

I. Primary prevention of drug abuse

1. As the global community renews its commitment to tackling the world drug problem over the next 10 years, policymakers are increasingly looking to demand reduction to make a key contribution.¹ The term “demand reduction” refers to all activities aimed at reducing demand for drugs and includes primary, secondary and tertiary prevention. The present chapter focuses on primary prevention, that is, measures to prevent and reduce drug use in populations that are either not using or not seriously involved with drugs. The chapter includes a brief review of the extent of drug use and factors associated with such use, a description of primary prevention measures supported by scientific evidence, a discussion on the positioning of a focal point for prevention at the national level and recommendations for action to enable societies to build their capacity for prevention.

2. In the present chapter, the term “drugs” refers to narcotic drugs and psychotropic substances covered by the international drug control conventions: the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol;² the Convention on Psychotropic Substances of 1971;³ and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.⁴ The distribution of those narcotic drugs and psychotropic substances are permitted by law only if they are distributed through medical and pharmaceutical channels for medical and scientific purposes. In this chapter, the term “drug use” should be understood to mean illicit use of those drugs.

3. International drug policy is led by the international drug control conventions. The supervision of the conventions and the monitoring of their implementation by States rest with the Commission on Narcotic Drugs and the International Narcotics Control Board, respectively. The conventions are concerned with the public health and social problems resulting

from drug use. The conventions stress the need for demand reduction and prevention, along with measures to control the supply of narcotic drugs and psychotropic substances. For example, article 38 of the 1961 Convention as amended by the 1972 Protocol states:

“The Parties shall ... take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved, and shall coordinate their efforts to these ends.”

4. In the Declaration on the Guiding Principles of Drug Demand Reduction,⁵ adopted by the General Assembly at its twentieth special session, in 1998, it is stated that demand reduction efforts should be integrated into broader social welfare and health promotion policies and preventive education programmes. Health promotion and primary, secondary and tertiary prevention together contribute to the overall aim of reducing problems associated with drug use. Treatment activities are aimed at individuals diagnosed with drug dependence. Secondary prevention measures are aimed at reaching early those individuals who are seriously involved with drugs but are not dependent on drugs. Primary prevention, the third critical and complementary element in a demand reduction framework, is directed at populations not currently using or not seriously involved with drugs. Such populations are much larger than those targeted by secondary and tertiary prevention; hence their potential for reducing rates of drug use in a jurisdiction is significant.

5. Primary prevention promotes the non-use of drugs and is aimed at preventing or delaying the first use of drugs and the transition to more serious use of drugs among occasional users. Most drug use begins during adolescence and early adulthood, when young people are developing cognitively and socially. For that reason, primary prevention is mainly directed at those life stages and those before them. Primary prevention activities may be directed at whole populations (also referred to as universal prevention) or at particular groups of people who may be vulnerable because of

¹ See, for example, the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (A/64/92–E/2009/98, sect. II.A); and *World Drug Report 2008* (United Nations publication, Sales No. E.08.XI.11).

² United Nations, *Treaty Series*, vol. 976, No. 14152.

³ *Ibid.*, vol. 1019, No. 14956.

⁴ *Ibid.*, vol. 1582, No. 27627.

⁵ General Assembly resolution S-20/3, annex.

risk conditions in their lives (i.e. selective prevention).⁶ Drug use may be prevented, directly through activities aimed at preventing drug use or indirectly through activities that prevent drug use by promoting the overall health of a population.⁷

6. There is good reason for society to give considerable attention to preventing drug use. There is no doubt that a single drug-using experience can have unpredictable and serious consequences (such as injury or overdose), particularly for naive users. Immediate problems are more likely to occur if large amounts of drugs are used and if particularly hazardous modes and contexts of drug use are involved (e.g. use of drugs by injection, use of multiple drugs, use of drugs in association with work or sexual activity or use of drugs while pregnant). Frequent use of drugs over a long period can have a number of consequences for the individual, the community and society. Personal consequences can include structural damage to the brain (e.g. due to chronic cocaine or methamphetamine use) or other organs, deteriorating family relations, poorer performance in school or work, unwanted and/or unprotected sexual activity, violence and trouble with the authorities. Of particular concern is the greatly increased risk for blood-borne infection (HIV, hepatitis B and C) associated with the use of drugs by injection. Widespread use of drugs by injection and other forms of chronic drug use in a community can result in reduced community safety and cohesion and elevated criminal activity. Drug use exacts a significant economic toll on communities and societies due to increased law enforcement, social welfare and health care and lost productivity. According to the World Health Organization (WHO), close to 1 per cent of ill health in the world can be attributed to drug use; for developed countries, the figure is 2.3 per cent.⁸

⁶ Individuals who are more seriously involved with drugs but are not drug-dependent are also addressed through targeted services referred to as “indicated prevention”. Those services are not part of primary prevention.

⁷ For the remainder of this chapter, it should be assumed that primary prevention includes health promotion measures and principles.

⁸ World Health Organization, *World Health Report 2002: Reducing Risks, Promoting Healthy Life* (Geneva, 2002).

A. Extent and nature of drug use

7. Societal efforts to prevent drug use need to be based on the best possible available data. It is challenging to generate reliable information on the nature and extent of the drug use situation; without a good understanding of the situation, it is impossible to plan properly or know whether strategies are having a positive effect. School and household surveys on the prevalence of drug use provide a broad view of the situation regarding drugs of concern and age and gender differences. Other sources of useful data on drug use vary from region to region but may include hospital emergency units, drug treatment centres, medical networks, police departments, government health and social service offices and university research institutes. In some jurisdictions, networks with representation from these groups have been established to monitor trends in drug use at the municipal, district or national level. However it is gathered, relevant information for primary prevention aimed at preventing or delaying the onset of drug use includes information on the prevalence of drug use, the age of first drug use, gender differences, factors linked to the use and non-use of drugs and the socio-cultural context of drug use. A primary prevention strategy aimed at preventing in a population the transition of occasional drug use into serious involvement with drugs should include the collection of information on the frequency of drug use, the amount of drugs used and the factors linked to making the transition to more serious drug use.

8. It is estimated that between 172 million and 250 million persons in the world used a drug in the past year.⁹ What that estimate does not reveal is that rates of drug use vary greatly depending on the drug type, region, age group and gender:

- Cannabis is by far the most commonly used drug among young and older adults: in 2007, 3.3-4.4 per cent of the world’s population aged 15-64 years reported having used that drug in the past year. The next most commonly used drugs among person aged 15-64 years are amphetamine-type stimulants (including methamphetamine (0.4-1.2 per cent) and methylenedioxyamphetamine (MDMA,

⁹ *World Drug Report 2009* (United Nations publication, Sales No. E.09.XI.12).

commonly known as “ecstasy”) (0.3-0.5 per cent)), followed by cocaine (0.4-0.5 per cent) and opiates (0.3-0.5 per cent).¹⁰

- Rates and patterns of drug use in different regions are constantly in flux, affected by socio-economic forces and the availability of various drugs. Generally, the highest rates of drug use are found in North America, Oceania and Western Europe, although countries in those regions and subregions have reported drug use to be stable or declining in recent years. While cannabis is the most commonly used drug in most regions, the use of amphetamine-type stimulants is more common in East and South-East Asia. The highest rates of opiate use in the world are reported in countries along the main drug trafficking routes leading from Afghanistan. Increases in the use of drugs by injection and the HIV infection rate in Central Asian countries are among the steepest in the world, partly because those countries are used as transit areas for Afghan heroin bound for the Russian Federation and other countries in Europe. While rates of drug use are currently stable or declining in regions and subregions with high drug use rates, countries with economies in transition (e.g. countries in Eastern Europe and South America) and countries used as illicit drug production or transit areas (e.g. Central Asian countries) are at risk for and, in some cases, show signs of increasing drug use. This shift may be part of a larger phenomenon of “risk transition” resulting from marked changes in living patterns in many parts of the world.¹¹
- The abuse of prescription drugs is common in most regions, although comprehensive data on prevalence rates are difficult to obtain because data on the abuse of prescription drugs are not systematically collected in most countries. Where the abuse of prescription drugs is monitored, the prevalence of abuse of such drugs has been found to be high. In North America, for example, the abuse of

prescription drugs is second only to the prevalence of cannabis abuse. In the United States, 6.2 million persons aged 12 or older, or 2.5 per cent of the population, abused prescription drugs in the past month, and 15.2 million persons in that age group, or 6.1 per cent of the population, abused prescription drugs in the past year.

- Rates of drug use tend to be higher during the teenage and early adult years. First use of drugs most often occurs in adolescence. In the past, it could generally be said that if young persons had not begun using drugs by the end of their adolescent years, they were unlikely to begin; however, an increase in the number of persons first using drugs in their early adult years has been reported in numerous countries, perhaps partly because of marriage being delayed: getting married (and beginning a family) generally has the effect of reducing drug use. In the past, young males were more likely to use drugs; while that is generally still the case, the gap between drug use among females and drug use among males has narrowed for certain drugs in various countries throughout the world.¹²

9. The question of why some young people begin to use drugs and others do not is complex. It is understood to hinge on the interplay of a number of factors, including genetic and environmental factors. The terms “risk factor” and “protective factor” refer to those attributes or conditions that serve to either increase or decrease the likelihood of drug use. Everyone possesses or experiences a combination of those factors, in their personal, family, social, school, community and societal environments. Drug use or any other problematic behaviour (such as violence, criminal activity or poor school performance) or less socially disruptive internalized problems (such as extreme shyness, depression or anxiety) share many of the same risk and protective factors.

10. Risk and protective factors can affect an individual’s development at any point, from conception through childhood to adolescence and adulthood. Some children become vulnerable because of risk factors accumulating early in life. For example, weak

¹⁰ Ibid.

¹¹ World Health Organization, *World Health Report 2002*

¹² *World Drug Report 2009*

child-parent attachment at infancy may contribute to early behavioural problems, which can affect school performance and engagement with peers. In other cases, young people who are faring well can become vulnerable as a result of the onset of risk factors at a particular life stage (such as feeling abandoned by one or both parents due to their parents' separation, life in a new community or lack of school attachment). Protective factors help set a healthy pathway and provide a buffer against risk factors, particularly through challenging periods in life. Some children have certain innate traits and abilities that confer protection (see paragraph 11 below), but all children benefit from the protective effects of healthy family, social, school and community environments.

1. Personal factors

11. A number of personal factors, including genetics, biology, personality, mental health and life skills, help to determine whether a young person engages in drug use or other problematic behaviour. A person's genetic make-up may lead to vulnerability to drug use problems that may or may not be expressed, depending on the person's environment (e.g. parent and community attitudes towards drug use) and specific individual experiences. Exposure to substances such as drugs, alcohol or tobacco during pregnancy can either subtly or dramatically affect a child's future development and vulnerability, depending on the substance and the timing and extent of the exposure. Childhood mental health problems, especially conduct disorder and attention deficit disorder (ADD), are associated with later drug use. Use of tobacco and alcohol in late childhood or early adolescence may stem from earlier challenges and is a risk factor for later drug use. Mental health issues tend to become more prevalent during adolescence and are often associated with increased risk for drug use. Drug use by some youth may be an attempt to relieve mental health problems. In adolescence, a sensation-seeking personality is a risk factor for drug use, but so are internalized problems (such as anxiety). In early childhood, an easy-going temperament is a protective factor that buffers the influence of risk factors, reducing the likelihood of later drug use and other problematic behaviour. Important protective traits or abilities throughout childhood include being able to trust, having confidence in oneself and in one's ability to meet life's demands, being able to take initiative,

having a well-formed sense of identity and being able to experience and express intimacy. In terms of drug use, as a child proceeds into adolescence, a cautious temperament is a protective factor.

2. Family factors

12. The quality of family life is a large factor affecting health and behaviour throughout childhood and adolescence. Early deprivation (e.g. lack of affection from caregivers, neglect or abuse) often has a profound affect on a child's pathway through life. Children of drug- or alcohol-dependent parents are at particular risk for later drug use. In adolescence, discipline and family rules are factors, and extreme approaches (i.e. being either too permissive or too punitive) are associated with problems. Transitions or significant changes in family life (such as parental separation, loss of a close family member or moving to a new neighbourhood or school) can place any young person at risk. Parents who are good listeners, set reasonable expectations, monitor their child's activities and model healthy attitudes and behaviour (e.g. in relation to use of medication) have a protective effect.

3. Social factors

13. Social influences play an increasingly prominent role as children approach adolescence. In some societies, the media have contributed to a normalization of drug use. That is important because young people tend to be influenced by their perception of how common or "normative" drug use is in their networks. If a young person's friends or peers smoke, drink or use drugs or it is believed that they do, the young person is more likely to do those things, too. However, the phenomenon of peer influence as a risk factor is complex; peer influence rarely takes the form of overt coercion to try drugs, as is sometimes assumed. Decisions on the use of a particular drug are also linked to perceptions of the risk associated with the use of that drug. An emerging drug may go through a phase in which there is little information available about the risks or consequences of its use. Inaccurate information often fills that void, leading to an image of the drug being safe or of its users being somehow different from other drug users. As the perceived risk associated with the use of the drug increases, the rate of its use tends to decline. However, the concept of drug-related risk is best considered in relation to the benefits perceived by the young person. Some young

people may perceive unhealthy behaviour such as drug use as having important social benefits (for example, supporting a desired identity or making friends). Consequently, knowledge about drug risks does not serve as a protective factor in itself, but belief that the relative risks of drug use outweigh the benefits does. Spiritual engagement, active involvement in healthy recreational activities and service to a community are all important social factors that provide protection during adolescence.

4. Gender factors

14. It is important to consider gender differences for protective and risk factors in relation to drug use. Certain protective and risk factors may hold equal importance for boys and girls (e.g. social support, academic achievement, poverty) but may be expressed in different ways. Boys have a higher prevalence of conduct disorder and ADD¹³ during childhood, which can lead to them having earlier association with deviant peers and earlier initiation into drug use than girls. Other risk factors tend to be more important for girls; such risk factors include negative self-image or self-esteem, weight concerns, early onset of puberty, or a higher level of anxiety or depression. During adolescence, girls tend to give greater priority to social relationships than do boys; girls also appear to be more vulnerable to the influence of drug-using friends. Certain protective factors, such as parental support and consistent discipline, tend to be more important for girls than for boys.

5. School factors

15. The opportunity to attend school is an important protective factor; for children who are able to attend school, the quality of the school experience has an impact on their health and on their likelihood of engaging in risky behaviour, including drug use. Young people who are not engaged in learning and who have poor relationships with their peers and teachers (e.g. young people who are bullied or who experience a feeling of not belonging or who are not engaged in

their schoolwork or other activities) are more likely to experience mental health problems and to be involved in various types of health-risk behaviour, including drug use. Students with positive teacher, learning and social connectedness fare best in terms of mental health and resistance to health-risk behaviour and are more likely to have a good educational outcome. Schools that give systematic attention to promoting bonds among teachers, parents and students provide an important protective effect in terms of both learning and well-being. Students in secondary school are less likely to use drugs when the norms in school reflect a clear disapproval of drug use.

6. Community and societal factors

16. Many of the above-mentioned factors affecting young people arise from community conditions and other broad social factors (e.g. adequacy of income, employment and housing and the quality of social support networks). Internal migration, in particular migrating from a rural setting to an urban one, may be a risk factor when it causes a sense of uprooting, loss of traditional family values and relationships, loss of social structure with respect to the community of origin, difficult cultural adaptation or a feeling of alienation. Not having a reasonable income is a risk factor, as are having jobs with boring tasks, having no supervision and having no opportunity for promotion. Insufficient financial resources are deepened by poor community conditions such as badly maintained schools and lack of access to community services. Weak communities are more likely to experience crime, public drug use and social disorder, which, in turn, can further weaken those communities. Social capital (a community's cohesiveness and ability to solve common problems) is an indicator of community health that may have a bearing on a number of issues, including drug use.

7. Vulnerable populations

17. Young people around the world live in a vast range of circumstances. Many young people are exposed to ordinary levels of risk in the various areas of their lives, and most choose not to use drugs. However, some young people at least try drugs, particularly cannabis and amphetamine-type stimulants (along with alcohol, tobacco and, increasingly, without a doctor's supervision, psychoactive medicines), and some experience problems as a result. In every region,

¹³ See World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (Geneva, 1992); and American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR*, 4th ed. (Washington, D.C., 2000).

however, there is a population of children and young people exposed to more than an average level of risk. That risk may be manifested in various ways; if drugs are available to young people during adolescence and adulthood (e.g. as a result of drug use in the family or a high level of drug trafficking in the neighbourhood), they are more likely to use drugs. The challenge (and opportunity) for society is to systematically offer protective conditions and experiences to all children and youth, particularly those who are more vulnerable.

B. Strategies for preventing drug use

18. Primary prevention strategies need to ensure that attention is given to both whole (or universal) populations as well as targeted (selective) populations. Well-based whole population initiatives can both reduce demand and help identify gaps or population groups that are not being sufficiently addressed. To effectively address their needs, particular groups or vulnerable populations may benefit from initiatives with greater focus or intensity. Consequently, a prevention plan needs to include both types of measures: measures targeting the general population and measures targeting the more vulnerable population groups. Research provides good direction on the most fruitful whole population and targeted approaches for the various life stages.

1. Early childhood

19. Initiatives to promote the health and social development of children in their preschool years (children up to 6 years of age) can have the effect of averting a range of problems, including drug use, during adolescence and later. Prevention needs to begin with prospective parents, raising their awareness of the harm caused by using drugs, alcohol or tobacco during pregnancy. Home visit initiatives directed at young families experiencing problems (parental mental health problems or drug abuse, lack of partner support etc.) are a very effective intervention for preschool children. Such programmes typically involve a longer-term intensive relationship with the mother and family, beginning prior to or just after delivery. The aim of visit programmes is to support the mother with her own health needs, with child development issues and with help in accessing services. Higher-quality early childhood education programmes have been shown to

improve academic performance and social skills among vulnerable children, yielding long-term dividends, including reduced drug use, in a range of life areas. Programmes directed at families of preschool children can identify and reduce behavioural problems in early childhood (such as non-compliance and conduct disorder), improve parenting practices and help parents to create an environment promoting positive child development.

2. Later childhood

20. Primary prevention resources for the later childhood years are best devoted to family-based initiatives. Most parents benefit from support, and the extended family can play a crucial supportive role, particularly in societies without established welfare systems. Circumstances and needs vary considerably, however. Brief advice may suffice in some cases; in others, parenting training involving the whole family or therapeutic support may be most beneficial. A tiered arrangement offering services for a variety of needs or levels of risk is ideal. It has the effect of exposing all families in the community to programming support while allowing families with particular challenges to access services without being stigmatized.

21. In some regions, family skills training programmes are becoming increasingly common, bringing groups of families together for approximately eight sessions. They have been found effective for groups of families assembled on the basis of shared risk factors (e.g. families with a drug-dependent parent), as well as those assembled without regard to their risk level. In both cases, the programmes typically help parents to improve their ability to listen and communicate effectively, solve problems, provide appropriate discipline and monitor their children's activities during adolescence. The sessions need to be interactive (instead of in a lecture format) and to include opportunities for parents and children to test new ideas and skills together. The sessions are often organized in concert with the local school, emphasizing mutual support between parents and teachers. Providing incentives such as paid transportation, arrangement for childcare, free communal meals and vouchers for consumer goods at the end of the programme can greatly enhance the participation of parents and families. On the whole, family skills training programmes are among the most effective drug use prevention options; they have also

been shown to decrease other types of problem behaviour (aggressiveness, truancy) and increase attachment to school.¹⁴

3. Early and middle adolescence

22. For children in early adolescence who are able to attend school, education aimed at raising awareness of the risks of drug use is an important prevention component. The ability of classroom instruction to prevent drug use is much strengthened when such instruction is delivered in the context of a “health-promoting school” approach integrating attention to the environment in and around schools, good access to services and strong parent and community involvement. The most promising classroom models for such education ensure that accurate, balanced information on the risks and consequences of drug use is provided in the context of exploring social influences and teaching key life skills (such as coping, decision-making, critical thinking and assertiveness).¹⁵ But in order to be manageable for schools, such education needs to be woven with other issues (e.g. mental health problems) that share the same risk and protective factors. Interactive teaching approaches are essential to effective education about the risks of drug use, as simply providing information has been found to be ineffective. Because relevance is critical, culturally appropriate education programming is likely to increase the potential of programmes for educating students of differing ethnicity about the risks of drug use.¹⁶ The effectiveness of even the best programmes is limited given that many of the risk factors lie beyond the school grounds. However, such programmes are viewed as cost-effective because they are relatively inexpensive to deliver and have been shown to have an impact on other types of behaviour and because delaying the onset of drug use by even a year or two

for a few students helps avoid significant social costs in the future.

23. Having school policies on substance use is important as it enables the school to address drug use issues and to influence the norms and culture within the school. The content of school policies on substance use is important, but so is the process by which such policies are developed, communicated and enforced. While a participatory approach to that process is time-consuming, it has a positive effect in that it gives students and staff a sense of ownership over that part of their lives. It will lead to greater support for policies and decisions. School policies on substance use should cover the use of drugs, alcohol and tobacco among students and staff. A balanced policy on substance use is one that seeks instructive and health-promoting solutions to issues, including logical consequences for infractions, and minimizes punitive action such as suspension. Suspension often leads to increased antisocial behaviour, so policies on substance use should foster creative ways to help youth who are at higher risk to maintain their links with school.

24. All students may potentially benefit from universal prevention measures aimed at imparting knowledge or life skills or improving the overall environment in school. However, some students (e.g. those who are not succeeding in school, those who have behavioural issues or learning disabilities or those who are not involved in extra-curricular activities) are at risk for a variety of problems, including drug use, and may benefit from targeted prevention measures. Initiatives that help students at higher risk by supporting them academically, teaching them life skills or engaging them in sports and recreation programmes can be effective. Some initiatives that have brought together higher-risk students in targeted programmes have had negative effects because they resulted in the students having relationships with deviant peers and spending less time in a regular class with more conventional peers; hence caution is advised. Brief interventions using motivational approaches have shown particular promise for students who use alcohol and may have a similar effect on students who use drugs.

25. Agencies serving youth, sports clubs and other entities providing out-of-school activities offer good opportunities to promote youth development and health. By simply providing alternative activities for

¹⁴ *Guide to Implementing Family Skills Training Programmes for Drug Abuse Prevention* (United Nations publication, Sales No. E.09.XI.8).

¹⁵ World Health Organization, *Skills for Health: Skills-Based Health Education Including Life Skills – An Important Component of a Child-Friendly/Health-Promoting School*, Information Series on School Health, No. 9 (Geneva, 2003).

¹⁶ *Drug Abuse Prevention among Youth from Ethnic and Indigenous Minorities* (United Nations publication, Sales No. E.04.XI.17).

children and youth, they play an important role in promoting healthy use of leisure time. However, such entities can strengthen that role by building programmes in which: all youth feel physically and psychologically safe; rules and expectations are clear and age-appropriate; and there are plentiful opportunities to assume increasing responsibilities. Much of the potential of those entities depends on the quality of the young people's relationships with the adult leaders and coaches. If they are characterized by respect, warmth and good communication, child health is promoted. The challenge for adult leaders is to make every effort to ensure that all children and youth feel included, particularly those who might otherwise feel excluded due to their gender, sexual orientation, disability, ethnicity or religion. Community programmes for vulnerable adolescents and young adults should be evidence-based, work hard to engage participants (e.g. through sports and the arts), be of sufficient duration to cultivate trusting, supportive relationships between staff and all participants and pay more attention to learning and skill development than results.

26. Mass media campaigns are used by societies around the world to support primary prevention. Campaigns may have a variety of aims such as promoting healthy lifestyles, shifting community norms in relation to drug use and supporting parents in their preventive role. Keys to an effective campaign are having a good understanding of the targeted youth or parents and having sufficient resources to reach the target group. Evidence suggests that the following are also important:

- When presenting drug-specific information, campaigns need to ensure that the information is accurate and balanced.
- While noting longer-term consequences, it is important to emphasize immediate personal and social consequences (e.g. looking unattractive, being embarrassed by intoxication and antisocial behaviour the next day, growing apathy, inability to concentrate, getting arrested).
- Because youth are a very diverse population, it is important to be clear about the target group and the image or social representation that the group applies to a drug; for example, a media message developed for adventurous youth

should differ from a message directed at youth who may find drug use appealing because of their anxiety issues.

- It is extremely difficult for most adults to keep abreast of youth trends and age-specific considerations; hence, it is important to involve members of the target group in designing media initiatives.

27. It is challenging for drug prevention media campaigns to be noticed in the midst of unprecedented media traffic. Partnerships in which the public sector and the private sector pool their resources are effective in extending the reach of prevention campaigns. Used creatively, both traditional (e.g. street interviews) and newer media approaches (e.g. social networking on the Internet) can provide access to target groups among youth without being prohibitive in cost.

4. Late adolescence and early adulthood

28. Given their dominant role in the lives of many older adolescents and young adults, the workplace, nightlife settings (such as clubs, discotheques, bars, parties and music festivals) and post-secondary institutions (e.g. colleges and universities) are important for primary prevention.¹⁷ A "healthy-setting" approach that recognizes their potential to either promote or hinder health can be effective in all cases:

- Working conditions and organizational practices can either alleviate or aggravate stress on workers, which has a large influence on workers' health and drug use. Giving employees input into the way their work is organized can help reduce stress, as can measures such as providing regular feedback on performance and having work schedules that are reasonable and flexible. Companies, large and small, can also reduce drug use by raising the awareness of employees and supervisors about drug issues, implementing an effective approach to identifying drug users

¹⁷ In all societies, there is a population of older adolescents and young adults who have less access to resources. Young people who are unemployed and living in poor housing or on the street (for example, due to an abusive or unstable upbringing, or mental illness) are more likely to benefit from intensive targeted services than primary prevention activities.

and achieving a balance between disciplinary measures and access to assistance.¹⁸

- Prevention of drug use in nightlife settings is best addressed through comprehensive interventions aimed at promoting the health and safety of both staff and customers. Health and safety issues within those settings are wide-ranging; such issues may include ventilation, fire, sound levels, sexually transmitted infections and unwanted pregnancies, unintentional injuries due to falls or violence, and impaired driving upon leaving the workplace. Such issues are best addressed by a combination of basic venue policies, training serving staff and door supervisors and helping with access to treatment for staff if necessary.
- Post-secondary institutions are also advised to take a comprehensive approach that ideally combines awareness and education, as well as the training of peer leaders, with policy that is consistently applied. Initiatives in such institutions should be based on understanding that drug use interferes with academic performance.

5. All life stages

29. Societies clearly have a wide range of opportunities (e.g. in terms of population targets, life stages and settings) to promote the health of young people and to prevent drug use. While adolescence is often the focus of primary prevention, the early and middle childhood years also offer good opportunities. Primary prevention opportunities are more limited as young people make the transition into adulthood, but attention at that life stage is also important. During all life stages, prevention needs to be infused into the way all members of the community (i.e. families, schools, media, youth agencies, religious groups and nightlife establishments) view their responsibilities. For prevention policymakers and programmers, the challenge is to show how incorporating prevention-oriented policies and approaches can support the core

mission of those members of the community, so that, for example, nightclub owners come to see that a healthy setting can make good business sense and school authorities understand that prevention contributes directly to educational objectives. Ideally, everyone in a community should see the prevention of drug use and the promotion of health as their business and regard them not as projects but as the best way to do their work.

30. Every single initiative, when based on evidence and carefully designed and delivered, makes an important contribution to prevention; however, positive outcomes are much more likely when individual initiatives are brought together into comprehensive, long-term community action. Nurturing healthy young people who do not use drugs means engaging all members of the community in helping children and youth develop strong personal and social capabilities. Skill-building opportunities are most powerful when presented in the context of day-to-day living (e.g. coping with relationships, drugs or bullying). These skills are best groomed by families (including extended families), schools, recreational associations and others in the community working together to support healthy development.

31. Well-coordinated, long-term community programmes for preventing drug use are complex undertakings that require commitment, partnership-building, leadership development and public participation. The challenges are not small but the rewards can be significant. Even in weak communities caught in a downward spiral, collective efforts can bring about small but important changes (e.g. a reduction in the amount of drugs sold or in the extent of drug use in public places) that strengthen cohesion and a sense of common purpose. Because poor social conditions can contribute to drug use, prevention professionals need to work with others to monitor conditions and advocate creative policies and initiatives to reduce social inequality and alleviate poverty (e.g. promoting access to adequate housing and food, quality jobs and early childhood education and care). Governments have a definite role to play in supporting local action but they need to exercise care. With their access to data and research, professionals can unintentionally intimidate citizens into thinking that they do not have the competence to address their own local issues. The residents (including the youth) of a community need to define their concerns and arrive

¹⁸ International Labour Office, *Management of Alcohol- and Drug-Related Issues in the Workplace*, ILO Code of Practice (Geneva, 1996). Available from http://www.ilo.org/public/libdoc/ilo/1996/96B09_297_engl.pdf.

at a sustainable plan, and prevention professionals need to support that role and help build the capacity of the community to do that work.

C. Building capacity for primary prevention at the national level: challenges and opportunities

32. Primary prevention strategies based on evidence have considerable potential to reduce drug demand; to realize that potential, however, Governments need to bring primary prevention out of the shadows of other strategic measures and be committed to that work. Drug control strategies aim to achieve a balance between various components, yet primary prevention continues to suffer from lack of attention relative to other components. Supply reduction is a vitally important part of the mixture of components needed to effectively address drug problems. Although evaluation and cost-benefit analyses of drug supply reduction measures are scarce, it is assumed that those activities have the effect of raising drug prices and making drugs less accessible in communities. To the extent that that is the case, supply reduction activities have the effect of reducing demand. The reverse is also likely to be true: effective drug demand reduction, including primary prevention, has the effect of reducing drug supply in communities. Primary prevention also needs to re-establish its place alongside secondary prevention, which has dominated the discussion in recent years. While the needs of those seriously involved with drugs must be addressed, promoting the non-use of drugs has obvious public health benefits as well. Finally, it is important for primary prevention to come out of the shadow of treatment for drug abuse. Historically, much of the work in the area of prevention of drug use has been done by treatment and medical practitioners. Their close knowledge of drug use problems has provided important insight into prevention work; however, clinicians tend to deal with problems using an individual, case-by-case approach rather than a “system” approach. It is vital to adopt a “system” approach that takes into account the various contexts or environmental factors that influence drug use.

33. In fact, the greatest challenge of primary prevention may be to clearly organize and account for the range of linkages that need to be a part of an

effective primary prevention plan. The Board calls for policymakers to establish a clear focal point for primary prevention and to develop both vertical and horizontal linkages in Government:

- *Vertical linkages*: drug use issues are fundamentally health issues, and prevention is most closely connected to public health, health promotion and child and youth development; consequently, health authorities at all levels of government need to be an integral part of primary prevention efforts. Vertical linkages are necessary because a focal point for drug use prevention should have input into social policy decision-making at the highest levels of government. Risk for drug use most often originates in broad socio-economic factors, and prevention policy needs to advocate social policy at the government level that promotes more equitable access to protective factors for children and families (e.g. anti-poverty and social inclusion initiatives).
- *Horizontal linkages*: early factors can render a child at risk for drug use later in life. Thus, strategies for drug use prevention need to be linked with and support child development initiatives. Ministries of education have a large role to play in primary prevention but often experience severe constraints, so it is critical for authorities responsible for prevention and those responsible for education to arrive at plans for drug use prevention in school that are both feasible and effective. The factors that contribute to drug use also contribute to other behavioural and social problems such as poor school performance, mental health problems, violence and criminal activity; therefore, it is important for a focal point for drug use prevention to link with strategies directed at those other types of behaviours that represent a health risk. A priority topic of inter-strategy discussions is the need for other strategies to include drug use prevention among their objectives and in their evaluations and for strategies for drug use prevention to reciprocate. Because early use of legally available substances is linked to later drug use, a plan for drug use prevention needs to include or be linked to efforts to address the abuse of such substances. Finally, primary prevention

services need to be linked with secondary prevention and treatment components of a demand reduction continuum to ensure seamless coordination between service levels.

34. The critical importance of collaborative work between Government offices means that system capacity should be strengthened in that direction. Governments need to establish formal and informal mechanisms for coordination and cooperation, to assign staff to support interdepartmental and interdisciplinary cooperation at all levels and to promote the active exchange of knowledge within and between sectors.

35. Government action alone cannot be effective in primary prevention; it is essential that focal points for primary prevention and non-governmental organizations collaborate with one another. Partnerships between government and civil society need to be forged at the local, national and international levels to ensure that scarce resources are used as efficiently as possible and to increase the effectiveness of efforts to reduce the prevalence of drug use. Credible non-governmental organizations that help children and youth and that are accustomed to working alongside community representatives are best able to deliver evidence-based, culturally appropriate prevention at the local level. In some regions, the work of non-governmental organizations is increasingly being evaluated, and that development should be encouraged. The large and direct involvement of non-governmental organizations in that area lends them an important perspective that should be taken into account by government representatives at the policymaking level.

36. It is important for a strategy for drug use prevention to present clear targets and aims:

- In any population of young people, there is a large group of people who are not using drugs or use them occasionally; those people would benefit from measures and messages that promote not using drugs. Some of those young people have advantages or protective factors and would benefit from broad universal prevention measures; others are more vulnerable because they have one or more risk factors. Governments may be tempted to allocate their limited resources to either one population group or the other, but they are

advised to set aside resources for both. Universal prevention interventions tend to have a limited effect (that is, they prevent only a small percentage of the population from starting drug use than would otherwise be the case); however, because they are serving whole populations, that percentage of the population may represent a significant number of people and provide an important public health benefit. Targeting vulnerable population groups allows for interventions to be more closely tailored to the needs of particular population groups.

- Key words in statements of long-term outcomes include “prevent use”, “delay use”, “promote non-use among occasional users” and “prevent occasional use from shifting to serious use”. More immediate outcomes that can contribute to those long-term aims include “developing health-related life skills”, “building protective factors”, “promoting resiliency” and “promoting individual or organizational capacity”. All elements of a strategy (e.g. targets, aims and activities) need to be logically linked in an accountability framework.

37. Governments and other stakeholders (e.g. schools, youth agencies, the media, religious groups, police, community coalitions and the private sector) need to emphasize an evidence-based approach to primary prevention work. Most prevention research and evaluation continue to be carried out in a handful of countries. That is a matter of concern because prevention activity is inevitably affected by its social and cultural context. To move beyond that situation, Governments and funding bodies throughout the world need to take greater responsibility, for example, by undertaking studies on interventions that have been shown to be promising or effective elsewhere. That means making more resources (e.g. funding, technical assistance) available for the design, implementation and evaluation of programmes for drug use prevention.

38. At the local level, persons responsible for programmes for drug use prevention should strive for quality in their work. That means that they should be able to show that they addressed the identified needs, that activities were implemented as planned (e.g. the intended number and types of individuals were reached), that activities resulted in the desired changes

or outcomes (e.g. fewer students using cannabis) and achieved the changes at a reasonable cost and so on. If local organizers adopt a programme that has been found to be effective elsewhere, they will need to retain core elements of the programme when adapting it to the local culture and circumstances. As programmers around the world increasingly evaluate and share their work, the understanding of what works in different populations and cultures will improve considerably.¹⁹

39. A number of Governments and research institutes have published summaries of scientific evidence to guide prevention strategies and activities. Those guidelines on good practice are helpful. They could serve as the basis for standards in prevention, providing benchmarks for quality prevention. When augmented by resources to support continuous improvement, such standards could raise the overall quality of prevention work. Efforts to improve the quality of programming and practice have the effect of professionalizing the prevention workforce. That not only brings better service to society, it provides important support for prevention workers, giving them a clearer identity and career path. In an environment emphasizing quality standards, it will be easier to retain prevention workers and to build organizational capacity. Relevant international authorities can encourage this development by preparing, in consultation with national authorities, experts, service providers and young people, international principles of effective primary prevention. Such guiding principles could lead to broad standards and quality criteria that Governments could use in monitoring and reporting their performance in primary prevention.

40. To fulfil the potential of primary prevention, society needs to move from rhetoric to action. Prevention is too often lauded and poorly supported. In response to a perceived drug-related “crisis”, Governments often give priority to strong but short-lived responses such as a stand-alone media campaign or heightened law enforcement. Governments need to work against the cycles of panic and indifference that have often characterized reactions to drug issues. In

order to maintain support for prevention strategies over the long term, societies need to understand that drug problems are not a one-time crisis but an ongoing challenge. While it is unrealistic to expect drug use and the resulting problems to be eliminated, the prevalence of drug use can be reduced and significant social and economic benefits can be realized. Increasingly rigorous research and practice are showing the way. Factors contributing to drug use are better understood, realistic aims are being defined and evidence of the cost-effectiveness of various primary prevention activities is mounting. Policymakers now need to commit resources to implement this important work.

D. Recommendations for building capacity for primary prevention at the national level

41. To ensure the implementation of effective primary prevention, the Board has made the following recommendations:

- Governments should establish a clear focal point and accountability for primary prevention. That will enable primary prevention to assume its proper place alongside secondary and tertiary prevention.
- Governments should integrate primary prevention into the national drug control strategy and use a public health framework. A public health framework provides a scientific basis for prevention and ensures that the full range of factors that contribute to drug use are addressed.
- Governments should build capacity for and ensure collaboration and linkage among all government sectors pursuing similar prevention aims. Because a wide variety of factors contribute to drug use and many of those factors also contribute to other kinds of health issues or risk behaviour (e.g. mental health problems, violence, criminality), linkages with other government offices having similar aims will lead to synergies at the government level.
- Governments should encourage various groups with a stake in prevention (e.g. families, schools, youth agencies and non-governmental

¹⁹ For a useful resource to guide the evaluation of prevention at the local level, see *Monitoring and Evaluating Youth Substance Abuse Prevention Programmes* (United Nations publication, Sales No. E.06.XI.7).

- organizations, the media, religious groups, police, community coalitions and the private sector) to work together towards the achievement of prevention aims. Limited resources are most effectively and efficiently utilized when relationships are characterized by open communication and commitment to collaboration.
- Governments should establish mechanisms to improve the understanding of drug use and the factors that influence drug use. It is important that prevention be data-based to the extent possible. Only with a clear understanding of the current extent and nature of drug use is it possible to determine whether prevention initiatives are having the desired effect.
 - Governments should seek to build and disseminate knowledge of best practices within their jurisdictions. Governments must take the lead in preparing and testing innovative local models and adapting approaches that have been shown to work elsewhere, with a view to determining which best practices are locally relevant.
 - Governments should increase their commitment to the evaluation of primary prevention. It is important to have not only the financial resources but also the technical assistance to guide programmers in undertaking evaluation that is both manageable and useful.
- Governments should develop the primary prevention workforce. That means establishing prevention as a defined field of practice, ensuring adequate initial and ongoing training and promoting practice-based networks.
 - The United Nations Office on Drugs and Crime (UNODC) should collaborate with others to develop standards against which Governments may measure their efforts in primary prevention. Collaboratively prepared standards can be used as a benchmark for parties intent on continuously improving their primary prevention efforts.
 - UNODC should collaborate with the United Nations Children's Fund (UNICEF), the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, WHO, relevant non-governmental organizations and the private sector to develop, promote and disseminate resources to help Governments strengthen the quality of their primary prevention work.