COHERENCE POLICY MARKERS FOR PSYCHOACTIVE SUBSTANCES

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Pompidou Group

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Council of Europe

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Glossary of initialisms and acronyms

ABD	addiction behaviour and dependency
ACSS, IP	General Administration of Health Systems, Public Institute (Portugal)
ANSR	Road Security National Authority (Portugal)
ATS	amphetamine-type stimulants
AUDIT	alcohol use disorders identification test
BAC	blood alcohol content
CAST	cannabis abuse screening test
CND	Commission on Narcotic Drugs
COI	cost of illness
DALY	disability-adjusted life year
DATF	drugs and alcohol task forces
DGS	General Directorate of Health (Portugal)
DiD	drug-related infectious disease
DPA	Department of Anti-Drug Policies (Italy)
DRD	drug-related death
DRG	diagnosis-related group
DRUID	driving under the influence of alcohol, drugs and medicines
DTF	drug task force
ECATD	Study on the Consumption of Alcohol, Tobacco and Drugs
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENP	Ethiopian National Project
ESPAD	European School Survey Project on Alcohol and other Drugs
FCTC	Framework Convention on Tobacco Control
FOPH	Federal Office of Public Health
GCDPC	Government Council for Drug Policy Co-ordination (Croatia)
GDP	gross domestic product

GPS	general population surveys
HBSC	health behaviour in school-aged children (study)
HBV	hepatitis B virus
HCV	hepatitis C virus
HFA	Health For All
HIV	human immunodeficiency virus
HRB	Health Research Board
HSE	Health Service Executive
IADA	Israel Anti-Drug Authority
ICD	International Classification of Diseases (ICD-10)
ICGE	immigrants from countries of generalised epidemic
IDIG	International Drugs Issues Group
IDT, IP	Drug and Drug Addiction Institute, Public Institute (Portugal)
IDU	injecting drug users
IMPA	Israel Money Laundering and Terror Financing Prohibition Authority
INE, IP	National Institute of Statistics, Public Institute [Portugal]
INML, IP	National Institute of Legal Medicine and Forensic Sciences (Portugal)
INPG 2012	General Population National Survey, field work in 2012 (Portugal)
INSA	National Health Institute Dr. Ricardo Jorge, Public Institute (Portugal)
ITC	International Training Centre of the International Labour Organization
JP	Judiciary Police (Portugal)
KEF	local co-ordination forums on drugs (Hungary)
LDTF	local drugs task forces
LTP	lifetime prevalence
LYP	last-year prevalence
MAI	Ministry of Internal Affairs (Portugal)
MDA	Misuse of Drugs Acts
MDMA	3,4-methylenedioxymethamphetamine
MOU	memorandum of understanding
MPOWER	WHO's tobacco-control model
MSM	men who have sex with men
NACD	National Advisory Committee on Drugs

NACDA	National Advisory Committee on Drugs and Alcohol
NGO	non-governmental organisation
NHP	National Health Plan (Portugal)
NPS	new psychoactive substances
NSP	needle and syringe programmes
NTCO	National Tobacco Control Office
OFD	Oversight Forum on Drugs
PCM	Presidency of the Council of Ministers
PDU	problem drug use
PG	Pompidou Group
RDTF	regional drugs task forces
REITOX	European Information Network on Drugs and Drug Addiction
RSNS	Road Security National Strategy (Portugal)
SICAD	Addictive Behaviours and Dependencies Intervention Service (Portugal)
SOC	sense of coherence
SOGS	South Oaks Gambling Screen
TCU	Tobacco-Control Unit
TDI	treatment demand indicator
TFRI	Tobacco Free Research Institute Ireland
ToR	term(s) of reference
UNGASS	UN General Assembly Special Session
UNODC	UN Office on Drugs and Crime
WHO	World Health Organization

Editors and other contributors

The editors

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The Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group) is an intergovernmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe. Thirty-seven countries are now members of this European multidisciplinary forum which allows policy makers, professionals and experts to exchange information and ideas on a whole range of drug misuse and trafficking problems. Its mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states. It seeks to link policy, practice and science.

Through the setting up in 1982 of its group of experts in the epidemiology of drug problems, the Pompidou Group was a precursor of the development of drug research and monitoring of drug problems in Europe. The multi-city study which aimed to assess, interpret and compare drug use trends in Europe is one of its major achievements. Other significant contributions include the piloting of a range of indicators (treatment demand indicator) and such approaches as a methodology for school surveys, which gave rise to the ESPAD (European School Survey Project on Alcohol and other Drugs).[1]

The Research Platform has superseded the group of experts in epidemiology, active between 1982 and 2004. There has been a change of function from developing data collection and monitoring methodologies to assessing the impact of research on policy. This started with the 2004 Strategic conference on linking research, policy and practice – Lessons learned, challenges ahead, which identified as a major gap the lack of exchange of knowledge.

The Research Platform's prime role was to support better the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy. Moreover, it also signalled the latest issues that arose from drug research in the social and biomedical fields and promoted interaction between research disciplines such as these and psychological drug research. Reports on these subjects have been published and are listed in the appendix.

Following the mandate by the ministers for the 2011-14 Pompidou Group work programme at the Ministerial Conference in November 2010, the Research Platform has now been superseded by expert groups related to specific topics. Coherent policies in the area of psychoactive substances was selected as one such topic and hence the expert group was formed at the end of 2010. During 2012-14 it met four times to produce this, the fourth publication in the series.

1. See Pompidou Group list of documents and publications at the end of this publication.

The activities follow on from an initial request and funding from the Federal Office of Public Health in Switzerland to acquire information on the ways in which drugs policy is formulated and applied by other countries. This information provided the basis for the first publication, entitled *From a policy on illegal drugs to a policy on psychoactive substances,* which consisted of a retrospective analysis of drug policy in 17 member countries, taking into account the social and cultural context. These contributions were aided by an overall synopsis that reflected on the move to think about the change from single policies on alcohol, tobacco and drugs to one that incorporates all psychoactive substances.

The second publication was a further attempt to understand the scientific basis for the choice of a single policy for each substance or one that incorporates all substances and in addition provided empirical information on how such a choice today is currently put into practice. Seven countries, namely Germany, Ireland, the Netherlands, Norway, Portugal, Switzerland and the United Kingdom, provided the means through which this issue was addressed. Thus, the third publication in this area attempted to make more headway in the area of coherent policies for psychoactive substances. This fourth publication once again raises the bar one notch higher in this field, as the markers developed have been tested, and the results herein testify to the need to continue down these lines of engagement in this area.

Preface

Health, well-being and coherency

At first glance, drugs policy seems quite simple: to reduce supply and demand in order to influence prevalence of use and adverse consequences. How to get there however, requires participation from several contributors and sectors at a local, regional, national and even an international level. This makes it already more complicated. In addition, the policy area must take into consideration and reflect historical and cultural aspects, core values and the political agenda, as well as comply with legislation. Moreover, bureaucracies – within which drugs policy is worked out, implemented and operated – tend to be better fitted for vertical rather than horizontal co-operation. Drugs policies with a strong need for co-ordination and complementary approaches may suffer within such a system.

With all these purposes and considerations, it is easy to get lost. To avoid that one has at least to be aware of the challenges and possible traps. Such consciousness alone is helpful, but hardly an operative tool.

How understanding our past can help shape our future

The existence and use of psychoactive drugs cause problems. To reduce the size of the problems, allocation of quite a lot of resources is necessary. Making sure that these resources are well spent is of course important. This project aims to be a contribution in this regard.

The challenges and questions the project has dealt with are well known and they never go away. Thus the aim is significant and the tool produced may fill a gap. I have had the opportunity as a policy maker to take part in this work, which has been an interesting experience during which several lessons have been learned. The matters studied by the project and the sets of questions it intends to answer are indeed recognisable to me. I am neither a researcher nor an evaluator. My core responsibility, and hopefully ability as well, is to be forward-looking and prepare plans rather than to be backward-looking. I do however have full respect for the need to learn from the past and its effect in creating a better future.

I will not comment very much or make any attempt to evaluate the markers or the Spider chart – the tool – as such. That I leave to others better qualified than me. I do however want to express some reflections after having participated in the project and all the interesting discussions we have had.

What I will mention first, maybe surprisingly, is a reminder that the over-riding objective for drugs policy is health and well-being. This should be obvious, and hopefully it is, but it still needs to be continually repeated, especially when keeping supply reduction and the control aspect in mind. That leads to my next observation, which also is a reminder: the need for good co-ordination. In a system where different sectors, ministries and departments have different responsibilities, there is a risk that they may set objectives and make efforts quite separately from each other. Without a strong co-ordination body with a mandate in this area, fragmented approaches are more likely. Third, I have been reminded of the importance of best practice as a prerequisite for coherency. The policy may appear to be coherent, but if measures are not based on best practice, they may be not only ineffective, but even counter-productive and the coherency false.

To arrive where we are, it has been necessary to look backwards – not for the purpose of evaluating national action plans, but to develop the tool. For this purpose I am impressed by the work my colleagues have done on the country reports, and by the interesting discussions the reports have created. It has been a pleasure to take part in this and I am sure there are matters I will see differently and handle better in the future than in the past. This could be described in several ways, but to keep it simple it can be summed up in a set of check-points or one crucial control question: "Will this contribute to – better – health and well-being?"

Also we need to keep in mind, as Brigid has said, that, as a minimum, no effort – regardless of demand or supply, I would add – should compete with or undermine another. If rival projects compete or undermine each other, it is very likely that at least one of the efforts will be a waste of money and should be terminated. Indeed, it could happen that this is unavoidable. If so, by doing this exercise one will be able to explain and understand why: that it was not an unintended consequence but rather a deliberate decision.

When describing national action plans, strategies or white papers, hardly anyone does so without mentioning a comprehensive, multisector, integrated, balanced approach. But I have hardly, if ever, heard these words conceptualised. Whether coherence is a better concept than any of these may be debatable. To me it is clearly better, but that could be because I have spent much more time on understanding and describing the concept. And that is where I think the added value of this project is – the tool that is developed.

I am just now about to start writing a new action plan and I already hear echoes from the discussions in the project group and I have thoughts, considerations and a new tool to bring to this work. Hopefully this will guide me and make sure that every suggestion and initiative will pass the health and well-being test and contribute to more consistent work than formerly.

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Introduction

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Developing coherent policies on psychoactive substances is a priority area of the work programme 2011-14 adopted at the 15th Ministerial Conference on 4 November 2010, in Strasbourg. The principal objective of this activity sector 1 is to identify effective approaches in relation to coherent policies for licit and illicit drugs.

The terms of reference – for this particular activity on experiences with coherent/integrated policies for licit and illicit drugs – were adopted by the Permanent Correspondents in 2011.

As a follow-up study to the three publications – *From a policy on illegal drugs to a policy on psychoactive substances* in 2009, *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis* in 2010, and *Reflections on the concept of coherency for a policy on psychoactive substances and beyond* in 2012 – the objective of the present project is to refine these indicators and then test them in the countries which participated in their development and possibly also in other countries which may be interested, to better verify whether they provide a valid tool by which the effectiveness and efficiency of a coherent policy on psychoactive substances may be measured. This objective is in line with the Pompidou Group's major objective, which is to better support the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy.

The outcome of the discussions was that the six indicators – namely:

- conceptualisation of the problem;
- policy context;
- legislative/regulatory framework;
- strategic framework;
- response/interventions; and
- structures and resources,

are viewed as "soft" indicators or markers to determine whether a policy is working at national level, and also at international level, to ensure that policies do not compete with each other. The goal of a drug policy should be to promote the health and well-being of individuals and there should be coherency between illicit drugs policy, tobacco policy and alcohol policy.

The objective of the first part of the exercise was to conduct a pre-pilot study to test the defined markers for coherency that are to be used to articulate whether a policy for drugs, alcohol and tobacco is coherent in the current context.

A marker per se implies that something may need attention or not: it raises a flag of concern. Each of the six markers will serve to describe and assess the situation on drugs, alcohol or tobacco in terms of identifying the problem and the solution which has been put in place.

The results of this first pre-pilot study conducted in the Czech Republic, the Netherlands, Israel and Portugal appear in a document that was discussed by the group in February 2013.

The use of markers for policy coherence

Following discussions at the meetings of the group in September 2012, February 2013 and September 2013, it is now proposed that the markers developed to date are articulated as outlined below.

Well-being

The over-riding goal of policy in the field of drugs, alcohol and tobacco or for that matter psychoactive substances is that of well-being. Thus the description by the World Health Organization (WHO) in the preamble to its 1946 constitution – "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" – is the standard by which any policy in this field is to be judged. More to the point, such policies must be judged by whether they are in line or not with the WHO description.

This concept – that one should look for the factors that provide for a healthy individual rather than concentrating on those that give rise to disease – was first elegantly put forward by Antonovsky in 1979. His salutogenesis approach to health was based on the idea that health was a continuum, with good health on one end of the spectrum and disease on the other. Thus he operationalised salutogenesis by suggesting that individuals in good health had a good sense of coherence (SOC), which in turn involved three factors, the ability to understand the problems of daily life (comprehensibility), the ability in turn to solve those problems (manageability) in the context so that in doing so one has achieved something and moved forward (meaningfulness). Antonovsky was puzzled as to why some people are able to cope with the daily stressors of life while others are not; for the latter group, that in turn resulted in what is termed bad health. He thus put together a questionnaire that measured one's sense of coherence and to date this has been used in some 32 countries and has been found to be age-, gender- and culture-neutral, though there has been some comment on the fact that SOC may alter between childhood and adulthood.

That stress can lead to disease is not new. Stress is known to have an effect on pain thresholds as well as being a possible trigger for depression. However, the issue that arises is this: does a low SOC precede the disorder in question or does it follow as a consequence of the disease? It is argued that it is the former,

because SOC does not change much over a lifetime and hence may be a better predictor of treatment outcome later in life.

The fact of the matter is that feelings of confidence and a positive outlook are symptomatic of a high SOC and thus (perceived) good mental health, which then normally also relates to good general health – though not necessarily so. There are other factors that interact with a person's positive outlook, such as social class, social support, upbringing and to some extent financial assets. The bottom line, however, is the finding that a strong SOC enables one to develop and maintain a positive state of mental health and this can impact on general health.

Moreover, positive emotions form one of the five factors that have been identified as serving the state of well-being. The others are achieving work goals (which may be construed as manageability in respect to SOC), having a meaning in life (which may be akin to SOC's meaningfulness), engagement with people you care about and maintenance of good relationships, which could to some degree fit in with the overall concept of salutogenesis in which one lives in a society with people who care.

Thus salutogenesis and its operational dimension, sense of coherence, to a large extent fulfil the preamble to the WHO constitution, which states that health is more than the "absence of disease or infirmity". Consequently, if one is to have policies in place that address the issues of psychoactive substance use then, if well-being is construed to include a sense of coherence, the least one should aspire to achieve is that the policies themselves are coherent.

Consequently the six markers (discussed below) can be used to best describe and assess the effectiveness and efficiency of the current policy. In turn, this should be a means through which one may understand what the problem is envisaged to be and what has been suggested to solve or at least counter the said problem(s). Again, the first marker is the one through which all the others will be gauged, in the sense that from a hierarchical perspective the first one is the highest ranking and then the rest, that is Nos. 2-6, follow on.

The first marker – conceptualisation and policy context – may fall into two parts, namely 1A and 1B, in which the former is related to the state of the problem and the latter to the solutions drawn up in a policy to address the said problem. Hence an overview of the policy documents in place should be the main starting point, as suggested below.

Policy

State of the problem

If we are to attempt, using present prevalence estimates and trends, to gain an insight into the use of psychoactive substances in the general population, along with problem drug use, alcohol use and tobacco use, we need to identify particular problems of substance use and their urgency, for example substance-related deaths and social costs. Our understanding of the current situation may be further supported by providing the socio-historical context, as exemplified in the first project and related publications, in the form of public opinion, mass media and political manifestos. Assessments should use these different data sources.

Table 1: Assessing the problems

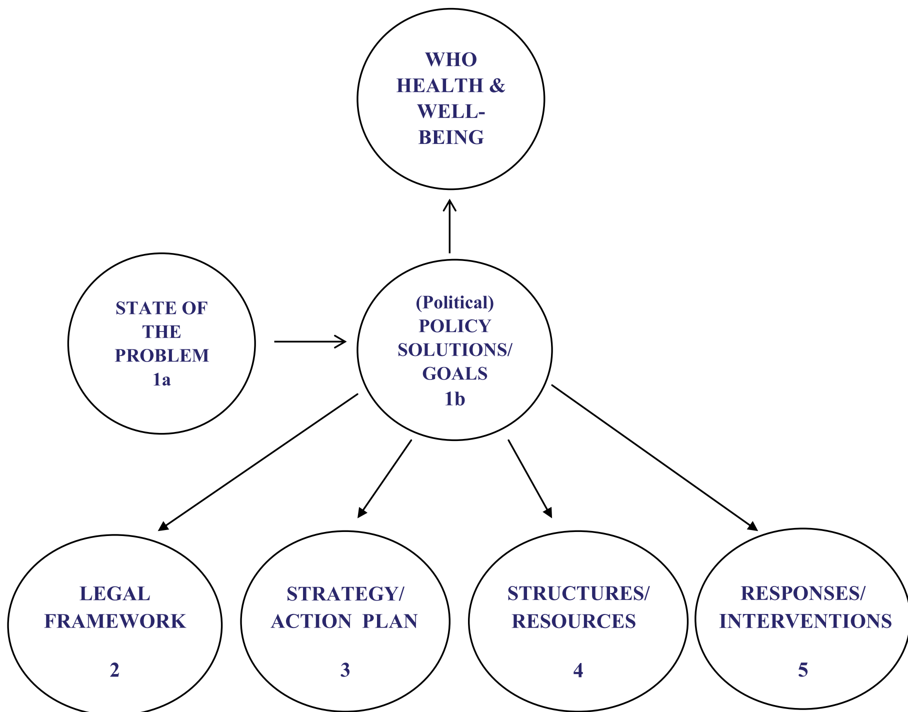
	Illicit Drugs	Alcohol	Tobacco
Prevalence			
Public opinion			
Cost of illness			
Media			
Documents citing problem			

Context

This second aspect requires us to identify policy documents that outline the specific goals by which the problem may be addressed. Are these goals in line with the WHO definition of well-being cited above, or do they at least not conflict with the WHO goals and aspirations?

It is essential that all the markers that follow, Nos. 2-6, are evaluated by reference to the first marker. For each substance, we ask whether the relevant policy is coherent in itself and then whether it is coherent with the other policies in place dealing with other substances.

Figure 1: Model for using policy markers



Legislative/regulatory framework

Are there documents that show whether there are laws and regulations in place that not only adhere to international conventions, resolutions and recommended actions in relation to both demand and supply, but are also related to national requirements? This in turn may be gauged by asking the following questions:

a. What laws and regulations are in place?
b. Do they adhere to the international conventions, resolutions, recommendations?
c. How does the legislation align with policy goals?

Table 2: Assessing the regulations

Demand	Illicit drugs	Alcohol	Tobacco
Laws and regulations			
Compliance with international conventions			
Alignment with policy goals			
Supply	Illicit drugs	Alcohol	Tobacco
Laws and regulations			
Compliance with international conventions			
Alignment with policy goals			

Strategy/action plans

Are there any strategies or action plans in place that are in line with the overall policy goals and those of WHO? Are they comprehensive in taking into account all the policy goals highlighted? This may be gleaned from asking the following questions:

a. Does the strategy/action plan refer to the state of the problem as revealed by analysis under 1b above?
b. Does the strategy/action plan address supply reduction, demand reduction and harm reduction and does it comply with the policy goals?
c. Are there any specific objectives that match the various reduction measures and are related to "well-being"?

Table 3: Assessing strategies and action plans

	Illicit drugs	Alcohol	Tobacco
Reference to state of problem			
Supply reduction			
Demand reduction			
Harm reduction			
Specific objectives			
Budgetary issues			
Activities			

Structures

Have specific structures to implement the policy been put in place? The key question here is whether the model adopted by a specific country is functioning appropriately. Consequently, which bodies are responsible for drug policy, alcohol policy and tobacco policy? Is there a co-ordination body? Who is in charge of co-ordination?

In effect, the following questions should be addressed to provide the answer regarding whether the structures are in place that can facilitate the development of coherent policies:

a. Is there an over-arching responsible authority and if so to what extent does this function effectively?
b. Is there a national co-ordination body in place and if so to what extent does this function effectively? What is its mandate?
c. What are the means/mechanisms through which the co-ordination body fulfils its mandate? Is it through a memorandum of understanding (MOU) with regional and local bodies at each level?
d. To what extent is there a system in place that monitors explicitly the implementation of the strategy and action plan and that takes into account the demand, supply and harm-reduction aspects? Is a final evaluation undertaken?

Table 4: Assessing structures of responsibility

	Illicit drugs	Alcohol	Tobacco
Responsible body			
Co-ordination body			
Mechanisms			
Monitoring system			
Final evaluation			

Responses/interventions

What specific, major actions have been put in place? What types of intervention have been adopted to ensure their success?

Here we propose to look at groups of actions, and not single interventions such as market control from the supply side or, for example, a number of actions that may fall under harm reduction from the demand side. The following questions once again should be used to provide the relevant answer for this marker.

a. To what extent are there specific actions planned with respect to the strategy/action plan?
b. How far have they been implemented?
c. To what extent have the actions been monitored with the aim of altering them according to circumstances or unintended consequences – that is, are the actions dynamic or static?

Table 5: Specific actions and monitoring

	Illicit drugs	Alcohol	Tobacco
Specific actions			
How far implemented			
Monitoring of action plan (dynamic or static/unintended consequences)			

Resources

This marker relates to both the financial and human resources in place that enable the said policy to be put into practice. Hence the type of information required here in the main relates to expertise in the relevant structures and financing, as well as the finances needed to conduct the specific activities intended to achieve the overall goal of the said policy. Thus the questions about resources cover both human and financial needs, and whether these are supported by specific public expenditure.

a. Are there enough staff present in the relevant structures to support the policy goals?
b. Are there enough trained staff in the relevant structures to support implementation of the said policy?
c. To what extent are there continuing education programmes in place to support staff development?
d. Is the budget adequate to support the number of trained staff needed to effect the policy?
e. Is the budget sufficient for the continuing education of staff?
f. Is the budget sufficient for activities related to demand?
g. Is the budget sufficient for activities related to supply?

Table 6: Human and financial resources

	Illicit drugs	Alcohol	Tobacco
Staff number			
Trained staff			
Continuing education programme			
Budget for staff			
Budget for training			
Budget for demand activities			
Budget for supply activities			

It is suggested that, for the first marker (1A and 1B), 1A provides a description of the state of the problem whereas 1B, the policy goals, can be used as a marker for 1 and then can be combined with 1A to give an overall value. All the markers, 1-6, will be assigned a value of low, medium or high, a three-point scale: 1, 2 or 3. It is also suggested that in due time this might be enlarged to five items – adding

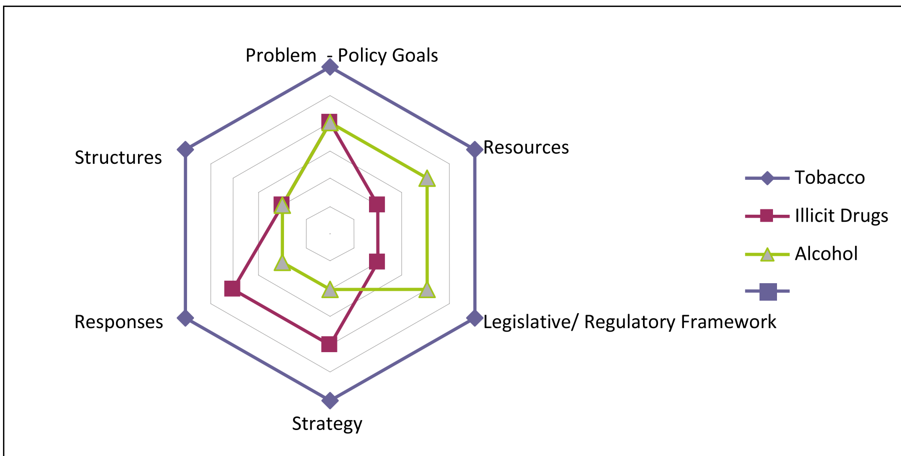
low-to-middle and middle-to-high – so in effect the following scale will be created: low, low to middle, middle, middle to high, and high.

Table 7: Initial assessment of levels

	Tobacco	Illicit drugs	Alcohol
State of the problem/policy goals	3	2	2
Legislative/regulatory framework	3	1	2
Strategy action plan	3	2	1
Structures	3	2	1
Responses/interventions	3	1	1
Resources	2	1	1

Once each marker has been assigned one of the levels suggested, that is low, medium or high, these may be graphically illustrated in a spider chart, where the outside of the web is high and the centre of the web is low, as shown below.

Figure 2: Initial assessment of markers using a spider diagram



The country reports that now follow describe the attempts by each member of the Coherent Policy Expert Group to use the six policy markers outlined above. In turn, they also suggest how to better make use of these markers to have a more rounded tool to determine coherency among policies that address psychoactive substances. These new insights are then tackled in the concluding chapter.

Chapter 1

Croatia – Coherence policy markers for addictions

Dijana Jerković and Lidija Vugrinec
Office for Combating Drug Abuse of the Government of the Republic of Croatia

The World Health Organization has identified well-being as the over-riding goal of policies in the field of licit and illicit drugs as well as other addictive behaviours (such as addiction to gambling or the Internet). Since health represents a state of complete physical, mental and social well-being, the Pompidou Group of the Council of Europe has recognised the issue of coherent policies on psychoactive substances as a priority area of its Work Programme 2011-14 adopted at the 15th Ministerial Conference in November 2010.

Coherence

Policy coherence is observed through the level of coherence between various public policies, that is, the extent to which different policies support each other. Therefore, mutual coherence between policies on licit and illicit drugs as well as other addictive behaviours is the key prerequisite for the development of an integrative approach to addictions in a broader sense. Given the above, the Pompidou Group has initiated a survey project on experiences with coherent/integrative policies on licit and illicit drugs. The project further analysed the issues in three publications by the Pompidou Group: *From a policy on illegal drugs to a policy on psychoactive substances* in 2008, *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis* in 2010 and *Reflections on the concept of coherency for a policy on psychoactive substances and beyond* in 2012.

To that effect, the Coherent Policy Expert Group has been established within the Pompidou Group and it consists of the representatives of a number of interested European countries, including the Republic of Croatia.[1] In the course of 2012 the expert group further developed the six markers for coherence.[2] The markers underwent preliminary testing in the countries that had participated in their development, in order to verify whether they provided a valid tool for measuring the effectiveness and efficiency of a coherent policy on psychoactive substances. The final markers for coherence (conceptualisation of the problem, policy context, legislative/regulatory framework, strategic framework, response/interventions and structures and resources) are to be used to articulate whether a policy for drugs, alcohol and tobacco is coherent in the current context and whether the complete national addiction policy is working. Each marker per se will serve to describe and assess the situation in each of the defined areas, in terms of identifying the problem and the solution, and thus indicate the shortcomings and irregularities of the national policy, if any.

This project is in line with the Pompidou Group's major objective of supporting the use of survey evidence in policy and practice, thus helping to develop evidence-based policy.

The countries which have participated in this European project on a voluntary basis have been asked to check the above-mentioned markers for coherence of policies on drugs, alcohol and tobacco against a questionnaire drawn up by the members of the project group established within the Pompidou Group (see Introduction) for the purpose of their further development. The report was to be submitted to the Pompidou Group by 25 August 2013.

Rationale of the project in Croatia

The Office for Combating Drug Abuse of the Government of the Republic of Croatia (hereinafter "the Office") was responsible for testing these markers for coherence in Croatia. It is noteworthy that the basic Pompidou Group survey project at this stage has been focused solely on testing markers for policy coherence in the areas of drugs, alcohol and tobacco. However, taking into account the previous knowledge about policies on various addictions in Croatia and the severity of the issues relating to certain psychoactive substances, as well as other addictive behaviours, the Office has decided to expand this project activity at the national level. Since addiction to games of chance is a widespread problem and there is no national framework for addressing different aspects of this issue systematically, Croatia has introduced gambling into its project activity[3] in addition to tobacco, alcohol and drugs. According to the population survey (Glavak Tkalić et al. 2012) conducted in 2012, approximately

1. The representatives of the Office for Combating Drug Abuse of the Government of the Republic of Croatia joined at a later stage of the project, in February 2013.
2. The term "markers for coherence" has been used for the survey project of the Pompidou Group. For professional and linguistic reasons, the Office has transformed it in Croatian into "coherence indicators" (hr. *pokazatelji koherentnosti*).
3. In the International Classification of Diseases (ICD-10), pathological gambling is classified under one of six habit and impulse disorders.

two thirds of the respondents (67.0%) aged 15-64 had played a game of chance at least once in their lifetime, and around one third had played in the past month.

There are numerous other important areas not covered by this survey project, but requiring deeper knowledge of the situation and inclusion in the interventions focused on addictions. For example, in the case of legal psychoactive substances, health and social problems are not posed only by tobacco and alcohol, although these are the most common substances in terms of use. Over recent years, a rapid rise in the incidence of a wide variety of new psychotropic substances has raised particular concern. Most of them have not been brought under the control of the drug law and are, therefore, easily available. Research on new trends in the consumption of psychoactive substances (Kranželić and Doležal 2013) has shown that "new drugs" in Croatia are usually obtained from friends or in specialised shops. By mimicking the effect of illicit drugs, with attractive packaging and sale in specialised shops, these new drugs[4] attract many users who consider them safe for use due to the above characteristics. The reality is often different and these are usually psychoactive substances which pose high health risks, in particular due to polyuse with other legal or illegal psychoactive substances.

Another important issue is the increasing abuse of prescription pharmaceuticals, in particular sedatives and tranquillisers. According to the annual report prepared by the UN Office on Drugs and Crime (UNODC 2013), over 60% of countries ranked them among the three most misused substances. In Croatia, a quarter of respondents (24.9%) aged 15-64 had consumed sedatives or tranquillisers at least once in their lifetime. These were mostly women and older people, but the fact that over 40% of young people (aged 15-34) obtained pharmaceuticals without a prescription the last time they used them, that is, outside the health-care system, is of particular concern (Glavak Tkalić et al. 2012). The legislator has recognised the harm potential of performance-enhancing drug abuse and by virtue of the new Criminal Code of the Republic of Croatia has made the manipulation of substances banned in sport (except for consumption) a criminal offence (Official Gazette 125/11, 142/12). However, this has regulated only the supply of such substances, while additional efforts should be made in the protection of the at-risk population.

When considering theories and models of addiction, West (2013) has defined addiction as "a repeated powerful motivation to engage in a purposeful behaviour that has no survival value, acquired as a result of engaging in that behaviour, with significant potential for unintended harm". Therefore, if we look at addiction as an interaction between the motivation and capabilities of individuals and the opportunities afforded to them, the term "addiction" should be considered in a much broader context, implying an integrated approach to solving addiction problems.

Considering the above, when selecting interventions aimed at modifying behaviour, the key role should be given to systematic analyses of capabilities, opportunities and motivations in the target population, as well as changes needed for achieving the behavioural targets. Therefore, in addition to addictions to legal and illegal psychoactive substances, an integrated policy on addictions should also cover a wide range of other addictive behaviours (such as pathological gambling, compulsive use

4. "Legal highs".

of the Internet, addiction to computer gaming, food, work, shopping or sex). Having in mind the concept of multifinality (Hosman 2011), which is the fact that the same risk and protection factors may result in multiple adverse outcomes, it is important to plan comprehensive measures aimed at common factors for the development of different addiction types and other risk behaviours.

In addition to testing the Pompidou Group markers for coherence, the Office decided to conduct a deeper analysis of the problem. Different stages and a combination of survey approaches have enabled an insight into the actual complementarity of the policies in question. Therefore, in this report the markers for coherence have been provisionally considered final and used for efficiency analysis of the existing national policy on addictions, which has resulted in clear recommendations for improving the approach.

A policy on drugs and other addictions is more than a set of laws and programmes. It requires consistency among policy elements. The interaction of drug-related policies with other areas, such as economic policy, employment policy, family policy and youth policy, has to be taken into consideration if it is to be effective and have a widespread effect. Non-compliance with such contextual factors will generate risks, which may lead to inconsistency with objectives in other areas or even create adverse effects. Policy inconsistency leads to increased risk of duplication, inefficient consumption, lower-quality services, difficulties in achieving strategic objectives and, ultimately, reduced management capacities. As a result of the differences in the legal status of the above substances, individual policies for each of the given substances have to be implemented separately. This leads to a policy that has not been co-ordinated with special programmes and budgets for each of the mentioned substances.

Even though various legal and strategic documents provide for elaborated measures and activities for preventing addiction to substance abuse within the competence of the relevant body, and establish the basis for an institutional framework, reports on activities and measures at national and local levels indicate a continuing problem of incoherence in the functioning of all segments of the overall system for prevention of drug abuse and other addictions. The reason for this lies in the fact that the institutional framework for the prevention of drug abuse and other addictions consists of different bodies of the state and local government that, in their own scope of work, make individual decisions on the implementation method for strategic objectives. This makes the co-ordination of activities more difficult and leads either to overlapping or lack of activities in their respective areas. Such a situation requires systematic changes and establishment of an operating umbrella body which would base its co-ordination task on vertical and horizontal hierarchical and executive authorities, and focus the segmented strategic and financial conduct of addiction-prevention activities on the defined single strategic objectives. Since there is no systematic policy on prevention for the above-mentioned addiction types in Croatia, nor does the existing structure allow a harmonised approach to conducting addiction-prevention policy, it is necessary to set up a body in charge of preventing and combating not only drug abuse, but also other addictions.

For example, the Report on Implementation of the National Strategy on Combating Drug Abuse, which is submitted to the Government of the Republic of Croatia and

the Croatian Parliament on an annual basis, clearly shows the need for the introduction of an efficient and co-ordinated approach to creating and implementing the objectives of prevention, treatment, rehabilitation, resocialisation, co-operation with the non-governmental sector and legislative framework. In addition, reports on the implementation of strategic documents in the area of other addictive substances often indicate that different bodies undertake the same or similar activities based on various strategic documents, the implementation of which has not been co-ordinated among the holders of these documents. Shortcomings can be observed in the segmented implementation of prevention policy, inconsistency in the media campaign, a non-functional institutional system for preventing and combating addiction at the local level, inadequate treatment systems and so on.

The results of the research conducted by the Office in co-operation with the Institute of Economics in Zagreb in 2012 (Budak et al. 2013) show that the estimated non-specified public expenditure together with the specified public expenditure only in the area of drug-related policy implementation for the period 2009-12 amounted to between HRK 702 and 742 million. Therefore, the reasons for the establishment of a strategic, institutional, legislative and financial framework for the implementation of a coherent policy in the area of prevention and combating of all addiction types do not lie only in the enhanced quality of the activity and policy implementation, but in the opportunity to use it for the purpose of ensuring central planning and monitoring of the execution of the planned strategic objectives. This would considerably facilitate policy implementation, since there would be a central body with authority and responsibility to pool all data on the execution of activities, and clarify the reasons for possible failure to execute the planned activities. It would also enable central planning and spending of funds intended for combating addictions, which would, in turn, prove to be more cost-effective compared to the current dispersion of funds.

Coherence markers testing methodology in Croatia

The purpose of the project is to test the questionnaire and create evidence-based foundations for the development of single national policies. The over-riding goal of the project is to determine the coherence in policies on psychoactive substances and addictive behaviour. In order to reach this goal, the following survey questions have been identified in the project:

- Is there a strategic and regulatory framework in place that defines respective policies on psychoactive substances (tobacco, alcohol, drugs) and addictive behaviour (gambling)?
- Are there co-ordination mechanisms in place that ensure the implementation of respective policies on psychoactive substances and addictive behaviour?
- Is there a monitoring system for respective policies on psychoactive substances and addictive behaviour?
- Are policies on respective psychoactive substances and addictive behaviour coherent?
- What are the possibilities for improving the existing situation in terms of a more effective and cost-efficient implementation of respective policies?

Coherence analysis of policies on addictions (tobacco, alcohol, drugs and gambling) in the Republic of Croatia was prepared in several steps. The questionnaire, drawn up by the Office in line with the markers for coherence set out in the Pompidou Group's Coherency policy markers – diagnostic tool, was sent in mid-April 2013 to the competent bodies dealing with creation and co-ordination of policy implementation with respect to the addictions concerned. The questionnaire was completed by the Office for Combating Drug Abuse, the Ministry of Health and the Croatian Institute of Public Health, and by renowned experts and scientists at the Sestre Milosrdnice Clinical Hospital Centre (Psychiatric Clinic) and Vrapče Psychiatric Hospital (Addiction Treatment Ward). The replies had to be submitted by the end of May 2013. The questionnaire was sent to six addressees for additional comments; five replied. With respect to the Office, tasks were strictly divided between the National Focal Point and International Affairs Department in charge of the project implementation, while a randomly selected person from the Department for General Programmes and Strategies participated in the research by completing the questionnaire and taking part in the focus group.

In May and June 2013, relevant bodies and experts in charge of the co-ordination and implementation of policies on psychoactive substances and addictive behaviour completed the questionnaire prepared by the Pompidou Group on coherence assessment of the policies in question. Since triangulation (application of multiple methods) increases confidence in the results being genuine (Propst et al. 2008), a focus group was used to supplement the questionnaire because it is considered an effective method for collecting quality data in a social context (Redmond and Curtis 2009). Taking into account that qualitative methodology is increasingly applied today (Jeđud 2007), and in order to obtain a more detailed insight into the issues and clarify possible ambiguities found while completing or interpreting the questionnaire, experts and policy makers who had completed it were invited to participate in the focus group.[5] The homogeneity of the focus group was achieved by selecting participants with similar experiences and knowledge, thus increasing the probability of exchanging ideas and obtaining more detailed information on the topic (Wibeck et al. 2007).

The focus group meeting was conducted on 12 June 2013 on the premises of the Office for Combating Drug Abuse of the Government of the Republic of Croatia and lasted 90 minutes. The sequence of answers was determined randomly using the seating arrangement of the participants (from left to right, in a circle). In order to achieve equal participation of all those present, the participants answered the first question, then the second, following the pattern until the last question. As a rule, the participants respected the planned sequence of questions and answers, and responded to all the questions. For the purpose of ensuring quality analysis and

5. They were: Prof. Slavko Sakoman MD PhD, head of the Addiction Reference Centre of the Ministry of Health, Psychiatric Clinic, Sestre Milosrdnice Clinical Hospital Centre; associate professor Zoran Zoričić MD PhD, Chairman of the Croatian Association of Clubs of Alcoholics in Treatment, Psychiatric Clinic, Sestre Milosrdnice Clinical Hospital Centre; Ms Dragica Katalinić MD, head of the Registry of Treated Psychoactive Drug Abusers of the Croatian Institute of Public Health; Iva Pejnović Franelić MD PhD, School and Adolescent Medicine and Addiction Prevention Service of the Croatian Institute of Public Health; Jadranka Ivandić Zimić PhD, adviser to the government and the Government Office, Dept for General Programmes and Strategies of the Office for Combating Drug Abuse. The Ministry of Health representative excused himself.

interpretation of answers, the interview was audio recorded and a team of facilitators participated in the focus group. Ms Dijana Jerković, senior expert adviser to the Office for Combating Drug Abuse, moderated the discussion, Ms Lidija Vugrinec, head of the National Focal Point and International Affairs Department of the Office, took notes and Ms Smilja Bagarić, expert assistant within the professional training at the Office, audio recorded the interview and made a transcript thereof. Scientific support for information analysis and interpretation was provided by associate professor Ivana Jeđud Borić at the Faculty of Education and Rehabilitation Sciences, University of Zagreb, who conducted 6 hours of training on qualitative methodology for persons in charge of the project implementation.

With respect to the ethical dimension of the project, we must emphasise that participants took part in all stages of the project voluntarily; they were given information in the form of an interview guide containing a brief project description, the purpose of the focus group, participation requirements, a list of invited and present participants, themes (questions for discussion) and information on follow-up activities within the project. Information confidentiality and privacy protection of the participants were ensured through cumulative presentation of the results and coding of their exact statements when quoted. Moreover, upon completion of the project the participants will be provided with the conclusions thereof.

The focus group transcript represents information that was further processed in line with the qualitative approach principles. Information provided by the focus group was processed by applying thematic analysis,[6] which is a process for identifying, analysing and reporting patterns (themes) within data (Braun and Clarke 2006). In general, a theme may be identified in two ways: in an inductive or a deductive way (Zhang and Wildemuth 2009). The deductive way was selected for the focus group analysis, while themes were identified according to the researcher's theoretical or analytical interest (Braun and Clarke 2006). In line with the above, the information analysis set up a framework for the interpretation of information through six themes identified on the basis of an insight into the participants' answers in the previously completed questionnaires. Furthermore, taking into account participants' specific knowledge, a possibility was left open for their contributions to the theme ("special themes").

The following themes were used as a framework for the information analysis:

- monitoring system for policies on psychoactive substances and addictive behaviour;
- complementarity of respective policy objectives;
- compliance of national strategies and action plans with the WHO definition of health;[7]
- policy implementation at national and local levels;
- co-ordination of policy implementation;
- policy adaptability to current circumstances;
- special themes.

6. The entire thematic analysis is available for inspection at the Office for Combating Drug Abuse.
7. The preamble to the 1946 Constitution of the World Health Organization reads: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

The focus group qualitative analysis procedure included the following analysis stages: (1) focus group transcript reading, (2) definition of codes within each theme, (3) definition of categories within each theme, (4) interpretation of results for each theme, with categories substantiated by literal quotes of the respondents, and (5) reaching of conclusions and recommendations. The results were shown in a way that was usual for the presentation of results of a qualitative survey: each theme was accompanied by appropriate codes and categories, and interpretation was substantiated by literal quotes of the project participants. Literal statements were written in italics, without quotation marks. When quoting, the exact wording of a participant was used. Statements made by different participants were separated by a semicolon (;) whereas statements by the same participant were separated by a comma (,).

Table 1.1 contains an example of coding. Coding units were identified for each theme and assigned appropriate codes. They were defined as "a word or group of words that could be coded under one criterion category" (Schamber 2000: 739, in Zhang and Wildemuth 2009). In the course of coding, other experts from the Office were consulted who were engaged in other parts of the project. At a later stage, codes were grouped into more abstract categories.

Table 1.1: An example of coding

Theme	Source text	Code	Category
Complementarity of respective policy objectives	"The things I have mentioned at the beginning have also been partially repeated by you. Therefore, objectives are complementary. However, as regards the reduction and control thereof, interests differ. Interest areas for alcohol and gambling differ from the interest areas for illicit drugs, it is up to the society because this is a legal activity and the other one is illegal. Therefore, the methodology of the approach cannot be the same, it will have to differ and this is what makes these two systems different."	Complementary objectives Different interests Different interests depending on the (il)legality of substances Different methodology	Objectives Interests Method

Analysis of answers to policy coherence questionnaire

Answers to the questionnaire on policy coherence for tobacco, alcohol, drugs and gambling varied significantly in terms of the information quality, though (an expert from) each institution did respond to the part referring to their scope of work. Two bodies submitted almost identical answers, one questionnaire was completed with

very short answers (sometimes only "yes" or "no") and one response was received as a document in the form of an overview of the marker 1A: Policy – State of the problem. However, it contained an analysis of the situation for various types of illicit drugs, alcohol, tobacco and gambling, and a critical overview of the addiction monitoring system. Areas where the research participants provided no answer or incomplete answers were clarified in detail in the focus group. As regards the marker 1B: Policy – Context, the person conducting the survey suggested a small supplement to the overview based on publicly available information, which was considered necessary for a better understanding of the context of the respective issues.

In addition, there was a detailed analysis of the key strategic documents, with an overview of certain questions in the questionnaire but also a somewhat broader context giving a clear presentation of the relationship between the strategic documents in the area of health and certain areas of addiction, the level of their complementarity, objective coherence, the importance they gave to co-operation with other areas, and so on. Since the answers received did not clearly show coherence with the World Health Organization definition of health, this part was addressed in the analysis of strategic documents and particularly in the conclusions and recommendations of the focus group analysis.

Markers 2-5 (2. Legislative/regulatory framework, 3. Strategic framework, 4. Structures and resources, 5. Responses and interventions) were addressed at the level of coherence assessment within a particular policy and its compliance with other policies analysed in the area of addiction. The coherence level assigned to each marker (low, medium, high) represents the result of the assessment made by the person conducting the survey based on the answers to the questionnaire, as well as the documentation analysis and focus group analysis described below. The reason for such an approach arose out of the fact that the answers received did not contain all the relevant information required for the assessment.

Coherency policy markers

Policy

State of the problem

Illicit drugs

The problem of illicit drug abuse in Croatia was well under control until 1990. During the war (1991-95), post-war period and transition, and in parallel with the rise of corruption and organised crime, drug demand and supply multiplied. Therefore, until 2001 there was a continuous increase in consumption, and in the number of illicit drug consumers and addicts. Croatia has a well-established system for epidemiological monitoring of the addiction problem. The most valuable epidemiological instrument, used since 1978 for precise monitoring of drug abuse trends, is the national Register of Persons Treated for Psychoactive Drug Abuse of the Croatian Institute of Public Health. According to this register, 7 855 persons treated for illicit

drug abuse were registered at health-care institutions in the Republic of Croatia in 2012. This was an increase of 2.5% in relation to the previous year.

Of those, 1 120 persons were treated for the first time (14.3%). Among new requests for treatment, opiates accounted for a smaller proportion (27.9%), while there were 72.1% of non-opiate addicts. The increase in the average age of persons treated showed that persons remained in the treatment system for a number of years, while the number of the newly admitted was stable. As in previous years, the majority was male (82.5%) and the male–female ratio was 4.7:1. The population of addicts in the Republic of Croatia is getting older, and the average age of treated persons (male and female) shows an increase. In 2012 the average age of treated men was 33.1 years and of women 31.8 years. As in previous years, only 66.8% of treated persons (5 248) had completed secondary education; only 41.4% had regular employment. It can be concluded that, considering the low educational level of treated addicts, their education, employment and resocialisation are very important elements in overall treatment and later abstinence. If we take into account the overall number of treated drug addicts per 100 000 inhabitants aged 15-64, the average rate in the Republic of Croatia (257.0) was a bit higher compared to the previous year (in 2010 it was 250.3). When looking at the counties, the highest treatment rate was registered in Istria County (542.5) for several consecutive years, followed by Zadar County (493.7), the City of Zagreb (435.6), Šibenik-Knin County (344.4) and Primorje-Gorski Kotar County (340.8).

As regards particular drugs, the heroin epidemic had the severest consequences, significantly aggravated by war circumstances. At national level, methadone maintenance treatment has been provided through a decentralised approach since 1991. Buprenorphine has been applied since 2004. Nowadays, out of the total number of addicts, 50% are in methadone substitution therapy and 50% use buprenorphine. The number of new opiate addicts and those treated and registered for the first time increased from 120 persons in 1990 to 1 066. Since then the incidence, and thus the number of newly treated opiate addicts, has shown a continuous downward trend. Out of 6 357 persons treated for opiate addiction in 2012, 313 persons were registered for the first time. The number of opiate overdoses increased from 2001 to 2007, when over 100 people died per year, but in recent years the number of such cases has halved. In 2011, 55 persons succumbed to the consequences of fatal intoxication by illicit drugs, of which as many as 38 cases were related to methadone (as in the previous year), 13 to heroin and four to cocaine. According to the answers provided by survey participants, the return to a treatment policy based on individually assessed indications and the principles of best medical practice, suggesting that opioid agonist maintenance and psychosocial treatment would be the best option for over 80% of actively treated chronic patients, is considered to have contributed to the mortality decrease. The possibility of a buprenorphine treatment has also contributed to lower mortality. On the other hand, it is believed that the methadone intoxication increase can be attributed to the illicit use of methadone, the fact that it is relatively easily accessible, excessive treatment doses, inappropriate use or reduced tolerance.

In line with the decrease in incidence and the number of overdoses, year after year the number of persons positive for hepatitis viruses has decreased (in 2012,

HCV 27%, HBV 8%). The number of HIV-seropositive has remained low (0.5%). This favourable epidemiological trend is primarily a result of the treatment system and the Croatian model for treatment of heroin addicts, which is characterised by a high level of expertise and quality. The system is based on a network of specialised services for mental health protection, addiction prevention and outpatient treatment, which co-operate with the network of family medicine physicians on a therapy of complex psychosocial treatment and accessibility of substitution (pursuant to the Guidelines for Opioid Agonist Pharmacotherapy and recommendations of the specialists working at the services, family physicians prescribe required medications on a daily or weekly basis). In recent years, reduced incidence of opiate addicts has also been a result of reduced heroin availability, partly due to global heroin supply distortions and partly due to enhanced efficiency of the repressive system. Opiate addiction is usually developed at the age of 22, and treated for the first time approximately four years later (at age 26).

Cannabis has remained number one as regards the number of consumers, and number two in terms of treatment requests. Cannabis availability correlates directly with the number of consumers applying for treatment. After a stagnation period over recent years, its availability has been on the increase again, along with the number of consumers, especially among the young. The quality of cannabis has increased, as has its price in comparison to the years immediately following 2000. It is grown in the country but also smuggled in from several sources. The supply and demand of synthetic cannabinoids in Croatia have been on the increase over recent years. The number of psychiatric hospitalisations of psychotic patients who have used cannabinoids is also rising. According to the population survey on the prevalence of addictive-substance abuse (Glavak Tkalić et al. 2012), cannabis had been used by 2.9% of those aged 15-64, and 6.1% of those aged 15-34, over the past 30 days.

Cocaine has remained easily accessible in urban areas, where it attracts buyers among well-off persons. There has been a progressive increase in the newly treated, with about 150 cases a year, but this is still insignificant in comparison to the overall number of almost 6 500 opiate addicts treated annually. From 2009, cocaine consumption significantly decreased due to the economic crisis, which significantly reduced citizens' financial means. Approximately 20% of opiate addicts use cocaine as an additional substance. A waste water analysis in the City of Zagreb (Terzić, Senta and Ahel 2010; Thomas et al. 2012; Terzić and Ahel 2012) confirmed reduced cocaine consumption in Zagreb in 2011 and 2012 in comparison to 2009.

The availability and consumption of amphetamines showed a continuous increase for a decade, starting from the mid-1990s, followed by stagnation. However, since about 2008, in parallel with the recession and reduced cocaine consumption, consumption of amphetamines has risen (due to relatively low prices). Some sporadic incidence of methamphetamine has also been reported. Still, there have been few requests for treatment of persons who have used amphetamine as the primary drug (less than 100 cases a year). From 1992 there was a surge in MDMA abuse that was stopped around 2002 by a serious of very specific measures. Today the consumption of this drug is at very low levels, though its return to the market has been observed over the past years.

The number of addicts in therapeutic communities showed a continuous decrease from 2009 to 2011. In that year 821 persons were treated in all therapeutic communities, down by 12.6% in comparison to 2010, and by 27.8% in comparison to 2009. In 2012 there were 685 addicts in therapeutic communities, a decrease of 16.6% from 2011.

Since 1995, Croatia has continuously participated in the European School Survey Project on Alcohol and Other Drugs (ESPAD) (Hibell et al. 2012). According to the results of this European survey, the use of alcohol and inhalants in Croatia has increased. As regards all three indicators for cigarette, alcohol and drug use, Croatia is above the European average. Croatia is ranked third as regards cigarette smoking, and in the period 1995-2011 smoking slightly increased. As regards drinking in the past 12 months, Croatia is ranked 11th. The fact that Croatia is placed third when it comes to having five or more drinks on one occasion (binge drinking) is worrying. With respect to lifetime cannabis use, Croatia is also above the European average and is ranked 19th. Cannabis was consumed by 23% of boys and 15% of girls, and in the past 30 days by 9% of boys and 5% of girls. Some other drugs were consumed by 6% of boys and 4% of girls in Croatia. Surprisingly, Croatia is ranked first as regards inhalant use. Inhalants were used by 25% of boys and 31% of girls, or, on average, 28% of respondents, while the EU average was 9%.

The first national survey on addictive-substance abuse in Croatia (Glavak Tkalić et al. 2012), covering all the interest areas of this project, was conducted in 2011 using a representative multilayered stratified population sample aged 15-64. According to that survey, 16% of all respondents had tried one of the illicit drugs, namely cannabis 15.6%, ecstasy 2.5%, amphetamines 2.6%, cocaine 2.3%, heroin 0.4% and LSD 1.4%. The prevalence of drug use in the population increases the younger the respondents. For example, 25.7% of the population aged 15-34 had tried one of the illicit drugs at least once in their lifetime. In the past 30 days, 3.2% of the total population and 6.2% of the younger population had consumed an illicit drug.

Since 2009, the City of Zagreb has used another very important objective indicator of drug consumption, the analysis of illicit drug metabolite concentration in waste waters, which is based on the assumption that waste water collected from the inlet of the central treatment system may be considered to be a very dilute urine sample of the entire city population. The Ruđer Bošković Institute conducted the first research of this kind in 2009 (Terzić, Senta and Ahel 2010); it was repeated as part of the European research in 19 cities during seven consecutive days in March 2011 (Thomas et al. 2012) and again as an individual project from April to August 2012 (Terzić and Ahel 2012).[8] Comparison of the above research results indicates a continuous increase in cannabis and methadone use, an increase in amphetamine and ecstasy, and a decrease in cocaine, especially heroin use, which was affected by the significantly lower quality of this type of drug sold in the streets. Each year, 1 tonne of marijuana, 151 kg of heroin and 125 kg of cocaine were consumed in Zagreb, a city of around 800 000 people.

8. Internal material from the Office for Combating Drug Abuse of the Government of the Republic of Croatia.

Supplement based on information available to the person conducting the survey

Croatia is primarily a transit country and the production of drugs is restricted to the growing of cannabis for personal use or sale on the Croatian market. In 2012, there were 6 381 seizures of all types of drugs, thus continuing the upward trend started in 2009. Heroin seizures in the past couple of years have been 3.5 times smaller than in, for example, 2006. In addition, heroin is of extremely poor quality. The number of seizures and quantities of seized cannabis herb have been continually increasing for a number of years. In 2012 a record-high quantity of 6 703 kg was seized, which was twice the average of the mid-2000s. It seems that cannabis resin is also becoming increasingly accessible, and the potency of all cannabis products is rising. Ecstasy tablets (with actual content of MDMA[9]) have returned to the drug market, whereas cocaine seizures on the domestic market are quite small.[10] This is in line with the findings of the waste water analysis described above. It is interesting to notice that waste water analysis indicates an upward trend in amphetamine use, yet police statistics show a downward trend. The survey "Availability and prices of illicit drugs in the Republic of Croatia" (Doležal 2011), conducted among addicts who use different types of drug almost daily and are beneficiaries of the harm-reduction programme, indicates similar trends to the waste water analysis. There is wide accessibility to methadone on the illegal market, usually taken intravenously, but also available as products, whereas heroin is relatively difficult to obtain.

Like other European countries, since 2010 Croatia has registered an increasing number of new psychoactive substances sold legally or on the black market, and has used the multidisciplinary approach in order to find adequate solutions to the phenomenon of "legal highs". Particularly worrying is the increasing use of various legal and illegal psychoactive substances, entailing numerous co-morbidity disorders and higher intoxication risk, including fatal consequences. The Office for Combating Drug Abuse has invested its best efforts in promoting evidence-based prevention measures, strengthening the role of psychosocial treatment, raising awareness of the dangerous effects of legal highs, enhancing intersectoral co-operation on a regular basis and fostering efficient measures at local level. One example is the National Addiction Prevention Programme for Children and Youth in Educational Settings, as well as for Children and Youth outside the educational system for the period 2010-14, aimed at combating and preventing the occurrence of all forms of addiction among children and youth, and their at-risk behaviour in experimenting with addictive substances.

9. It is well known that the content of the active substance MDMA has been particularly low in ecstasy tablets in the past decade, being replaced by other, mostly new psychoactive substances that have been sold as ecstasy.
10. Despite fewer seizures and relatively small quantities of cocaine in Croatia, the Croatian police have had a leading role in initiating and conducting international operations aiming to break smuggling rings.

Although no surveys have been conducted on the social costs of respective addiction types, it is worth noting that the research on public expenditure in the area of drugs (Budak et al. 2013) has shown that public expenditure on drug abuse prevention in Croatia amounts to 0.2% of the GDP, and in the period 2009-12 it ranged from HRK 702 to 742 million.

Alcohol

Croatia has a long tradition of a quality system for the treatment and rehabilitation of alcoholics, which was established by Professor Vladimir Hudolin in the late 1960s. In addition to specialised alcohol-addiction treatment programmes within psychiatry, a wide network with over 600 clubs of anonymous alcoholics has been set up. Unlike Narcotics Anonymous, the clubs are organised as therapy support groups led by educated professionals. The national registry of treated alcoholics was set up as early as 1965 in order to ensure very reliable epidemiological monitoring of alcoholism at the highest level, which was at the time considered a particularly severe problem for society and public health. As early as 1976, the database for monitoring treated alcoholics was computerised. The drinking epidemic reached its peak in 1983 when the number of newly registered alcoholics and those being treated for the first time exceeded 6 000 persons (Sakoman 1987). Since then alcoholism prevalence has decreased. At the beginning of the war (in 1991), the number of clubs was reduced to approximately 200. However, due to a number of other social factors, alcoholism prevalence has not risen. Systematic monitoring of alcohol addiction at the national level is no longer available.

Since the early 1990s, a pronounced increase in drug abuse has not been followed by an increase in alcohol consumption. On the contrary, social measures regarding better control of alcohol in circulation, introduction of zero tolerance of domestic violence (compulsory psychosocial treatment is imposed on a person who has committed domestic violence), considerably lower tolerance of drinking by employers and employees' fear of losing their job in the situation of high unemployment have significantly affected the increased responsibility level of adults with respect to drinking.

The weak point of the social preventative measures lies in the protection of adolescents and youth up the age of 30. Since 2000 the production and sale of beer have risen significantly. Since beer is considered food, it can be advertised freely in all media. The influential brewing industry has conducted successful advertising via mass media, and its victims are young people with easy access to alcoholic beverages due to poor monitoring of implementation of the measure that prohibits the sale of alcohol to minors. According to a recent ESPAD survey, almost every third student (30.7%) had bought themselves a beer in a shop in the past 30 days and every fourth (24.3%) had bought wine. This shows the level of alcohol availability and (non-)adherence to the law.[11] With the decrease in

11. Article 11 of the Trade Act (OG 87/08, 96/08, 116/08, 114/11, 68/13) stipulates that retail shops shall not sell alcoholic beverages and other drinks with alcoholic content to persons under the age of 18. All shops selling such goods are required to display a notice prohibiting such sales to persons under 18. The Hospitality and Catering Industry Act (OG 138/06, 43/09, 88/10, 50/12, 80/13), Article 12 stipulates that no hospitality and catering facility shall serve or allow consumption of alcoholic beverages on their premises to persons under the age of 18.

consumption of illicit drugs since 2000 (which, except for cannabis, are no longer "in"), the interest of young people in alcohol drinking as an "acceptable" behaviour model has grown. This was confirmed by the ESPAD survey (Hibell et al. 2012), which showed that alcohol drinking has surged, and Croatia is now high on the list for 15-year-olds who drink alcohol regularly, excessively or in combination with tablets.

Boys still drink more than girls; however, an increase in drinking among girls is worth noting. In Croatia, as in most of the ESPAD countries, almost every boy or girl (93.5%) had used alcohol at least once in their lifetime, while 41.9% of boys and 23.4% of girls reported use of alcohol frequently (on 40 or more occasions) and 60.9% of boys and 48.2% of girls reported use on six and more occasions in the past 30 days. In the past 12 months 11.3% of boys and 5.9% of girls had consumed alcohol on 10 and more occasions (once a month on average). In the past 30 days, 31.7% of boys and 20.1% of girls had drunk five drinks in a row on three or more occasions (defined as binge drinking). According to the international survey on health behaviour in school-aged children, known as the HBSC (Currie et al. 2012), conducted in Croatia in the school year 2009/10, 44% of boys and 26% of girls under the age of 15 reported drunkenness on two or more occasions in their lifetime. The survey among students (Kuzman et al. 2011) conducted in the academic year 2008/09 at Zagreb and Rijeka universities showed that only 4.8% of students never consumed alcohol, and 41.4% of them had consumed alcohol on 40 and more occasions in their lifetime. In the past 30 days, among those who reported alcohol consumption, 6.9% of students had consumed alcohol 10 or more times. In the past year, 15.7% of students reported alcohol consumption on 40 and more occasions, though 27.9% of students had never been drunk in their lifetime. In the past 30 days 79.9% of students reported no alcohol use. Male students drank more, and more frequently, than females.

In addition to easy availability, the increase in alcohol consumption by young people above 20 is also affected by the poor quality of life and low social status caused by high unemployment. According to the national survey on the prevalence of drug and other addictive substance abuse (Glavak Tkalić et al. 2012), 8.6% of the population aged 15-64 consumed six or more glasses of an alcoholic beverage in a row once a month, which was considered binge drinking, and 5.6% of them once a week. Among young people aged 15-34, 14.1% of them reported drunkenness once a month, 9.6% once or several times a week and 1% every day. Among the population aged 15-24, most drank once a week (12.1%) or once a month (17.1%), whereas in the age group 25-34 the largest number of respondents drank less than once a month (26.5%).

According to WHO data, the estimated alcohol consumption per capita in 2009 in Croatia was 12.76 litres, of which unregistered alcohol consumption accounted for 2.5 litres (WHO 2012b). According to the survey on household consumption conducted by the Croatian Bureau of Statistics, the annual alcohol consumption per household member in Croatia in 2010 averaged 27 litres: beer 15.6 l, wine 10.7 l and spirits 0.7 l. Monitoring of excessive alcohol consumption, as a public health problem, usually includes data on alcohol-related mortality, morbidity and traffic accidents, as well as hospitalisations related to excessive use of alcohol.

Supplement based on information available to the person conducting the survey

According to the health indicators for the Republic of Croatia outlined in the National Healthcare Strategy for the period 2012-20 (OG 116/12), registered alcohol consumption in Croatia increased progressively in the period 2000 to 2009. Taking into account the WHO data, the strategy indicates that alcohol abuse causes loss of 2 748 DALYs[12] per 100 000 inhabitants for men, meaning it accounts for 17% of the total DALY rate for men. For women, it accounts for 5% of DALYs, or 599 years lost due to early death and reduced quality of life per 100 000 inhabitants. The alcohol-related death rate is estimated at 92/100 000 inhabitants, or 17% of the total deaths for men, and 21/100 000 inhabitants or 9% of deaths for women. Considering the mortality caused by liver diseases and cirrhosis, Croatia has a higher rate than the "old" EU member states or the Czech Republic. Annually, around 8 500 men and 1 200 women are hospitalised by an alcohol-related problem. Most of them belong to the age group 50-59, followed by the age group 40-49.

Tobacco

The survey *Addictive substance abuse in the general population of the Republic of Croatia* (Glavak Tkalić et al. 2012), conducted by the Ivo Pilar Institute of Social Sciences in the course of 2011, showed that 36.3% of Croats smoke tobacco on a regular basis (39.7% of men and 32.9% of women). Men smoke more often than women in all age groups. Over the entire sample, smoking is least prevalent in the age group 55-64, where it accounts for 25.7%, and most prevalent in the age group 35-44, accounting for 43.5%. The largest number of smokers (16.5%) smoke 10 to 20 cigarettes a day.

According to the ESPAD survey conducted in 2011 (Hibell et al. 2012), Croatian 16-year-olds are ranked third out of 37 participating European countries by the indicator "smoking in the past 30 days", with a prevalence of 41%. The results of the last two ESPAD surveys indicate an upward trend in smoking among boys. According to the modified ESPAD survey conducted in 2009 among first-year students at Zagreb and Rijeka universities (average age 19 years 9 months), 33.3% of male students and 34.9% of female students had smoked in the past 30 days (Kuzman et al. 2011). The survey was conducted by the Croatian Institute of Public Health in co-operation with the Ministry of Science, Education and Sports. According to the study on health behaviour in school-aged children or HBSC (Currie et al. 2012) conducted in the school year 2009/10, 21% of boys and 19% of girls aged 15 smoked on a daily basis. This represented an increase of 4% for boys and 2% for girls in relation to the same survey conducted in 2002. According to the Global Youth Tobacco Survey (GYTS 2011) cigarette smoking among youth (aged 13-15) had increased since 2003 from 18.3% to 24.1% in 2007, and to 27.2% in 2011. As many as 67.1% of pupils in Croatia had tried smoking or experimented with cigarettes.

12. Disability-adjusted life years (DALYs), calculated as the sum of years of life lost to premature mortality and years lost to disability.

Following the EU policy of reduced tobacco product consumption, Croatia has undertaken a number of measures aimed at reducing and restricting the use of tobacco products,[13] which should contribute to reduction of the number of smokers, in particular among youth[14] whose number is increasing progressively. Concern about insufficient implementation of the prohibition on sale of tobacco products to minors is particularly prominent in the replies. It is also stressed that all the measures for reduction of tobacco product availability are not adequate to meet the actual needs. Quality (prominent) media campaigns against tobacco smoking are launched on a sporadic basis. Therefore, there is a need to enhance the implementation of addictive behaviour prevention programmes in schools, integrating them into the health education curriculum.

Supplement based on information available to the person conducting the survey

The National Healthcare Strategy for the period 2012-20 (OG 116/12) contains the estimates of the World Health Organization, according to which smoking is the leading cause of the burden of disease in Croatia, accounting for 15.8% out of the total DALY rate. The results of the 2003 Croatian Health Survey indicate that 27.4% of persons smoked in Croatia (33.8% of men and 21.7% of women) aged 18 and older. This is above the smoking prevalence in the old member states (25.6%), as well as the new ones (25.4%). It is estimated that over 9 000 persons die (every sixth death) of a smoking-related disease in Croatia annually.

According to a survey on the impact of fiscal policy on tobacco product consumption in Croatia (Zelenka 2009), the tobacco-control policy in Croatia refers to the pricing policy, prices and excise duties, as well as laws. While various regulations on the restriction of tobacco use, health-care warnings and advertising restrictions try to impact consumption directly, acts relating to increasing excise duty have two opposite effects. One is the fiscal effect of the state budget increase, and the other is consumption reduction through the increase in the tobacco product price. It is the second effect that is disputable. According to the laws of economics, increased prices of a product should decrease consumption of such a product. However, the effect will not be sufficient if there are no close substitutes, as is the case with tobacco. Moreover, tobacco products create addiction which additionally reduces the possibility for quick adaptation to new higher prices.

Gambling

The answers received clearly show the perception that Croatia has a poorly regulated system for prevention and monitoring of problems related to games of chance, the

13. Act on the Restriction of the Use of Tobacco Products (OG 125/08, 55/09, 119/09, 94/13).
14. The Trade Act (OG 87/08, 96/08, 116/08, 114/11, 68/13) and Act on the Restriction of the Use of Tobacco Products stipulate that no tobacco products shall be sold to persons under the age of 18, tobacco products shall not be sold by persons under the age of 18, and all shops selling tobacco products shall have a notice prohibiting the sale thereof to persons under the age of 18.

restriction of which might result in reduced legal budget revenues from this source. A similar form of entertainment is widely accessible to Croatian citizens in numerous bars with slot machines and on the Internet. "[I]n many locations offering games of chance, there is a link to the elements of organised crime (money lending, usury, money laundering)", one respondent stated in a questionnaire. As in the case of alcohol and tobacco sale, there is insufficient implementation of the legal restriction that prohibits minors entering facilities offering games of chance.[15]

According to the survey *Playing of games of chance in the general population of the Republic of Croatia* conducted by the Ivo Pilar Institute of Social Sciences at the request of the Office for Combating Drug Abuse within the survey project *Addictive substance abuse in the general population of the Republic of Croatia* (Glavak Tkalić et al. 2012), approximately two thirds of adults (67.0%) have played a game of chance at least once in their lifetime. The highest lifetime prevalence was in the age group 35-44 (74.2%), and the lowest in the age group 15-24 (59.0%). Lifetime prevalence of games of chance was higher among men (72.9%) than women (61.2%). In the past 30 days, 32.5% of the population aged 15-64 had played a game of chance. Also, 2.5% of respondents aged 15-64 and 3.2% of young people (aged 15-34) confirmed that they had had problems in their lifetime caused by playing games of chance. In the past 30 days, 1.5% of all respondents and 1.9% of younger respondents had faced difficulties because they had played a game of chance (mostly sports betting houses). Over one third of respondents (34.7%) stated that they personally knew somebody who had problems relating to games of chance; among younger adults this proportion was a bit higher.

According to the data collected from the 2009 survey *Health-related habits and behaviour of first-year students at the Zagreb and Rijeka universities* (Kuzman et al. 2011), the majority of students at both universities had bet in sports betting houses (52.0% from Zagreb and 47.8% from Rijeka) in the past 12 months, followed by playing slot machines, visiting a casino and playing cards for money. Online betting was least frequent. In general, boys were more inclined towards all forms of gambling and betting, except for the lottery, for which there was no difference between the sexes. The 2011 ESPAD survey (Hibell et al. 2012) showed that 15% of boys played on slot machines from which they could win money at least once a week.

In Croatia there is no systematic monitoring of the occurrence of game-related disorders. There is no systematic epidemiological monitoring of trends in pathological gamblers, so no evidence-based estimate of the total number of gambling addicts can be given (prevalence), nor the annual increase in the number of newly identified gambling addicts (incidence). The available data of the Croatian Institute of Public Health show that, in 2012, 32 persons were hospitalised for pathological gambling (ICD code: F 63.0) in inpatient and outpatient services at health-care institutions across the country.

Since problematic gambling affects several different areas, a need for a "multidimensional approach for the purpose of developing a reasonable social policy" has been emphasised. While some of the initiatives and recommendations should be similar

15. The Act on Games of Chance (OG 87/09, 35/13) stipulates that no bets shall be received from persons under the age of 18, and a visit to a casino and participation in play, as well as a visit to and use of slot machines, shall be allowed only to adults.

to the current policy on alcohol and other drugs, it is considered that other measures should be specific and aimed at gambling. Considering the fact that gambling and betting are widely accepted forms of entertainment, it is important to prepare young people for responsible behaviour, taking into account the frequency of gambling and betting at a later stage in life. Initiatives have been launched to integrate special measures for prevention of this type of at-risk behaviour into the health education curriculum within the educational system.

Supplement based on information available to the person conducting the survey

According to the 2009 Global Gambling Report,[16] Croatia has 562 betting houses per 1 million inhabitants or approximately 2 600 betting houses across the country. On the basis of the decision issued by the Government of the Republic of Croatia and authorisation of the Ministry of Finance, games of chance may be organised by companies having their registered seat in the Republic of Croatia. In order to acquire rights to organise games of chance, apart from the requirements stipulated by the Act on Games of Chance (OG 87/09, 35/13), the bidder is obliged to meet special requirements stipulated by the minister of finance within a public tender procedure.

In the Croatian National Television *Evening News* broadcast on 15 August 2013, it was reported that there are around 50 000 gambling addicts in Croatia, who are able to try their luck in 220 registered gambling machine clubs, 1 431 betting houses and 2 363 self-service terminals. Companies which do business with games of chance have paid more than 550 million kuna into the national budget. According to new, stricter terms of the Games of Chance Act, a ban on betting in catering establishments will be implemented, betting on lottery games will be abolished and every gambling machine will be linked to a public administration server in order to get a complete insight into the business practices of such companies. In the spirit of prevention, new provisions also define the minimal distance of such objects from schools, new spatial terms and fiscal cash registers. According to research conducted by the Faculty of Education and Rehabilitation Sciences, around one third of high school boys bet on a regular basis, around 10% play on gambling machines, every fifth boy visits betting houses with his parents, and they also find a way to try their luck on their own, even at casinos (Dodig and Ricijaš 2011).

In addition to pathological gambling, there are other psychic disorders in almost every case. Pathological gamblers suffer from addiction diseases (25-65%) four to six times more frequently than the general population (overall 25-63%; tobacco 60-85%; other substances 40%; alcohol 45-55%). In a clinical sample, 19-50% of gamblers had records of alcohol or drug addiction (Koić 2009).

16. Available at: www.monitor.hr/clanci/hrvati-sve-ovisniji-o-sportskom-kladenju/19631/, page viewed on 25 July 2013.

Context

The political objectives for each area analysed are reflected in the adopted strategic documents and legal framework.

Illicit drugs

The first national strategy for drug monitoring, drug abuse prevention and assistance to drug addicts in the Republic of Croatia was adopted by the Croatian Parliament in 1996. On the basis of the above document, the (Narcotic)[17] Drug Abuse Prevention Act was adopted (OG 107/2001, 87/2002, 163/2003, 141/2004, 40/2007, 149/2009 and 84/2011), which provided for the establishment of the Office for Combating Drug Abuse (hereinafter the Office)[18] as an expert service of the Government of the Republic of Croatia. In its capacity as the body in charge of monitoring the situation in this area, as well as implementing the national policy on drugs, and in co-operation with other competent bodies, the Office prepares the National Strategy on Combating Drug Abuse and accompanying action plans, which are submitted to the Government of the Republic of Croatia and the Croatian Parliament for adoption. As a response to the need for an integrated, harmonised and multidisciplinary approach to solving drug issues in society, and harmonisation of Croatian legislation with that of the European Union, in 2005 the Croatian Parliament adopted the second National Strategy on (Narcotic) Drug Abuse in the Republic of Croatia for the period 2006-12. It was implemented through two three-year action plans on combating drug abuse in the Republic of Croatia.

Usually a national strategy on drugs covers a period of six years, and the current one covers the period 2012 to 2017. It has been prepared on the basis of results and recommendations derived from scientific evaluation of the previous national strategy, as well as indicators of the drug situation and drug addiction in Croatia. As regards its content, the current strategy sets out strategic objectives, priorities and measures aimed at ensuring responsibility for the implementation of the overall national policy on combating drugs at national, local and international levels. As the fundamental strategic document in the area of drugs, it provides a framework for the engagement of all competent government institutions and civil society organisations in solving the overall drug issue, but also society's response to issues relating to drug abuse and active participation in the maintenance and enhancement of security, health, justice and protection of freedom in the society, in line with the basic principles and values of the legal system of the Republic of Croatia and the *acquis communautaire* of the European Union, as well as expertise and surveys in the field. Among the six key principles of this strategy, we would like to emphasise the human rights protection principle, which means that:

> the National Strategy has recognised and promoted common international and European values, encompassing the respect of human dignity, freedom, democracy, equality, solidarity, responsibility, rule of law and human rights including the rights to health, health-care protection and equal access to services.

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17. In amendments to the Drug Abuse Prevention Act (OG 149/09) the term "narcotic" was deleted.
18. Ordinance on the Establishment of the Office for Combating Drug Abuse (OG 18/02, 12/05, 111/06, 19/10).

The vision of this strategy is to reduce drug demand and supply in society through an integrated and balanced approach to the drug issue and to provide adequate protection of the lives and health of children, youth, families and individuals, and, in relation to this, to keep the drug issue within the socially acceptable levels of risk in order to preserve the fundamental values of society and the safety of the population.

The above clearly shows that the document speaks in favour of a balanced approach to drug demand and supply. Given the above, drug supply reduction requires continuous and efficient undertaking of all legal measures and actions aimed at combating the production and trafficking in drugs and precursors, and enhanced efficiency of procedures and methods aimed at combating the production, smuggling, trafficking and abuse of drugs, as well as related money laundering, with a view to measurable reduction in drug availability at all levels and all forms of drug-related offences. To achieve the main objective of the drug demand reduction measure – to provide adequate protection of the life and health of children, youth, families and individuals, and to keep the drug issue within socially acceptable risk levels in order to preserve the fundamental values of society – there must be measurable reduction of drug abuse, addiction and drug-related health and social risks. The strategy in question has a number of specific objectives leading to an efficient solution of the drug issue.

The national strategy implementation is ensured through two three-year action plans on combating drug abuse, which, in addition to measures and activities aimed at achieving the national strategy objectives, provide clear tasks to competent bodies and an estimate of the financial costs. The Action Plan on Combating Drug Abuse for the period 2012-14 contains 26 measures and 208 implementing activities. In order to ensure any necessary corrections to the planned measures and activities in the light of new trends or incidents, and to ensure close monitoring of implementation, an implementing programme of the Action Plan on Combating Drug Abuse is adopted on an annual basis.

Supplement based on information available to the person conducting the survey

The document provides that the implementation of the national policy on combating drug abuse requires a balanced, multidisciplinary and integrative approach. The integrative approach is of particular importance in the area of drug demand reduction, which is preferred due to increasing polydrug use, as is clear from the following: "The main principle of the prevention programme implementation should be integrated and aimed at all types of addiction, including consumption of legal substances such as tobacco and alcohol, consumption of illicit drugs (marijuana and heroin) and inappropriate use of legal substances (inhalants) and prescription medications, as well as other addictions such as gambling, the Internet, etc."

Significant progress has been reported in connecting public health and repressive policies in the area of drugs. A new approach has been introduced in punishing addicts so that they are primarily observed as persons in need of

treatment. This is also clear from the political will of the legislator expressed through new amendments to the Criminal Code of the Republic of Croatia (OG 125/11, 144/12). That has also been confirmed by the fact that drug abuse-related criminal offences have been transferred from the category Criminal offences against values protected by international law into the category Criminal offences against human health. The implementation of measures of compulsory treatment and addiction withdrawal for perpetrators of criminal offences has been strengthened by the adoption of the new Probation Act (OG 153/09, 143/12), which, *inter alia*, stipulates the role of the probation service in monitoring the implementation of the compulsory treatment measure imposed together with conditional release and/or community work.

In addition, the Act on Amendments to the Misdemeanour Act (OG 39/13) was drawn up in 2012 and came into force in 2013. The Act, *inter alia*, regulates special obligations and protective measures of addiction treatment or withdrawal. The protective measure of compulsory addiction treatment may now be ordered in addition to any punishment and suspended sentence. It is executed at health-care institutions or other specialised institutions within the prison system and outside it. A novelty is the fact that, if the duration of this protective measure is longer than the pronounced or replaced sentence, it should be executed even after a person is released, which is in line with modern misdemeanour jurisprudence. The catalogue of special obligations has been expanded so that a court may, with consent of the perpetrator, order a special treatment or treatment continuation obligation for alcohol, drug and other types of addiction at a health-care or other specialised institution, or withdrawal to a therapeutic community if it considers this necessary for the protection of health and safety of the person to whose detriment the misdemeanour has been committed or when it is required for the elimination of consequences that are favourable to or instigate perpetration of a new misdemeanour. The Guidelines for psychosocial treatment of drug addiction in the health-care, social-welfare and prison system (under preparation) also indicate a closer interaction of bodies working in the area of public health and criminal law.

Alcohol

By its resolution WHA 63.13 in 2010, the World Health Assembly adopted the Global Strategy to Reduce the Harmful Use of Alcohol (WHO 2012a), encouraging member countries to adopt and implement it according to the assessment of the national situation. The European Action Plan to Reduce the Harmful Use of Alcohol 2012-20 is closely linked to the European Strategy for the prevention and control of non-communicable diseases for the period 2012-16 but it contains more detailed objectives and actions. Non-communicable diseases and their risk factors are a priority of the World Health Organization in the period 2012–20, as well as of the new European health policy "Health 2020".

Following global developments in this area, in 2010 the Government of the Republic of Croatia adopted the National Strategy to Reduce the Harmful Use of Alcohol and

Alcohol Use Disorders for the period 2011-16. Its vision is to enhance health-care and social-welfare outcomes for individuals, families and the community, while significantly reducing morbidity and mortality caused by harmful use of alcohol and other resulting social consequences. The goals of the above strategy are to raise awareness among the general population of the magnitude and characteristics of health-related, social and economic problems caused by harmful use of alcohol; to continue research on the magnitude and characteristics of the harm caused by alcohol, while strengthening efficient interventions for the prevention and reduction thereof; to strengthen and enhance resources for the prevention of harmful use of alcohol and treatment of diseases and disorders caused by drinking alcohol; to strengthen partnerships and co-ordination among sectors and investment of all efforts into appropriate and harmonised work on the prevention of harmful use of alcohol; and to enhance the system for monitoring and control as well as more efficient sharing and application of information for the purpose of fostering and developing policies and evaluating strategy implementation. By explaining the role of the health-care system, the strategy stresses the importance of the development and efficient co-ordination of integrated and/or linked programmes and activities in the area of prevention, treatment and care of disorders caused by harmful use of alcohol and related diseases, including disorders caused by drug abuse, depression, suicide, HIV/AIDS and tuberculosis.

A draft Croatian action plan on alcohol 2012-20 has been prepared (the document has not been adopted yet, though its title suggests the year 2012 as the beginning of its validity period). It has been aligned with the objectives of the European Action Plan to Reduce the Harmful Use of Alcohol 2012-20.

Some of the answers received mention that the alcohol issue has been covered by the National Healthcare Strategy 2012-20, and the National Strategy on Mental Health Protection 2011-16, without specific comments on their connection to this issue.

Supplement based on information available to the person conducting the survey

According to the National Healthcare Strategy 2012-20 (OG 116/12), the most important indicators of health in Croatia are linked to behavioural risk factors, such as irregular eating habits, physical inactivity, being overweight and obese, and also smoking, alcoholism and narcotic drug abuse. Some of the priorities are "in prevention, emphasis should be put on major health-related issues among Croatian citizens – chronic non-communicable diseases, malign diseases, injuries, mental disorders and at-risk behaviour, including smoking, alcohol and drug abuse, physical inactivity and unhealthy eating habits."

The purpose of the National Strategy on Mental Health Protection, in addition to already adopted complementary strategies in other areas, in particular those in the area of health protection, is to establish guidelines for enhancing the existing means of mental health protection and developing new ways, reducing the occurrence of mental disorders and increasing balanced access

to quality and timely treatment, rehabilitation and social inclusion of persons with mental disorders by strengthening their role in decision making in the above processes, with a view to increasing citizens´ personal satisfaction, reducing costs and encouraging economic and social development. In line with the Healthcare Act (OG 150/08, 155/09, 71/10, 139/10, 22/11, 84/11, 154/11, 12/12, 70/12, 144/12, 82/13), in August 2009 a network of health-care services was agreed, according to which services for mental health protection and addiction prevention were established within county institutes of public health (45 teams in total). Mental health protection in the local community is less developed, except for individual programmes such as addiction prevention, which require continuous enhancement. In its analytical overview, the strategy indicates that mental disorders caused by alcohol and schizophrenia have been the leading diagnostic categories in overall hospital morbidity due to mental disorders for years. In 2008, there were 10 020 hospitalisations registered for mental disorders caused by alcohol.

The National Strategy to Reduce the Harmful Use of Alcohol and Alcohol-Use Disorders is led by the principle of prevention and reduced harmful use of alcohol as the priority in the area of public health. It is emphasised that public health measures for the reduction of the harmful use of alcohol are sometimes in conflict with other objectives such as a free market and consumers' freedom of choice and may be regarded as detrimental to economic interests and state revenues.

Tobacco

The goal of the Action Plan to Strengthen Tobacco Monitoring for the period 2013-16 is to improve citizens' health by adopting non-smoking as a healthier way of life, while simultaneously reducing smoking prevalence as a risk factor for many chronic diseases such as circulatory system diseases, malignant neoplasms and chronic obstructive pulmonary disease. Special objectives have been set to prevent non-smokers from starting to smoke, especially among children and youth; to teach young people to resist the temptation and make the right decisions on non-smoking; to reduce the number of smokers in the population; to reduce exposure to tobacco smoke in public places, workplaces and homes; and to reduce adverse consequences to human health caused by consumption of tobacco products, that is, to reduce smoking-attributable morbidity and mortality.

Some of the answers received included mention of the National Strategy on Mental Health Protection 2011-16 and the National Healthcare Strategy 2012-20, but without specific comments on their connection to the issue of smoking.

Gambling

There were no comments on this segment in the answers received. After subsequent research, the project implementation body has established that there is no specific strategic document referring to this segment. Gambling as a disorder has been mentioned in the National Strategy on Combating Drug Abuse 2012-17

and the National Addiction Prevention Programme for Children and Youth in the Education System, as well as children and youth in the social-welfare system, for the period 2010-14.

Legislative/regulatory framework

Tables 1.2 to 1.5, relating to markers 2-5, contain assessments made by the person conducting the survey, which is based on answers to the questionnaire, documentation analysis and focus group analysis. The text accompanying each table expands on the answers to the questionnaire that were received for each marker.

Table 1.2: Coherence of the legislative/regulatory framework, assessment by area

Submarker	Area			
	Illicit drugs	Alcohol	Tobacco	Gambling
Legal regulations	high	high	high	medium
Compliance with international conventions	high	high	high	-*
Alignment with policy goals	high	medium	medium	low

*The project implementation body has no knowledge of the existence of international conventions in this area.

Croatia has adequate, complementary legal regulations encompassing the entire area covered by the survey. For example, the Drug Abuse Prevention Act (OG 107/2001, 87/2002, 163/2003, 141/2004, 40/2007, 149/2009 and 84/2011) stipulates requirements for the growing of plants from which drugs can be obtained, requirements for the production, possession and sale of drugs and substances which can be used for the production of drugs, monitoring of the growing of plants from which drugs can be obtained, measures for combating drug abuse, an addiction-prevention system and systematic provision of assistance to addicts and occasional narcotic drug abusers. The above act also provides for the procedure for adopting special programmes on prevention among pre-school children, children in elementary or secondary schools and university students, addiction treatment and withdrawal, programmes of assistance to addicts and occasional drug abusers, programmes on social reintegration of former addicts, programmes for members of the Croatian Armed Forces and Croatian war veterans, programmes for persons in custody and those serving their prison sentences. Following the proposal of the competent ministry, the programmes are adopted by the Commission for Combating Drug Abuse of the Government of the Republic of Croatia, after gaining the prior opinion of the Office for Combating Drug Abuse.

A new criminal law (OG 125/11, 144/12), which came into force on 1 January 2013, modified the provisions for the drug abuse offence. New provisions enable a differentiation between possession of drugs/substances banned in sports for personal

use from possession with intent to put them on the market, so that possession of quantities for personal use is punished as a misdemeanour with a fine and mandatory treatment according to provisions in the Act on Combating Drug Abuse. For unauthorised production (and "production" also means cultivation), processing, import and export of drugs which are not meant for sale, a punishment of up to three years in prison is provided; for actions leading to the sale of drugs or otherwise placing them on the market, up to 12 years' imprisonment is provided for. Also, a range of aggravated circumstances is included which did not exist previously, as well as stricter punishment of sale networks organisers, who can be sentenced to long-term imprisonment if the crime is committed as part of a criminal organisation. There are also a number of other complementary acts relating to the drug issue.

It is important to bear in mind that the legal drugs, alcohol and cigarettes, are illegal for children and youth under the age of 18 because the sale thereof to children and youth is prohibited by the Act on the Restriction of the Use of Tobacco Products (OG 125/08, 55/09, 119/09, 94/13), the Trade Act (OG 87/08, 96/08, 116/08, 114/11, 68/13) and the Hospitality and Catering Industry Act (OG 138/06, 43/09, 88/10, 50/12, 80/13). The State Inspectorate regularly takes measures to enforce the prohibition on offering or selling alcoholic beverages and tobacco products to children and minors. Consequently, the Trade Act stipulates that retail shops shall not sell alcoholic beverages, tobacco and tobacco products to persons under the age of 18 and that they shall place a notice prohibiting such sale at each location where such drinks or tobacco products are sold. The Act on the Restriction of the Use of Tobacco Products prohibits the sale of tobacco products to persons under the age of 18, and sale from automatic vending machines, and stipulates the requirement of placing a notice prohibiting such sale at all locations where tobacco products are sold.

The Hospitality and Catering Industry Act stipulates that no hospitality and catering facility shall serve or allow consumption of alcoholic beverages on their premises to persons under the age of 18, and requires a notice prohibiting the serving and consumption of alcoholic beverages to persons under the age of 18 in such facilities. Moreover, the Act on the Restriction of the Use of Tobacco Products prohibits smoking tobacco products during public appearances, showing persons while smoking on television and smoking in all public indoor places (except in special rooms for smoking furnished with an adequate ventilation system pursuant to the provisions of the act). Rooms for smoking are not allowed in health-care and educational institutions. Legal and natural persons providing hospitality and catering services pay a tax on consumption of alcoholic beverages (brandy, rakia and spirits), natural wines, special wines, beer and non-alcoholic beverages on their premises. The tax amounts to 3%.[19]

In addition, an excise duty on tobacco and tobacco products is paid by the producer and importer of tobacco products pursuant to the Tobacco Products Tax Act (OG 136/02 – consolidated text, 95/04, 152/08, 38/09) and the Ordinance on excise duty

19. Act on Financing Local and Regional Self-Government Units (OG 117/93, 33/00, 73/00, 59/01, 107/01, 117/01, 150/02, 147/03, 132/06, 73/08, 25/12); Decision of the Constitutional Court of the Republic of Croatia (OG 26/07).

on tobacco products and handling of the stamps for marking them (OG 112/99, 50/00, 119/01, 59/03, 155/08). The tax base consists of: for cigarettes – 1 000 cigarettes, 9 cm in length, without a mouthpiece or filter, and the cigarette retail price; for tobacco – 1 000 grams; for cigars – one cigar; for cigarillos – a pack of 20. The excise duty on cigarettes increases if the length of a cigarette without filter or mouthpiece exceeds 9 cm, while the number of cigarettes used for the calculation of the excise duty on cigarettes is established by dividing the length of a tobacco roll by nine and rounding up the resulting number. The proportional excise duty for cigarettes in groups A, B and C amounts to 30% of the retail price, and specific excise duties as of 1 June 2009 amounted to HRK 180.00 per 1 000 cigarettes in groups A, B and C; for tobacco it was HRK 38.00 per kg; for cigars HRK 1.10 per piece; for cigarillos HRK 4.40 per pack. The tax amounts are increased or decreased depending on tobacco weight, and whether a pack contains one or more cigars, or more or less than 20 cigarillos.

Consumption of alcoholic beverages in public places in the Republic of Croatia is not prohibited by a special act, but the Act on Misdemeanours against Public Law and Order (OG 05/90, 30/90, 47/90) allows units of local and regional self-government to adopt a decision on proscribing other misdemeanours than the ones mentioned in the act. Particular attention has been paid to road traffic safety,[20] that is, driving under the influence of alcohol. The Road Traffic Safety Act (OG 67/08, 74/11) stipulates that professional drivers, driving instructors and young drivers[21] may not operate a vehicle if they have alcohol or drugs in their system. All other drivers are allowed to have a blood alcohol concentration of 0.05% while driving. The fine for driving with unpermitted blood alcohol concentration increases with the alcohol concentration, starting from HRK 700.00 for concentrations up to 0.05%, and up to HRK 15 000.00 for concentrations exceeding 0.15%.

The Act on Games of Chance (OG 87/09, 35/13) stipulates the system, types and requirements for organising games of chance; the rules and procedures for acquiring and withdrawing the right to organise games of chance; the rights and obligations of a person organising games of chance; the method for allocation of proceeds from games of chance; and control of the organisation of games of chance. The act, *inter alia*, stipulates that no bets shall be received from persons under the age of 18, and a visit to a casino and participation in play, as well as a visit to and use of slot machines, shall be allowed only to adults.

In the course of the accession of the Republic of Croatia to the European Union, the national legislation was fully aligned with the Community *acquis*, thus achieving full compliance with all relevant international conventions as well.

Alignment of legal regulations with policy goals is at a satisfactory level (Table 1.2), except for gambling, for which there is no clearly defined goal or perception regarding this type of addiction and accompanying issues.

20. National Programme on Road Traffic Safety of the Republic of Croatia 2011-2020 (OG No. 59/11).
21. A young driver is a driver aged 16-24. After passing their driving test, they are given a driver's licence for a period of 10 years.

Strategy/action plans

Table 1.3: Coherence of the strategy/action plan, assessment by area

Submarker	Area			
	Illicit drugs	Alcohol	Tobacco	Gambling
State of the problem	high	medium	medium	low
Supply reduction	high	medium	medium	low
Demand reduction	high	medium	medium	low
Harm reduction	high	medium	medium	low
Specific objectives	high	high	high	low
Budgetary issues	high	low	medium	low
Activities	high	medium	medium	low

The national strategy and accompanying action plans in the area of drugs contain all elements expected in a strategic document, namely: a clearly defined purpose, vision, goals and objectives, elaboration of key areas, specific measures and activities based on the actual situation and needs, and harmonised with the goals and objectives, including measurable implementation and impact indicators, defined implementation stakeholders, implementation deadlines and ensured funds. In addition to the above, they are based on scientific evaluation of the previous strategic documents. Mechanisms have been set up to ensure continuous monitoring of their implementation, and results are available to the public through annual reports on implementation of the national strategy and action plan on drugs. The documents are also flexible since they are put into practice through annual implementation programmes of the action plan, thus ensuring adaptability of measures and activities to new circumstances and trends. They provide for an integrative approach to the drug issue, aimed at actions coherent with other addiction areas, particularly when it comes to prevention.

The structure of the strategic documents in the areas of tobacco and alcohol is of somewhat lower quality, but they clearly set out the objectives and direction of national policy in these areas. The major downside of the strategy on alcohol is the fact that the anticipated action plan has not yet been adopted. It should ensure full implementation of activities, including monitoring and an assessment of the required funds. The action plan on strengthening the monitoring of tobacco products probably requires a clearer structure. Both documents provide an analysis of the state of the problem, from which it follows that there is no systematic, multisectoral monitoring of the problem, particularly in relation to monitoring the prevalence of alcohol and tobacco use in the general population and by at-risk groups, as well the impact of legal and strategic measures on prevalence of use. Although they cover all relevant areas in their segment in a comprehensive manner, they do not take note of other addictions, even in the context of prevention. Since alcohol and tobacco are legal substances, it is only logical that their supply, demand and harm-reduction measures

differ from those of illicit drugs. However, there should be a stronger link in the area of demand reduction since all substances are connected by a similar mechanism of addictive behaviour. An increase in combined use of legal and illegal addictive substances is of particular concern. In addition, both strategic documents should ensure implementation monitoring, availability of reports on implementation thereof, and process and outcome evaluations of the impact of the documents concerned, as provided for in their content.

Funds for implementation of strategic documents are secured in the national budget which, on the government's proposal, is defined by the Croatian Parliament, while responsibility for budget planning and control over spending on activities planned in strategic documents lies within bodies responsible for the implementation of individual activities.

As regards gambling, there is no strategic document, and gambling (a pathological disposition to games of chance) has not been mentioned either in the National Healthcare Strategy or National Strategy on Mental Health Protection. Therefore, all areas in the context of gambling in Table 1.3 are marked as low.

Structures/resources

Table 1.4: Coherence of structures/resources, assessment by area

Submarker	Area			
	Illicit drugs	Alcohol	Tobacco	Gambling
Responsible body	high	medium	high	low
Co-ordination body	high	low	medium	low
Mechanisms	high	low	medium	low
Monitoring system	high	low	low	low
Final evaluation	high	medium	medium	low
Funding for co-ordination bodies	high	low	medium	low

With the exception of gambling, which is not represented in any of the elements of the structure and resource assessment due to the lack of adequate mechanisms, Table 1.4 shows that bodies responsible for the issues of drugs, alcohol and tobacco have been defined by national regulations. The National Strategy to Reduce the Harmful Use of Alcohol and Alcohol-Use Disorders for the period 2011-16 provides for the establishment or appointment of a body that would be responsible for monitoring the implementation of this strategy, and the leading role in the development thereof would be given to the Ministry of Health. In the case of tobacco, the implementation of measures for strengthening tobacco monitoring has been supported on a continuous basis by the National Commission to Combat Smoking of the Ministry of Health of the Republic of Croatia. There are no local co-ordination bodies in the areas of alcohol or tobacco monitoring. Monitoring of both issues is

poorly developed, and implementation monitoring of relevant strategic documents has so far existed only as a plan. The dynamics of providing and spending the funds aimed at the execution of measures for strengthening tobacco monitoring are established every year in the course of adopting the state budget, whereas funds for the prevention of harmful use of alcohol and alcohol-use disorders will be provided to implementation bodies only upon adoption of the relevant action plan.

In order to ensure timely and efficient implementation of the policy on combating drug abuse, the Government of the Republic of Croatia set up a Commission on Combating Drug Abuse, while the Office on Combating Drug Abuse of the Government of the Republic of Croatia (hereinafter the Office) has been established to co-ordinate and monitor the implementation of national strategic documents and other activities. To that effect, the Office continuously monitors and analyses drug abuse factors, monitors trends and execution of measures and activities for combating drug abuse, suggests measures and programmes aimed at eliminating the causes of drug abuse and its consequences for the quality of human life, provides expertise and in particular suggests measures and programmes on addiction prevention for children and youth.

Based on systematic analysis and monitoring of the status and implementation of the national strategy, the Office prepares a draft national strategy and action plans on combating drug abuse, which are submitted to the Government of the Republic of Croatia and the Croatian Parliament for adoption. In co-operation with other state administration bodies responsible for implementing national strategy measures, it conducts regular evaluation of programme quality and efficiency. The activities of the National Focal Point within the Office have shown that stakeholders in drug policy implementation are capable of providing necessary information as a basis for subsequent surveys and analyses. In addition to the monitoring of drug policy implementation, the Focal Point develops standardised methods for collecting and analysing relevant data in the area of drugs. Co-ordination at the local level is conducted by county commissions on combating drug abuse.

According to the first national survey on public expenditure in the area of combating drug abuse (Budak et al. 2013), total specified public expenditure in the state and county budgets, and the financial plans of public bodies and civil society organisations, amounted to HRK 93.5 million (in 2009), HRK 100.0 million (in 2010) and HRK 102.8 million (in 2011), while for 2012 a significantly lower amount of HRK 87.6 million was planned. Non-specified public expenditure was estimated per public function: public order and safety, health care, education and social welfare. Total estimated non-specified expenditures are between HRK 620 and 650 million annually and are 7.9 to 9.4 times higher than specified public expenditures. In the total specified public expenditure for combating drug abuse, ministries account for 30%, public bodies at state level 56%, counties 11% and civil society organisations only 3% (all figures approximate).

Responses/interventions

Table 1.5: Coherence of responses/interventions, assessment by area

Submarker	Area			
	Illicit drugs	Alcohol	Tobacco	Gambling
Specific actions	high	medium	medium	low
Implemented	high	high	medium	low
Lack of implementation because of budgetary constraints*	low*	high*	medium*	high*
Monitoring in view of action plan	high	low	medium	low
Budget (adaptability to changing circumstances)	high	low	medium	low

*Since in the original questionnaire the submarker with an asterisk was formulated in the opposite way in relation to other submarkers, opposite values are used in the questionnaire interpretation (for example, "low lack of implementation" means "high implementation", and is therefore marked with the positive green colour).

It has already been mentioned that there is no strategic document on pathological disposition to games of chance and that, on the basis of the National Strategy to Reduce the Harmful Use of Alcohol and Alcohol Use Disorders, no action plan has been adopted to develop specific implementation activities. The Action Plan to Strengthen Tobacco Monitoring for the period 2013 to 2016 entered into force only in 2014. Therefore, it is difficult to assess the level of implementation and adaptation of budgetary funds to new circumstances. Apart from that, the document provides for specific measures aimed at reaching clearly defined goals.

Pursuant to the Action Plan on Combating Drug Abuse for the period 2012-14 (hereinafter the Action Plan), specific measures and activities have been provided for, in order to ensure efficient and effective implementation of the National Strategy on Combating Drug Abuse at all levels, including measures aimed at finding for society an adequate solution to new methods and new trends in drug consumption and abuse. Taking into account the basic principles of the national strategy, in particular the decentralisation principle, the aim of the Action Plan is to ensure equal availability of different programmes and their contents across the country in line with the actual needs of respective local communities (counties). All the above-mentioned tasks are executed in co-ordination and co-operation with competent ministries and state administration bodies at state and local level, and in co-operation with other competent government institutions and civil society organisations, as well as with international bodies, institutions and organisations. Once a year the Office prepares a report on implementation of the National Strategy and Action Plan on Combating Drug Abuse, and submits it to the Government of the Republic of Croatia and the Croatian Parliament for adoption.

All line ministries that are specified as the stakeholders for the implementation of measures provided for in the Action Plan adopt annual implementing programmes pursuant to priorities and deadlines with respect to a particular area and stakeholder. A comprehensive draft annual programme on the implementing activities of the Action Plan is adopted by the Commission for Combating Drug Abuse of the Government

of the Republic of Croatia. Such an approach allows timely adaptation of measures and activities to new circumstances and trends, thus adapting the allocation of budgetary funds. In the event that certain activities have not been implemented at the annual level, this is stated in the report on the annual implementation programme together with an explanation.

Comments on questionnaire structure and quality

Focus group participants who also completed the questionnaire on policy coherence pointed out certain ambiguities in the questionnaire structure and formulation of the questions. Following the answers received in relation to the marker 1A. Policy: State of the problem and 1B. Context, it is suggested that these two segments should be put into one since they represent closely connected themes that are difficult to differentiate when trying to explain the development of an occurrence and the causal links. The formulation of the question in English turned out to be rather difficult to translate into Croatian.

Since a table is not an adequate means for entering answers to a group of questions posed in connection with a certain marker (markers 2-5), some of the survey participants gave their answers outside the table, some provided descriptive answers in a separate document without following the structure of the markers and sequence of questions, some submitted yes or no answers in connection with certain markers (for which yes and no did not provide sufficient information to interpret these answers) and other respondents left some boxes empty. Difficulties in the completion and interpretation of the questionnaire also followed from the lack of definitions for the terms used in the questionnaire (e.g. 3e. Any activities outlined that correspond with the objectives, reduction measures and finally the goals of the said policy?). It was also observed that the contents of some questions overlapped, as indicated by the same or very similar answers. Finally, under marker 5, Responses/interventions, the submarker "Lack of implementation due to budgetary constraints" was formulated in the opposite way in the original questionnaire in comparison to other submarkers in that group. This, in turn, required the use of the opposite values in evaluation thereof.

It is necessary to give clearer definitions of the evaluation criteria for certain markers.

Analysis of strategic documents in the area of addiction

This segment of the survey included a detailed analysis of the five strategic documents in the area of health, namely addiction to tobacco, alcohol or drugs. The documents were mentioned in the answers to the policy coherence questionnaire, and the purpose of the analysis was to get a better insight into the level of their complementarity with other related areas.

The content of each document was analysed in relation to the primary area, but also other areas which were subject of this survey in order to determine the links between them, if any. For comparison, each document was analysed in terms of its goal or purpose, its relation to the definition of health of the World Health Organization, any link to previously defined strategic documents, the number of repetitions of

the defined key words or terms and the context of their use, comments and a brief conclusion. When selecting the key words,[22] account was taken of the structure and purpose of the questions forming the policy coherence questionnaire in the area of addictions. The key words were searched in all grammatical cases, including verb forms and derivatives. In some cases, in addition to the defined key words, the tables also contained alternative terms that in certain contexts refer to the relevant key word. In the case of documents directly linked to alcohol and tobacco, the analysis contained additional key words deemed specific for the respective areas, but also unnecessary for the analysis of other documents due to their rare use.

In general, the terms "polyuse of psychoactive substances" and "co-morbidity disorders" were rarely used, as well as their synonyms, even though the occurrence of both problems was observed. On the list of the key words, in addition to "addiction" as a disease and the individual addictive substances (tobacco, alcohol, drugs, gambling), the term "other addictions" was separated on purpose in order to determine to what extent the document referred to other types of addiction that, according to the available indicators, were becoming increasingly present in society and were often linked to typical addictions, but lacked adequate responses from the institutions (e.g. addiction to the Internet, shopping, work). The results will serve as a supplement to the answers to the policy coherence questionnaire and the findings of the focus group.

Before looking at the respective document, it may be noted that the fundamental strategic documents in the area of health (in particular, addictions) cover different periods, as seen in Table 1.6. The National Strategy on Mental Health Protection and the National Strategy to Reduce the Harmful Use of Alcohol and Alcohol Use Disorders were adopted before the National Healthcare Strategy, which referred to these documents, even though the reverse process would have been more logical. The strategies covering mental health, drugs and alcohol are adopted for a period of five years, while the National Healthcare Strategy covers an eight-year period.

Table 1.6: Overview of the analysed strategic documents with period of validity

Document	Time period
National Strategy on Mental Health Protection	2011-16
National Strategy to Reduce Harmful Use of Alcohol and Alcohol Use Disorders	2011-16
National Strategy on Combating Drug Abuse in the Republic of Croatia	2012-17
National Healthcare Strategy	2012-20
Action Plan to Strengthen Tobacco Monitoring	2013-16

22. The key words used in the analysis: promotion of health, addiction (as a disease), addict, tobacco/cigarette/smoking, alcohol/alcoholism/alcoholic, drug, psychoactive substances/products, games of chance/gamble/gambling, other addictions, polyuse/use of multiple substances, co-morbidity, integrated, coherent, co-ordination, co-operation, monitoring, responsible body.

Certain discrepancies among the analysed documents are the result of different policies and society's perception of legal and illegal addictive substances, deriving from the proportions of visible health and social harm caused by substance use or addictive behaviour, though the addiction mechanism is the same regardless of the substance. In addition, most documents use terms such as "combating", "combat" or "control", even in segments which do not refer to the work of repressive bodies or application of legislation, but to prevention, treatment and care of addicts, which is no longer preferred terminology at EU level. It should also be noted that there is terminological incoherence about addictive substances. For example, the strategic document on drugs often mentions "psychoactive substances or products" referring to legal and illegal substances with psychoactive effect, while other documents never or rarely use the term. The addiction prevention issue is also mentioned in different contexts and with different emphases.

Unlike the other four documents analysed, the National Healthcare Strategy 2012-20 refers to all strategic documents on addiction existing at the time of its preparation (only references to the Action Plan to Strengthen Tobacco Monitoring for the relevant period are missing). This document also provides the most comprehensive reference to the WHO definition of health. It deals with the issues of tobacco, drugs and above all alcohol. This is completely justified considering the extent of the epidemic of problematic use of alcohol. The term "other types of addiction" is mentioned only once, without specific comments on other addictive behaviours. The integrative approach is mentioned several times in terms of pooling together different aspects of the health-care system. Attention is paid to the co-ordination and coherence of policies. It is also observed that some segments of the health-care system lack co-ordinated action. On several occasions the document stresses the importance of co-operation at all levels within the health-care system, but also with other sectors. Monitoring the status and implementation of measures is another important segment, as can be observed from the fact that a significant part of the text refers to health indicators in Croatia.

The National Strategy on Mental Health Protection for the period 2011-16 is in line with the National Healthcare Strategy. It refers to a number of strategic documents but, when it comes to addictions, only the national strategy on drugs is mentioned, while the documents on alcohol and tobacco are completely left out. It is interesting that, despite this, drugs are mentioned only in the title of the strategic document, while alcohol-related issues are more frequent. Other types of addiction are not mentioned separately, though there is emphasis on prevention and measures for all types of addiction. Parallel use of multiple psychoactive substances is not mentioned, even though it is a modern problem. Co-morbidity is mentioned sporadically in relation to behavioural disorders caused by abuse of psychoactive substances. There is no direct reference to an integrative or co-ordinated approach to different aspects of mental health, though priority has been given to a single approach to all addictions in institutional and operational terms. The monitoring of mental disorders and the co-operation of all stakeholders in the system are considered fundamental for successful planning and implementation of mental health policy. According to the wording of the document, the strategy on mental health protection aims to enhance the overall health of the population.

The National Strategy on Combating Drug Abuse for the period 2012-17 contains no reference to any of the strategic documents subject to this analysis. However, more than any other document, it mentions other addiction types or substances

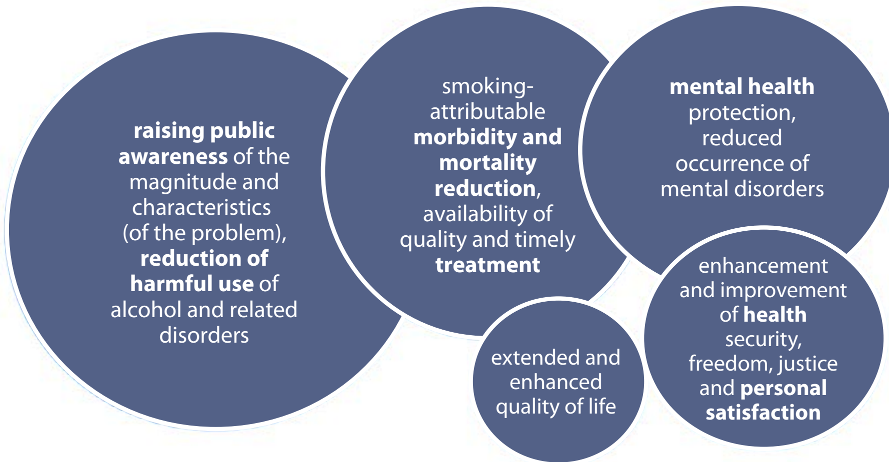
as a general term or with a specific reference. In comparison to the analysed documents, it emphasises the polyuse of psychoactive substances and co-morbidity disorders relating to addiction, for which there are no adequate capacities despite their increasing occurrence. It is the only document that deals with new psychoactive substances mimicking the effects of popular drugs and representing a big challenge for the health-care and repressive systems due to their adverse impact on health and their legal status. In addition, it is the most significant advocate of the need for an integrated approach to the drug issue in all of its segments, but also to other addictions, and the need for co-ordination at all levels as a prerequisite of efficient co-operation among responsible bodies in implementing the planned measures and achievement of the set goals. Quality and continuous monitoring of the state of the problem and implementation of the strategy are considered key elements of a successful national policy on drugs. The document continually mentions health, in particular the protection of health of children and youth, and promotion of healthy lifestyles. However, unlike the health-care strategy and the strategy on mental health protection, the term "health" is used in a rather narrower sense, although it is often used in addition to terms suggesting physical and mental health accompanied by the enhancement of security, justice and freedom in the society, that is, well-being.

The National Strategy to Reduce Harmful Use of Alcohol and Alcohol Use Disorders for the period 2011-16 mentions addiction only in the context of alcoholism and contains no reference to other types of addiction and polyuse of psychoactive substances. There is only one mention of disorders related to alcohol addiction, including those related to drug use, and an integrative approach to the treatment of alcoholism and related disorders. Co-ordination of measure implementation is also mentioned on one occasion, while the need for coherent activities is slightly more emphasised. As in the above documents, monitoring of the phenomenon occurrence and of strategy implementation is well represented. Overall health is mentioned sporadically, but with quite a few references to the WHO determinants.

The Action Plan to Strengthen Tobacco Monitoring for the period 2013-16 also does not cover other types of addiction, so alcohol and drugs are mentioned only in the title of the European survey. Promotion of health is mentioned in the context of non-smoking, without emphasis on other healthy habits or lifestyles, while health is primarily observed as absence of diseases caused by smoking. This action plan is far more concise than previously analysed strategies, but concept-wise less connected. It makes no reference to the integration and coherence of measures, programmes or policies, and co-ordination is considered only at the national level. On the positive side, it encourages co-operation among different sectors and levels, and emphasises the monitoring of tobacco consumption, consequences of smoking and legal regulations. Monitoring the economic costs of tobacco consumption is also mentioned. This is also contained in the strategy on drugs, but in a different form.

Figure 1.1 shows that the goals of the analysed strategic documents range from specific objectives, directly linked with the main theme of the document, to more general goals such as enhancement of health, personal satisfaction of citizens and extending and improving the quality of life. An objective in one of the documents is even to "reduce costs and encourage economic and social development" implying the health of the population as a prerequisite.

Figure 1.1: Overview of the goals of the strategic documents analysed



Focus group analysis

Overview of the results

Table 1.7 shows the thematic framework of the focus group: themes and their contents serving as a framework for data analysis. The contents within a particular theme arose out of questions that were the subjects of the focus group. Table 1.8 shows that most of the contents were addressed in the theme on implementation co-ordination of the policies in question, implementation of policies at national and local level, and complementarity of goals of respective policies.

Table 1.7: The focus group thematic framework

Theme	Contents included in the theme
Monitoring system for policies on psychoactive substances and addictive behaviours	Monitoring systems for respective policies Co-ordination among systems for monitoring different addictions
Complementarity of respective policy goals	Goals of respective policies Complementarity of goals Need for different policies on the issue of addiction
Compliance of national strategies and action plans with WHO definition of health	WHO definition of health Compliance of policies with the definition
Policy implementation at national and local levels	Policy implementation in terms of structure Policy implementation in terms of financing National level Local level

Theme	Contents included in the theme
Co-ordination of policy implementation	Co-ordination Activity financing Implementation monitoring Evaluation Co-ordination body/bodies
Adaptability of policies to changing circumstances	Strategy duration Possibility to adapt measures/activities in existing documents
Special themes	Additional comments

An overview of the results according to the given themes and related codes (i.e. categories) is given below. The results have been substantiated by direct quotation of the participants. Each theme has been presented separately, and contains a table with codes and categories.

Implementation monitoring system for policies on psychoactive substances and addictive behaviour

The theme on the implementation monitoring system for policies on psychoactive substances and addictive behaviour provides an analysis of the contents relating to the system for monitoring and coherence of the respective policy implementation. Table 1.8 shows codes and related categories for this theme. As can be observed, the participants established incoherence of the monitoring systems, encouraged efforts in establishing policy coherence and identified some indicators for monitoring the respective policies.

Table 1.8: Overview of the theme "Implementation monitoring system for policies on psychoactive substances and addictive behaviour" and related codes and categories

Theme	Code	Category
Implementation monitoring system for policies on psychoactive substances and addictive behaviour	Coherence in policy implementation monitoring Need for a coherent policy Different monitoring mechanisms Single addiction prevention	Policy coherence
	Different interests Incoherent monitoring Incoherence in monitoring systems Need for harmonisation Need for joint approach to monitoring Adaptability of data within addiction treatment Need for expanding existing strategic documents	Incoherence in monitoring systems
	Absence of indicators for monitoring in all areas Role of surveys in addiction monitoring Successful drug monitoring	Policy monitoring indicators

All participants encouraged the efforts of the Office for Combating Drug Abuse in establishing coherence of these policies and recognised the need to harmonise monitoring systems for different policies. The statements of some participants illustrate this: "I definitely support this integrative approach; availability reduction policy has to be coherent, similar, but mechanisms, elements within these policies are different; … I support this kind of a joint approach." As a major difficulty in achieving the above, one participant mentioned different interests: "My only dilemma is how we are going to harmonise the interests."

Participants believed that drug policy monitoring was the most developed area and that the above monitoring system was characterised by clearly developed indicators (drug supply and demand, surveys and similar). Other policies showed incoherence in monitoring, lack of co-ordination of monitoring systems and lack of indicators for implementation monitoring. The participants were quoted as saying: "As regards gambling, there is nothing but assessments, everything that once existed in the area of alcohol has unfortunately been shut down, and for drugs financial means have been provided and there are people in charge of this issue … ; I think that drugs and illegal substances have a very well-developed monitoring system, while in other areas, namely alcohol, gambling and tobacco, such a system has not been developed at all or has been developed to a lot lesser extent; certainly, Croatia has elaborated plans for policies on drugs, harmful use of alcohol [brief pause], tobacco smoking, of course, that is clear, as regards gambling, there is simply no special national policy in general; when it comes to monitoring … well, for drugs, this has been elaborated in detail."

Surveys were recognised as one of the indicators enabling implementation monitoring of all the above policies. Indeed, the Republic of Croatia has a long tradition in conducting surveys on the use of certain addictive substances among pupils (for example, the European School Survey Project on Alcohol and Other Drugs has been conducted since 1995, and the health behaviour in school-aged children study since 2001). In addition, the first survey on addictive substance abuse in the general population of the Republic of Croatia, conducted in 2011, examined the use of legal and illegal substances and gambling (Vugrinec et al. 2012). The following statements made by some participants illustrate the above: "there are three international studies which are relevant and comparable to our work … ; I have mentioned the ESPAD here … I have also mentioned the wastewater survey … and we have analysed gambling in particular."

Within harmonisation of one part of the monitoring system, a possibility was recognised of monitoring data on other addictions within the addiction treatment system. Indeed, the Pompidou form,[23] completed for each newly admitted person in the treatment system, allows indication of other substances in addition to the primary substance: "so that in that Pompidou form for persons who have been admitted to treatment on drug addiction we could monitor the overlapping of all these substances." Furthermore, a participant also mentioned the possibility of expanding the

23. The Pompidou form is a unified form used since 2000 for the collection of data on inpatient and outpatient treatment of addicts for the register of persons treated for psychoactive drug abuse kept at the Croatian Institute of Public Health. The form was published in the Official Gazette in the Ordinance on implementing the Health Records Act in the area of inpatient care and addiction monitoring (OG 44/00).

existing strategic documents in achieving coherence within the monitoring systems for respective policies: "we would not change all strategies and integrate one thing at the beginning, but we could do it all together."

Addiction prevention was recognised as an integrated area aimed at common risk and protective factors, and simultaneously focused on a number of at-risk behaviours: "the school prevention is fully integrated and there is not special prevention for this or that."

Complementarity of respective policy goals

Policy goals were discussed within the theme on respective policy goal complementarity, as well as their complementarity and the need for different policies dealing with the issue of addiction. Table 1.9 shows the related codes and categories. Five categories have been obtained as a result of the analysis: policy goals, different interests of the state and society, methods for achieving those goals, financial means and policy implementation.

Table 1.9: Overview of the theme "Complementarity of respective policy goals" and related codes and categories

Theme	Code	Category
Complementarity of respective policy goals	Complementary goals Equal goals Complementary goals in prevention Need for single (health) policy	Policy goals
	Different interests Different interests depending on substance (il)legality State ambivalence towards legal addictive substances Non-compliance between the society and state interests Society interests State interests Health as priority	State and society interests
	Different methodology Different approach Different measures for achieving the same goals Different target groups	Methods for achieving goals
	State revenue Financial means Revenue Means Society costs State loss	Financial means

Theme	Code	Category
	Lack of systematic treatment of alcoholics Lack of systematic treatment of gamblers Role of the health-care system Role of the educational system Role of the social-welfare system Role of advertising in promoting health	Policy implement-ation

The participants provided an insight into the way they perceived the complementarity of the respective policy goals. In that context, the participants agreed that the policies concerned were characterised by complementary general goals, but that interests differed on whether they referred to legal or illegal addictive substances, that is, addictive behaviour. To that effect, it was mentioned that the methodology for achieving goals should be adapted to the existing interest. This is substantiated by the following quotes: "the goals are complementary, but this is not the case with the interests in the reduction and control thereof … the methodology of the approach cannot be the same, it will have to differ … ; these policies have to differ in their respective segments since the aetiology of the occurrence of these problems differs … indeed, the goals have to be [brief pause] the same … but measures and methods for achieving this cannot be completely the same".

Furthermore, the participants pointed out two types of interest: social (common) interests and state interests with related financial (and other) means. It was emphasised that the state received revenue from taxes imposed on the sale of legal addictive substances (such as tobacco products). According to the participants, this indicated ambivalence in the interests and raised concern about the priority of interests, whether it should be given to citizens' health or the state budget. The following quotes illustrate this: "the state has interests, financial ones; … the state receives large means automatically, and the fight against it [brief pause] makes that difficult in a way. As long as you receive such large proceeds from tobacco … and you fight it, it is like tilting at windmills; the state is ambivalent when it comes to alcohol and gambling; If health were given priority in each country, this would be great." Moreover, it was stressed that the consequences of an addictive lifestyle (for example, diseases and death) represented social costs: "What are the social costs for all these treatments? If only all this were put on one side of the scale, and on the other the loss incurred by the state, the question is which side would outweigh the other."

The roles of different systems in achieving common goals, namely the health-care, educational and social-welfare systems, were identified. It was emphasised that today in Croatia there is no systematic treatment of alcoholics and gamblers and the implementation of measures in the above areas depends on experts' personal preference: "psychiatrists do it slopp[ily], without putting too much effort into it, there is no systematic treatment". The role of the education system in preventing all types of addiction is significant – "these two ministries are crucial, the one is for treatment and the other for primary prevention" – as is the importance of the social-welfare system in taking care of persons who leave the education system earlier: "the social-welfare system seems rather important to me … and we have young people who drop out of school". In the area of promoting citizens' health, the developments in advertising

used for years in promoting the consumption of legal addictive substances should be used: "Or if we had the advertising used for example in [the] tobacco or alcohol industry, if we could use their skills in that respect for health, it would also be very good."

Compliance of national strategies and action plans with the WHO definition of health

Table 1.10 shows codes and categories attributed to coding units within the theme on compliance of national strategies and action plans with the WHO definition of health. Two categories have been identified based on the code classification: health definition and financial means.

Table 1.10: Overview of the theme "Compliance of national strategies and action plans with WHO definition of health" and related codes and categories

Theme	Code	Category
Compliance of national strategies and action plans with the WHO definition of health	Addiction = absence of health Drugs = unrealistic search for well-being Strategies aim at the WHO definition Disease-orientated health care Concept of positive development Promotion of healthy lifestyles	Health definition
	Funds Implementation means Costs Advertising funds Profit	Financial means

The participants stressed the importance of aiming at the health definition in question, while taking into account realistic possibilities. It was pointed out that addiction could not include health or social well-being, but that it was a problem endangering the health of individuals and entire families: "so that there is no health, not only for an individual but also for the whole family; our objective was not to achieve complete social well-being since it is not realistic considering the circumstances; I think that our national strategies are coherent, and that action plans are at least aiming at the integration of this definition in their objectives". One participant said that the health-care system was disease- and not health-orientated: "again, the health-care policy is important because it is not orientated to health, protection and improvement of health, but to diseases". In addition, emphasis was put on the role of financial means allocated to health-promotion activities, which were linked to whether there were state or social interests involved: "and implementation, on the other hand, depends on the interests, and finally funds".

The participants discussed the need for raising awareness among the general public of the harmful effects of different addictive substance abuse and pointed out the possibility of using advertising developments in raising citizens' awareness. The importance of directing efforts into promoting the concept of positive development was stressed: "I think that one should strengthen, this is what I suggest, strengthen this concept of development … ; to work on this area of promoting healthier lifestyles."

Policy implementation at national and local levels

Within the theme on policy implementation at national and local levels, the contents regarding implementation in structural and financial terms as well as implementation at national and local levels have been analysed. Table 1.11 shows related codes and four categories: financial component of policy implementation, structural component of policy implementation, training of experts and availability of addictive substances.

Table 1.11: Overview of the theme "Policy implementation at national and local levels" and related codes and categories

Themes	Code	Category
Policy implementation at national and local levels	Drugs = existence of the system at national and county levels Need for alcoholism treatment system at county level Uncertainty about establishment of treatment system for gamblers Implementation depends on individuals Pharmacotherapy vs. psychosocial treatment Uneven number of experts per county Absence of coherent health policy	Structural component of policy implementation
	Ensured financing of drug policy Uncertainty regarding programme financing in alcohology Absence of the financing system for gambling Uneven financing at county level Establishment of the prevention fund (proposal)	Financial component of policy implementation
	Training Inadequate training of physicians Training of physicians Raising physicians' awareness Pharmaceutical industry courses	Training of experts
	Ambiguous policy on reducing addictive substance availability Differences in drug availability among counties Ambiguous supply reduction policy	Availability of addictive substances

All participants agreed that in structural terms the system for combating drug abuse had been well set up at national and county levels. Furthermore, finances for implementation of the policy on combating drug abuse were provided annually in the state budget of the Republic of Croatia as well as in county budgets. However, it was pointed out that there were significant differences in the financing of programmes among

respective counties: "Well, as regards drugs, I think that structure-wise we have had a good structure established in each county… implementation here is better organised through ensured financing; there is uneven planning of such funds at the county level."

The participants established that the financial means provided affected the implementation of respective policies. Following on from this, they pointed out problems in the implementation of alcoholism treatment policy. Although they represent a component part of the treatment system, clubs for treated alcoholics have the status of NGOs and are financed through calls for proposals on an annual basis. Furthermore, a policy on problematic gambling is still being developed and its implementation at county level is yet to be determined. The above is substantiated by the following quotes: "On the other hand, there is no systematic financing of rehabilitation programmes in alcohology, which are the most important element in abstinence maintenance… as regards gambling, there has been no financing system so far, not even a policy that would provide for the development of the system at the national level." In addition, there were suggestions for the enhancement/set-up of the system: "I think that it should be provided … introduced at the level … of all counties."

Following the discussion on adequate and regular provision of financial means for the implementation of respective policies, a participant suggested that a fund for implementing prevention activities should be established: "it would be best [laugh] if there were a fund, not only for promotion and prevention, but also a fund that would be provided and from which financial means, at least a small[…] part of them, would be continuously allocated to implementation".

Training is considered an indispensable factor for quality and equal policy implementation. The participants expressed their dissatisfaction with existing training. According to their opinion, policy implementation could be enhanced through training and a regular system of further education of physicians, various courses for experts working on the implementation of respective policies and through learning from experience in other disciplines/industries: "training of people is important … education of students, i.e. future physicians; and in the course of the six-year study in psychiatry they only have one lecture on addictions; on the other hand, you have the pharmaceutical industry organising courses; at least their awareness of that would be raised".

On the downside of the implementation of existing policies, the participants mentioned the absence of clear policy on the availability of different addictive substances – "When it comes to availability reduction, I do not see a clear national policy there" – as well as the absence of coherent health-care policy – "therefore, there is no coherent health-care policy in the area of mental health" – and the uneven presence of certain experts at the county level: "as regards measures for mental health protection, there are no psychiatrists for children and adolescents in some counties".

Co-ordination of policy implementation

Within the theme of co-ordination of policy implementation, the following contents were emphasised: co-ordination, activity financing, implementation monitoring, evaluation and the need for co-ordination body/bodies. Based on the analysis, three separate categories were observed: co-ordination body, provision of co-operation and funds for policy implementation (Table 1.12).

These three categories represent the indispensable elements for successful policy co-ordination. The participants' answers indicate that successful policy co-ordination requires a co-ordination body that works with all relevant partners, provides financial means for programme implementation on a continuous basis and organises training for experts.

Table 1.12: Overview of the theme "Co-ordination of policy implementation" and related codes and categories

Theme	Code	Category
Co-ordination of policy implementation	Government office on combating addictions Highest level in drug policy co-ordination Office for Combating Drug Abuse as the umbrella, technical and expert body Office for Combating Drug Abuse as the co-ordination body for other addictions as well One or several co-ordination bodies required Addictions are under the competence of the health-care system Efficient functioning of a single co-ordination body difficult to achieve Disputable efficiency of a single co-ordination body Existing county commissions should also be responsible for other addictions Office for Combating Drug Abuse needs greater powers Need to restructure the Commission on Drugs	Co-ordination body
	Co-operation with other bodies Office for Combating Drug Abuse has contributed to co-operation Relationship between politics and profession	Provision of co-operation
	Provision of funds for treatments Provision of funds for programmes Activity funding as a component part of the state budget Insufficient funds for prevention	Provision of funds required for policy implementation

Two participants suggested that a single co-ordination body for all addiction policies should be established: "I think that there should be a similar co-ordination body… the Government Office for combating addictions; therefore, I would like to see this body at least… co-ordinate all addictions and the state policy in the reduction implementation regarding tobacco and alcohol consumption, and gambling". Since the highest level of co-ordination has been achieved in the area of drug abuse policy, the two participants mentioned that the Office for Combating Drug Abuse should

also be responsible for implementation co-ordination with other related policies: "When we speak about co-ordination, the highest level of co-ordination has been achieved for drugs… this Office is expected to be the umbrella, [a] technical and also partly expert body, a body that would co-ordinate this work". Another participant mentioned that there was a need for one or several co-ordination bodies, in particular for co-operation with all relevant partners in the area of combating addiction; at the same time, he thought that addictions should be primarily under the competence of the health-care system – "in any case I am in favour of a co-ordinative body, regardless whether it should be located in one or several places… the issue of all types of addiction under the competence of the Ministry of Health". Two participants said that the efficiency of a single body was disputable: "I believe that technically it would be very difficult to accomplish; I am afraid that we would get one … how efficient it would be".

As previously mentioned, the participants believed that the role of the co-ordination body would be, *inter alia*, to provide financial means for policy implementation – "policy on the provision of funds for programmes". They thought that a similar structure should be organised at county level. According to a participant, the existing county commissions on combating drug abuse should also co-ordinate activities for other addictions: "Interdisciplinary co-ordination bodies set up in all counties for the implementation of policies on combating drug abuse and the Action Plan at the county level have already been in place. … these bodies should also in a way be responsible for all addictions at the county level". Partnership, namely co-operation of professionals and decision makers in activity implementation, was recognised as a very important factor in policy implementation: "politics have the upper hand in relation to the profession".

Adaptability of policies to changing circumstances

Within the theme on adaptability of policies to changing circumstances, there was discussion of the differences in duration of various strategies and the adaptability of measures/activities in the existing documents.

Table 1.13: Overview of the theme "Adaptability of policies to changing circumstances" and related codes and categories

Theme	Code	Category
Adaptability of policies to changing circumstances	Different strategy duration periods Single prevention of all types of addiction	Need assessment
	Possible supplements to existing strategies When drafting documents, existing ones should be consulted Policies to be adapted through action plans Role of action plans in adaptation of existing strategies Use of capacities of existing institutions Treatment should take into account specificities of respective addiction	Possible measures

Table 1.13 shows an overview of the codes and resulting categories: "need assessment" summarises the situation in the area of policies in question and "possible measures" covers ideas, knowledge and recommendations showing possible ways to adapt existing policies to changing circumstances, if any.

The participants established that, despite the fact that the applicable national strategies had been adopted for different periods, it was possible to adapt measures (activities) to changing circumstances, if any. The above could also be put into operation through action plans: "national strategy does not require a complete change, a motion can be submitted to the government to change a particular part of the strategy so that amendments can be adopted on the basis of that; the strategic document is a framework, which surely provides for all required elements, it is wide enough so that all the necessary [measures] can be provided for in action plans". In order to increase coherence among policies, another participant pointed out that the existing documents should be consulted when drafting strategic documents: "The later ones should consult our documents to a certain extent".

It was pointed out that the highest coherence level had been achieved in the area of addiction prevention – "when it comes to addiction prevention, we do not distinguish illegal from legal substances, but we are strictly focused on prevention of all addictions" – and that we needed to learn from experience – "they would not give a single penny for a simple brochure which would not be presented everywhere" – and use the capacities of existing institutions: "our system has institutions which are functioning well, it certainly has its traditions, even regardless of the officially amended strategies or action plans which will be adapted to the actual situation".

Special theme: additional comments

At the end of the focus group, the participants were able to make additional statements or comments on any of the contents that they considered relevant but had not been sufficiently (or at all) covered by the focus group. One participant stressed the importance of the role and authority of the co-ordination body in relation to other government bodies: "the thing that we have mentioned regarding the authorit[y] of the co-ordination body and its status in relation to other government bodies". The participants also stressed the importance of introducing gradual changes in current policies: "you have to come and work in the field".

Conclusions and recommendations: results of the focus group analysis

In order to get a deeper insight into coherence assessment of policies on psychoactive substances and addictive behaviour, a focus group was conducted with the representatives of relevant bodies and experts in charge of co-ordination and implementation of the policies in question, who voluntarily agreed to take part in the project. A transcript analysis conducted according to the principles of qualitative methodology resulted in an insight into the above issue and a description through six specific themes and one additional theme. From relevant experts' perspectives, based on the analysis thus conducted, several conclusions and recommendations can be drawn for the coherence enhancement of policies on psychoactive substances and addictive behaviour.

Conclusions

- Except for policy on combating drug abuse, there is no coherence in the monitoring of policy implementation in the area of psychoactive substances and addictive behaviour.
- There is a need for greater coherence of the policies in question.
- Surveys allow implementation monitoring of all policies mentioned above.
- The addiction prevention area has been recognised as an integrated area focused on common risk and protective factors against a number of negative outcomes.
- The above-mentioned policies have complementary goals, but methods and means for their achievement differ, depending on the il/legality of psychoactive substances.
- Strategic documents of the Republic of Croatia are still primarily orientated to disease, instead of health.
- At the national and county levels there is a system, with financial means provided, for implementing the policy on combating drug abuse. Other policies do not have an adequately defined structural or financial component in policy implementation.
- Training is considered an indispensable factor for quality and equally distributed policy implementation.
- A need has been established for some form of co-ordination body/bodies that will maintain co-operation with all relevant partners, provide continuous financial means for policy implementation and organise training for experts.
- Adaptation of measures and policies in applicable strategic documents is possible through action plans and other operating documents.

Recommendations

- Results and conclusions should be presented to survey participants and decision makers in the field.
- In the forthcoming strategic documents, the health definition should be aligned with the WHO definition.
- Health and the concept of positive development should be promoted.
- A fund for prevention (implementation of prevention activities) should be established.
- Policy implementation should be enhanced through training and a regular system of further education of physicians, with courses for experts dealing with addictions, and people should learn from experience in other disciplines.
- An addiction prevention and treatment system should be developed at county level within the existing bodies.
- In accordance with existing resources, a body responsible for co-ordination of policies on all psychoactive substances and addictive behaviour should be established.

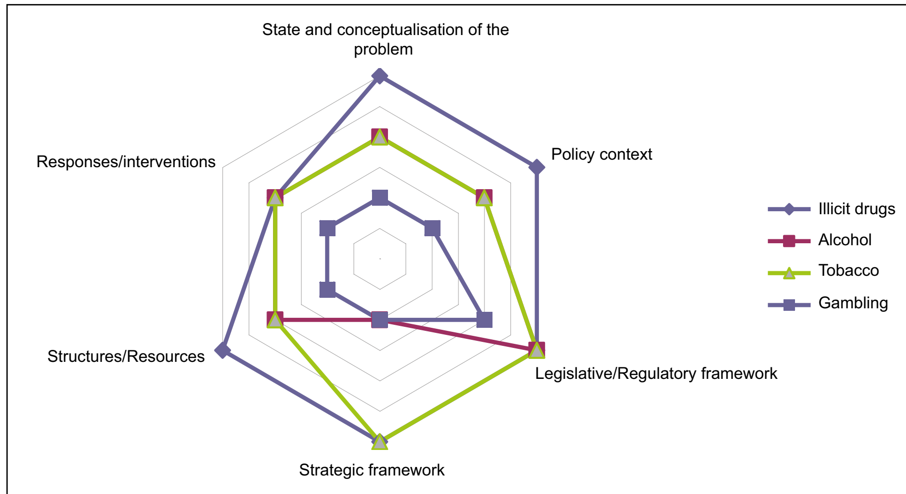
Conclusions and recommendations of the survey project

By combining the findings of previously described methods in this research project, each of the policy coherency indicators has been assigned its own grade (Table 1.14). These grades were then used in a spider diagram to provide a clear picture of the inner coherency of tested policies and their interrelations (Figure 1.2).

Table 1.14: Assessment of markers for coherence of policies on illicit drugs, alcohol, tobacco and gambling

Marker	Area			
	Illicit drugs	Alcohol	Tobacco	Gambling
State of the problem	3	2	2	1
Policy context	3	2	2	1
Legislative/regulatory framework	3	3	3	2
Strategic framework	3	1	3	1
Structures/resources	3	2	2	1
Responses/interventions	2	2	2	1

Figure 1.2: Summary of the survey project findings in a spider diagram



In relation to the conclusions and recommendations resulting from the focus group analysis, as well as the results presented in this research project, the following propositions are to be considered.

The institutional framework for combating drug abuse and other types of addiction is made up of different national and local government institutions, each of which, in its field of work, independently decides how to implement strategic goals. Because of this fact, the degree of harmonisation of political goals and strategic documents in each field is medium to low, except in the field of illegal drugs. This also makes

the harmonisation of activities harder and leads to overlapping activities or lack of activity implementation in certain areas. Establishment of one main operative and co-ordinative body, whose mission would be based on vertical and horizontal hierarchical and executive authority, would ensure that segmented strategic and financial implementation of activities for combating drug abuse and other addictions would be directed towards singular and defined strategic goals.

During the drafting process of future strategic documents in the field of addiction and health, it is necessary to consider basic definitions of existing relevant documents at national (and EU) level in order to harmonise goals and measures, as well as to ensure congruence of the time period they relate to.

With the aim of increasing efficiency and transparency in the spending of public funds, integrated planning and management of budget funds for prevention and combating of addiction should be established, in such a way that the process of planning, execution, monitoring and control of budget funds for implementing different programmes is equalised, as well as integrated with strategic goals in the field of addiction.

In order to improve co-operation between national and local bodies responsible for activities, and to improve the quality of monitoring, a unique authority should be created with responsibility for creation and proposition of guidelines for national policies for addictions, and the same should be done for authority over control of the methods and implementation quality of planned activities.

Implementation of coherent policy in the field of addiction would ensure central planning and control over the execution of planned strategic goals, which would considerably facilitate policy implementation since there would be only one central body with a mandate to consolidate all data on activity execution and to explain the reasons for any non-implementation of planned activities.

If this role were given to the Office for Combating Drug Abuse, it would be necessary to fulfil certain legal, organisational and financial prerequisites, which would enable establishment of coherent policy in the field of prevention and combating of addiction.

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Act on Financing Local and Regional Self-Government Units (OG 117/93, 33/00, 73/00, 59/01, 107/01, 117/01, 150/02, 147/03, 132/06, 73/08, 25/12); Decision of the Constitutional Court of the Republic of Croatia (OG 26/07).

Act on Games of Chance (OG 87/09, 35/13).

Act on Excise Duty on Tobacco Products (OG 136/02: consolidated text, 95/04, 152/08, 38/09).

24. In amendments to the Drug Abuse Prevention Act (OG 149/09) the term “narcotic” was deleted.

Act on Misdemeanours against Public Law and Order (OG 05/90, 30/90, 47/90).

Road Traffic Safety Act (OG 67/08, 74/11).

Act on the Restriction of the Use of Tobacco Products (OG 125/08, 55/09, 119/09, 94/13).

Regulation on the Establishment of the Office for Combating Drug Abuse (OG 18/02, 12/05, 111/06, 19/10).

Chapter 2

Czech Republic – Coherence policy markers

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This study is conducted in the framework of the Pompidou Group's research project on coherent policy. The objective is to test defined markers for coherency, which are to be used to articulate whether a policy for drugs, alcohol and tobacco is coherent in the current context.

This pre-pilot study is done with the aim of providing practical examples and experience with proposed markers for coherency in the Czech Republic, thus providing information for further discussion of these markers and their further development and definition.

There are six markers defined by the working group. These are viewed as "soft markers" to determine whether a policy is working at national level by ensuring that policies do not compete with each other. Markers per se imply that something may need attention, or not, and thus raise a flag of concern. Each marker will serve to describe and assess the situation on drugs, alcohol and tobacco by identifying the problem and the solution that has been put in place. These markers are:

1A Policy – problem conceptualisation
1B Policy – solution (policy framework)
2 Legislative/regulatory framework
3 Strategy/action plan
4 Structures/resources
5 Responses/interventions

The goal by which the policies on psychoactive substances are to be tested is that of the health and well-being of the individuals. The goal is described by WHO in the preamble to its 1946 constitution thus: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Coherence is tested in each marker in terms of the above goal, but it is also tested for each marker between different substance policies: what is the coherency between illicit drug policy and alcohol policy, between alcohol and tobacco policy, and between tobacco and illicit drug policy?

Policy

Policy: problem conceptualisation

As a working definition of a marker, we may describe it as an attempt, using existing policy documents, to gain an insight into a problem that has been identified. For example, in America there has been a move from regarding drug users as criminals to seeing them as people who need attention, be it medical or social or psychological. Documents attesting to this conception of the problem may be found in a national health plan, for example. Moreover, this shift in the state of affairs may be further supported by providing the socio-historical context as exemplified in the first project and the publication resulting from such work.

Because in the Czech Republic there is only one specifically focused policy document, that for illicit drugs, the information in this chapter is divided differently for specific strategic documents and related strategic documents.

Problem conceptualisation from specific strategic documents

For illicit drugs

In the period 1998-2000 there was a shift in the perception of drugs in drug policy documents from the perception of drugs as a direct threat to society to a more realistic perception of drugs as a phenomenon presenting health and social risks (Radimecký 2004a).

The drug policy's purpose – as defined in the current national strategy – is to ensure the protection of individuals and society from the health, social and economic risks of the harm that drug use may cause and to secure individuals, society and property against the consequences of crime associated with drug trafficking (National Drug Policy Strategy 2010).

The use of addictive substances is seen in this document as a complex and multi-faceted phenomenon involving a range of interacting potential risks to both individuals and society. The greatest concerns are the adverse social, health, legal, safety and economic implications, which have a negative impact on the healthy development of both individuals and society in all these aspects (National Drug Policy Strategy 2010).

For alcohol and tobacco

There is no specific strategic document focused on alcohol and/or tobacco, so the official definition of the problem conceptualisation is hard to find. There is a strategic document approved by the Czech Government in 2002 – *Health for all in the 21st century* (Ministerstvo zdravotnictví 2002).

Problem conceptualisation from related strategic documents

Goal 12 in the document *Health for all in the 21st Century* covers alcohol, tobacco and illicit drugs. The main purpose of this document is to protect and improve the

health of people during their entire life and to decrease the prevalence of illness, injuries and deprivation that are caused to people (Ministerstvo zdravotnictví 2002). The harms caused by the abuse of illicit drugs are seen in this document from the social and health perspective: "Drugs besides strong toxicity have significant social impacts and increase the risk of infection diseases."

The harms caused by the abuse of alcohol are also seen in this document from the social and health perspective: "The abuse of alcohol brings besides the social consequences also health risks." The problems caused by the use of tobacco are, in this document, only seen from the health perspective ("damages the health of people").

Following our discussion in the working group, the idea of also taking into account the social and public opinion context in the whole marker was suggested. Therefore I defined six aspects that were individually assessed in terms of the main goal of the health of individuals: i) prevalence of use of a substance, ii) public opinion, iii) media analysis, iv) cost of illness (cost of substance use for society), v) problem conceptualisation from the specific strategic documents, vi) problem conceptualisation – from the related strategic documents. (For more information on the description on each aspect/sub-theme see Appendix I.) By calculating an average, a total mark for each substance for marker 1A was obtained.

However, mixing all these aspects into one marker was not a good idea; it did not reflect the real picture of the problem conceptualisation. Table 2.1 shows the marks arrived at.

Table 2.1: Coherency of policies on psychoactive substances in marker 1A in terms of the main goal – health and well-being of an individual

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 1	3.8	2.0	1.8

The problem here is that the formal definition of a problem in official documents is totally coherent in terms of the main goal defined by WHO. The problem of drug use is seen in the official documents from the perspective of a multidimensional, interdisciplinary phenomenon, the problems associated with tobacco use are seen from the health perspective and those associated with alcohol are seen from the health and social perspectives.

Therefore, if we also want to take into account the social/public context, it is proposed that we make a new marker. By doing so the psychoactive substance policies in place would obtain the marks shown in Table 2.2.

Table 2.2: Coherency of policies on psychoactive substances in the social/public context in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for a new marker	3.0	1.3	1.0

Table 2.3 gives the marks for problem conceptualisation; note that these are averages of the problem conceptualisation in the main strategic documents and related strategic documents. The lower marks for legal substances in this problem conceptualisation in official documents are caused by the fact that there is no specialised strategic document for these substances.

Table 2.3: Coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 1A in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for a marker	5	3	3

Table 2.4: Mutual coherency of policies on psychoactive substances in marker 1A (including the social/public context)

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	3.0	2.8
Alcohol		–	4.0
Tobacco			–

As we can see in Table 2.4, there is relatively strong coherency in problem conceptualisation between legal drugs, but there is not such strong coherency between illicit drug policy and legal drugs. (This correctly reflects the actual situation.)

Policy: solution (policy framework)

To begin with a working definition of the marker, this second aspect requires one to identify how the problem is to be addressed: as a criminal justice issue, in a medical context, in the context of a value set like social inclusion, human rights or equality, as a combination of the above, or via some other policy framework?

A modern drug policy as known today began to take shape in the Czech Republic in the 1990s. It was based on the principles of so-called mainstream drug policies: a pragmatic and rational approach which lays down realistic and attainable goals rather than a "drug-free society" (Radimecký 2001). The drug problem and policy are seen from a multidimensional perspective. The main co-ordination body is cross-sectional: the Governmental Council (the GCDPC), the executive body, is situated in the Office of the Government (which is not a ministry, but rather a body dealing with the functioning of the government and multidimensional issues such as human rights and drugs). As a monitoring body there is the National Focal Point for Drugs, established in 2002. There are specific strategic documents for drug issues. These take into account the multidimensional aspect of drug issues.

Alcohol- and tobacco-related issues are mainly seen from the perspective of health. The main responsible body is the Ministry of Health, where there is also a National Monitoring Centre for alcohol and tobacco responsible for the monitoring, research and implementation of the European action plans for alcohol and tobacco – established

in 2004. There is no specific strategic document, but the one mostly related to alcohol and tobacco problems is set in the health context.

The aspect of integration of substances in the definition of problem conceptualisation was also looked at. In defining the problem and its conceptualisation the strategic documents (mainly the national strategy) take into account all psychoactive substances – the word "drug" refers also to alcohol, tobacco and medications. In the only document that the Czech Republic has for alcohol and tobacco, the problems of the use of these substances are perceived individually for each substance – for alcohol, tobacco and illicit drugs.

Table 2.5: Coherency of policies on psychoactive substances in marker 1B in terms of the main goal – health and well-being of an individual

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 1	5	5	5

Table 2.6: Mutual coherency of policies on psychoactive substances in marker 1B

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	5	5
Alcohol		–	5
Tobacco			–

Legislative/regulatory framework

Working definition/description of the marker – documents to support whether there are laws and regulations in place that, first, adhere to international conventions and, second, that are related to national requirements. To what extent are the controls and regulations in the areas of illicit drugs, alcohol and tobacco complementary, and consistent with (and supportive of) the desired outcome?

An important law was adopted in 2005 for the policy on psychoactive substances – the Act on Measures for Protection from Harm Caused by Tobacco Products, Alcohol and Other Addictive Substances (Law No. 379/2005 Coll.). The law codified some principles and fundamentals that had been included in all the national drug strategies since the 1990s. These principles were applied in practice but lacked a clear legal basis. For the purpose of the law, the term "drug policy" covers not only illegal drugs but also tobacco products and alcohol. According to the law, drug policy includes primary, secondary and tertiary prevention measures. The implementation of drug policy at national level is undertaken and co-ordinated by the government through the ministries and other central public administration authorities. By virtue of the law, the government has the power to establish a special advisory body for drug policy co-ordination; this role is played by the GCDPC (Kiššová 2009).

An amendment in 2010 introduced a number of changes and detailed specifications, including better definitions of public places where smoking is prohibited, the exact

division of the competences of the regulatory authorities, and stricter penalties for selling tobacco, electronic cigarettes and alcohol to individuals under 18 years of age. As far as a ban on smoking in restaurants and other similar establishments is concerned, the legal regulation has remained lenient and rather ineffective in terms of preventing passive smoking and protecting against it. The amendment failed to include an absolute ban on smoking in restaurants and other public places serving food and drinks, which is presently a common practice in some EU member states and elsewhere in the world (Mravčík et al. 2011).

On the ban on smoking in the workplace, Law No. 379/2005 Coll. focuses on only some kinds of buildings (schools, health facilities, etc.). Law No. 262/2006 Coll. on employment bans smoking indoors (in the workplace) where the non-smoker could be exposed to risks of passive smoking. There is also a ban on working while under the influence of alcohol and other psychoactive substances set by the law. There is zero tolerance of driving while under the influence of alcohol, set by the law.

There is no satisfactory regulation of alcohol and tobacco retail in the Czech Republic. The law defines places where alcohol and tobacco can be sold but this is a minimal restriction: they must be sold in specialised corners in grocery stores and other retail outlets, but there is no requirement to obtain a licence. There is a ban on selling alcohol or tobacco products via vending machines, or anywhere where the age of a customer cannot be checked, or to sell alcohol to people already under the influence of a psychoactive substance.

Law No. 379/2005 Coll. states that medical doctors must intervene promptly and provide a consultation for people using alcohol, tobacco and drugs. The legal age for buying alcohol and tobacco products is 18 years; the use itself of these substances is not regulated by age.

The Czech Republic is one of those countries with excise taxes lower than the European average. However, among the newly accessed countries from 2004, the Czech Republic is one of the countries with higher taxes.

Act No. 40/1995 Coll. on advertisements regulates the advertisement of alcohol and tobacco and its products. The amendment passed in 2011 did not include interventions on alcohol or tobacco products. Advertising of tobacco products is restricted, but alcohol less so; alcohol advertising is allowed in all mass media.

Following an independent research study conducted by a British team from the University of Bath, the tobacco regulation policy in the Czech Republic was declared to be ″extremely weak″ and the "fourth of the less effective in Europe". Researchers also indicated that "there is a clear influence of big tobacco companies on the former and current Czech Government on the issues of advertisement and taxes" (Shirane et al. 2012).

Act No. 40/2009 Coll. of the Penal Code, effective from 1 January 2010, marked the culmination of the re-codification of the material criminal law. The new penal code has also brought significant changes in the legal definitions of drug-related criminal offences. To a certain degree, the new legislation differentiates drugs according to their health and social risks as it makes a distinction between cannabis and other drugs in relation to the cultivation of cannabis for personal use and the

possession of this substance for personal use (Mravčík et al. 2011). The possession of cannabis in a quantity greater than "small" carries a sentence of up to a year's imprisonment, while an offender found guilty of the possession of other narcotic or psychotropic substances or poisons in a quantity greater than "small" may be sent to prison for up to two years. A person convicted of possessing any narcotic or psychotropic substance or poison, including cannabis, to a significant extent may be sentenced to imprisonment for a term of between six months and five years (Mravčík et al. 2011).

The possession of a narcotic or psychotropic substance in a "small" quantity and the cultivation of plants and mushrooms containing a small quantity of narcotic or psychotropic substances are punished as misdemeanours by Act No. 200/1990 Coll. on misdemeanours (Mravčík et al. 2011).

Act No. 167/1998 Coll. on addictive substances was last amended in 2011, adding 33 more substances to the list of narcotic and psychotropic substances already scheduled in the appendices to the law on addictive substances; they include not only the legal highs, but also substances used in pharmacy and medicine (such as ketamine and tapentadol). Salvinorin A (a Salvia divinorum alkaloid) was also added to the schedule.

The question here was how deep does one delve into the laws and specific provisions? Too much detail starts to interfere with the marker 5 Responses/interventions. Again sub-themes/aspects were created for this marker and tested in terms of the main goal of health of the individual: i) main national documents forming the legislative framework of substance use policies; ii) adherence to international conventions; iii) examples of legal provisions (where I tested each provision set by the law and described above in the text individually). However, one questions whether this is the way to do it. For more details please refer to Appendix II.

Table 2.7: Coherency of policies on psychoactive substances in different aspects of marker 2 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 2	4.6	3.5	3.6

It was very tricky to assess the coherency between different psychoactive substance policies in each intervention set by law. In many cases it was not sure whether it could be done at all. However, an attempt was made and the results are shown in Table 2.8.

Table 2.8: Mutual coherency of policies on psychoactive substances in marker 2

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	3.6	3.4
Alcohol		–	3.3
Tobacco			–

Strategy/action plans

In defining this marker, we have to ask two questions. Are there any strategies or action plans in place that provide the means through which the policy/policies may be implemented? Are the strategies or action plans consistent with the desired outcome and comprehensive in that they take into account all the policy measures highlighted?

There is a National Drug Policy Strategy for the period 2010-18. It is a long-term document, the purpose of which is to define, in political terms, the framework for drug policy, the key areas of interest and the principles and approaches underpinning Czech drug policy. It defines four general objectives which correspond to the four pillars of the drug policy: prevention, treatment and social reintegration, harm reduction and drug supply reduction – complemented by three supporting domains: co-ordination and funding, monitoring, research and evaluation, and international co-operation.

Specific short-term drug policy procedures and measures are defined in the action plans for implementation of the National Drug Policy Strategy. There are three action plans, each spanning a period of three years. For the legal drugs, alcohol and tobacco, there is no specific action plan or strategy. The only document that sets policy goals for alcohol and tobacco is *Health for all in the 21st century*. Therefore this was also tested in relation to this document.

The sub-themes created for this marker and then tested in terms of the main goal of health of the individual were: i) specific national strategy; ii) related strategic documents; iii) goals of main strategic documents; iv) goals of related strategic documents; v) activities; vi) last actualisation; vii) evaluation/monitoring of implementation. By calculating an average, a total mark for each psychoactive substance policy was obtained for marker 3. For details, please see Appendix III.

Table 2.9: Coherency of policies on psychoactive substances in different aspects of marker 3 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 3	4.1	2.1	2.1

Table 2.10: Mutual coherency of policies on psychoactive substances in marker 3

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	2.6	2.6
Alcohol		–	4.5
Tobacco			–

Structures/resources

We need first to describe the marker. Which ministries are taking the leading role in drug, alcohol and tobacco policies? Is the location of responsibility conducive to achieving the desired outcome and to implementing the policy framework? Are

there any other bodies such as interministerial bodies that co-ordinate the policy/policies? And do their priorities coincide with the overall goal?

The main co-ordination body for illicit drugs is the Government Council for Drug Policy Co-ordination (GCDPC). Its main spheres of activity are the development of a comprehensive national strategy, its co-ordination, and collaboration in practical implementation at central and local levels. The members of the GCDPC are the heads of the relevant ministries dealing with the issue of drugs – Health, Interior, Education, Youth, and Sports, Labour and Social Affairs, Justice, Defence and Finance – with the Association of Non-Governmental Organisations, the Society for Addictive Diseases of the J. E. Purkyne Czech Medical Association and lastly an expert nominated by the prime minister. The executive body is situated in the Office of the Government.

The council has several committees and working groups to implement the policy on illicit drugs. The Committee of Departmental and Institutional Representatives deals with different aspects of drug policy, there is an Advisory Committee for Drug-Related Data Collection and one composed of regional representatives, and there are committees for funding drug services and for certification and quality assurance of drug services. There is also a National Monitoring Centre for drugs and drug addiction at the GCDPC in the Office of the Government.

The main political body and responsible institution for dealing with issues of alcohol and tobacco is the Ministry of Health. It is responsible for legislation on protection against the harm caused by tobacco products, alcohol and other addictive substances, including treatment of addictive diseases. The health ministry's other duties include provision and funding of drug treatment, reduction of health risks and provision of education and interventions promoting healthy lifestyles and professional training for health practitioners. No specific permanent working groups exist, though there are ad hoc working groups. There is also a National Monitoring Centre for alcohol and tobacco at the Ministry of Health, National Institute of Public Health.

The sub-themes created for this marker were: i) main body/institution responsible for the co-ordination and implementation of a policy; ii) co-ordination mechanisms, e.g. working groups; iii) body responsible for monitoring and evaluation; iv) outputs of the monitoring available; v) co-ordination at regional level. For more information see Appendix IV.

Table 2.11: Coherency of policies on psychoactive substances in different aspects of marker 4 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 4	4.5	3.5	3.3

Table 2.12: Mutual coherency of policies on psychoactive substances in marker 4

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	3.5	3.3
Alcohol		–	4.8
Tobacco			–

Because financial resources are now at the forefront of political discussion it is suggested that financial resources should be a separate marker. This gives a targeted focus on this aspect and a clear picture of how the government pays attention to the different psychoactive substances.

However, for the Czech Republic there are no satisfactory data available on finances directly devoted to alcohol or tobacco – that is, labelled expenditures spent by the state authorities. Therefore it is not possible to analyse this marker correctly for the Czech Republic.

There are data available from the current study on the cost of illness – costs that society pays for using psychoactive substances. The direct costs paid (treatment, health insurance, law enforcement, co-ordination of drug policies, etc.) were estimated by the study as follows. For illicit drugs: 5.9 billion Czech crowns; for alcohol: 8.8 billion Czech crowns; for tobacco: 9.3 billion Czech crowns.

Table 2.13: Coherency of policies on psychoactive substances in different aspects of marker 4 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 4 – expenditure	2	3	3

Table 2.14: Mutual coherency of policies on psychoactive substances in marker 4

	Illicit drugs	Alcohol	Tobacco
Illicit drugs	–	2	2
Alcohol		–	3
Tobacco			–

Responses/interventions

For a working definition or description of this marker, we must ask several questions. What major responses to the problem have been put in place? What types of intervention have been adopted to ensure their success? To what extent are they logically consistent and mutually supportive, and in line with the over-arching policy goals and aspirations?

Unfortunately there was not enough time to deal in detail with this marker, though how best to do it was indeed considered. One way to test this marker could be to list the interventions that are considered to be effective (at European level) and study whether these are in place in a country, or not, and at what level.

For example, it is believed that the most effective policies on alcohol are those based on restrictions and regulations. The literature review and WHO agree on the following policies as being cost effective: regulation of the environment/market of alcohol products, increasing the price of alcohol, reducing the physical accessibility of alcohol products by decreasing the number of retail outlets, their density and hours

of sale, then restricting advertisements and enforcing restrictions on driving under the influence of alcohol. For illicit drugs, in the area of harm reduction, evaluation already shows that the effective interventions are thought to be: low-threshold facilities, outreach programmes, application rooms and substitution treatment.

We could go on with defining effective policies in all aspects of different drug policies, and then we should test these interventions to see how they are implemented in our country and whether they are coherent in terms of the main goal. The example of how the above-mentioned interventions were assessed for the case of the Czech Republic is given in Appendix V.

Table 2.15: Coherency of policies on psychoactive substances in different aspects of marker 5 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
Overall/average mark for marker 5 – expenditure	4.2	2.4	2.8

Summary

Table 2.16: Coherency of policies on psychoactive substances in each marker in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
1A. Policy: problem conceptualisation	5.0	3.0	3.0
1A. Policy: social context	3.0	1.3	1.0
1B. Policy: solution (policy framework)	5.0	5.0	5.0
2. Legislative/regulatory framework	4.6	3.5	3.6
3. Strategy/action plan	4.1	2.1	2.1
4A. Structures	4.5	3.5	3.3
4B. Resources	2.0	3.0	3.0
5. Responses/interventions	4.2	2.4	2.8

Table 2.17: Coherency of policies on psychoactive substances in each marker in terms of the main goal – health and well-being of an individual – rounded marks (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco
1A. Policy: problem conceptualisation	5	3	3
1A. Policy: social context	3	1	1
1B. Policy: solution (policy framework)	5	5	5
2. Legislative/regulatory framework	5	4	4

	Illicit drugs	Alcohol	Tobacco
3. Strategy/action plan	4	2	2
4A. Structures	5	4	3
4B. Resources	2	3	3
5. Responses/interventions	4	2	3

Figure 2.1: Spider diagram showing coherency of policies on illicit drugs, alcohol and tobacco in the Czech Republic in each marker in terms of the main goal – health and well-being of an individual (rounded: 5 = very coherent, 1 = not coherent)

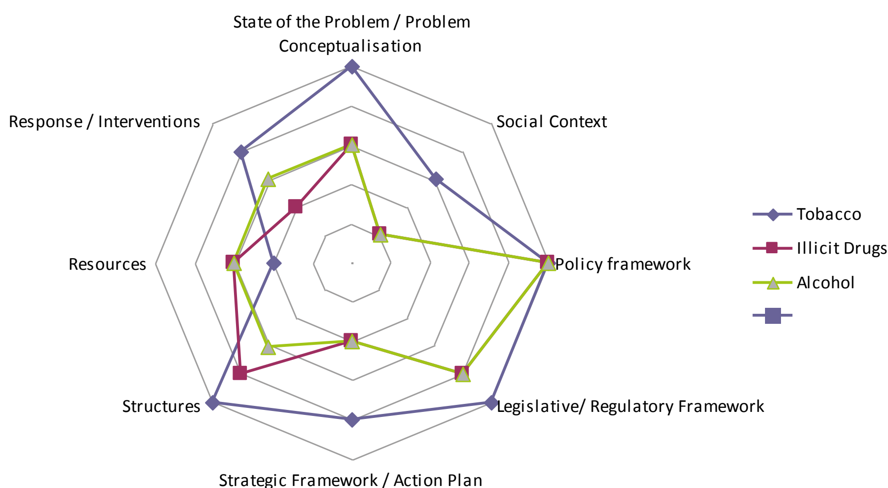


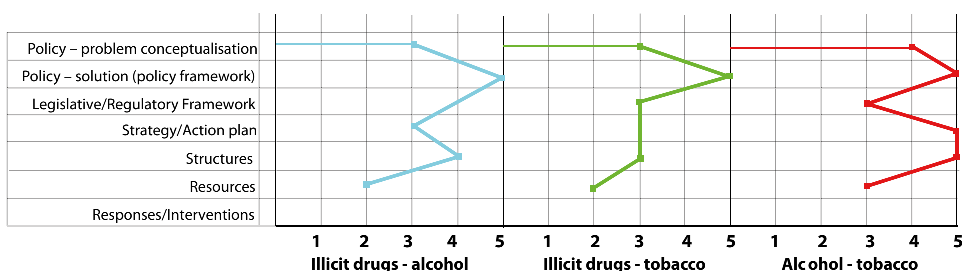
Table 2.18: Mutual coherency of policies on psychoactive substances in the Czech Republic in each marker

	Illicit drugs - Alcohol	Illicit drugs - Tobacco	Alcohol - Tobacco
1.A Policy – problem conceptualisation and social context	3.0	2.8	4.0
1.B Policy – solution (policy framework)	5.0	5.0	5.0
2. Legislative/regulatory framework	3.6	3.4	3.3
3. Strategy/action plan	2.6	2.6	4.5
4.A Structures	3.5	3.3	4.8
4.B Resources	2.0	2.0	3.0
5. Responses/interventions			

Table 2.19: Mutual coherency of Czech policies on psychoactive substances in each marker (rounded marks)

	Illicit drugs - Alcohol	Illicit drugs - Tobacco	Alcohol - Tobacco
1.A Policy – problem conceptualisation and social context	3	3	4
1.B Policy – solution (policy framework)	5	5	5
2. Legislative/regulatory framework	4	3	3
3. Strategy/action plan	3	3	5
4.A Structures	4	3	5
4.B Resources	2	2	3
5. Responses/interventions			

Figure 2.2: Mutual coherency of Czech policies on psychoactive substances in each marker



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Appendix I. Policy: problem conceptualisation

How to get to a mark for policy: problem conceptualisation? (for discussion)

The problem that arises is how does one mark a marker? How can one seriously judge the level of coherency, based on what? The idea was hit upon of creating something like a list of sub-themes for each marker and assessing the level of coherency in each of these sub-themes. It would be preferable to use a scale of one to five. For the whole marker an average of marks given in these sub-themes is then used.

Epidemiological situation

The epidemiological situation is thoroughly analysed and described every year in the Annual Report on the drug situation in the Czech Republic. The next two paragraphs summarise the level of use of psychoactive substances in recent years in the Czech Republic.

Two studies were conducted in 2010 that also monitored the use of alcohol and tobacco – among the general population (Institut pro kriminologii a sociální prevenci 2010) and among the general population of Internet users aged 15–34 (Národní monitorovací středisko pro drogy a drogové závislosti a Median 2011). Lifetime prevalence of alcohol use in the age group 15-34 was reported to be 93.8% to 98.2% (according to the survey) and last-year prevalence 89.3% to 93.8%. Lifetime prevalence of tobacco use in the age group 15-34 years was reported to be 72.3% to 82.9% and last-year prevalence 50.2% to 52.5%.

Based on studies in the years 2008-10, the most frequently used illicit drug in the general population (lifetime prevalence) is cannabis (23.4% to 34.3%, depending on the study), followed by ecstasy (4.0% to 9.6%). Last-year prevalence in cannabis use was reported as 9.7% to 15.2%, while the use of other illegal drugs was less than 4% (Mravčík et al. 2011). In 2010 the mean estimate of problem drug users reached the level of 39 200 people. There was an increase in comparison with previous years, though not statistically significant. A significant increase was reported in problem users of pervitin (28 200), but the number of problem opiate users fell to 11 000 (Mravčík et al. 2011).

Social context – public perception

The Czech population is relatively tolerant of the use of licit psychoactive substances and the use of cannabis. In 2011, according to a Public Opinion Poll Centre's annual survey among people aged over 15 years, a total of 82% of respondents found tobacco smoking acceptable and 77% also considered the consumption of alcohol acceptable behaviour. The use of pills (such as sleeping pills, painkillers and tranquillisers) also met with a high level of acceptance. Cannabis use was acceptable for 25% of the interviewees (Centrum pro výzkum veřejného mínění 2011).

In 2011 the Eurobarometer thematic survey among young people (15-24 years) showed that, in comparison to their peers in other European countries, young people in the Czech Republic reported relatively easy access to alcohol, tobacco and cannabis (75% of the interviewees had found it rather easy to obtain marijuana or hashish) but, contrary to other countries, they considered it more difficult to obtain heroin and cocaine – only 6% and 8% of the respondents, respectively, found these drugs easily available (Gallup Organisation 2011).

The vast majority of the respondents in the public opinion poll survey (Centrum pro výzkum veřejného mínění 2011) agreed with criminal prosecution for the production and sale of drugs (88-94% of the respondents); while 86% of the interviewees were in favour of sanctions for the growing of marijuana for sale, 83% stated that users of drugs other than cannabis should be prosecuted and 61% were in favour of the prosecution of cannabis users. A total of 60% of the interviewees were against penalties

for the cultivation of marijuana for personal use and 74% of the respondents were against punishing the medical use of cannabis (ibid.).

In Table I.1, COI=cost of illness, LTP=lifetime prevalence, LYP=last-year prevalence.

Table I.1: List of sub-themes that could be assessed in marker 1

	Illicit drugs	Alcohol	Tobacco
Prevalence of substance use	LYP of cannabis use – 9.7-15.2% among general population LTP of cannabis use among 16-year-old students – 42.3%[1] LYP of other drugs – less than 4% among general population LTP of other drugs among 16-year-old students – 11%[2]	LYP – 89.3-93.8% in 15-34 age group LTP of alcohol among 16-year-old students – 98%[3]	LYP – 72.3-82.9% in 15-34 age group LTP of tobacco use among 16-year-old students – 75%[4]
Public opinion	Using cannabis tolerated – a strong notion of legalising marijuana for medical use Less tolerated is use of more problematic drugs: heroin, methamphetamine (pervitin)	Highly tolerated behaviour, beer seen as national drink/identity	The most tolerated behaviour
Media analysis	www.lekarsky.herba.sk/lekarsky-obzor-3-2010/medialni-obraz-uzivatele-navykovych-latek-a-jeho-socialne-psychologicky-rozmer	A proposed sub-theme that I did not have time to study more closely in this project, even though we have data available	
Cost of illness – cost to society of substance use	Total COI = 6.7 billion Czech crowns (CZK) and 0.19% of GDP	Total COI = CZK 16.4 billion, 0.46% of GDP	Total COI = CZK 33.1 billion, 0.93% of GDP
Problem conceptualisation from the direct/specific strategic documents	In 1998-2000, policy documents shifted their perception of drugs, from seeing them as a direct threat to society to (more realistically) a phenomenon presenting health and social risks (Radimecký 2004a).	There is no specific strategic document on alcohol and/or tobacco, so an official definition of problem conceptualisation is hard to find. There is a strategic document approved by the Czech Government in 2002 – *Health for all in the 21st century*	

1. ESPAD 2011 – Zaostreno na drogy.
2. Ibid.
3. Ibid.
4. Ibid.

	Illicit drugs	Alcohol	Tobacco
	The national strategy defines drug policy's purpose: to ensure the protection of individuals and society from health, social and economic risks of harms that drug use may cause and to secure individuals, society and property against the consequences of crime associated with drug trafficking (National Drug Policy Strategy 2010). The use of addictive substances is seen in this document as a complex, multifaceted phenomenon involving a range of interacting potential risks to individuals and society. The greatest concerns are the adverse social, health, legal, safety and economic implications, which negatively affect the healthy development of individuals and society in all the above aspects (National Drug Policy Strategy 2010)		
Problem conceptualisation – from the related strategic documents	Goal 12 of *Health for all in the 21st century* covers alcohol, tobacco and illicit drugs. The main purpose of this document is to protect and improve people's health during their entire life and to decrease the prevalence of illness, injuries and deprivation caused to people (Ministerstvo zdravotnictví 2002).		
	The harms caused by the abuse of illicit drugs are seen in this document from the social and health perspective: "Drugs besides strong toxicity have significant social impacts and increase the risk of infection diseases"	The document sees the harms caused by alcohol abuse in a social and health perspective: "The abuse of alcohol brings besides the social consequences also health risks such as… "	The problems caused by the use of tobacco are, in this document, seen only from the health perspective ("damages the health of people")
	Note: to what extent we can take this as a problem conceptualisation?		

Table I.2: Coherency of policies on psychoactive substances in social and public context in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Prevalence of substance use	3	1	1	High prevalence (among the highest in Europe) is not coherent with health
Public opinion	3	1	1	High public tolerance of substance use is not coherent with health
Media analysis	?	?	?	
COI	3	2	1	
Overall/average mark for a marker	**3**	**1.3**	**1**	

Table I.3: Coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 1A in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Problem conceptualisation – from the direct/specific strategic documents	5	1	1	For illicit drugs there is formal conceptualisation of a problem, for legal drugs not
Problem conceptualisation – from the related strategic documents	5	5	5	Formal conceptualisation from related documents is coherent with health
Overall/average mark for a marker	**5**	**3**	**3**	

Table I.4: Mutual coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 1A (5 = very coherent, 1 = not coherent)

		Illicit drugs	Alcohol	Tobacco	Notes
Prevalence of substance use	Illicit drugs	–	3	3	High prevalence rate is coherent among substances but negative in terms of health: how to judge it? I marked it as coherent.
	Alcohol		–	5	
	Tobacco			–	

		Illicit drugs	Alcohol	Tobacco	Notes
Public opinion	Illicit drugs	–	3	2	Could this be assessed (at all)?
	Alcohol		–	5	
	Tobacco			–	
Media pictures	Illicit drugs	–	?	?	–
	Alcohol		–	?	
	Tobacco			–	
COI	Illicit drugs	–			Could this be assessed?
	Alcohol		–		
	Tobacco			–	
Problem concep-tualisation – from direct/ specific strategic documents	Illicit drugs	–	1	1	No formal con-ceptualisation for all substances – not coherent
	Alcohol		–	1	
	Tobacco			–	
Problem concep-tualisation – from the related stra-tegic documents	Illicit drugs	–	5	5	
	Alcohol		–	5	
	Tobacco			–	
Overall/average mark for marker 1A	Illicit drugs	**–**	**3**	**2.8**	
	Alcohol		**–**	**4**	
	Tobacco			**–**	

Appendix II. Legislative/regulatory framework

In this marker too some sub-themes were created and assessed. Existence of laws and adherence to international conventions were the first two, followed by specific provisions in the main laws, which were then marked individually.

Table II.1: List of sub-themes that could be assessed in marker 2

	Illicit drugs	Alcohol	Tobacco
List of main national documents forming legislative framework of substance use policies	Act No. 379/2005 Coll. on measures for protec-tion from harm caused by tobacco products, alcohol and other addictive substances Act. No. 40/2009, Coll., the Penal Code – effective on 1 January 2010 Act No. 200/1990 Coll. on misdemeanours Act No. 167/1998 Coll. on addictive substances	Act No. 379/2005 Coll. on measures for pro-tection from harm caused by tobacco products, alcohol and other addict-ive substances Act No. 40/1995 Coll. on advertisement regulation	Act No. 379/2005 Coll. on measures for protection from harm caused by tobacco products, alcohol and other addict-ive substances Act No. 40/1995 Coll. on advertisement regulation

	Illicit drugs	Alcohol	Tobacco
Adherence to international conventions *Note: detailed assessment not possible in this pre-pilot study*	1961 Single Convention on Narcotic Drugs 1971 Convention on Psychotropic Substances 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	Global WHO Strategy to Reduce Harmful Use of Alcohol European Alcohol Action Plan 2012-20	WHO Framework Convention on Tobacco Control
Examples of law provisions	See the description of interventions set by law in the section of the chapter on marker 3		

Table II.2: Coherency of policies on psychoactive substances in different aspects of marker 2 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Existence of a law	5	5	5	The question for me here is should we mark only the single existence of a law itself? How? Does not make sense to me
Adherence to international conventions	4	2	3	
Interventions set by laws:				
Legal age – 18	–	4	4	In number of countries it is 21 – the evidence shows the higher the better
Ban on smoking (protection from public smoking)	–	–	2	No absolute ban on smoking in restaurants and other public places – not coherent
Ban on smoking in the workplace	–	–	3	
Ban on working under influence of alcohol and other psychoactive substances	5	5	–	
Regulation of alcohol and tobacco retail	–	2	2	Not satisfactory – the sale is not conditional on holding a licence
Short intervention by a medical doctor	5	5	5	

	Illicit drugs	Alcohol	Tobacco	Notes
Policy on excise taxes	–	3	3	
Advertising	–	1	4	Weak restriction for alcohol, better restriction for tobacco – not coherent
Driving under influence	5	5	5	Zero tolerance
Differentiation of drugs	4	–	–	
Use in small quantity a misdemeanour	4	–	–	
Overall/average mark for marker 2	**4.6**	**3.5**	**3.6**	

Table II.3: Coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 2 among each other (5 = very coherent, 1 = not coherent)

		Illicit drugs	Alcohol	Tobacco	Notes
Existence of a law	Illicit drugs	–	5	5	The question for me here is should we mark only the single existence of a law itself? How? Does not make sense to me.
	Alcohol		–	5	
	Tobacco			–	
Adherence to international conventions	Illicit drugs	–	2	2	Illicit drug policy adheres to international documents but the legal drug policy doesn't really – therefore there is no coherency between legal and illegal drug policies.
	Alcohol		–	3	
	Tobacco			–	
Legal age – 18	Illicit drugs	–	4	4	Could we say that if the legal age is 18 it is also coherent in terms of illicit drugs policy? If it were 21 the marker would be 5 (??)
	Alcohol		–	5	
	Tobacco			–	
Ban on smoking (protection from public smoking)	Illicit drugs	–	–	2	
	Alcohol		–	3	
	Tobacco			–	

		Illicit drugs	Alcohol	Tobacco	Notes
Ban on smoking in the workplace	Illicit drugs	–	–	–	
	Alcohol		–	–	
	Tobacco			–	
Ban on working under influence of alcohol or other psycho-active substance	Illicit drugs	–	–	–	
	Alcohol		–	5	
	Tobacco			–	
Regulation of alcohol and tobacco retail	Illicit drugs	–	2	3	
	Alcohol		–	3	
	Tobacco			–	
Short inter-vention by a medical doctor	Illicit drugs	–	5	5	
	Alcohol		–	5	
	Tobacco			–	
Policy on excise taxes	Illicit drugs	–	–	–	
	Alcohol		–	2	
	Tobacco			–	
Advertising	Illicit drugs	–	2	3	?
	Alcohol		–	1	
	Tobacco			–	
Driving under the influence	Illicit drugs	–	5	–	?
	Alcohol		–	–	
	Tobacco			–	
Differentiation of drugs	Illicit drugs				?
	Alcohol				
	Tobacco				
Use in small quantity a misdemeanour	Illicit drugs				?
	Alcohol				
	Tobacco				
Overall/average mark for marker 2	Illicit drugs	**–**	**3.6**	**3.4**	
	Alcohol		**–**	**3.3**	
	Tobacco			**–**	

Appendix III. Strategy/action plans

Because there is no specific strategic document for alcohol and tobacco, the related document *Health for all in the 21st century* was assessed. This was also why sub-themes or aspects of proposed markers should be assessed/taken into account to gain an objective assessment.

Table III.1: List of sub-themes that could be assessed in marker 3

	Illicit drugs	Alcohol	Tobacco
Specific national strategy	National Drug Policy Strategy 2010-18	No	No
Specific national action plan	Drug Policy Action Plan 2010-12	No	No
Related strategic documents	*Health for all in the 21st century*	*Health for all in the 21st century*	*Health for all in the 21st century*
Goals of main strategic documents	<u>For the drug strategy</u> Purpose: – To ensure protection of individuals and society from health, social and economic risks of harm which drug use may cause, and to secure individuals, society and property against the consequences of crime associated with drug trafficking and use Goals: – To reduce the level of experimental and occasional drug use, particularly among young people – To reduce the level of problem and intensive drug use – To reduce potential drug-related risks to individuals and society – To reduce the availability of drugs, particularly to young people	No	No

	Illicit drugs	Alcohol	Tobacco
	For the action plan No goals set, but priorities: – To implement interventions aimed at reducing the high level of cannabis use, and also of other legal and illegal drugs; – To address high levels of problem use of opiates/pervitin by developing and applying specific programmes tailored to the users of these drugs; – To strengthen drug policy in relation to legal drugs (alcohol and tobacco), primarily in terms of policy and co-ordination mechanisms and treatment; – To develop and improve the drug policy's overall legislative, financial and co-ordination mechanisms		
Goals of related strategic documents	For *Health for all in the 21st century* Goal 12: Reduce harms related to drugs, alcohol, tobacco; by 2015, significantly reduce negative consequences of psychoactive substances such as tobacco, alcohol and drugs. Goal 12.3: Decrease the spread of drugs by at least 25% and drug-related morbidity by 50%.	For *Health for all in the 21st century* Goal 12: Reduce harms related to alcohol, drugs and tobacco; by 2015, significantly reduce negative consequences of psychoactive substances: tobacco, alcohol, drugs. Goal 12.2: Cut alcohol consumption per capita to maximum of 6 litres/year (for those younger than 15 years, it should be zero).	For *Health for all in the 21st century* Goal 12: Reduce harms related to tobacco, drugs and alcohol; by 2015, significantly reduce negative consequences of psychoactive substances: tobacco, alcohol, drugs. Goal 12.1: Over 15 years increase non-smokers to 80% of population, and 100% of those under 15.

	Illicit drugs	Alcohol	Tobacco
Activities	Drug Policy Action Plan has 105 activities in eight intervention areas. Assessing all 105 is beyond the scope of this pre-pilot study. *Health for all* contains eight activities: one legislative (drug driving), one in the field of treatment (accessibility and availability of treatment, counselling and harm reduction) and six in prevention (development of targeted specific prevention programmes at school, provision of financial support for NGOs active in drug prevention, develop departmental (Ministry of Health) education programme of drug prevention, realise prevention campaign, conduct drug testing in the workplace, to finance and evaluate drug prevention activities)	*Health for all* has 12 activities: six aimed at co-ordination and legislative framework (establish co-ordination and monitoring body, develop national alcohol programme, targeted tax policy, legislate for drunk driving, ban advertisements, define responsibilities of alcohol vendors in law). The other activities are preventive (develop specific targeted programmes at school, financial support for NGOs active in alcohol prevention, develop education programme of alcohol prevention for Ministry of Health, realise prevention campaign, conduct alcohol testing in the workplace) apart from one activity aimed at treatment (create network of out- and inpatient facilities).	*Health for all* has eight activities: five to develop legislative interventions (ban advertising, protection from passive smoking, targeted tax policy, develop specific law for protection from harm caused by tobacco products, alcohol and other addictive substances (375/2009), develop legislation in the field of prevention). One focuses on media campaigns, one aims to establish a co-ordination and monitoring body for tobacco policy; only one activity is aimed at the accessibility and availability of treatment.

	Illicit drugs	Alcohol	Tobacco
		Note: a problem with this document and its activities is that it was not evaluated, and most of the activities were not implemented at all. So in real praxis this document has had little impact (personal opinion).	
Last actualisation	In 2010; actualisation of the action plan was under way in 2012	2002 (2004?)	2002 (2004?)
Evaluation/ monitoring of implementation	Regular/mid-term evaluation of action plan (every year or 18 months). Drug policy is evaluated and actualised regularly every three years by developing new drug action plan.	Not done. Monitoring, evaluation and actualisation of goals and interventions was planned for 2010 but this was not finished; in 2011 no such activities were conducted.	Not done. Monitoring, evaluation and actualisation of goals and interventions planned for 2010 was not finished and in 2011 no such activities were conducted.

Table III.2: Coherency of policies on psychoactive substances in different aspects of marker 3 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Specific strategic documents	5	1	1	Existence of a strategic document is a sound basis for successful policy implementation. How to assess/mark the (non)existence of such a document? Should this be part of the assessment?
Related strategic documents	3	3	3	
Goals of main strategic documents	5	1	1	
Goals of related strategic documents	4	4	4	
Activities	3	3	3	
Last actualisation	5	2	2	If policy is not revised periodically, it cannot react flexibly to the changing drug situation. Should this be part of the assessment?
Evaluation/monitoring of implementation	4	1	1	
Overall/average mark for marker 3	**4.1**	**2.1**	**2.1**	

Table III.3: Coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 3 among each other (5 = very coherent, 1 = not coherent)

		Illicit drugs	Alcohol	Tobacco	Notes
Specific strategic documents	Illicit drugs	–	1	1	No specific document for either legal drug – is this coherent between these two policies?
	Alcohol		–	5	
	Tobacco			–	
Related strategic documents	Illicit drugs	–	5	5	
	Alcohol		–	5	
	Tobacco			–	

		Illicit drugs	Alcohol	Tobacco	Notes
Goals of main strategic documents	Illicit drugs	–	1	1	No specific document for either legal drug – is this coherent between these two policies?
	Alcohol		–	5	
	Tobacco			–	
Goals of related strategic documents	Illicit drugs	–	4	4	
	Alcohol		–	4	
	Tobacco			–	
Activities	Illicit drugs	–	3	3	
	Alcohol		–	3	
	Tobacco			–	
Last actualisation	Illicit drugs	–	2	2	
	Alcohol		–	5	
	Tobacco			–	
Evaluation/ monitoring of imple-mentation	Illicit drugs	–	2	2	
	Alcohol		–	5	
	Tobacco			–	
Overall/average mark for marker 3	Illicit drugs	–	**2.6**	**2.6**	
	Alcohol		–	**4.5**	
	Tobacco			–	

Appendix IV. Structures/resources

In order to incorporate information on the functioning of established bodies such as monitoring or co-ordination bodies, an attempt was made to define one sub-theme/ aspect as “Outputs available” (as a proposal).

Table IV.1: List of sub-themes that could be assessed in marker 4

	Illicit drugs	Alcohol	Tobacco
Main body/institution responsible for co-ordination and implementation of a policy	Main co-ordination body is the Government Council for Drug Policy Co-ordination. Its main areas of activity: development of a comprehensive national strategy, its co-ordination and collaboration in implementation at the central and local levels. Its members are the heads of the ministries involved in dealing with the issue of drugs (Health, Interior, Education, Youth and Sports, Labour and Social Affairs, Justice, Defence and Finance), Association of Non-Governmental Organisations, Society for Addictive Diseases of the J. E. Purkyne Czech Medical Association and an expert nominated by the prime minister. The executive is in the Office of the Government.	The main political body and responsible institution for issues of alcohol is the Ministry of Health. It is responsible for legislation on protection against the harm caused by tobacco products, alcohol and other addictive substances, and the treatment of addictive diseases. Its other duties include provision and funding of drug treatment, reduction of health risks, provision of education and interventions promoting healthy lifestyles and professional training for health practitioners.	The main political body and responsible institution for issues of tobacco is the Ministry of Health. It is responsible for legislation on protection against harm caused by tobacco products, alcohol and other addictive substances, and the treatment of addictive diseases. Its other duties include provision and funding of drug treatment, reduction of health risks, provision of education and interventions promoting healthy lifestyles and professional training for health practitioners.

	Illicit drugs	Alcohol	Tobacco
Co-ordination mechanisms, e.g. working groups	The Government Council has several committees and working groups to implement the illicit drug policy: committees of departmental and institutional representatives dealing with different aspects of drug policy, for funding drug services, for certification/quality assurance of drug services, of regional representatives and Advisory Committee for Drug-Related Data Collection.	No specific permanent working groups exist; there are ad hoc working groups.	No specific permanent working groups exist.
Body responsible for monitoring and evaluation	National Monitoring Centre for drugs and drug addiction, at the Government Council in the Office of the Government.	National Monitoring Centre for alcohol and tobacco at the Ministry of Health – National Institute of Public Health.	National Monitoring Centre for alcohol and tobacco at the Ministry of Health – National Institute of Public Health.
Outputs of monitoring available	Systematic and regular data collection. Regular studies mapping core issues of drug problem. Annual Report on the drug situation in CZ. Better situation in financial and personal resources so far (but not ideal).	No systematic data collection. Ad hoc studies but their results are hard to find on the Internet or elsewhere. No annual report on alcohol consumption or interventions. Strong financial constraints.	No systematic data collection. Ad hoc studies but their results are hard to find on the Internet or elsewhere. No annual report on tobacco use or interventions. Strong financial constraints.
Co-ordination at regional level	One of the possible aspects (sub-themes) that could be assessed. I did not study it for this pre-pilot study.		

Table IV.2: Coherency of policies on psychoactive substances in different aspects of marker 4 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Main body/institution responsible for co-ordination and implementation of a policy	4	5	5	
Co-ordination mechanisms, e.g. working groups	4	2	1	
Body responsible for monitoring and evaluation	5	5	5	
Outputs of monitoring available	5	2	2	
Co-ordination at the regional level	–	–	–	
Overall/average mark for marker 4	**4.5**	**3.5**	**3.3**	

Table IV.3: Mutual coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 4 (5 = very coherent, 1 = not coherent)

		Illicit drugs	Alcohol	Tobacco	Notes
Main body/institution responsible for co-ordination and implementation of policy	Illicit drugs	–	5	5	
	Alcohol		–	5	
	Tobacco			–	
Co-ordination mechanisms, e.g. working groups	Illicit drugs	–	2	1	No working groups for legal drugs – therefore coherency (?)
	Alcohol		–	4	
	Tobacco			–	
Body responsible for monitoring and evaluation	Illicit drugs	–	5	5	
	Alcohol		–	5	
	Tobacco			–	
Outputs of monitoring available	Illicit drugs	–	2	2	
	Alcohol		–	5	
	Tobacco			–	
Co-ordination at regional level	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Overall/average mark for marker 4	Illicit drugs	–	**3.5**	**3.3**	
	Alcohol		–	**4.8**	
	Tobacco			–	

Appendix V. Responses/interventions

For illicit drugs, in the area of harm reduction, it has already been evaluated that these are effective.

Table V.1: List of sub-themes that could be assessed in marker 5

	Illicit drugs	Alcohol	Tobacco
Price and taxes	–	The Czech Republic is one of the countries with lower excise taxes, lower than the European average. However, among the newly accessed countries after 2004, the Czech Republic is one of the countries with higher taxes.	
Decrease the density of retail outlets	–	No regulation	No strict regulation (see the chapter on legal framework)
Decrease the hours of sale	–	No restriction	No restriction
Restriction of advertising	–	Weak regulation: see section on legislative/regulatory framework	Regulation of advertising in place: see section on legislative/regulatory framework
Driving under influence	Zero tolerance	Zero tolerance	–
Low-threshold facilities	Good coverage with low-threshold facilities	–	–
Outreach programmes	Good coverage with outreach programmes	–	–
Application rooms	No application rooms so far in the Czech Republic	–	–
Substitution treatment	Methadone treatment only in specialised treatment centres. Buprenorphine substitution treatment with good accessibility through the network of practitioners		Substitution substances with good availability
etc.			

Table V.2: Coherency of policies on psychoactive substances in different aspects of marker 5 in terms of the main goal – health and well-being of an individual (5 = very coherent, 1 = not coherent)

	Illicit drugs	Alcohol	Tobacco	Notes
Price and taxes	–	3	3	
Decrease the density of retail outlets	–	1	1	
Decrease the hours of sale	–	1	1	
Restriction of advertising	–	2	4	
Driving under influence	5	5	–	
Low-threshold facilities	5	–	–	
Outreach programmes	5	–	–	
Application rooms	1	–	–	
Substitution treatment	5		5	
etc.	–	–	–	
Overall/average mark for marker 5	**4.2**	**2.4**	**2.8**	

Table V.3: Mutual coherency of policies on psychoactive substances in different aspects (sub-themes) of marker 5 (5 = very coherent, 1 = not coherent)

		Illicit drugs	Alcohol	Tobacco	Notes
Price and taxes	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Decrease the density of retail outlets	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Decrease the hours of sale	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Restriction of advertising	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Driving under influence	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	
Low-threshold facilities	Illicit drugs				
	Alcohol				
	Tobacco				

		Illicit drugs	Alcohol	Tobacco	Notes
Outreach programmes	Illicit drugs				
	Alcohol				
	Tobacco				
Application rooms	Illicit drugs				
	Alcohol				
	Tobacco				
Substitution treatment	Illicit drugs				
	Alcohol				
	Tobacco				
etc.	Illicit drugs				
	Alcohol				
	Tobacco				
Overall/ average mark for marker 5	Illicit drugs	–			
	Alcohol		–		
	Tobacco			–	

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Chapter 3

Hungary – Coherent addiction policies: piloting a diagnostic tool

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This study and the conclusions drawn from it do not necessarily reflect the opinion of the Hungarian Government.

The Pompidou Group in its 2011-14 Work Programme continued the research activities of previous years, concentrating on policy issues by identifying effective approaches to coherent policies for licit and illicit drugs. In previous years the Research Platform and ad hoc expert groups had launched a series of publications dealing with effective policy making and investigated the question: which policy solutions seem to be the more efficient in the addiction field?

The current project is trying to pilot a diagnostic tool for coherency to systematically investigate national addiction policies. The criteria of the proposed diagnostic tool are the consequences of previous research and analytical activities (Muscat et al. 2008, 2012). This is the first time that Hungary has participated in this ad hoc expert group with the ambition to contribute to the development of usable methodology to gauge coherency by conducting a diagnostic check on existing and prospective public policies in the addictions field.

This report consists of two parts: the first describes the analysis of the coherence of public policies related to addictions (illicit drugs, alcohol and smoking) according to a predefined set of criteria based on publicly available relevant documents; the second outlines the conclusions of the focus group discussions with public officials and non-public official professionals.

Both parts of the study brought to light the fact that at the moment there are no comprehensive addiction policies in place and – at the same time – that there is general agreement that coherence among addiction policies is of the utmost importance. However, the study also highlighted the fact that all the documents (legislative measures, strategic plans, action plans even if they are not in force) which guide the activities of professionals are in line with the WHO founding statement: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946).

Apart from describing the situation, we have also suggested some slight modifications based on our experience of the analytical tool.[1]

Introduction

Hungary joined the Coherent Policy Expert Group in 2012, after the initial period during which several pilot and pre-pilot case studies were written and partly discussed during the expert group meetings (Muscat et al. 2012).

The issue covered by the expert group is of the utmost importance for those who are involved and interested in public policy research/analysis because most scientific evidence suggests that different addiction problems can be seen and tackled under the same umbrella. Already existing results support the interpretation of addiction disorders in a common conceptual frame (Frascella et al. 2010; Demetrovics and Kun 2010). From this point of view it is highly relevant to see if there is a global, unifying underpinning (or over-arching) philosophy that can properly and efficiently connect the different addiction policies at national and international level.

To find an appropriate set of criteria according to which the consistency of these policies can be checked is also an interesting and important methodological aspect of the problem. Therefore, in our understanding, the exercise being reported in the current study serves at least two different aims:

- to describe the current situation in Hungary in relation to these policies;
- to see if the criteria/markers defined in the previous phases are appropriate and feasible for the purpose.

Historical background

There is a long history of addiction problems in Hungary, and a very high prevalence rate can be detected in drinking and tobacco use in the Hungarian population, while illicit drug use is still moderate with a tendency towards steady increase (detailed prevalence data are presented below, under the section: State of the problem).

Hungary has never had an independent alcohol or smoking strategy, though since 2000 we have had a drug strategy. Alcohol and smoking issues were presented and planned as being tackled within the framework of a national public health strategy. This public health strategy (approved by parliament in 2003) has never been fully implemented, partly or mostly because of limited financial resources. This national public health strategy expired in 2013; it is said that a new strategy is now under development.

An alcohol-related strategic plan was developed in 2009, but it remained just a plan; there was no official approval and no related action plan was developed.

Tobacco use was considered to be part of the aforementioned national public health programme. Tobacco-related legislation in line with EU directives was implemented in different steps.

1. The present study would not have been possible without the kind support and help of the focus group participants who devoted their precious time to this endeavour.

Hungary's first national drug strategy was approved by parliament at the end of 2000, and implementation started in 2001. This strategy was meant for a nine-year period, so it expired at the end of 2009. By that time a new strategy had been developed and approved by parliament. The implementation of it did not start at all as a new government came into power and their understanding of the drugs phenomenon was different from that of the previous government. After three years, a new strategy was agreed by the government and passed to parliament for approval.

Apart from the strategic initiatives, we must mention other policy documents that mention and/or plan to tackle addiction-related problems, among them the crime prevention strategy (now expired), the youth strategy and a comprehensive plan to help the renewal of health-care services (the Semmelweis Plan). The concept of and legislation on social care also deal with addiction-related issues but just from a particular perspective.

Over-arching and comprehensive policy documents or strategies dealing with illicit drugs, alcohol and tobacco use are not in force currently, though laws and by-laws relevant to these fields are in force (see below); we hope they efficiently contribute to tackling the problem.

The method we used

As we described in the previous section none of the fields in question are covered by a comprehensive and functional strategy at the moment. To be able to carry out the exercise, we could make use of three different data sources.

- To describe the state of the problem we could rely on regular data collections (in the case of illicit drugs, the national reports inform us about trends and tendencies in the prevalence and severity of the drugs problem); we could also use research data, which we hoped would inform us about the prevalence of alcohol and tobacco use in the general population and among young people. In the case of alcohol and tobacco use, apart from targeted research, we looked for mortality data directly linked with these substances (lung cancer mortality data, liver cirrhosis mortality data).
- To check if the WHO statement was present in the policy documents we did document analysis on those strategic documents which, though probably not in force any more, still have an impact on day-to-day operation of professional groups.
- Because there are no comprehensive policy documents in force, we wanted to get acquainted with the perceptions of professionals in the field and responsible public officers on the current situation and especially on the perceived consistency of the measures, structures and finances related to the fields in question. In order to get this information, three focus groups were organised with the participation of professionals/experts (service providers, representatives of treatment agencies, of local co-ordination forums on drugs and alcohol, researchers, responsible public officers).

In the following sections, we describe our experiences according to the pre-negotiated structure of markers (see analysis below) and then the experiences we gathered

during the focus group meetings (qualitative study). The first section is rather an expert opinion, whereas the second section is based on qualitative research findings (focus group discussion).

The study was carried out by the Eötvös Loránd University, Institute of Psychology, Doctoral School of Psychology. No financial support was provided for this task; the research activity was done by Katalin Felvinczi PhD, associate professor, and by two students of the Doctoral School: Ms Anna Péterfi and Ms Anna Magi. The study and the conclusions drawn do not necessarily reflect the opinion of the Hungarian Government.

The analysis

State of the problem

National statistics on illicit drugs

The National Focal Point on drugs (part of the REITOX network) was established in 2004. Since then the drug situation has been reported on in detail by this agency on a yearly basis. To describe the current drug situation we are using the text and figures (verbatim citations) and data from the annual report of 2012 (it contains relevant figures for 2011).[2] The information is provided according to key epidemiological indicators (GPS=general population surveys, PDU=problem drug use, TDI=treatment demand indicator, DiD=drug-related infectious disease, DRD=drug-related death).

General population surveys (GPS)

Drug use in the school and youth population

When the fifth survey of the ESPAD series was carried out in 2011 (Elekes 2011), 19.9% of the 16-year-old pupils interviewed had already used illicit drugs in their lives. The differences by gender were not significant: among boys the proportion was 20.9%, while among girls it was 18.9%. The proportion of those who had used any substance with the purpose of abuse was higher, at 24.9%. The lifetime prevalence of the use of substances with the purpose of abuse was 26% among boys and 23.7% among girls. (The difference is not significant.) The lifetime prevalence of the misuse of medicines was significantly higher among girls (18.7%) than boys (11.1%). The lifetime prevalence relating to the entire sample was 14.7%.

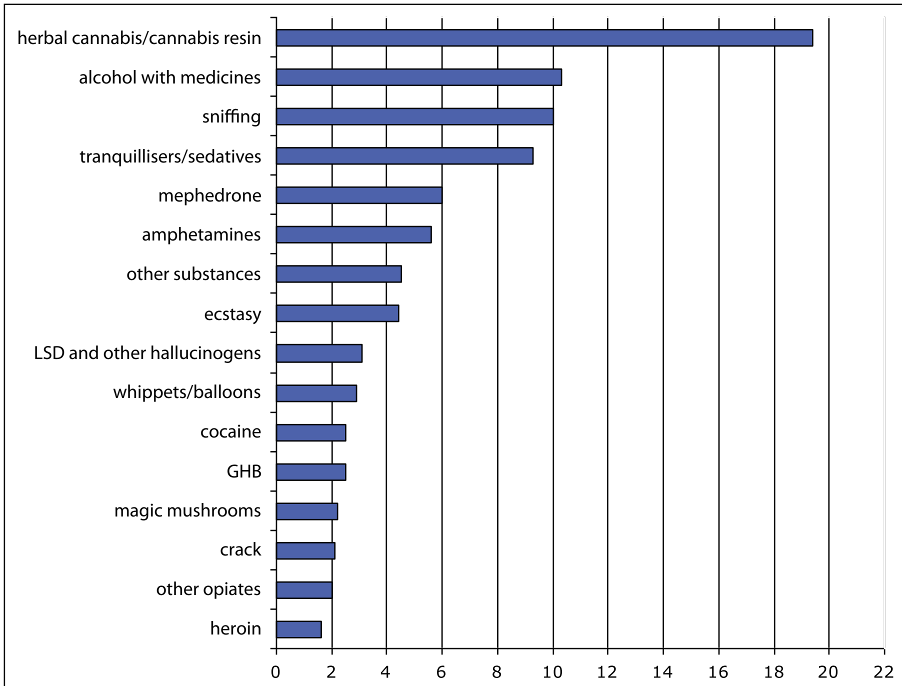
Among the 16-year-old pupils interviewed, the lifetime prevalence of all (illicit and licit) substance use was 28.8%, averaging 28.3% of boys and 29.4% of girls.

As in previous years, on the basis of lifetime prevalence, in 2011 the most commonly used drug among young people was cannabis. Also as in earlier years, after cannabis, the most commonly used drugs were licit substances: alcohol combined with medicines, inhalants and tranquillisers/sedatives without prescription.

2. See http://drogfokuszpont.hu/wp-content/uploads/HU_National_Report_2012.pdf.

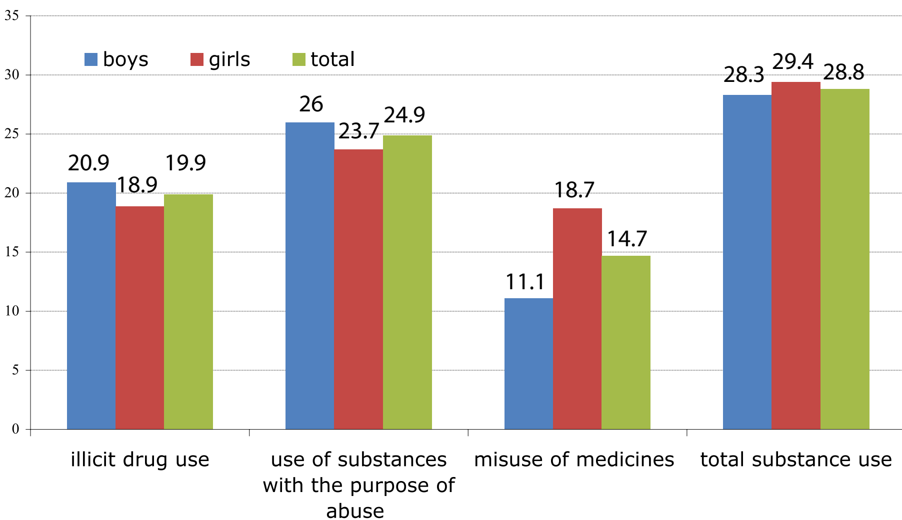
Mephedrone – included in the questionnaire for the first time in 2011 – was in fifth position. It was followed by amphetamines, other substances and ecstasy.

Figure 3.1: Lifetime prevalence by drugs among 16-year-old pupils in 2011 (%)



Source: Elekes (2011)

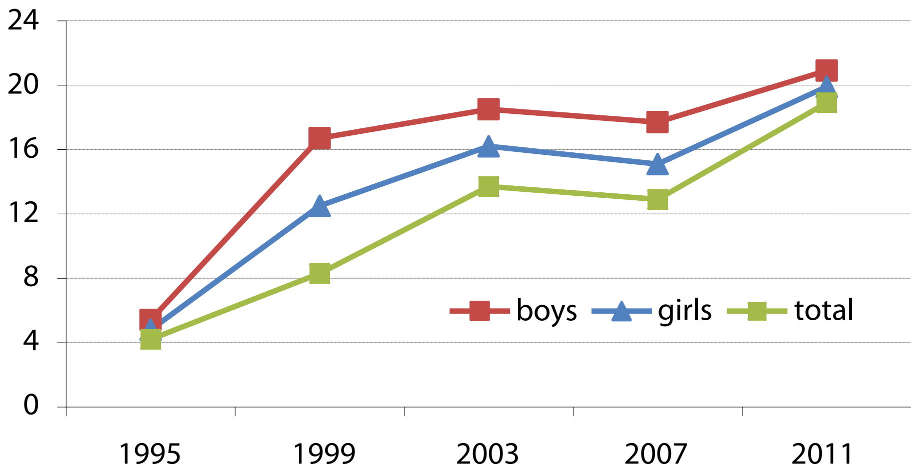
Figure 3.2: Lifetime prevalence of different types of drugs among 16-year-old pupils in 2011, by gender (%)



Trends

The total lifetime prevalence of illicit drug use increased fourfold in Hungary between 1995 and 2003. At the beginning this increase was more significant among boys, while between 1999 and 2003 it was more significant among girls. In 2007 the proportion of those who had ever tried illicit drugs dropped slightly among boys and girls. The data collection in 2011 indicated a further significant increase in the lifetime prevalence of all illicit drug use. It increased by 3.2 percentage points among boys and by 6 percentage points among girls.

Figure 3.3: Change in lifetime prevalence of illicit drug use among 16-year-old pupils between 1995 and 2011, by gender (%)



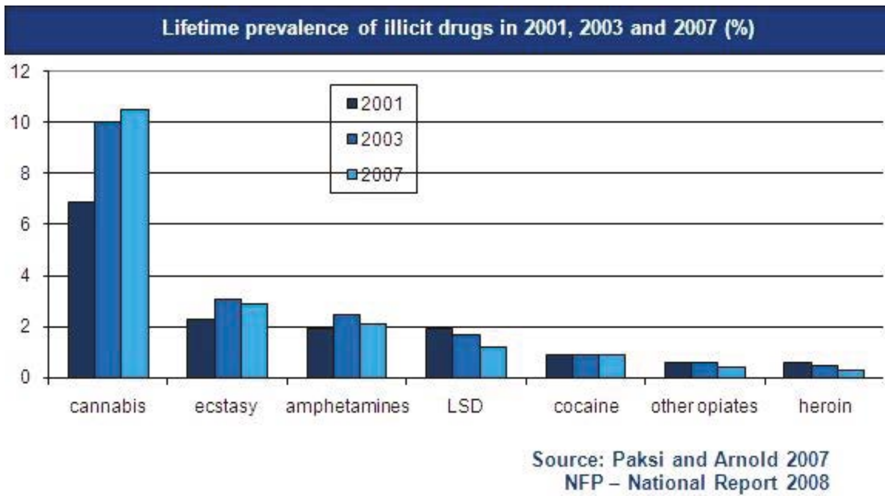
Source: Elekes (2011)

Drug use and trends among adults

According to the results of a survey (Paksi and Arnold 2007) carried out in 2007 on a representative sample of the national adult population, 9.3% of the respondents aged 18-64 had already used an illicit drug in their lives. The last-year prevalence rate was 2.6%, and the last-month prevalence rate was 1.3%. Among young adults, drug use was similar to that observed among the population aged 18-64, the only difference being in the frequency of drug use: 20.9% of the population between the ages of 18 and 34 had already used an illicit drug in their lives, 6.4% in the last year and 3% of them in the last month.

On the basis of the prevalence rates of the general population, from surveys carried out in 2001, 2003 and 2007 and calculated for comparable ages (the population between the ages of 18 and 53) we can state: while between 2001 and 2003 the lifetime prevalence rate of illicit drug use increased significantly (by 3.6 percentage points) and the last-year prevalence rate also increased (by 0.9 percentage points), between 2003 and 2007 the lifetime prevalence rate did not change (in 2003 it was 11.1%; in 2007 it was 11.2%), and the last-year prevalence rate moved in a favourable direction (decreasing from 3.9% to 3.1%).

Figure 3.4: Lifetime prevalence of illicit drugs



Prevalence and problem drug use (PDU)

The definition of problem drug use (PDU) used in producing estimates is the same as the definition used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), that is, it relates to the occurrence of heroin, cocaine or amphetamine use. Therefore here the phrase "problem drug use" does not relate to an addiction, health or social problem; it simply indicates the use of one of the above three drugs at least once during the two-year period.

The last prevalence estimates covering all forms of problem drug use in one index were done in 2005 and they were published in the EMCDDA Statistical Bulletin.[3] Targeted research on this phenomenon was done later, but to show the relevant comparable data we are presenting the findings of that year. Table 3.1 is the edited version of the published data.

Treatment demand indicator (TDI)

According to TDI data for the year 2011, a total of 4 783 persons started treatment, and 3 222 of these persons (73%) started treatment for drug use for the first time in their lives. That year, 72% (3 453 persons) of all clients entering treatment started the treatment as an alternative to criminal prosecution.

Among all clients starting treatment the most commonly reported primary drug was cannabis (3 321 persons, 69% of all cases); the most common drug types were stimulants (786 persons, 16%) and opiates (325 cases, 7%).

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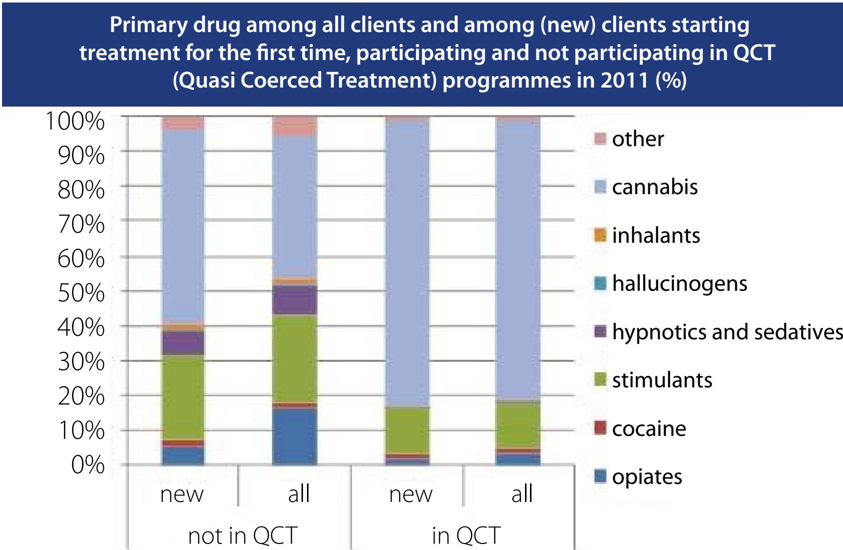
3. See www.emcdda.europa.eu/stats11/pdutab1a.

Figure 3.5: Primary drug among all and new clients

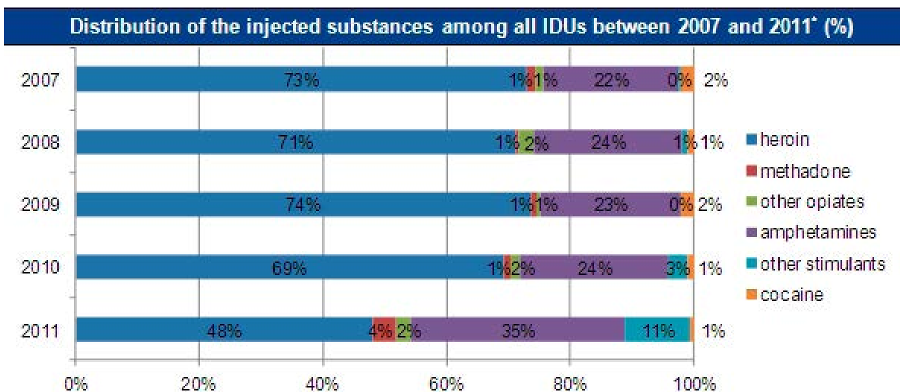


Source: TDI data collection (OAC); analysed by: NFP
Hungarian National Focal Point – 2012 National Report

Treatment demand:

A few years ago injecting was mostly associated with heroin use, but by 2011 this picture had changed significantly. Injecting drug users (IDUs) included nearly the same proportions of heroin users (48%) and stimulant users (46%, of which 35% used amphetamine, 11% used other stimulants). A slight increase was seen in the proportion of IDUs injecting methadone and other opiates. The dominant factor behind this was presumably lack of access to heroin.

Figure 3.6: Injected substances among all IDUs



* Taking into consideration users of opiates, amphetamines, other stimulants and cocaine, on the basis of the typical route of administration in the 30 days before entering treatment.

Source: TDI data collection (OAC); analysed by: NFP
Hungarian National Focal Point – 2012 National Report

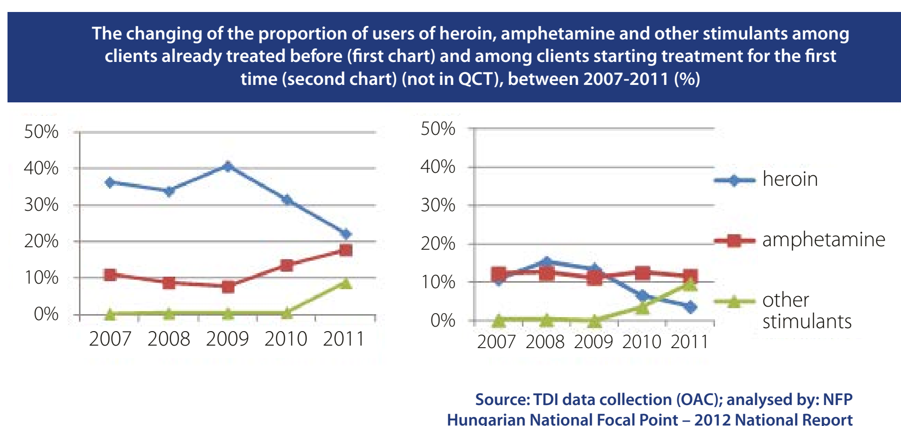
Table 3.1: Estimates of prevalence of problem drug use at national level: summary table, 2004-9, rate per 1 000 aged 15-64
([1]: The range of estimation from either confidence intervals or sensitivity analysis.)

Country	Year	Central rate	Estimated number of users	Max./min. prevalence estimates [1]		Target group, data sources and estimation methods
Czech Rep.	2009	5.04	37 400	33 300	41 500	Problem opioid and stimulant users. Low threshold facilities. Treatment Multiplier.
Denmark	2009	9.12	33 074	31 151	34 997	The target population are clients admitted to treatment for their drug problems over all. The National Patient Register. National Register of Drug Abusers Undergoing Treatment. Capture-recapture.
Germany	2008	n.a.	:	196 836	233 743	Problem opioid and stimulant users. National extrapolation from treatment data. Treatment multiplier.
Greece	2009	3.2	24 097	21 362	27 272	Problem drug users. Drug treatment data. Capture-recapture.
Spain	2008	1.3	40 015	37 904	42 730	Problem opioid users. Drug treatment and surveys data. Treatment multiplier.
France	2008	n.a.	:	144 000	367 000	Problem drug users. Health and socio-economic indicators drug treatment, surveys, criminal justice system, emergency services, general practitioners, low-threshold services, hospitals, social services, methadone programmes. Multivariate indicator method.
Italy	2009	10.0	393 490	382 500	404 500	Problem stimulant and opiate users. Treatment data. Treatment multiplier.
Cyprus	2009	2.5	1 398	1 182	1 688	Long-term/regular opioid and/or cocaine users. Treatment data. Truncated Poisson.
Latvia	2006	n.a.	:	4 794	9 588	Problem drug users. Treatment data. Treatment multiplier.
Lithuania	:	:	:	:		:
Luxembourg	2007	7.7	2 470	2 089	3 199	Problem drug users. Drug-related deaths, criminal justice system, drug treatment, infectious diseases registries and methadone programmes. Multi-methods: treatment multiplier, police multiplier, mortality multiplier, capture-recapture and truncated Poisson

Country	Year	Central rate	Estimated number of users	Max./min. prevalence estimates [1]		Target group, data sources and estimation methods
Hungary	2005	3.5	24 204	19 333	29 075	Problem drug users. Data from drug treatment and police records. Capture-recapture.
Malta	2006	5.4	1 606	1 541	1 685	Problem drug users defined as daily heroin users. Treatment data. Capture-recapture.
Austria	2009	4.6	25 777	24 867	26 687	(Poly-) drug use including opiates. Treatment and police data. Capture-recapture.
Poland	2005	4.2	112 500	100 000	125 000	Problem drug users. General population survey and treatment data. Benchmark method.
Portugal	2005	n.a.	:	30 833	53 240	Problem drug users. Treatment and mortality data. Treatment multiplier, outreach work teams multiplier.
Slovenia	2004	7.8	10 654	9 078	12 593	Problem opioid and stimulant users. Treatment and police data. Capture-recapture.
Slovakia	2008	2.7	10 519	8 182	33 489	Problem drug users. Low-threshold agencies. Multiplier method.
Finland	2005	4.8	16 600	14 500	19 100	Problem stimulant and opiate users. Hospital, criminal justice, infectious diseases data. Capture-recapture.
Sweden	2007	4.9	29 513	n.a.		Problem drug users. Inpatient treatment centres (hospitals, emergency services), Swedish Prison and Probation Service. Truncated Poisson with Chao's estimator.
United Kingdom	2004-7	10.1	404 884	396 267	431 120	Problem drug users. Treatment, population density, prison, drug-related deaths, drug offences, police, probation. Capture-recapture, multivariate indicator method.
Turkey	2008	0.5	25 853	21 573	51 456	Problem opioid users. Drug-related deaths. Mortality multiplier.

The changes in distribution by primary drug could be observed first among clients starting treatment voluntarily (i.e. not as an alternative to criminal procedure), which also affected the numbers of all other cases. Among clients entering treatment voluntarily on the basis of their treatment history, a drop was seen in the proportion and number of treatments because of heroin use, both among clients entering treatment for the first time and among clients previously treated. Treatment demand relating to the use of other stimulants increased in parallel. Among clients treated before, treatment demand arising from amphetamine use also increased. This may have been due to the wrong categorisation of cathinones, but it is also possible that some former heroin users have changed over to amphetamine.

Figure 3.7: Differences in drug use among clients previously treated and those entering treatment for the first time



The changing of the proportion of users of heroin, amphetamine and other stimulants among clients already treated before (first chart) and among clients starting treatment for the first time (second chart) (not in QCT), between 2007-2011 (%)

Source: TDI data collection (OAC); analysed by: NFP
Hungarian National Focal Point – 2012 National Report

Drug-related infectious disease (DiD)

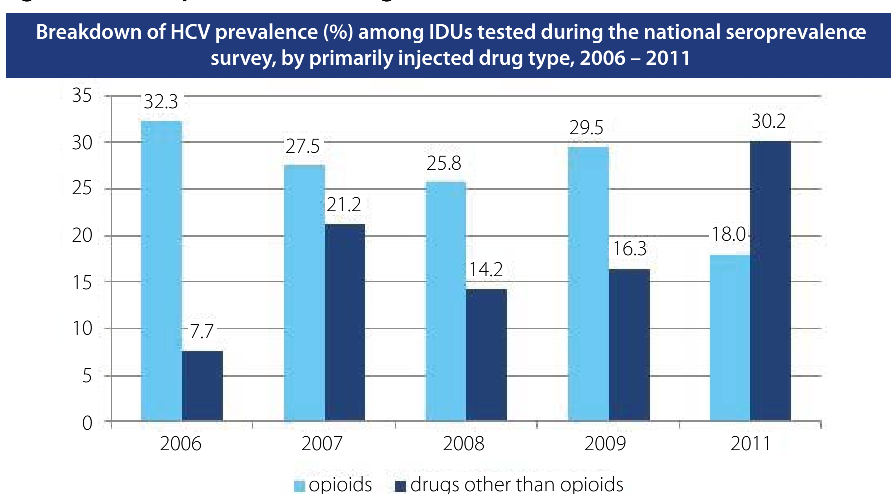
In 2011 in Hungary, 162 newly diagnosed HIV-positive cases were reported, an incidence rate of 16 cases per million inhabitants. The transmission route was known in the case of four fifths of the persons registered as HIV-positive. Within identified risk groups of HIV-positive persons and clients with AIDS, no one belonged to the risk group of IDUs. According to the results of the national seroprevalence survey conducted in 2011 by the National Centre for Epidemiology, none of the 666 IDUs tested positive for HIV.

In that year, 66 acute hepatitis B infections were reported, an incidence rate of 0.7‰. The risk group was known in the case of 18 patients, six of whom were IDUs. According to the 2011 national seroprevalence survey conducted by the National Centre for Epidemiology, three people (0.5%) tested positive for hepatitis B among 664 IDUs. In addition, 43 cases of acute hepatitis C infection were reported, an incidence rate of 0.4‰. The risk group was known in the case of 22 out of the 43 patients, 16 of whom probably became infected through injecting drug use; of those 16 patients, 62.5% were registered in Borsod-Abaúj-Zemplén county. From 2006 to 2010 an average of four IDUs were identified per year among registered cases of acute hepatitis C infection, but in 2011 there were 16. The 2011 national seroprevalence survey indicated

that 157 persons (24.1%) tested positive for hepatitis C among the 652 IDUs. The prevalence of hepatitis C among IDUs tested in Budapest was 34.2%; among IDUs tested outside Budapest, it was 9.9%. The difference between the infection ratios of men and women (21.9% and 30%) was significant.

By age, HCV prevalence was highest in those aged over 34 (26.5%). By length of use, HCV prevalence (33.6%) was highest in IDUs who first injected drugs 5 to 10 years earlier. Analysed by drug type in 2011, while in the previous four years significantly higher rates of hepatitis C were seen in primarily opioid injectors, 18% of IDUs primarily injecting opioids and 30.2% of those primarily injecting other drugs were HCV-positive. Probably this new pattern of HCV prevalence rates per drug type is a result of IDUs' tendency since 2010 to move from injecting opioids to injecting amphetamines or new psychoactive substances.

Figure 3.8: HCV prevalence among IDUs



Source: National Centre for Epidemiology and National Focal Point NFP HU – National Report 2012

According to the EMCDDA report, Hungary is one of the countries with the lowest prevalence of HIV and HBV. As for hepatitis C, Hungary belongs to the countries with low prevalence, if the national prevalence rate is considered.

Drug-related death (DRD)

In 2011 there were 14 deaths directly related to illicit drug use, a slight decrease on previous years (2010: 17 cases; 2009: 31 cases; 2008: 27 cases; 2007: 25 cases; 2006: 25 cases). Of the 14 direct drug-related deaths, 13 were men and one was a woman. In three cases there was intoxication by an opiate (excluding methadone or other drugs), in three cases other substances could be detected as well as opiate and in four cases fatal intoxication was caused by methadone. In three cases intoxication was caused by other non-opiate type substances; in these cases amphetamines could be detected. Intoxication caused by other drugs was recorded – in one case, death

was caused by inhaling organic solvent vapours – and cannabis was also detected in the biological samples. In 9 of the 14 cases polydrug use was detected.

The mean age of the persons who died because of direct overdose was 32.1 years. The youngest person to die was a 16-year-old female (overdose caused by other drugs); the oldest deceased person was a 52-year-old male (opiate overdose). Eight of the deceased persons had a place of residence in Budapest or its immediate conurbation, and two further homeless men died here too. In four cases the deceased persons lived in a large city other than Budapest.

Figure 3.9: Drug-related deaths

Direct drug-related death cases in 2011 (persons)

	2006	2007	2008	2009	2010	2011
Heroin	22	18	23	28	9	3
Methadone and other opiates	2	5	3	2	5	7
Amphetamines	0	1	1	1	0	3
Cocaine	1	0	0	0	3	0
Other illicit drugs	0	1	0	0	0	1
Illicit substances in total	25	25	27	31	17	14

Source: OAC 2012c
Hungarian National Focal Point – National Report 2012

National statistics on alcohol use

Data collection related to alcohol problems/use is much less systematised than for drugs. No single agreed method of data collection is applied consistently in Hungary. In the next section – unless otherwise mentioned – we present data that were used in drafting the alcohol policy plan. We also present data from national population surveys that primarily focused on drug use but also investigated alcohol and tobacco use in the general population.

Per capita alcohol consumption is considered to be a good indicator of the extent of any alcohol problem. Alcohol consumption in Hungary can be seen as very high for some decades in European and international comparisons. During the 1980s it was more than 13 litres of pure alcohol; it decreased a bit during the 1990s and after 2000 it stabilised at 11.4 litres.

Consumption of different alcoholic beverages

The pattern of alcohol use is very much different from that of other European countries. In Hungary the consumption of distilled spirits is outstandingly high within the total alcohol intake, amounting to more than 30% of all legally available alcoholic beverages. Such a high proportion can be found, apart from the former Soviet Union member states, only in Slovakia. In other European countries this percentage is much lower.

The characteristic features of this region (Hungary, former Soviet Union and Slovakia) are as follows: high level of per capita alcohol intake, high proportion and dominance of distilled spirits and high number of addicted persons, with a high percentage of at-risk alcohol consumers.

Epidemiological data – trends among young people

A great emphasis should be put on alcohol consumption among young people. The trends, according to the HBSC data, can be seen in tables 3.2 and 3.3.

Table 3.2: Lifetime prevalence of alcohol consumption, grades 5 to 11 (%)

		2002	2006	2010
Boys				
grades	5	39.5	46.8	44.0
	7	66.5	68.0	68.5
	9	89.3	85.6	86.3
	11	92.8	92.5	91.3
Girls				
grades	5	23.8	35.4	30.5
	7	58.1	64.6	61.5
	9	82.9	84.3	83.9
	11	91.3	93.0	90.6

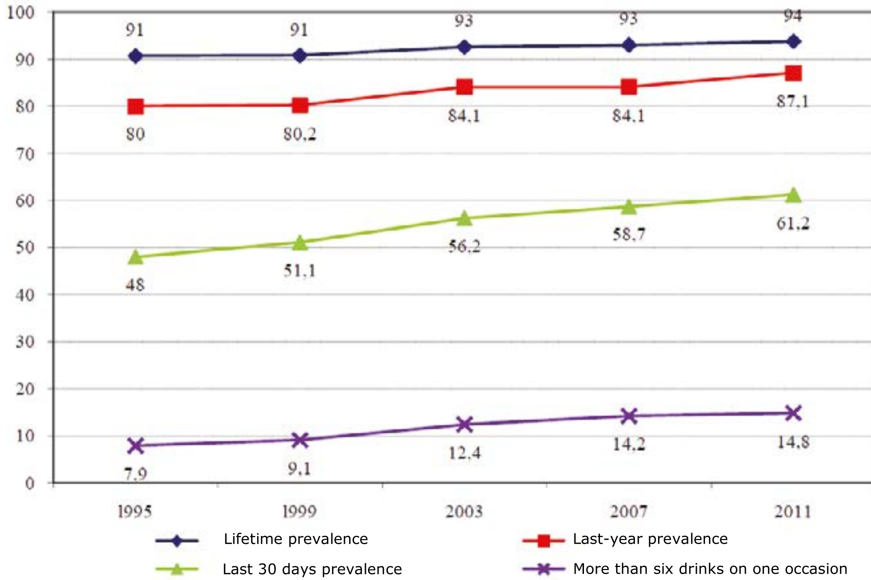
Table 3.3: Lifetime prevalence of being drunk at least twice, grades 5 to 11 (%)

		2002	2006	2010
Boys				
grades	5	3.7	4.0	4.1
	7	13.8	14.4	15.7
	9	48.3	46.9	50.5
	11	63.7	71.0	70.7
Girls				
grades	5	1.5	1.5	2.3
	7	7.4	10.2	7.4
	9	27.9	33.3	36.0
	11	40.8	51.3	54.5

Source: Aszmann (2001); Németh (2007); Németh and Költő (2011)

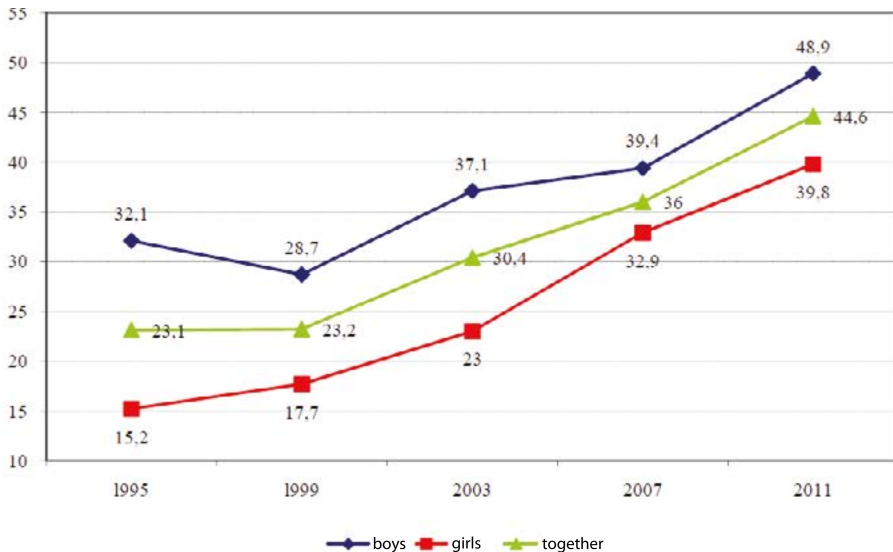
Based on the European School Survey of 2011 (ESPAD), we can identify the following: in the 30 days before the data collection, 57% of the respondents reported drinking alcohol and about 14% reported doing so more than once a week. If we look at the relevant indicators of alcohol consumption we can say that almost all prevalence data show an increase compared to 2007. Figure 3.10 summarises these data and trends (Elekes 2011).

Figure 3.10: Changes in alcohol consumption among 16-year-old students in Hungary, 1995-2011



Excessive drinking is an important indicator of alcohol consumption habits. It describes a problematic situation among Hungarian young people, as can be seen in Figure 3.11.

Figure 3.11: Excessive drinking among 16-year-old students in the last 30 days, Hungary 2011



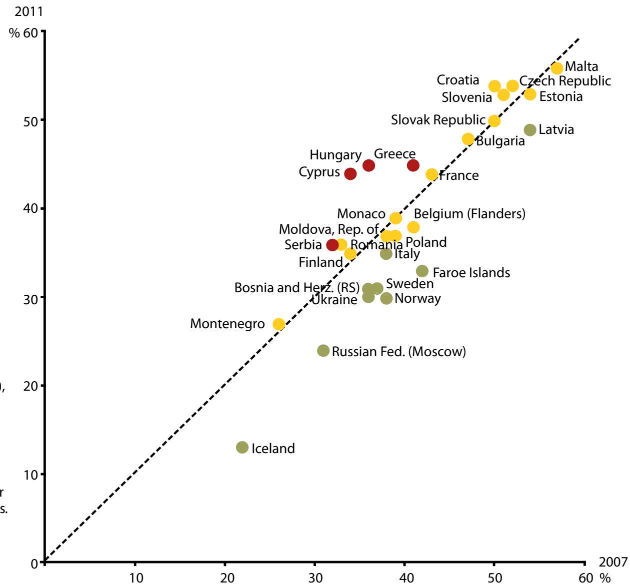
Source: Elekes 2011

We can see a steady increase in these prevalence rates from the mid-1990s onwards (Elekes 2011). Figure 3.12 reproduces a graph in the 2011 ESPAD report that shows Hungary's relative position as far as excessive drinking is concerned.[4] Hungary is among the very few ESPAD countries where this significantly increased between 2007 and 2011.

Figure 3.12: Alcohol and 16-year-olds, 2007-11

Changes between 2007 and 2011 in the proportion reporting having had five or more drinks[a] on one occasion during the past 30 days. All students. Percentages. (Table 56)

- Significant increase
- No change
- Significant decrease



[a] "A 'drink' is a glass/bottle/can of beer (ca 50 cl), a glass/bottle/can of cider (ca 50 cl), 2 glasses/bottles of alcopops (ca 50 cl), a glass of wine (ca 15 cl), a glass of spirits (ca 20 cl or a mixed drink)."

[b] In 1995-2003 the question refers to "five or more drinks in a row" and neither cider nor alcopops were included among the examples. However, a 2006 questionnaire test in eight countries found no significant differences between this and the recent version.

Source: B. Hibell et al., *The 2011 ESPAD report* (Strasbourg: Pompidou Group/Council of Europe 2012), p. 132.

Adult population

In Table 3.4 we can see the main epidemiological indicators related to alcohol consumption among the adult population. The data were collected in the Hungarian Population Survey on Addiction Problems in 2001, 2003 and 2007 (Paksi 2009).

Table 3.4: The main epidemiological indicators related to alcohol consumption by adults

	males			females			together		
	2001	2003	2007	2001	2003	2007	2001	2003	2007
Lifetime prevalence in %	91.4	90.7	90.8	73.6	79.9	81.4	82.4	85.3	86.1
Last-year prevalence in %	91.2	85.2	87.2	77.8	75.0	74.5	84.5	80.0	80.9
Last 30 days prevalence in %	74.8	70.2	70.6	42.8	42.3	44.6	58.5	56.1	57.7
Weekly alcohol consumption in %	42.9	43.4	36.9	11.6	12.3	10.7	26.9	27.7	23.9
Six or more drinks in the last year in %	38.9	34.4	45.5	9.2	9.0	14	23.3	21.0	29.7

4. www.espad.org/Uploads/ESPAD_reports/2011/The_2011_ESPAD_Report_FULL_2012_10_29.pdf.

	males			females			together		
	2001	2003	2007	2001	2003	2007	2001	2003	2007
Drunkenness in the last year in %	43.1	40.9	41.6	9.6	11.1	12.9	26.4	26.0	27.3
Drunkenness in the last month in %	12.8	16.8	17.4	1.9	3.9	3.7	7.3	10.3	10.6
Amount of alcohol consumed on the last occasion (pure alcohol in ml)	44.2	43.2	44.9	16.3	19.3	18.7	30.3	31.0	31.9

The prevalence of alcohol intoxication

We can say with a high level of certainty that at least 20% of the Hungarian adult population can be considered as heavy drinkers; in fact, 11% of all Hungarian men cannot control the amount they consume on different drinking occasions, and 6% reported losing control, rising to almost 9% of the middle-aged male population. In the case of females the situation is better (1.4%). Even at an optimistic estimate, we can say that different types of drunkenness happen about a million times per year in Hungary. Just a very small proportion of these cases appear in the Hungarian health-care system requesting detoxication. The great majority of these cases do not even require medical assistance. In Budapest and its surrounding area, the number of cases of acute alcohol intoxication in 2004 was 4 788, and in 2005 it was 5 072.

The prevalence of alcohol dependence

Based on the Jellinek formula, the estimated number of persons with alcohol dependence in 2004 was about 700 000 (the exact estimate is 692 352); 178 272 of them were females. This number is lower than that calculated for previous years, mainly due to changes in information gathering.

Alcohol-induced health burden – deaths related to alcohol use

The number of alcohol-related deaths per 100 000 inhabitants in Hungary was 129.47 in 2005. The figure in the Czech Republic was 80.96, in Slovakia 90.55 and in Poland 89.47. The EU mean (including recently joined countries) is 65.79. These figures are even more worrisome if we look at males exclusively. For every 100 000 Hungarian men, the alcohol-induced death rate was 211.36 in 2005. The figure in the Czech Republic was 125.42, in Poland 149.64, in Slovakia 152.95 and in the whole EU 101.71. In Hungary, alcohol-induced mortality in both genders is almost twice as high as the EU mean and 50% higher than in those countries that joined the EU in 2004 together with Hungary. In the whole EU, only the former member states of the Soviet Union are in a worse position than Hungary.

National statistics on smoking[5]

In the case of smoking and tobacco use we have to mention again – as with data on alcohol use – that there is no regular, well-structured method of data collection (unlike that for illicit substances). The data here are taken from the National Tobacco Focal Point website – www.fokuszpont.dohanyzasvisszaszoritasa.hu/en/content/responsibilities-focal-point-tobacco-control – as is (verbatim) the text that follows.

> In past years experts have tried to quantify the economic burden of smoking-related illnesses and deaths in Hungary, but a lack of basic data limited the accuracy of such estimates. The National Institute for Health Development initiated "The social burden of smoking" study to fill this gap in available data as well as to monitor the effects of the new smoke-free law.
>
> According to the study results, the proportion of daily smokers among men has declined since 2000, while there has been no major change in the proportion of women who smoke. The rate of women who smoke regularly has increased 1% since 2009. As of early 2012, 32.3% of men and 23.5% of women in Hungary smoke daily.
>
> The results also indicate that the number of cigarettes smoked has decreased by nearly 8% since 2009, while the proportion of rolled (rather than factory-made) cigarettes has increased significantly: in 2012 the number of rolled cigarettes was almost double, reaching one third of the total amount of cigarettes smoked.
>
> Passive smoking remains a significant problem: 12% of non-smokers reported that they inhale cigarette smoke at home; 7% are exposed to tobacco smoke at work or in restaurants and other closed public spaces; 5% reported that people smoke in waiting rooms despite the prohibition; and 21% are exposed to tobacco smoke while waiting for public transport at stops.
>
> Nearly two thirds of non-smokers (61%) agree that it should be forbidden to smoke in bars or pubs. The smoking ban in restaurants, workplaces and public transport is supported by 80% of non-smokers, and moreover endorsed by half of smokers.

Health and economic impacts – smoking

The report notes that half a million patients are treated in hospitals annually due to smoking-related diseases. In 2010, more than 20 000 people died as a direct result of smoking in Hungary. This means that 16 out of 100 deaths can be attributed to smoking. Women who smoke die 19 years prematurely, and men live at least 16 years less due to smoking.

> In 2010, tobacco-related state revenue exceeded HUF 360 billion (approximately 347 million euros), but societal expenditures related to smoking totalled HUF 441 billion. The balance of total individual and state income and expenditure thus gave rise to a loss of HUF 80 billion in 2010.

5. Source: www.euro.who.int/en/where-we-work/member-states/hungary/sections/news/2012/06/hungary-releases-new-data-on-the-social-burden-of-smoking.

Summary

In previous sections we tried to give an overview of the situation in Hungary for the different substances/addictions. We can say that the situation is far from being homogeneous. The drug situation is not severe, though there are signs which suggest that some worsening can be expected as lifetime prevalence data show some increase. Other indicators are quite moderate; Hungary can be proud of the low drugs-related death rate and the relatively low percentage of infectious disease among drug users. The alcohol situation is outstandingly bad if we compare our data with other EU member states. In the case of smoking/tobacco use, some favourable changes have been observed lately. The availability of data on the current situation informs us about the institutional framework that is supposed to tackle this problem. The structure of the available data, their accessibility and their methodological clarity are all tell-tale signs of the situation which will be further explored later on.

Context

We reviewed three policy documents that deal with drugs, smoking, alcohol and public health issues. The last-mentioned overlaps with the other three at some points. These documents were drafted at different periods and none of them are currently in force.

The drug strategy was drafted in 2011-13 and was approved by the government in July 2013.

The alcohol strategic plan was drafted in 2009; no political decision has been made about this document to date, though it is said that a new strategy will be launched soon.

The national public health strategy was originally approved by the government in 2001 and then revised, slightly restructured and confirmed by parliament in 2003. This strategy covers alcohol and tobacco-use issues as well; illicit drugs are mentioned but it is clearly stated that the national drug strategy of that period would take care of most such problems/issues mentioned in this document.

In the section below these strategic documents are briefly introduced; if the WHO statement is presented in them, the relevant parts are cited in a verbatim translation. The presentation follows chronological order.

The national public health strategy, 2003-13

The national public health strategy was initiated in 2001 and then, as its implementation was delayed, a new, slightly restructured version of it was produced, which later became a parliamentary decision having immense political support and commitment at that period. The document refers to many WHO documents, most frequently citing the *Health for All* programme (1981) and the Ottawa Charter (1986). As these documents have a direct link with the founding statement of WHO, we can confidently say that the document is very much in line with that statement.

The national public health programme tries to combine two different aspects while proposing action for improving the health status of the Hungarian population. It aims at implementing programmes and actions under four headings:

- the development and enhancement of health promoting/supporting social and political environments;
- lifestyle programmes to decrease the health risks of the population (interventions related to alcohol problems and tobacco use can be found under this heading);
- the prevention of avoidable morbidity and mortality;
- the development of the institutional conditions in the field of health-care services and public health.

The programme was meant for a 10-year period, starting in 2003. Actual implementation of it was not very successful as the necessary financial resources were not properly secured. The programme was strongly prone to budgetary cuts, and there was no clear budget defined for its implementation.

During the first few years of the implementation period, grant schemes were created to support implementation but the number of grants and the financial resources became more and more limited during the following years. The economic and financial crises affected this field badly, and most of the available resources were allocated to health-care services; no priority was given to issues related to public health or health promotion.

As has been mentioned, alcohol and tobacco use were presented under the umbrella of this comprehensive programme with specific aims. The goals and aims regarding smoking were:

- to decrease by 20% the amount of time spent in passive smoking conditions;
- to reduce the harm from passive smoking by limiting the number of public places where smoking is allowed;
- to appropriately implement existing rules and regulations in this regard;
- to increase the number of those in the population who have never smoked;
- to follow the EU and WHO directives on tobacco-use regulations;
- to decrease the public acceptance of smoking and the tobacco industry;
- to develop social conditions that encourage non-smoking behaviour as a social norm.

The goals and aims for alcohol use were:

- to reduce per capita alcohol intake by a substantial extent;
- to reduce substantially the amount and extent of alcohol-induced psychosocial problems;
- to reduce the prevalence rates of alcohol use and the quantities consumed among young people;
- to initiate measures by which the age of onset of alcohol use is delayed.

Alcohol policy and strategy, 2009

This document does not have any official status right now. From the data describing the current situation in Hungary we believe it is obvious that alcohol use (and especially problematic alcohol use) is a really serious problem in Hungary and has

been for decades. Though this situation has always been clear to professionals, a lot of political and economic interest was linked to this commodity and it was always difficult to formulate an appropriate and realistic alcohol policy. Just a few data will support that statement.

Table 3.5: Revenue tax on different commodities, 2001-7 (in millions of HUF)

	2001	2002	2003	2004	2005	2006	2007
Fuel	324.492	386.220	407.003	427.304	453.955	488.492	501.882
Alcoholic drinks	52.972	57.406	57.540	65.055	66.776	81.362	87.608
Tobacco products	112.293	120.261	152.011	184.356	173.562	216.982	254.126

Source: Alcohol policy (2009), p. 31.

About 10% of these state budget revenues were from the alcohol industry, so obviously the government was interested in the production of these products.

The aforementioned detailed alcohol policy/strategy document was based on very careful data analysis (targeted research data and regular data collections) and defined a set of goals, which fall basically into two categories:

- environmental prevention issues (rules and regulations which control the availability of alcoholic drinks);
- community based programmes which were supposed to strengthen in-community relationships and to develop individual coping mechanisms.

The document did not refer directly to the WHO founding document, but is using as a basic source the HFA programme and the Ottawa Charter.

National anti-drug strategy: clear head, sobriety, fighting drug-related crime, 2013-20[6]

The long process of drafting a new national drug strategy started in 2011 and was completed and approved by the government just before this publication appeared. It is important to note that no structured argumentation was made available to explain the rejection of the previous strategy, which is still in force though no efforts were made to implement it.

The new drug strategy is hoping for a drug-free Hungary by 2020, though it admits that this general aim might seem to be slightly unrealistic.

There is no direct reference to the WHO statement throughout the 97 pages of the document, though its language suggests that the authors were aware of this statement and wanted to make use of it. They speak about the general well-being of people, saying that drugs-related issues should be presented in the context of health promotion and/or mental health. They also mention very frequently the importance of local communities. The strategy clearly states that drugs-related problems cannot

6. H/11798 . számú országgyűlési határozati javaslat a Nemzeti Drogellenes Stratégiáról 2013-2020 Tiszta tudat, józanság, küzdelem a kábítószer-bűnözés ellen, 2013 július.

be tackled independently, the need for an alcohol strategy is definitely mentioned and also a strategy on the abuse of prescription pharmaceuticals. It is also clearly stated that drug problems do not appear in a vacuum; therefore, they can be efficiently tackled only in a synergic relationship with other relevant public policies.

As far as the basic values are concerned, the strategy also speaks about a clear head and staying sober, and about an approach that focuses mostly on the right to health as a basic value for all people.

Another important value-like element of the strategy is the full recovery-centred approach in treatment and care. Harm reduction is not a core value; it is just a method or technology to help those in trouble because of their drug use.

The main (general) goals of the strategy are as follows:

- In the value concept of society and its smaller communities, a commitment to the health of individuals and groups as a basic value should become more emphasised.
- Community and professional initiatives serving the better health and healthy lifestyles of young generations should be broadened and strengthened.
- To cope better with new manifestations of drug problems, more efficient community and professional responses should be developed.

The main areas of intervention are also listed:

- health promotion – drugs prevention;
- treatment, care and recovery;
- supply reduction.

In summary we can say that there is no direct reference to the WHO statement, but indirectly we can see that the authors were aware of it, they relied on it and a comprehensive understanding of health was an important driving force in formulating the strategy. We can also say that broader public health values were not that important: the harm-reduction concept and approach is seldom mentioned (in the main text only four times).

Summary

Based on the previous sections, we can say that there are many policy documents dealing with addiction-related issues. In some cases we can see that they exist in parallel to each other and they try to cover the same field. We also see that the implementation of these policy documents is very problematic; in some cases just the financial resources are lacking, but in other cases political changes make their implementation impossible.

We have to say clearly that none of the mentioned strategies/policy documents are in force at the moment, so if they are still being implemented it is just because of the helplessness of the system, a lack of information in the field or the lack of alternatives to adhere to.

We also have to mention that none of the documents reviewed states clearly that it relies on the WHO founding statement, but all of them rely on derivatives of this founding regulation, *Health for All* or the Ottawa Charter.

Legislative/regulatory framework

What legal regulations are in place?

As we have seen, comprehensive policy documents are missing or are not in force (they do not have an accepted and/or obligatory official status), yet at the same time there are a lot of laws and by-laws which are mandatory and which regulate activities related to the different fields of addiction. Here we list those legal measures that are relevant from this perspective.

The legal instruments are different, as some of them are very specific to a given field of addiction while others set a broader context. Here we try to specify the situation accordingly.

All substances are involved

Act CLIV of 1997 on Health (extract from the preamble):

Parliament,

- inspired by its responsibility for the population's health status,
- guided by the conviction that the interest of the individual in his health and well-being must take priority, and that the achievements of the development of medical science should be utilised to ensure positive benefit[s] for present and future generations;
- being aware that health as a prerequisite for the individual's quality of life and self-realisation has a major impact upon the family, work and, as a result, the entire nation;
- in consideration of the fact that the system of means and resources available to health services cannot serve the promotion, maintenance and restoration of health unless completed by a social-welfare system, the protection of the natural and man-made environment, together with the social and economic environment, as well as by health promoting public policies and practices;
- with regard to recent scientific, technical, ethical and social changes as well as to amendments and changes affecting the legal system, furthermore to our international obligations, hereby creates the following act setting out the complex system of conditions for the promotion and improvement of health.

This act deals with prevention, treatment and care issues covering all three fields considered in this report.

Act CXC of 2011 on National Public Education (extract from the preamble):
Parliament, alloying the noble traditions of Hungarian education with the possibilities of the future, being the pledge of the rising of the nation, for the purposes of patriotic instruction and quality education of the future generations, to enforce the right to education as laid down in the Fundamental Law, to realise the right of the nationalities to education in their mother tongue, to determine the rights and obligations of those participating in public education and to control and operate a public education system which provides contemporary knowledge, hereby adopts the following act:

In the act there is no specific mention of drugs, smoking or alcohol though it deals with general health and health promotion and prevention issues incorporating addiction-related fields as well.

Act III of 1993 on Social Governance and Social Benefits.

Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship.

Act CLXXXV of 2010 on Media Services and Mass Media (extract from the preamble): Parliament, upon recognition of the interests of the community and the individual, with a view to the promotion of the integrity of society and with a view to strengthening the appropriate functioning of democracy and the national and cultural identity, by respect for the constitution, constitutional principles and the norms of international law and of the European Union, by taking into consideration the circumstances ensuing from technological development, by preserving the freedom of expression, speech and the freedom of press, by recognising the prominent cultural, social and economic importance of media services and the importance of ensuring competition on the media market, has adopted the following act on media services and mass media:

Specific references to alcohol issues:
Article 24
(1) The commercial communication broadcasted in the media service
(b) may not show minors consuming alcohol;
(c) may not encourage immoderate consumption of such beverages;
(d) may not depict immoderate alcohol consumption in a positive light and refraining from alcohol consumption in a negative light;
(e) may not show exceptional physical performance or the driving of vehicles as a result of the consumption of alcoholic beverages;
(f) may not create the impression that the consumption of alcoholic beverages contributes to social or sexual success;
(g) may not claim that the consumption of alcoholic beverages has stimulating, sedative or any other positive health effects or that alcoholic beverages are a means of resolving personal conflicts;
(h) may not create the impression that immoderate alcohol consumption may be avoided by consuming beverages with low alcohol content or that high alcohol content is a positive attribute of the beverage.

Specific references to tobacco issues:
Article 27
(1) The following entities may not sponsor media services or programmes:
a) parties or political movements;
b) undertakings manufacturing tobacco products.
(4) Programmes shall not contain product placements of the following products:
(a) tobacco products, cigarettes or other products originating from undertakings, the primary activity of which is the manufacture or sale of cigarettes or tobacco products.

Alcohol

Act LXXIII of 2008 on *pálinka* and fruit brandy, on the National Council of Pálinka: The act controls usage of the designation "*pálinka*" (a traditional distilled alcohol in Hungary), regulates *pálinka* distribution and the National Pálinka Committee.

The 2010 amendment of the act, together with Act CXXVII of 2003 on revenue taxes and special regulations on the marketing of excise goods and Regulation 8/2004. (III. 10.) of the Ministry of Finance, legalised small-scale home distillers.

Self-distillation of *pálinka* is allowed for personal use in the household up to a maximum quantity of 50 litres per year. Self-distillation has to be carried out on the property of the distiller from the fruit harvested from the fields of the distiller.

Smoking

Act XLII of 1999 on the Protection of Non-Smokers and Certain Regulations on the Consumption and Distribution of Tobacco Products:

The act regulates activities related to smoking, the designation of smoking areas, and distribution of tobacco products. The most important development is the restriction of smoking in closed public areas. This amendment came into force in January 2012.[7]

Section 2 (1): Apart for areas designated for smoking – and with the exceptions specified in subsection (3) – no smoking is permitted
a) in rooms of public institutions that are open to the public,
b) on means of public transport,
c) at work places,
d) in the following areas qualifying as public areas:
da) underpasses open to passenger traffic and in other connecting spaces of public passageways with closed air spaces, in playgrounds in public places and within 5 metres of the external borderlines of playgrounds,
db) in the areas of railway operation facilities in place for the provision of public railway services and in the areas of the railway track that are open to the public, in the stops and stations constructed for or designated to passengers boarding or alighting from the means of public transport, in waiting areas or rooms, and within a distance of 5 metres of the external borderlines of outdoor stops or waiting areas, providing that if the external borderline of the area under smoking restriction cannot be unambiguously determined, then smoking is prohibited within a 5 metre range of the board or other sign designating the stop or waiting area.

Act III of 2005: WHO Framework Convention on Tobacco Control
The Parliament of Hungary enacted the WHO Framework Convention on Tobacco Control by means this act.

Act CXXXIV of 2012 on reducing smoking prevalence among young people and retail of tobacco products[8]
From 1 July 2013, only licensed shops are allowed to sell tobacco products in Hungary. The National Tobacco Trading Non-profit Company (a 100% government-owned

7. English version: www.fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/Act_XLII_of_1999_on_the_Protection_of_Non-Smokers.pdf.
8. English version: www.fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/Act_XLII_of_1999_on_the_Protection_of_Non-Smokers.pdf.

joint-stock company) is established under the mandate of this law. The responsibilities of the company are:

- to conduct a call for tender for shops;
- to choose applicants;
- to supervise licensed stores.

The act defines the appearance of these stores, the goods to be sold there and the name of these stores: "National Tobacco Store". By means of the act, sales of tobacco products are only allowed to people above 18 years of age. If there is any doubt, official documents showing the age of the customer must be provided. Fines may be imposed if retailers do not adhere to this provision.

Illegal substances – controlled substances

Act C. of 2012. The Penal Code[9]
The new penal code came into force on 1 July 2013. It includes several amendments related to illicit drugs.

Specific references to drug issues:
Chapter XVII (on crimes hazardous to health), sections 176-184 of the penal code, discuss drug-related crimes including:

- drug trafficking;
- drug possession;
- initiation of pathological passion;
- assistance in drug production;
- misuse of drug precursors;
- misuse of new psychoactive substances.

Act XCV of 2005 on medicinal products for human use and on the amendment of other laws regulating the pharmaceutical market[10]
The act regulates possible licensed activities, and licensing and supervising procedures related to illicit drugs, psychotropic substances and new psychoactive substances. It provides the legal framework (Section15/B-F) for the regulation of new psychoactive substances. The act creates the definition of "new psychoactive substance" (Act XCV of 2005 §1/37), which is: a compound or chemical compound group that currently appears on the market; has no therapeutic value; affects the central nervous system so it has the ability to change mental state, behaviour or perception; therefore it can pose as serious a threat to public health as the substances listed on drug schedules; and therefore the government schedules it in a decree. The act and the government decree create a schedule (Schedule C of Annex 1 of Government Regulation 66/2012) for new psychoactive substances that lists individual substances and compound groups (applying the generic approach).

By the act, if a substance is reported in a formal notification under Council Decision 2005/387/JHA, it has to be assessed whether it should be scheduled under the

9. Full text: http://net.jogtar.hu/jr/gen/hjegy_doc.cgi?docid=A1200100.TV.
10. See http://drogfokuszpont.hu/szakteruleteink/korai-jelzorendszer/korai-jelzorendszer-tenyek-es-szamok/?lang=en (Hungarian National Focal Point).

government decree. The rapid assessment has to prove that no information available at national authorities or professional institutes:

- suggests that the given substance has a medical use; and
- rules out that it poses as serious a threat to public health as the substances listed on narcotic and psychotropic drug schedules.

A risk assessment shall be carried out in the case of all substances listed individually on the (new) schedule within three years of their scheduling. As a result of the risk assessment the substance is either scheduled on psychotropic drugs schedules (schedules of Act XXV of 1998) or dropped from the schedule of new psychoactive substances. Risk assessment is not to be applied in the case of compound groups which stay on the schedule as long as any substance that belongs to the given group fulfils the requirements of the rapid assessment. Every activity related to new psychoactive substances defined by regulatory actions may be carried out only with a valid licence (obtained from the authority defined by the act).

Government Decree 159/2005 on procedural rules, tasks and competencies of authorities related to drug precursors.

159/2005 Government Regulation (VIII. 16.) sets particular procedural rules for and lays down tasks and competencies of authorities related to precursors. The government regulation implements the following Community laws: Regulation (EC) No 273/2004 of the European Parliament and of the Council, Regulation (EC) No 111/2005 of the European Council and Commission Regulation (EC) No 1277/2005.

Government Regulation 66/2012. (IV. 02.) on activities that may be conducted with drugs, psychotropic substances and new psychoactive substances and on the scheduling of such substances and on the amendment of their schedules.

Schedule C of Government Regulation 66/2012. (IV.02.) valid from 3 April 2012 contains a list of individual substances and compound groups classified as new psychoactive substances; determines the bodies participating in the procedure of adding new substances to the list and their tasks; and determines the tasks of the institutes when granting permission for activities conducted with new psychoactive substances.

Government Regulation 23/2011. (III.8.) on increasing the safety of music and dance events, enacted on 16 March 2011, regulates the operating conditions of such events. The scope of the regulation extends to music and dance events held in premises suitable for accommodating more than 300 people at the same time, and also to open-air events where the number of participants is above 1 000. Events within the scope of the regulation can only be held with a licence from the competent notary public. The regulation prescribes preparing a security plan relating to the event, employing security staff in accordance with the size of the location and the presence of staff trained to give first aid at the location of the event, and it also determines the method and rules for inspecting the events.

The above listing is far from being complete, because illicit substances, alcohol and tobacco appear in a great number of other legal instruments; however, those listed are the most comprehensive ones and also devote specific attention to the substances under consideration.

We can say that all the acts – as explicitly formulated in their preambles – make reference to international conventions or to EU directives if and when it is necessary. It is hard to say if they are in line with the strategies or comprehensive policies of the relevant field. As has already been said, there are no strategic documents in force in the addiction field; consequently it is hard to say if the legal instruments support or counteract them. The grades given to this marker are 5 in all cases because legal instruments are in place, and they regulate several aspects of the problem.

Do they adhere to the international conventions?

The legal instruments mentioned are in line with international conventions where such documents are known. The preambles of the acts as presented in the previous section in most cases refer to international stipulations.

The most important acts related to illicit drug use are the penal code, amended in 2012 (in force since 1 July 2013), and the 66/2012 Government Decree. It is important to know that Hungary's penal code, as far as illicit substances are concerned, is one of the strictest in the EU. Not only possession and trafficking are criminal acts but simple use as well. This latter is a new development. There is no difference from the criminal perspective between a simple user and an addicted person as far as the quantities are concerned (in the previous penal code the severity of the punishment partly depended on the medical status of the perpetrator). The international conventions are respected and EU directives are also taken into account.[11]

For alcohol, the only exception is Act LXXIII of 2008, which was amended in 2011 and modified the tax revenue regulations related to home-made *pálinka*. This particular legal instrument is a problematic one from public health perspectives. The fact that people drink a huge amount of distilled spirits and that, among them, home-made *pálinka* has a very prestigious position is a real public health issue. Of all alcohol consumed, 30% is distilled spirit; the problem is further aggravated by the fact that home-made spirits like *pálinka* are widely used as they are cheaper and readily available. The Pálinka Act promotes the use and production of this alcoholic beverage, and the new legislation on revenue taxes legalises the home-based production of this commodity to a certain extent. We do not know if this legislation is argued against by the international community, but obviously it is risky from a public health perspective.

In the case of smoking a lot has also been done in the early 21st century in the field of legislation. Though the national public health strategy has just expired, smoking-related legislation has followed EU directives and the recommendations of the international community (specifically WHO).

How do these regulations align with policy goals?

Without relevant comprehensive strategic documents, our judgment of this marker must be very vague.

11. See: Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking.

In the case of illicit drugs we can rely on the strategy that was adopted by the government and we can investigate the consistency between legal instruments and the proposed strategy. Most of the legislative instruments mentioned above seem to support this document as it envisages a drug-free Hungary by 2020 as an idealistic goal. The penal code is very strict on punishing all manifestations/behaviours leading to or involving illicit drug use. The Act on Social Services supports care facilities for problematic drug users in limited numbers though it is not mandatory to provide this type of service throughout the country. Their financing is also insecure as it is provided via grant schemes. There are hopes that prevention will appear in the context of health promotion programmes, whose implementation is regulated by the National Public Education Act in the school setting. Act CLIV of 1997 on Health regulates the health services to be provided for addicted persons/problematic drug users. It is important to note that the legal instruments mentioned did not result from the comprehensive policy document, but they are not in conflict with it either. It is also true that we cannot say that the legal instruments will substantially contribute to realising the goals and aims specified in the policy document. Even if the strategy were approved by parliament, it would be a political declaration rather than a source of legal regulations. The grade given is 4, mainly because the strategy itself is not a really consistent document and some acts in force support it more while others support it less.

Without an alcohol strategy in force we can compare alcohol policy and strategy with the current legislation in this field. Those pieces of legislation that regulate health-care provision and social services for persons with alcohol problems are not against the goals and aims envisaged in the strategic document. As these acts are not promoting developments in this field, there is no reason to say that they are supporting the objectives of an alcohol policy. So we can say that they are mostly neutral from this point of view. The Pálinka Act counteracts the strategic document as this act is promoting alcohol use rather than controlling availability, which is a definite goal of this document. The grade given is 2.

The situation is best in the realm of smoking. Though there is no smoking/tobacco strategy for the whole country and the national public health strategy is not in force any longer, the strategic objectives are reflected in the legal instruments in force. There is a clear message: there is no acceptable (harmless) way of using tobacco, so availability is being restricted, all the legal instruments are trying to make that clear and implementation of the legal measures is closely supervised. Supply reduction measures are well represented in the legal instruments, though demand reduction is less so. The grade is 5, as there are no obvious inconsistencies between the policy aims and the legal instruments.

Table 3.6: Alignment of regulations with policy goals

	Illicit drugs	Alcohol	Tobacco
Legal regulations	5	5	5
Comply with intl. conventions	5	5	5
Alignment with policy goals	4	2	5
Mean	14/3=4.6	12/3=4	15/3=5

Strategy/action plans

In our understanding comprehensive public policies appear in the format of strategies[12] and then are developed into action plans. The policy measures/instruments by which strategies and action plans can be implemented are as follows (based on Galla 2012):

- legislation
  - formulation of fundamental principles for civil and penal code
- regulation
  - setting of norms, bringing under government control and supervision
- taxation
  - incentive: rewarding desirable behaviour (e.g. low VAT on fruit)
  - discincentive: discouraging behaviour (e.g. sales tax on tobacco)
- benchmarking and minimum standards
  - (e.g. for funding eligibility)
- research and analysis
  - evaluation of phenomena and their causes
  - promoting innovation
  - deployment of effective policies and programmes (evidence-based policy)
- subsidies and grants
  - incidental – innovation, set-up grants, ad hoc actions
  - structural – structural activities and tasks, maintenance after initiation
- public affairs, communication, public relations
  - information and communication strategy to inform stakeholders/target groups
  - public awareness raising

As we clearly stated previously, there are no strategic documents in force at the moment; nevertheless, action plans are implemented in some areas and/or actions are taken even if the action plans are missing. We also said that there are strategic documents which are supposed to be approved by political decision takers in the near future (e.g. national anti-drug strategy). Consequently, under the next heading, we speak about actions and/or action plans and also about strategies where appropriate.

In the case of tobacco use, the document we refer to is Antmann, *Dohányzás Ellenes Nemzeti Akció Terv, 2005-2010* (National anti-smoking action plan, 2005-10). This document, like the earlier alcohol strategic plan, is a conceptual paper, but clear-cut actions are suggested in it.

In the case of alcohol issues, we are referring to *Alkohol-politika és stratégia*, the Alcohol policy and strategy of 2009.

On illicit drugs, we can refer to H/11798 (2013), the national anti-drug strategy: clear head, sobriety, fight against drugs-related crime, 2013-20. In the previous section we concentrated on general aims and objectives. Now we deal with tasks as specified in the document.

12. Policy is … an overarching strategy or goal encompassing a number of different 'policy instruments', the means to achieve the policy (Stern E. 2007).

Does the strategy/action plan refer to the state of the problem as revealed by the analysis above?

For illicit drugs, the data describing the current situation are mentioned in the strategies and action plans. Activities are said to be formulated on the basis of these data. The only question is whether the conclusions drawn from these data are correct or not, and if the chosen direction of the planned interventions is appropriately substantiated.

From the drug strategy we see that the drug situation is getting worse in Hungary: the lifetime prevalence rate is increasing and new psychoactive substances are highly prevalent on the market. The proposed solution is to strengthen law enforcement and widely apply a recovery-centred approach to treatment and care measures. The given grade is 3, because the proposed actions are not seen as effective, other possible interventions are not properly emphasised, and prevention activities and law-enforcement measures get a higher priority than treatment, care and harm-reduction interventions.

In the alcohol strategic plan, the data accurately describe the difficult and severe situation in Hungary. Almost all aspects of the problem are correctly presented. The proposed actions are in line with the data in anticipating the four main directions that have to be followed in order to tackle the gradually worsening alcohol situation:

- legal measures to tackle alcohol problems, including rules and regulations to be followed by the population;
- measures and interventions to reduce the prevalence of problem drinking, and measures dealing with high-risk populations;
- development of knowledge and personal skills, plus prevention programmes;
- treatment and care of alcohol-dependent persons.

The given grade is 5 because the proposed actions are well balanced and truly reflect current scientific findings and recommendations.[13]

In the case of tobacco, the document that is most like a strategy or action plan that we can refer to is a conceptual paper from 2005. This is a real action plan, stemming from the national public health programme. Consequently the actions envisaged in it are relevant to the aims and goals of the national public health programme and also reflect the available data related to tobacco use. The given grade is 5.

Does the strategy/action plan address supply reduction, demand reduction and harm reduction?

All the above-mentioned documents deal with law enforcement, with regulatory instruments mostly meant to limit availability of the substances (supply reduction). Illicit drugs fall under the jurisdiction of penal code, by which availability is not controlled but rather strictly forbidden; alcohol and tobacco use is regulated. These regulatory measures are very different as moderate alcohol use and the consumption

13. J. Rehm, K. D. Shield, M. X. Rehm, G. Gmel and U. Frick, *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: Potential gains from effective interventions for alcohol dependence* (Centre for Addiction and Mental Health, Canada 2012).

of quality alcoholic drinks are promoted (not by the strategic document, but by other legal instruments), whereas smoking is (hardly) tolerated under certain circumstances. But, if we concentrate just on the documents, we can say that the strategic documents on alcohol and tobacco try to limit their availability while activities with illicit drugs are punished by serious legal measures. The grade given is 5 in both cases though we have to bear in mind that the reality (implementation) is very different from the intentions specified in the strategies/action plans.

Both strategies/action plans address demand reduction. They are more characteristic and more detailed in the drugs strategy and the anti-smoking action plan than in the alcohol programme.

Harm-reduction measures are envisaged in the drug strategy and also in the alcohol strategic plan. There is no reference to this type of intervention in the anti-smoking action plan. It is important to note that harm-reduction measures are presented in the drug strategy as a technique, not as a specific approach to or philosophy of tackling the problem. There is a strong intention that these measures should be integrated into broader treatment and care arrangements. This understanding is presented very clearly: "However, it is important to note that different harm-reduction services should be closely integrated into other recovery centred complex programmes; and they should collaborate with treatment and care facilities."[14]

In the case of alcohol programme harm-reduction measures, interventions are mentioned in a broad sense, though no specific interventions are defined, apart from interventions focusing on the environment of alcohol intake. Environmental prevention issues and harm reduction appear under the same umbrella.[15] As is widely accepted among professionals, smoking does not have any acceptable form or amount, so no harm-reduction measures are mentioned in the national anti-smoking action plan nor in the national public health programme. The grades given are: 4, 3 and 1.

Any specific objectives outlined that coincide with the various reduction measures?

In our view, this particular marker requires a deeper and more systematic analysis. Simple document analysis is not appropriate for deciding this issue. To check the inner consistency of a strategy and/or the consistency between a strategy and its action plan would require the use of the logframe technique. This method is suggested for use – among others – in checking the consistency between general goals and specific objectives (mostly specified in action plans), actions or activities. In an optimal case, specific objectives can be derived from general ones, and the activities or actions are direct consequences of the specific goals or objectives. To carry out a logframe analysis, the plain text of the strategy should be transcribed into the logframe and this is a very time-consuming task. The current study does not provide us with this opportunity (lack of resources, limited time frame). Without this type of thorough analysis, the only thing we can formulate is an expert opinion, which is hard to support with evidence.

14. H/11798, national anti-drug strategy, p. 49.
15. Room 2006.

Any activities outlined that correspond with the objectives, reduction measures and goals of the policy?

The doubts specified earlier could be repeated here as well, but this marker is not looking for a truly comprehensive analysis so we may try to answer it. In both documents we find many activities that properly correspond to the aims and objectives of the strategies. We cannot say that all the planned measures are appropriate from this point of view, but it can be said that all activities and specific measures can be linked to the objectives. Whether the objectives are realistic and/or scientifically sound is another question. This set of markers is not inviting us to make a judgment in this regard. Based on these considerations, and bearing in mind the limitations, the proposed grade is 5 in all cases.

Table 3.7: Alignment of activities with objectives, reduction measures and goals

	Illicit drugs	Alcohol	Tobacco
Reference to state of problem	3	5	5
Supply reduction	5	5	5
Demand reduction	5	3	5
Harm reduction	4	3	1
Specific objectives			
Activities	5	5	5
Mean	22/5=4.5	21/5=4.2	21/5=4.2

Structures/resources

In analysing the situation under this heading, we rely at some points on our experience of the focus group discussions, which are described in more detail in the analysis below.

Is there an over-arching responsible authority?

Is there a co-ordination body in place? Is it effective at different levels? What is its mandate? As far as co-ordination structures are concerned, different arrangements are in place.

Illicit drugs

The most relevant information about the co-ordination structures as seen from an official point of view came from discussions with officials at the Ministry of Human Resources.[16] All addiction-related fields (drugs, alcohol, tobacco) are its responsibility. National drugs co-ordination is under the State Secretariat for Sport and Youth Affairs, which has a line division responsible for youth, drug prevention and issues of co-ordination. It is a small organisation with executive and strategic development

16. The Ministry of Human Resources is an umbrella ministry responsible for health issues, social policy, education (public and higher), youth and sport.

tasks. National co-ordination is strengthened by the Intergovernmental Committee on Drugs, which replaces the Co-ordination Committee of Drug Affairs. The main difference between the previous body and the current one is that there are no civil organisations in the latter. The responsibilities remain the same: to advise the government on drug-related issues and monitor implementation of the drug strategy.

As civil organisations play an important role in tackling the drug problem, a civil council was established. This incorporates many civil organisations that might have responsibility and/or vision in this field. There are no clear-cut procedures to ensure communication between the two bodies apart from the fact that the same person (deputy state secretary) heads both of them. None of these bodies have any decision-making power; they are entitled to advise and to represent different perspectives of the field in question. Previously representatives from the government and civil organisations sat on the same advisory body, and the selection procedure for civil organisations was clearly defined. Now civil organisations are not elected but invited by the government. None of the bodies has any binding force; they can formulate their opinion on agenda items, but there are no procedures that make it mandatory to follow the recommendations of the advisory bodies. The main operative responsibility for treatment and care lies with the State Secretariat for Health Care. Supply reduction issues belong to the Ministry of the Interior and the Ministry of Public Administration and Justice.

Local co-ordination

This is a bit confused as the whole public administration system is being reorganised. Local co-ordination forums on drugs (KEF in Hungarian) still operate in some places. These forums were suggested in Hungary's first national drug strategy (2000-09). They were supposed to act locally in settlements with more than 25 000 inhabitants. Their responsibilities were to act as local think-tanks to facilitate drugs-related intervention activities in local communities, to be centres of excellence and to create collaboration among local actors. They were supposed to carry out or encourage the implementation of needs assessment and to develop local drug strategies. They did not have a legal personality but they were supposed to be supported and used by the local governments.

After the initial period, county and regional KEFs were also established, reflecting the fact that there are a lot of smaller settlements in Hungary where drugs problems are also present. These KEFs at county and regional level had even less official power than the ones at city level but these semi-organisations could help in networking and knowledge sharing. After the first four or five years, professional development of the local forums became evident, so the national co-ordination bodies decided that they would need financial resources to spend on the activities of local organisations taking part in the implementation of local strategies. In parallel, the national co-ordination bodies tried to move in the direction of creating legal personality for the KEFs. The process was delayed and after 2010 stopped as there were general doubts about the direction of former drug policy. KEFs hardly function at the moment, though the new drug strategy is determined to provide them with better conditions and with opportunities for development.

As we have seen, the co-ordination bodies have very limited executive power, which lies with the ministry; the main instruments are grant schemes, laws and by-laws initiated by different government organs. The National Bureau on Drug Prevention[17] also plays a role. It is expected to act as a centre of excellence on drugs-related issues. The National Focal Point on Drugs, part of the REITOX network, is responsible for data collection and analysis in this field (see below on monitoring and evaluation).

As regards alcohol

Here the co-ordination bodies are much less defined. It is the Ministry of Human Resources that has the mandate but there is no alcohol strategy in force at the moment and, as no alcohol strategy was approved or implemented in previous years either, no co-ordination bodies were developed at an earlier stage. The relevant line departments of the ministry are responsible for particular issues, such as prevention programmes, treatment and care. The alcohol strategy and action plan mentions the necessary co-ordination structures that are envisaged acting under the Public Health Intergovernmental Committee. However, this committee is not functional at the moment.

Smoking-related issues

These also are the responsibility of the Ministry of Human Resources and its departments of Public Health and Health Policy. The National Institute for Health Promotion operates a National Focal Point on Smoking, which defines its main responsibilities as:[18]

- performing comprehensive monitoring and evaluation tasks; supervising the collection of social, economic and health indicators related to tobacco consumption; conducting research, performing tasks relating to organisation and co-ordination;
- performing activities of strategic planning and negotiation regarding tobacco control in many sectors;
- implementing smoking-prevention activities targeting youth and devising prevention programmes, collecting best practices, preparing cadastres and advising on programmes for education institutions. Developing methodologies of national dissemination and participating in the implementation of these;
- implementing pilot programmes and assessment of the effectiveness of these;
- implementing national and international programmes, co-operation with foreign, national, regional and local partners active in the field of tobacco control, using international experiences in the design of national programmes;
- following up the activities of civil organisations; co-operation and joint programme design with them;
- creating and maintaining a database of laws, provisions and instructions for their use;
- participating in the preparation, implementation and evaluation process regarding the WHO Framework Convention on Tobacco Control and national implementation of it.

17. From 2001 to 2010 it was the National Institute for Drug Prevention, with reorganisation taking place after 2010.
18. Source: www.fokuszpont.dohanyzasvisszaszoritasa.hu/en/content/responsibilities-focal-point-tobacco-control.

By what means/mechanisms does the co-ordination body conduct its mandate?

As we saw in the previous section, the responsibilities of the different co-ordination bodies vary.

In the case of illicit drugs, though there is no approved national strategy, the government body responsible for this field conducts its mandate, based on the experience and traditions of previous years, by initiating legal changes, nationwide programmes – such as the designer drug campaign in 2012[19] – grant schemes, information provision on funding opportunities and helping to set priorities of grant schemes financed from EU Structural Funds. The rating given in this regard is 3 because the finances are insufficient and, as development objectives are financed from grant schemes, the sustainability of the initiatives is insecure.

As there is no real, dedicated co-ordination body for alcohol problems, the health services and social care provided in this field are regulated and promoted by the Act on Health and Social Services. These are the mainstream activities; the few development activities in this field are mainly pursued by grant schemes mostly financed by the National Development Plan (Új Széchényi Terv). The given rating is 3; available funds are very inadequate.

The same is true in the field of smoking: mainstream treatment and care-related services are financed from the central budget, and service provision is regulated by the aforementioned acts. Development-focused programmes are financed by grant schemes, mainly from the EU Structural Funds. A call for applications in 2012 invited organisations to implement activities that might contribute to realisation of the following specific objectives:

- dissemination of healthy lifestyle patterns and strengthening of the relevant institutional framework;
- reduction of mortality rates and the burden of disease induced by non-communicable diseases via services connected with primary health care;
- development of services encouraging physical activity and healthy eating habits among the population, prevention of non-communicable diseases;
- combating smoking and extensive alcohol consumption;
- promoting mental health.

The above objectives of the call for proposals should be considered just as an example which shows that the necessary developments are supported via the priorities of the grant schemes. In this particular case, activities related to alcohol and smoking prevention appear under the same umbrella, applying a coherent approach. The given rating is 3.

Monitoring

Is there a system in place that monitors in an explicit way the implementation of the strategy and action plan and that takes into account the demand, supply and harm-reduction aspects? Is a final evaluation undertaken?

19. See www.designerdrog.hu/.

The monitoring system is very disproportionate. There is a well-developed and functional monitoring system in the realm of illicit drugs. The Hungarian National Focal Point on Drugs functions as part of the REITOX network,[20] the method of data collection is thus prescribed, the epidemiological key indicators are supposed to give a general picture of the state of the art and trends can also be followed. The main purpose of the National Focal Point is to monitor the drug situation, not to monitor implementation of the national drug strategy, but as a side effect of their regular activity decision makers can get a proper understanding of that issue as well. The only difficulty is that the Focal Point's budget does not allow them to initiate large-scale research, so an adult population drug epidemiological survey was not implemented between 2007 and 2013.[21] The Focal Point – based on regular data collections and targeted research – compiles annual reports; its observations are presented at the Intergovernmental Co-ordination Committee meetings and other gatherings organised for professional groups.

Final evaluation of the National Drug Strategy was carried out in 2009 and it reflected on the implementation of Hungary's first National Drug Strategy. After that, no final evaluation was commissioned as the new drug strategy adopted in 2009 was not implemented, and the one currently going through parliament has not yet been approved, though stipulations are clearly formulated in it regarding midterm and final evaluations. The given grade is 5.

In the field of alcohol issues there is no specific institution responsible for data collection. In the National Institute for Health Promotion/Development there is a special unit (the National Centre on Addictions) with multiple responsibilities; there is no specific expectation that this organisation should be responsible for data collection related to alcohol consumption. Morbidity and mortality are monitored by the National Statistical Office but epidemiological data related to the extent and pattern of alcohol consumption can only be gathered from population surveys. The last adult population survey on health status and behaviour was carried out in 2009[22] according to Regulation (EC) No. 1338/2008 of the European Parliament and Council of 16 December 2008 on Community Statistics on Public Health and Health and Safety at Work. Regular, comprehensive monitoring and publishing of alcohol consumption/problem data, as in case of illicit drugs, is not available in Hungary at the moment. The given rating is 2.

In the case of tobacco there is a Focal Point; as already mentioned, evaluation and monitoring tasks are clearly defined in its mission statement: "Performing comprehensive monitoring and evaluation tasks. Supervising the collection of social, economic and health indicators related to tobacco consumption; conducting research, fulfilling organising duties and co-ordination." Data related to the smoking

20. A short description of the network's function can be found on the EMCDDA website: www.emcdda.europa.eu/about/partners/reitox-network.
21. In May-June 2013, some social-science-focused research included a block of questions related to illicit drug use, smoking and alcohol consumption, so after six years prevalence estimates became possible; data from this research are not yet available (principal investigator of the drugs related part: B. Paksi; the research was conducted at the Eötvös Loránd University, Doctoral School of Psychology).
22. ELEF 2009: see www.ksh.hu/docs/hun/xftp/gyor/jel/jel310021.pdf.

situation are available on the website of the Smoking Focal Point, where domestic and international data and trends can also be found. There has been no targeted research to check if the aims and objectives specified in relation to smoking in the national public health programme and/or in the action plan have been met, though indicators are specified. The given rating is 4.

Funding

Is the funding available adequate for each body to conduct its mandate?

To make a judgment whether the financial resources are appropriate for the co-ordination bodies to fulfil their tasks is almost impossible. As will be indicated in the second part of the study, the question itself is not clear enough. If we would like to see whether the financial resources are sufficient to finance implementation of the relevant strategies, it can be said that we have no information because there are no strategies in force and no well-evidenced estimates of the amount necessary for implementation of the strategic objectives. If the question relates to financing the personnel working at the co-ordination bodies, the answer is yes, as the number of people employed at ministerial level is a consequence of the available funds.

Table 3.8: Alignment of funding with the needs of co-ordination bodies

	Illicit Drugs	Alcohol	Tobacco
Responsible body	5	5	5
Co-ordination body	5	2	5
Mechanisms	3	3	3
Monitoring system	5	2	4
Final evaluation	5	0	0
Funding for co-ordination bodies	?	?	?
	23/5=4.6	12/5=2.4	17/5=3.4

Responses/interventions

Specific actions

Are there specific actions planned with respect to the strategy or action plan? Have they been implemented? Have they been monitored with a view to altering them according to circumstances – that is: are the actions dynamic and not static?

The only action plan in force deals with tobacco issues. Regarding the other two fields of addiction examined, there is no officially approved action plan. However, various activities are implemented and in most cases there is a reference to national strategies like the National Reform Programme and the National Development Plan. In the case of smoking there is an action plan in force and specific programmes are implemented under this umbrella. The actions belong to three different areas:

- prevention;
- protection of non-smokers;
- cessation promotion.

Success indicators are defined according to these areas but no specific monitoring system is designed to check if the implementation is properly done. However, data related to the actual situation and describing the trends are provided according to the different intervention areas.

In the case of alcohol and illicit drugs no action plans are in place, though the national anti-drug strategy and the alcohol policy and plan speak about specific actions. The drug strategy contains a definite expectation that a detailed action plan with responsible persons/authorities, deadlines and financial specifications should be developed as soon as the strategy is approved by parliament.

Table 3.9: Are action plans specific? Are they dynamic or static?

	Illicit Drugs	Alcohol	Tobacco
Specific actions	1	1	5
Implemented	1	1	No information
Dynamic/static	n.a.	n.a.	No information

Summary of the findings – expert opinion

In previous sections we reviewed the relevant documents in the fields under consideration. Table 3.10 shows the means calculated for the individual criteria/markers. For "State of the problem" the given grade reflects the severity of the problem based on national statistics; under "Policy goals" we investigated whether the objectives of a given policy document were in line with the WHO founding statement. At this point we have to emphasise that we are now presenting expert views and document analysis, so the evidence base of the conclusions drawn is much more varied.

Our conclusions under "State of the problem" are based on research data or regular data collection systems. These data and the trends are presented in most cases in a European or international context. The conclusions under "Policy goals" are based on document analysis. Readers must bear in mind that none of the policy documents studied are currently in force, but they apparently have an impact on activities in the field and/or on grant scheme priorities.

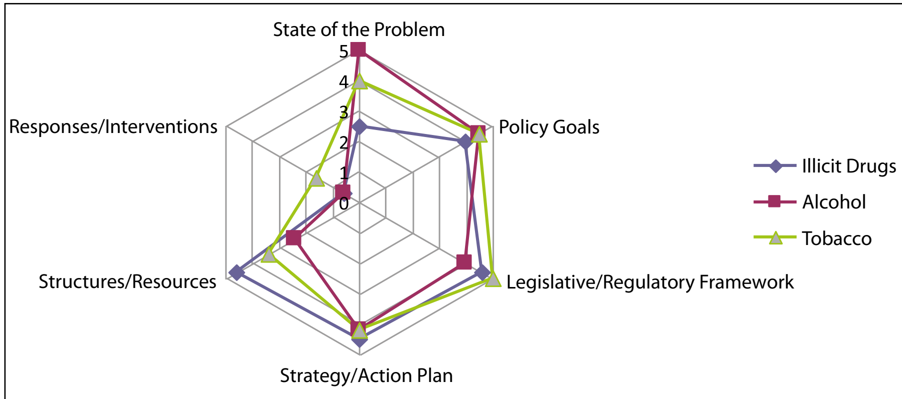
Table 3.10: Summary of policy coherence markers – mean of the individual grades

	Illicit Drugs	Alcohol	Tobacco
State of the problem	2.5	5.0	4.0
Policy goals	4.0	4.5	4.5
Legislative/ regulatory framework	4.6	4.0	5.0
Strategy action plan	4.5	4.2	4.2
Structures/resources	4.6	2.4	3.4
Responses/ interventions	0.6	0.6	1.6

Figure 3.13 informs us of the respective position of the different markers. It shows that the severity of the problem varies between a high level (alcohol) and medium level of seriousness (illicit drugs). The level of seriousness is not reflected in the other

markers as they are somewhere between 4 and 5 in all cases, apart from responses/interventions, as very few characteristic interventions could be identified. The lack of comprehensive strategies or action plans in force, as described above, can give a good explanation for this situation.

Figure 3.13: Summary of the markers – spider diagram



General remarks on the method – the way forward

The initiative to study whether addiction policies in a country are coherent with each other and whether they reflect general health-related objectives is very important and potentially useful for policy makers and professionals. The proposed methodology aimed to provide the participating experts/countries with a diagnostic tool for this. In the preliminary discussions it was always an issue whether the markers could be properly operationalised and whether valid judgments could be made. Having completed this exercise, our doubts are still there. In the next few paragraphs we make some comments on the usability of this set of criteria and try to offer alternatives that might increase the validity and acceptability of the findings.

State of the problem

This seems to be the least problematic element of the markers if well-structured data collection systems are in place and regular data collection is carried out according to a pre-negotiated set of criteria. These arrangements cannot be seen independently; they are functions of "Structures and resources", "Legislative framework" and "Policy goals". If the data collection system is not well prepared and information is not available on a regular basis, there is no way to make a valid statement on the severity of the problem. The ability to properly describe the state of the problem could have an impact on public opinion and consequently on political commitment to tackling the given problem.

Policy goals

We were supposed to make a judgment on whether the policy goals reflect the severity of the problem and if they refer to the WHO's health definition. Without more detailed

instructions on how to make a judgment of the severity aspect, it was impossible to accomplish this part of the exercise. In most cases there is no consensus on interpretation of the data and, more importantly, it is really difficult to say which policy goals are the most appropriate in a given situation. For instance, in Hungary we see a slight but significant increase in prevalence rates of illicit drug use. Various policy goals can be pursued in this situation: you might strengthen law-enforcement efforts, or you might broaden the choice of demand reduction interventions. In both cases you could refer to the WHO health definition, saying that you were protecting the physical, social and psychological well-being of those who do not use illegal substances (option 1), or you could say that you were applying a broader demand reduction approach in which you look at the problem as a public health issue and promote the well-being of the whole of society, including drug users (option 2). Authoritative scientific literature can help in making a proper decision between the two options, but there is no clinching evidence in this regard; therefore, ideological assumptions will lead the decision-making process.

If the task is restricted to the analysis of strategic documents and the question is to check if they properly refer to the WHO health definition, then it is quite easy to make a judgment. This type of analysis would give some direction on the coherence between the WHO statement and the policy goals of a given public policy. Coherence among the policies would require a further analysis in which additional criteria should be used to check whether the policies actually and literally reflect each other.

Legislative/regulatory framework

It was easy to check if the legislative and regulatory frameworks are in line with international conventions or EU resolutions and directives. To answer the question whether there is coherence among the different pieces of legislation regulating the various addiction fields is much more difficult because the regulatory framework is evolving in most cases – at least in Hungary – and not necessarily as a consequence of broader policy. These frameworks are formulated by diverse public administrative authorities with divergent responsibilities and mission statements. As a consequence, a much deeper and more comprehensive analysis of the legislative framework should have been carried out to better understand what the actual intention of the legislator was and what the message of the given piece of legislation is for the general public and for those who are supposed to apply it. A further layer could be analysis of the implementation of legislation, which would further broaden the circle of interpretations.

Strategy/action plan

This marker, at first glance, seems again to be very simple, though in reality it is not. If there is a strategy, and an action plan derived from the strategy, then the logframe technique has to be applied. This is a systematic examination that can lead to a proper understanding of the consistency/coherence between strategy and action plan. If this analysis is systematically done in all cases (illicit drugs, alcohol, tobacco) we can see the coherence within individual fields. If we have already arrived at the conclusion, on policy goal level, that the policies are coherent with each other and if the individual policy fields can also be described as coherent, we can formulate a logical conclusion that the action plans are also coherent with each other.

Structures/resources

In the course of implementation, policy structures and resources are more than important. The analysis should go in two different directions again:

- to see if the structures and resources are appropriate from the perspective of policy goals, strategy and action plan;
- to see if different fields are under the same jurisdiction, and if measures or interventions in one field are formulated in light of the other(s).

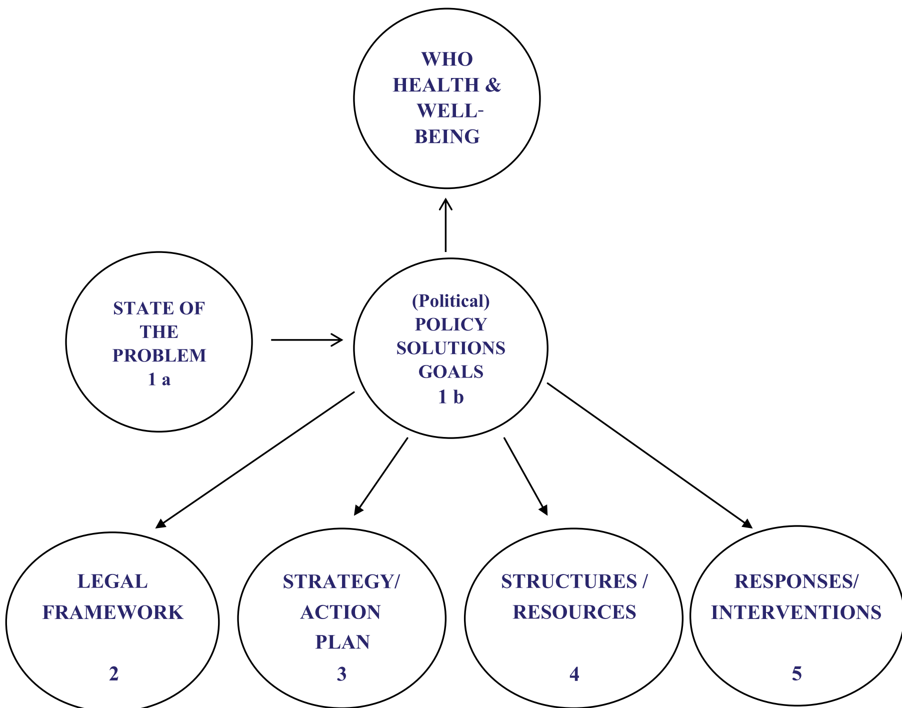
In the current analysis we focused just on the first element, on the horizontal aspects of the problem, and described the situation in the different fields. Using these criteria, it was not possible to draw real conclusions regarding the coherence at this level.

Responses and interventions

These are direct consequences of the relevant strategy/action plan in a given field. If we have already arrived at the conclusion that the strategies/action plans are coherent with each other, the only question is whether the planned activities/interventions are implemented or not.

How to improve the methodology

Figure 3.14: Model used here for understanding the elements of an addiction policy



The document we used as a guide in this exercise proposed a structure for positioning and understanding the different elements of an addiction policy (Figure 3.14). This is a perfect model for analysing coherence within an individual policy field, but it is not fully appropriate for modelling and leading our thinking when checking coherence among the different policy fields. Therefore we suggest some modifications.

The whole analysis can be carried out in two steps.
Step 1: Do policy goals reflect the WHO statement and the state of problem? Do they reflect each other?
Step 2: Does the legal framework reflect the WHO statement? Is it in line with policy goals?

After Step 1, as suggested above, we have a more or less clear picture of the coherence between and among:

- the state of the problem and policies;
- the WHO statement and the individual addiction policies (goals and aims);
- the legal framework, the WHO statement and the policies.

This way we have an understanding of horizontal and vertical coherence. In Step 2 we have to address the analysis of individual policies or strategies. If we arrive at the conclusion (after Step 1) that the addiction policies are coherent with each other and reflect the WHO statement, and that the legal framework supports the latter, then we just have to check if their inner consistency is there or not. Individual addiction policies can also be coherent (or not) within themselves. If we continue to systematically study the situation using the markers, finally we can argue for a new set of categories:

- overall coherence (horizontal and vertical), in which the addiction policies are coherent with each other, the goals and aims properly and proportionately address the severity of the situation, the aims and goals are scientifically supported, the legal framework is in line with the WHO statement and supports the policy aims and goals, the different fields of addiction refer to each other or appear under the same umbrella, means the inner coherency of the individual policies is evidenced;
- partial coherence (horizontal and vertical), where at least two of the addiction policies are coherent with each other, the goals and aims properly and proportionately address the severity of the situation, the aims and goals are scientifically supported, the legal framework is in line with the WHO statement and supports the policy aims and goals, and two of the addiction fields refer to each other or appear under the same umbrella, means the inner coherency of the individual policies is evidenced;
- horizontal coherence only, by which the addiction policies reflect each other, but their connectedness to the WHO statement is not evident, means they lack inner coherence;
- vertical coherence only, where in the case of individual policies the goals and aims properly and proportionately address the severity of the situation, the aims and goals are scientifically supported, the legal framework is in line with the WHO statement and supports the policy aims and goals, means that the inner coherency of the individual policies is evidenced;
- no coherence at all.

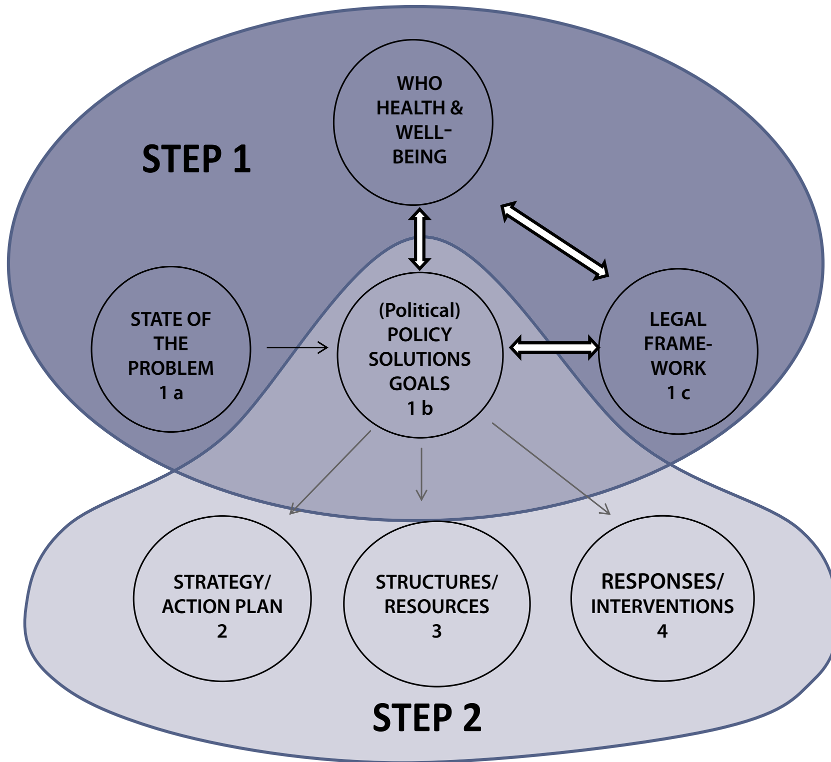
Table 3.11: Model for improving the methodology – coherence between policies

Criteria	D	A	T	Source of information	Method	Requested expertise
Policy goals are coherent with severity of problem; a scientifically sound (evidence-based) policy option is offered				Analyse national statistics, description of policy formulation process, policy options considered; national strategy – public policy in force	Document analysis; if written (public) information is not available interview with responsible persons/ authorities; independent experts (3) rating which will compare the situation, the chosen policy goals and the relevant scientific literature on a 5-grade scale; in case of disagreement among the raters they should sit together and find a mutually satisfactory consensus	Social/health science researcher, policy analyst; knowledge of authoritative, relevant scientific literature; draft detailed terms of reference beforehand to get the most reliable expertise
Policy goals in/directly refer to WHO statement				National strategy – public policy plan in force	Document analysis; expert ratings on three-grade scale (1= not at all, 2=indirectly, 3=directly).	See above
Policy goals conceived in the context of other addiction policies or appear in the same policy document				National strategy – public policy plan in force	Document analysis; expert ratings on a five-grade scale (1= no relationship stated at all, 2=at least two policy fields refer to each other, 3=all three refer to each other, 4=two policy fields appear under one umbrella, 5=all policy fields appear under one umbrella); if raters disagree, they should sit together to reach a mutually satisfactory consensus	See above
Legal framework reflects WHO statement				All legal measures in force mention the relevant addiction fields, national strategy – public policy plan in force	Document analysis from legal perspective: what did legislator intend? What is "message" of legislation in question? Expert ratings (4) on a three-grade scale: (1=no reference to WHO statement at all, 2=indirect reference to WHO statement/*Health for All*, Ottawa Charter, 3=direct verbatim reference to WHO statement); if raters disagree, they should sit together to reach a mutually satisfactory consensus	See above + legal expert

Criteria	D	A	T	Source of information	Method	Requested expertise
Legal framework is in line with the policy goals in force				All legal measures in force mention relevant addiction fields, national strategy – public policy plan in force	Comparative analysis of two sets of documents, expert ratings (4) on five-grade scale; if raters disagree, they should sit together to reach a mutually satisfactory consensus. In this analysis, identifying "hidden message" of legal framework may play an important role.	See above
Legal framework brings different addiction fields under one umbrella				All legal measures in force mention the relevant addiction fields	Document analysis, expert ratings on six-grade scale (1=different addiction fields are tackled independently in all legal measures in force, 2=comprehensive acts, at least two addiction fields are tackled together, 3=comprehensive acts, all three addiction fields are tackled together, 4=in most legal measures, at least two addiction fields are tackled together, 5=in most legal measures, all three addiction fields are tackled together, 6=legal measures put forward different messages on different addiction fields); if raters disagree, they should sit together to reach a mutually satisfactory consensus.	

This proposed approach, shown in Figure 3.15, slightly rearranges the figure presented earlier.

Figure 3.15: Revised logic of conceptualising coherent addiction policies



Qualitative study

As mentioned in previous sections, there are no comprehensive addiction policies in force right now in Hungary. Obviously this is a problem if we wish to study the coherence among addiction policies. In the earlier part of the analysis we relied on publicly available documents and their analysis in order to follow the recommendations of the Coherent Policy Expert Group. We knew from the very start that we would not be able to produce a comprehensive picture as we lacked those documents that provide the basis of a well-functioning addiction policy. So, after a lot of consultation, we decided to subdivide the task into two parts; in this second part we present the perceptions of professionals active in the field and/or having official responsibility on behalf of the public administration in the field.

In order to get acquainted with the perception of these professionals we organised focus group discussions. In the following sections we present the experiences of these focus groups.

Participants

As we wanted to know the perception of different professional groups, we invited officers from the Ministry of Human Resources. This is a large ministry responsible for illicit drugs, alcohol and other public health issues, for health and social care, and – among other things – for public education. We also invited experts from the National Institute for Health Development and the National Bureau of Drug Prevention, representatives of local co-ordination forums on drugs (KEF), chief representatives of civil organisations and researchers. Not all those invited were able to attend; altogether 13 people participated in three focus groups, as shown in Table 3.12.

Table 3.12: Professionals attending the focus groups

Date of the focus group / Participant categories	July 17	July 18	July 22
Co-ordination Forum on Drugs	4	1	
Chief representatives of civil organisations and service providers (covering treatment, prevention, harm reduction in the relevant fields)		4	
Researchers		1	
Public officials			3
Total	13		

Method

During the focus group discussions our ambition was to get acquainted with the perceptions of professionals about the issue under consideration. Focus groups are an appropriate methodology for this purpose because they are the best way to collect information on views and perceptions; focus groups are carefully prepared discussion groups in which perceptions and competing/conflicting views on the topic under consideration can be revealed (Krueger 1988).

A focus group guideline was developed on the basis of the coherent policy markers[23] document; the main topics were these:

- How severe do the participants consider the current state of the problem?
- Which data sources do they rely on when making their judgment?
- How do they perceive the public's opinion in this regard?
- How proportionate is resource allocation among these three areas in the light of the connected problems?
- Are the different addiction fields independent or interrelated?
- Which national strategic documents do they think define the policy frameworks of addiction?
- Which institutions are responsible for executing the policies of the given areas (alcohol, tobacco, drugs)?

23. The complete guide can be seen in the Introduction.

Apart from discussion topics, short questionnaires were also used in the focus groups to facilitate discussion, giving the participants an opportunity to think a bit about the issue and to formulate their views in a more reasoned way. Three short questionnaires required participants:

- to judge the independence of the three fields of addiction by a set of criteria, namely;
  - strategy development process;
  - legal regulation;
  - prevention;
  - harm reduction;
  - treatment;
  - financing;
  - monitoring/evaluation;
- to judge if the different addiction policies are interrelated (smoking–alcohol use; alcohol use–illicit drug use; illicit drug use–smoking; all three), using the criteria above;
- and, given the strategic documents mentioned previously, to evaluate on a five-point scale how much the decision-making routines adopt the approaches and guidance of the different policy documents/drafts.

The focus group discussions were recorded (with the permission of the participants) and then a verbatim transcription was made to ease the analysis.

Results

1. How severe do the participants consider the current state of the problem?
In all three focus groups, the majority of participants agreed that the alcohol problem is the most serious of the three, and 10 participants ranked this problem in first place. It is important to note that the experts' opinion of the severity of the problem is very much in line with the statements formulated under "State of the problem", which were based on available national statistics.

2. On which data sources do they rely on when making their judgment?
The vast majority of the respondents referred to research data, though there were some critical voices saying that data are hardly available, research activities are scarce or the data obtained from different research are difficult to compare. One respondent (head of a low-threshold service) referred to personal experiences.

3. How do the respondents perceive the public's opinion of the severity of the problem?
Again, almost all the respondents agreed that public opinion sees the most serious situation as being in the drugs field. Only one respondent said that the alcohol problem seems to be the most serious in the eyes of the public. There was a short debate on the definition of public opinion as some respondents expressed their doubts about the validity of public opinion surveys.

4. How proportionate is resource allocation among these three areas in the light of the connected problems?
While answering this question, the respondents first almost unanimously stated that the available resources are far from sufficient. Public officials reluctantly formulated

their views on the relative perceived amounts spent on the three policy areas. The reason they gave for their unwillingness to give a definite answer in this regard was partly because they considered their knowledge was not comprehensive and partly because they wanted to avoid being biased. The other difficulty, and this was mentioned not just by officials, was that the financial resources are not clearly labelled: treatment-related expenditures are in the health budget – National Health Insurance Fund[24] – while social service expenditures are in another pocket. Apart from agreeing that the resources are not sufficient in general, all respondents shared the view that the finances for tackling the alcohol problems are the least appropriate. Interestingly, field professionals and public officials both had the perception that the financial resources available for tackling the different problem areas are disproportionate if the severity of the problem and the available resources are compared.

5. Are the different addiction fields independent or interrelated?
This topic was introduced by two short questionnaires which were filled in individually; then the participants shared their views with each other. The picture according to the respondents is not quite clear. The different fields have individual policy concepts (as we saw, there is no strategy in force in any of the fields) and they are quite independent, though some of them (the new drug strategy) do refer to other addiction fields. The respondents mostly agreed that the legislation for each field is also independent. In service provision the level of interrelatedness is much higher, especially when speaking about prevention, treatment and care. Alcohol and illicit drug issues, according to the perception of the respondents, appear more frequently together while smoking is tackled rather independently. All respondents agreed that monitoring and evaluation, if they happen at all, deal with all policy fields. Actually it can be seen from the transcript text that respondents, when speaking about monitoring and evaluation, rather mean population surveys like ESPAD and HBSC (health behaviour in school-aged children), which deal with multiple problem areas.

6. Which national strategic documents do they think define the policy frameworks of addiction?
The formulation of the question might seem odd in a study that deals with the coherence of addiction policies; however, Hungary's specific situation may justify this phrasing. As we saw earlier, comprehensive strategic documents are missing at the moment. Nonetheless, professional work is happening and we wanted to know which directives/documents help the professionals and officials to organise their activities. For this reason we asked them to list the documents they thought relevant in this regard. This particular bit of the discussion proved to be quite lengthy as participants argued a lot over the topic. Originally we expected obvious differences between the views of officials and other professionals. Actually we experienced a lot of perplexity in both cases. Non-public officials referred to acts (Act CLIV of 1997 on Health; Act on Social Services, Act on Child Protection, penal code, etc.), protocols, minimum standards, local strategies and professional guidelines as well as the national public health programme, and the alcohol policy and plan. Interestingly, they did not mention the anti-smoking action plan. There was agreement among them that the health-care and social service-related protocols, professional guidelines and other legal regulations

24. OEP in Hungarian.

(by-laws) have the most relevant impact on everyday functioning and decisions on finances. They also emphasised that, without comprehensive strategies in force, it is very difficult to organise well-structured, systematic field work. Officials were also uncertain about the most influential policy documents. They listed almost the same documents as other professionals, with some additional elements: the Semmelweis Plan (mentioned earlier), the government's programme of national co-operation,[25] the national anti-drug strategy currently in parliament and the national public health programme (in this latter case the expiry of the document was mentioned too). It was salient that both public officials and other professionals hesitated a lot about giving a definite answer on the most influential policy documents in the relevant field, and different documents were identified depending on the criteria[26] by which the relevance of the document was supposed to be judged. Public officials also mentioned that there is a government decree on strategic planning – 38/2012. (III. 12.)[27] – which describes content and structure-related expectations of public policy documents, and that most of the strategic documents mentioned do not reflect these expectations.

7. Which institutions are responsible for executing the policies of the given areas (alcohol, tobacco, drugs)?
Finally we wanted to learn the participants' views and perceptions of policy implementation: the structures, institutions and responsible bodies. First, the participants were asked to name the relevant institutions and then map them and describe the way they are connected. This part of the discussions proved to be the longest, partly because all participants hesitated a lot as the public administration system is being reorganised and the former arrangements are not valid any longer. The functions are more or less the same, but appear in a different structure. Many institutions and bodies were mentioned, most frequently the Ministry of Human Resources as this ministry covers different but interrelated fields (health and social issues; public and higher education; sport and youth affairs). This is the umbrella ministry having the main responsibility for the addiction fields considered. All participants expressed their view that the establishment of the new ministry is a great opportunity for more co-ordinated action in those fields where the clientele is shared and where previous interventions and programmes did not necessarily reflect each other. Professionals who were not public officials said this was more a hope than a reality.

Altogether 15 different bodies were mentioned as responsible for addiction-related public policy. Apart from the ministry, background institutions were mentioned: the National Institute for Health Promotion (NIHP; the National Focal Point on Smoking functions as part of this organisation), National Centre on Addictions (also part of NIHP), National Institute of Social Policy and Family Affairs (the National Bureau of Drug Prevention functions within this body), Hungarian National Focal Point on Drugs, National Institute of Quality and Organisational Development in Healthcare and Medicine, General Directorate of Social Affairs and Child Protection and National Office for Rehabilitation and Social Affairs. The institutions listed are mostly responsible for executing policies. Advisory bodies were also referred to, those

25. Source: www.miniszterelnok.hu/in_english_article/the_programme_of_national_cooperation.

26. Criteria were: decision making; regulation; financing.

27. Source: http://net.jogtar.hu/jr/gen/hjegy_doc.cgi?docid=A1200038.KOR.

most frequently mentioned being the Intergovernmental Committee on Drugs and the Drugs Council (their current responsibilities and history were described earlier under Structures and resources). Non-public official professionals also mentioned the role and importance of the Health Board, a committee of professionals which is supposed to advise the minister on particular issues. Participants also mentioned the local co-ordination forums on drugs (KEFs). They expressed widely varying views on whether KEFs are still functional or not, though all agreed that it was a very useful initiative (for a description, see earlier under Structures and resources). Among the bodies relevant to addiction policies, NGOs were also mentioned, most frequently the umbrella organisations whose members are civil organisations active in the field.

The focus group participants were asked to describe the relationship among the different bodies. The pictures they drew were very complicated, and even public officials were not quite sure about the position of the given organisations or the nature of the relationship (who is supposed to commission a task, to supervise implementation, etc.). The uncertainty was greater among non-public official professionals as they were slightly confused about the current and previous institutional structures and the relevant responsibilities.

There was clear agreement among all participants that stronger co-operation between institutions would be beneficial; non-public official professionals emphasised that the system does not encourage horizontal co-operation, and decision making is not truly reacting to needs and considerations stemming from the field. Public officials also said that, though there is a vertical system of co-operation among public institutions and bodies which is based on their hierarchy, horizontal co-operation among the three examined fields is weak.

Summary of the findings

The focus group discussions developed the expert views formulated in the earlier analysis. The statement that there are no addiction policies in force at the moment was reinforced. Participants widely agreed that alcohol is the most severe problem in Hungary. They also almost unanimously agreed that public opinion and professional views are different in this respect, as the public perceive illegal drugs as the most worrying problem of the three.

Though there are no strategic documents in force in the fields considered, focus group participants were able to list those strategic documents that have an impact on field activities, legislation and resource allocation. They concluded that interventions, legislation and resource allocation in the three fields under consideration are not properly co-ordinated; it was mentioned several times that the anti-drug strategy (to be adopted by parliament in the second half of 2013) is currently the only policy document that is firm on co-ordinated activities, mostly in the field of alcohol use and mental health problems. All participants saw an obvious need – and non-public official professionals were more definite about this – for synergic approaches to be applied and for public policies to be in force. This was seen as having very high importance as this is the leading concept which can be referred to and which sets the standards; a strategy in force supplemented with an adopted action plan can be a proper basis for resource allocation. The most demanding part of the focus

group discussions was to identify the relevant organisations. It turned out that the system is very much segmented and people coming from the field are much more hesitant about identifying the institutional structures. Surprisingly, some uncertainty could be observed among public officials as well. It might be an important message to government actors and stakeholders that communication on this issue is very important because more information creates a more secure environment.

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Chapter 4

Ireland – Coherency of policies on illicit drugs, alcohol and tobacco

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Introduction

This chapter reviews the coherency of Ireland's policies on alcohol, tobacco and controlled psychoactive substances, meaning those controlled under the UN drug conventions (referred to here as "illicit drugs"), in relation to an over-arching health objective.

Policy coherency is defined as "the extent to which different public policies complement or support each other. At best, policy coherence creates synergies between different public policies; it leverages capacity to realise a common policy goal. At a minimum, it ensures that different policies do not undermine one another or cancel each other out."[1]

The three policy domains are assessed against six dimensions of policy, which provide "markers" of various aspects of coherency:

- conceptualisation of the problem: risk and risk perception;
- policy context: ideological framing;
- legislative and regulatory framework: control;
- strategies and action plans: action;
- structures: governance;
- resources: political choices.

The definition of health is that used by the World Health Organization in its founding charter and adopted in Ireland's national health strategy: "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity".[2] In pursuit of this over-arching objective, the Irish Government has developed a "population health" approach, defined as "one which promotes and protects the health of the whole population or sub-groups, with particular emphasis on reducing inequalities".[3] It has also developed a policy framework for "improved

1. Pike (2012a), "Policy coherence: notes towards a concept".
2. Department of Health and Children (2001), *Quality and fairness*.
3. Health Service Executive (2008), *The HSE population health strategy*.

health and well-being", adopting a co-ordinated approach that involves government departments, local authorities and public bodies, businesses and employers, sports and voluntary groups, and communities and families in realising the aim of a "healthy Ireland".[4] Ireland's policies and strategies on illicit drugs, alcohol and tobacco are all mentioned in this suite of health policies.

Evidence with regard to the six markers has been taken from published policy documents and reports. Corroboration of the markers and the evidence has been sought in the academic and research literature.

For an account of the context and development of Ireland's drug policy from the 1970s up to 2008, and its links with alcohol and tobacco policies, readers are referred to the chapter on Ireland in the first report from this project.[5] The main change in Ireland's policy environment since 2008 has been the political decision taken in 2009 to combine illegal drugs and alcohol within the one policy domain.[6]

Conceptualisation of the problem

This marker focuses on risk and risk perceptions. An idea of society's perceptions of substance-related risks may be derived by comparing evidence of the adverse impact or harms deriving from the use of each substance on its individuals and communities with the same society's perceptions of the toxicity and adverse impacts or harms associated with the substance. Thus:

- What are the probabilities of harms associated with the use of illicit drugs, alcohol or tobacco?
- How do policy, the media, public opinion, cultural expressions and social, economic and political conditions influence representations of the harms and the probabilities?

As risk perception is a factor that influences policy choices, it may be expected that changes in perception may lead to changes in policies.[7]

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4. Department of Health (2013a), *Healthy Ireland*.
5. Pike (2008), "Irish drug policy".
6. Action 1 in Dept of Community, Rural and Gaeltacht Affairs (2009), *National Drugs Strategy, 2009–2016*.
7. See K. Lancaster and A. Ritter (2014), "Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents, 1985–2010", *International Journal of Drug Policy* (25/1), 81-7; J. Edman and K. Stenius (2014), "Conceptual carpentry as problem handling: the case of drugs and coercive treatment in social democratic welfare regimes", *International Journal of Drug Policy* (25/2), 320-8; S. MacGregor (2013), "Barriers to the influence of evidence on policy: are politicians the problem?" *Drugs: Education, Prevention and Policy* (20/3), 225-33; J. Tieberghien and T. Decorte (2013), "Understanding the science–policy nexus in Belgium: an analysis of the drug policy debate (1996–2003)", *Drugs: Education, Prevention and Policy* (20/3), 241-8; E. Houborg (2012), "The political pharmacology of methadone and heroin in Danish drug policy", *Contemporary Drug Problems* (39), 155-92; M. Monaghan (2011), *Evidence vs politics: exploiting research in UK drug policy making*, Bristol: The Policy Press; N. McKeganey (2011), "From harm reduction to drug user abstinence: a journey in drug treatment policy", *Journal of Substance Use* (16/3), 170-94; T. A. Deseran and J. D. Orcutt (2009), "The deconstruction of a drug crisis: media coverage of drug issues during the 1996 presidential campaign", *Journal of Drug Issues* (39/4), 871-91.

Table 4.1: Probabilities of harms associated with drug, alcohol and tobacco use

Indicator	Illicit drugs	Alcohol	Tobacco
Prevalence of and trends in use: in general population among problem users	In late 2010/early 2011, 7% of Irish adults aged 15-64 reported using an illegal drug in the past year.[8] Problem users:[9] In 2006 there were 11 807 opiate users, known from contact with drug treatment or hospital inpatient services, or Gardaí. Since the previous estimate in 2001: opiate use among those aged 15-24 had decreased, indicating that fewer young people started opiate use, opiate use outside Dublin had increased, and a higher proportion of opiate users in Dublin were in treatment than elsewhere, reflecting the more recent spread of opiate use outside Dublin and later development of treatment services.	In late 2010/early 2011 87% of Irish adults aged 18-64 reported drinking alcohol in the past year.[10] Problem users: Using data from the same prevalence survey, 50% of Irish adults (aged 18-64) and 58% of current drinkers were classified as consuming alcohol harmfully.[11]	In December 2012, 21.7% of adults aged 15 or over reported they were smoking currently.[12] Problem users:[13] The National Tobacco Control Office (NTCO) monitors the reported number of cigarettes smoked daily by smokers, who are categorised as: *Occasional*: 1 to 5 cigarettes per day *Light*: 6 to 10 cigarettes per day *Regular*: 11 to 20 cigarettes per day *Heavy*: 21 or more cigarettes per day As at December 2012: *Heavy smokers*: 5.0% *Regular smokers*: 35.9% *Light smokers*: 34.0% *Occasional smokers*: 23.9% The NTCO reports that occasional and light smokers are an increasing proportion of all smokers and the relative prevalence of heavy and regular smokers is declining.

8. NACD and PHIRB (2011), *Drug use in Ireland*.
9. Health Research Board, Irish Focal Point (2012), *2012 National Report (2011 data) to the EMCDDA*.
10. NACD and PHIRB (2012), *Drug use in Ireland*.
11. The survey examined patterns of harmful drinking using the WHO's AUDIT-C screening tool, and harmful drinkers were identified as those who had a score of five or more.
12. The National Tobacco Control Office in the Health Service Executive (www.hse.ie) monitors cigarette smoking prevalence, based on data from a monthly quota survey on Ipsos MRBI's telephone omnipoll. Prevalence rates are estimated from the number of positive responses to the question, "Do you smoke one or more cigarettes per week?" and are presented as 12-month averages to provide more stable estimates.
13. www.hse.ie/eng/about/Who/TobaccoControl/Research/ (retrieved 6 August 2013).

Indicator	Illicit drugs	Alcohol	Tobacco
Related deaths	Between 2004 and 2010 there were 3 972 deaths among drug users by drug poisoning (2 364) or other causes (1 608), as recorded in the NDRDI. Deaths in 2010 decreased to 575, compared to 652 in 2009.[14]	Every month 88 deaths in Ireland are directly attributable to alcohol: 1 056 deaths per year.[15]	Each year 5 500 people in Ireland die from tobacco use. Half of them die as a direct result of smoking; half die prematurely. Average smokers lose 10 healthy quality years of life.[16] It is estimated that Ireland's 2004 workplace smoking ban reduced the number of deaths from tobacco use by over 3 500.[17]
Other social costs: health, accidents, crime, vandalism, absenteeism	To date, no study of the social costs associated with illicit drug use in Ireland has been conducted.	Alcohol costs Ireland €3.7 billion (2007 estimate) in problems of health, premature death, suicide, vandalism, crime, absenteeism, workplace or traffic accidents.[18]	No data on social costs available but significant productivity losses have been alleged from lost output owing to excess absenteeism, smoking breaks and premature death.[19]

14. Health Research Board (2013), *Drug-related deaths*.
15. http://alcoholireland.ie/facts/alcohol-related-harm-facts-and-statistics/ (retrieved 6 August 2013).
16. www.hse.ie/eng/services/list/1/environ/Tobacco_Control.html (retrieved 6 August 2013).
17. Stallings-Smith S., Zeka A., Goodman P., Kabir Z. and Clancy L. (2013), "Reductions in cardiovascular, cerebrovascular, and respiratory mortality following the national Irish smoking ban: interrupted time-series analysis", *Public Library of Science ONE* 8(4). www.drugsandalcohol.ie/19756/.
18. Byrne (2010), *Costs to society of problem alcohol use in Ireland.*
19. Department of Health (2013a), *Healthy Ireland*.

The most recent prevalence data summarised in Table 4.1 indicate that alcohol is the psychoactive substance most widely used by the general population (87%), followed by tobacco (21.7%) and then illicit drugs (7%). The most recent data on deaths associated with each category of substance, summarised in Table 4.1, indicate that tobacco use causes more deaths (5 500 per annum) than alcohol (1 056 per annum) or illicit drugs (575 in 2010; 652 in 2009).

Table 4.2: Attitudes, opinions and research on illicit drugs, alcohol and tobacco[20]

Indicator	Illicit drugs	Alcohol	Tobacco
Political manifesto/ government programme[20]	"We are committed to providing renewed impetus to the fight against drugs and to ensuring that the Strategy once again becomes relevant and effective. We will where possible enhance demand reduction strategies." (p. 49) Document lists 15 specific proposals on supply reduction, prevention, harm reduction, treatment and rehabilitation.	"We support the principles and objectives of the National Addiction Strategy. … The new National Addiction Strategy deals with both drugs and alcohol addiction. … integrate drug and alcohol abuse strategies at local level." (pp. 49-50) No other mention of alcohol.	"We will increase the penalty for tobacco smuggling for commercial purposes and provide robust detection measures to counteract such smuggling." (p. 47) No other mention of tobacco or smoking.

20. Quotations from Fine Gael and Labour Party (2011) *Towards recovery*.

Indicator	Illicit drugs	Alcohol	Tobacco
Public opinion	A 1998 public opinion survey indicated great concern about the extent of drug use and drug-related crime, but 56% saw alcohol abuse as a greater problem than drugs.[21] This survey was reiterated in 2001 (unpublished); since then there has been no general survey of knowledge, attitudes and beliefs about drugs. The 4-yearly all-island general population (ages 15-64) survey of drug use shows consistently strong (over 67%) support for the medical use of cannabis. Support for recreational use of cannabis is much lower (around 20%).[22] Results of the 2010/11 survey on use of cannabis for medical reasons are not yet published.	A 2012 public opinion survey showed a strong belief among respondents (85%) that levels of alcohol consumption are too high and a general perception (73%) that Irish society tolerates high levels of alcohol consumption. Many (58%) did not think the government was doing enough and most (78%) believed the government had a responsibility to address high alcohol consumption through new public health measures.[23]	A survey in 2012 of attitudes to tobacco among Europeans showed that support among the Irish for tobacco-control policies was high and had increased since the previous survey in 2009, except for increases in taxes on tobacco products, where support among the Irish had dropped since 2009.[24]
Media coverage	No analysis has been undertaken in recent years.	No analysis has been undertaken in recent years.	No analysis has been undertaken in recent years.

21. Bryan et al. (2000), *Drug-related knowledge, attitudes and beliefs*.
22. NACD and DAIRU (2005), *Drug use in Ireland*; NACD and PHIRB (2008), *Drug use in Ireland*; NACDA (2013), *Drug use in Ireland*.
23. Ipsos MRBI (2012) *Alcohol: public knowledge, attitudes and behaviours*. Dublin: Health Research Board. www.drugsandalcohol.ie/18022/.
24. European Commission (2012) *Attitudes of Europeans towards tobacco: report*. Special Eurobarometer 385 / Wave EB77.1 – TNS Opinion & Social. http://ec.europa.eu/public_opinion/index_en.htm.

Indicator	Illicit drugs	Alcohol	Tobacco
Cultural mores and attitudes	Since the 1980s the "drug problem" in Ireland has been framed as (1) a public health issue, focusing on the need to reduce the harms associated with intravenous drug use, and (2) a social problem, especially opiate use, linked with social exclusion and poverty.[25]	The problems associated with alcohol in Ireland were already recognised in the mid-1990s, but it has been hard to reach consensus on how to address these problems, a difficulty attributed to divergent cultural attitudes: alcohol has been regarded as part of everyday life and "essentially benign" while illicit drugs have been seen as "unspeakably evil".[27]	No information available. The European survey of attitudes to tobacco-control policies, mentioned above, indicates that tobacco use is regarded as a public health issue.

25. Pike (2012b), "Ireland", Section 5.2.1.
26. Butler (2002), *Alcohol, drugs and health promotion*.

Indicator	Illicit drugs	Alcohol	Tobacco
Research	The NACDA (National Advisory Committee on Drugs and Alcohol) advises the government on the prevalence, prevention, consequences and treatment of problem drug use, based on analysis and interpretation of research. In line with Action 55 of the National Drugs Strategy 2009-16, the NACDA develops and prioritises an annually revised research programme. In 2012 it completed studies on prevalence patterns of problem substance use among prisoners and illicit drug markets. On the EMCDDA's five key epidemiological indicators: The NACDA has lead responsibility collecting data on prevalence/patterns of drug use in the general population and problem drug use. The Health Research Board (HRB) has lead responsibility for data collection of demand for drug treatment, drug-related deaths, mortality of drug users and drug-related infectious diseases.[27]	The 1996 National Alcohol Policy and 2004 Strategic Task Force on Alcohol advised setting up an independent research and monitoring unit to build capacity in alcohol research, examining drinking patterns, alcohol-related harm, effectiveness of policy measures and other issues. The National Drugs Strategy 2009-16 identified the need for the Department of Health and Children to develop suitable harmful alcohol-use indicators and associated data collection mechanisms.[28] To date, no independent research and monitoring unit has been established. The Department of Health commissions research to support design of its proposed legislative measures.	The NTCO in the Health Service Executive monitors cigarette smoking prevalence and behaviour monthly to gain a detailed picture of smoking patterns and identify trends. Established in 2000, the Tobacco Free Research Institute Ireland (TFRI) is a partnership between the Office of Tobacco Control and ASH Ireland (an anti-tobacco advocacy group) and its parent organisations: the Irish Cancer Society and the Irish Heart Foundation. TFRI has four core research programmes: 1. treatment of tobacco dependence 2. tobacco-control policy 3. smoke-free areas 4. inequalities and smoking.[29]

27. Department of Health (2013b), *National Drugs Strategy 2009-2016: progress report*.
28. Department of Health (2012a) *Steering group report on a national substance misuse strategy*.
29. www.hse.ie/eng/about/Who/TobaccoControl/Research/ and www.tri.ie.

The data on perceptions of the harms associated with tobacco use, summarised in Table 4.2, indicate a broad consensus in Ireland that tobacco is an issue that needs to be addressed and a shift towards a focus on public health. This shift has been accompanied by a shift in government policy: in 2009 the government decided to combine alcohol and drug policies in one "substance abuse policy". To support this decision, the government surveyed public opinion, which shows support for a stronger government response, and initiated research projects to provide a sound evidence base for its policies. Table 4.2 shows that perceptions of illicit drugs in Ireland are ambivalent, seeing them as a criminal justice problem and a public health/social inclusion issue.

A comparison of tables 4.1 and 4.2 suggests that the relationship between prevalence, problem use and risk of death associated with each of the three categories of psychoactive substance on the one hand, and perceptions of risk associated with each category of psychoactive substance on the other hand, is complex. Steps to increase policy coherency around public health goals need to take this complex relationship into account and be designed to ensure that probabilities and perceptions of risk are logically aligned.

Policy context

Where drug, alcohol and tobacco policies are located within the overall policy environment – for instance, in a criminal justice or medical context, or in the context of a value set like social inclusion, human rights or equality – indicates how policy makers make sense of the problems. It shows the prevailing ideological perspective, for example: neo-conservative, a moral standpoint that supports prohibition and abstinence-based approaches; welfarist, pursuing broad goals such as equality or social inclusion, and supporting pragmatic responses such as harm reduction; or neo-liberal, based on calculations of risk and favouring utilitarian solutions that reduce risks to individuals, families and communities.[30]

Such ideological preferences may be detected in the following aspects of the policy environment:

- obligations and commitments made in line with international agreements;
- policy makers' underlying preferences in the role of the state ("political rationalities"); and
- the mix of responses in national policy frameworks, be they punitive, preventative, economic, harm reductionist or rehabilitative.

Recent drug policy research has peeled back the "politicised debate" on illicit drug policy, which tends to reflect prevailing perceptions of harms and risks as discussed above, to reveal what might be termed the ideological substratum. Researchers argue that attempts to alter prevailing perceptions of harms and risks need to recognise and work with these underlying ideological preferences as well.[31]

30. E. Houbourg (2012), Review of N. McKeganey (2011), *Controversies in drugs policy and practice* in *Drugs: Education, Prevention and Policy* (19/5): 427-8; E. Houbourg and B. Bjerge (2011), "Drug policy, control and welfare", *Drugs: Education, Prevention and Policy* (18/1), 16-23.

31. J. Edman (2013), "An ambiguous monolith: the Swedish drug issue as a political battleground 1965–1981", *International Journal of Drug Policy* (24/5), 464-70; F. Matthew-Simmons, M. Sunderland and A. Ritter (2013), "Exploring the existence of drug policy 'ideologies' in Australia", *Drugs: Education, Prevention and Policy* (20/3), 258-67.

Table 4.3: Obligations/commitments in line with international agreements

Illicit drugs	Alcohol	Tobacco
UN: Ireland has ratified the UN conventions:[32] 1961 Single Convention on Narcotic Drugs (amended by 1972 Protocol) 1971 Convention on Psychotropic Substances 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. **European Union:** Ireland complies with EU drugs strategies and action plans, and the EU *acquis* relating to controlled substances:[33] *EU Drugs Strategy 2013-2020*: four pillars, a "balanced … evidence-based" approach *EU Drugs Action Plan 2013-2016*: same four pillars, focus on common standards across, and co-operation between, member states	In the absence of formal international conventions/frameworks on alcohol use, Ireland observes these initiatives: **UN/WHO**: *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (A/RES/66/2) (66th session Agenda item 117, 24 January 2012), which recognises "that the most prominent non-communicable diseases are linked to common risk factors, namely tobacco use, harmful use of alcohol, an unhealthy diet and lack of physical activity". This declaration endorses the *Global Strategy to Reduce the Harmful Use of Alcohol* (WHO, 63rd World Health Assembly, Geneva, 17-21 May 2010, Resolutions and Decisions, Annexes (WHA63/2010/REC/1), Annex 3. **European Union:**[34] The first EU Alcohol Strategy (COM (2006) 625 final) was adopted by the European Commission in October 2006, and endorsed by other EU institutions. It is designed to help governments and other stakeholders co-ordinate action to reduce alcohol-related harm.	On 21 May 2003 the World Health Assembly unanimously adopted the **Framework Convention on Tobacco Control (FCTC)**. Parties to the treaty, including Ireland, must initiate comprehensive tobacco-control measures to "protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control … to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke."[35] **European Union:** Ireland complies with EU directives, regulations and recommendations, including:[36] *Tobacco Products Directive* (2001/37/EC) On 14 March 2014 the Council approved a revised law regulating tobacco products in the EU to improve the functioning of the internal market for tobacco and related products, so tobacco products look and taste like tobacco, thereby discouraging young people from starting to smoke. This legislation is awaiting signature by the presidents of Council and parliament. Member states will then have two years to transpose the directive into law.

32. For texts of conventions, visit www.unodc.org/unodc/en/treaties/.
33. For more information, visit http://ec.europa.eu/justice/anti-drugs/european-response/index_en.htm and www.emcdda.europa.eu/.
34. For more information, visit http://ec.europa.eu/health/alcohol/policy/index_en.htm.
35. For more information, visit www.who.int/fctc/en/.
36. For more information, visit http://ec.europa.eu/health/tobacco/introduction/index_en.htm.

Illicit drugs	Alcohol	Tobacco
EU directives: The legal basis of EU drugs policy under the Treaty of Lisbon is twofold: judicial co-operation in criminal matters (Articles 83 (1) and 84), and public health (Article 168). EU countries have also agreed on legislative instruments to tackle illicit drugs at EU level.	Ireland is an active participant at both government and NGO level in EC implementing structures, including: Committee on National Alcohol Policy and Action (CNAPA) – governments share information, knowledge and good practice on how to reduce harmful alcohol use. European Alcohol and Health Forum (EAHF) – a platform where European bodies can debate, compare approaches and act to tackle harmful levels of alcohol consumption. Committee on Data Collection Indicators and Definitions (CDCID) – develops indicators for monitoring overall performance of the strategy.	*Tobacco Advertising Directive* (2003/33/EC) on approximation of laws, regulations and administrative provisions of member states relating to the advertising and sponsorship of tobacco products. *Audiovisual Media Services Directive* (2007/65/EC) bans tobacco advertising/sponsorship in all forms of audiovisual commercial communications, including product placement. *Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control* (2003/54/EC) covers other forms of tobacco promotion. *Council Recommendation on smoke-free environments* (2009/C 296/02). *Council Directive on the structure and rates of excise duty on manufactured tobacco* (2010/12/EU).

Ireland has tended to be a "policy taker" in relation to the three categories of psychoactive substance; it has followed the policy priorities agreed at international level (see Table 4.3). These international policy frameworks focus on long-term health and well-being. The international policy framework for illicit drugs is a more conflicted area, as evidenced by the international debate on the UN drug conventions in the lead-up to the UN General Assembly Special Session (UNGASS) on drugs scheduled for 2016.

Illicit drugs

Following ratification of the UN conventions on drugs, Ireland translated the provisions into Irish law. As a consequence, Irish drug policy is partly located in a criminal justice context, in which the customs and police authorities work to reduce the supply of, and demand for, drugs through law enforcement. Since the first recognition of a "drug problem" in Ireland, the national response has also included a health-based aspect. Initially, this involved treatment for individual drug users. From the late 1980s onwards, following acknowledgement of the links between the spread of infectious diseases and injecting drug use, harm-reduction measures were gradually introduced. This was done at local level and only gradually absorbed into mainstream policy.[37] In 1996 a ministerial task force on measures to reduce demand for illicit drugs used epidemiological data on problem drug use to highlight the association between problem drug use, especially of opiates, and social exclusion and poverty.[38] This framing of the drug problem continued to underpin government policy on illicit drugs for the next 14 years.[39]

After a change of government in 2011, national policy on the links between illicit drugs and social policy issues, including health inequalities, became less clear.[40] The government's four national priorities for drugs, set out in the Justice and Law Reform section of its current programme, include "renewed impetus to the fight against drugs".[41] In November 2013, following debate on a private member's motion to regulate the cultivation, sale and possession of cannabis and cannabis products, TDs (members of parliament) voted 112 to 8 in favour of a government amendment that recognised the health risks associated with cannabis and its role as a "gateway" drug, recognised that leniency in cannabis control could endanger international efforts against drugs, to which Ireland signed up under the 1961 and 1971 UN drug conventions, and endorsed government policy "to maintain strict legal controls on cannabis and cannabis products in Ireland".[42]

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37. S. Butler and P. Mayock (2005), "An Irish solution to an Irish problem: harm reduction and ambiguity in the drug policy of the Republic of Ireland", *International Journal of Drug Policy* (16/6), 415-22.
38. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), *First report of the ministerial task force on measures to reduce the demand for drugs*. www.drugsandalcohol.ie/5058/.
39. Dept of Tourism, Sport and Recreation (2001), *Building on experience*, para. 6.1.9; Dept of Community, Rural and Gaeltacht Affairs (2009), *National Drugs Strategy 2009–2016* (interim), para. 6.21.
40. Pike (2011), "Inequality and illicit drug use".
41. Fine Gael and Labour Party (2011), *Towards recovery*.
42. Cannabis regulation: motion (Private Members) (5-6 November 2013) *Parliamentary Debates Dáil Éireann* (Official Report – unrevised), Vol. 819/1, pp. 91-111 and Vol. 819/2, pp. 846-69. Available at www.oireachtas.ie/parliament/.

Alcohol

The Irish Government's announcement in 2009 that it intended to combine drug and alcohol policies in one "national substance misuse" strategy marked a turning point in alcohol policy.[43] The government established a National Substance Misuse Strategy Steering Group, tasked with reviewing existing policies and reports, including at EU and international level, and setting out an evidence-based framework of effective policies and actions to tackle the harm caused to individuals and society by alcohol use and misuse. In its report,[44] the steering group adopted a population-based approach, as advocated by WHO, pointing out that it "benefits those who are not in regular contact with the health services and those who have not been specifically advised to reduce their alcohol intake".[45] In late 2013 the government announced legislative measures based on the recommendations in the steering group's report (see below). The government deferred the steering group's recommendation to develop a joint drugs and alcohol "national substance misuse strategy" until after the National Drugs Strategy expires in 2016.

Tobacco

Tobacco constitutes a separate and distinct policy domain, located entirely within the population health context, including the health of tobacco users and the wider environmental health risks created by tobacco smoke. The 2013 policy document Tobacco Free Ireland states that the overall aim of tobacco-control policy is "to reduce and eliminate tobacco-related harm in the population and the unnecessary and preventable deaths and disability caused by tobacco use."[46] The policy framework is informed by the MPOWER model, developed by WHO to enable countries to implement the Framework Convention on Tobacco Control (FCTC) measures.

Legislative/regulatory framework

The legislative and regulatory control of psychoactive substances determines how the markets in the various categories of substances are managed, which in turn has an impact on how the over-arching goals of health and well-being are achieved. For example, O'Mahony has argued that the criminal law has shaped Ireland's response to illicit drug use since the late 1970s (when legislation was enacted to comply with the UN drug conventions): the legislation criminalised drug use and therefore drug policy as well.[47] O'Mahony further argued that the law-enforcement agencies are often deployed in demand reduction as well as supply reduction, and that their engagement is not just preventative but also coercive. Legislation on

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43. For an account of alcohol policy up until this milestone, see Pike (2008), "Irish drug policy".
44. Dept of Health (2012a), *Steering group report*.
45. D. Mongan (2012), "Steering Group launches report on a national substance misuse strategy", *Drugnet Ireland* (41), 1-2. www.drugsandalcohol.ie/17264/.
46. Tobacco Policy Review Group (2013), Tobacco Free Ireland.
47. O'Mahony (2008), *The Irish war on drugs*.

tobacco is contained in public health bills – as is, for the first time, the legislation on alcohol currently being drafted.

Control of psychoactive substances may be broken down into three parts:

- compliance with international agreements;
- control of supply and demand; and
- control of external costs.

Illicit drugs

Drugs and precursors in Ireland are classified in accordance with the UN conventions of 1961, 1971 and 1988. Irish legislation defines as criminal offences the trade in and import, manufacture or possession of, other than by prescription, most psychoactive substances. The main criminal legislative framework is the Misuse of Drugs Acts (MDA) 1977/1984 and the Misuse of Drugs Regulations 1988. The latter lists under five schedules the substances to which the laws apply.

In response to the emergence of head shops selling "legal highs", the Criminal Justice (Psychoactive Substances) Act 2010 made it a criminal offence to sell or supply substances which might not be specifically controlled under the MDA but which have psychoactive effects. In a study of the impact of this 2010 legislation, Ryall and Butler argued that while it may have provided for an "effective cross-cutting activity between the health and criminal justice sectors", it has had a deleterious effect on efforts to reduce the harms associated with illicit drug use.[48]

A consequence of prohibition is that there are no measures controlling the quality of substances traded in the illegal drug market or regulating this market. With regard to harm reduction, a review of Irish legislation governing the production, possession and supply of controlled drugs found that methadone treatment by medical practitioners and pharmacists is provided for under the MDA but it is not legally permissible to operate a drug-consumption facility in Ireland.[49] Given the residual uncertainty surrounding the legality of other harm-reduction measures, such as giving advice on safe drug use or needle exchange, organisations providing these types of service in Ireland have been advised to seek legal advice and to communicate and work co-operatively with local police personnel.[50]

As regards external costs, from the 1980s, and increasingly from the 1990s, banning the market in illicit drugs led to a surge in drug-related criminal activity. In response, successive Irish governments introduced a large body of criminal justice legislation to tackle drug trafficking, smuggling and money laundering, giving powers to detain and interrogate suspects, impose harsher sentencing for offences relating to possession of drugs for supply, confiscate illegally-acquired assets and combat organised criminal activity and drug dealing in communities

48. G. Ryall and S. Butler (2011), "The great Irish head shop controversy", *Drugs: Education, Prevention and Policy* (18 /4), 303-11.
49. Moore et al. (2004), *A review of harm reduction approaches in Ireland*.
50. Ibid; E. Kiely and E. Egan (eds) (2000), *Harm reduction: an information and resource booklet for agencies engaged in drug education*. Cork: Dept of Applied Social Sciences, NUIC, at www.drugsandalcohol.ie/5445/.

and prisons.[51] The consequences of "intoxication" by illicit drugs and/or alcohol are addressed in a range of laws dealing with public order offences, antisocial behaviour and dangerous driving.[52]

Tobacco and alcohol

Markets in tobacco and alcohol products in Ireland are controlled, increasingly strictly, under the Public Health (Tobacco) Acts 2002, 2004 and 2009, and the Intoxicating Liquor Acts 2000, 2003 and 2008. A key objective of this legislation is to ensure that young people are neither exposed to nor have access to tobacco or alcohol products. The legal minimum age for purchasing tobacco and alcohol is 18 years.

By law, advertising and display of tobacco products is prohibited on TV, in shops and around cigarette vending machines, and access to tobacco products in retail outlets and licensed premises is strictly controlled. Health warnings on tobacco products occupy 32% of the front of each packet and 45% of the back. Given that tobacco price elasticity has been found to be comparatively high among low income groups and young people, pricing of tobacco products is used in Ireland as a policy tool to discourage people, including children, from purchasing tobacco; taxation represents approximately 80% of the retail price of cigarettes. It is also illegal to sell cigarettes in packs of less than 20, again to deter people, especially children, from buying tobacco products. In November 2013 the government approved the publication of the General Scheme of a new Public Health (Standardised Packaging of Tobacco) Bill 2013 and authorised the drafting of the legislation based on this general scheme.[53]

The alcohol market is not as tightly controlled as tobacco. Legislation specifies the opening hours for licensed premises and off-licences, and prohibits the "happy hour" – the sale of alcohol at reduced prices for a limited period during any day. However, there is little control of alcohol marketing at point of sale, for example product promotions and placements in mixed retail outlets such as supermarkets. By law, it is an offence to supply alcohol to a drunken person or to admit a drunken person to a bar.[54] Children under the age of 18 are allowed in licensed premises only if they are with a parent or guardian, subject to certain time and other restrictions, and may not drink alcohol;[55] children may not enter an off-licence unless accompanied by an adult.

Voluntary codes on alcohol advertising and sponsorship are negotiated between the Department of Health and representatives from the Irish alcohol and advertising

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51. For example, Criminal Justice (Drug Trafficking) Act 1996; Criminal Assets Bureau Act 1996; Europol Act 1997; Criminal Justice (Theft and Fraud Offences) Act 2000; Criminal Justice Acts 1999 sections 4-6/2006/2007.
52. For example, Road Traffic Act 1994; Criminal Justice (Public Order) Acts 1994/2002; Maritime Safety Act 2000; Safety, Health and Welfare at Work Act 2005; Railway Safety Act 2005; and Intoxicating Liquor Act 2008.
53. General Scheme of the Public Health (Standardised Packaging of Tobacco) Bill. Downloaded on 10 December 2013 at www.dohc.ie/wp-content/uploads/2014/03/General_Scheme.pdf.
54. Intoxicating Liquor Act 2003, s. 4.
55. Children may only drink alcohol in a private residence and only with the permission of their parents.

industries. The codes aim to reduce the exposure of young people to alcohol advertising and marketing, and limit the volume and placement of alcohol advertisements across all media in Ireland. The effectiveness of the codes in discouraging inappropriate consumption of alcohol has never been evaluated.

In November 2013 the government approved a package of measures to deal with alcohol misuse as part of a Public Health (Alcohol) Bill. The measures included provisions for minimum unit pricing for alcohol products, regulation of advertising and marketing of alcohol, structural separation of alcohol from other products in mixed trading outlets, health labelling of alcohol products and regulation of sports sponsorship.

Addressing the public "bads" associated with tobacco, in line with WHO's Framework Convention on Tobacco Control, Ireland enacted legislation in 2004 to protect third parties, such as workers, from the ill-effects of exposure to second-hand smoke. Compliance with this legislation is reportedly high.[56] In 2011, Europol reported that Ireland, because of its relatively high tax on tobacco, had become one of several preferred destinations for organised crime groups who are increasingly active in cigarette smuggling, seen as "an attractive alternative to drug smuggling because of the lower penalties and larger profits".[57] At the same time a review of the international literature, commissioned by the Irish Heart Foundation, concluded that price was not a key driver for increased smuggling, although in some cases increasing tobacco taxation could make matters worse if a large illegal tobacco market already existed.[58]

Legislation to address public "bads" associated with alcohol was noted above in discussing the external costs of illicit drug consumption, specifically the effects of "intoxication". In a study of violence in Ireland, Hope and Mongan reported research showing a declining number of court cases under liquor licensing laws and an increased number of public order offences, suggesting a preference for controls in the public arena (street) rather than the drinking environment.[59]

Strategies and action plans

In translating policy into action, policy direction may shift. Over-arching strategic goals and aspirations may align and be consistent but, with health and well-being goals, short-term objectives and actions may not align so well.[60]

56. Tobacco Control Policy Fact Sheet Ireland: Smoke Free Places. Washington: Tobacco Control Laws. www.drugsandalcohol.ie/20537/.
57. Europol (May 2011), *EU organised crime threat assessment: OCTA 2011*. The Hague: Europol Public Information, p. 24.
58. H. Reed (2011), *Tobacco taxation, smuggling and smoking in Ireland*. Dublin: Irish Heart Foundation, p. 52.
59. A. Hope and D. Mongan (2011), "A profile of self-reported alcohol-related violence in Ireland", *Contemporary Drug Problems* (38/2), 237-58.
60. See K. Duke (2013), "From crime to recovery: the reframing of British drugs policy?" *Journal of Drug Issues* (43/1), 39-55; S. R. Friedman, P. Mateu-Gelabert and D. Rossi (2012), "Has United States drug policy failed? And how could we know?" *Substance Use and Misuse* (47), 1402-5; P. Hitchens (2012), *The war we never fought*, London: Bloomsbury Consortium.

A discrepancy may also occur in the course of implementation, for example in a public health context where there tends to be an increased emphasis on treatment quality standards, in-house organisational characteristics may hinder the adoption of best practice. It has been suggested that, to avoid slippage, a multilevel approach – including best-practice research, effective dissemination of the results and state policies requiring implementation of best treatment practices – might be adopted.[61]

Illicit drugs

The strategic objective of the National Drugs Strategy 2001-8 was "to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research".[62] In the National Drugs Strategy 2009-16, the objective itself was significantly reduced (note the first three words) to "continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research".[63] Related aims in the 2009-16 drugs strategy include a safer, healthier society, comprehensive treatment/ rehabilitation services for individual problem drug users, and sound, relevant data on the extent and nature of problem substance use to inform future policy decisions.

While reviews of the two strategies have reported progress in implementing most actions,[64] no evaluations have been undertaken of either strategy. As a result, it is difficult to determine how far the over-arching objective and aims have been achieved, or to assess the degree of logical consistency between over-arching aims and objectives and operational targets. A case study of implementation of the drug court model in Ireland illustrates how a considerable gap can open up between policy aspiration and implementation.[65] Similarly, in an overview of Ireland's illicit drug policy and legislation, it was observed that the judiciary, police and professionals such as probation workers are empowered by the system to implement sanctions and treatments with drug offenders at their own discretion and "this discretion is not infrequently used in ways that deliberately or inadvertently undermine the explicit or implicit intentions of legislation".[66]

Alcohol

Based on international evidence showing that the higher the per capita consumption of alcohol in a country, the higher the incidence of alcohol-related harm, the

61. McBride et al. (2009), "Reflections on drug policy".
62. Dept of Tourism, Sport and Recreation (2001), *Building on experience*, para. 6.7.
63. Dept of Community, Rural and Gaeltacht Affairs (2009), *National Drugs Strategy 2009–2016*, para. 7.4-5.
64. Ibid; *idem* (2005), *Mid-term review*; progress reports on National Drugs Strategy 2009–16, Dept of Health 2011/2012: www.drugsandalcohol.ie/17109/ and www.drugsandalcohol.ie/20159/.
65. S. Butler (2013), "The symbolic politics of the Dublin drug court: the complexities of policy transfer", *Drugs: Education, Prevention and Policy* (20/1), 5-14.
66. O'Mahony (2008), *The Irish war on drugs*, p. 6.

Steering Group on a National Substance Misuse Strategy proposed as a central aim for Ireland's national alcohol policy the reduction of per capita consumption of alcohol from 11.9 litres per adult aged 15 and over (the 2010 level) to 9.2 litres by 2016.[67] On foot of this proposed target, the government's 2013 framework for improved health and well-being has set as an indicator for alcohol consumption in Ireland: "decrease alcohol consumption across the population".[68]

The proposed alcohol strategy recommends 45 actions grouped under the same four pillars as in the National Drugs Strategy: supply reduction, prevention, treatment and research. Its key aim is:

> the promotion of healthier lifestyle choices throughout society in relation to alcohol. Given the range of health problems that can arise from alcohol consumption, or to which alcohol can be a contributory factor, a population health approach is being taken with a focus on reducing alcohol-related harm and the amount of alcohol we drink. While personal responsibility is of central importance in the management of alcohol use, the state can play a crucial role by intervening to prevent problems through addressing factors that cause difficulties and also through tackling the negative consequences that arise when problems occur.[69]

The aspiration is clear; implementation may take time. An epidemiological study of the treatment of alcohol disorders in Ireland over 20 years showed that, while treatment policy shifted from the disease to the public health model in the mid-1980s, change on the ground was slow and some of the main tenets of the disease model remained in place in some regions until the mid-2000s.[70]

Tobacco

In 2000 the government launched its policy, Towards a tobacco free society,[71] promoting that aim. The four "key strategic objectives" were to change attitudes, help people give up smoking, protect people from passive smoking and focus on children. In 2010 the Health Service Executive (HSE) published Tobacco Control Framework to provide an evidence-based approach to its work on tobacco-related harm in the whole population and in particularly vulnerable groups like children, adolescents and those at the margins of society.[72] Building on the 2000 policy document, this framework adopted the MPOWER package of evidence-based tobacco-control policies, promoted by WHO, and the nine elements in the HSE's Population Health Strategy, noted in the introduction (see Table 4.4).

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67. Dept of Health (2012a), *Steering group report*, para. 6.1.
68. Dept of Health (2013a), *Healthy Ireland*, para. 5.2.1.
69. Ibid., p. 4.
70. B. Cullen (2011), "Treating alcohol-related problems within the Irish healthcare system, 1986–2007: an embedded disease model of treatment", *Drugs: Education, Prevention and Policy* (18/4), 16-23.
71. Tobacco Free Policy Review Group (2000), Towards a tobacco free society.
72. Health Service Executive (2010), Tobacco Control Framework. www.drugsandalcohol.ie/20249/.

Table 4.4: Responses to tobacco-related problems in HSE's Tobacco Control Framework

WHO MPOWER Principles	HSE's Population Health Strategy[73] – Nine Principles
Monitoring tobacco use and prevention policies **P**rotecting people from second-hand smoke **O**ffering help to people who want to quit **W**arning of the dangers of tobacco **E**nforcing bans on advertising, promotion and sponsorship **R**aising taxes on tobacco.	1. Addressing the wider determinants of health and tackling health inequalities 2. Planning for health and social well-being, not just health and social care services 3. Developing and employing reliable evidence to improve health and social care outcomes 4. Making choices for health investment 5. Measuring and demonstrating the return for investment in health and social care services 6. Shifting the balance from hospital to primary care and health promotion 7. Integrating services across the continuum of care 8. Proactively engaging and working with other sectors to improve health 9. Engaging the population with the issue of their own health.

In 2013 the government published a new policy document, Tobacco Free Ireland.[74] It endorses the objectives of the 2000 policy document and the WHO MPOWER model adopted in the 2010 Tobacco Control Framework, but it upgrades the overall ambition. Ireland has now set itself the target of being tobacco free, defined as "the achievement of a smoking prevalence rate of less than 5% of the Irish population by 2025. Tobacco will still be available but at a higher price and in restricted outlets." The new policy emphasises four themes, designed to help progress towards the overall target: protecting children, denormalising tobacco use, building and maintaining compliance with tobacco legislation, and regulating the tobacco retail environment.

Structures

How far do the design and disposition of organisational structures, the governance framework, support the alignment of illicit drug, alcohol and tobacco policies with overall population health objectives? Research has shown that institutional dynamics of state structures, administrative capacity and policy legacies,[75] and epistemic communities,[76] may all influence the drug policy choices pursued within a jurisdiction.

73. Health Service Executive (2008), *The HSE population health strategy*.
74. Tobacco Policy Review Group (2013), Tobacco Free Ireland.
75. E. Benoit (2003), "Not just a matter of criminal justice: states, institutions, and North American drug policy", *Sociological Forum* (18/2), 269-94.
76. M. Elvins (2003), *Anti-drugs policies of the European Union: transnational decision-making and the politics of expertise*. Basingstoke, Hants: Palgrave Macmillan.

Different structural arrangements at national, regional and local level may also result in particular drug policy emphases at each level at different times.[77]

Structures may be considered according to the cycle of policy functions:

- develop policy;
- draft, administer and/or enforce legislation;
- co-ordinate policy implementation across departments, statutory agencies and voluntary and community bodies; and
- monitor, report on and evaluate policy and legislation.[78]

Illicit drugs

After the government first adopted an explicit policy on illicit drugs in the 1960s, responsibility for illicit drug policy development and implementation was reorganised again and again, reflecting shifting views on the nature of the challenges.[79] This continues to be the case.

Between 1997 and 2011, drug policy and co-ordination of its implementation rested with government departments that also had responsibility for local and/or community development. In March 2011 the new government transferred responsibility for illicit drugs back to the Department of Health, which had had lead responsibility until the mid-1990s. This department is now tasked with overseeing both the National Drugs Strategy and the new substance-misuse strategy. It convenes a quarterly Oversight Forum on Drugs (OFD), with representatives of all relevant government, statutory, voluntary and community bodies, to review progress and address bottlenecks, chaired by the minister of state in the Department of Health who is responsible for the National Drugs Strategy. The same department convenes the International Drugs Issues Group (IDIG), where officials from all government departments and statutory bodies that represent Ireland in international drug-related meetings and forums share information.

Responsibility for drug-related legislation and regulation rests with different departments. For example, the Controlled Drugs Legislation Unit in the Department of Health develops and implements policy and legislation on the control of drugs and precursor substances in accordance with national policy and international conventions, and maintains Misuse of Drugs legislation as fit for purpose. The Irish Medicines Board (IMB), a statutory body, is responsible for licensing the manufacture, preparation, importation, distribution and sale of medicinal products, including all drugs. The Department of Justice is responsible for drug-related criminal justice legislation.

Ever since the 1990s Ireland has placed a strong emphasis on "social partnership". There are 14 local drugs task forces (LDTFs), set up in the late 1990s in the areas experiencing the highest levels of problematic drug use, and 10 regional drugs task

77. McBride et al.(2009), "Reflections on drug policy", found that while US federal drug policy focused on a prohibitionist, deterrent approach, at state level there was experimentation with a "drug policy continuum", from prohibition at one end through harm reduction and medicalisation to decriminalisation at the other end.

78. For organisational structures for drug, alcohol and tobacco policy to 2011, see Pike (2012b), "Ireland".

79. B. Pike (2011), Where do drugs fit in? *Drugnet Ireland* (37): 3-4. www.drugsandalcohol.ie/14983/.

forces (RDTFs) established in 2004/5 to cover the rest of the country. The DTFs bring together representatives of relevant government departments, statutory bodies, and voluntary and community-sector bodies. These 24 DTFs ensure the development of co-ordinated and integrated responses to tackling the drugs problem at regional and local level. The DTFs are funded by and report to the Department of Health.

Following a review of DTF structures in 2012, the DTFs were retitled drugs and alcohol task forces (DATFs)[80] and in January 2014 a new nationwide co-ordination body was launched – the National Co-ordinating Committee for Drug and Alcohol Task Forces (NCC).[81] Its terms of reference include overseeing, monitoring and supporting implementation of the National Drugs Strategy at local and regional level, ensuring that drugs policy is informed by the work of the drugs task forces and making recommendations to the minister about implementation of the National Drugs Strategy and effective co-ordination of service delivery locally and regionally.

Responsibility for monitoring and reporting on the implementation of the National Drugs Strategy rests with the Department of Health.

Alcohol

Two government departments have primary responsibility for all policy functions in relation to alcohol: Justice for policy, legislation (licensing of retail outlets) and criminal justice aspects; and Health for health-related issues. Other departments have responsibility for or an interest in specific aspects: Finance (excise duty), Tourism, Sport and Transport (sponsorship, advertising), Agriculture (production) and Enterprise, Jobs and Innovation (pricing, impact on economy).

As of March 2014, no formal structures to support alcohol policy had been put in place, but the Steering Group on a National Substance Misuse Strategy recommended that the Department of Health should play the lead role in implementing the strategy. It pointed out that this would require regular interaction with the departments of Justice and Equality, Education and Skills and Children and Youth Affairs, at ministerial and official levels. The steering group also proposed that a process be put in place at national level involving relevant departments and agencies, as well as the community and voluntary sectors, to monitor and support implementation of the strategy and to put forward proposals where necessary to deal with any situations arising in relation to alcohol use and misuse.

The steering group noted that a majority of its members favoured using the OFD (which could be reconstituted to incorporate alcohol) as part of this process. Such a forum could be chaired by the minister with responsibility for the National Drugs Strategy and could meet quarterly.[82] It has already been noted in relation to illicit drugs that in 2012 the drugs task forces were renamed the drugs and alcohol task forces. In addition, the National Advisory Committee on Drugs (NACD) was reconstituted in 2013 as the National Advisory Committee on Drugs and Alcohol (NACDA).

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80. Dept of Health (2012b), *Report on the review of drugs task forces.*
81. S. Scally (2014), "Supporting local efforts to tackle drug problem", *Drugnet Ireland* (49): in press.
82. Dept of Health (2012a), *Steering group report*, paras. 6.3-5.

Tobacco

The structures supporting the development and implementation of Ireland's tobacco policy are quite separate and distinct from those supporting illicit drugs and alcohol policies. Responsibility is divided between two bodies – one focusing on policy and one on operations.

The Tobacco-Control Unit (TCU) in the Department of Health is responsible for tobacco-control policy and legislation, monitoring enforcement of legislation and participating in international forums, including WHO Framework Convention on Tobacco-Control activities. The NTCO in the Health Service Executive (HSE) co-ordinates the tobacco-control programme in the HSE. It has responsibility for discharging the statutory functions prescribed under the Public Health (Tobacco) Acts 2002 to 2012 and for supporting and driving delivery of the 61 actions in the Tobacco Control Framework 2010. The TCU and NTCO work together "to build compliance".

Recognising the need to work with other bodies, the HSE has established a national expert group on tobacco control in partnership with key stakeholders to help develop a co-ordinated national approach to tobacco use. This national expert group includes representation from the Department of Health, the NTCO and non-governmental organisations with an interest in tobacco control. On monitoring, the HSE's Tobacco Control Framework lists 12 actions to support the MPOWER policy of monitoring tobacco use and prevention policies.

Resources

How are resources allocated across the "pillars" and objectives in the three policy domains? By revealing mismatches between expressed intentions/aspirations and actual interventions, resource allocation is a useful marker of the political preferences of policy makers.[83] The allocation of resources may also highlight particular perspectives or ideological positions.[84]

In a study of drug-related expenditure in Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) distinguished between "labelled" expenditure, which it defined as "the *ex ante* planned public expenditure made by the general government in the budget that reflects the voluntary commitment of a country in the field of drugs" and "non-labelled" expenditure, defined as "the non-planned, *ex post*, public expenditure faced by the general government in tackling drugs, that is not identified as drug-related in the budget".[85]

Table 4.5 summarises the most recent data on public expenditure on the three categories of psychoactive substances. Given their limitations, these data do not

83. Carnevale Associates, LLC, have published several policy briefs on the US federal budget (e.g. September 2009 and December 2011) pointing out mismatches between the research evidence, strategic drug policy goals and budget allocations. www.carnevaleassociates.com.

84. K. Duke (2013), "From crime to recovery: the reframing of British drugs policy?" *Journal of Drug Issues* (43/1), 39-55; McBride et al. (2009), "Reflections on drug policy".

85. For a detailed discussion of non-/labelled expenditure: EMCDDA (2008), *Towards a better understanding of drug-related public expenditure*.

help an understanding of how resource allocations relate to over-arching goals and objectives or reflect particular policy preferences. They do, however, suggest how more comprehensive and accurate estimates of public expenditure could assist in assessing how policies and programmes in the three domains contribute to achieving one over-arching public health goal – assessing policy coherency.

Illicit drugs

Each year the Department of Health releases data on labelled public expenditure on the drugs issue (see Table 4.5). Since 2008 expenditure has decreased by 12%, from roughly €0.3 to €0.2 billion. In 2012, supply reduction activities (Department of Justice and Equality, Irish Prison Service, An Garda Síochána and the Customs Service) amounted to 34.5% of total expenditure, while demand reduction activities (all other entries in Table 4.5) amounted to 65.5%. It should be noted that these data relate to "labelled" drug-related expenditure only. The EMCDDA report on public expenditure cited above observed that the labelled and non-labelled estimates of public expenditure on the drugs issue revealed a different balance in the allocation of money: public order and safety expenditure exceeded health expenditure in the non-labelled expenditures.

Table 4.5: Expenditure and allocations directly attributable to drugs programmes, 2008-12

Department/agency	Expenditure 2008 (€m)	Expenditure 2009 (€m)	Expenditure 2010 (€m)	Expenditure 2011 (€m)	Expenditure 2012 (€m)
Dept of Health (previously Office of the Minister for Drugs)	65.207	39.377	34.992	32.876	31.475
Dept of Health (formerly Dept of Health and Children)	1.033	0.949	0.763	0.704	0.901
Dept of Children and Youth Affairs (formerly OMCYA)	0.000	28.501	25.740	25.000	22.669
Dept of Education and Skills	12.386	3.643	2.461	0.411	0.815
Health Service Executive	101.867	104.867	105.400	91.149	90.752
Dept of Social Protection (previously FÁS area)	18.800	18.800	18.000	14.934	11.859
Dept of Environment, Community and Local Government	0.496	0.461	0.461	0.400	0.200
Dept of Justice and Equality	12.340	14.801	14.478	18.681	18.580
Irish Prison Service	5.000	5.000	5.200	5.200	5.000
An Garda Síochána	44.400	45.004	44.500	45.014	45.850
Revenue's Customs Service	14.900	15.867	15.797	15.470	14.241
Total:	**276.429**	**277.270**	**267.792**	**249.839**	**242.342**

Source: Drug Policy Unit in the Department of Health[86]

86. Data from Health Research Board and Irish Focal Point (2013), *2013 National Report (2012 data)*.

Alcohol and tobacco

Available estimates of alcohol- and tobacco-related public expenditure cover a mix of labelled and non-labelled expenditure. A study has estimated the cost to the health and criminal justice systems in Ireland in 2007 of alcohol-related illnesses and crimes as €1.5 billion (see Table 4.6).

Table 4.6: Estimated costs incurred by public services in responding to alcohol-related problems, 2007

Estimated costs	€million
Cost to the public health-care system of alcohol-related illnesses	**1 178**
– Hospital inpatient care	500
– GP and allied services	574
– Mental health services	104
Costs to the criminal justice system	**319**
– Garda Síochána resources devoted to alcohol-related crime	191
– Prison Service resources associated with alcohol-related crime	51
– Court resources devoted to alcohol-related crime	77
Total	**1 497**

Source: Byrne (2010), ***Costs to society***, paras. 4.5 and 6.3.

With regard to tobacco, an EU study estimated that in 2009 Irish health expenditure on smoking-related diseases was approximately €0.5 million.[87] In 2013 it was estimated that 6-15% of Ireland's annual health budget was spent on treating tobacco-related disease, i.e. €1-2 billion.[88]

Discussion

The above review indicates that tobacco is the policy area most consistently aligned with a population-based approach to health. Causing a substantial number of deaths and recognised widely in Ireland as a public health problem, tobacco is the subject of comprehensive legislation and policy focusing on prevention of both individual use and exposure to tobacco smoke. Dedicated structures for policy development and implementation are in place, and regular monitoring and research are undertaken to ensure effective prevention efforts.

With regard to alcohol, up until 2012 there was no overall strategy to guide policy, and responses ranged from self-regulation and licensing to criminal justice measures. Published in 2012, the report of the National Substance Misuse Strategy Steering Committee called for a population-based approach and recommended 45 actions grouped under the same four pillars as the National Drugs Strategy – supply reduction, prevention, treatment, and research – to achieve a reduction in per capita alcohol

87. *A study on liability and the health costs of smoking*. DG SANCO (2008/C6/046), April 2012.

88. Dept of Health (2013a), *Healthy Ireland*.

consumption in Ireland. In March 2013 the first public health bill to focus on alcohol measures was being drafted. These policy initiatives have been underpinned by steps to strengthen the evidence base and to deepen understanding of the public's views on the alcohol issue. How these activities will influence perceptions of the alcohol issue and support the shift towards a public health focus remains to be seen.

A population-based health approach has also been used when planning responses to problematic illicit drug use. However, because of the criminal activity, public disorder, antisocial behaviour and violence that may be associated with illicit drugs, criminal justice responses have also been adopted. While these responses may achieve the desired criminal justice outcomes, such as a lower incidence of violent crime or safer communities, they may also serve to undermine the population-health ethos by criminalising and/or stigmatising problem drug users.

This continuing lack of coherence among policies on various psychoactive substances, particularly alcohol and illicit drugs, in relation to an over-arching population-health objective may be expected to hinder the realisation of "a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity" among the Irish population.

With regard to alcohol, it is expected that coherence around over-arching population health goals will be greatly enhanced when the Public Health (Alcohol) Bill 2013 is enacted and the 45 actions recommended by the Steering Group on a National Substance Misuse Strategy are implemented.

With regard to illicit drugs, the on-going lack of coherence may be attributed to a more intractable obstacle, namely the UN drug conventions, to which Ireland is a party. In 2011 a representative of UNAIDS, the Joint United Nations Programme on HIV/AIDS, described how drug-control policies that comply with the UN drug conventions may undermine harm-reduction initiatives:

> Effective HIV responses among drug users can be quickly undone by counter-productive policing or criminal procedures. For example, if drug users face criminal penalties because they are carrying a clean needle, then needle and syringe programmes are rapidly undermined. Programmes which have carefully and over years built up trust among drug users so they may be able to reduce problematic drug use and avoid HIV and related health threats can be devastated within weeks if legal or policing authorities demand names and addresses of clients with a view to prosecuting them. … All too often, drug control and AIDS authorities seem to inhabit different worlds.[89]

In the lead-up to the 57th Session of the Commission on Narcotic Drugs (CND) in Vienna in March 2014, the executive director of the UN Office on Drugs and Crime (UNODC) contributed the following thought on the interpretation of the drug conventions:

> It is important to reaffirm the original spirit of the conventions, focusing on health. The conventions are not about waging a "war on drugs" but about protecting the "health and welfare of mankind". They cannot be interpreted as

89. M. Bartos (23 March 2011), *All new HIV infections prevented among people who use drugs*. Address to 54th Session of Commission on Narcotic Drugs, Vienna, Austria (downloaded 25 March 2014). www.unaids.org/en/media/unaids/contentassets/documents/speech/2011/20110323_unaids_cnd.pdf.

> a justification – much less a requirement – for a prohibitionist regime but as the foundation of a drug control system where some psychoactive substances are permitted solely for medical and scientific purposes because, if used without the advice and supervision of medical doctors or licensed health professionals, they can cause substantial harm to people's health and to society.[90]

In the 21st century, policy researchers have been exploring options for minimising the negative impacts of law-enforcement approaches on public health objectives while still complying with the international policy framework. One option is to foreground harm reduction rather than coercive law-enforcement responses.[91] Alternatively, policy makers might shift the goalposts. For example, in place of a legislative framework to address the drugs problem, a pyramid of regulatory interventions, ranging from "persuasion" at the base to "licence revocation" at the top, might be adopted.[92] Another avenue might be to situate drug policy within a country's equality policy, on the grounds that the distribution of drug-related harm is determined as much by how welfare policy distributes risks and benefits, as by the degree of "strictness" of drug policy.[93]

Strategies and structures are in place, or in the process of being put in place, for all three policy domains. However, at the time of going to press, there was a lack of clarity about whether progress in reaching over-arching goals and objectives was being monitored, assessed or evaluated – and, if so, how. This lack of clarity is largely because all three policy domains are in various stages of transition. Illicit drugs and alcohol are being combined in one substance misuse strategy; tobacco control has recently been restructured and a new goal of a tobacco free Ireland by 2025 has been set. It may be anticipated that in developing the new strategies and action plans, and bedding in the new structures, in all three policy domains, attention will be given to ensuring there are monitoring, assessment and evaluation frameworks in place that will yield evidence and insights relevant to assessing the level of coherency with population-health goals.

Available data on funding for illicit drug, alcohol and tobacco policies reveal gaps and inconsistencies in knowledge of expenditure in these policy domains. The EMCDDA concluded its report on better understanding drug-related public expenditure with a comment that is applicable to all three domains:

> an assessment of the efficiency of government action is not feasible without a clear and well-defined formulation and classification of expenditure, where costs are properly identified in the relevant budget appropriations. The budget is the financial mirror of government policy; if the budget excludes important expenditure, there

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90. Y. Fedotov (6 December 2013), *Contribution of the Executive Director of the UNODC to the high-level review of implementation of the Political Declaration and Plan of Action on international co-operation towards an integrated and balanced strategy to counter the world drug problem*. UNODC/ED/2014/1.
91. R. J. MacCoun and P. Reuter (2001), *Drug war heresies*. Cambridge: Cambridge University Press; M. A. R. Kleiman, J. P. Caulkins and A. Hawken (2011), *Drugs and drug policy*. Oxford: Oxford University Press.
92. T. Seddon (2011), *A history of drugs. Drugs and freedom in the liberal age.* Abingdon: Routledge.
93. A. Stevens (2011), *Drugs, crime and public health. The political economy of drug policy*. Abingdon: Routledge.

> can be no assurance that scarce resources are allocated to priority programmes and that proper control and public accountability are enforced.[94]

The EMCDDA warned that public expenditure studies must be complemented by economic evaluations, where expenditure is considered not just in terms of efficiency but also in relation to the benefits obtained.

In preparing to evaluate the English and Welsh drug strategies, which expire in 2016, the Home Office has decided that evaluation of expenditure against objectives and over-arching goals will be the central evaluative mechanism. Although the over-arching goals are non-quantitative and aspirational, the Home Office argues that value for money will be achieved if the money spent on tackling drug use is found to be less than the "monetised benefits" of the drug strategy.[95]

Conclusions

The preceding assessment has not been systematic or comprehensive. Neither does it claim to be precise and accurate. Assessing policy coherence around an independent objective such as health and well-being is not a means for measuring policies. Rather, it is a tool to facilitate discussion about a challenging policy issue: how to strengthen the impact of policies relating to misuse of illicit drugs, alcohol and tobacco on the health of the population? The evidence assembled under each of the "markers" has been chosen because it highlights issues relevant to thinking about the degree of coherence between the three policy domains.

The following measures might be proposed to help address weaknesses in policy coherence that have been highlighted in the preceding discussion:[96]

- eliminate policy inconsistencies – for example, seek to ensure that coercive drug policies do not cancel out the benefits of harm-reduction measures; ensure that taxes to disincentivise the purchase of legal psychoactive substances do not inadvertently incentivise participation in black markets in those substances;
- identify opportunities for policy enhancement – for example, seek acceptance of a "whole population" approach to reducing consumption of various substances; use research-based evidence to tackle the use of substances from the different categories (perhaps reducing the incidence of polydrug use involving both illicit drugs and alcohol); design organisational structures and co-ordination/integration mechanisms that help to ensure a balanced approach to the over-arching population health objective; develop planning systems that identify budgets, and provide for comprehensive monitoring, reporting and assessment, and robust evaluation;

94. EMCDDA (2008), *Towards a better understanding*, p. 24.
95. HM Government (2013), *Drug strategy 2010 evaluation framework – evaluating costs and benefits*. London: Home Office. www.gov.uk/government/uploads/system/uploads/attachment_data/file/265393/Drug_Strategy_Evaluation_Framework_FINAL_pdf.pdf.
96. See Pike (2012a), "Policy coherence: notes towards a concept", para. 2.3.3, for a discussion of how to operationalise policy coherence in a set of tangible objectives, for which actions may be identified.

- develop mitigation policies to overcome adverse effects of non-psychoactive-substance policies – for example, consider alternative regulatory or governance arrangements; set policies on psychoactive substances within a broader policy context such as equality or social inclusion; or review strategies in areas like mental health, suicide prevention, education and training, employment and housing, to ensure they do not undermine policy initiatives in the psychoactive substances policy area;
- ensure consistency in advocacy – for example, use the national "voice" at international forums to put forward arguments and policy options that may help to resolve contradictions between international agreements which have an adverse impact on health-related outcomes.

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Chapter 5

Israel – Coherency of drugs policy: a structured analysis

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This chapter presents the findings of a pilot study conducted in Israel as part of the development and testing of the methodology to evaluate the coherency of national drug policy, a methodology developed by the Pompidou expert group. At the heart of the new methodology lies a set of six markers that indicate the various dimensions of a drug policy that have to be consistent, coherent and complementary, and that together provide an assessment of the coherency of the policy as a whole, and whether or not it is compliant with the overall principle of "well-being", as stated in the WHO preamble of its 1946 constitution. The objective of the project is to apply the six refined markers and test them in the countries which participated in their development, to better verify whether they provide a valid tool to measure the effectiveness and efficiency of a coherent policy on psychoactive substances.

Carrying out the pilot analyses

The analysis was carried out by gathering the expert opinions of 15 senior staff members representing the Israeli Anti-Drug Authority (IADA), the ministries of health, welfare, education and public security, and the Israeli police. All these experts are actively involved in developing and/or implementing various parts of the policies under investigation, each from the perspective of his or her organisation and expertise. Regardless of their specific areas of focus, all are well aware of and knowledgeable about the policy on alcohol and drugs. Some of the experts are less exposed to the tobacco policy, since in Israel tobacco is in the mandate of the Ministry of Health and is implemented independently. The analysis in this chapter, therefore, is mainly focused on alcohol and drug policy, though the scores of the experts on the tobacco policy are included in the results.

The discussions and scoring of the markers of policy coherency were carried out in two stages. First, nine experts who are members of the IADA Board of Governors participated in a meeting that began with a presentation and discussion of the project goals, the concept of coherency, its relevance to policy effectiveness, the markers, the methodology and some examples. This was followed by a structured process of scoring the markers on individual scoring sheets, replicating the Excel tool developed by the Pompidou team, adapted to a five-degree scale. The structured process included a detailed presentation of each marker separately, followed by scoring that marker, then moving to the next. When all markers were scored, the nine scoring sheets were put into the Excel file and the aggregated mean scores were displayed for further discussion.

The second stage included individual meetings with six additional experts representing the same partner agencies. They too were provided with a detailed explanation of the project, the markers and the methodology, and were asked to score the markers accordingly. All in all, 15 senior experts were involved, and the scores of the markers presented below are the aggregated scores of all 15 participating experts.

The six markers are:

1. Policy:
   a. State of the problem;
   b. Policy context;
2. Legislation, regulatory frameworks;
3. Strategic framework and action plans;
4. Structures and resources;
5. Responses/interventions.

Policy

The first marker is conceptualisation and policy context. This may fall into two parts, namely 1A and 1B, in which the former is related to the state of the problem and the latter to the solutions drawn up in a policy to address the problem. Hence an overview of the policy documents in place should be the main starting point.

State of the problem

In general, compared to most countries in Europe, Israel has relatively low rates of prevalence of problem drinking and drug use. It is also not a major narcotics producing or trafficking country, but has a significant domestic market for illegal drugs.

The Chief Scientist Office at the IADA is responsible for development, implementation, dissemination and use of scientifically sound research and monitoring systems that provide comprehensive and coherent information to enable evidence-based policy and intervention strategies in the fight against drugs and alcohol. These data provide on-going up-to-date information on prevalence estimates and trends in the use of these substances in the general population as well as the prevalence of and trends in problem drug use, alcohol use and tobacco use. The data gathered provide information that enables us to identify trends in new psychoactive drugs and other problems of substance use, and how urgently they need to be addressed.

IADA implements a host of research systems. Those include national epidemiology surveys, monitoring systems, comprehensive and targeted evaluation studies and an extramural funded research programme supporting academic scientific studies ranging from laboratory experiments to psychosocial determinants research.

The on-going national surveys include the WHO–HBSC survey (ages 11-18), the IDF-Drug and Alcohol survey (ages 18-21), the national epidemiology survey on drugs and alcohol (ages 18-60) and the "finger on the pulse" Internet survey that provides ad hoc information on a sample of about 1 500 respondents ages 12-40, every three months. IADA is also planning to conduct the ESPAD survey (ages 11-18) in 2012, thus having ESPAD and HBSC alternate every two years.

Since 1994, Israel has been collecting drug and alcohol information on representative samples of schoolchildren aged 11-18 as part of the WHO health behaviour in school-aged children (HBSC) cross-national survey. In addition, IADA conducts periodical national epidemiological surveys on youth 12-18 years of age and adults 19-40 years of age.

The HBSC survey is funded jointly by the Ministry of Education, Ministry of Health and IADA. Its findings include complete information on smoking (cigarettes and nargila "water-pipes"), alcohol, drugs and related behaviours such as involvement in youth violence and truancy. It also includes an array of information on psychosocial determinants of risk behaviours covering most social settings, including home, community, school, peer group and Internet. The comprehensive nature of the survey, and the way the findings are disseminated, contribute to an on-going synergy between government agencies involved in policy and programmes related to youth smoking, alcohol, drugs and violent behaviours.

The 2011 HBSC survey showed for the first time, after a decade and a half in which they had increased dramatically, declining rates in alcohol binge drinking and drunkenness. For example, binge drinking among 11- to 15-year-olds climbed from about 12.5% in 1998 to 20.5% in 2009. Following implementation in 2010 of the national programme to reduce alcohol drinking, the rate declined to 12.5% in 2011. Despite the increase in problematic alcohol drinking in Israel between 2000 and 2010, Israel is still ranked in the countries with the lowest rates of problem drinking among the 47 HBSC countries. The use of extensive data gathered on patterns of alcohol use among youth is an example of the use of data in Israel to follow trends, identify problems, influence policy, evaluate policy effectiveness and create a process of learning from success.

IADA's national epidemiology survey on drugs and alcohol in the adult population, last conducted in 2009, is going into the field in spring 2014 and will then be conducted every two years instead of every four. Among the adult population (18-40), 11.4% reported using some kind of illegal substance: 8.9% reported using cannabis and 1.91% reported using "other drugs". In general, the findings were similar to the previous survey. Even so, there was a decrease in drinking wine (other than for religious ceremonies) and a minor increase in the rate of drinking beer. In addition, there was a minor increase in the rate of people reporting getting drunk.

As part of the collaboration with the EMCDDA in Europe, IADA has begun setting up the Israeli Monitoring Centre for Drugs and Alcohol. This involved getting representatives

from over 20 government agencies to co-operate in providing information on the drug-related data they obtain and developing a structured mechanism to pool these data in a national observatory that will be used by all agencies. This will provide a broad, updated picture of all aspects of drug and alcohol demand, supply and treatment across the country. A first national report on the EMCDDA indicators is to be sent for inclusion in the international European EMCDDA in June 2014. A summary of current prevalence rates of drugs and alcohol in Israel can be found in Harel-Fisch et al. 2014.

Data are disseminated regularly by annual reports, publications, briefs and presentations, to policy makers in the Knesset, health and education professionals and the general public. Media campaigns followed by ad hoc surveys attempt to influence public opinion and measure the outcome. For example, data show that over 75% of the public support recent extensive legislation and enforcement efforts aimed at supply reduction of drugs and alcohol. In addition, only 25% of the population is in favour of legalisation of cannabis, whereas 75% are either opposed or have no opinion. This is in contrast to the statements of those advocating legalisation who claim that the majority of the population supports legalisation.

Evaluation: using the working table of marker 1A, which includes prevalence, public opinion, cost of illness, media and documents citing problems, the panel of experts rated this marker on a 1-5 scale as: 5.00 for tobacco, 3.89 for alcohol and 4.78 for drugs.

Policy context

This second policy aspect requires one to identify policy documents that outline the specific goals through which the problem of substance use is being addressed and whether these are in line with the overall WHO definition of well-being as highlighted above, or at least are not in conflict with WHO goals and aspirations.

Since the 1990s, the Israel Anti-Drug Authority has been developing, co-ordinating and leading implementation of an integrated national policy and intervention strategy aimed at reducing drug and alcohol use and their consequences. These policies and programmes are orchestrated on a national level collaboratively with all relevant ministries and national agencies, and on the local level, with close synergy and co-operation with local leadership and all relevant municipality agencies and organisations. This integrated approach uses "round table" steering committees, in both national and local settings, that oversee activities and ensure a well-integrated and coherent implementation of policy and strategies aimed at reducing drug and alcohol problems in Israel.

During the mid-1980s it became obvious that there was an immediate need for implementing a uniform national policy to provide a co-ordinated balanced approach for prevention, training, treatment, rehabilitation and adequate law enforcement. Consequently, an interministerial committee drafted the Israel Drug Control Authority Law 5748. It was approved by parliament, leading to the establishment of the Israel Anti-Drug Authority (IADA) in 1988. In addition to addressing internal needs, the establishment of IADA was part of Israel's efforts to comply with the 1971 UN Convention on Psychotropic Substances (Article 6), which called for a national anti-drug authority. Israel is signatory to the three UN drug conventions (1961, 1971 and 1988).

The policy related to tobacco and the responsibility to implement it have both been in the mandate of the Ministry of Health since the early 1980s. This policy is very well documented, measured and implemented using a partnership of several government agencies led by the Ministry of Health. The success of their efforts is evident in the significant decline in smoking rates in both the young and adult population.

Due to the multifaceted and complex nature of the drug problem, which calls for an on-going partnership across the many government agencies that focus on various relevant areas, it was decided that the Prime Minister of Israel would be the minister responsible for realisation of the Drug Control Authority Law. Since 2009, however, the IADA operates under the minister of internal security, who is also responsible for the police.

From the mid-1990s, there was an alarming increase in problem drinking and drunkenness among the adolescent and young-adult populations in Israel. Concerned with this trend, the government decided in 2005 to extend IADA's mandate to include alcohol abuse. The comprehensive approach to drug prevention, treatment and law enforcement was expanded to include alcohol abuse. National surveys, such as the WHO–HBSC survey and the national epidemiology survey on drugs and alcohol, have shown that drug use in Israel has remained relatively low and fairly stable among youth and young adults, placing Israel well below most countries in Europe and North America. The fact that IADA was charged with the war on alcohol abuse meant it could apply its successful experience from the field of drugs to the war against alcohol abuse, in an attempt to contain the rising trend.

Under IADA's umbrella, professionals in government and non-governmental agencies work together to rid Israel of the plague of drugs and alcohol. This interministerial and inter-institutional co-operation and co-ordination – in prevention, treatment and law enforcement – enables IADA to fulfil its main duty, as defined by law: "to formulate all national supply and demand reduction policies on drugs and alcohol abuse".

For example, the policy and goals related to prevention of drug and alcohol use among youth and young adults are carried out jointly by a coalition of partners that include the ministries of education, health, welfare and internal security, and are implemented throughout the formal education system and local municipalities in an integrated and co-ordinated effort using intervention strategies and programmes developed collaboratively. By doing so we can ensure on-going implementation of an integrated and coherent intervention strategy across the country.

The stated vision of IADA policy is "to lead the State of Israel in coping with the problems caused by drugs and alcohol, as a condition for a healthy and ethical society to enhance the well-being and quality of life of its population". This stated vision is in accordance with the main focus of marker 1B.

National alcohol strategy

The national alcohol strategy seeks to cover all areas related to the excessive use of alcohol, paying particular attention to youth and young adults, focusing on areas of prevention, awareness and change in youth culture. Nevertheless, it is a comprehensive strategy that takes into account the four-pillar approach of prevention, treatment, law enforcement and harm reduction.

Here too, a national steering committee is overseeing the development, implementation and evaluation of the policy, and the documentation describing the process and responsibilities gets updated and disseminated periodically.

Mediators, such as parents, teachers, mentors, social workers, doctors and counsellors, play a key role in the prevention and treatment of alcohol abuse among youth. Special attention is given to interventions and training aimed at providing significant adults with tools to enable more effective mentoring to facilitate effective prevention interactions with youth.

The main aim of the strategy is to significantly decrease the excessive consumption and abuse of alcohol, reduce the physical and mental health outcomes of alcohol use, influence the social well-being of youth by influencing a youth culture that will be free of alcohol (and drugs) and address other social and economic hazards to society related to alcohol use.

The WHO recommendations and the target areas put forward in the Global Strategy to Reduce the Harmful Use of Alcohol were easily incorporated in and adapted to the parallel target area of the Israel national strategy, due to the high degree of correspondence of these two strategies. Key target areas of the national strategy are: (1) leadership and awareness; (2) health services' response; (3) community action; (4) drinking and driving; (5) law enforcement and legislation; (6) reducing the negative consequences of drinking and alcohol intoxication among youth; (7) protection of high-risk groups; (8) development of professional human resources; (9) research, monitoring and evaluation.

Evaluation: using the guidelines for marker 1B, the panel of experts rated this marker on a 1-5 scale as: 3.56 for tobacco, 3.11 for alcohol and 4.11 for drugs.

Following their evaluation of markers 1A and 1B, the panel of experts adopted the guidelines, stating that it is now essential that all the markers that follow, namely 2-5, are evaluated first by referring to the first marker, next for whether the policy related to a substance is coherent in itself and then whether it is coherent with the other policies in place dealing with other substances.

Legislative/regulatory framework

Law enforcement and legislation

IADA is by law the body responsible for co-ordinating effective collaboration between the various law enforcement bodies in Israel (even though it is not in itself a law-enforcement body), among them: the Israel National Police and Israel Prison Services; the Israel Defence Force Police; the National Anti-Drug Money Laundering Unit (under the Israel Tax Authority); the Ministry of Justice and other ministries and law enforcement bodies in the community.

Law enforcement continues to link drug offences to a number of other crimes, including human trafficking, illegal labour and money laundering. The Dangerous Drugs Ordinance establishes the main drug-related offences. The first covers abuse of drugs and possession of drugs for personal use, as distinct from possession for trafficking. Offenders may be given a maximum penalty of 3 years' imprisonment and a €9 000 fine. The second makes it

an offence to produce drugs, trade in them, export them or import them, if such activities are undertaken without an official permit; and covers possession of drugs, premises and utensils connected with the commission of one of the above offences. These offences carry a maximum penalty of 20 years' imprisonment and a €375 000 fine.[1]

On tobacco, by Section 61(a)(1) of the Penal Law, a fine shall be imposed on a person selling tobacco products or selling, lending or leasing a product used to smoke tobacco to a minor.

Since 2007[2] it has been illegal to smoke in public places, including cinemas, shopping centres, hospitals, public transportation, restaurants, pubs, schools and kindergartens. Furthermore, the owner of a public place must place signs there regarding the prohibition against smoking, and is obligated to inspect and do all in her/his power to prevent smoking in the place he/she owns.[3]

An amendment to this law, issued on 4 February 2008, expands the prohibition against selling tobacco products to minors, to include a ban on selling products used to smoke tobacco to minors. Furthermore, the amendment stipulates that a person shall not lease nor lend a product used to smoke tobacco to minors.[4] Israel has increased tobacco excises overall since 2008. Total taxes were 72.1% in 2008, and now they are at 83.5%.[5]

New psychoactive substances

As in many countries in Europe, Israel has been experiencing an influx of new designer drugs that hit the market occasionally and play havoc on the party scene of the large cities. The cat-and-mouse struggle of the authorities with the suppliers has taken a new turn with a development of new legislation giving the government the upper hand temporarily.

Over the years, new substances have been added to the Dangerous Drugs Ordinance 5733-1973 (amendments to the first schedule). In 2010, the schedule was amended to include four groups and their derivatives: amphetamines, methamphetamines, cathinone, methcathinone. This was referred to as the "Derivatives Law". In 2013 this action was further expanded to include families of synthetic cannabinoids (the "Second Derivatives Law").

In August 2013, Israel issued a new ordinance on "The fight against the phenomenon of the use of dangerous substances law", 5773-2013, which aims to tackle the problem of new psychoactive substances. Under this ordinance, law enforcement authorities are granted powers to seize and destroy substances considered to be "dangerous substances" according to the definition provided therein. Following the seizure of a substance considered to be a dangerous substance, the possessor is issued with a summons to appear, within seven days, before the authorities in order to prove that

1. Dangerous Drugs Ordinance (New Version), 5732-1973. Available at: www.antidrugs.gov.il/download/files/Dangerous%20drugs%20act_2.pdf.
2. Amendment to the Prohibition of Smoking in Public Places and Exposure to Smoking Law 5743-1983.
3. UN Convention on the Rights of the Child (2010), *Combined periodic reports due in 2008: Israel.*
4. Ibid.
5. WHO (2013), *Report on the global tobacco epidemic*.

the substance is not a dangerous substance and avoid its destruction. The order of destruction can be appealed through a civil proceeding within 30 days. Under this new legislation, in case of urgency and to protect public health, the distribution of dangerous substances can be prohibited through a declaration by the Director-General of the Ministry of Health, following consultation with the Director-General of the IADA, or anyone empowered by him/her, and the Inspector General of the Israeli police, or anyone empowered by him/her. The declaration is valid for up to 12 months and the manufacture, sale, presentation for sale, import, export, supply or trade of prohibited substances is punished by 3 years' imprisonment, or 5 years' imprisonment if a prohibited substance is supplied to a minor.

In Europe in 2012, 73 new drugs were identified, so it is important for an authority in charge of drug strategy to react quickly. Currently, about 150 substances are controlled by law.[6]

Alcohol

In regard to legislation, the main idea was to cut off the supply of and demand for alcohol at the peak hours of consumption – on the way to a party or to meet friends and when coming back. Therefore, it became prohibited to sell alcohol at stores between the hours of 11 p.m. and 6 a.m., except in restaurants, coffee houses and places serving alcohol for consumption on the premises (pubs, night clubs, catering services, etc.). Offenders face a minimum penalty of €1 800.[7] In addition, the authority of the Israeli police was expanded, allowing them to pour away alcoholic beverages if found in public places. Furthermore, regulations were enacted restricting the advertising of alcoholic beverages.

According to the law it is prohibited to sell, offer or serve alcoholic drinks to minors. It is also prohibited to consume alcoholic drinks or possess alcoholic beverages in an open container (bottle, can, glass, etc.) in a public place or inside a car parked in a public place between 9 p.m. and 6 a.m. (for minors, it is prohibited during all hours of the day).[8]

The goal of the promotional strategy was to educate the population about proper alcohol consumption. Activities were focused on two age groups, with each group receiving different and specific messages. Teens under 18 were informed about the dangers of alcohol consumption and recommended to avoid alcohol altogether. Young adults aged 18 and older were informed about responsibility, maturity and making personal choices. In the realm of law enforcement, an extensive programme was constructed which included mapping out locations that sell alcohol and where teens hang out, increasing police activity during more dangerous hours, increasing penalties and initiating raids on certain establishments. Additionally, as part of the effort to target teens and youth, parental and social service involvement was increased.

Evaluation: using the working table of marker 1A, which includes legal regulations, compliance with international conventions, alignment with policy goals and supply, the panel of experts rated this marker on a 1-5 scale as: 4.22 for tobacco, 3.44 for alcohol and 4.44 for drugs.

6. Ibid.
7. Business Licensing Law 2010 (26th amendment).
8. Law to control alcohol intoxication 2010.

Strategy/action plans

This marker explores the strategies or action plans in place that are in line with overall policy goals and that of WHO – are they comprehensive in taking into account all the policy goals?

The strategy and action plans translating the policy of the Israeli Government into effective action are summarised in Harel-Fisch et al. 2014, which demonstrates the existence of such strategies and action plans, and the way they are actually implemented throughout the country.

The strategies are divided into the following areas of need and action, according to the national policy goals:

- prevention;
- drug-related treatment;
- residential treatment programmes for drug users;
- harm reduction;
- health correlates and consequences;
- responses to health correlates and consequences;
- fight against money laundering;
- prisons;
- international co-operation;
- regional co-operation;
- bilateral co-operation.

Here is a summary of the activity found under some of those headings.

Prevention

Prevention is implemented throughout the country, targeting the general and at-risk populations: parents; workplace/professionals; university students; youth and soldiers; middle school and high school; primary school; kindergarten. The main idea is "prevention for all".

IADA is responsible for formulating national education and prevention policies, developing prevention programmes, and co-ordinating the activities of all relevant ministries and public entities. IADA works in close co-operation with various ministries, among them, the Ministry of Education and Ministry of Social Affairs and Social Services, to develop new prevention programmes for the general and specific target populations. This is based on research findings and actual needs.[9] The school has an important role in the shaping of attitudes and world views and in the prevention of risky behaviour, including the use of dangerous substances. In 2011-12, primary school represented 827 717 pupils, and middle/high school 638 463.

There is a wide variety of programmes taking into account individual and social components, aimed at shaping attitudes and values to reject substance use. These programmes are based on a comprehensive approach promoting a healthy lifestyle which begins as early as kindergarten and continues until adulthood, and focuses

9. IADA website, at: www.antidrugs.org.il/english/template/default.aspx?mainCatid=46.

on developing and using one's inherent resources and strengths. To be more effective and significant, programmes combine interactive methods that are specifically tailored to particular target groups. Thus, at all levels of prevention, programmes are developed with the needs of specific populations in mind: parents, new immigrants, different sectors and genders, employees, soldiers and so on.

Drug-related treatment

Israel believes that substance addiction is a health disorder requiring treatment, so Israel has implemented a wide array of treatment services offering a myriad of treatment solutions to address the different needs of individuals based on gender, age, cultural or religious background and prior treatment experiences, to ensure accessibility for all addicts seeking treatment.

The treatment framework includes a variety of programmes which are under direct supervision of the Ministry of Health and Ministry of Social Affairs and Social Services. There are also treatment programmes supervised by the Israel Prison Services. Other programmes are directed by public institutions and by IADA. Private treatment centres are also available.[10]

IADA is responsible for establishing policies and co-ordinating all public entities involved in the treatment of substance-abuse victims. The policies are established by IADA's Treatment and Rehabilitation Committee (consisting of representatives of public bodies involved in the treatment and rehabilitation of substance-abuse victims). IADA is also responsible for initiating and establishing new treatment models, with an emphasis on finding treatment solutions for sub-populations for which there are currently no particular structures.

Addiction treatment services are involved at community, regional and national levels. The comprehensive treatment system of pharmacological and psychosocial interventions provides a wide array of treatment solutions addressing the different needs of individuals based on gender, age, and cultural and religious background. Addicts and substance abusers who seek treatment are referred to the type of programme with which they will be most compatible, based on personality, cultural considerations, substance-abuse situation and prior treatment experiences.[11]

Among the solutions are:

- physical detoxification;
- therapeutic communities;
- day-care centres;
- drug substitution: methadone and Subutex;
- individual and group treatment sessions;
- family intervention, and rehabilitation;
- involving legal counselling;
- assistance with studies.

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10. IADA website, at: www.antidrugs.org.il/english/template/default.aspx?mainCatid=47.
11. Muscat et al. (2012), *Reflections on the concept of coherency*.

Residential treatment programmes for drug users

Residential treatment programmes are essential. Drug addicts need a protective environment during withdrawal and for the immediate post-withdrawal period, when physicians recommend, where possible, that addicts rest in a pleasant environment that is sufficiently removed in time and space from the environment in which they previously consumed substances.

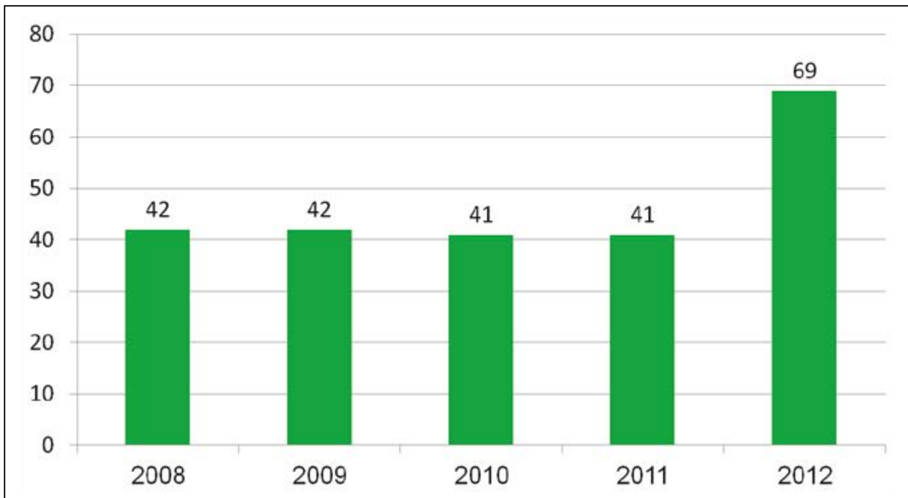
Harm reduction and health correlates and consequences

Drug use can be the direct cause of viral infections (HIV/AIDS and hepatitis), other injection-related infectious diseases, disorders related to the use of substances, especially overdose, and even death. The number of drug-related deaths is unknown, but we know that opioids followed by amphetamine-type stimulants (ATS) are the primary cause of such deaths.[12] Prevalence of HIV/AIDS among adults aged 15 to 49 in 2011 was 0.2%[13] – approximately 8 500 people.

Table 5.1: Epidemiology of HIV and viral hepatitis[14]

Hepatitis B surface antigen (anti-HBsAg) prevalence among people who inject drugs (%)	Hepatitis C antibodies (anti-HCV) prevalence among people who inject drugs (%)[15]	HIV prevalence among people who inject drugs (%)
2.8	67.6	2.94

Figure 5.1: Number of HIV cases among injecting drug users in Israel



12. United Nations Office Against Drugs and Crime, *World Drug Report* 2012.
13. UNAIDS *World AIDS Day report* 2012.
14. HARM Reduction International (2012), *The global state of harm reduction*.
15. Nelson et al. (2011), "Global epidemiology of hepatitis B and hepatitis C in people who inject drugs".

From 1981 to 2010, 6 579 HIV/AIDS cases were reported, in an upward trend from 3.6 new HIV diagnoses per 100 000 population in 1986 to 5.6 in 2010. Immigrants from countries of generalised epidemic (ICGE) comprised 2 717 (41.3%) of all cases: 2 089 (76.9%) were Israeli citizens and 628 (23%) were non-Israeli citizens, mostly migrant workers. Only 796 (12.1%) of all HIV/AIDS cases were heterosexuals who were non-ICGE and not injecting drug users (IDUs). IDUs comprised 13.4% (N=882) of all cases. Men who have sex with men (MSM) accounted for 33.2% (N=1403) of all men reported, while the annual number of MSM reported with HIV/AIDS quadrupled between 2000 and 2010. It is estimated that the HIV point prevalence rates in 2010 for Ethiopian-born Israeli citizens, IDUs and MSM aged 16-45 were 1805, 1492 and 3150 respectively. The crude estimated transmission rates among Israeli citizens, excluding the Ethiopian-born, was 10.5, while among Ethiopian-born Israeli citizens, IDUs and MSM the rates were 3.6, 6.3 and 13.2 respectively.[16]

Responses to health correlates and consequences

Seeking to minimise the adverse consequences of drug abuse for society, Israel also developed a harm-reduction approach to reduce illicit drug use, beginning with the first methadone substitution programmes in 1975. Today, other drug substitutes are available for addicts who are unable to undergo complete drug detoxification, affording these individuals a chance to lead more normal lives.[17]

As part of this approach, needle-exchange programmes are available in several locations, and walk-in clinics assist addicts with rapid admission into treatment programmes. These efforts have led to a significant decrease in the number of cases where individuals contract HIV/AIDS due to drug use. Special attention is given to drug abuse victims suffering from co-morbidity. Treatment is offered as an alternative to incarceration and in prison settings.[18]

Fight against money laundering

According to the US Drug Enforcement Administration (DEA), 2013 saw an increase in drug-related money laundering cases involving Israelis working in both the United States and Israel.[19]

As part of the global effort against such crimes, the Israel Money Laundering and Terror Financing Prohibition Authority (IMPA) was established within the Ministry of Justice in January 2002, under the Prohibition of Money Laundering Law 5760-2000. IMPA assists in the investigation and prevention of money laundering, terror financing and related crimes.[20] These offences are mostly conducted by drug dealers and criminals belonging to organised crime, working with ever-growing sophistication, as a means to keep the profits of their criminal activities.

16. Mor et al. (2013), *Thirty years of HIV in Israel*.
17. Harel-Fisch (2012), "Evolution of an integrated and coherent policy on drugs and alcohol in Israel".
18. Ibid.
19. US Dept of State (2013), *International Narcotics Control Strategy Report, Volume II*.
20. Ministry of Justice website. Available at: www.justice.gov.il/MOJEng/Halbanat+Hon/.

Israel has established systems for identifying, tracing, freezing, seizing and forfeiting narcotics-related assets, as well as assets derived from or intended for other serious crimes, including the funding of terrorism. The identification and tracking of such assets is part of the on-going function of the Israeli intelligence authorities and IMPA. In 2004, the Israel National Police seized approximately $27 million in suspected criminal assets. Three quarters of these assets were seized for money laundering offences relating to fraud, illegal gambling, extortion and prostitution; the rest related to drug cases.[21]

Israel is also part of the Committee of Experts on the Evaluation of Anti-Money Laundering Measures and the Financing of Terrorism (MONEYVAL). The aim of MONEYVAL is to ensure that its member states have in place effective systems to counter money laundering and terrorist financing, and comply with the relevant international standards in these fields.[22]

Prisons

The prison population on 31 December 2012, including pre-trial detainees and remand prisoners, was 20 195 people or about 262 prisoners per 100 000 of the national population.[23] The United States of America has the highest rate, with 716 prisoners per 100 000 population. However, the rate in Israel is quite high, compared to other areas of the world. The average in the Middle East[24] is around 133, and in Europe is around 144.

There are rehabilitation programmes supervised by the Prison Rehabilitation Authority. The Hermon Prison has a rehabilitation centre with diverse individual, familial and group therapy sessions. It was opened in 1998, and at present includes a multi professional staff of 150 people, among them: narcotics specialists, clinical psychologists, clinical criminologists, social workers, education officers and security guards. The focus at the Hermon Prison is on improving the conditions of incarceration and restoring the inmates' dignity and self-esteem by providing them with appropriate housing conditions and an aesthetic environment.

Drug treatment in prison has several goals:[25]

- reducing drug abuse during incarceration,
- improving the prison climate,
- reducing recidivism,
- supporting prisoners' rehabilitation in the community.

Evaluation: using the working table of marker 3, which includes reference to the state of the problem, supply reduction, demand reduction, harm reduction, specific objectives, budgetary issues and activities, the panel of experts rated this marker on a 1-5 scale as: 3.89 for tobacco, 3.33 for alcohol and 4.00 for drugs.

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21. US Dept of State (2009), *International Narcotics Control Strategy Report, Volume I*.
22. MONEYVAL website: www.coe.int/t/dghl/monitoring/moneyval/About/MONEYVAL_in_brief_en.asp.
23. International Centre for Prison Studies website: www.prisonstudies.org.
24. International Centre for Prison Studies, Middle East: Bahrain, United Arab Emirates, Israel, Saudi Arabia, Kuwait, Lebanon, Iraq, Jordan, Oman, Qatar, Syria, Yemen.
25. Santo et al. (2008), *Drug Treatment Outcomes at the Hermon Prison*.

Structures and resources

The pilot study in Israel combined the marker of "structures" with the marker of "resources", although in later meetings of the Pompidou Group we decided to separate them.

The structures marker explores whether the country has specific structures to implement the policy in place. The key question here is whether the model adopted by the country is functioning appropriately. Consequently, which bodies are responsible for drug policy, alcohol policy and tobacco policy? Is there a co-ordination body? Who is in charge of co-ordination?

In Israel, IADA is the over-arching agency responsible for the development, implementation and evaluation of drugs and alcohol policy. The Ministry of Health – in particular, the Health Education and Promotion Department within the ministry – is responsible for developing, implementing and evaluating the policy related to tobacco.

Both over-arching agencies have created a coalition of partners across government and relevant agencies on the national level, along with local authorities, school systems, institutions of higher education, the Israeli Defence Force and the workplace. Round-table steering committees that include representation of the partner agencies and organisations have been established and maintained to oversee implementation of the policy. The round-table approach has also been adopted at local authority level, where IADA's drug and alcohol local co-ordinators facilitate the partnership across local agencies to mirror co-operation at national level.

Similar structures of partnership at national level have been established in the areas of treatment (mainly with the ministries of health and welfare), legislation and enforcement (ministries of internal security and justice, and the Israeli police force).

Monitoring system

As noted above, IADA's Chief Scientist Office provides a comprehensive monitoring system through both the population surveys described above and the data gathered and disseminated by the Israeli Monitoring System for Drugs and Alcohol. In addition, we are currently extending data collection methods to enable local authorities to collect their own data with identical measures and methods, so their data will be comparable with national estimates. This will enable local authorities to plan their policies with quantitative goals and evidence-based evaluation.

The committee also explored the allocation of financial and human resources, for the development and implementation of the drugs policy. The allocation of funding and human resources is quite complex since the co-ordinating body is IADA, but a significant proportion of the activities are carried out by the appropriate partner agency. Thus, the resources are allocated to the various ministries and agencies accordingly.

Evaluation: using the working table of marker 4, which includes reference to the responsible bodies, co-ordinating bodies, mechanisms, monitoring system and final evaluation, the panel of experts rated this marker on a 1-5 scale as: 3.44 for tobacco, 3.11 for alcohol and 4.00 for drugs.

Responses/interventions

This marker explores what major actions have been put in place and what type of interventions have been adopted to ensure their success.

Each division of IADA co-ordinates a host of specific programmes and activities to carry out the drugs policy and must submit an annual programme and plan of action in order to be allocated its budget. This submission has to include details of the specific programme and activities. In 2012-13 we established a structured process, aided by a computerised system, that enables evaluation of the level of fit between the proposed annual programme and its array of activities and the specific goals of the drugs and alcohol national policy. This process focuses on several aspects, including prevention, education, training, treatment/rehabilitation, legislation and re-enforcement, public relations, research and coverage of local authorities, communities and target populations.

There are over a hundred IADA co-ordinators of drugs and alcohol activities in local authorities, and each has to submit a similar annual programme of action in which all aspects have to be spelled out and evaluated in light of the national policy goals prior to allocation of funds.

Prevention programmes

There is a wide variety of programmes taking into account individual and social components, aimed at shaping attitudes and values to reject substance use. These programmes are based on a comprehensive approach promoting a healthy lifestyle which begins as early as kindergarten and continues until adulthood, developing and using one's inherent resources. To be more effective and significant, programmes combine interactive methods that are tailored to particular target groups. Thus, at all levels of prevention, programmes are developed with the needs of specific populations in mind: parents, new immigrants, different sectors and gender, employees, soldiers. Several prevention programmes are implemented. Here are some of them.[26]

Never too young

This programme was developed for kindergarten children. It focuses on teaching children about self-esteem and health awareness by showing them how to distinguish between harmful and healthy substances, and promoting a healthy lifestyle.

Inhalants/volatile substances kit

This programme provides a kit to prevent the use of inhalants, for teachers of students in 6th through to 9th grade. The kit includes a 10-session plan with a CD and DVD.

26. IADA website, at: www.antidrugs.org.il/english/pages/1326.aspx.

Addicted to life

This programme promotes the prevention of substance abuse, combining entertainment with an educational experience (3D movie, for example). It is aimed at students, parents and soldiers.

From high risk to new opportunities

This programme combines challenging sports, arts and leisure activities for high-risk youth.

Alternative project

IADA operates the "alternative project", which relies on interactive methods for disseminating information on the consequences of drug and alcohol abuse. It uses a mobile platform (van) and movie, taking activities to schools, boarding schools, universities, youth centres and the army.

Yes to sports, no to drugs

This programme combines sports activities with prevention. It promotes a healthy lifestyle. It is aimed at youth sports teams in general, as well as high-risk groups from specific populations.

Character (OFI)

This programme, OFI, which means "character" in Hebrew, stands for the following three words: training, development and coping skills. This programme is an educational and treatment intervention for training and developing coping abilities, based on the American SAP model (Student Assistance Program). The programme consists of 10 meetings, and is administered by a school counsellor who has undergone specific training.

Programmes for the workplace

Interventions in the workplace focus on the dangers and risks of drug and alcohol use, personal responsibility and providing information to the employee and employer.

Other programmes

Another programme being implemented by IADA targets students learning in colleges and universities across the country. In co-operation with the academic leadership of higher education institutions, IADA is training and funding the activity of students who become campus co-ordinators and co-ordinate the implementation of a host of awareness campaigns, peer education programmes and other drugs and alcohol prevention activities on campus.

Culture-sensitive programmes have been developed specifically for certain populations. There are programmes for preventing substance use among immigrants

from the former Soviet Union and Ethiopia, and for the Arab sector population. That programme is aimed at youth and parents.

As mentioned above, the Ethiopian National Project (ENP)[27] has launched a series of workshops to educate Ethiopian-Israelis about drug and alcohol abuse. The programme runs in partnership with a variety of government ministries, including welfare, education, and immigration, as well as the Efshar organisation. The programme comprises 25 workshops: 15 for youth, 7 for parents and three for both parents and youth. Facilitators of these programmes are substance-abuse specialists from the Ethiopian-Israeli community. Professionals in substance abuse and prevention provide these leaders with three days of intensive training before the workshops begin and accompany them to the sites.

Residential treatment programmes for drug users

As mentioned above, residential treatment programmes are essential. Drug addicts need a protective environment during withdrawal and for the immediate post-withdrawal period.

Selected residential programmes in Israel

The Malkishua Drug Rehabilitation Centre[28] was established jointly by the IADA and the Beit Shean Valley Regional Council. Malkishua Village has an adult and a youth community, and a community for religious youth; all three communities are supervised by the Ministry of Social Affairs and Social Services. Malkishua's mission is to support detoxicated addicts, helping them to acquire healthy, coping patterns of behaviour and the lifestyle of independent persons, interacting positively and constructively with their environment. The Malkishua community sets an example for them and gives them hope that after rehabilitation they will be able to start a new life. Its activities help to prevent the expansion of drug abuse in society. The village accepts drug addicts who have undergone detoxication and been referred there by hospital wards, agencies treating drug addicts, probation officers or lawyers. Personal requests are also considered.

The Haifa drug abuse treatment centre[29] offers a therapeutic home for women only, from age 18 and upwards, who are addicted to drugs and/or alcohol. It is funded by IADA, the Ministry of Health and the Ministry of Social Affairs and Social Services, and operated by the Association for Public Health, an Israeli NGO. The centre began operating in 2000, offering a unique programme specifically for women recovering from substance abuse. The programme's primary goals are to help these women to complete their recovery programmes successfully and to gradually help them get back on track to become contributing members of the community. The Haifa Therapeutic Home is an inpatient residential treatment setting. It is staffed around the clock, seven days a week, by professional and paraprofessional female staff. The

27. Ethiopian National Project website: www.enp.org.il/en/programs/Alcohol_Drug_Prevention/.
28. Malkishua website. Available at: www.malkishua.org.il/eng/.
29. Haifa website. Available at: http://mabat-nashi.com/Aboutus.aspx.

professional staff includes therapists and social workers. The paraprofessional staff is made up of counsellors who themselves are recovered drug and alcohol addicts, and have had two years of professional training. There are also a growing number of volunteers who help and support the programme.

Kfar Izun (literally the Village of Balance) was established in February 2001 to provide a new therapeutic approach to young Israelis, returning from backpacking journeys abroad, suffering mental imbalance due to hallucinogenic or mind-altering drugs. The village is internationally recognised as a unique centre for non-addicts, specifically dedicated to the recovery and rehabilitation of youths. Located on the shores of the Mediterranean Sea, Kfar Izun brings nature, body and mind together. The result is strong, active minds back on track.

Evaluation: using the working table of marker 5 – specific actions implemented, monitoring in view of the action plan, and consequences, target population and social settings – the experts rated this marker on a 1-5 scale as: 4.17 for tobacco, 3.00 for alcohol and 3.33 for drugs.

Criteria for certification of intervention programmes

In 2010 IADA established an ad hoc expert committee to develop a set of standardised criteria to enable it to map out, review and certify all drugs and alcohol-related prevention intervention programmes implemented in Israel under the auspices of IADA. This set of criteria will be used to review all future submissions of new programmes or activities in order to certify them as authorised by IADA and to be used as part of its intervention strategies throughout the country.

Seven main criteria were established:

- targeted goals and their relevance to IADA's mission;
- theoretical basis of the intervention and the scientific evidence for its effectiveness;
- methods of the intervention process;
- target population/s;
- professional staff – experience and expertise;
- evaluation and measurable outcomes;
- documentation, including manual, settings and observations.

The expert committee, headed by Professor Moshe Israelshvili, a Tel Aviv University expert in the evaluation of intervention programmes, reviewed and analysed about 75 applications submitted as a response to IADA's call for drugs and alcohol prevention programmes. During the meticulous examination of these submitted programmes, the committee was able to refine the set of seven criteria and develop a review and certification process for future submissions.

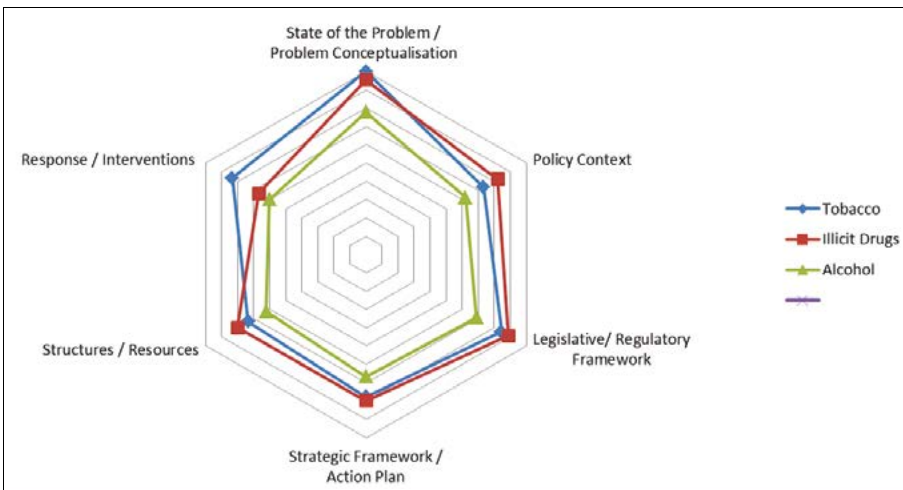
Following completion of the experts' work, IADA set up a permanent review and certification committee to provide regular on-going evaluation and certification for new proposals of prevention and intervention programmes. In future, only certified interventions will be allowed in schools, extracurricular activities and the community. This regulation process will ensure implementation of high-quality, evidence-based programmes throughout IADA's activities.

Findings on the six markers of policy coherency

Table 5.2: The Israeli experts' assessment of policy coherency (mean scores)

	Tobacco
State of the problem / problem conceptualisation	5.00
Policy context	3.56
Legislative/ regulatory framework	4.22
Strategic framework / action plan	3.89
Structures / resources	3.44
Response / interventions	4.17
	Alcohol
State of the problem / problem conceptualisation	3.89
Policy context	3.11
Legislative/ regulatory framework	3.44
Strategic framework / action plan	3.33
Structures / resources	3.11
Response / interventions	3.00
	Drugs
State of the problem / problem conceptualisation	4.78
Policy context	4.11
Legislative/ regulatory framework	4.44
Strategic framework / action plan	4.00
Structures / resources	4.00
Response / interventions	3.33

Figure 5.2: The Israeli experts' assessment of policy coherency (spider diagram)



Interpretation

As seen in Table 5.2 and Figure 5.2, the coherency of Israeli policy in all three substance areas is quite high. On a scale from 1-5, the scores for all markers range from 3 to 5. The findings also indicate that the policy on tobacco, the policy that was established first and that has been running the longest, has the highest scores for coherency. The policy on drugs scored high on most markers but, as Figure 5.2 shows, the area of specific responses needs additional discussion. This might be due to the ambiguity of the response to the growing use of marijuana for medical purposes and the intense public debate on the demand for legalisation of cannabis. Alcohol policy has the lowest scores in all markers, mainly reflecting fewer years' development, implementation and evaluation of the national action plan. However, here too the scores are above 3 for all markers.

After using it to discuss and evaluate the coherency and effectiveness of national policy, the 15 experts viewed the marker scheme as a "great tool to provide a structured opportunity for brain-storming discussions" of national policies, with valuable insights for their improvement.

In Israel we plan to use the tool in the near future in cross-disciplinary meetings, bringing together drug professionals, policy makers and researchers, in an attempt to better understand how we can improve the policy and its implementation, to influence its position as a high-priority issue on the policy agenda and to bring about much closer collaboration and co-operation between researchers, professionals and politicians.

Some thoughts for further discussion

Similar or diverse policy perceptions

During the discussions of the policy coherency marker methodology, the concept of inter-expert agreement came up: if the state of the policy (tobacco, alcohol or drugs) for a particular marker is well documented, clear and visible or known, then there should be a high level of agreement among the experts, resulting in marker scores that are similar with few variations. However, if that particular dimension of the policy is less known, less well documented or in a state of development, the experts rating it might have different perceptions of its relative coherency, resulting in a wide range of scores given to that marker. The level of agreement among experts, over and above the mean score, may indicate various perceptions of the policy due to levels of clarity, documentation, visibility or exposure to that particular policy marker.

Changing drug scene – a challenge for policy adaptation

We face on-going issues, such as the introduction of designer drugs, public debates about legalisation and de-criminalisation of cannabis, and the introduction of medical marijuana to a larger patient audience. Changes like this pose a significant challenge to current policy. If policy does not adapt, it may lose coherency and

become irrelevant. On the other hand, a rushed change might cause inconsistency and incoherency if the process is not carried out appropriately. A good policy system should have a built-in structure for adapting to change.

Subjectivity v. objectivity

This issue affects documentation, policy makers, health or welfare service providers, prevention and education professionals, scientists, academicians, people responsible for development and/or implementation of drug policy and people challenging policy (lobbyists or political opponents). One possible solution is to design between one and three standard methods with an international research protocol that is mandatory so data or findings can be compared. For example, this could be an expert group discussion, like the one carried out in Israel, but structuring tobacco, alcohol and drug experts into three separate evaluations so that each policy is evaluated by those who know it best.

Variations in policy coherency between central government and local authorities

One should also include a panel of substance-use co-ordinators at local authority level to learn about variations in policy coherence perceptions between central government and communities.

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Chapter 6

Italy – Drugs policy coherence: from policy markers to policy makers

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The Italian National Drug Action Plan foresee co-operation and negotiation among various key players in order to create a strategic plan which takes into account all levels of action and intervention, in particular two important and diversified components:

- coherence with European directives in the field of drug policies;
- coherence among the regions in applying the National Drug Action Plan.

This was also done in order to guarantee, as far as possible, a common intent and approach that would make the fight against drugs coherent and effective.

Understanding ToRs

The evaluation report on coherency stems from the document provided by Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs, Ref P-PG/CoherPol (2013) 2 26 February 2013, concerning its coherency policy markers diagnostic tool. The understanding of this document is complemented by the analysis in the Pompidou Group document "Policy coherence framework: context, systems, measurement", in which Richard Muscat and Brigid Pike explain the rationale and concepts of policy coherence and coherency.

Since terms of reference (ToRs) pose questions, the method of answering them is described below:

- first, a background section is presented so that the Italian context is understood;
- then, coherency policy markers are detailed and illustrated in three sections;
- ToRs recall those written in the coherency policy markers diagnostic tool;
- a description of the Italian context follows;
- evaluation comments and related scaling are provided; a scale 1-5 was chosen as suggested in the ToRs (1=Low, 2 = Low to Middle, 3= Middle, 4= Middle to High, 5=High).

The understanding of the ToRs is recapitulated with a scheme measuring policy coherence.

Background: legal framework

First, the Italian legal framework foresees different institutions competent in drugs, alcohol and tobacco issues. Drugs, in the meaning set out by the UN conventions, are managed by the Department of Anti-Drug Policies, part of the Presidency of the Council of Ministers (PCM), whereas alcohol and tobacco are managed by the Ministry of Health. As a result, this chapter on coherency policy markers deals only with drug policies, and not alcohol or tobacco.

Second, according to the legislative framework (DPR 309/90) and in line with European law, drug issues are regulated by the National Action Plan on Drugs and by the Department of Anti-Drug Policies (DPA) Action Plan, containing both the strategy and related action plan. The DPA Action Plan 2010-13, approved by the Council of Ministers on 29 October 2010, is the basis of this chapter and serves as the reference for Italian drug policies and the legal documents, bringing together European and national laws on drugs. The DPA Action Plan covers a different period from that expected by the EU (EU Drugs Action Plan 2009-12, EU Council 2008/C 326/09) because the previous DPA Action Plan covered just 2008-9, as stated by the previous Italian Government.

Third, in accordance with the Italian Constitution, regions that are deemed competent to handle the drugs issue are given a specific budget from the government to implement their actions. Regional action is co-ordinated by a purpose-built institution at national level and harmonised with government action through a State–Regions Unified Conference, which also plays a ratification role in transferring government policy or sharing common issues on drug policies.

The legislative framework for regional action is Presidential Decree No. 309 of October 1990 complemented by the UN conventions on narcotic drugs (1961, 1971 and 1988).

Background: evaluation approach

In 2008, the Italian Government asked an agency of the United Nations to evaluate the effectiveness of the DPA Action Plan of 2008. The evaluation approach stemmed from the monitoring framework and focused on "compliance criteria". The evaluation was carried out through two questionnaires with before-and-after administrative procedures, which gathered data on the initial action expected from the Action Plan (January 2008) and its completion (December 2008). The questionnaire focused on the content of the DPA Action Plan: co-ordination, demand reduction, supply reduction, international co-operation, information, training and research.

The online compliance questionnaire was designed to produce a matrix in which the rows represented the DPA Action Plan areas, as detailed in 106 actions, and the columns reported on compliance criteria, namely initial and completion dates, factors hampering the action start-up, operational programmes in force and co-ordination structures. This research was accompanied by a customer-satisfaction survey, carried out through an additional questionnaire detecting:

- relevance (such as the relationship between needs and DPA action plans);
- adequacy (description of comprehensiveness of each action);
- internal coherence (relationship between goals and related actions);

- external coherence (relationship between goals and actions);
- congruence (match between stated actions and needed actions); and
- exhaustiveness of indicators.

Following presentation of this evaluation in March 2009, a new evaluation mechanism was designed according to the revised evaluation goals discussed with the Department of Anti-Drug Policies. The new evaluation framework follows the Public Policy Analysis methodology and has been applied to the DPA Action Plan 2010-13.

A meta-evaluation was used to identify strengths and weaknesses in the previous evaluation (DPA Action Plan 2008) leading to the novel evaluation framework summarised here:

a. According to the Public Policy Analysis methodology, three components were identified, such as policy needs, programming and policy evaluation.

b. The time frame of the evaluation includes:

- a first stage, looking at EU–Italy drugs policy alignment;
- a second stage, where national problems are analysed, and the national action plan designed;
- and a third stage, when the national action plan monitoring and evaluation have been delivered.

c. The evaluation tools introduced cover projects carried out by the Department of Anti-Drug Policies foreseen within the DPA Action Plan 2010-13 (Tool 1), institutional and legal appraisals related to regional action plans (Tool 2), regional drug policies mapping (Tool 3) and territorial good practices monitoring (Tool 4).

Among the novel evaluation tasks adopted for the DPA Action Plan 2010-13, three deserve mention:

I. a study of problems related to drugs, carried out through focus groups;
II. a study of territorial good practices in facing the problems;
III. an agreement between government and regions on drug policy priorities, achieved through a national conference.

In conclusion, the evaluation of Italian drug policies can be summarised as follows:

a. Problem identification and related institutional agreement.
b. DPA Action Plan designed and related legal framework.
c. Action implementation at central and territorial level.

Coherent policy markers

Going back to the terms of reference relating to the Italian drugs policy markers, it is worth comparing the Pompidou Group (PG) scheme with the Italian evaluation scheme. This is the PG model:

I. Conceptualisation of the problems
II. Policy context
III. Legislative framework
IV. Strategic framework
V. Responses
VI. Structures and resources

This is the Italian evaluation scheme:

I. How are problems associated with different psychoactive substances?
II. Where are psychoactive substances policies located? Criminal Justice? Medical context? Social inclusion? Human rights? To what extent is there a consistent approach across different psychoactive substances?
III. How are various psychoactive substances controlled and regulated? To what extent do the controls complement the desired outcomes?
IV. What are the goals of drug policies? How far do they overlap with one another?
V. Are interventions locally consistent and mutually supportive? Are they in line with over-arching policy?
VI. To what extent does the organisation of structures support the co-ordination and integration of drugs policies?

The hierarchical perspective and layered approach in the PG model seem close to the programme structure adopted by the Department of Anti-Drug Policies so as to identify outputs from one stage, say conceptualisation of the problems, as inputs for the subsequent stage. The dynamic nature of the EU mechanism will be understood more clearly when the EU Action Plan on Drugs and its national adoption are in force.

A second similarity is in the realms to be covered. In the PG model, five areas coincide with the core components of a drug action plan: problem identification, context, legal frame, strategy and delivered mechanism.

A third similar factor is the equation leading to drug policies:

drug policy = context + systems + mechanism

and the same equation has been used by an agency of the UN and by the Department of Anti-Drug Policies to measure structure effectiveness after understanding variables that influence their actions, such as historical, cultural or economic factors.

The last comparison point goes hand in hand with Italian Government policy on health and well-being, where the World Health Organization constitution is mentioned in the preamble words: "Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity". This is particularly true for diseases caused by drugs.

First marker: state of the problem

Terms of reference (ToRs)

Prevalence, estimates, trends, substance-related deaths, social costs and socio-historical issues (public opinion, media and political manifestos) are all mentioned.

Description

The following data are from the Department of Anti-Drug Policies' report to parliament. In the 2013 general population survey (a sample group of almost

20 000 people aged 18-64), drug usage was reported as follows: heroin 0.1%, cocaine 0.6%, cannabis 4%, stimulants (amphetamines, ecstasy) 1.1%, hallucinogens 1.7%. The student population survey (36 000 subjects aged 15-19) showed quite different data: heroin 0.3%, cocaine 1.9%, cannabis 19.1%, stimulants 1.1% and hallucinogens 1.7%. A comprehensive analysis of trends in drug use from 2010 to 2012 is also included in the study together with the distribution of percentages by geographic areas. The student population survey also reports the distribution by region and type of academic institution.

The marker underlines "estimates", thus reinforcing awareness of the tacit nature of drug use. In this respect, the Department of Anti-Drug Policies carried out parallel surveys on metabolites in user urine through wastewater analysis, and by drug testing in high-risk professions. Eight major cities were identified and the population lifestyle was studied using samples of wastewater entering the principal urban treatment plants and from collectors for wastewater exiting secondary schools. Distribution of the average number of doses of cannabis, cocaine, heroin, methamphetamine, ecstasy and ketamine was provided. In turn, almost 89 000 individuals in the Italian State Railways Group and the National Agency for Flight Assistance were tested for drugs. First and second clinical verification findings were also provided. These studies showed evidence-based data complementing those given by the population surveys mentioned above.

Data about deaths and health consequences were documented in the report to parliament detailed by accidents, deaths and injuries. In addition, HIV and viral hepatitis prevalence ratios were illustrated, with related trends. An estimate of social costs was included in the report, split into individual costs and loss of work capacity (more than 31 billion euro).

On problem drug use (PDU), one of the five key epidemiological indicators used by the EMCDDA to monitor drug-use phenomena, the Department of Anti-Drug Policies provides an in-depth investigation and data. This is particularly relevant since the PDU study captures information on the more problematic patterns of drug use that are not effectively captured by the general population surveys. Problem drug use, defined as injecting drug use or long-duration use of opioids, cocaine and amphetamines, is observed in Italy through a multiplier value for clients in need of treatment for opiate use combined with data at local levels (regional institutions). The trend in prevalence remained stable between 2005 and 2011, with about 200 000 subjects in need of treatment. The truncated Poisson model was adopted to calculate the use of cocaine, strengthened by the Zelterman estimates (217 391 subjects). The same methodology was used to obtain estimates of cannabis users (about 1 350 000 subjects).

Evaluation

The informative framework described above confirms knowledge of the problem by Italian institutions in charge of drugs policy. The Anti-Drug Policies Department uses a matrix where problems (rows) are described for each psychoactive substance (column). As a result, the score for the first marker is 5.

Second marker: policy context

ToRs

Here, the evaluation is of policy documents that outline the specific goals: in short, psychoactive substance policies located within an overall policy context such as justice, medicine or social inclusion should be outlined.

Description

The Department of Anti-Drug Policies (DPA) was tasked with devising the methodology and technical co-ordination needed for a more detailed analysis of drug-related issues in Italy, starting from the findings of the 5th National Conference on Drug Policies (Trieste, 12-14 March 2009), in order to prepare the national action plan, and also to comply with relevant European guidelines. In this regard, it arranged interministerial co-ordination, by virtue of the role assigned to the DPA by the Prime Minister's Office, and collection of all the guidelines which the various organisations and administrations invited wished to provide for the drafting of the plan. All this work was done in order to make the policies and strategies of the individual central governments coherent and homogeneous.

The new action plan is conceptually structured and arranged to provide national guidelines, in line with European guidelines, to central government and the regions and autonomous provinces. It must be made very clear that the regions and autonomous provinces maintain their complete independence in formulating local policies and strategies, as well as in planning and organising their own services by virtue of the reform of Title V of the constitution. However, central government keeps its role of co-ordination and definition of national policies, by virtue of its competences and the directives from EU bodies.

It was, therefore, considered necessary to proceed with drafting the national action plan in a way that did not prescribe or dictate to the regions, but merely offered general guidelines that are expected to be accepted and agreed in transforming and realising individual plans and regional action plans.

The Department of Anti-Drug Policies carried out projects in 10 areas: prevention, related pathologies prevention, treatment and community support, rehabilitation, epidemiology, early detection, programming, research, training and international activities. It is worth noting that the research area has important co-operation at international level with organisations such as NIDA (the US National Institute on Drug Abuse) and other scientific and research centres covering relevant neuroscience issues.

Third marker: legislative framework

ToRs

The terms of reference referred to specific documents to support whether there are laws and regulations in place that adhere to international conventions and, second, that are related to national requirements. Three questions about regulations in place, alignment with international conventions and with national goals, were drafted.

Description

As mentioned earlier, the legislative framework (DPR 309/90) ensures a common reference to those institutions and NGOs that act and operate to implement drug-policy goals. Nevertheless, the legislative power of the regions, constitutionally based, causes regulative segmentation and organisational fragmentation. On one hand, this great profusion of regulation at local level matches the population's needs. On the other, it hampers standardisation of services and responses.

Considering the national legal framework, alignment with the UN conventions is proven and strengthened by strong co-operation with UN bodies such as UNODC, WHO and ITC of the ILO.

Alignment with EU regulation is also in force. Legislative Decree No 50 of 24 March 2011 implementing EC Regulations 273/2004, 111/2005, 1277/2005 and 297/2009 on drug precursors is one case, along with ministerial decrees of 31 March 2011 (updating tables containing descriptions of narcotic and psychotropic substances), and 11 May 2011, 2 August 2011 and 25 June 2013 on the same matter. These regulations call attention to the implementation of EU Law on precursors according to the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (Vienna, December 1988, ratified in Italy on 5 November 1990 by Law 328). The Italian legislative revision of 2011 includes the amendment introduced by EC Regulation 225/2011.

Important legislative arrangements are in force on information systems. The National Monitoring Centre, as set forth in DPR 309/90 (Article 1), during 2011-12 participated in the realisation and assessment of all on-going projects, working closely with the national focal points to bring about the reorganisation of national data flows, aligning them with European standards through the National Information System on Addiction (SIND) and the Italian Network of Addiction Monitoring Centres (NIOD).

In addition, the Scientific Community on Addiction, part of UNICRI's responsibility and carried out in collaboration with the Ministry of Health and the Ministry of Education, has developed a multidisciplinary community and launched a national training school on drug addiction.

During 2011 and 2012 the Department of Anti-Drug Policies strengthened its involvement in international activities with European institutions and international organisations through bilateral agreements.

Evaluation

The Italian legal framework is articulated in two public policy profiles, national and regional, and both adhere to international conventions. Moreover, each regulation profile is aligned with European policy goals.

The aforementioned laws in force and related activities need a detailed evaluation so as to quantify markers at different levels, as shown in Table 6.1.

Table 6.1: Evaluation of legal framework for illicit drugs

	Illicit drugs	
	Anti-Drug Policies Department	Regions
Legal regulation	5	5
Compliance with international conventions	5	5
Alignment with policy goals	5	3

Fourth marker: strategic framework

ToRs

Questions here referred to the relevance of strategy to the state of the problem, the coverage of demand reduction, supply reduction and related pathologies prevention measures, accountability for implementation, budgetary decisions, activities corresponding with goals and reduction aims.

This marker, in short, aims to identify drug policy goals and their overlapping methods, or congruence.

Description

In public policy evaluation, strategy is linked to needs and relevance is measured. In fact, the first question follows the same aim: the relation between problems and strategy. The remaining questions focus on drug policy actions in terms of their coverage (demand and supply reduction) and budgetary responsibilities. Needless to say, in Italian strategy, the DPA Action Plan is the reference document, since it is the key document in Italian and European contexts.

The interdependence between problems and strategy has been sought by the Anti-Drug Policies Department through two actions:

- the diagnosis of drug-related problems;
- the identification of an agreed strategy.

The first action was pursued by a thematic focus group involving national and local actors operating in the drug field, public and private organisations. The second action was carried out through a national conference gathering together thousands of actors, from representatives of central government institutions like ministries to micro co-operatives dealing with social inclusion. Both initiatives were evaluated and the results were published on the public website.

The analysis of drugs problems

The analysis was carried out through three thematic focus groups or workshops held in Rome on 19 June, 8 July and 22 July 2009. The aim of these initiatives was to identify "priority problems" to be tackled by the DPA Action Plan. In the first round, devoted to prevention (19 June), 125 managers and focal points were invited and 38 participants attended; for the second round, addressing treatment (8 July), 133 were

invited and 43 participated; for the third round, focused on rehabilitation, 134 were invited, and there were 27 participants.

The evaluation report showed weak and strong factors in achieving expected goals and, above all, clarified concept meanings for prevention, treatment and rehabilitation as key principles of drug policies. The programme structure was tested in terms of relationship flows between output of one phase, say programming, and input for implementation. Even the problem–solution relationship was replaced by a multidimensional interdependence between cause and effect, thereby showing the drug context as more complex than just a medical perspective. The involvement of the territorial level, both public (municipalities) and private (NGO and social sector), revealed interesting connections and showed networking issues to be a key determinant for the effectiveness of rehabilitation measures. The concept of "dependence" rather than "drug use" was prioritised among other lines of investigation highlighted in the evaluation report.

Identification of an agreed strategy

A national conference was organised during the same year, preceding Rome's workshops, to study drug-related problems, identify appropriate solutions and design a national plan for public health. Common guidelines on drug policies were the aim of the national conference held in Trieste, organised in thematic sessions managed by speakers and participants. Parallel sessions devoted to academic and scientific discussions and stands accompanied the conference, which had about 6 000 participants. The evaluation approach was based on "customer satisfaction" supported by a consensus-building investigation. An evaluation tool was designed to observe the thematic session's results and each participant used a remote evaluation device for timely scoring of satisfaction and consensus about results.

A useful matrix was presented showing the relationship between the consensus for each theme and the feasibility of proposals emerging from the problem analysis. The national conference provided important information for the Department of Anti-Drug Policies and supported the preparation of the DPA Action Plan.

DPA Action Plan design

Two preliminary actions finalised the preparation phase:

- review of EU legislative framework on drug policy;
- comparison of drug policy action plans already in force in the EU member states.

The review aimed to complement the Department of Anti-Drug Policies' effort to align the Italian DPA Action Plan with the EU Strategy on Drugs. The review highlighted difficulties in reaching consensus among EU countries due to the opposing approaches of northern and southern countries. This debate is confirmed by the *Acquis Communautaire* on Drugs, which is the only regulation in force relating to co-operation against drugs (2046/97). There was full agreement on the aim of health (Article 152) and its relation with psychoactive substances, while different positions emerged on demand reduction.

The EU strategy (2000-04) replacing the first generation of programmes against drugs (1995-9) introduced a prevention approach, which obtained a broader agreement. A focused analysis was carried out for the EU Drugs Action Plan 2007-13 in order to compare goals and actions in line with the Italian drug policy. Finally, the EU strategy on supply reduction in co-operation with international institutions against crime and the results of the EU evaluation exercise on drug policy have been covered as additional information supporting the Italian DPA Action Plan design.

The comparison of drug action plans in force in other member states was useful in preparing the set of actions that the Department of Anti-Drug Policies should have drafted according to the EU Drugs Action Plan, approved in 2008 for the legislative period 2009-12 (2008/C 326/09).

In particular, the action plans of Germany, the UK, Sweden, Scotland and Ireland were compared with the expected Italian DPA Action Plan. After the preparation phase and action, the Italian DPA Action Plan was finalised and approved by the Italian Government on 29 October 2010. It reflects the European action plan in that it:

- sets out the national policy through a set of goal–action connections;
- is based on a regional plan which puts into practice DPA Action Plan goals and actions;
- provides scientific guidelines for prevention and treatments;
- is supported by national projects managed by the Anti-Drug Policies Department.

Three programming levels are shown in the Italian DPA Action Plan:

- strategic and legislative level;
- programming level;
- over-arching scientific level.

The logical framework of the DPA Action Plan is organised as a matrix showing on rows the horizontal actions, such as co-ordination, international co-operation, information, research and evaluation, organisation and training; and, for the columns, five policy areas such as prevention, treatment, rehabilitation, monitoring drug usage, legislation and youth justice. The first four areas pertain to demand reduction while the fifth area covers supply reduction.

Prevention is detailed in 16 objectives and 76 actions, treatment is split into 22 objectives and 70 actions, rehabilitation is divided into 11 objectives and 26 actions, monitoring is articulated in 9 objectives and 25 actions and, finally, legislation entails 31 objectives and 80 actions. In total, there are 89 objectives and 277 actions.

The DPA Action Plan appraisal

In light of evaluating the logical framework of the DPA Action Plan and related goals–action structure, the Department of Anti-Drug Policies launched an evaluation initiative through an online questionnaire addressed to regions, public territorial drugs services (SERD) and private social co-operatives and communities. The questionnaire covered all the actions envisaged for prevention, treatment, rehabilitation, co-ordination, international co-operation and supply reduction, evaluated on the following criteria: exhaustiveness, utility, coherence, feasibility.

The results highlighted a general agreement on the DPA Action Plan, raising at the same time consideration of new issues deserving public interest for each DPA Action Plan area, such as prevention initiatives at the workplace (prevention area), new pharmacological solutions in the treatment of subjects using heroin, to facilitate their inclusion (treatment area) and stronger co-operation with social enterprises (rehabilitation area). The evaluation report also showed a matrix obtained from the combination of goals (critical and effective) on an x-axis and thematic actions (redundant and strategic) on a y-axis. Four areas were calculated, outlining strategic areas to be strengthened and thematic action to be broadened to all regions.

Evaluation

The preparation and appraisal phase confirmed that:

- the strategy is coherent with the state of the problem (Question a);
- the strategy addresses demand and supply reduction covering harm-reduction measures (in Italy, harm reduction was replaced by related pathologies prevention) (Question b);
- the strategy envisages specific objectives for various reduction measures in both demand and supply (Question c);
- the strategy details central institutions and regional institutions accountable for the DPA Action Plan implementation profile (Question d);
- the strategy is made up of the alignment between EU and national policy, and that policy is translated into specific objectives which are linked to related actions, where the expected reduction measures are located (Question e).

Evaluation of strategy and action plans

As far as markers are concerned, the assessment of marker four in Table 6.2 is worth noting.

Table 6.2: Evaluation of marker four

	Anti-Drug Policies Dept	Regions	Ministries
Reference to state of the problem	5	5	5
Supply reduction	5	not applicable	5
Demand reduction	5	5	4
Harm reduction	5	4	3
Specific objectives	5	5	4
Budgetary issues	5	4	3
Activities	5	5	5

It follows that the general evaluation for marker four is quite remarkable even if some improvement is needed in the standardisation of drug policy and in the co-ordination profile, both at national (among ministries) and local level (among regions).

Fifth marker: structures and resources

ToRs

What is asked here refers to structures and resources implementing the drug policy and whether the Italian model is functioning appropriately.

Description

Leaving aside the alcohol and tobacco issues, as previously explained, the focus here is on other psychoactive substances or illegal drugs. The overall structure, delivering services for drug users, includes 575 public services and 2 500 NGOs and social enterprises, distributed across the national territory. Regions have a statutory competency by virtue of the constitution and act through autonomous laws and regulations allowing the establishment of additional structures and resources. The layered nature of Italian drug policies offers a great number of structures, agencies and mechanisms dealing with demand reduction policies. In their turn, ministries intervene in supply reduction, therefore covering core areas of drugs policy. In addition, they manage international relations and intergovernmental action against crime and narcotics trafficking. Within the evaluation of the DPA Action Plan, a key evaluative component was addressed to regional structures so that their administrative profile and programming capacity was monitored.

Administrative profile

In 2012 an evaluation exercise was carried out to:

- understand the relationship between regional law and national law on drug policies;
- gather information on policy priorities of regions and their action plans;
- monitor the DPA Action Plan implementation in the regional territory;
- identify good practice in the DPA Action Plan areas.

All regions had laws or administrative acts issued by the political authority dealing with drugs.

Three governance schemes were observed. In the first one, the drug problem is managed by the body dealing with social affairs; in the second one, it is managed by the Office of Health; and the third scheme shows full integration between social and health functions.

Evaluation

Now, coming to the questions:

- There is an over-arching responsible authority for EU drug issues: the Department of Anti-Drug Policies (DPA).
- There are several co-ordinating bodies in place within the DPA, namely groups of experts (*consulta*). Their mandates include scientific improvement in neuroscience, harmonisation of local drug policy, and so on.
- The mechanism is a combination of regular meetings and day-to-day interaction between regional offices and the DPA secretary.

- A Monitoring and Evaluation Plan is in force and managed by ITC of the ILO.
- Funding is possibly insufficient to conduct various mandates.

Even for this marker, separate observations are envisaged to describe differences between DPA and regional responsibilities.

Table 6.3: Evaluation of marker five

	Anti-Drug Policies Dept	Regions
Responsible body	5	5
Co-ordination body (CB)	5	4
Mechanism of CB	4	3
Monitoring system	5	1
Final evaluation	5	1
Funding for CB	1	5

Sixth marker: responses and interventions

ToRs

This marker covers specific actions put in place and types of intervention adopted. Groups of actions and not single interventions are to be reported. Here the last evaluation task is consistency with over-arching policy goals.

Description

The evaluation report of the DPA Action Plan provides detailed information about questions related to the sixth marker. In fact, the DPA Action Plan evaluation goals were, among others, to:

- monitor specific actions put in place by regions and the DPA;
- understand the coverage of DPA Action Plan actions and the consistency between DPA action plans and delivered actions;
- highlight innovative and good practices.

To this end, in 2012 a survey was carried out in Italian regions over a timeline of nine months (February to October). The questionnaire was first designed and then tested through a pilot appraisal in two regions. Afterwards, validation was conducted in the group of regions where permission to conduct interviews was obtained.

A parallel evaluation exercise observed the effectiveness and consistency of projects delivered by the DPA itself, employing a self-evaluation procedure. The results were published in the 2013 DPA report to parliament.

Evaluation

Coming to the ToR questions, here are the answers:

- There are specific actions planned with respect to the strategy (Question a).
- Expected actions have been implemented with varying levels of performance (Question b).

- Budgetary restrictions due to the economic and financial crisis have hampered actions focused on prevention and labour market reintegration (Question c).
- Actions have been monitored through an independent evaluation (Question d).

The annual budget of regions does not reflect emerging phenomena. In particular, DPA recommendations on neuroscience and innovative prevention/treatment methods, are not matched by adequate funding.

Table 6.4: Evaluation of marker six

	Anti-Drug Policies Dept	Regions
Specific actions	5	5
Implementation	5	5
Budgetary constraints	1	1
Monitoring	5	3
Budget for emerging phenomena	3	1

Conclusion

After the analysis was carried out, it was possible to confirm that there is a good level of coherence in the actions taken at regional level and the national action plan.

Table 6.5: Legislative framework, assessment

	Markers	
Drugs policy issues	DPA	Regions
Legal regulation	5	5
Compliance with international conventions	5	5
Alignment with policy goals	5	3

Figure 6.1: DPA legislation, spider diagram

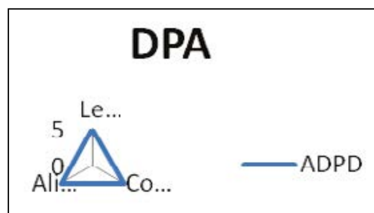


Figure 6.2: Regional legislation, spider diagram

Table 6.6: Strategic–Action Plan Framework, assessment

	Markers		
Drugs policy issues	DPA	Regions	Ministries
Reference to state of the problem	5	5	5
Supply reduction	5	not applicable	5
Demand reduction	5	5	4
Harm reduction	5	4	3
Specific objectives	5	5	4
Budgetary issues	5	4	3
Activities	5	5	5

Table 6.7: Structures, assessment

	Markers	
Drug policy issues	DPA	Regions
Responsible body	5	5
Co-ordination body	5	4
Mechanism of CB	4	3
Monitoring system	5	1
Final evaluation	5	1
Funding for CB	1	5

Figure 6.3: DPA structures, spider diagram

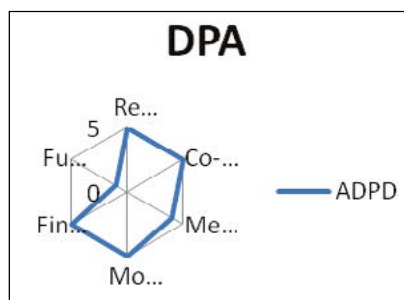


Figure 6.4: Regional structures, spider diagram

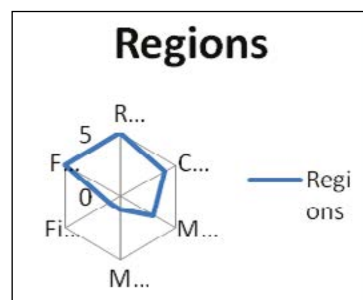


Table 6.8: Responses, assessment

	Markers	
Drugs policy issues	DPA	Regions
Concrete actions	5	5
Implementation	5	5
Budgetary constrains	1	1
Monitoring	5	3
Budget for emerging phenomena	3	1

Figure 6.5: DPA responses, spider diagram

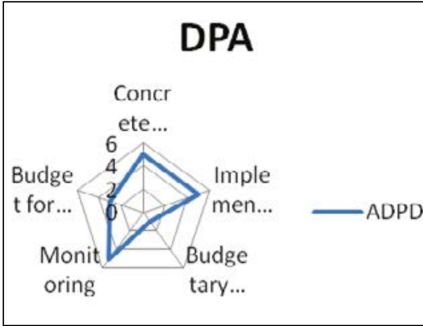
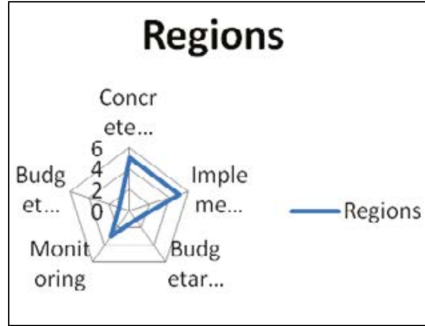


Figure 6.6: Regional responses, spider diagram



Chapter 7

Portugal – Coherent policy markers for drugs

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Following the September 2013 meeting of the Pompidou Group Coherent Policy Expert Group, the Portuguese report was redrafted in accordance with the conclusions reached. The current report does not include tobacco, since the National Programme for the Prevention and Control of Tobacco Use is not within SICAD's competences. The co-operation of the Director General of Health may be required to submit a report on that matter; however, for the time being it was judged best to perform this exercise solely for illicit drugs and alcohol.

The first marker, conceptualisation and policy context, may fall into two parts, namely 1A and 1B, in which the former relates to the state of the problem and the latter the solutions drawn up in a policy to address the problem. Hence an overview of the policy documents in place should be the starting point.

Policy: state of the problem

The National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20 presents an extensive appraisal of the problem and presents updated data for 2012, both within a national perspective and within each life-cycle partition. Objectives, indicators and goals were defined and set in accordance with the state of the problem and national data, and with reference to European benchmark figures (see Appendix 1). Table 7.1 sums up the main indicators for 2012.

Table 7.1: Indicators for illicit drugs and alcohol by age group, 2012

Prevalence	Illicit Drugs	Alcohol
	Portuguese population 15-74 (life prevalence): Any drug – 9.5% Heroin – 0.6% Amphetamines – 0.5% LSD – 0.6% Cannabis – 9.4% Cocaine – 1.2% Ecstasy – 1.3% Hallucinogenic mushrooms – 0.6% (source: INPG 2012)	Portuguese population 15-74: Life prevalence – 73% (source: INPG 2012)
	Students aged 16 (last 12 months): Cannabis – 16% (source: ESPAD)	Students aged 16 (last 12 months): Drunkenness – 29% (source: ESPAD)
	Portuguese population 15-74 (last 12 months): Any illicit drug – 2.3% (source: INPG) New psychoactive substances consumption among ages 15-74 is residual, with 0.4% lifetime prevalence and 0.1% last-12-month prevalence. NPS consumption occurs more in males 15-44.	Portuguese population 15-74 (last 12 months): Last-year prevalence – 60% Binge drinking (at least once) – 7.4% Binge drinking (more than once a month) – 3.4% Drunkenness – 5.1% (source: INPG 2012)
	Portuguese population 15-74 (high risk and dependency, last 12 months): Cannabis (CAST) High risk – 0.3% Moderate risk – 0.3% (source: INPG 2012)	Portuguese population 15-74 (high risk and dependency, last 12 months): Alcohol drinks (AUDIT) Risk and harmful – 2.7% Dependency – 0.3% Alcohol drinks (CAGE) Abuse or dependency – 0.8% (source: INPG 2012)

Prevalence of psychoactive substances in Portugal is lower than in other European countries. Between 2007 and 2012 the trend among the general population aged 15-64 was towards a reduction or stabilisation of consumption, despite occasional increases in some indicators or specific age groups (Balsa, Vital and Urbano 2013). However, studies conducted in specific contexts, namely school and recreational settings, point to some critical consumption patterns and prevalences in some age groups, especially ages 15-24, with an increase in consumption (Calado and Lavado 2010; Feijão 2012; Feijão, Lavado and Calado 2012; Guerreio, Costa and Dias 2013).

For users of public detox and therapeutic facilities, the average age of onset of illicit drug, alcohol and benzodiazepine consumption was between 16 and 23 (SICAD 2013). Likewise, the average age of those referred by Drug Deterrence Commissions was between 16 and 24 (IDT, IP 2012). As in Europe, there is also a decrease of intravenous drug use in Portugal.

In 2012, 45 863 patients with drug- and alcohol-related problems were seen in the public and conventional network, of which 10 373 were admitted during the year. There were 3 142 inpatients, 811 of them in the alcohol centres. Within a prison context, 1 184 inmates started pharmacological therapeutic programmes and 223 inmates registered into prison free wings (where they undergo detox treatment). There were 12 550 users of harm-reduction structures, mostly without family or other support (80%).

Regarding adverse consequences of drug use, from 2010 there was a continuous decrease in the proportion of HIV/AIDS cases in the disease's various stages associated with drug use (38% of the cumulative total of cases), as well as of newly diagnosed HIV cases due to drug injection (HIV 12% and AIDS 21%).[1] In 2010 and 2011 there was a decrease in drug-use-related deaths. In 2011 there were six deaths caused by illicit substance dependency according to the European Succinct List (INE, IP) and 10 deaths according to the EMCDDA protocol. From IMNL, IP data, in 2011 there were 157 deaths with positive post-mortem toxicological results (illicit substances) of which 19 were appraised as overdoses (IDT, IP). More than one substance was detected in these cases. The victim's average age was 38 years old.

Alcohol-related inpatient treatment rises along the life cycle, with a peak in the age group 50-59 (868 inpatients in 2011). In 2011 there were 3 163 hospitalisation episodes by DRG (cirrhosis and alcoholic hepatitis) in mainland Portugal, of which 218 resulted in the patient's death. According to INE, IP, the standardised mortality rate for alcohol-attributable disease before 65 years of age was 12.7%000 in mainland Portugal, six times higher in males than in females. According to DGS, alcohol-related diseases are one of the 10 main causes for males' premature death in mainland Portugal (DGS 2012).

According to INML,IP, the number of fatalities in road accidents with a level of blood alcohol content (BAC) equal to or higher than 0.5 g/l has been decreasing, with 193 fatalities in 2012 (INML,IP 12 June 2013). Still within the roads context, results from the European project DRUID reveal that, among diseased drivers, the most common substance found is cannabis (4.2%), followed by cocaine (1.4%), with no traces of opiates and amphetamines. Alcohol prevalence among drivers is especially worrisome: about 45% with BAC ≥0.1 g/l and 35% with BAC ≥0.5 g/l. Portugal has the highest prevalence among the four countries in the study (Dias 2012).

As for drug seizures, the trend has been for a rise in amounts and number of seizures of cocaine, hashish and liamba in 2000 to 2005, in comparison to a decrease in substance amounts and number of seizures of heroin and ecstasy. Most drug seizures are related to cannabis, which is also the most prevalent illicit substance consumed in Portugal. The second most seized substance is cocaine, with the most notable significant quantities per seizure. Other than heroin, there is an increase of opium,

1. Ad hoc data supplied by Instituto Nacional Dr Ricardo Jorge (INSA).

methadone and buprenorphine seizures. Synthetic substance seizures are residual. In 2012 there was an increase in the market for ecstasy, well beyond 2001 and 2009 figures, with a significant increase in the number of pills seized. Tests performed by the Scientific Police Laboratory of the Judiciary Police show an increase of purity in street market MDMA pills. In 2011 and 2012 there were atypical seizures of LSD stamps. Portugal remains a pivotal link in geostrategic terms. Morocco and Spain are the main origin points for hashish, the Netherlands and Spain for heroin and ecstasy, and several Latin American countries (with Brazil leading) for cocaine (IDT, IP 2012; JP 2013). Despite Portugal's important geostrategic position in drug trafficking, it is agreed that major criminal organisations are not based in the country (MAI 2012).

In 2011, 49% of young people aged 15-24 perceived the access availability of cannabis within 24 hours as easy or very easy. Perceived access availability for cocaine was 23%, for ecstasy 22% and for heroin 18%. In European terms, Portuguese young people of this age have a lower access availability perception for cannabis (European average: 57%), fairly equal for ecstasy and cocaine (European average: 22%) and higher for heroin, where the European average is 13% (Gallup Organisation 2011).

Enforcement by police authorities in 2012 resulted in the identification of 6 206 presumed drug traffickers. The highest figures since 2002 were registered from 2010 onwards. This is also the case for enforcement operations in the field of drug deterrence law, with 6 898 individuals identified as users. As for judicial decisions for crimes under the Drug Law, in 2011 there were 1 878 files involving 2 759 individuals, of which 2 404 were convicted. By 31 December 2012, there were 2 252 inmates convicted under the Drug Law, mostly for drug trafficking, a figure higher than in 2011.

Table 7.2: Risks and availability of illicit drugs and alcohol

<table>
<tr><td rowspan="3">Public opinion: perceived market availability (if desired)</td><td>Students aged 16:
Cannabis – 30%
Ecstasy – 15%
(source: ESPAD)</td><td>Students aged 13-15:
Beers – 49%
Wines – 48%
(source: ECATD)</td></tr>
<tr><td rowspan="2">Age 15-24:
Amphetamines – 14%
Cocaine – 23%
Heroin – 18%
(source: Eurobarometer)</td><td>Students aged 13-15:
Spirits – 33%
(source: ECATD)</td></tr>
<tr><td>Students aged 16-17:
Spirits – 70%
(source: ECATD)</td></tr>
<tr><td>Public opinion: perceived risk</td><td>Age 15-24:
Occasional consumption (one or two times) of:
Cannabis – 24%
Cocaine – 65%
Ecstasy – 51%
Regular consumption of cannabis – 64%
(source: Eurobarometer)</td><td>Students aged 16:
1-2 alcoholic drinks almost every day – 64%
(source: ESPAD)</td></tr>
</table>

Cost of illness: illicit drugs

Information regarding public expenditure in the area of drugs and drug addiction is scarce and with plenty of gaps. The fact that institutions with broad competences in the field of drugs and drug addiction, such as SICAD (previously IDT, IP), also encompass alcohol-related problems makes it difficult to present public expenditure figures for illicit and licit substances separately.

From 2009 to 2012 the amount of labelled expenses imputed to drug, drug addiction and alcohol-related problems was as follows: €95 148 600 in 2009, €92 376 762 in 2010, €86 312 992 in 2011 and €65 585 204 in 2012, with another €5 394 791 for undisclosed years between 2009 and 2012 in Ministry of Education, HIV/AIDS Programme, Road Security National Authority and Portuguese Youth Institute expenditure. In terms of GDP, the labelled expenditures on drug, drug addiction and alcohol-related problems represented 0.056% in 2009, 0.055% in 2010 and 0.050% in 2011 (SICAD 2013, undisclosed data).

A study carried out by Fundação Francisco Manuel dos Santos appraised the social cost of drug addiction from 1999 to 2008. The quantitative analysis restricted its conclusions to 1999-2004. It concluded that, as a whole, there was a decrease in the social cost of drug addiction due to the decrease in direct and indirect costs of illness (hepatitis, HIV, premature death) and the decrease in direct costs associated with offenders against the Drug Law. (In 2000 the Drug Use Decriminalisation Law came into force.)

Cost of illness: alcohol

According to Resolution of the Council of Ministers CM/Res5(2014), which published the interim evaluation of the National Road Safety Strategy, the estimated value (at constant 2006 prices) of the economic and social cost of road accidents in Portugal in 2010 was, in a recently published study, €1 890 000 million.

In 2010, 37.1% of drivers killed in road accidents had BAC ≥0.5 g/l, with 193 fatalities in 2012 (INML,IP 12 June 2013). It is not possible to calculate the number of road accidents solely due to alcohol.

Media[2]

Some 4 784 news stories on illicit drugs were published or aired. In 2012 the subjects most often quoted related to drug trafficking, drug consumption, legislation and drug seizure.

A total of 1 003 news stories on alcohol abuse were published or aired. In 2012 the subjects most often quoted related to driving, alcohol consumption, legislation and courts or enforcement.

2. This was appraised based on SICAD's clipping service subscription. The subscription includes national and regional newspapers and magazines, television and radio as well as digital platforms.

Policy: context

This second aspect requires one to identify policy documents that outline the specific goals by which the problem may be addressed and whether these are in line with the overall WHO definition of well-being as highlighted above, or at least are not in conflict with the WHO goals and aspirations.

- Which policy documents specify the goals by which the problem may be addressed?
- Are they aligned with WHO goals and aspirations?

The policy documents for the cycle 2013-20 regarding illicit and licit psychoactive substances, with the exception of tobacco, are: The National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-20 (NPRABD); and The Action Plan for the Reduction of Addictive Behaviours and Dependencies 2013-16 (APRABD).

Problems associated with addictive behaviours and dependencies present risks and costs for individuals, families and society. The new national plan drafted in 2013[3] – the National Plan for the Reduction of Addictive Behaviours and Dependencies – focuses on establishing the basis for health policies aimed not only at the reduction of illicit drugs and alcohol but also on the so-called new psychoactive substances and non-prescribed medicines and steroids (excluding competitive sports use), as well as gambling. The policy documents explicitly state that, other than health, the policy aims to "consolidate and build" sustainable gains in social well-being.[4]

The policy documents build upon the framework internationally set by the WHO global strategy and European action plan, UN conventions and UNODC recommendations, as well as the European Union strategy and action plan. Thus, the new national framework addresses both substance-based and non-substance-based addictions and dependencies, focusing on the individual, rather than on the substance or on the addictive behaviour. This focus is continuous throughout life, considering the individual from before birth until past 65 years old.

The policy strategic vision is to "consolidate and build an integrated and effective public policy in the context of addictive behaviours and dependencies based on inter-sectorial co-ordination, aiming at sustainable gains in health and social well-being", which is "based on the citizen", throughout his/her life cycle, with a focus on special intervention contexts, rather than based on substance addiction.

The policy has a balanced approach, focusing both on demand and supply and aiming to develop comprehensive and integrated global interventions under a

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3. The NPRABD 2013-20 and the APRABD 2013-16 were proposed in 2013 to the minister for health and await the approval of the Interministerial Council for Drug, Drug Addiction and Alcohol Related Problems. Nevertheless, the competent authorities are already pursuing their activities using the NPRABD 2013-20 and the APRABD 2013-16 as their "road map".
4. "Social welfare is concerned with the quality of life that includes factors such as the quality of the environment (air, soil, water), level of crime, extent of drug abuse, availability of essential social services – including the provision of adequate health services, as well as religious and spiritual aspects of life", www.businessdictionary.com/definition/social-welfare.html#ixzz2poNVVafu (accessed 8 January 2013).

biopsychosocial model in the fields of prevention, drug dissuasion, harm reduction, treatment and reintegration, all within the legal framework as far as supply is concerned (criminalisation of drug production and trafficking, prohibition of NSP and regulation of the alcohol and gambling industry).

Drug users or users in possession of illicit substances for personal use amounting to an average of ten days or less have not been submitted to the criminal justice system since July 2001, though they are subject to an administrative sanction. Thus, when in possession of a small amount of illicit substance or upon using it in a public context, drug users are referred to a Drug Deterrence Committee within 72 hours, to start the process of appraisal and a made-to-order programme, which may include voluntary treatment. Therefore, the demand area of the national plan includes drug dissuasion. Alcohol-related problems are addressed in the same way as drugs and drug addiction, with the exception of the dissuasion system in place.

A referral network has been put into place, comprising public and private entities. This network builds upon best practices in place up until the end of the former policy cycle. The Referral Network/Addictive Behaviour and Dependencies Articulation System redefines the complementarity between the different actors involved. It encompasses the different systems potentially involved with this population, as well as devices directed to domestic violence, children and youngsters at risk and young people with adaptation and social inclusion problems.

Regarding supply, the main difference within the policy refers to the illicit or licit nature of substances or activity (in the case of alcohol, medicines, steroids and gambling), pursued within their regulatory frameworks.

Legislative/regulatory framework

Are there documents to support whether there are laws and regulations in place that in the first instance adhere to international conventions, resolutions and recommended actions, including WHO and EU baseline documents, in relation to both demand and supply and secondly are these related to national requirements? This in turn may be gauged by asking the following questions.

What legal regulations are in place?
Regulations in place may be of two types: laws approved by parliament or government law decrees and ordinances. They either structure the context and the boundaries of the legal framework or regulate the implementation of policy measures. Table 7.3 presents a summary of the main legal regulations in place.

Do they adhere to the international conventions, resolutions, recommendations?
Yes, in some cases, such as Law Decree 15/93, they translate into the legal Portuguese framework dispositions of UN conventions.

How do these regulations align with policy goals?
These regulations are either the framework on which the policy builds, or are the necessary instruments and devices that allow that policy measures be translated into action.

Table 7.3: Legal framework

Demand	Illicit Drugs	Alcohol
Legal regulations	Law 30/2000 (drug decriminalisation), Law Decree 279/2009 (legal regime for private health institutions), Ordinance 331/2013 (distribution of profits from social games), Law Decree 139/2013 (legal framework for private health institutions to establish agreed services), Ordinance 27/2013 (Integrated Responses Programme financial framework), Law Decree 22/2012 (legal framework of Regional Health Administration), Law Decree 17/2012 (legal framework of SICAD), Law Decree 124/2011 (legal framework of Ministry of Health), Ordinance 748/2007 (set up harm-reduction socio-sanitary structures), Law 3/2007 (to prevent spread of disease in prisons)	Law Decree 279/2009 (legal regime for private health institutions), Ordinance 331/2013 (distribution of profits from social games), Law Decree 139/2013 (legal framework for private health institutions to establish agreed services), Ordinance 27/2013 (Integrated Responses Programme financial framework), Law Decree 22/2012 (legal framework of Regional Health Administration Services), Law Decree 17/2012 (legal framework of SICAD), Law Decree 124/2011 (legal framework of the Ministry of Health), Ordinance 748/2007 (setting up harm-reduction socio-sanitary structures)
Comply with international conventions and WHO/ EU framework	Yes	
Align with policy goals	The regulations set the framework on which the policy builds	
Supply	Illicit Drugs	Alcohol
Legal regulations	Main ones are Law Decree 15/93 and Ordinance 94/96 (the so-called Drug Law for illicit drugs), Law 30/2000 (drug decriminalisation), Law Decree 541/2013 and Ordinance 154/2013 (NPS)	Law Decree 332/2001 (Code of Advertising), Law Decree 50/2013 (legal framework for the provision, sale and consumption of alcohol) The national plan allows for more stringent regulation of age limits, happy hours, publicity, fiscal measures, etc.

Strategy/action plans

The following questions should be addressed to provide the answer whether structures are in place that can facilitate the development of coherent policies.

- Does the strategy/action plan refer to the state of the problem as analysed under 1B above?
  The national plan makes a thorough appraisal of the state of play according to the different life cycles, and within them, as well as according to the contexts outlined as subject to specific interventions (community, family, school – primary, high school – college, professional and university, recreational, road, prison and sports contexts).
- Does the strategy/action plan address supply reduction, demand reduction and harm-reduction measures and comply with the policy goals?
  The national plan sets the policy goals for the next four and eight years, and the action plan that operationalises it outlines the measures and procedures to attain the policy goals.
- Are any specific objectives outlined that concur with the various reduction measures that are related to "well-being"?
  The vision sets the mood "to consolidate and build an integrated and effective public policy in the context of addictive behaviours and dependencies based on intersectoral co-ordination, aiming at sustainable gains in health and social well-being".

Two of the principles in the national plan, "citizen orientation" and "integrated interventions", point to a policy of decentralisation on substances and the design of strategies and interventions that view individuals as a whole. The competent authorities are viewed as managers of citizens' health capital, "health" meaning WHO's full definition.

Structures

Have specific structures to implement the policy been put in place? The key question here is whether the model adopted by the specific country is functioning appropriately. Consequently, which bodies are responsible for drug policy, alcohol policy and tobacco policy? Is there a co-ordination body? Who is in charge of co-ordination?

- Is there an over-arching responsible authority? If so, how far does it function effectively?
- Is there a national co-ordination body in place and, if so, to what extent does this function effectively? What is its mandate?

The Portuguese Structure of National Co-ordination defines the responsible authorities at each of the following levels: political (prime minister), executive (National Co-ordinator), advisory (National Council) and supplementary powers (minister for health).

The prime minister is the head of the Interministerial Council which approves the national strategy and its annual reports and which has delegated to a technical commission, composed of representatives of the ministers gathered at the Interministerial Council, the conduct of current business. This committee is headed by the National Co-ordinator, who has powers to conduct policy management. In matters of policy, all the competent authorities have to comply with his/her requirements, providing

required information and data, and ensuring policy co-operation. The National Council is composed of representatives from constitutional authorities, judicial authorities and civil society. Under the law, it is mandatory to present all policy documents, including annual reports, to this advisory body.

- What are the means/mechanisms through which the co-ordination body may conduct its mandate? Is it through an MOU with regional and local bodies at the different levels?
  The co-ordination body mandate is outlined in a law decree, and has authority to conduct its mandate at national, regional and local levels.
- To what extent is there a system in place that monitors explicitly the implementation of the strategy and action plan and that takes into account the demand, supply and harm-reduction aspects? Is a final evaluation undertaken?
  Other than a national monitoring service at SICAD, reuniting key indicators' source services, the technical committee created 10 sub-commissions whose mandates include the annual monitoring of activities outlined in the action plan, with nine of the sub-commissions overseen by the Sub-Commission on Monitoring and Evaluation. An internal evaluation is conducted annually and at the end of each action plan, with an external evaluation at the end of the national plan. The evaluation scheme is based on the national plan outline and the action plan activities.

Responses/interventions

What major specific actions have been put in place and what type of interventions have been adopted to ensure their success? Here it is proposed to look at groups of actions and not single interventions such as market control from the supply side. Note that a number of actions may fall under harm reduction from the demand side.

- To what extent are there specific actions planned with respect to the strategy/action plan?
  The outline of the national plan envisages strategic options in the area of demand reduction, namely the types of intervention – prevention, drug dissuasion (deterrence), harm reduction, treatment and reintegration – and the contexts of intervention – community, family, school (primary, high school), college, professional and university, recreational, road, prison and sports – and it sets goals according to the individuals' life cycle. It also establishes two structuring measures, the Referral Network/Addictive Behaviour and Dependencies Articulation System and the Integrated Responses Operational Programme, as well as cross-cutting areas that support demand and supply reduction, information and research, training and communication, international relations and co-operation and quality. The Integrated Responses Operational Programme (PORI) is a tool to leverage synergies available at national level, through the development and implementation of methodologies to perform diagnostics to underline interventions, which are afterwards implemented by so-called integrated responses programmes. With PORI it is possible to put forward "calls for tenders" with the objective of attaining specific results in territorial areas where there are specific needs for intervention, using named integrated response programmes (PRIs). These PRIs have a financial allocation attached to them. Non-profit entities are eligible to answer the call and

the selected entity, by means of a rated selection process, conducts specific interventions according to the agreed programme within the time frame established. The specific actions outlined in the action plan are planned in accordance with the national plan, having in view the goals proposed for each four-year cycle. Each outlined action has its own four markers: the schedule within which it must be accomplished, the authority/ies responsible for its implementation, the indicators by which it will be monitored and evaluated, and the means by which its accomplishment will be checked.
A major breakthrough is that the action plan's co-ordination area envisages one action meant to incentivise the accomplishment of the other actions, by which responsible authorities should include in their annual activity plans specific actions from the action plan.

– To what extent have they been implemented?
This is an on going process; it is not yet possible to appraise it. A monitoring model is planned and a meeting of the Sub-Commission on Monitoring and Evaluation has been scheduled, but many of the structuring programmes are in place, and steps have been taken to implement most of the actions.

– To what extent have the actions been monitored with a view to altering them according to the circumstances or unintended consequences – that is, are the actions dynamic or static?
The national plan is dynamic and includes a clause dealing with the changing environment or the shortage of means and resources. As the monitoring of the action plan has not yet started, this has not yet been done.

Resources

This marker relates to both the financial and human resources needed to be able to put into practice the said policy. Hence the type of information required here in the main relates to the expertise in the relevant structures and the finances to support them, as well the finances to conduct specific activities to bring about the changes required by the overall goal of the policy.

Thus the questions that arise relating to resources cover both human and financial resources, and whether these are adequately supported by public expenditure.

- To what extent are the numbers of staff present in the relevant structures adequate to support the policy goals?
- How far is the number of trained staff in the relevant structures adequate to support the implementation of the said policy?
- How far are there continuing education programmes in place to support staff development?
- Is the budget adequate to support the number of trained staff needed to effect the policy in question?
- Is the budget sufficient for the continuing education of staff?
- Is the budget sufficient for activities related to demand?
- Is the budget sufficient for the activities related to supply?

Due to the special financial circonstances that Portugal is currently experiencing, the resources allocated (general state budget allocations and human resources) are

scarce and force the competent authorities be more efficient. Responsible entities may be subject to budget, personnel and structural cuts, depending on the state national budget position, so there is no final answer to this question. Based on the items report, the justification for the scores is shown in Table 7.4.

Table 7.4: Illicit drugs – justification for assessment

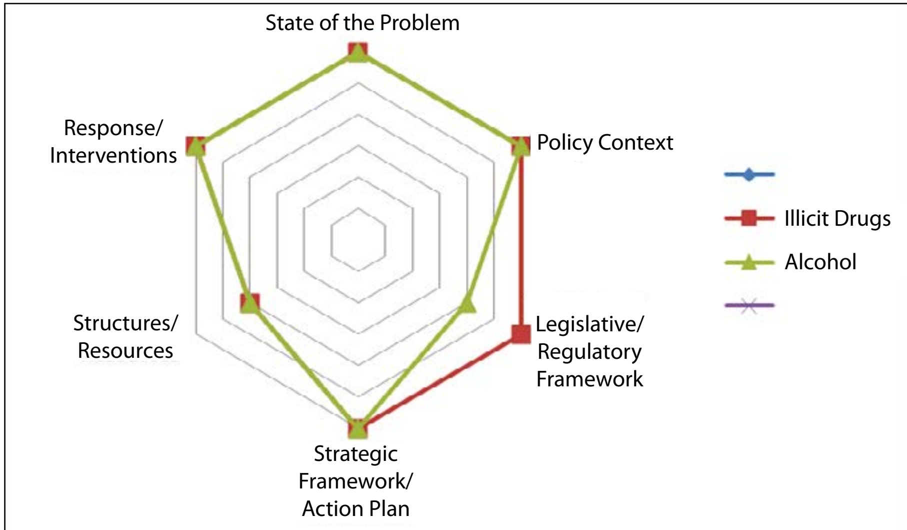
	Illicit drugs	Justification
State of the prob-lem/ policy goals	3	Policy goals established in light of the state of the problem. Reasoned and sustained conceptualisation, based on 14 years' policy development and practice
Legislative/regu-latory framework	3	Consolidated framework
Strategy/ action plan	3	Clear framework put into place by strategy and action plan for the next 8-year cycle, with room to accommod-ate changes in the state of the problem and allocation of resources, sustained by the involvement of nearly 150 stakeholders in their formulation
Structures	3	Despite a change of administrative competences in most of the public demand reduction network, the top score was granted to this marker
Responses/ interventions	3	Well-grounded responses and interventions, based on past best practice
Resources	2	Uncertainty due to the EU/IMF Financial Assistance Programme

Table 7.5: Alcohol – justification for assessment

	Alcohol	
State of the prob-lem/policy goals	3	Policy goals established in light of the state of the problem. Reasoned and sustained conceptualisation, based on 14 years' policy development and practice.
Legislative/regu-latory framework	2	Room to accommodate legislative and regulatory framework in line with WHO policies.
Strategy/ action plan	3	Clear framework put in place by the strategy and action plan for the next 8-year cycle, with room to accommodate changes in the state of the problem and allocation of resources, sustained by the involve-ment of nearly 150 stakeholders in their formulation.
Structures	3	Despite a change of administrative competences of most of the public demand reduction network, the top score was granted to this marker.
Responses/ interventions	3	Well-grounded responses and interventions, based on past best practice.
Resources	2	Uncertainty due to the EU/IMF Financial Assistance Programme.

The spider graphic is therefore as shown in Figure 7.1.

Figure 7.1: Assessment, spider diagram



Conclusions

The first Portuguese Strategy on Drugs was launched in 1999 and the state of play of drug and drug addiction policy shows the maturity attained in the time that has elapsed since then.

From the 1999-2004 cycle until today the competent Portuguese authorities have implemented three action plans and performed three internal and two external evaluations.

As for alcohol-related problems, the responsibility for a national policy was entrusted in 2006 to IDT, the public institute already in charge of drugs and drug addiction. Alcohol-related problems were included in the Portuguese National Co-ordination Structure in 2010. The National Plan for the Reduction of the Harmful Use of Alcohol 2010-12 was approved at the same time. Alcohol policy benefited from synergies with the structure already in place for illicit drugs, but it is clearly less robust in the sense that, being more recent as an integrated policy, some fundamental legislation in terms of market procedures still needs to be addressed. In the debate during the drafting of the new national plan, in 2013, industry representatives wanted more enforcement and fewer new legislative measures. Alcohol policy measures are dynamic and face different cultural backgrounds in Europe. Since there is no framework convention for alcohol, unlike illicit drugs and tobacco, it lacks more consensus among stakeholders, both at national and international levels.

As far as this exercise is concerned, the three-scale markers seem insufficient to modulate the different aspects chosen, in particular structures, resources and response/interventions. Scoring on a scale of one to five seems to address better the different levels of policy.

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Appendix 1

National Plan to Reduce Addictive Behaviours and Dependencies GENERAL OBJECTIVES AND GOALS

The overall results obtained so far with the policies and measures implemented indicate that the strategy and models used form the basis of an appropriate public policy that nevertheless needs improvement and investment.

The integration of new issues related to addictive behaviours and dependencies, including gambling, requires special attention. The global strategy of action under the National Plan to Reduce Addictive Behaviours and Dependencies is based on co-ordinated action, with a view to maximise the synergies between the strategic frameworks and budgetary constraints of services and organisations active in these fields.

General objectives (specific objectives are drawn up for age groups and sub-groups in the demand dominium, for illicit substances, licit substances and gambling in the supply dominium and for each of the cross-cutting areas).

- To prevent, deter, reduce and minimise problems associated with the consumption of psychoactive substances, addictive behaviours and dependencies (ABD) through an integrated intervention based on mechanisms of prevention, deterrence, harm reduction, harm minimisation, treatment and reintegration, used in accordance with the stage of the life cycle of the citizen and the context in which it is structured, and a network referral and co-ordination of care.
- To reduce the availability of illicit drugs and new psychoactive substances on the market through prevention, deterrence and dismantling of trafficking networks of illegal substances, in particular organised crime, strengthening domestic and international judicial co-operation, police and customs and border management.

- To ensure that the availability, access and consumption of licit psychoactive substances on the market, be done safely and not inducing its hazardous and harmful use/abuse
through suitable education, regulation, and enforcement.
- To provide opportunities for legal and safe gambling, not inductive of addictive behaviour
through suitable regulation, and enforcement.
- To ensure the quality of services provided to citizens and sustainability of policies and interventions
through the creation of knowledge, professional training, communication and international co-operation.

Indicators and goals:

To reduce the easiness of market access perception (if desired)

Psychoactive Substances	Indicators	Baseline	2016	2020
To place Portugal below the current European average by 2 percentage points in 2016 and 5 percentage points in 2020				
	Easyness (*easy / very easy*) perceived access (*if desired*)	2011		
ESPAD: Students 16 years	Cannabis	PT: 30% European average: 29%	**27%**	**24%**
	Ecstasy	PT: 15% European average: 13%	**11%**	**8%**
	Amphetamines	PT: 14% European average: 12%	**10%**	**7%**
Eurobarometer: 15-24 years	Cocaine	PT: 23% EU27: 22%	**20%**	**17%**
	Heroin	PT: 18% EU27: 13%	**11%**	**8%**
To reduce by 15% by 2016 and by 30% by 2020				
	Easyness (*easy / very easy*) perceived access (*if desired*)	2011		
ECATD: Students 13-15 years	Beer	49%	**42%**	**34%**
	Wine	48%	**41%**	**34%**
ECATD: Students 13-15 years 16-17 years	Spirits	33% 70%	**28%** **59%**	**23%** **49%**

To increase the perceived risk of substance use

Psychoactive Substances	Indicators	Baseline	2016	2020
To place Portugal above the current European average by 2 percentage points in 2016 and by 5 percentage points in 2020				
	Perception *of high risk to health*	2011		
Eurobarometer: 15-24 years	Occasional consumption (once or twice) of cannabis	PT: 24% EU27: 23%	**25%**	**28%**
	Occasional consumption (once or twice) of cocaine	PT: 65% EU27: 66%	**68%**	**71%**
	Occasional consumption (once or twice) of ecstasy	PT: 51% EU27: 59%	**61%**	**64%**
	Regular consumption of cannabis	PT: 64% EU27: 67%	**69%**	**72%**
	Perception of *high risk of getting hurt* (physically or in other ways)	2011		
ESPAD: Students 16 years	Consumption of 1-2 alcoholic beverages almost every day	PT: 25% European average: 30%	**32%**	**35%**

To delay the age of onset substance use

Psychoactive Substances	Indicators	Baseline	2016	2020
To decrease the onset consumption of people aged 13 or less by **15% by 2016 and 30% by 2020** and the onset of harmful drinking patterns at age 13 or less by **at least 25% by 2016 and 50% by 2020**				
	Onset consumption at 13 or less	2011		
ESPAD: Students 16 years	Cannabis	PT: 4% European average: 3%	**3.4%**	**2.8%**
	Alcoholic beverages	PT: 51% European average: 57%	**43%**	**36%**
	Tranquillisers or sedatives without prescription	PT: 2% European average: 2%	**<1,5%**	**<1%**
	To get drunk	PT: 8% European average: 12%	**6%**	**4%**

Psychoactive Substances	Indicators	Baseline	2016	2020
To raise by 1 year by 2016 and by 2 years by 2020				
	Mean age of onset consumption	2012		
INPG: Portuguese population 15-74 years (sub-group 15-24 years)	Illicit drugs	17 years	**18 years**	**19 years**
	Alcoholic beverages	16 years	**17 years**	**18 years**
	Medicines (sedatives, tranquillisers or hypnotic) with or without prescription	17 years	**18 years**	**19 years**

To decrease the prevalence of recent use (past 12 months) consumption patterns of risk and dependence on psychoactive substances

Psychoactive Substances	Indicators	Baseline	2016	2020
To reduce by 10% by 2016 and by 20% by 2020				
	Recent consumption prevalence (last 12 months)	2011		
ESPAD: Students 16 years	Cannabis	16%	**14%**	**13%**
	Drunkenness	29%	**26%**	**23%**
	Recent consumption prevalence (last 12 months)	2012		
INPG: Portuguese population 15-74 years	Any illicit drug	2.3%	**2.1%**	**1.8%**
	Binge consumption (at least once) Binge consumption (1 + times each month)	7.4% 3.4%	**6.7%** **3.1%**	**5.9%** **2.7%**
	Drunkenness (staggering, having difficulty speaking, vomiting and/or not remembering what happened afterwards)	5.1%	**4.6%**	**4.1%**
	Medicines (sedatives, tranquillisers or hypnotic)	13.7%	**12.3%**	**11%**
	Risk and dependency consumption prevalence (last 12 months)	2012 (%) - ‰		
INPG: Portuguese population 15-74 years	Cannabis (CAST) High risk Moderate risk	(0.3%) - 3‰ (0.3%) - 3‰	**2.7‰** **2.7‰**	**2.4‰** **2.4‰**
	Alcoholic beverages (AUDIT) Risk and harmful dependency	(2.7%) - 27‰ (0.3%) - 3‰	**24‰** **2.7‰**	**22‰** **2.4‰**
	Alcoholic beverages (CAGE) Abuse or dependency	(0.8%) - 8‰	**7‰**	**6‰**

To decrease the prevalence of gambling addiction and dependence risk

Psychoactive Substances	Indicators	Baseline	2016	2020
To reduce by 10% by 2016 and by 20% by 2020				
	Prevalence of risk gambling (money) and pathological (12M) (SOGS)	2012 (%) - ‰		
INPG: Portuguese population 15-74 years	Risk (some problems)	(0.3%) - 3‰	**2.7‰**	**2.4‰**
	Pathological	(0.3%) - 3‰	**2.7‰**	**2.4‰**

To decrease the morbidity associated with ABD

Psychoactive Substances	Indicators	Baseline	2016	2020
To reduce by 25% by 2016 and by 50% by 2020				
	Hospital inpatients DRG 202 (cirrhosis and alcoholic hepatitis)	2011		
DGS/ACSS.IP: Portuguese population /mainland Portugal	Number of outbound users	3 163	**2 372**	**1 581**
To reduce by 3 percentage points by 2016 and by 6 percentage points by 2020				
	Reports of cases diagnosed in the last 3 years with HIV/AIDS associated with drugs	31/12/2012		
INSA: Portuguese population	Proportion of total HIV cases	12%	**9%**	**6%**
	Proportion of total AIDS cases	21%	**18%**	**15%**

To decrease mortality related to ABD

Psychoactive Substances	Indicators	Baseline	2016	2020
To follow the goals set up in the NHP				
	Standardised mortality for diseases attributable to alcohol	2009/2011		
DGS/ACSS.IP: Portuguese population /Portugal Continental	Rate by 100 000 inhabitants aged less than 65 years	PNS. 2009: 12.9%000 INE.2011: 12.7%000	**12.5%000**	*
To follow the goals set up in the RSNS				
	Mortality in road accidents related to alcohol consumption	2012		
ANSR/ INML.I.P: Portuguese population	Number of drivers deceased in road accidents with BAC ≥ 0.5 g/l	105	**	**
To reduce by 10% by 2016 and 20% by 2020				
	Fatal overdoses due to illicit drugs consumption	2011		
INML.I.P: Portuguese population	Number of overdose deaths in the last 3 years	127	**114**	**101**
To reduce by 3 percentage points by 2016 and 6 percentage points by 2020				
	Notifications of deaths occurring in the last 3 years of AIDS cases associated with illicit drugs	31/12/2012		
INSA: Portuguese population	Proportion of total death cases from AIDS	44.9%	**42%**	**39%**

* definition to be included in the next National Health Plan;
** definition to be included in the next Road Security National Strategy.

Concluding remarks

Richard Muscat

There has to date been significant use of the term coherence mainly with respect to policy related to development, but this seems now to be lost in the wash with increasing budgetary restraints. If anything, now is the right time to look at coherence between policies effected by nations that relate both internally as well as that on the international scene. This exercise in the drug field conducted by some of the Pompidou Group member countries is an attempt to do just that. It is a continuation of the previous exercise to get to grips with using markers to provide an indication of coherence at least among policies related to psychoactive substances as a starter.

The initial target as set for the use of these six markers is that all policies in this particular field should attempt to be in line with the concept of "well-being" as exemplified in the WHO preamble of 1946. At best they should support each other, but at the least not impinge on each other in a negative way. The very first problem that arises is one's understanding or definition of the use of the term well-being. This term or concept has now gained ground over the past 30 years or so and is a result of the gradual evolution of policy from that of mainly looking after the infirm as a result of disease to preventing disease through health promotion to now what may be termed as policies that support the well-being of the individual (but see Seedhouse 1995). Thus well-being as ascribed by the WHO preamble of 1946 is not one where there is merely the absence of disease, but one where the individual has what may be called physical as well as mental well-being as well as the socio-economic conditions that enable one to lead a productive life whatever that may be. This is now also being brought into further focus by the fact that we do not live in a vacuum; thus environmental factors also need to be accounted for when talking of well-being (see Carlisle et al. 2009). All in all the concept of well-being seems to be undergoing a transition and yet we still do not have a final definition of what this may be even though most would concur with what aspects substantiate such.

Consequently the seven contributions in this book look at the coherence of policies for psychoactive substances that adhere to the over-arching goal of well-being. Each of the contributions has used the six markers to determine the degree of coherence resulting in a final graphically produced picture through the use of a spider diagram to show this. To arrive at this point has been a major undertaking and, as outlined below, there is yet much to be done.

All of the contributions have used the six markers to gauge drug policy and a number have also done so with respect to alcohol policy and others with tobacco policy also. One contribution, that of Croatia, has included gambling policy. In turn they also suggest one should also look at policies for the new legal highs as well as the non-prescription use of medicines in the main sedatives and tranquillisers that appear to be on the rise in the older age cohort in contrast to the use of what may be termed illegal drugs that are normally considered the domain of the younger age cohorts. Moreover, this contribution is the only one that suggests that it may be time to also consider coherency of policies for psychoactive substances and other addictive behaviours with economic policy, employment policy and family policy. This indeed would be a major step forward where all government policy is considered in total as well as that related to international obligations – a very tall order indeed, even though all governments are under the impression that all their policies are indeed coherent with their aims and objectives – politics.

In addition, this paper also brings to the fore the publication by West on "Models of Addiction" as published by the EMCDDA in 2013, in that all policies that address addiction in whatever form should consider the model presented herein that suggests that treatment of addiction needs to focus on the capacity, opportunity and motivation of the individual with motivation having a prime position. Thus any definition of addiction and treatment of such needs to address motivation.

Subsequently some other issues were also raised in this paper that are also common to some others. The first one of these is the fact that the group may wish to consider further developing the said markers so that as in the case of the Czech Republic these may be broken down into sub-themes which then can be graded on a Likert scale of 1 to 5 and them summed and averaged for the said marker. Again the Czech Republic and a number of others have opted for a five-point scale to produce the spider plot as opposed to the suggested three-point scale of low, medium and high. As emphasised below in relation to the article by Hungary and the proposed improved model, a vertical and horizontal grading scale should be taken into account. Again as in Hungary the use of a focus group proved to be invaluable with regard to the completion of the marker scheme for coherence.

The same may be said of the Czech Republic in relation to the use of a focus group to attempt to complete the marker scheme. The use of the focus group resulted in a number of recommendations, foremost of which was that to break down each item and each marker into a five-point scale with 5 to reflect most effective and 1 least effective, with 3 to represent neither. This was also suggested for determining marks between the different policies in operation so here we may have an example

again of the need to vertically assess within each of the policies what is the degree of coherence with the over-arching goal, that of well-being, and horizontally across the different policies the degree or not to which it is so.

As mentioned above, the submission by Hungary makes a number of observations following the use of the tool to assess coherency there. Firstly, the suggestion as indeed the method used to complete the scheme was that of document analysis followed by the use of a focus group to sure up the exercise. This in turn resulted in a firm set of recommendations in which the model proposed for the use of markers be amended to move the legal framework to the first level – that would also enable one to directly assess whether this is in line with the concept of well-being. This now relates to step 1 of the recommended action; thus for Step 2 it is a matter of marking each individual policy separately as it is assumed that if in step 1 there is a degree of coherence this may also be the case in the others. Again the use of a five-point scale is indicated that takes into account both the vertical and horizontal dimensions as shown below. Figure 1 is the original model as put forward in Chapter 3 on the six markers.

Figure 1: Original model for coherency of policies on psychoactive substances

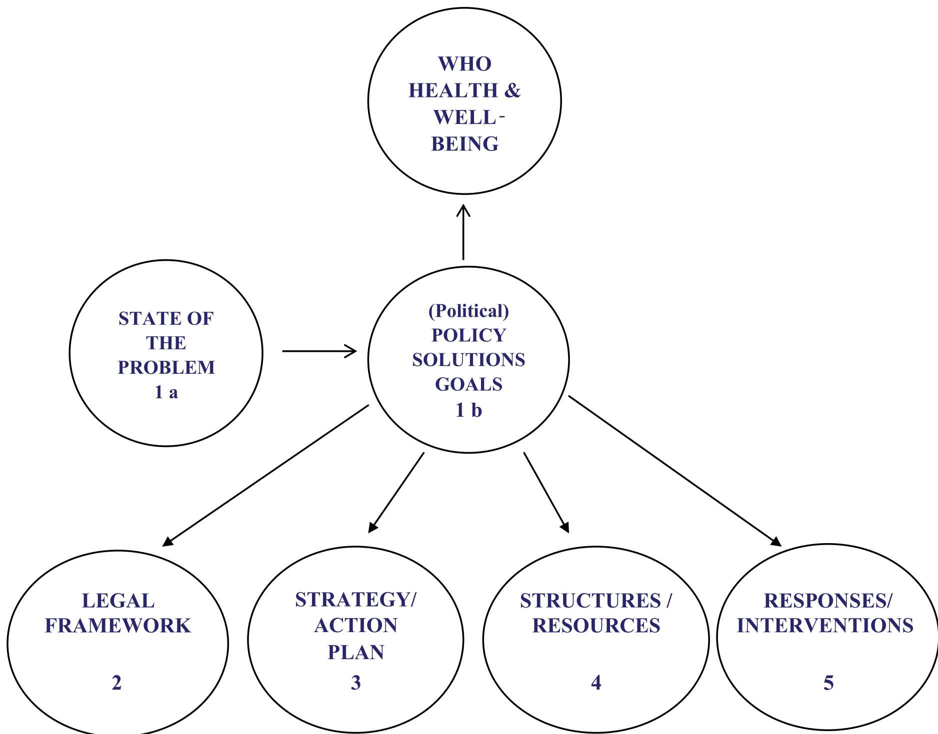
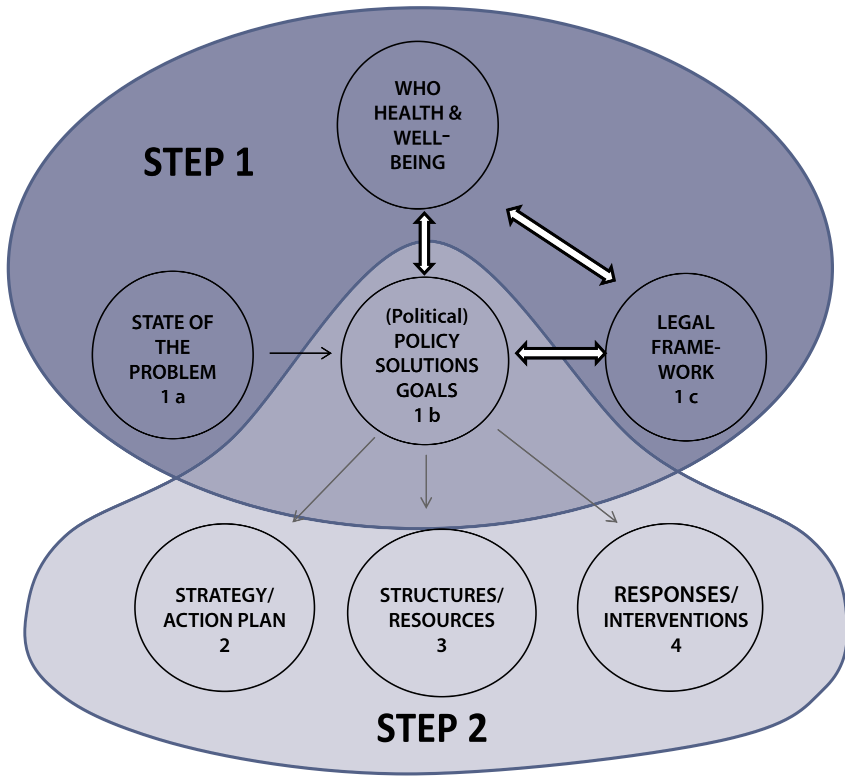


Figure 2: Model for coherency of policies on psychoactive substances, as suggested by Hungary



Ireland's approach to the use of the six markers for coherency among policies for the substances in question – namely, drugs, alcohol and tobacco – has been re-cast to some extent in that the markers have been translated as follows:

- State of the problem – risk perception;
- Political context – ideology;
- Legal framework – control;
- Structures – governance;
- Strategy – action;
- Resources – political choices (will).

Thus for each marker the evidence has been determined using published policy documents and reports. The next step, which is somewhat new, uses "corroboration" for the suggested markers and the evidence from the academic and research literature. The outcome of this is first for a population-based health approach which is in line with that suggested by WHO. The second is the suggestion that drug policy be situated within a country's equality policy and this might also be the case for all policies related to psychoactive substances. Thirdly one may consider the position of the UK in evaluating expenditure versus objectives and over-arching goals with

value for money achieved if the monies spent addressing the drug problem are less than the "monetised benefits" arising from the drug strategy.

In conclusion, the manuscript from Ireland highlights the point that the exercise has not been entirely systematic or comprehensive but provides a tool for discussion "to strengthen the impact of policy" in this area. Ireland goes on to suggest four ways in which this may be achieved with the relevant examples, namely:

- eliminate policy inconsistencies;
- identify opportunities for policy enhancement;
- develop mitigation policies;
- ensure consistency in advocacy.

An example of such, to eliminate policy inconsistencies, is an occasion where policies related to supply should not counteract the effects of those in place for demand, such as harm-reduction measures.

Israel in the main has also opted for the focus group approach among the relevant experts in the field; even though they hail from the drug and alcohol sphere they were also asked to complete the marker exercise for tobacco as well. Thus to a lesser extent the inclusion of tobacco has been accomplished but possibly this is less well determined. However, as tobacco policy has been in place for the greatest amount of time this fact may to some extent have alleviated the fact that the experts may have had less understanding of the policy per se and its coherence, and that in relation to the other substances, drugs and alcohol. In addition to completing the marker scheme, the experts then discussed their outcomes and a number of suggestions arose. The first was that of inter-expert reliability which in effect needs to be taken into account when conducting such exercises as this will strengthen the outcome of the conclusions of the focus group approach. More to the point though was the fact that the exercise provided an opportunity for the experts to have discussion of the like that hitherto may not have been the norm. This aspect also came to the fore in the contribution from Ireland and again in the preface by the Norwegian policy maker.

Italy used the tool as outlined in their contribution to this exercise with respect to drug policy only. This in effect has been done because it would appear that policy in this area is the most well developed in Italy in that the drug policy unit sits within the prime minister's office under the banner of the Presidency of the Council of Ministers. In addition, both alcohol and tobacco policies fall under the wing of the Ministry of Health. As to addressing the issue of drug policy at ministerial level in relation to international obligations as well as at regional and local levels, it appears that there is a great degree of coherency but this is referred to as congruency which in effect implies that there is more than no competition between each domain but more of agreement and harmony with the overall goal of well-being. That being said, the exercise has been one of deducing coherency more or less in a vertical strand only and once again they have opted to use a five-point scale rather than three as in the case of the other countries mentioned above.

Unlike Italy, Portugal completed the task in both the drug and alcohol policy fields, but not tobacco as this falls under the Ministry of Health and not SICAD. Again, like other countries completing the exercise, a focus group was used as well as a five-point scale to apportion values to each of the six markers.

Returning now to the objective of the exercise, namely that of policy coherence, the reason for this may in the first instance provide for better co-ordination, reduce duplication and fragmentation, make better use of limited resources and offer the possibility of pooling resources. Moreover, policy coherence should then be considered to involve holistic government if the above is to be attained and thus, according to Chaliss 1988, "harmonious compatible outcomes" may be the order of the day. The OECD opts for what may be termed as those "reinforcing policies" across a number of government entities that provide for summation of efforts towards defined objectives.

It is of interest that a number of chapters in this publication suggest both vertical and horizontal coherence within and between polices, and this aspect has been brought to the fore by Briassoulis (2004) in which it is argued that two policies may be coherent if they are linked specifically in the following domains, goals, objectives, instruments, procedures and the implementors. Duraiappah (2004) also suggests both vertical and horizontal coherence between policies in the form of both policies at each level for the former and in the latter case this refers to organisations, institutions and instruments. Finally on the issue of vertical and horizontal coherence, Gerling and Stead (2003) put forward four types of policy coherence, namely, horizontal, vertical, inter-territorial and intersectoral. The position here is in line with the above but also seeks to further strengthen policy coherence in that both the vertical and horizontal aspects have been inserted into a model that includes the necessary domains as put forward by Hungary.

All in all the ingredients for policy coherence from what has been posited previously and that found in this publication seem to be synonymous; but how one goes about achieving it is then left open to question, which has in turn been tackled by this effort. In essence it is clear now that in order to achieve coherence among policies there are at least three factors that need to be considered: coherence of the policy goals, coherence of the institutional structures and lastly coherence among the implementors. Then if one acknowledges these and in addition they are subdivided within each level then one may indeed assess whether policies are coherent. In truth the exercise described here has attempted to do just that and the outcome would appear to be that some contributors have opted for more stringent methods to produce a coherence outcome measure in the form of the spider diagram using a five-point scale, whereas others have used the exercise to create discussion and thus have favoured a more loose interpretation of the same markers using a three-point scale, though no less stringent.

All attempts have however used a documental analysis approach be it for one policy, that of drug policy in the case of Italy at one end of the scale, or the four policies in question as in the case of Croatia. It is clear then that this form of analysis may be made more rigorous in that it may be possible to conduct what may be termed a content analysis of which there are two categories, conceptual analysis and a more detailed relational analysis. If we opt for starters for the former, key words in the documents may be selected and then, using a further step, we can convert the points obtained into a numeral after normalising the data, as suggested by Duraiappah and Bhardwaj (2007). This would result in a number between zero and one, in which a value of 0.5 would be neutral and that below 0.5 tending to coherence and above that less

so. Introducing such a method for the document analysis part of the exercise would make the effort more quantitative and then possibly more robust, but it should also be aided by the second part of the exercise in which a qualitative analysis may be conducted through the use of focus groups as has been the practice here in the main.

The seven chapters in this publication have made use of the six markers developed by the working group to assess the degree of coherence among policies for psychoactive substances. The results provide at the least a basis for consideration and discussion of the issue of coherence and at most a means by which one may better understand how to put in place policies that are coherent in respect to psychoactive substances and also possibly in the future those that also address other forms of addictive behaviour. The ideal goal however always remains that all government policy is coherent in this day and age; for the time being this seems to be out of our reach, though not because of the current lack of effort.

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Appendix: Pompidou Group publications from the Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs

Snapshots of Social Drug Research in Europe by Jane Fountain, Marije Wouters and Dirk J Korf (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-911-3, 2013

Reflections on the concept of coherency for a policy on psychoactive substances and beyond by Richard Muscat, Brigid Pike and members of the Coherent Policy Expert Group (ISBN 978-92-871-7345-4), March 2012

The 2011 ESPAD Report: Substance use among students in 36 European countries by Björn Hibell, Ulf Guttormsson, Salme Ahlström, Olga Balakireva, Thoroddur Bjarnason, Anna Kokkevi, Ludwig Kraus, The Swedish Council for Information on Alcohol and other Drugs (CAN), The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Council of Europe, (Pompidou Group) ISBN 978-91-7278-233-4, May 2012

The meaning of high, variations according to drug, set, setting and time by Marije Wouters, Jane Fountain, Dirk J Korf (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-831-4, 2012

Market, methods and messages, Dynamics in European drug research by Jane Fountain, Vibeke Asmussen Franck, Dirk J Korf (eds) ISBN 978-3-89967-741-6, 2011

Treatment systems overview by Richard Muscat and members of the Treatment Platform of the Pompidou Group, ISBN 978-92-871-6930-3, October 2010

Pleasure, Pain and Profit. European Perspectives on Drugs by Tom Decorte and Jane Fountain (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-654-9, 2010

Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis by Richard Muscat, Dike Van De Mheen and Cas Barendregt, ISBN 978-92-871-6295-9, October 2010

Signals from drug research by Richard Muscat, Dirk J. Korf, Jorge Negreiros and Dominique Vuillaume ISBN 978-92-871-6694-4, Strasbourg, December 2009

Old and New Policies, Theories, Research Methods and Drug Users across Europe by Zsolt Demetrovics, Jane Fountain, Ludwig Kraus (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-583-2, 2009

The 2007 ESPAD Report: Substance use among students in 35 European countries by Björn Hibell, Ulf Guttormsson, Salme Ahlström, Olga Balakireva, Thoroddur Bjarnason, Anna Kokkevi, Ludwig Kraus, The Swedish Council for Information on Alcohol and other Drugs (CAN), The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Council of Europe, (Pompidou Group) ISBN 978-91-7278-219-8, February 2009

From a policy on illegal drugs to a policy on psychoactive substances by Richard Muscat and members of the Pompidou Group Research Platform ISBN 978-92-871-6480-3, Strasbourg, January 2009

Old and New Policies, Theories, Research Methods and Drug Users across Europe by Zsolt Demetrovics, Jane Fountain, Ludwig Kraus (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-583-2, 2009

Cannabis in Europe: Dynamics in Perception, Policy and Markets by Dirk Korf (ed.) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-512-2, 2008

Risk factors in adolescent drug use: evidence from school surveys and application in policy by Richard Muscat, Thóroddur Bjarnasson, François Beck and Patrick Peretti-Watel ISBN 978-92-871-6196-3, February 2007

Drug treatment demand data – influence on policy and practice by Hamish Sinclair ISBN 10:92-871-6086-4/ISBN 13:978-92-871-6086-7, October 2006

Psychological drug research: current themes and future developments by Jorge Negreiros ISBN-10:92-871-6032-5/ISBN-13:978-6032-4, September 2006

Biomedical research in the drugs field by Richard Muscat ISBN-10: 92-871-6017-1/ ISBN-13: 978-92-871-6017-1, July 2006

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Research on Drugs and Drug Policy from a European Perspective by Ludwig Kraus and Dirk Korf (eds) and the European Society for Social Drug Research (ESDD) ISBN 978-3-89967-270-4, 2005

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Identifying effective approaches to creating coherent policies regarding licit and illicit drugs has been the priority of the Pompidou Group during its 2010-14 work programme. Over the years, research has evolved in this field as demonstrated in the group's publications: *From a policy on illegal drugs to a policy on psychoactive substances* in 2008 and *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis* in 2010, and then *Reflections on the concept of coherency for a policy on psychoactive substances and beyond* in 2012.

This last publication attempted to put into perspective the salient points of what may be termed a coherent policy on psychoactive substances. It proposed six indicators, around which the concept of coherency was developed: conceptualisation, policy context, legislative and regulatory frameworks, strategic frameworks, responses/interventions and structures and resources.

The initial target for the use of these six indicators is that all drugs policies should be in line with the concept of "well-being". At the very least, they should not contradict each other and at best they should be in harmony. On this basis, in 2013 and 2014, researchers refined these indicators and tested them in their countries, namely Croatia, the Czech Republic, Hungary, Ireland, Israel, Italy, Norway and Portugal to verify whether they provided a valid tool to measure the effectiveness and efficiency of a coherent policy on psychoactive substances.

The results appear in this publication and indicate that such markers may be indeed used as a basis for discussion on the issue of coherence and in some cases as a means to better implement coherent policies in respect to psychoactive substances, and also possibly policies that address other forms of addictive behaviour.

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