foetal injuries; these prenatal defects cannot be corrected in postnatal life. Thus different physical, intellectual and social disorders are observed:

- Central nervous system alterations with delays in psychological and motor development, language, intelligence and behavioural disorders; therefore these children require special medical treatment, designed by a multidisciplinary team, and they also need special education.

- Prenatal and/or postnatal malnutrition that requires nutritional support, or in the more severe cases, permanent stays in nutritional centres.

- An increase in morbidity and mortality rates due to immunodeficiency, which coupled with an adverse family environment, can cause more severe pathologies and delayed evolution, requiring prolonged hospital stays and in more complex paediatric units, with a greater expenditure on health.

- Family abandonment, which often requires social support, through protection resources so that these minors can go to adoption homes, foster homes or be under the guardianship of other family members.

- Difficulty in rehabilitation of the parents, due to lack of conviction regarding their illness and rapid addiction to drugs, especially to base paste. Also, psychotherapy groups and rehabilitation institutions are insufficient in number and capacity due to the fact that these therapies are normally of a prolonged nature.

8.2.3. Uruguay

The National Drugs Board, from its Demand Reduction Area, reports that reducing demand for drugs, through the coordination and execution of drugs prevention actions, is a priority for the organisations involved in different work fighting psychoactive substance abuse. To materialise this it proposes:

Activities and programmes

- Organisation and Coordination of Pro-Life Forums

- Information/Awareness Raising/Training of teaching staff in both Public and Private Education.

- Coordination with the Health Sector: doctors, Nursing graduates and Nursing auxiliaries.

- Coordination of activities with NGOs

- Participation in national and international events representing the National Drugs Board (JND)

- Coordination of the International Cooperation aimed at supporting Prevention, Health Promotion, Treatment and Rehabilitation.

- Coordination of awareness raising campaigns in mass and minority media.

- Design of graphic and audio-visual support material.

The "Live" Initiative

This is oriented towards parents and educators, and invites them to remember their own adolescence, so that they can help those living through adolescence now, the teenagers with whom they live or teach.

From "Live" they are urged to remember this life cycle:

- An independent morality appears; norms emerge from relations of reciprocity and cooperation, rather than being imposed by adults.

- This is a period in which body, affective, and cognitive changes take place along with their values and social relations.

- The adolescent has a great need for recognition and acceptance in order to form a positive self image.

Adolescents and drugs consumption

- It is fundamental to delay the first contact with drugs for as long as possible. The younger the starting age, the greater the risk of later drugs problems.

This is why it is necessary to intensify preventive actions for this age group, with special work on the relationship of students with their peer group. This is because first consumption nearly always takes place with friends.

- The most consumed drug amongst 14 to 18 year old schoolgoers is alcohol, (more than a third of schoolgoers drink regularly).

- In terms of prevention, it is a good idea to alert students to the marketing techniques used for the sale of alcohol.

- The idea that students have of alcohol consumption needs to be worked on, it differs little from that held by the rest of society: there is a tendency to underestimate the risks involved in using legal drugs as opposed to illegal drugs.

- Reinforce the capacity to resist peer group pressure.

- Lessen the relationship between maturity and the habit of smoking or drinking.

Greater consumption at weekends, shows the association between leisure time and drugs consumption, which indicates the need to promote healthy habits when occupying free time.

Cannabis

Delaying consumption of marihuana is one of the central objectives of prevention, as it delays the moment of the first contact with the overall group of illegal drugs.

Tranquillisers

Many young people claim to have consumed tranquillisers without a prescription at some stage. This indicates that, for effective prevention, the availability of these drugs should be reduced, as well trying not to offer models of abusive consumption.

Ecstasy, LSD and Speed

Amongst all drugs, these are the most frequently consumed by young people in the phase of initiation into the consumption spiral.

There are some young consumers for whom drugs are an end in themselves, linked to entertainment, music and nightlife, and a distinguishing identity feature that differentiates them from non-consumers.

The effects related by consumers of Ecstasy (MDMA and similar) give us a clue to the reason for its success amongst young people; given that this drug **mainly acts by increasing sociability and providing a rapid and comfortable (though fictitious) group cohesion**, so it is no surprise that, at an age when the peer group is the main area of socialisation and the reference framework for social life, its use has spread amongst them with such ease.

For this reason, from the Prevention perspective, it will be necessary to reinforce the resistance to peer group pressure, encourage the capacity for establishing relationships not dependent on the peer group, and promote distinguishing features that are opposed to drugs use, these being the priority objectives of our intervention.

In addition, the new forms of economic exploitation of young people's leisure (huge discos where they dance to a kind of "trance" inducing music) have provided free time usage guidelines that combine drugs use with dance, music, movement, etc.

Therefore the creation of alternative options for occupying free time and the education of favourable attitudes towards a creative occupation of leisure time (through the cultivation of hobbies and interests) is also a highly important preventive task.

Other drugs

The consumption of other drugs, whose use is more or less frequent in our society (cocaine) has a very low incidence rate amongst schoolgoers. But for a country such as Uruguay, the cocaine problem lies in the place that it occupies in social discourse, as it is the symbol of "drugs" par excellence.

8.2.4. Nicaragua

- Comprehensive prevention programme aimed at vulnerable young people.

Managua (Nicaragua)

Subsidised by: The Town Council of Seville.

- Project duration

12 months

- Local counterpart

ACRA-INPRHU[84]

- Background and context

The situation in Nicaragua is marked by the war and national disasters, which have left a very precarious economy, with huge problems of a social nature:

- 620,000 displaced people

- 10,000 people disabled in the war

- 600,000 children in difficult circumstances, of which 6,000 live on the streets in a state of abandonment.

Most of the young people in a vulnerable situation live in "focal points" where complete family units are not a very frequent occurrence and young people usually live with their mother's new partner. This situation, in conjunction with extreme poverty, causes situations of abandonment, sexual abuse and child abuse, and in a high percentage of cases leads the minors out onto the streets.

A dangerous increase is observed in the number of children and teenagers (5-18 years) who habitually consume drugs. These groups show destructive behavioural tendencies, jeopardising both themselves and society, with no viable alternatives to counteract the situation (there are no real policies or strategies, aimed at this type of project).

"On a theoretical level, there is a legal framework to tackle the problem, but the reality is that the social situation does not allow the necessary resources to be destined for their application" ("Intercambio" 1999)

[84] **ACRA**: An Italian NGO with 30 years of experience, working in Africa and Latin America. It focuses on sustainable rural development projects. **INPRHU**: A Nicaraguan NGO with a long track record of work with marginal groups of the population and active in the focal points where the Project is being run.

The reason for consumption is generally therapeutic; in other words, people consume to escape from their personal situation:

- Family breakdown

- Child abuse and sexual abuse

- Child labour

- Lack of schooling

- Terrible infrastructures

- Poor healthcare conditions (outbreaks of malaria due to the proximity of some areas to the Lake of Managua).

- Programme Objectives

General Objective

To improve the quality of life and expectations for the future of the target population, based on developing drug addiction prevention actions, which directly influence the risk factors detected.

Specific Objectives

- Training of a group of promoters and mediators, equipping them with the technical resources and assistance necessary for them to carry out preventive actions.

- Running of prevention programmes, based on the start up of pre-employment training workshops.

- Offer of support to minors and young people who, within the programmed actions, are in a more vulnerable situation.

- Involving formal and non-formal resources from the close environment in the development of preventive actions.

- Encourage monitoring and publicising of the objectives reached, within the NETWORK of NGOs that work in drug addiction prevention in Nicaragua, with the aim of supporting the sustainability of the actions already underway and increasing their snowball effect.

- Actions to be carried out

- Action 1

Start-up of the programme and involvement in its development of the relevant formal professions.

- Responsibility: Programme Coordinator.

To increase cost effectiveness of the mission, the course for training trainers is programmed as a continuation of this activity, and this person is incorporated as a speaker.

- Action 2

Holding of a training course for trainers, aimed at preparing experts from the counterpart institutions in the Project for preventive work.

Responsibility

Two Spanish experts with experience in training and setting up of drug addiction prevention programmes.

Target group

- Human Resources from the ACRA-INPRHU Partnership: 14 technicians.

- School and community heads from the focal points covered by the extension of the preventive programmes: 12 promoters (4 per focal point).

- Local governmental representatives.

- 6 local agents (2 per focal point).

- Members of the NETWORK of NGOs that work in prevention. (On this point and although they are not directly involved in the Project, the idea is to seek maximisation of the snowball effect of the action, its visibility, and, in consequence, support for future self-sustainability.

- Action 3

Review and production of materials for training and the extension of preventive programmes, based on the FAD's library.

Responsibility

The FAD technical team, in coordination with the ACRA-INPRHU technical team.

Targets

Material aimed at training mediators and the setting up of preventive Programmes: 150 sets of material.

Material aimed at the target population: 1,500 sets of material, split into two age ranges.

- Action 4

Holding of three mediator training courses, one in each focal point, which work on both the preparation of those attending and the production and launch of the future drug addiction prevention programmes, included in the pre-employment workshops, and linked to the socialisation areas of the target populations, fundamentally school and community.

Responsibility

The 14 technicians who have undergone the trainer training process will be responsible for running mediator training courses and setting up the prevention programmes (three courses, one per focal area)

Targets

- The instructors of the pre-employment workshops: 6 instructors (2 per focal point).

- The social educators that work in the focal points: 9 social educators (2 per focal point)

- Members of community participation platforms: 12 community leaders (4 per focal point)

- Teachers in influential schools within the target population: 12 teachers (4 per focal point)

- Mediators from other NGOs who are running community programmes in the focal points attended to in the Programme: 15 mediators (5 per focal point).

- Action 5

Setting up of prevention programmes, based on pre-employment workshops. The work areas, from which a workshop is selected for each focal point, according to the real labour possibilities of the environment: serigraphy, carpentry, bakery.

Responsibility

- The coordination team: 4 coordinators (1 general coordinator and 1 coordinator per focal point)

- The remaining people involved in this action are the same as those who took part in action 4.

Direct targets

- Participation in pre-employment workshops: 180 young people (60 per focal point).

- The trained mediators will work with them and they will receive preventive material: 1,320 young people.

- Action 6

Educational psychology support for a population of 45 young people in a "vulnerable" situation, based on a multi-professional team made up of the focal point coordinators, plus an educational psychologist, who is an expert in working with marginal groups, and who will coordinate the Team action.

Responsibility

Psychological education team: 4 members.

Targets

45 young people in a vulnerable situation: 15 per focal point.

- Action 7

Support in the implementation of preventive programmes being run, as well as possibilities in terms of feasibility and self-sustainability, based on the involvement of organisations of a local or regional nature.

Responsibility

Spanish expert in coordination with the local Project manager.

- Action 8

Holding of regular meetings (quarterly) that enable participation in and monitoring of the project by representatives of NGOs involved in the Prevention Network.

- Action 9

Final Project evaluation mission

Responsibility

Spanish expert in coordination with the local Project manager.

8.2.5. Colombia

Historically, State resources have been fundamentally directed at counteracting the problem of consumption through repressive systems, and a very low proportion are used for education and prevention programmes. Prevention has a very short history in Colombia, 15 to 20 years; therefore, it is undoubtedly a process in construction. A shift has been made from strategies based on fear towards strategies aimed to strengthen individuals, so that they are prepared to take decisions, and to improve self-care and self-awareness.

"Information and education strategies are used, with the emphasis on all that is social, family, school, work and individual; trying to thus build a new way of thinking, different ways of relating to others where self-respect, respect for others and for the social environment are key elements in preventive dynamics."[85]

From another angle, we find the work of the "**SURGIR**" (*ARISE*) organisation, whose director, Jorge Melguizo, comments on the characteristics of their proposals for the prevention of drug addiction.[86]

[85] TELLO, Angela, Executive Director of the Corporación Caminos. "Intercambio" No.5.1999.
[86] "Intercambio" Ed. FAD. No. 2, 1998.

SURGIR's focus is determined by the risk factors and protection factors model, and in turn, with a high degree of influence from the psychosocial model, which takes into account the individual's entire set of social relations and how individuals determine their ideological positions and attitudes, as regards drugs and the situations arising from drugs consumption.

One of the most commonly used strategies is recruitment of social mediators (teachers, community leaders, youth group leaders, etc.) who are trained so that in turn they can promote preventive actions at school.

The new trend in prevention work, both on a general level and within SURGIR, is to promote the building of networks of social participation that allow strengthening of the opportunities for discussion and analysis of the educational and preventive proposals that are presented both on a local and a national level.

The departments of the Cauca Valley are running a project called **"The adventure of life"** in 19 school institutions; in the Department of Antioquía in 7 municipalities, apart from Medellín and its Metropolitan Area, where the project is being run with greater intensity.

Through the **"Network Project"** for training educators for the prevention of the misuse of drugs, run by the Vice-ministry of Youth, prevention actions in a school setting reached 25 departments, 95 municipalities and 190 educational institutions.

8.2.6. Bolivia

According to the guide for social action "**Map of poverty**", published by the Ministry of Human Development of Bolivia, more than one third of Bolivian homes are in extreme poverty (31.7% of the family units live in conditions of exclusion, and 33% in moderate poverty). These socio-economic circumstances mean that the Bolivian age for starting work is 8 years, with a

severe tendency to reduce this to 6 years, an age when human beings hardly begin to discern regarding their existence.

In the country there are around 569,000 children and teenagers working, and they make up 28.5% of the population aged between 7 and 18 years of age. Of this population, 138,000 work with their families and receive no pay, and 431,000 are in paid work, with approximately 164,000 of these in urban areas.

Given this entire situation, **Enda-Bolivia** has proposed the running of an alternative programme of comprehensive prevention of social isolation in the child and teenage population from or on the streets in Bolivia, with a fundamental task being the development of an alternative educational and social alternatives process that includes comprehensive training to aid children at risk.

Main objectives

- Reducing the risks of boys, girls and adolescents on the streets.

- Improving their socialisation.

- Encouraging their integration into the community.

Phases

The programme is run based on five stages that make up the educational and social process of Enda-Bolivia, which are:

- Street subculture.

- First community integration.

- Personal responsibility.

- Reinsertion in the jobs market.

- Social insertion.

Areas Programme

In order to supervise the development of children from and on the streets, Enda-Bolivia works with a multidisciplinary team of professionals that ensures that none of the areas that are important in this objective are overlooked.

Social and legal area

- Family reinsertion, support and social monitoring.

- Occupational strengthening.

- Incorporation into the jobs market.

- Community organisation.

- Emergency community bedrooms.

- Community social savings system.

Educational Psychology area

- Schooling reinsertion, monitoring, support and assessment.

- Vocational counselling and training.

- Culture, sports and recreation.

Health and nutrition area

- Healthcare: General medicine, Dentistry, Nursing and Pharmacy.

- Preventive health: Educational talks and Health programmes.

- Nutrition: Help for dining halls and educational talks.

Work resources area

- Pre-workshops.

- Productive social units.

- Jobs bank.

- Work training.

Research, communication and projects area

- Social research into the problems of boys and girls from and on the street.

- Information, publicising and communication of the institutional experience.

- Production of projects.

Programme strategies

To be able to achieve the objectives outlined by the Programme and develop all the projects and subprojects, the following strategies have been proposed.

- Research and communication strategy.

- Participative management strategy.

- Services strategy.

- Work resources strategy.

- Labour insertion strategy.

- Human resources training strategy.

Cities covered

Enda-Bolivia is currently working in the most depressed cities in Bolivia.

The programme is being run in El Alto (La Paz), the Altiplánica area and the towns of Trinidad, Guayaramerín and Riberalta in the Department of Beni, a tropical Amazon area on the border with Brazil.

8.2.7. Venezuela

The Childhood and Family Research Centre at the Universidad Metropolitana in Caracas, organised a Forum titled "Drug use and abuse prevention in the community, family and school spheres". From there the following recommendations were made:

- A **Comprehensive prevention** policy. In Venezuela inter-sectorial coordination for prevention has recently been implemented involving the different Ministries and Institutions from the educational, legal, social and health spheres, which make up the National Anti-drugs Commission.

- The need to change from a reduction in drugs supply orientation towards a new focus of **reducing consumption through education**.

- **Education understood** as a process that begins at home, **at the heart of the family,** in daily life, in the hands of the first and true child educators: their parents.

- **School**, with its capacity both for diagnosing the risk factors that surround its work, and for early intervention in both the environment of children and teenagers and in their educational community, becoming a **travel companion on the road to prevention**.

- **The need to link up alliances and national and international networks to work together on the task of prevention**, optimising the use of both material and human resources. The importance of international cooperation programmes has been proven in Venezuela by participation in regional programmes such as those run by the **FAD** to great success in the meetings held in Lima and Medellín in August 1996, with the participation of **19**

NGOs belonging to the Andean Pact countries. This programme gave institutional reinforcement to the organisations, favouring a methodological consensus in addition to the technical development of the same. It provided a reference for cooperation in the drugs sphere, serving as a two-way bridge for programmes between Europe and Latin America.

8.2.8. El Salvador

"**FUNDASALVA**" is a non-profit and apolitical institution that has been working in prevention since 1989; it was based on an initiative from a group of professionals and businesspeople to tackle the increase in the misuse of drugs.

- Prevention Department

Its work is oriented towards all population groups, with special emphasis on programmes aimed at children and young people.

The programmes destined for the formal sector have achieved national coverage through coordination with the Ministry of Education, following an agreement signed in 1990.

In the non-formal sector, programmes have been developed directly with developing communities, rural communities and urban marginal communities.

- The Agreement with the Ministry of Education has, to date, capitalised on an important amount of programmes experience:

- Comprehensive preventive education model programme, basic level.

- Student social service programme: "Young and healthy".

- School for moms and dads.

- Support for the educational reform process in middle level education (area of applied training).

- Prevention and psychosocial care for children in the educational community of former areas of conflict.

- Prevention and reduction of student violence.

- Prevention education programme in communities identified with high violence levels and the presence of Maras (EDUCO schools).

- In the non-formal sector Programmes have been run in developing Municipalities and Communities through:

- Coordinated efforts with the Ministry of Public Health and Social Welfare since 1992, through an agreement signed with this Ministry.

- Direct interventions.

REINTEGRATION FOR DRUG ADDICTS

REINTEGRATION FOR DRUG ADDICTS

- Introduction

The terms reintegration, resettlement, or social rehabilitation, besides other background considerations regarding the conceptual differences that exist between them, are used indiscriminately to refer to that area of intervention in drug dependency that deals with processes of socialisation and normalisation of individuals in treatment.

We find that, although theoretically there are usually five basic *areas* highlighted in reintegration programmes: relations, employment, education, health and leisure-recreation; in practice, all resources (Day Centres, Therapeutic Communities, Outpatient Treatment Centres, etc.) focus work mainly on the area of employment, and to a lesser degree, in the areas of education, relations and leisure-recreation.

A drug addict's reintegration into society is a process that begins with the first moment of treatment, despite the fact that in many programmes this phase comes after detoxification and breaking the drugs habit. This model, which is extremely common, has become somewhat obsolete with the spectacular increase in methadone programmes.[87]

Equally, one should not be speaking of reintegration into "society" in general, but rather of reintegration into the individual's social environment, sufficient in itself. Moreover, during this process, and throughout any

[87] In Spain: 1,401 methadone prescribing and/or dispensing centres. 63,030 users. (National Drugs Plan Annual Report, 1999)

patient's lifetime, a series of cycles exists, marked out by advances and relapses in their social reintegration.

As regards these five basic forms of social reintegration, each patient will show different points of vulnerability; what is relatively easy to achieve for some is difficult to achieve for others. What does this variability depend upon? For Jesús Cancelo[88], it depends fundamentally on the psychological and social factors accompanying each individual.

If we work on the basis that western societies have adapted to living with the drugs problem, logically we can deduce that nowadays they are showing greater tolerance towards this problem. This means less social rejection, and also changes that can be indisputably confirmed, in the legislative, judicial, police, health, employment, education, and social services spheres, etc. The philosophy is now one of encouraging the drug addict's social integration. The concept of addiction as an “illness” is increasingly widespread, to the detriment of moralising and repressive views.

But if things are changing, what is it that prevents addicts from becoming suitably integrated into their social environment? There are various factors; lack of social assistance, employment resources, etc. However, the hypothesis is a different one: it is not a case of putting everything down to the lack of resources, as material resources are not the be all and end all. If the individual is not psychologically prepared for Social Reintegration, or cannot find any sense in social integration, sooner or later that individual will fail.

There have been plenty of experiences where patients, for example on methadone, display an evident lack of interest in taking part in activities of an educational and occupational type (without financial incentives) offered to them: health classes, sporting activities, self-help groups, etc. These offers

in themselves are not sufficient, unless accompanied by the efforts of professionals to feed and maintain their motivation on a daily basis.

Anyone who uses a "missionary" approach to drug addiction is making a mistake. Drug addicts, generally speaking, are neither disabled nor mentally handicapped, even though at times the results of their addiction may make them seem so. They have the qualities to function like any other person, yet they do not do so. They need affection, but they don't know how to handle it. They need somebody to offer them an opportunity, but when one arises they often do not make the grade. Thus, it would be necessary to create a "Scientific theory on social reintegration", that would put order where none exists, that would eliminate improvisation and "anything goes", and facilitate the decision-making process according to each patient's evolution.

Moreover, and according to Jesús Cancelo, the two most relevant factors that really hinder social reintegration are: consumption factors (of drugs) and the psychological variables linked to the "personality" of each individual. If the first is resolved, in other words the individual stops consuming illegal drugs (drugs free programmes, substitution programmes, etc.), then most patients can achieve an acceptable level of social reintegration, even those who use their own resources.

As regards the second, psychopathological factor, this needs to be tackled from a multidisciplinary perspective, especially from a psychotherapeutic and educational viewpoint, in order to modify or attenuate attitudes and behaviour that are not very favourable for social reintegration.

A whole universe of personal and biographical circumstances exists that may condition social reintegration. Some suffer exclusion due to their drugs habit. Others, on the contrary, take drugs because they are already suffer exclusion, or to find it easier to cope with their exclusion. Some addicts display

[88] CANCELO, J. "Reinserción en Drogodependencias: una respuesta a la Exclusión Social" (*Reintegration for Drug Addicts: a response to Social Exclusion*) : Records of the International Meeting. Ed. Junta de Castilla-

psychopathological profiles that cause rootlessness, in others it will be only symptoms of anxiety, fear of failure, or a lack of social skills and of self-esteem. Positive reinforcement does not always work, and negative even less.

Some addicts desire integration but are unable; others base their integration on isolation, and on dependence upon the institutions. This provides them with an identity, and although it seems contradictory, a place in the social network.

In the face of this chaotic panorama, where not even the concept of social reintegration is clear, it is impossible to forecast or predict with any accuracy, the future of each individual's social reintegration. Surprises happen. One cannot say "it all depends on the individual", nor leave it all to the "patient's willpower", because, although this may end up being the case, it would lead us nowhere. It is up to everyone, and especially to the professionals, to "heal", to motivate, to create strategies, to mobilise resources, to enhance awareness throughout society in general, to be catalysts for change, and to do all this based on a theory of social reintegration that is increasingly scientific in nature (Cancelo, J., 1999).

1. Institutional Support for Reintegration

1.1. The Institutional Framework of the European Union[89]

1.1.1. Structural Funds

The Structural Funds, together with the fund for Cohesion[90], form the main instrument for development of economic, social and territorial cohesion within the EU, and are the main factor in its productive modernisation.

La Mancha and GID.

[89] FRANCI, J. "Gestión de la Formación Continua en las Organizaciones".(*Management of Continued Training in Organisations*) University of Barcelona, 1999.

The Structural Funds correspond to three areas of Community policy, and finance actions of modernisation in the member States within their specific sphere of action.

These Funds are:

- ESF: The European Social Fund
- ERDF: The European Regional Development Fund
- FEOGA: The European Agricultural Guidance and Guarantee Fund
- FGI: The Fisheries Guidance Instrument
- The Cohesion Fund.

- Structural Funds Objectives

Three priority objectives:

- Objective 1. Promote development; structural adjustment of less developed regions.
- Objective 2. Support the economic and social restructuring of areas with structural difficulties.
- Objective 3. Support the adaptation and modernisation of education, training and employment policies and systems. This objective involves financial intervention outside the regions referred to in Objective 1 and ensures a political reference framework for the overall set of actions in favour of human resources on a national territory, without overlooking regional specifics.

[90] Instrument created in 1992 in favour of the four least prosperous countries in the EU: Spain, Ireland, Portugal and Greece.

- European Social Fund

The ESF works to support measures to prevent and fight unemployment and promote development of human resources and integration into the employment market in order to promote a high level of employment, equality between men and women, sustainable development and economic and social cohesion.

In particular, the ESF contributes towards promoting actions undertaken within the framework of the European Employment Strategy and the Directives for employment established on an annual basis. The Commission's General Directorate of Employment, Labour Relations and Social Affairs, holds Community responsibility for the management of the ESF.

- INTEGRA Support Structure, European Social Fund.[91]

From the INTEGRA Support Structure we can provide a partial balance of what Community Employment Initiatives, especially the INTEGRA chapter, have contributed and meant in the development of specific actions and/ or policies directed at groups with special difficulties in terms of integration, including ex-drug addicts. The INTEGRA chapter is also aimed at immigrants, the gypsy population, the homeless, single mothers, etc.

At the beginning of the nineties, the European Commission invited Member States to present applications through National Operating Programmes, in order to be able to develop specific innovative projects that would facilitate access to the jobs market for groups with special integration difficulties, including former drug addicts. These Operating Programmes, for the period 1991-1994 and the period 1994-1999, articulated and defined a series of aspects that all projects should and/or must follow. These are projects whose main characteristic is INNOVATION. They should mean a qualitative step

forwards, a laboratory and testing ground for direct work with these groups. The TERRITORIALITY concept means acting from and within the territory, thus being closer to needs and giving a response to them, always in cooperation with the numerous organisations working in the field. This is what has been called the "down-up" focus. In this sense, the work of organisations more closely linked to the specific problems faced by these groups is fundamental, as is working together with a network of organisations in the territory whose participation in the programmes improves and increases the possibilities of giving a response to problems in a COMPREHENSIVE way.

What is sought with this type of project, is that once the project results and good practices are known, they may be extrapolated to other contexts where these new procedures many also be of use, with the aim of avoiding the same mistakes. The so-called Snowball Effect means, therefore, that these good practices for projects may be taken on board by the public organisations responsible and those co-financing projects, thus opening a way forward in the general policies that affect intervention in all these groups, including drug addicts.

A final characteristic of the Community Employment Initiatives worth underlining is their TRANSNATIONAL nature, which means not only the enriching of each organisation as a result of exchanging information and knowledge with other European organisations, but also aims to build tools that add value to the task of the promoters from each member State. In addition, many programmes have carried out user exchanges between member countries. The fact that these people have the possibility of leaving their own country, or even their close context, in many cases for the first time ever, has a very positive value in itself, beyond what the experience can offer them on a training and employment level.

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[91] International Meeting "Reintegration for drug addicts: A Response to Social Exclusion" Pub. Board of Communities of Castilla La Mancha and GID. Toledo 1999.

The limitations and lack of development suffered by official employment policies, traditionally designed for the population in general, have prevented contemplation of the lack of protection suffered by those people who are close to or in situations of social exclusion, such as the long-term unemployed, young people from marginal social environments, ethnic minorities, immigrants, former drug addicts, etc. In these cases, those people who do not have a normalised work history find that they fall outside the scope and coverage of employment policies relating to compensatory benefits, training, information services, support, etc. We should add to this the fact that the employment capabilities of these groups are often limited by problems of personal breakdown, which have negative repercussions on attitudes, aptitudes and habits suitable for access to, and the later performance of a normalised work activity. Community initiative projects are set within the framework of the task of resolving such deficiencies. They have meant, in the case of work with drug addicts, going beyond mere therapeutic treatment and achieving comprehensive intervention in the social and work environment, considered as one of the guaranteeing factors of true integration.

The INTEGRA projects with drug addicts range in type, mainly according to whether they deal with people who are not in prison, or people who are in prison or who have just been released, but several elements can be identified as common to all of them.

Firstly, a fundamental element is the development of prior and/or basic educational training, including literacy activities and also social and job skills such as learning team work, resolving conflicts, increasing self-esteem, assertiveness training, etc. In the beginning these pre-training actions were established as an initial module prior to occupational training actions. Experience has demonstrated, in many cases, that the continuation of these prior training activities throughout the professional training and/or integration is very useful, as they deal with skills that need to be acquired over time and that may serve, at specific moments, to resolve any conflicts as they arise.

When it comes to defining the professional training that is going to be offered, it is fundamental that it is directly linked to the requirements and potential of the jobs market, and that a balance is maintained between the skills and requests of the users/beneficiaries, the future workers. This link is not only desirable in the definition of the training spheres, but also, and perhaps more especially so, in the definition and specification of possible business start-up projects. Therefore it is essential to carry out market studies or economic prospecting, prior to designing training and employment projects.

In-company work experience as the culmination of occupational training, in addition to training in job rotation, appears to be a very suitable training-integration model. This is not only due to the training contents in themselves, but also the vital experience provided by "stepping inside the company" and getting to know it from within.

In this sense, good results are being achieved by business simulation workshops, which may later be converted into real and feasible new business projects, whose founding process has been accompanied. In some cases these have been assured a protected market, at least in the first moments of the start-up of the company as such.

The dissemination of project objectives and awareness-raising actions for the business sphere now constitute an essential element that all work integration projects with these groups should contemplate.

Many project initiatives enjoy the involvement of an employment promoter, tutor or work intermediary, who is the person entrusted with acting as a link, for liaison and support between the future worker and the business sector, in order to achieve any of the aforementioned options or a direct employment contract. This person will be responsible for responding to and supporting employees in their work performance, and resolving any incident that may arise, always in coordination and communication with company personnel.

The final aim is to provide a normalised work experience that may serve as a support for true social integration.

The success of these proposals is partly based on the definition of individual integration itineraries, which contemplate the capacities, potential and the demands of the users themselves, and which are monitored on an individualised basis throughout the entire process.

The fact that these itineraries are defined and agreed with the beneficiaries of the actions themselves, implies making them responsible for their own integration process, motivating them and providing them with the skills to become the agents for their own change.

Work integration schemes are rich and varied: there are examples of integration both in hired employment and in self-employment. In terms of self-employment, a fundamental element is support in the definition of products, in management and in the development of business skills, in orientation and in market knowledge, etc. The company legal formats usually applied include partnerships, worker's co-operatives and self-employment. In this sense the Social Economy is playing an important role and is providing results in this type of project.

In many cases these are companies involved in recycling: there are especially interesting projects involving urban solid waste recovery, artistic recycling workshops, and other experiments. The long-awaited regulation of Integration Companies would give the necessary legal coverage for developing initiatives for people with special difficulties.

In any case, and besides the legal specifics, what does seem to be convenient is that new employment initiatives be related to the demands and potential of the local market.

Another aspect under debate is whether it is a good idea for companies to be set up with heterogeneous characteristics. There are schemes that

exclusively support the constitution of co-operatives involving only former drug addicts whilst others consider it essential for these potential companies to be staffed by former addicts and other people. It is our opinion that the richness involved in working with people who have different life experiences can be a beneficial factor in the social and employment normalisation of former drug addicts.

The monitoring and continuity of support over time, by professionals, are fundamental in fighting against possible relapses amongst users.

Measures to raise awareness amongst the business community, as commented previously, are further fundamental elements in integration processes. In addition, work with families and society in general must not be overlooked.

There are many examples of INTEGRA projects that are contributing new ways of understanding work for this collective, and that demonstrate the much-needed turnaround that has taken place in Social Intervention. Some associations that traditionally worked exclusively in therapeutic treatment with drug addicts, have started to contemplate the issue of work integration as a fundamental phase in achieving true rehabilitation.

Other examples exist of projects that work with prison inmates (some on parole or weekend release) that have developed training actions outside the prison environment and have promoted self-employment. For example, the start-up of self-employed horticultural producers who are offered support in business management and who have been ceded plots of public land by local authorities for them to grow their crops. In other cases, the work integration promoted has been as an employee in local companies, or temporary contracts with public organisations.

It is important to stress that when we talk of social and work integration of former addicts, we are referring to COMPREHENSIVE PROCESSES. These essentially need the participation of different agents who take responsibility

for different areas of intervention required by the specific problems of former drug addicts. Unless the basic needs of these people are covered, any attempt at integration will be fruitless.

In society today, integration and "normalisation" of these individuals is unavoidably linked to WORK. Getting a job not only means a source of income necessary for living, but it grants social power, as it makes social relations possible and encourages self-esteem and social recognition; the pillars of self-development and conversion into a fully-fledged citizen.

- Eligible measures in ESF (2000-2006)

Eligible measures means those that can be financed by the Fund's community resources in accordance with its regulatory stipulations.

For the period 2000-2006 these are the following:

- Assistance for individuals, for the following activities in human resources development, that could form part of the professional integration itineraries:

(a) Professional education and training (including job training equivalent to compulsory school education), learning, prior training, including the acquisition and the improvement of basic competencies, professional rehabilitation, measures for promoting aptitudes for employment in the labour market, counselling, advice and professional improvement.

(b) Aid for employment and self-employment

(c) Postgraduate university training and the training of directors and technical staff in research centres and companies, always in the sphere of scientific and technological research and development.

(d) Development of new areas of employment, including the social economy sector.

- Aid for structures and systems, with the aim of increasing the effectiveness of assistance activities designed to help people:

(a) Development and improvement of professional training, education and qualifications, including training of teachers, instructors and staff, and improvement of worker access to training and qualifications.

(b) Modernisation and improvement of efficiency in employment services.

(c) Development of links between the world of work and education centres, training in research.

(d) Development of systems for anticipating changes in employment and qualifications, especially in relation to new modalities and forms of work organisation, taking into account the need to combine family and work commitments and to allow older workers to continue with stimulating activities until retirement, excluding the financing of early retirement.

- Accompanying measures, also designed to increase the effectiveness of activities based on assistance for people:

(a) Assistance in the services offered to beneficiaries, including making services available and care installations for dependent people.

(b) Promotion of social and educational accompanying measures, to facilitate a comprehensive itinerary of professional integration.

(c) Awareness raising, information and advertising.

- Technical assistance measures for the set of ESF interventions within the framework of Objectives 1 and 3, as well as upon the initiative of the European Commission itself.

ESF interventions will concentrate on a limited number of areas or issues and on the most important needs and the most effective actions, based on the

priorities established in the National Action Plans for Employment. When distributing the funding available between each of the five spheres of policy action, national priorities will be taken into account.

- Community instruments for the development of professional training, for the period (2000-2006)

- The European Social Fund (already examined)

- The EQUAL community initiative; synthesis and improvement of the initiatives for the period (1994-1999): ADAPT ("Adapting the labour force for industrial change") and EMPLOYMENT.

- The Leonardo da Vinci II programme.

- The EQUAL community initiative[92].

The EQUAL community initiative's aim is to intensify cooperation between member States and the Commission to promote new resources designed to fight against all forms of exclusion, discrimination and inequality in the labour market, within the framework of application of the European strategy for employment and the national action plans. This initiative forms part of the European Union structural policy reform for the 2000-2006 period, the seed of which can be found in the "2000 Agenda", approved by the Council on 21 June 1999.

With the objective of improving cooperation in favour of achieving the aims mentioned, EQUAL will support:

(a) Associations of organisations (public and private partners and NGOs) and the trial of new focuses, methods and practices in transnational cooperation;

[92] See the European Commission's web site.

(b) Policy formulation for the member States and the dissemination of best practices through the setting up of national association networks, facilitating access to innovation and best practice in other parts of the European Union;

- Background initiatives that feed EQUAL: Adapt and Employment

The EMPLOYMENT initiative:

EMPLOYMENT is a Community Initiative from the European Social Fund aimed at those collectives who face special difficulties in finding work due to their lack of qualifications or possibilities.

The initiative is composed of four sections. In each, EMPLOYMENT tackles the problems of a specific collective: women in NOW; disabled people in HORIZON; young people without qualifications in YOUTHSTART. In 1997 the fourth new section of EMPLOYMENT was created, called INTEGRA[93], to reinforce the Community Initiative. This collective is made up especially by those who formed part of the "disadvantaged" sub-section within HORIZON. In other words, immigrants, refugees, homeless people, drug addicts, travelling workers, single mothers, prisoners and ex-criminals.

EMPLOYMENT projects

Projects are the centre of activity of this Initiative. Their financing depends on several basic conditions:

(a) They must be operational for a period of three years.

(b) Each forms part of a partnership together with selected EMPLOYMENT projects from other member States.

(c) Each project must reflect its country's priorities, as established between the Commission and the national authorities.

[93] Mentioned at the start of this study.

(d) Each project is selected on a national level, or occasionally a regional level, according to the procedure established in each State.

(e) Each project receives combined community and national financing, which can be of a public or private nature.

All the experiences, innovations or significant products resulting from EMPLOYMENT will be disseminated and made available to European networks, with the aim of making the most of the results and positive experiences, and even the negative ones, and analysing their possible use in a generalised way. Again, exploiting innovation appears as a key to financing and the efforts developed through EMPLOYMENT and the other Community Initiatives.

EMPLOYMENT measures.

In addition, each EMPLOYMENT project should intervene in one or more Measures related with the Initiative's objectives:

(a) Development of new systems of orientation, training and employment

(b) Offer of training plans

(c) Creation of jobs and support for the creation of new companies

(d) Dissemination of information and awareness-raising actions amongst employers regarding the problems of access to employment faced by each beneficiary group.

The INTEGRA section also introduces a fifth measure: the development of focus and practice models that improve access to and the quality of public services, the reinforcement of local skills and the promotion of actions aimed at the integration or reintegration of beneficiaries.

2. Terminology Clarification[94]

We consider it opportune to unify and clarify the use made amongst experts of the terms: facility, programme and resource, as in reality they are used indiscriminately, and this terminological ambiguity also contributes to confusion on a conceptual level.

The following is by way of clarification:

- **Facility** makes reference to the physical space where intervention takes place.

- **Programme** makes reference to the formulation of objectives and actions that will have to be carried out to achieve the said objectives.

A certain amount of confusion may exist since, from an institutional perspective, the term "programme" is used a great deal in budgetary planning. On the intervention level, these institutional programmes become resources, which may or may not be used, in relation to the production of an integration programme for a particular individual. This is why it is necessary to distinguish between institutional programmes and individualised programmes.

- **Resources** are the tools, the different means used to carry out the said actions.

- Proposal for arranging intervention:

- First sphere: Specific assistance oriented facilities with objectives related to integration or social reintegration. On this level the main strategy is the differentiation between objectives, the differentiation between types of intervention that purely provide care and those that are oriented towards integration.

[94] JIMENEZ, A; Comas, D; Carrón, J "Los programas de integración social de drogodependientes" (*Social*

- Second sphere: Specific resources for social integration, outside the care framework, exclusively for drug addicts. These resources may be supported by different facilities specifically for drug addicts or by facilities to which the general population has access. In this case, the strategy would be how to suitably coordinate the set of resources for maximum optimisation, ensuring that they reach those individuals suitably referred from the assistance network, or from the coordinating body if one exists.

- Third sphere: General resources or services of a general nature. These are in the general networks and can be used by anybody. The strategy will be to create a reference, as without that specific reference for drug addicts people do not attend, they feel lost and they are wary of general systems.

If we take what it is, rather than what it should be, different strategies are needed that share a common differentiation between assistance and social integration.

Of course, outside of these levels, are those individuals who do not need any type of reintegration programme, but only an assistance programme.

The differentiation of these levels includes, expands and completes the development of the intervention process in the following aspects:

A) As regards the population they address

- First sphere: They cater for all individuals with a drug addiction problem.

- Second sphere: They address all those drug users in the process of rehabilitation that, due to their drugs habit, present characteristics and/or associated problems that make it necessary to resort to intermediate structures, which offer the conditions necessary to be able to progress from the assistance, on level one, to normalisation, on level three.

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integration programmes for drug addicts), Ed. GID, Madrid 1995.

The defence of these specific integration resources is based, precisely, on the existence of this type of drug addict whose rehabilitation process is interrupted because of a lack of structures along the way.

- Third sphere: This is addressed at the general population, with the defining criterion being their situation of need and not that of drug addiction.

B) Regarding the objectives pursued

- First sphere: These are objectives of a fundamentally therapeutic nature that bear influence above all on the relationship the individual has with himself or herself and with the substance abused.

- Second sphere: These are objectives that basically refer to the relation of the individual with his or her social environment and it could be said that, in those resources supported by specific facilities, the objectives lie halfway between the educational-training and the therapeutic, whilst in second level resources supported by non-specific facilities, the objectives are eminently more of a training type, related, basically, with employment aspects.

- Third sphere: These are the real objectives of social integration, where the individual starts to be incorporated as just another citizen, in the social structures of his or her environment.

C) As regards the actions they carry out

- First sphere: These include care facilities known as Outpatient Treatment Centres which may, in turn, have an influence on social integration objectives through the production of social integration programmes for each individual, contemplating the use of second and/or third level resources.

- Second sphere: These include resources supported by specific facilities for drug addicts (Day Centres, Activities Centres, Activities Classrooms, specific Workshops, etc.) and resources that are specific for drug addicts but

supported by non-specific facilities (Craft Network Programme, employment programmes for former addicts, etc.)

- Third sphere: These include the normalised general resources that any citizen has the right to use.

D) As regards completion criteria

- First sphere: Criteria primarily related with the individual's capacity to achieve and maintain abstinence, in a drugs-free programme, or to reduce the risks associated with drugs consumption in harm reduction programmes.

- Second sphere: Criteria primarily related with the individual's capacity to learn to carry out a specific task and to learn to respect the demands of its execution.

- Third sphere: Criteria related with the achieving of integration and the individual's permanence in the normalised resources.

It seems clear that, in reality, the use of one level or another of intervention, will be determined by the personalised evaluation of the individual and the design of an intervention programme for the same. In this respect, it is important to point out that intervention on different levels can be simultaneous in time terms and that, it will be precisely the adaptation between the order of the intervention and the needs and characteristics of the individual that will lead to greater or lesser success in achieving the planned objectives.

3. Example of a Reintegration Phase in a Therapeutic Community Programme

In the Reintegration Phase, the Community shows itself open to an environment that offers a support structure for the new emotions generated by incorporation into society, the family and work.

The objectives to achieve are:

- Acquire a greater degree of independence, developing potential, clarifying the scale of values and channelling difficulties.

- Provide complete integration in the living environment (family, friendship relations, work, etc.).

Structure

It is usually structured into three periods that, progressively, reduce the contact with the programme (Phases A, B and C).

- The First, lasting approximately 3 months, is the only one that is carried out on a residential board basis from Monday through Friday.

- In the other two Phases, the resident goes to a therapeutic group once a week (Phase B) or every 15 days (Phase C). The duration of these latter two phases depends on the personal processes of each patient.

Reintegration Programme

This usually contains a series of "Plans":

Social Skills Training Plan

- Functional rehabilitation and behaviour model.

- Behaviour testing.

- Workshops on emotional self-control, assertiveness training and social skills.

Compensatory education

- Literacy and basic skills.

- General School Certificates.

- Postgraduate

Combined training and employment actions

- Occupational job training; actions that were carried out previously with other sources of financing.

- Careers counselling and advice office.

Community Intervention and Awareness Raising of the Setting.

- Training Plan for agents.

- Plan for social awareness-raising.

4. Specific programme for people who do not require a residential stay in the TC.

This is for users who after a valid period in Care, are no longer considered as requiring residential stay, as it means distancing them from their living environment. For this reason, the work will be carried out on an outpatient basis. It is structured into Three Levels, where it is aimed to achieve the objectives of the Traditional Community (behavioural, affective and personal knowledge areas); together with those of the Reintegration TC (greater independence from inter-dependence on their environment, in such a way as to favour a complete integration in their living environment).

The approximate duration of this process is 14 months (6, 5 and 3 months, respectively, for each of the 3 Levels).

5. Intervention and Schemes in Spain.[95]

5.1. The ESF and Employment Directive Lines (LD)

LD1- Improving the capacity for professional integration

- The ESF plays an essential role in the promotion of active measures for employment, given that its quantitative importance reaches 0.40% of the GDP, which means more than a third of the total volume of activated employment measures in Spain.

- It fights against youth unemployment and to prevent long-term unemployment, through the co-financing of actions such as:

(a) Professional Occupational Training (FPO): co-financing, within the framework of Objectives 1 and 3 of the FIP Plan (Professional Training and Integration Programme), managed by the INEM (National Employment Institute) and by the Autonomous Regions with responsibilities in this area (Catalonia) and aimed at young unemployed people and those in long-term unemployment.

(b) Educational Workshops and Trades Houses: co-financing, within the framework of objectives 1 and 3 of this programme, of training/ employment designed to give qualifications to young people aged under 25 in sectors such as the recovery of artistic, cultural, natural or historical heritage, the environment, or improvement of the cities. This programme is managed by the INEM in conjunction with local authorities.

(c) Jobs and Careers Guidance: ESF support for the actions and services offering guidance organised by the INEM and the Autonomous Communities for young people and the long-term unemployed.

[95] **Budgets by area: Prevention** 16,476,586 PTAs. **Assistance intervention and social integration:** 97,673,676 PTAs. **Training, documentation and research,** 1,824,333 PTAs. **Institutional coordination,** 14,011,159 PTAs.

(d) Facilitate the transition from school to work. The ESF contributes, in Objectives 1 and 3, to the development and implementation of the new system of Professional Training regulated or initially envisaged in the Law of General Organisation of the Educational System. This programme is managed by the Ministry of Employment and those Autonomous Communities with responsibilities in this area. The main objective of the new system is to reinforce the relationship between the educational system and the world of work and to facilitate, in consequence, the transition from school to work. For this, Training at Work Centres (work experience in companies) has been incorporated as a compulsory subject in the study plans of initial Professional Training. Also, the ESF contributes to the professional integration of young people who have failed at school and disadvantaged young people through the Social Guarantee Programmes. Such programmes cater for young people aged over 16 years who end their schooling without any academic or professional qualifications, with the objective of offering them basic and professional training that allows them access to work or their return to the educational system.

LD2- Developing the spirit of enterprise

- To facilitate the launch and creation of businesses. Within the framework of Objectives 1,2,3 and 5b[96] the ESF contributes towards the creation of self-employment and of new businesses, through the co-financing of two types of measures: help for independent workers to set up in business and specific training courses.

- Exploit new opportunities for job creation:

(a) Support for local and urban development, with the objective of facilitating the development of neighbourhood services and the tasks of local development agents.

[96] Objective 5b from the old 1994-1999 Plan is absorbed by objective 2 of the 2000-2006 Plan.

(b) ESF intervention in new spheres of economic activity, not yet covered by the market, especially in relation to new pockets of employment.

- Converting the tax system to make it friendlier towards company creation. Participation of the ESF in the financing of grants for hiring personnel and the creation of stable employment, according to the conditions established by the agents in their agreement of April 1997.

LD3- Promote the capacity to adapt of companies and their workers

Support for continued education activities:

- Co-financing of activities managed by FORCEM within the framework of the programme of Objective 4[97]. This cooperation contributes an amplifying effect to the entirety of Continuing Education, facilitating the participation of less advantaged groups (women, workers with poor qualifications, SME employees) in training plans.

- In addition, the ESF contributes to developing a culture of anticipation in company training, through the introduction, since 1995, of actions to improve and accompany training (analysis of training needs, intermediate evaluation of actions and programmes, adapting of training to the characteristics of companies and employees, support for the creation of training and consultancy services for SME, etc.).

- Finally, the ESF co-finances, within the framework of objectives 1,2 and 5b, training actions and support for the creation of micro-companies managed by the Autonomous Communities.

LD4- Reinforce equal opportunities policies

- Co-financing of actions in favour of equal opportunities in the framework of Objectives 1 and 3: aid for the formation and creation of

[97] Ibid.

female employment, development of professional integration itineraries including guidance and accompaniment in job finding. Although the participation of women in programmes co-financed by the ESF is high (50%), the evaluations carried out consider it necessary to increase the resources allocated in Spain to support this directive, given the high level of female unemployment and low occupational rates that currently exist.

5.2. Integration Companies

The social integration of those people who, for a wide range of reasons, find themselves in a situation of exclusion, makes up the primary objective of organisations of a social nature working in different fields. And all of them coincide in pointing out the importance of employment in those integration processes established, due to its normalising and integrating nature, as well as being a learning tool for both habits and knowledge.

In this sense, we can affirm that there are numerous integration schemes being run in the Spanish economic sphere. They are being run under different company and organisational formats and in very varied sectors.

The need to join forces and coordinate existing realities have led to some existing schemes forming Spanish Federation of Integration Companies (FEDEI). Initially, this federation is made up of the following associations: Spanish Association of Salvage Recovery Workers in the Social Economy of Solidarity –AERESS, Catalan Association of Salvage Recovery in the Social Economy of Solidarity – ACERESS, Madrid Association of Integration Companies – AMEI, CARITAS Spain, EMAUS Association in Spain, Network for the Alternative Economy and Solidarity – REAS and the ANAGOS Network, and it is open to the incorporation of new organisations.

FEDEI was created to bring together and represent all those organisations working towards the social and work integration of collectives in a situation of exclusion under the Integration Companies formula.

For this, it has equipped itself with a structure based on participation, either through territorial Coordinators or Federations, or through organisations with a nation-wide scope.

The Statutes governing the functioning of FEDEI include, also, the aims and objectives established in the defence, promotion and representation of Integration Companies in Spain.

As its first and fundamental action, due to the inexistence of a normative framework that regulates and promotes, FEDEI is pushing for the approval of a legislative text that contemplates a social reality that already exists.

When we talk of Integration Companies we are referring to the integration, in economic terms, of a determined collective. The collective we refer to is that of the most disadvantaged and it has been called many different things: the isolated, the socially handicapped, the excluded, etc. understanding as such, fundamentally and in summary, those people excluded in social and work terms and with a clearly broken down personal and/or family structure. Exclusion and breakdown of structure are very closely related and both, indiscriminately, can be a cause or an origin.

Exclusion, in these collectives, generally presents one or several of the following characteristics:

- Chronic economic misery. They cannot resolve basic needs: food, home, education, health, etc.

- Low cultural level. Their lack of literacy and of professional training means that they have no resources to escape their poverty.

- Family breakdown. When family relations are precarious, the appearance of economic difficulties leads to abuse, alcoholism, drug addictions, drug trafficking, leaving home, prison, etc.

- Strong deterioration in physical and health terms (permanent medication)

- Total insecurity and instability and low self-esteem. The severity of the problems presented by the excluded is greater than that of many other collectives and they do not have the capacity themselves for exercising the slightest social pressure, which leads them to total defencelessness.

- Mental problems with behavioural alterations.

- Social rootlessness.

- No work habit. They have never worked, they have been unemployed for a long time, or they do odd jobs here and there.

- Absence of sufficient opportunities.

- Institutional dependence. As they have no resources, they depend on help from third parties or institutions.

Above all, the aim is that people have the possibility of a global integration process. And all integration processes need a prior itinerary in which the different spheres of intervention and the peculiarities and differential elements of each are detailed.

Thus, we can differentiate the main spheres of social and work intervention which can be classified into four main groups:

1. Sphere of BASIC PROVISIONS. Contemplates all those measures aimed at resolving the basic needs for subsistence. Amongst others, we could mention:

- Sheltered flats and centres.

- Subsidised housing for rent or sale.

- Popular dining rooms.

- Distribution of food.
- Minimum Income or Social Salaries.
- Emergency aid.
- Other economic grants for subsistence, etc.

2. Sphere of PERSONAL ACCOMPANIMENT. This covers all the actions relating to specific treatments for the problems added to their basic needs that hinder normal personal and social development. Thus we have:

- Detoxification treatments or programmes: alcohol or drugs.
- Mental health centres.
- Psycho-affective support.
- Medical and health treatments.
- Leisure and free time programmes, etc.

3. Sphere of TRAINING AND WORK SKILLS. Includes all those programmes and interventions aimed at improving knowledge, both theoretical and practical, addressed at excluded groups. These are basically:

- Non-regulated training.
- E.P.A. (Basic school education certificate)
- Compensatory training.
- Professional Training Courses.
- Professional Initiation Courses.
- Occupational Workshops.

- Work experience training (Grant-salaries), etc.

4. Sphere of ACCESS TO EMPLOYMENT. This embraces all those schemes for normalised integration into the economy. This is achieved through the following modalities:

- Self-employment:

Individual (Self-employment, Co-ownership, Professional Activity).

Collective (Co-operatives and Workers' Co-operatives).

- Employment. This is effected in organisations with diverse mercantile structures, mainly ordinary companies. It also includes Special Employment Centres, Sheltered Workshops and Integration Companies.

5.2.1. Objectives and aims of the FEDEI

- To represent and defend the interests of people and collectives in a situation of social exclusion, in the political, social and economic spheres before all types of people, organisations and public or private bodies of a national or international nature.

- To promote Integration Companies linked to new pockets of employment and to jobs creation.

- To coordinate and harmonise the interests of Integration Companies on a national and international scale.

- To request from the Public Powers and social and political agents, especially, and from the world of business and society in general, preferential attention and cooperation in the sphere of social and work integration.

- To inform, advise and negotiate with the Public Authorities concerning the production, development, application and modification of any legal

stipulations that may be passed and that affect people and collectives suffering from exclusion in the social and work sphere.

- To establish, maintain and encourage contacts and cooperation with national and international associations and organisations with similar interests to those of this Federation.

- To inform and advise members regarding any matters that may be of interest, promoting the exchange of information and experiences between them for the best development of their activities.

5.3. Social Incorporation Programmes in Spain

Amongst the programmes and services developed by Autonomous Communities, Town Councils and Non-Governmental Organisations in 1998, to provide drug addicts with living conditions and economic independence sufficient to allow them to relate to others and leave the exclusion circuits, those related to employment occupy top position. In this sense, the section on training affirms the upwards tendency of training programmes specifically directed at work incorporation, with 7,891 pupils, out of a total of 11,289 users of the different programmes of education, pre-training and job training**.**

Social incorporation programmes. Type, number of programmes and resources, and number of		
	No. of	No. of
Day Centres	67	3,272
Residential Support Programmes	171	3,249
Education and Job Training	367	11,28
Work integration programmes	138	6,400

Amongst the work integration programmes, the so-called "special employment programmes", with more than 5,000 users (around 79% of the total) seem to be the most adequate for providing drug addicts with salaried occupation, followed, with much lower usage rates, by craft workshops (1,003 users).

A notable feature in residential support programmes (including flats, residences and lodging with families), is the increase in drug addicts accommodated in "flats" during the different phases of the rehabilitation process, amounting to 76% of the total.

Moreover, in the framework of the Agreement signed in 1997, between the Ministry of the Interior and the Minister of Employment and Social Affairs, for the cooperation between the INEM (National Institute of Employment) and the National Drugs Plan Governmental Delegation, twenty projects have been approved for Educational Workshops and Trades Houses, with a total of 591 students. Also, 416 drug addicts in rehabilitation processes took part in courses from the National Professional Training and Integration Plan.[98]

5.3.1. Example of a Programme in an Autonomous Community

"AVANCE" Integration programme

Basis

The "Avance" project is based on the philosophy that matters relating to intervention in integration processes propose, first of all, The Law of Solidarity of Castilla La Mancha, as a general framework that defines the basic principles for intervention in situations of social disadvantage, and secondly, in relation to the target collective of the project, the objectives of the Regional Drugs Plan.

- Law of Solidarity of Castilla La Mancha (5/1.995 dated 23 March):

[98] National Drugs Plan, 1998 Annual Report.

The Law of Solidarity of Castilla La Mancha, establishes, in the explanation of causes, that the principle of solidarity requires the promotion of positive action measures, aimed at those citizens in a situation of social disadvantage, that facilitate their development and full participation in society in conditions of equality.

This norm defines social exclusion as the absence of basic and essential elements to consider a determined situation acceptable in human and social terms.

The processes of social exclusion have increased due, amongst other causes, to the evolution of the jobs market and above all, the increase in unemployment. A common factor in exclusion is unemployment. Access to work, to labour activity, to occupational training, is a vital step for people to gain self-confidence and start off down the road towards social inclusion.

Chapter II of the Law of Solidarity of Castilla La Mancha refers to these integration programmes. In article 46 they are defined as those which serve to promote the development of activities, habits and social and work skills of people suffering from social exclusion, through the provision of educational activities, occupational training and sheltered employment.

- Regional Drugs Plan (1996-1999)

The Regional Drugs Plan philosophy in the area of integration is based on three basic principles:

1. The normalisation of drug addicts via the use in their process of social incorporation of normalised resources (those destined for the population in general).

2. Working on this process of normalisation on the basis of individual integration itineraries.

Individual integration itinerary means the planning of intervention according to the socialisation process of each of the subjects, in other words, detecting what they lack in terms of acquiring habits, knowledge, inclusion and belonging to groups, capacity to relate to others, etc.; and then to intervene in these areas.

3. Permanent evaluation: a fundamental element in the design and launch of this project has been the development and evaluation of an integration programme whose starting point was the same philosophy (normalisation and individual integration itineraries) called "Exit Employment Project". In broad outline it consisted of the work integration of drug addicts through resources created according to the individual integration itinerary of each of the users.

In the evaluation it was observed that the level of job training of drug addicts was inferior to that of the rest of the population served, although this was not the case in terms of basic education.

In the design of the project, equal attention was also given to promoting salaried employment and self-employment. It is known that, in general, disadvantaged groups obtain better results in salaried work. In the evaluation they detected that the trend for drug addicts, in this work modality, was even better than in the rest of the beneficiaries.

All this served as a starting point for creating a new programme that would reinforce, firstly, job training designed for salaried work, and secondly, that would create sheltered spaces for work, that would allow users to work in less competitive conditions.

- Process of Integration (general framework of the project):

They started from the hypothesis that the collective served by the project needed an intermediate job, in protected work spaces, before incorporation

into the normalised labour market. This allowed direct and individual attention to their training and work related deficiencies.

To achieve this objective, participation by different institutions and non-governmental organisations allow them, firstly, to achieve the flexibility needed in order to work with integration from a Non-profit Organisation and secondly, to maintain a stable structure such as that of the Local Administration and the Regional Drugs Plan (its assistance network) which are capable of having a global view of different collectives with problems in social and work integration, and that can correct the different deficiencies that are causing that "non-integration" from the viewpoint of different disciplines. This global view enables them to produce an individualised and complete integration itinerary for each of the people eligible for inclusion in the project.

Project Objectives

- General Objective

Creation of stable resources for the social and work integration of drug addicts in processes of reintegration in the region, under the methodology of integration companies, dedicated to economic activities within the general framework of new pockets of employment, procuring the normalisation of these resources through integration in the same, of non-drug addicts, coming from Social Services Primary Care resources.

- Specific objectives

To train drug addicts in processes of integration and those people referred from Social Services that need training, in the knowledge necessary for working in the integration resources created.

To give psychosocial support in the individual integration itinerary to drug addicts in reintegration using the project and other people referred to it, paying special attention to women with family members in their charge.

To provide technical support for the creation of integration companies in the region, as a stable resource for social and work integration.

1. To support job creation through subsidies for jobs effectively created.

2. Support for self-employment under the social economy companies format.

Referral of users (Integration Itineraries)

The itinerary of the groups attended to by the project (drug addicts in treatment and the "normalised" population) starts at different points, converging in local structures, to continue in the different phases and resources designed in the project.

The profiles of users eligible for the project, although with differing characteristics, have a common point of convergence in the objectives themselves of the project, in other words, the need to adjust deficient personal situations to meet the minimum requirements met by the rest of the population in order to gain independent access to social and work resources.

The target population's itinerary begins in the Drug Addiction Treatment Teams (E.A.D), where those users with the profile required to join the programme will be selected. This profile will be:

- Users who have been in treatment for at least 6 months.

- A lack of education or training, at any of the levels established in the project, to access the jobs market.

- The need, based on their individual shortcomings, to use a sheltered employment resource before going on to access the normalised world of employment.

Before referral, and throughout the project duration, work will be done with users on all their deficiencies related with their addiction problem, and monitoring and support will be maintained.

Once the person has been selected at the treatment reference sector, contact will be made with the local structures, informing on each person's characteristics and individual needs to jointly produce the itinerary of actions to be followed and the duration of each of these.

Once the itinerary has been designed, the coordination and information period will be established between professionals from both resources.

If the user needs, in addition to the actions carried out in the local structure, to go on to actions described in the second phase, sheltered work spaces, the design of the itinerary will involve three professional groups: treatment teams, local structures and integration company.

Finally, the decision on the user continuing in the sheltered space after training, due to lack of preparation for accessing the normalised jobs market, will be agreed by the three aforementioned parties and with the authorisation of the monitoring committee.

It must be taken into account that work will be on an individual basis with each user, specifically determining his or her itinerary, therefore not all patients will carry out all activities in a continued and linear way. In other words, the user will not adapt to the actions, but rather the actions will be adapted to the user, to achieve the final objective of preparing the user for facing the demands of the jobs market.

Organisations that participate in and co-finance The Project:

Name of the Organisation	Type of cooperation
Regional Drugs Plan - Health Council	Technical, Advice and Co-financing Organisation of Regional Coordination
The 8 Town Councils headquarters of the Project's Local Structures	Bodies that manage and co-finance the Local Structures
"Antigua Usanza, C.B." (Albacete)	Manages and co-finances the Business Project located in the province of Albacete
"Nuevos Horizontes" Association (Ciudad Real)	Manages the Business Project located in the province of Ciudad Real
Valdepeñas Town Council (Ciudad Real)	Co-finances the Business Project located in the province of Ciudad Real.
"SEMFORD, C.B." (Cuenca)	Manages and co-finances the Business Project located in the province of Cuenca
The Guadalajara Town Council	Manages and co-finances the Business Project located in the province of Guadalajara.
The Talavera de la Reina Town Council (Toledo)	Manages and co-finances the Business Project located in the province of Toledo.

Functions

- Non-profit Organisations

1. Manage business projects
2. Teach occupational training
3. Commercialisation of the product.

4. Coordination with local offices for the joint selection of beneficiaries who will start occupational training.

5. Monitoring of users during their time in the programme.

- Federation of Municipalities and Provinces of Castilla La Mancha

1. Coordination with 8 Local Structures.

2. Coordination with the P.R.D.

3. Coordination with the Non-Profit Organisations.

4. Coordination with the Administrative Unit of the European Social Fund.

5. Production of the annual budgets of all the participating entities and control of the budget.

6. Transnational and transregional aspects.

7. Management of Aid for the project from other institutions in the Communities Board.

- Local structures

1. Coordinator with the Town Council resources of Employment, Social Services and Tax.

2. Selection of the population from social services.

3. Coordination with the E.A.D of its health area for the selection of drug addicts in treatment.

4. Coordination with the managing organisations of the business projects for the referral of the most suitable beneficiaries for occupational training.

5. Coordination with the E.A.D of its health area for the selection of drug addicts in treatment.

6. Coordination with the managing organisations of the business projects for the referral of the most suitable beneficiaries for occupational training.

7. Carrying out of prior, basic, and pre-professional training, jobs and careers guidance and design of the individual integration itinerary, monitoring and evaluation of beneficiaries.

8. Management of grants for employment and self-employment.

- Regional Drugs Plan

1. Through the E.A.D, referral to the Local Structures of the project's target population (drug addicts in treatment with the E.A.D and in the phase of reintegration).

2. Ultimate responsibility for directing the project.

3. Technical support.

4. Global monitoring of the project.

6. Situation in Italy.[99]

6.1. Work as promotion

Social intervention in the field of drug addictions, once the first emergency phases have been overcome, and after having co-operated in the forming and spread of therapeutic communities and public services, after having dealt with interventions for recovery through the use of ergo-therapeutic activities, today decidedly backs the avoidance of a purely curative care logic for drug addicts.

[99] VACCARI, G "Estrategias de gestión de recursos multisectoriales en un territorio" (*Management strategies for multi-sectorial resources in one territory*). In: "International Meeting (...)" Junta Castilla-La Mancha y GID, Toledo, 1999.

It is considered necessary to carry out processes to promote the individual and collective resources of social and work integration. This desire-need (whether of the social workers or the drug addicts and former drug addicts) sees work as an important instrument, as a factor of evolution and of change. The "work" theme in projections linked to drug addiction now represents a very different thing to the care-repression stereotype of a few years ago.

Work therefore, is no longer just an economic resource, for the services, it is also a therapeutic, educational and social integration instrument. In Vaccari's opinion, for drug addicts work is experienced as a moment of recovery and revitalisation of their own existence, as a moment and place for promotion of their own skills, for the construction/reconstruction of their individual personal and social identity, for recognition of their capabilities. Work as an instrument requires, therefore, a culture that sees the person's active and visible complicity and the desire for real independence, more social than financial. If in recent years an interest has developed in the work/drug addiction theme by the services and realities of the social private sector, the resources and the notable skills acquired, have not yet had the possibility of becoming common heritage. Proof of this is the lack of specific studies on the projection, execution, models and good practices used and above all the follow-up of interventions that give complete descriptions of the projects and the destination of drug addicts or ex addicts who have resorted to therapeutic or work integration resources.

From these reflections is born the need to:

- Produce and promote education for work integration;

- Very clearly define the objectives, methods, actions or acts and the results envisaged by the projects;

- Carry out a reflection on the functions, professionalism, responsibilities and practices in situ, to reflect on which, amongst the various processes

carried out, and the new skills acquired can then be considered as exemplary and a model for the future.

- Verify and evaluate projects.

The step to be taken is to go beyond small partial schemes, to carry out an organised projection and take advantage of all the local resources. This would permit the production of a culture, theory-based practice, instruments and useful techniques that are priorities during the process of accompaniment, support, development and confrontation between the realities during the re-socialisation of drug addicts. In short, the setting up of a reflection whose objective is to order and restructure the "work" theme, opening it out to a logic of promotion and development.

It is especially necessary to develop work integration projects for drug addicts in social companies, crafts trades, and "profit-making" factories, in addition to activating forms of social initiatives where the protagonism of many young people from socially disadvantaged backgrounds is valued.

6.2 Integration Process

The Integration Process in Italy, according to Giuseppe Vaccari, can be divided into three phases:

1. Activation of integration into the labour market

Following the production of an individualised plan and the individualisation of the productive unit where the integration will take place (the ideal being to combine the individual's personality with the characteristics of the job), the next stage is the formal activation of integration into work. This envisages some instruments such as work integration agreements (this is the instrument that "has precedence" between the parties: companies, candidate, co-operative), and therapeutic norms (an instrument used by some services to reaffirm the commitments between the candidate and the service itself).

2. Management of the integration

Once the work integration process has been started up, management and monitoring are necessary, with regular verification of progress.

3. The evaluation of the integration

Evaluation requires a sounding out of the success or failure of the process begun. Frequently a work integration that has not been transformed into a continued and stable job once the trial period is over, is evaluated negatively. However, it is considered that the evaluation of the work integration should take into account not only the transformation of the relationship between the person integrated and the company, but also the changes that have take place in the individual (future outlook, social integration).

6.3. Some tools:

6.3.1. Project evaluation

One of the least known and developed aspects in the field of work integration, according to Vaccari, is project evaluation. This consists of a critical reading of the interventions carried out to verify the success or failure of the said intervention. It is important to evaluate the successes of the intervention relating it with the expectations of those involved (private and public operators, people responsible for work integration processes, employers, work colleagues), and also in relation to the prior objectives. This activity reveals the strong and weak points of the integration project. The use of tools and shared statistical tables may provide a more objective evaluation.

6.3.2. Promotion

To create the bases for contact between social requirements and the world of work, which finalises when there is a willingness on the part of business, an immediate work integration itinerary is ready, and the way has been prepared for the social workers who act as intermediaries in direct contact with the

company. A personalised strategy for the promotion is a publicity Campaign involving the sending of a leaflet and an accompanying letter. As far as possible use local "mass media", especially if they are newspapers from the authorities or from associations recognised as being of public value.

6.3.3. Awareness-raising.

Direct contact with companies (personnel managers, employers, people in charge) offers the possibility of communicating and transmitting a social culture of work integration.

Advertising is, in certain aspects, an awareness-raising activity, but it is aimed at a limited number of players (personnel managers, some companies). Awareness-raising, however, aims at a greater number of productive units and more specific objectives are demanded (tackling specific situations of need).

6.3.4. Epidemiology, monitoring and research activities

Monitoring, epidemiology and research activities are vital in the field of drug addiction. Research activity should be included in the programming of services and have precise and defined objectives, such as:

- Finding out the aspects, forms and ways in which drug addiction develops and alters.

- Finding out the characteristics and peculiarities of the drug addiction phenomenon in its own environment.

- Providing documented data for regional and business programming activity.

- Acquiring elements of knowledge and evaluation on the methods and instruments that have to intervene.

- Locating new and more suitable operative instruments.

6.3.5. Verification of interventions

With the aim of localising the most necessary instruments, optimising responses and using resources to allow for the extension, expansion and dissemination of forms of intervention, with the contracting, retaining or the correcting of those that have lacked effectiveness, constant verification of each intervention is necessary along with evaluation of the results achieved.

The verification of interventions and the evaluation of the results achieved in relation to objectives, is a required condition for continuing with the scheme and for access to public financing.

In treatment for people with problems involving psychoactive substance dependency, it is necessary to be aware of the physical, mental and social circumstances of the individual, an immediate (no more than 15-30 days) and documented diagnosis, based on respect for the person and taking into account their indications. This diagnosis should come from the group of professionals that is necessary for satisfying demands of interpretation and intervention in drug addiction. Formulating the diagnosis is the essential instrument for giving direction to the person's total reorganisation.

7. Initiatives in Greece[100]

The first programmes for drug addicts in Greece began in the 1980s, when addiction became a social problem.

After therapy, the subject of social reintegration rapidly became a priority issue, not only from the point of view of therapeutic programmes and of patients, but also for the community.

Gradually, two laws were established for tackling the problem of addiction.

[100] REZITI, V "Situación en Grecia" (*Situation in Greece*). In: Ibid.

The first law (1729/87) founded the Organisation for fighting drug abuse, called OKANA; this Law is responsible for studying, proposing and organising national policy in the sphere of prevention, therapy and social reintegration, also subsidising these programmes.

This Law provided the legal framework as well as the directives necessary for the creation of therapeutic communities and rehabilitation centres.

The legal right was also given, to those completing such programmes, to request the court to not include in their criminal history, requested by employers, prior convictions relating to drug use.

The second law (2161/93) gave the opportunity to other institutions (town councils, church, etc.) apart from the Ministry of Health and Social Services, to create social reintegration programmes in the community under the direction and support of OKANA.

The majority of the therapeutic programmes offering organised rehabilitation centres for the social reintegration of former drug addicts are those described below:

7.1. KETHEA

This is a non-governmental, non-profit organisation that is sponsored by the Ministry of Health and Social Services.

Kethea was the first centre to create a therapeutic drugs-free programme in 1983, based on the therapeutic communities philosophy. Kethea offers treatment, professional training and social rehabilitation for drug addicts.

Nowadays Kethea manages a large number of therapeutic programmes all around Greece. It has nine treatment centres, six therapeutic communities, six family programmes, seven programmes for addicts in prison, two outreach projects and eight residences working towards the social reintegration of former drug addicts.

With the aim of achieving social integration Kethea tries to eliminate deficiencies and increase social and professional skills. Courses on careers guidance and professional training form part of the therapy.

To overcome employment difficulties and help former addicts tackle their legal problems, Kethea is trying to organise a psychosocial support group in the community, co-operating with town councils and professional organisations.

Kethea has started a series of professional training courses financed by the European Commission and in collaboration with the Ministry of Employment, the National Institute of Employment, the University of Pantio, the Youth Administration and many municipalities.

Training is also offered to former drug addicts who after therapy are interested in becoming therapists to work in Kethea or in another programme related with drug addiction.

Kethea participates in the European Commission Initiatives: INTEGRA and YOUTHSTAR.

7.2. PROGRAMME 18

This programme was created in 1985 and it is financed by the Attica Psychiatric Hospital. Today it has many programmes running in Athens and Tessalonica; therapeutic rehabilitation and family therapy centres, programmes for young addicts and homeless women addicts, etc. For Programme 18, the social reintegration phase is the last part of the therapy and also the most crucial and its objective is to make patients capable of organising their own lives based on a new meaning, and to face up to reality without trying to escape from the difficulties and disappointments.

The therapeutic programme is the necessary transition for a slow and painful return to society. Through therapy the patients realise that they belong to the

therapeutic framework, to the group. This may be the first time that they feel that they form part of a group and at the same time they are independent.

Employment strengthens their feelings of independence and increases their sense of responsibility, social recognition and self-esteem. It also offers better circumstances for forging new relations, a new lifestyle and constant change.

The therapeutic objectives in the process of social reintegration are the following:

- Professional training and creative work

- Participation in educational activities and other activities for the mind

- Encouragement in taking up a hobby

- Participation in sporting activities

- Participation in cultural and artistic activities

- Participation in self-help groups (A.A.N.A)

- Learning to tackle crises and high risk situations

- Creation of a social support network

- Creation of new relationships in a spirit of community participation

- Adopting an important role for oneself and for others in the framework of a new lifestyle free of drugs, and full of values, meanings and objectives

- Aspire to and achieve a certain quality of life

- Acquire self-respect, self-control and feelings of self worth.

- Develop a critical way of thinking parallel to emotional expression: respect what is different.

- Be capable of programming and planning in long-term. Commit oneself to responsibilities.

- Independence with the original family at all levels

- Ensure and protect all human and democratic rights against social discrimination and racism.

7.3. THISEAS

This programme originated in the Municipality of Kallithea in cooperation with the Ministry of Health and Social Services. Thiseas accepts former drug addicts who have completed a therapeutic programme and are now facing up to and trying to overcome the difficulties of their social and professional rehabilitation.

This programme's objective is not only the social reintegration of its members. Its aim is to be capable of intervening in all activities connected with social reintegration of former addicts, ranging from national policy and social support networks to raising awareness in society.

The services offered by this programme include:

- Self-help groups

- Social activities groups

- Relapse prevention groups

- Drama therapy groups

- Careers counselling and professional training

- Medical care

- Legal aid

- Cultural and sporting activities

- Sailing lessons

7.4. OKANA

In 1996 OKANA began two substitution programmes (methadone) in Athens and Tessalonica.

These programmes include a phase of detoxification and a phase of social rehabilitation.

In the detoxification phase, methadone is supplied. Apart from that provided by the programme, the use of other substances is not permitted. There is a maximum time of two years for gradual detoxification from methadone and then the patient enters the phase of social rehabilitation. In the detoxification phase patients participate in individual and group therapies. The programme also facilitates social grants, medical services and access to cultural and artistic activities.

At the end of 1996 the programme offered its patients professional training courses in cooperation with the professional training authorities and the OAED (Organisation for Employment). The idea was that socialisation could begin before the rehabilitation phase. It can be carried out during detoxification and the patient can gradually adapt to the process of training and employment.

The social workers encouraged patients interested in working to apply to the OAED, the organisation responsible for finding work for the unemployed. In 1997 OKANA began its “legal aid” programme for all patients participating in OKANA programmes. At the end of the year training courses on prevention were provided for all those patients who were carrying out their therapy correctly. Some of these patients later worked in an OKANA outreach programme.

In December 1997, the first patients were moved from the detoxification centre to the social rehabilitation centre. During the first months of rehabilitation the option is given, and patients are encouraged, to take naltrexone with the objective of reducing the risk of relapse.

A statistical analysis showed that only 10% of the patients that took part in the programme when it began in 1996 managed to reach the social rehabilitation centre. The other 90% went back to the streets, mainly because they were expelled from the programme for consuming other substances at the same time or due to violent behaviour.

The rehabilitation centre offers individual therapy and group therapy as well as several opportunities to participate in artistic and cultural groups and events. Its social services cooperate with public and private institutions as well as town councils to provide former addicts with career training and job opportunities. The programme lasts one year. After finishing the course, those who want to start up their own business can apply to the OAED for a career loan.

8. A French Example: The "LE PEIRY" Treatment Centre[101]

Since 1974, the "Le Peiry", Specialist Treatment Centre for Drug Addicts, based in the French department of Lot, north of Toulouse, has been taking in men and women drug consumers, mainly intravenous heroin and also psychotropic drugs users. Most of them come from urban centres (Paris and the surrounding area, North, East, Provence, Cote D'Azur, etc.) where they live amongst situations of affective, physical, social and cultural exclusion. In general, they say that they want, like all drug addicts in the world, to understand the reasons for their dependence on drugs, with the exclusion of alcohol and cannabis; their deep desire is to know themselves better, to live

[101] MASSALOUX, C. "La inserción de drogodependientes (...)" (*The integration of drug addicts...*) In: Ibid.

like everyone else, a normal and decent life, without violence, without theft, without lying and without problems.

For the last few years, they have been receiving substitution users (around 60%) on Methadone or Subutex (high dose buprenorphine) and medical treatments: tranquillisers and hypnotics, anti-depressants, and on rare occasions, neuroleptics.

For Massaloux, the thing that has changed most is the social environment and this poses problems: vagrancy, precariousness, unemployment, poverty, single-parent families, Aids, hepatitis B and C are the main changes. Therefore, beyond the psychotherapeutic work, their integration objectives have changed completely.

For “Le Peiry” social accompaniment of the drug addict no longer only means treatment of exclusion or disadvantages for work. Basing themselves on Robert Castel's analysis, they think that these deficiencies reflect more “a shortcoming of the social organisation that does not give its members the necessary means for integration” than “the individual's own incapacity to satisfy the demands required”.

- Thus, how can the social requirement be satisfied?

- How can strategies be produced for the reintegration of drug addicts, when we do not trust the categorisations based on the definitions given by social policies?

- How should we accompany the recomposing of social identity, social incorporation, social integration, if not by applying pressure on social justice and recreating links?

To respond to these questions, the “Le Peiry” representative, showing great originality, takes a leaf from Freud, who in 1929, in his work Civilisation and its Discontents, says that “what human beings find hardest to bear are

relationships with their fellow human beings". In his view, one of the most important factors in this lack of harmony in the relationship with the Other, is aggressiveness. He also writes that "it is a representation of the death impulse".

According to "Le Peiry" the main work should be, in these times of mutation more than ever, to help drug addicts to renew their relationships with the Other, integrating their difficulty into this process. This is what they try to do every day, either at the Centre, in their printing and small heritage workshops, at the Methadone Centre, or in their network of Foster Families.

Since the creation of "Le Peiry", the Association's Board of Administration and its multidisciplinary teams work ceaselessly in the integration of the institution, an essential principle to avoid socio-economic and even socio-political separation.

All the players in this voluntarily limited universe, register within a multitude of economic and social networks that exist around the Association, with its deeply rooted heritage, traditions, and culture. They try to offer an environment of security, of calm, appropriate for restructuring the personality.

According to Massaloux, the region, apart from the tourist attractions it offers, continues to be deeply rural and is a good reflection of the traits of people tied to their land. And the network we mentioned, to which residents are invited, like rural evolution, has been sewn together bit by bit in the illustration of special values, typical of the environment, constructed without noise, with prudence, hesitation and perseverance. Despite the scattered habitat and the absurd infrastructures, a fraternal spirit of solidarity reigns that originated from the thousands of mishaps that took place over time.

In spite of the fact that comfort, mechanisation, electronics and computers all now have great importance in day to day life, the moments of life

proposed here, under the clouds, the sun or the rain, give or once more give form, day by day, and favour a profound change that perhaps reflects a first sense of rediscovery of a forgotten sense of society...

8.1. Potholing as a Reintegration activity

"Le Peiry", continuing with its originality, proposes Potholing as a social reintegration activity. Let's see how:

Setting and underground environment

Like many other activities, potholing requires that the objective be established with precision, that indications on a map be followed (itineraries) that a reconnaissance of the terrain be carried out (local initiatives) which means getting information by approaching the people living in the area.

An expedition of this type requires conscientious and meticulous preparation of material, both on an individual and group level. According to the time planned, a meal is normally prepared. Upon return, inspection and cleanliness are strict. These are somewhat boring and thankless tasks and it must be said that volunteers tend to vanish into thin air.

There are very few precipices that do not require an approach walk, loaded down with heavy materials. The cavities are, essentially, difficult to discover. The narrow mouth is hidden under a juniper wood, and, amongst the aggressive thorns, is where one has to search (social hostility), and sometimes this takes a long time. Some give up and let other more persevering or impatient colleagues take on the responsibility of continuing the search.

If it is sunny, they lie in the grass, if it is raining or icy, all skills are required to find a space in the cars. Suddenly shouts are heard, the cave has been

found, much to everyone's joy. Thus, potholing does not respond to the “all, immediately, here and right now” and forces a delay in pleasure.

Baptisms of clay, darkness, night-time, impressive silences or strange noises many affect even the most recalcitrant. Those of a more vandalic nature show a surprising respect when they have to try and find their way through the immaculate rock walls.

The ghostly shadows projected on the walls, mixed with stalactites and stalagmites, offer a fascinating spectacle. The tiny drops of water deposited on a calcite dagger provide discussions on past centuries and inexorably leads to the subject of ageing, unavoidable, and highly appreciated by drug addicts.

Contrary to the idea that we may have, the drug addict - except in a few isolated cases - is not a very reckless person nor suicidal; quite the opposite, they know fear, panic, and all the difficulties involved in hiding one's emotions in places of this type. The shakes, the trembling pulse, uneasiness, are inevitable in these places, and they require a self-control and a will to succeed that are not very commonplace. This is the moment where the drug addict starts letting other sensations penetrate apart from those related to chemical pleasures...

The specific conditions required by any expedition ensure an unequivocal learning experience. The exploring of a pothole is highly codified in all its aspects. Transgressions are few, males and females respect the norms (social and work laws), knowing that a false move may mean an immediate sanction.

Passing through narrow stretches, crevices or cracks often provokes cries of: “I won't get through! ¡I'll get stuck!

Pendulum movements in vertical potholes, the ascent up a narrow ladder with a mind of its own, require more a changing rhythm or synchronisation than aggressive outbursts or muscular strength.

The assimilation of these reflections plays an essential role, the drug addict is asked not only to learn how to make a great effort, but also a little ambition and a great deal of optimism.

The practice of potholing is not the result of a chance meeting with elements or individuals, at a particular moment in an uncertain place.

It requires the definition of precise objectives (itineraries), equipping oneself with adapted materials and instruments (training): “We are not going to use a 30 metre rope to descend a 50 metre pothole”.

Foreseeing and controlling their own weaknesses, daring to overcome their limits and not losing concentration before the slightest obstacle, are the essential characteristics experienced in these situations.

According to Massaloux, the learning of this discipline means passage through different stages of apprehension, acclimatisation, they need to be given the resources to be able to orient themselves in a given setting, always with uncertain limits. Constant fluctuations between two different views, often finding an analogy with the ambivalence and incoherence of adults in evasive or hypocritical answers. The idea, then, is to give the drug addict, in a newly sexed body, certainties, fixed reference points, the pleasure and enjoyment of independence.

This underground rodeo, Massaloux continues, had the single objective of touching a fundamental point of our therapeutic objective, the renewal of the relationship with the Other, which allows one to make peace with oneself.

The following point, is that of the integration of the Centre itself, an unavoidable prior step that allows ambitions of reintegration.

The association has a small printing works, a maintenance and heritage workshop and a centre for help in working life. They also practice the revision of “basic knowledge”, an approach to the modern world in which thousands of administrative procedures are learned, as well as the learning of new communication technologies.

These workshops are neither occupational nor ergo-therapeutic; their mission is productive and they generate income. They are also obligatory as half-day work. The money earned (without any social surcharges or taxes for the resident), is around 1,300 French francs per month (around 32,000 pesetas). This allows partial self-financing of the stay and a part contributes to a principle of financial independence.

The resident keeps 50% of the money for small expenses; a quarter is added to a collective reserve managed by the group. This reserve is used for external leisure projects.

This is an instrument which, given what is at risk, allows the normalisation of a certain dynamics regarding money and power.

More occasionally, as social cover reaches 60% to 70%, it may be used to finance what we call medical emergency.

The final quarter is managed individually and constitutes a small savings capital for integration projects, which is added, by some, to other income received during their stay such as the RMI (Integration minimum income), disability benefits or social security subsidies.

But the context of this turn of the century, Massaloux continues, leads them to have doubts about these actions. They are considering a different way of tackling reintegration for the year 2000. They are concerned about their global organisation, like any company, the objective no longer consists in an important volume of production.

Economic difficulties make forecasts impossible. Competition is important and the appearance of new companies will disturb their micro-organisation.

Problems with investment, regulations and the reinforcement of legislation, with new regulations, VAT, social surcharges, taxes, etc.

Inspired by reengineering, which is an organisational management concept that tends to bring together company resources around base processes, they are currently trying a restructuring process, not according to their resources but according to their objectives, and more precisely according to the activities that they practice to satisfy the needs of their residents.

9. Portugal

9.1. The DIANOVA Organisation as an Integration Company

The objective of the DIANOVA Portugal Association is the creation of jobs, and this involves a number of difficulties, not only due to the special nature of its worker group, but also the increase in expenditure demanded by the situation.

Thus, with the candidature for integration companies, the Association gives its those users who are at a greater professional disadvantage an opportunity, offering them professional training with a wage (co-financed by the State). The financing achieved by the Association allows it to increase the production capacity of some of its activities such as flower-growing, cattle-raising, etc., increasing the possibilities of achieving permanent work contracts for these people.

The Association's future workers mainly come from groups that are especially disadvantaged in terms of employment, with very low educational levels and no professional qualifications; they present weaknesses in basic conditions of a personal nature for exercising a profession in a work

organisation. An added problem is the lack of family support for social and professional participation.

Thus, the situation of the future workers demands a promotion of their employment conditions through professionalisation, and the overcoming of basic needs, with professional training programmes that are suitable for teaching them, with accompaniment in the search for a job and remaining in employment.

These demands are too much for the Association's resources, therefore it needs external support. In this context, the integration companies created by decree No. 348-A/98 dated 18 June, are one of the measures envisaged in the National Employment Plan, designed for responding to the needs listed above.

The integration companies are structures that enjoy administrative and financial autonomy and that are integrated into the Association's organisational set-up. They develop Association activities that display some economic feasibility, recruiting Association users for these.

As an integration company, the Portuguese State grants the Association technical support in the preparation of the integration process and the accompaniment of people in the process of integration, from admission to their effective integration into the jobs market, and financial support for investment and for the functioning of activities that are going to form part of the integration company. An integration prize is also awarded for each work contract that the Association obtains with people in a process of integration.

THERAPEUTIC COMMUNITIES

1. Adaptation of TCs to the chronicity and comorbidity of drug addicts
2. Origin and development. SYNANON, DAYTOP-VILLAGE
3. The TC of British and American origin. Development and basic characteristics, M. JONES
4. The TCD according to DAYTOP and the TC according to M. JONES
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THERAPEUTIC COMMUNITIES

The Therapeutic Community for Drug Addicts (TCD) takes the form of a therapeutic medium based on permanent interaction between the users, their peer group and the team. Intervention is intensive, multidisciplinary, coordinated and oriented towards the addict's complete rehabilitation.

Treatment in a TC means abstinence from drug abuse and a global change in lifestyle involving behaviour, cognitive and affective response patterns, attitudes and values, psychological equilibrium and an active commitment to resolve the consequences resulting from drug abuse. The agents of change are intervention strategies applied by a specialised team, comprehensive care and treatment, social learning within a group setting, self-help and personal motivation to change.

The professional Therapeutic Community for Drug Addicts (TCDA) in Spain[102], as in other European countries, offers a very useful rehabilitation model for a sector of drug addicts that need a safe environment and more intensive intervention. The development of these programmes is aimed at their adaptation to new user characteristics and aims to make the most of the resources available.

[102] COMAS, D "Criterios y Normas para la Homologación de Comunidades Terapéuticas Profesionales para Toxicómanos" (*Criteria and Norms for the Standardisation of Professional Therapeutic Communities for Drug Addicts)* APCTT. 1994.

1. Adaptation of TCs to the chronicity and comorbidity of drug addicts and new consumption patterns.

Clinical evidence suggests an increasing percentage of users presenting concurrent or past psychiatric disorders, especially emotional and personality disorders. Also, the data available show that TC users are individuals that in many cases present with a long drug-taking history and a background of numerous treatments, followed by relapses. Both of these characteristics (chronicity and comorbidity) often appear associated with poor treatment results for drug abuse.

Some TCs, in Europe and the USA, are adapting their programmes for chronic patients (for example, using methadone treatment), and for patients with concomitant psychiatric disorders (psychopharmacological medication).

Current clinical experience shows that a significant percentage of patients on methadone maintenance do not manage to achieve therapeutic objectives and continue with risk practices (use of drugs, high-risk sexual conduct, etc.). The TCs are starting to offer therapeutic alternatives for these types of patients who do not adapt to methadone treatment programmes on an outpatient basis.

2. Origin and development. SYNANON, DAYTOP-VILLAGE. Basic characteristics.

2.1. SYNANON

In California (USA), in 1958, a group of heroin addicts, led by Charles Diederich, organised (following the Alcoholics Anonymous model) a residential community: SYNANON, where they took in all types of drug addicts. They set up as a self-help group and rejected the participation of Mental Health professionals. The SYNANON community aimed to be a

kind of substitution family and gradually took on the form of an alternative community life that isolates itself. Based on a supposed incompatibility between drug addicts and society, it demanded that its members remained in the organisation indefinitely to ensure that they stayed clean, so dropping out or being expelled from SYNANON, meant that to return was impossible. (Roig-Traver[103], 1986; Comas[104], 1987).

This community adopted a rigid internal hierarchy where the resident occupied different positions according to his or her changes in attitude and/or behaviour. They proposed achievement of what they called "self-identification" or "finding oneself" and for this they used the so-called "SYNANON Games". These were peculiar group dynamics of "Attack or Confrontation", supervised by the older residents, where the negative behaviour or attitudes of members were reported and criticised in front of the group. In SYNANON recent arrivals were viewed "as if they were children" who in the community entered into a learning process to achieve maturity.

This organisation, which enjoyed notable expansion and reached a stage where it had thousands of members, later entered a process of deterioration to the point where is became consolidated as a fundamentalist and authoritarian sect, with a tyrannical and manic leader, Charles Diederich, who in 1987 put a poisonous snake in the letter box of a dissident member. SYNANON ended up, therefore, totally isolated and closed in on itself, without any real treatment function. (OTTENBERG[105], 1982; MANN[106], 1987).

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[103] ROIG-TRAVER, A. "El modelo americano de Comunidad Terapéutica y su difusión en Europa". XIII Jornadas Nacionales de Sociodrogalcohol. Palma de Mallorca, 1986.
[104] COMAS, D. "El tratamiento de la drogodependencia y las Comunidades Terapéuticas." Ministerio de Sanidad y Consumo. PNSD. Madrid, 1988.
[105] OTTENBERG, D. "The Therapeutic Community today" C.I.S. Rome. 1974.
[106] MANN, R.D; Wingard, J. "A cross-cultural study of drug rehabilitation methodologies in Sweden and the United States". In: Eisman, S. ED. Drug Abuse. Foundation for a psychosocial approach. Faarmingdale.Baywood, 1987.

However, as highlighted by O`Brien[107], in 1985: "The influence and impact of SYNANON on today's Therapeutic Communities for Drug Addicts is indisputable".

2.2. DAYTOP-VILLAGE

In 1964 a group of SYNANON members were hired by a North American public body to organise a Treatment Centre for Drug Addicts in conjunction with a team of Mental Health professionals.

This led to the emergence of DAYTOP-VILLAGE, the first TCD attended by a mixed team, made up of ex-drug addicts and Mental Health professionals. The DAYTOP TCD was proposed as a treatment resource for breaking the drugs habit and the later social reintegration of drug addicts. It proposed a limited stay in the Community, of around 16-18 months, and a return to society through what is called an intermediate programme, which included the use of sheltered urban apartments and support psychotherapy.

From SYNANON it retained the aim of achieving, through discipline and self-help, a degree of personal maturity that, it is supposed, the drug addicts lacks. It sustained that life in the community and the activities carried out there have positive effects on residents and lead to an internal hierarchical structure, also similar to that of SYNANON.

Intervention techniques, with priority given to group work, were formalised here as: "Meeting Groups", "Dynamic Groups", "Control Groups", "Special Groups", etc. and were perfectly defined. Intervention involving families, via the so-called "Family Meeting Groups" was progressively introduced as another very important element in this type of intervention in drug addiction (Comas, 1987).

[107]O'BRIEN, W. "The therapeutic Community –static or moving" Papers from the 8th World Congress of Therapeutic Communities. Rome, C.I.S. 1985.

All studies coincide in that the DAYTOP TCD was to be the mould, and the model that would be followed by the majority of Therapeutic Communities for Drug Addicts that begin to proliferate in the different countries when drug addiction, as a social phenomenon, began to become more widely extended. (Ottenberg, 1985; Comas, 1987).

3. The Therapeutic Community of British and American origin. Development and basic characteristics, MAXWELL JONES.

Some years before this, in the 1940s, after the Second World War, an important reform movement in the psychiatric sphere gradually emerged in the UK. The existing mental institutions were questioned and the true nature of the functions they fulfilled was condemned: asylum, custody and social control, before their supposed rehabilitation and treatment objectives. At the same time the effects were underlined of chronification, exclusion, hospitalism and depersonalisation produced in patients admitted to this type of institution.

Taking contributions from different theoretical fields: Psychoanalysis, Social Psychiatry, Occupational Therapy and Social Psychology, a series of authors carried out research and looked for alternatives in order to reform treatment in residential mental illness institutions.

Thus, in 1946 T.F. Maine published an article titled “The hospital as a Therapeutic Institution” dedicated to the work of the psychiatrists of the Northfield group, which notably included W. Bion and Richkman.

M. Jones, based on over twenty years' work in a series of Hospitals, published several texts developing the reforming concept of the Therapeutic Community.

R.N. Rapoport also published an own study, contributing operating elements for the functioning of the TC, and making an especially interesting affirmation regarding "the need to clearly differentiate the psychotherapeutic level from the level of activities aimed at the acquiring of social habits".

Thus then, a TC emerges that defines its objective and raison d'être as the rehabilitation and later reintegration of patients into a normalised community sphere, categorically rejecting any trace of isolation.

4. The TCD according to DAYTOP and the TC according to M. JONES

In the opinion of D.Comas, the new DAYTOP model TCDs represented a setback in relation to the achievements of JONES's TC model, and he points out that: "with the excuse of professionals being incapable of attending to drug addicts, they advocate not an alternative to the psychiatric systems, but they reconstruct the old asylum-type psychiatric hospitals, the old moral psychiatry and the hierarchical inter-hospital relationship. But not only that, they reach a stage where they fulfil a repressive function, from the moment in which Criminal Law begins to consider the effectiveness of penalising such conduct as drugs consumption" (Comas, 1988).

The same author quotes the opinion of R. Castel[108], who maintains that, when a drug addict is sent to one of these Institutions, "the judge knows that he is running no risks by showing this apparent softness, because such Communities, even though they are not prisons, when run by official representatives of the State, are also totalitarian Institutions"(Castel, R. 1984).

In the words of Comas "What happened in the USA at the end of the 1950s and beginning of the 1960s, which was when one of the peaks of heroin

[108] CASTEL, R. "La sociedad psiquiátrica avanzada" (*The advanced psychiatric society*) Anagrama, Barcelona, 1984.

consumption took place, was precisely that the Mental Health Institutions, at the height of their reform, could not play the repressive and total role that the drug addict demanded, many health Institutions were not sufficiently complete or repressive for the needs of a group that lived freedom as a risk". (Comas, 1988).

In the light of these opinions, it is probable that the demand of many of these drug addicted patients, was to dissolve in a group whole, led by an authority figure. It is already known that this is one of the most effective ways of achieving a kind of annulling of subjectivity, making it easier to lead the individual, even against his or her own fulfilment as a fully-fledged citizen. Thus, we find ourselves before a collective led by the voice of an indisputable, and little by little, omnipotent leader. Here we reach ground close to the violation of the most elemental Human Rights.

Maxwell Jones actually declared, in 1979, that DAYTOP was not a proper Therapeutic Community. Although later, in 1985, when invited to the Eighth World Congress of Therapeutic Communities, organised in Rome by the Italian Solidarity Centre (UOMO Project), similar to DAYTOP, he partially softened his posture, partly in consequence, according to Comas, of the evolution of TCs for Drug Addicts and of their progressive professionalisation in institutionalisation.

Following DAYTOP, another large TC group is applied in Italy through the UOMO (mankind) Project. The Uomo Project took basic elements from Daytop, including instruments more in line with the cultural and family reality of the Latin European family.

Admission into Daytop is through SPAN (Special Project Against Narcotics), and candidates must show interest and constancy to be admitted. Demands made of them may range from numerous telephone calls or reiterated appearances at inconvenient times, to the handing over of their most precious objects (for example their guitar) or even separation from their partners.

5. Europe. The new therapeutic community

5.1. Professionalism

The application of the TC movement in Europe began, as we have already mentioned, in 1970. From the very start it had a special emphasis, because as the movement started in the UK, Netherlands and Belgium, there were more professionals in these countries in comparison with other parts of Europe. In 1970, Dr. Martien Kooyman founded Emiliehoeve in Bloemendaal (The Hague, Netherlands). In Belgium, the three therapeutic communities (De Kiem, De Sleutel and Trempoline) *were established in the seventies under the leadership of three programme directors that were qualified graduates in psychology, education and social sciences* (J. Maertens at "De Sleutel"; E. Broekaert at "De Kiem" and G. Van der Straten at "Trempoline"). They followed training for therapists, equally being residents of a TC.

The first studies at "De Kiem" focussed not only on psychosocial characteristics and psychiatric diagnoses of the residents, but also on the communication structure within the TC, the programme of action and the monitoring of the first forty-five residents. Other important research pioneers were priests, such as Mario Picchi from the Italian Solidarity Centre.

It is also important to mention once more Maxwell Jones, whose focus was very important during the 1970s.

In Switzerland, the Vallmotorp Foundation (Lars Bremberg) was based on Milieu Therapy. In Germany, the therapeutic community developed in a relatively independent way, often beginning from the clinical system. In France, the TC was ignored from the very start. In general, greater emphasis was placed on professionalism in the countries in the Centre and the North than in those of the South, where volunteer work was much more important.

During the 1980s, the role of the professionals changed. A distinction was made between those professionals who acted as administrative directors, those who formed part of the medical personnel and those who were researchers.

5.2. Research

Currently, some researchers continue to belong to the TC's staff. The majority compile epidemiological data on the characteristics of the residents and search for monitoring data that show that programmes function adequately.

At the end of the 1990s, research networks were established, encouraged by the European Community. The following are important networks: the group for the development of the COSTA A-6 treatment (Uchtenhagen, Coletti, Tempesta et al.) and the IPTRP-Biomed 2 group, for the improvement of psychiatric treatment in residential programmes for new groups of addicts through the prevention of relapses. (Kaplan, Broekaert, Derks, Morival et al.)

Within these networks many scientific interests exist, both through quantitative research focuses and instruments (EuropaAsi, MAPS, MSNA) and qualitative (VACT –video- addiction challenge test). Especially taken into consideration is the close cooperation with TC researchers in this field (Papanastasatos ("Kethea", Athens), Van der Meer & Hendriks ("Emiliehoeve", The Hague), Raes ("De Sleutel", Belgium). Together with all these activities the oldest network of them all should be highlighted, EWODOR, which still exists and is even expanding.

From time to time tensions appear between independent researchers and the TC staff. It is not always easy to find the perfect balance between a concept or system of beliefs and a scientific focus.

5.3. Training

The TC professionals responsible for training also contribute to the training of staff members. In the 1990s, EU university programmes, such as Erasmus or Socrates, started to have an influence in the world of TC. An innovative range of training and educational activities centring on university students is being promoted by all European and American universities, in close cooperation with the TC. The Modena Institute was created four years ago as a joint initiative by the Modena TC, the EFTC (European Federation of Therapeutic Communities) and the University of Gante, who are working together on a Socrates project with Italian, Spanish, Portuguese, Scottish, Dutch and Swedish universities.

5.4. Networks

The original drugs free therapeutic community was characterised, as we have seen, by its hierarchical structure. The TC programme involved an induction phase, a treatment phase, and finally a reintegration phase. Initially, family therapy was hardly used. Thanks to the influence of H. Bridger of the Tavistock group, the first systematic proposals for open systems appeared. M. Picchi and J. Corelli began to develop a treatment system for residents, focussing on the structure of their families, with special attention to the role played by the addict's mother. However, the majority of the therapeutic communities integrated the family focus within the general educational project. They did not want to be considered as the pupils of any particular school. Rather, they used aspects from many different treatment models, for example: inter-generational (Nagy), strategic (Haley), structured (Minuchin), cybernetic (Selvini) and structural strategic (Stanton & Todd). In Italy and other countries in the South of Europe, considerable influence by Cancrini & Coletti could also be observed.

Some workers in Italian and Spanish TCs used the term “family collaboration” rather than therapy, thus indicating that they were using family resources to help the client.

However, the influence of the systemic focus became greater and a range of applications was established known as “new therapeutic communities”. Nowadays it is not rare to see TC networks that include TCs for patients with mental problems, adolescents, methadone programme patients, mothers with children, immigrants, minority groups, addicts in crisis, etc.

5.5. Values

Until the 1990s, drug consumption was viewed as an absolute hell and the laws and treatment focuses had clear objectives. But in the last decade some new developments have taken place: tolerance of cannabis consumption, increase in new designer drugs and smart drugs, massive consumption of ecstasy and other substances at raves and in other recreational areas, repression having a limited impact, new harm reduction programmes, a free market economy with strong competition and a loss of solidarity.

Post-modernism is party to a loss of values and a certain relativism. The complexity of the information and of the possibilities requires an intelligent decision-making process. The values system has to be based on flexibility. It is logical that in times of uncertainty, people return to traditional values systems, like the TC. Moreover, the TC has to find a balance between today's new challenges and the security of former times. This will have to be an open change without basic aspects being lost.

We should not forget the values on which the TC is based. The “science” of the TC does not stand alone; there is also the “art”, the wealth of experience and wisdom of the TC workers who carry out the daily tasks.

6. Quality Indicators in European Therapeutic Communities

The concept of quality in a drug addiction rehabilitation programme is difficult to define, both theoretically and operatively. The lack of a body of knowledge, solidly established around the etiology and maintenance of addictive disorders, favours the existence of great variations in theoretical approaches to the subject. This fact is associated with a lack of generally accepted theoretical models and of firm empirical bases to define what a "standard and suitable" treatment should be.

"In addition, the concept of quality arising from craft and industrial production is complicated when applied to services where "the product" consists mainly in the interaction between individuals, therefore it is not something immediately "tangible" and cannot be totally planned beforehand or measured afterwards". (Fernández Gómez[109], 1998)

Quality in care and treatment services could be defined in a broad sense as "the set of characteristics of the service that confer upon it the aptitude to satisfy the needs of the user or client, with the latter also understood in its broadest sense" (Silva, Monturiol and Rodríguez[110], 1991)

These characteristics group together components of scientific and technical qualities, effectiveness, efficiency, adaptation and consumer satisfaction (users attended, families, institutions and global community and that of the professional). Aspects traditionally related with quality in the healthcare services, including the field of drug addictions, involve the specification of basic norms that treatment agencies should fulfil in their response to client needs.

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[109] FERNÁNDEZ Gómez, C. "Investigaciones y desarrollo de la calidad en Comunidades Terapéuticas Europeas" (*Quality research and development in Therapeutic* Communities) ERIT Group on Quality Indicators. "Adicciones" (*Addictions*) magazine, Vol.10.No. 3. 1998.

[110] SILVA, A; Monturiol, F; Rodríguez, I. "Calidad Asistencial Aplicada a los Servicios de Drogodependencias" (*Treatment Quality Applied to Drug Addiction Services*) National Meeting on Sociology and Drug Addiction. National School of Doctors and Graduates in Political Sciences and Sociology. 357-386. Madrid, 1991.

Basic quality standards manuals specify criteria for several aspects in these treatment services: organisation, management and financing of the programme; physical environment; management of individual case histories; evaluation of patients; treatment process; patient rights; training, management and development of personnel; evaluation of the programme, etc.

Although these quality aspects may not be sufficient for an ideal treatment or even one that is suitable for the patient's needs, they are a precursor to that suitable treatment.

Even so, "it is extremely difficult to provide adequate treatment in an institution that has no lines of action oriented towards the structural and general aspects mentioned" (Mattick and Grenyer[111], 1990).

The European Federation of Associations Intervening in Drug Addictions (ERIT) includes improving care and treatment amongst its objectives. More specifically, ERIT has the objective of favouring the development of common research and studies between the European Interveners in treatment programmes and favouring the participation of these professionals in a European policy on drugs matters.

Some social institutions associated with ERIT have recently developed systems and norms for guaranteeing quality, for example, Neviv in Holland (Von Ooyen-Houben[112], 1997), FDR in Germany, SCODA in England, etc.

Others, such as the Association of Interveners in Therapeutic Communities (I.C.T., Spain), emerged with the aim of defining and developing a model based on professional and quality criteria, within a care plan aimed at the needs of the drug addict in rehabilitation. This aim is common to other

[111] MATTICK, R; Grenyer, BF "Quality Assurance in drug and alcohol treatment: the development of standards for treatment content" Drug and Alcohol Review 9, 75-79. 1990.
[112] VON Ooyen-Houben, M. "ISO-PLUS+. Framework for Appraising the Quality of Addiction Treatment and Care" Neviv. Trimbos Institut. Utrecht, 1997.

therapeutic community professionals in Italy, Germany, Portugal, France, Belgium, etc.

Recently, initiatives have been developed in Europe to decide common criteria that define the professional therapeutic community model. However, there are no known European norms on quality in treatment programmes, produced through discussion, exchange, consensus and collaboration of Interveners from different European Union countries.

This deficit is also obvious in the field of therapeutic communities for drug addicts (TCDAs).

7. Definition of the Professional Therapeutic Community

In 1996, with the support of the European Union, through the DGV, ERIT produced a project to form a group of European experts in the study and development of quality in the therapeutic community. This project was proposed by the ICT representative in ERIT (Jesús Martín Pozas. Fundación Girasol (Sunflower Foundation). Under his presidency, the Association of Professionals from Therapeutic Communities for Drug Addicts published the now classic study by Domingo Comas Arnau "Criteria and Norms for the Standardisation of Professional Therapeutic Communities for Drug Addicts"[113]).

A wide range of programmes exists to break drugs habits. This diversity is also notable in programmes that define themselves as "therapeutic communities".

The programmes associated through the Association of Intevenors in Therapeutic Communities (ICT), and other programmes represented in this

[113] COMAS, D. "Criterios de Homologación de Comunidades Terapéuticas Profesionales para Toxicómanos" (*Criteria for the Standardisation of Professional Therapeutic Communities for Drug Addicts*) APCTT, 1994.

ERIT work group define themselves as European professional therapeutic communities that:

Are run by a professional team, which develops an explicit programme of therapeutic and educational activities, with the objective of helping clients in their social integration as individuals with full rights.

They affirm the usefulness of the professional therapeutic community as a resource to achieve the priority objective, integrated with other modalities of treatment in residential or outpatient schemes (pharmacological treatment, individual therapy, etc.).

8. Proposal of a set of quality indicators

Once the documentation gathered had been reviewed and analysed, the criteria that could be considered as "quality indicators" in the treatment of drug addictions were grouped into specific areas and included in a list called the "Base-Document". This "Base-Document" was submitted for evaluation by the group. Each of the members evaluated each criterion or quality indicator on two scales: The scale named VALUE (from 1 to 5) values the validity of the item as a quality indicator in a therapeutic community. The INDICATION scale evaluates whether the quality indicator or criteria must always be met (E = "essential"), be met as far as possible (A = "applicable") or does not have to be applied in a therapeutic community (N = "non applicable"). The responses of the group members were brought together and the average score obtained by each quality criterion or indicator calculated. Later, those indicators that reached AT LEAST a score of "applicable" in the INDICATION scale and an average of 4 (very good quality indicator) on the VALUE scale were selected.

As a result of this selection a set of 120 quality indicators was obtained, grouped into 12 areas of functioning in treatment programmes for drug addictions.

The general content of the different sections of the Questionnaire or List of Quality Indicators is as follows:

FORMAL ASPECTS (3 items). The indicators included refer to compliance with the requirements demanded by the Administrations for the functioning, the accreditation/standardisation of quality by the Authorities or other groups and the importance of the programme within the range of care on offer.

ECONOMIC ACTIVITY AND FINANCIAL MATTERS (6 items). This specifies quality indicators referring to the existence of a system of accounting and financial control, economic feasibility of the project, adherence to the legal framework in terms of tax, etc.

RELATION WITH THE COMMUNITY AND WITH OTHER SERVICES (7 items). This specifies quality criteria consisting in the existence of a specific programme oriented towards coordination with other treatment and care services and professional collectives; the organisation and participation in training activities oriented towards professionals and community education. Also valued is the existence of a programme oriented towards exterior projection of the programme.

PHYSICAL RESOURCES, ENVIRONMENT, SANITARY CONTROL (14 items). This includes indicators that refer to the site, installations and materials used by the programme, the social climate, measures for sanitary control, etc.

TECHNICAL TEAM: COMPOSITION, TRAINING AND SUPERVISION (10 items). This refers to the existence of a professional and

multidisciplinary team, and to its characteristics of structure, base and continued training, coordination, supervision and management.

TREATMENT: GENERAL ASPECTS, ACTIVITIES AND EDUCATIONAL PROGRAMMES (16 items). The indicators included refer to the existence of a documented and precise description of the therapeutic and educational programme. The existence of a transparent programme from the theoretical and ideological point of view, well-known and widely disseminated, adapted and individualised, continued, integrated and periodically reviewed with the patient, with specific orientation towards his or her reintegration is valued. Also valued is the existence of specific and objective criteria for the application of techniques, which can be measured and evaluated.

ADMISSION PROCEDURE (9 items). This refers to the existence of a structured and detailed admission administration procedure, with clear criteria for indicating TC treatment, independence of the programme with respect to admissions, evaluation to be carried out with the patient, information requested and stored with each request for admission, etc.

COMPLETION, REFERRAL AND MONITORING (7 items). The existence of defined criteria for the completion of the programme, the planning of the patient's departure, existence of a monitoring programme agreed with the patient, family members and other resources, etc. are evaluated.

INDIVIDUAL PATIENT CASE HISTORIES (7 items). Includes indicators referring to the existence of a file or case history of each applicant and patient; information that includes: quality, use and usefulness of the information recorded for the programme; updating and conservation of the files or registers.

DIAGNOSIS AND EVALUATION OF PATIENTS (12 items). This refers to the existence of a formalised procedure for the diagnosis and evaluation of patients in different areas (problems at admission, during the treatment and upon completion of the programme). It values the quality of evaluation protocols and their usefulness for the planning and assessment of treatment.

PATIENT RIGHTS (8 items). Details the criteria that a TC has to fulfil, oriented towards guaranteeing the protection of the patient's human, legal and statutory rights.

QUALITY ASSURANCE (20 items). This area of indicators refers to the existence of a systematic plan for quality assurance in the programme. It includes various sections: 1. Programme research and evaluation; 2. Personnel evaluation: clinical rights and responsibilities and professional development; 3. Reviews of the use of services and resources; 4. Reviews of individual cases and auditing of patient service and attention.

9. Referral criteria in the therapeutic community

The choice of the context and modality of the intervention should be based on the demands of a treatment plan, the needs of the patient and the characteristics of the services available.

In principle, patients should be treated in the least restrictive environment possible as regards access to substances and other risk behaviour, and that has the greatest probability of being sure and effective.

Decisions on the place of treatment should take into account: **a**) the patient's desire and capacity to cooperate and benefit from the treatment; **b**) the patient's need for structure, support and supervision, to remain secure and distanced from activities and environments that entice him or her towards substance use and abuse; **c**) the specific need for treatments for medical and

psychiatric comorbidity; **d**) the need for particular treatments or a treatment intensity available in specific settings; and **e**) preference for a determined treatment.

The patients should be referred from one treatment level to another according to these criteria and the clinical evaluation regarding the patient's willingness and the possibility of benefiting from a treatment level of a lower intensity (Hoffman NG et al.[114] 1991).

The studies that compare benefits relating to different treatment modes present different methodological problems deriving from the heterogeneity of the samples and types of programmes, high drop-out rates, different results measures, etc. (Apsler R[115]. et al. 1991). However it is possible to indicate some criteria that could define the appropriateness of treatment in a therapeutic community for drug abuse or dependency problems.

These criteria should be subject to systematic research, with the aim of contributing to the establishment of the most appropriate user profile for TCs and other drug addiction programmes.

The range of services available in therapeutic community programmes includes detoxification; evaluation and treatment of general problems of a medical type; psychological, psychosocial, family and vocational evaluation; individual, group and family therapy; psycho-educational and motivational intervention; rehabilitation; relapse prevention; introduction to the concept and techniques of self-help; and production of a post-treatment plan. The TC usually also supplies (within its own environment or in collaboration with other resources) careers counselling, job training, psycho-pharmacological and psychiatric treatment.

[114] HOFFMAN, NG, Halikas JA, Mee-Lee D y cols. "Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders" American Society of Addiction Medicine. Washington DC, 1991.
[115] APSLER, R; Harding WM "Cost-effectiveness analysis of drug abuse treatment: current status and recommendations for future research" In: Background Papers (...) NIDA, 1991.

The following may be referred to the TC under a more restrictive scheme, always with a signed consent form:

- Patients with psychiatric comorbidity of moderate intensity; with poor control over their impulses and a high risk of drugs use; with risks of overdose or other risks for themselves or other people, who cannot be safely treated in a non-residential setting.

- Patients with a documented history of a lack of involvement in or benefit from less intensive treatments and whose abuse problem poses a risk for their physical and mental health.

Mainly, treatment in a TC is recommended for patients whose vital functioning and social interaction has come to be focussed mainly or exclusively on the use or abuse of substances, or that lack sufficient motivation or social support to maintain themselves abstinent in an outpatient environment, without displaying criteria for hospitalisation, severe medical or psychiatric comorbidity. (Llorente del Pozo, JM[116] et al., 1998).

Specifically, patients who are dependent on opiates, cocaine or a wide range of substances may be recommended for medium or long-term residential treatment, especially if there is little probability that they could benefit from non-residential treatment (De León G[117], et al., 1989).

The TC provides a secure and drug abuse-free environment, where behavioural modelling may be especially useful for patients that need a highly structured environment to begin treatment.

[116] LLORENTE del Pozo, JM.; Fernández, C. Et al "Las Comunidades Terapéuticas en el tratamiento del abuso y dependencia de sustancias" (*Therapeutic Communities in the treatment of substance abuse and dependency*) In: Adicciones (*Addictions*) magazine, Vol.X.No. 6, 1998.
[117] DE LEÓN G, Rosenthal, MS "Treatment in residential therapeutic communities" In: Treatment of Psychiatric Disorders: A Task Force. Report of the American Psychiatric Association, vol. 2. Washington DC, APA, 1989.

The criteria regarding the duration of the residential treatment should be in accordance with the time necessary to achieve specific benefits, which in turn presage a successful transition to a less restrictive treatment environment: for example, high motivation to follow an outpatient treatment programme, the capacity and motivation to remain abstinent when faced with situations that involve a risk of relapse; the availability of accommodation and social support that encourages abstinence; the stabilisation of medical and psychiatric comorbidity at levels that can be treated under an outpatient scheme, and the existence of a monitoring plan that includes a plan for readmission to residential treatment should this be necessary.

10. Cognitive-behavioural evaluation of heroin addicts in TCs

Treatment modalities for dependence on psychoactive substances are very varied. Within the types of treatments for breaking the drugs habit, applied after detoxification, we can distinguish those aimed directly at the problem of the addiction and those related in an indirect or hypothetical way to the central problem, for example psychiatric models of personality disorder (Gossop, 1993) or family problems, where addictive conduct is considered to be a symptom of a greater problem. Direct therapeutic focuses in addictive conduct are centred on substance consumption conduct, on situations where this takes place and on the factors that maintain it. The evaluation model used is usually functional behaviour analysis and the treatment strategies are those used in behaviour modification.

However, in a therapeutic community working to break the drugs habit of heroin addicts, it is not possible to subject direct consumption behaviour to evaluation and study, since the patients are abstinent. Consequently, the objective of evaluation and modification are behaviours that may unleash the return to consumption or relapse. These evaluation and intervention

strategies may be considered, therefore, as relapse prevention strategies and they are based generally on cognitive-behavioural models (Marlatt, 1993).

Different cognitive-behavioural models of relapse prevention exist (Leukefeld and Tims, 1989; Tucker et al., 1992). These models can be distinguished from each other by the operating definition of the concepts of recovery and relapse, the type of variables in which they are focussed (situational, behavioural, cognitive psychological or physiological and the interaction between them), by the explanation mechanisms and concepts proposed as factors that determine the process of returning to consumption (risk factors, factors that facilitate recovery) and in the specific methods of evaluation of the intervention that they use.

The models centred on environmental variables analyse consumption behaviour within the characteristics of the environment of the patient as regards availability of the substance, social pressure towards consumption and resources for supporting abstinence.

The interventions are usually directed towards counselling and educational, family, vocational and work interventions, with the aim of modifying the patient's lifestyle and directing it towards the achievement of reinforcing factors deriving from prosocial activity (Leukefeld and Tims, 1989; Catalano, 1991).

Cognitive-behavioural models evaluate the stress suffered by the subject in situations potentially associated with consumption, the repertoire of responses available to the individual for tackling such situations, the expectations that the patient has in terms of being able to avoid consumption and the affective and cognitive responses shown by the individual when before risk situations.

The treatment is aimed at increasing the patient's awareness of the risks, increasing the repertoire of behavioural and cognitive responses for tackling the risk and reducing stress levels through an increase in self-effectiveness.

Later, interventions work towards a change in lifestyle, increasing the commitment to abstinence by reducing positive expectations regarding the consumption of psychoactive substances (Brownell and Marlatt, 1986; Annis, 1990; Echeburúa, 1986).

The motivational-conditioned models focus on the analysis of external and/or internal stimuli that precipitate the desire to consume and on the frequency and intensity of the same (Rohsenow et al., 1991). Interventions are directed towards the modification of the desire to consume through the prevention of responses, extinction, the conditioning of negative reactions towards stimuli that precipitate the desire to consume and the establishment of alternative behaviour to consumption (O'Brien et al., 1986; Chidress et al., 1991).

11. Retention in therapeutic communities

Research into factors associated with retention in treatment for drug abuse has shown very varied and not very conclusive results. But, for example, in a study carried out in 22 Spanish TCs, the patients who completed treatment or were referred to other services, accounted for approximately 50% in the period 1991-1994[118]

In recent years, research on retention has been oriented towards the study of the individual's dynamic and motivational factors as dropout predictors. Most authors consider that each programme should systematically study the association between its retention rate and results, as well as which are

[118] FERNÁNDEZ, C; Llorente, JM; Carrón, J. "Sistema Estándar de Evaluación de la APCTT" (*The APCTT Standard Evaluation System*) APCTT, 1995

individual factors, of the programme and of the interaction between the patient and the programme, that are influencing retention, and indirectly, the treatment results.

12. Cost evaluation of the services of a Professional Therapeutic Community

In 1990 in the health sector, the barometers of the number of people (shifts, holidays, absences, minimum rest periods, etc.) required according to the Workers' Statute and the Health Sector Agreements and Regulations was calculated, and it could be confirmed that no treatment centre with a residential scheme, even with a minimum number of places, could function without at least ten to twelve monitors, hospital porters, auxiliaries and shift staff, apart from personnel working in specialised therapeutic and educational tasks.

The fact that the same criteria (and salaries) are not applied to Professional Therapeutic Communities is unfair; although demanding equality is still somewhat utopian. Therefore a more realistic and possible calculation - and one that is more in accordance with the culture and expectations existent in the Professional Therapeutic Communities -, indicates that the minimum support personnel that could be aspired to is seven people (Comas, D. 1994)

This minimum team can be completed with two or three specialists (psychotherapists, educators, specialised monitors and management) and others on a part-time basis (doctor, nurse, social worker, other monitors, etc.) The final result is a minimum team of ten or eleven people whose costs (employment contract and National Insurance contributions, without resorting to service contracts and other semi-legal mechanisms of an uncertain nature and with a salary equivalent to similar categories in the Public Health network) could not be inferior in 1990 to thirty million pesetas

a year, which today would mean around 60 million pesetas a year. We would be talking of a team of some 10-12 people and around 15 users.

With relation to this theoretical minimum budget, two strategies are possible:

- Stick exclusively to this minimum budget and therefore maintain also a minimum team (10-12 people) limiting the number of places to those that a team of this size can mange and that is estimated to be less than 20.

- Increase the budget, the team and the number of places to reduce unit costs.

Both strategies are permissible and both contain difficulties, although the first seemed unfeasible in the short and medium term by a series of Professional Therapeutic Communities that fall far below the expenditure mentioned. The second may allow a quicker cost effectiveness adjustment, but is paid for by breaking with the dynamics of therapeutic group dynamics. The increase in places can be carried out increasing the team by a new member for every 5-7 places.

According to the Standardisation Criteria described by Doctor Comas, a limit of fifty places was established, considering that this amount is the limit for a possible intervention of a "Therapeutic Community type".

When Standardisation began, in the early 1990s, a piece of data already known when the system was set up could be empirically confirmed: only three of the twenty-six centres analysed were handling a financial budget equal to or greater than that considered as a minimum, and as for the rest, most were lying at under half of this minimum budget.

13. Basic criteria for considering an institution as a Therapeutic Community for Drug Addicts of a professional nature.[119]

Therapeutic Communities of a professional nature should develop their tasks by subjecting themselves to the legislation and norms in force in the region where they are based, as well as the State health, labour and tax legislation and norms, and especially those relating to people's rights included in the constitutional order and other international declarations on human rights.

In this sense it is considered that:

- Admission into the centre is always voluntary and drug addicts can drop out of the treatment whenever they wish.

- A pre-established time limit for the drug addict's stay at the Community should be set.

- Treatment and care should be guaranteed in accordance with the physical, mental and social problems presented by most drug addicts.

- The rights and duties of residents should be known and accepted by them when they are admitted into the Centre, via a Therapeutic Contract or the existence of an Internal Regime Regulation.

- There will be no type of ideological indoctrination of residents or any proselytising pressure of any type.

- There will be no profit-making benefits for the institution from the work and activities carried out by the residents.

Professional Therapeutic Community status is acquired in addition:

[119] COMAS, D. "Criterios y Normas para la Homologación de Comunidades Terapéuticas Profesionales para Toxicómanos" (*Criteria and Norms for the Standardisation of Professional Therapeutic Communities for Drug Addicts*) Ed. APCTT. 1994.

- Due to the existence of a multidisciplinary group that is perfectly differentiated from the group being aided and with employment contracts.

- Because the team have the qualifications and necessary training to carry out the professional tasks that are demanded by a Therapeutic Community for Drug Addicts.

- Through the existence of a therapeutic programme that is described, known and identified within the perspective of knowledge and scientific training without this meaning the exclusion of orientations or therapeutic practices.

- Because these programmes are adapted to the characteristics of the centre, the material resources and team capacity.

The following should also be required:

- That evaluation, diagnosis, admission and release criteria should exist, supported by medical, psychological and social protocols that make the existence of evaluation systems possible, and that these be used for self-criticism and the continual improvement of the treatment and care process.

- That it collaborates with broad aid programmes and with other institutions dedicated to treating drug addicts or with general social aims coinciding with the fundamental objective of Therapeutic Communities: The reintegration of drug addicts into social life in the best health and quality of life conditions possible.

QUALITY MANAGEMENT IN DRUG ADDICTION

1. Evolution of Quality in Drug Addiction

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We can specify four fundamental phases in the evolution of quality in the sphere of drug addictions:

- In the 1970s, quality was not a concern. Demand for treatment was far higher than supply and the service offered was understood as an obligation, with evaluation criteria being primarily concerned with profits (when these existed)

- In the 1980s demand began to be absorbed by treatment networks and quality mechanisms started to be established based on two aspects: firstly, the structural apparatus (fundamentally consisting of a norm that develops administrative authorisations and accreditation), and secondly, the aspect of control at the end of the process (basically managed through concepts or retention and relapses).

- In the 1990s treatment provision presented virtually universal coverage and it was clearly considered that a lack of quality means a greater economic and social cost than does quality, with control of the process gradually being established along with certain total quality management mechanisms.

- In the near future, capital and priority importance will be attached to team work, with the organisation providing the service considered as a compact

block, substituting the concepts of inspection and control for commitments of accepted and shared responsibility (Pascual Fernández, C. 2000)[120]

Today, the quality of the organisations has become a "value received from the service by the client" The concept of quality has therefore become something dynamic linked to the changes in needs, preferences and demands of the users. Quality has become a strategic factor of fundamental importance if a service, in this case attention to drug addicts, is to be offered successfully.[121]

1.1. Concept of value

A client (user) in a drug abuse treatment resource, in short, is simply any person who receives the results of this service and hopes to receive them with a determined level of quality that was established beforehand.

Today users of services for treatment of drug addicts (our clients) are better educated, they demand more services and they have raised their quality expectations.

In general, users make an estimation of the value that different services provide them, in other words they create determined expectations regarding the value of the service that they expect to receive and they are in agreement. Later, they have a perception of the value received that affects their level of satisfaction and their probability of using the service again with expectations of effectiveness.

In summary: the behaviour of drugs users with relation to treatment services is not the same in all cases**,** *the clients of services for drug addiction consider or require that services are made to suit them, that they fulfil requirements that satisfy their needs*.

[120] PASCUAL Fernández, C."Gestión de la calidad en drogodependencias" (*Quality management in drug addiction*) In: "Adicciones" (*Addictions*) Magazine, Vol.12, no. 1, 2000.
[121] ENOR "Normas para el aseguramiento de la calidad" (*Quality Assurance Norms*) AENOR, Madrid 1992.

Thus we have a situation where users attend a service that provides them with maximum expectation of value (**expected value**). Meanwhile the **value received** is made up of the difference between positive and negative values. The total of positive values is constituted by the set of benefits that clients receive from a service (achieving abstinence, improvement in their state of health, shelter, other facilities, etc.) whilst the negative values are determined by the troubles and difficulties that they find or perceive in accessing or during the service (waiting lists, way in which they are treated, administrative difficulties, access requirements, etc.)

It must be taken into account that at the end of the day our client (user) will always have the last say. The determination of the final result of the service given will ultimately depend on patients themselves.[122] Despite the fact that we are not in a competitive market situation in the sphere of services for drug addicts, it is no less certain that different alternatives exist in terms of treatment, from both public and private initiatives, and it is the user who will finally decide whether or not to attend or receive the service we offer.

1.2. Care and Treatment Quality

With relation to care and treatment quality, we can discern three aspects:

Necessary Quality: By this we mean all that the client needs and expects, although on occasions the client does not know this or cannot express it with clarity. Therefore an interlocutor is required who understands the client and knows the service.

Programmed Quality: Programmed quality tries to adapt what the client needs and wants with what the organisation can offer. Therefore good communication is essential.

[122] MEDINA, G. "La importancia de la participación en los Programas de Calidad" (*The importance of participation in Quality Programmes*) Alta Dirección (*Top Management*), no. 179; 93-100. 1991

Achieved Quality: Achieved quality refers to all that is achieved in offering the service. It depends on the agreement between the person who designs and programmes and the person who puts them into practice.

1.3. Factors that have an influence on quality production

Regularisation in order to ensure and improve quality during the provision of a service is possible, taking into account the following factors:

- The human element, in the provision of services, is fundamental.

- The internal flow of information (knowledge management) should be complete and swift.

- The provision of the service cannot be based on rigid rules, but rather it involves a dynamic and flexible process.

- In many cases a repair of the provision of faulty service is not possible, which means that extreme care must be exercised with the quality of that service.

- Quality control should always be carried out in parallel with the provision of the service.

- The definition of objective indicators is not a sufficient condition and the degree of customer perception must be considered.

- Breaking down the process of service provision and detailing each of the parts is a fundamental instrument in the quality system.

1.4. Perception of quality

Quality has a great deal to do with the service provided, but fundamentally with the perception that the client has of the providing of that service. Therefore, when implementing quality management policies it is necessary to bear in mind a series of considerations relating to the perception of the service:

- Others perceive the service differently to how the service perceives itself.

- Others perceive the service very differently to how the service thinks that they perceive it.

- Different client groups perceive the service in a different way.

- Finally, the level of service perceived in an area of that service is representative for the whole service.

Therefore, it is necessary to consider the opinion that external clients (users) have of the service and of course, the opinion held by the professionals who actually provide the service in their role as internal clients[123] The perceived quality of the service depends, therefore, on the relationship between the service expected and the service received.

1.5. Quality systems

The establishment of any Quality Management System in drug addictions, as in any other area in the social and health sector, involves a prior philosophy of continuous quality improvement.

Establishing a quality management system or programme involves a set of structural elements and activities whose aim is to improve quality within the framework of a new culture for the entire organisation, involving all its members.

Quality management system or programme is understood to mean the organisational structure, the responsibilities, and the procedures, processes and resources necessary for carrying out quality management. This implies:

- *The existence of an express quality improvement philosophy or policy*. The quality system or programme is developed and implemented as a medium

[123] DONABEDIAN, A. "La calidad de la atención médica. Definición y métodos de evaluación" (*The quality of medical care. Definition and methods of evaluation)* La Prensa Médica Mexicana, S.A. México DF 1982.

for complying with quality policies and objectives. Each and every one of the activities related with the quality of the service must therefore constitute an integral part of the quality system or programme.

- *An organisational structure to develop this policy*. Any quality management system or programme needs to possess an organisational structure that has to be clearly identifiable and should be based on the organisation chart. At the same time, the development of norms is required to define the distribution of responsibilities, the information circuits for data on quality and the production of quality improvement plans; in other words, norms for functioning, generally included in a quality manual.

- A set of specific activities designed to achieve, control and improve quality and that can be divided into three groups:

1. Activities aimed at the identification and analysis of problems and opportunities for improvement (improvement cycles, evaluation, and evaluation cycle or quality assurance cycle).

2. Activities aimed at the design and production of indicators and their later monitoring (quality monitoring).

3. Activities aimed at designing processes for improving quality (quality design).

1.6. Quality focuses[124]

Quality can be structured around two focuses:

1. Internal quality, based on the control of:

- The design of the service.

- The processes and systems of operation.

- The service provided.

- The raw materials: the professionals and their training.

2. External quality, based on the control of the service-user relationship:

- The provision of the service and the results obtained.

- Complaints procedures.

1.7. Principles for obtaining a quality service

When implementing quality systems we must always bear in mind that:

- Easy and fast solutions do not exist. Total Quality is a long-term strategy that means a change in culture, therefore it constitutes an arduous process.

- There is no single or best way. All organisations and the people that make them up are different, and therefore, there is no single way of beginning a process of continuous quality improvement; rather as many ways will exist as organisations and groups of people.

- People are more important than systems. Quality is a culture, not a system, it is based on people, who are those that make quality into a reality that is produced.

- It is fundamental that false information be avoided. Time needs to be dedicated to rigorous and scientific training.

[124] PALMER, RH. "Evaluación en la asistencia ambulatoria. Principios y práctica." (*Evaluation in outpatient care. Principles and practice*) Ministry of Health and Consumer Affairs. Madrid 1989.

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