

COHERENCE POLICY MARKERS FOR PSYCHOACTIVE SUBSTANCES

Richard Muscat,
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Policy Expert Group,
Pompidou Group



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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

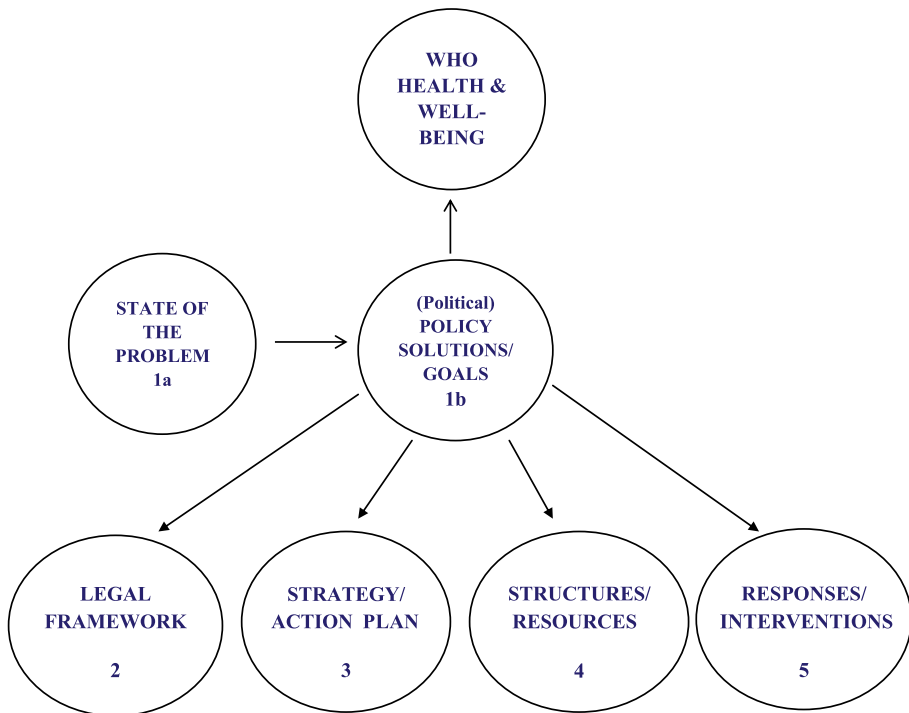
	Illicit Drugs	Alcohol	Tobacco
Prevalence			
Public opinion			
Cost of illness			
Media			
Documents citing problem			

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:

- What laws and regulations are in place?
- Do they adhere to the international conventions, resolutions, recommendations?
- 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:

- Does the strategy/action plan refer to the state of the problem as revealed by analysis under 1b above?
- Does the strategy/action plan address supply reduction, demand reduction and harm reduction and does it comply with the policy goals?
- 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			