



香港社會服務聯會
The Hong Kong Council of Social Service

Substance Abuse Definition, Trends, Harms, and Policy

David Cheung
22 October 2013

Substance Abuse - Definition

Substance Abuse (The World Health Organization Definition)

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Assessment

- Addiction Severity Index (ASI) contains multi-dimensions and takes more than a hour to complete
- Local Protocol produced by Dr Leung Shung Pun and some other workers, available for free at the Narcotics Division website: www.nb.gov.hk

Other tools like CAGE

DSM-IV vs ICD-10

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

DSM-IV

Diagnostic Criteria for Substance Abuse

A. Maladaptive pattern leads to clinically significant impairment or distress:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
2. Recurrent substance use in situations in which it is physically hazardous (e.g. drug driving)
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

B. The symptoms above never met the criteria for substance dependence for this class of substance.

Legal Highs

“Legal highs” is an umbrella term for unregulated (new) psychoactive substances or products intended to mimic the effects of controlled drugs. The term encompasses a wide range of synthetic and/or plant-derived substances and products, which are offered as “legal highs” (emphasizing the idea of legality), “research chemicals” (implying legitimate research use), “party pills” (an alternative to “party drugs”) and “herbal highs” (stressing the plant origin) etc. They are frequently sold via the Internet or in “smart shops” or “head shops” and in some cases are intentionally mislabelled, with purported ingredients differing from the actual composition.

Designer Drugs

Substances that have been developed especially to avoid existing drug control measures ... [and] are manufactured by making a minor modification to the molecular structure of controlled substances, resulting in new substances with pharmacological effects similar to those of the controlled substances.

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the European Police Office (Europol), such substances can be best defined as substances designed to mimic the effects of known drugs by slightly altering their chemical structure in order to circumvent existing controls.

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule/ How Administered**	Acute Effects/Health Risks
Tobacco			
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed	Increased blood pressure and heart rate/throat/leg disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Alcohol			
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed	In low doses: euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/ increased risk of injuries, violence, fetal damage (in pregnant women), depression, neurologic deficits, hypertension; liver and heart disease; addiction; fatal overdose
Cannabinoids			
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	Not scheduled, swallowed	Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired hearing, memory; anxiety; panic attacks; psychosis/tourette; frequent respiratory infections; possible mental health decline; addiction
Hashish	Boon, gangeta, hash, hash oil, hemp	Not scheduled, swallowed	
Opioids			
Heroin	Diacetylmorphine: smack, horse, brown sugar, dope, H, junk, skag, skank, white horse, China white; diacetylmorphine (with OTC cold medicine and antihistamine)	Injecta d, smoked, snorted	Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feelings of heaviness in the body; slowed or arrested breathing/constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose
Opium	Laudanum, paragon: big O, black stuff, black gum, hop	I, II, III, swallowed, smoke d	
Stimulants			
Cocaine	Cocaine hydrochloride: blow, bump, C, candy, Charika, zoka, crack, flake, rock, snow, tot	Not scheduled, smoked, injected	Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors, reduced appetite, irritability, anxiety, panic, paranoia; violent behavior; psycho-stimulant loss, insomnia, cardiac or cardiovascular complications; stroke, seizures; addiction Also, for cocaine —nasal damage from snorting Also, for methamphetamine —causes dental problems
Amphetamine	Bephatamine, Dexamphetamine: bennies, backbeards, crosses, hearts, LA turnaround, speed, track drivers, uppers	Not scheduled, snorted, smoked, injected	
Methamphetamine	Desoxy: meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	Not scheduled, snorted, smoked, injected	
Club Drugs			
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Ew, lover's speed, peace, uppers	Not scheduled, snorted, injected	MDMA—mild hallucinogenic effects; increased tactile sensitivity; empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/ sleep disturbances; depression; impaired memory, hyperthermia, addiction Flunitrazepam—sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/addiction
Flunitrazepam	Rohypnol: forget-me pill, Mexican Valium, R2, roach, rocha, roofies, roofies, rope, rophies	Not scheduled, snorted	
GHB	Gamma-hydroxybutyrate: G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, soxop, goop, liquid X	Not scheduled, swallowed	GHB—drowsiness; nausea; headache; dizziness; loss of coordination; memory loss/ unconsciousness; seizures; coma
Dissociative Drugs			
Ketamine	Ketalar, SK, cat Valium, K, Special K, vitamin K	Injecta d, snorted, smoked	Feelings of being separate from one's body and environment; impaired motor function/coordination; tremors; numbness; memory loss; nausea Also, for ketamine —analgesic; impaired memory; delirium; respiratory depression and arrest; death
PCP and analogs	Phencyclidine: angel dust, boat, hog, low boat, peace pill	I, II, III, swallowed, smoked, injected	Also, for PCP and analogs —analgesic; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked	Also, for DMN —euphoria; slurred speech; confusion; dizziness; distorted visual perceptions
Dextromethorphan (DXM)	Found in some cough and cold medications: RoboTripping, Robo, Triple C	Not scheduled/swallowed	
Hallucinogens			
LSD	Lysergic acid diethylamide: acid, blotter, cubas, microdot, yellow sunshine, blue heaven	Not scheduled, absorbed through mouth tissues	Altered states of perception and feeling; hallucinations; nausea Also, for LSD and mescaline —increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; paranoia; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion
Mescaline	Buttons, cactus, mesc, peyote	Not scheduled, smoked	
Peyote	Magic mushrooms, purple passion, strooms, little smoke	Not scheduled	Also, for LSD —Flashbacks, Hallucinogen Persisting Perception Disorder Also, for peyote —nervousness; paranoia; panic
Other Compounds			
Anabolic steroids	Anadrol, Oxandrolone, Durabolin, Depo-Testosterone, Equipoise roids, juic, gym candy, pumpers	Injecta d, swallowed, applied to skin	Sexoids—no intoxication effects/hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer; reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics
Inhalants	Solvents (paint thinners, gasoline, glues); gases (butane, propane aerosol propellants, nitrous oxide); nitrites (isoamyl isobutyl nitrate); laughing gas, peppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	Inhalants (varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule/ How Administered**	Acute Effects/Health Risks
Prescription Medications			
ONS Depressants	For more information on prescription medications, please visit http://www.nida.nih.gov/DrugProgram/PrescriptionDrugs.html .		
Stimulants			
Opioid Pain Relievers			

* Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.

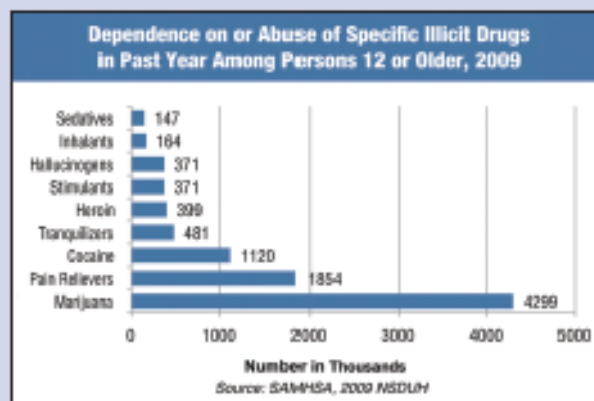
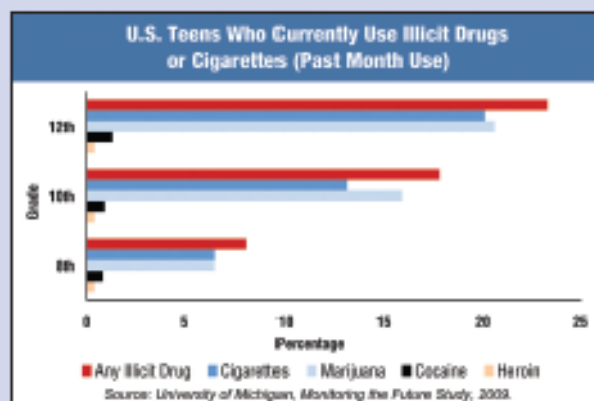
** Some of the health risks are directly related to the route of drug administration. For example, injection drug use can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

*** Associated with sexual assault.

Principles of Drug Addiction Treatment

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*. The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

- Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs alter the brain's structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.
- No single treatment is appropriate for everyone.** Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success.
- Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.
- Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.
- Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
- Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or an oral medication (bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person's changing needs.
- Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.
- Treatment does not need to be voluntary to be effective.** Sanctions or incentives from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
- Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.



NATIONAL INSTITUTE ON DRUG ABUSE

 RESEARCH DISSEMINATION CENTER

Order NIDA publications from DrugPubs:
 1-877-643-2644 or 1-240-645-0228 (TTY/TDD)

From the Narcotics Division

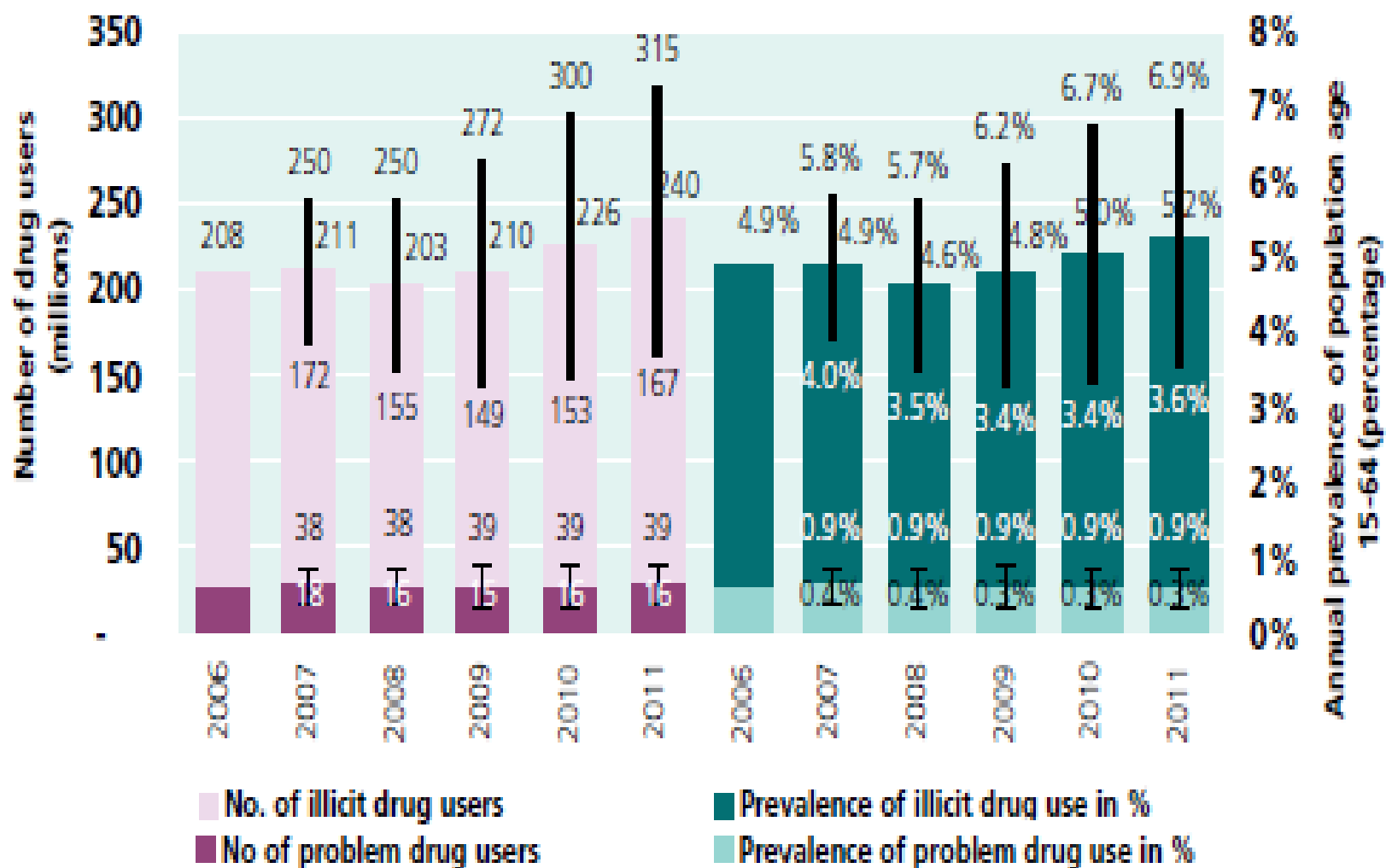


The world drug situation

- UNODC World Drug Report

Published by the United Nations Office on Drugs and Crime annually. Available for free on the web. According to the 2013 Report, the overall drug abuse situations are as follows:

Fig. 1. Trends in drug use, 2006-2011



- 1 The number of problem drug users is driven mainly by the estimated number of cocaine and opiate users and therefore reflects the overall stable trends in the use of those drugs.
- 2 Changes in the prevalence of different drugs may be an artefact owing to revised estimates within regions and subregions that may impact the global prevalence of the drugs.

Fig. 2.

Trends in the prevalence of different drugs, 2009-2011

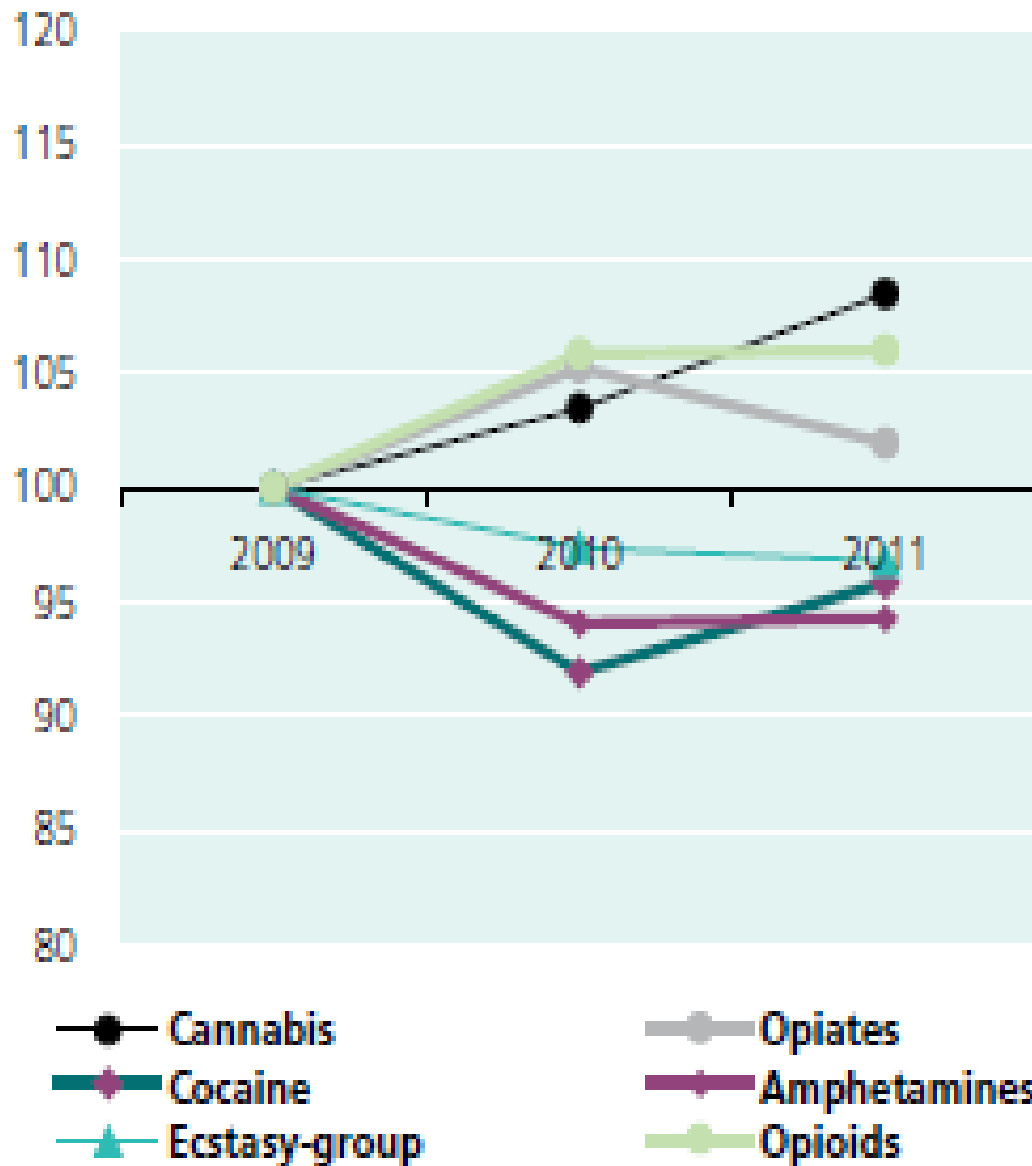
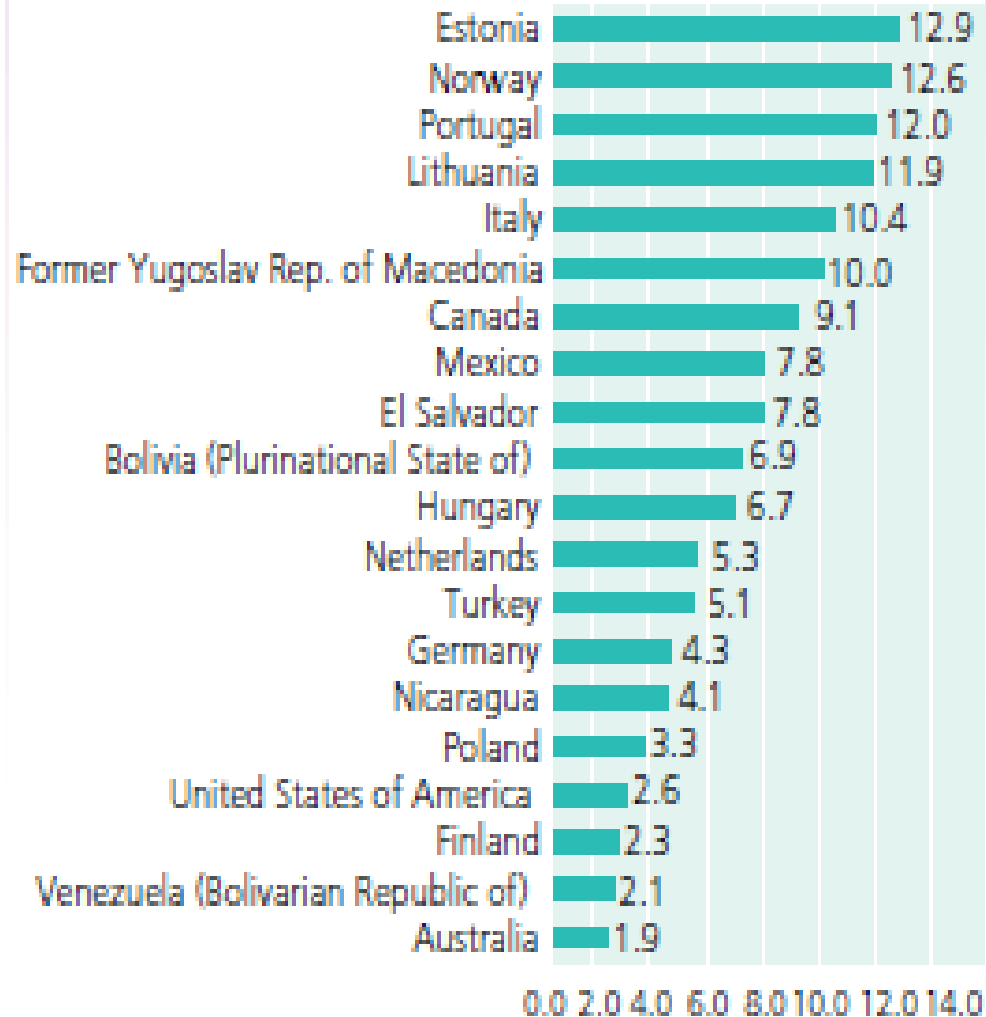
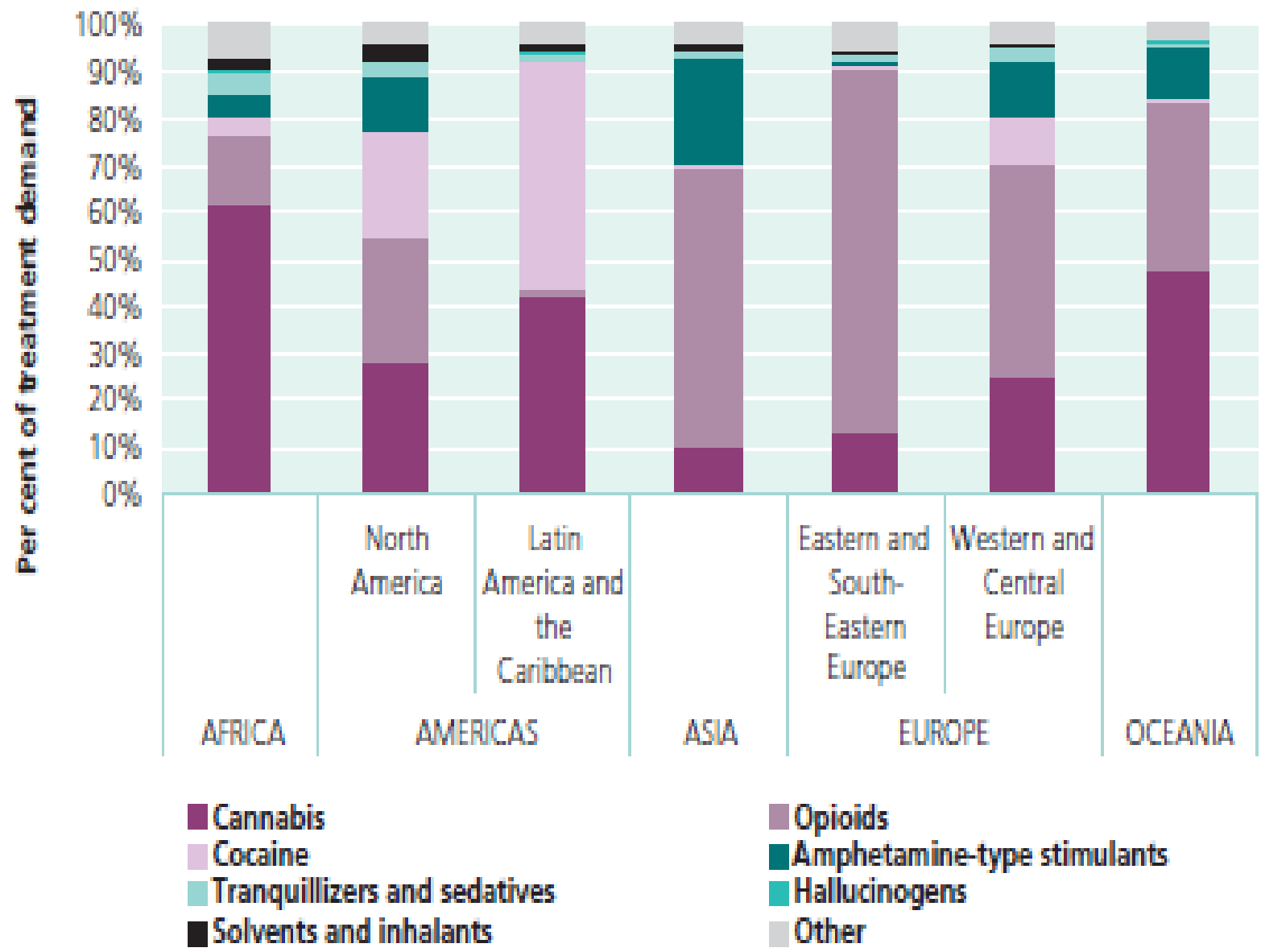


Fig. 3. Annual prevalence of non medical use of tranquilizers and sedatives among the general population in high-prevalence countries



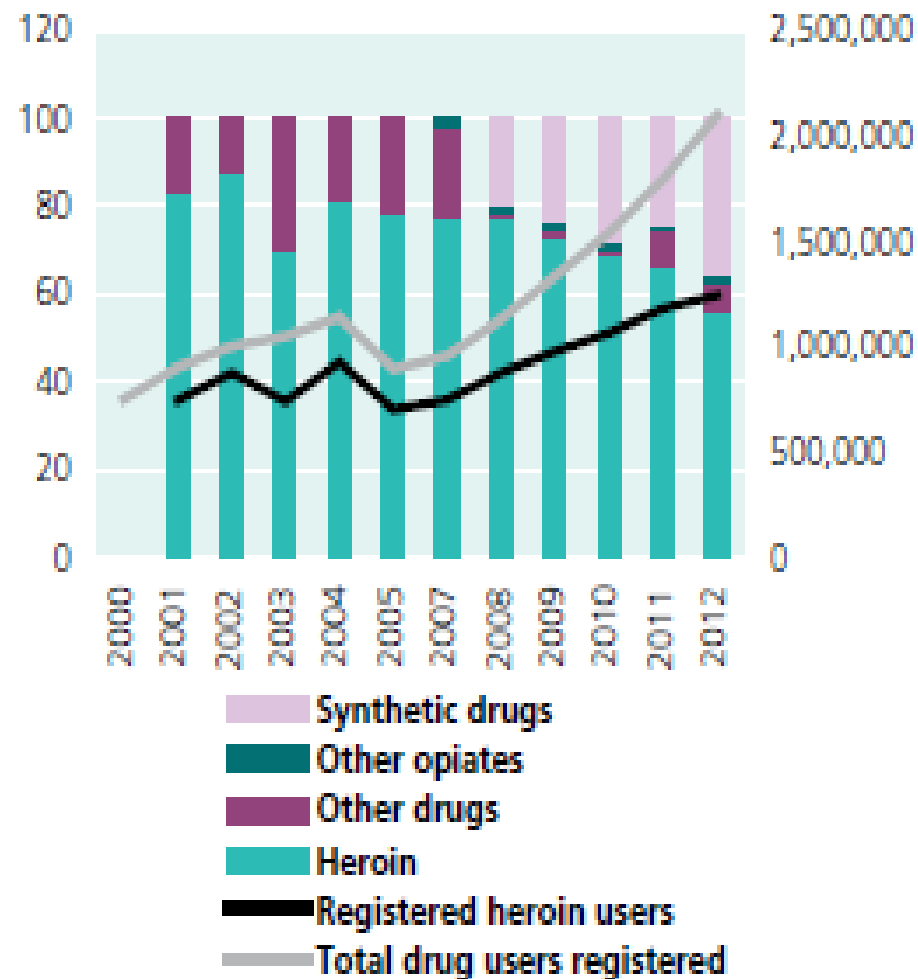
Source: United Nations Office on Drugs and Crime, data from the annual report questionnaire (2007-2011).

Fig. 10. Primary drug of concern for people in treatment, by region (2011 or latest year available)



Source: United Nations Office on Drugs and Crime, data from the annual report questionnaire, supplemented by national Government reports.

Fig. 14. Trends in registered drug users and proportion of registered drug users in China, 2000-2011



Source: Information provided by China in the annual report questionnaire, and annual reports on drug control in China published by the Office of the National Narcotics Control Commission of China.

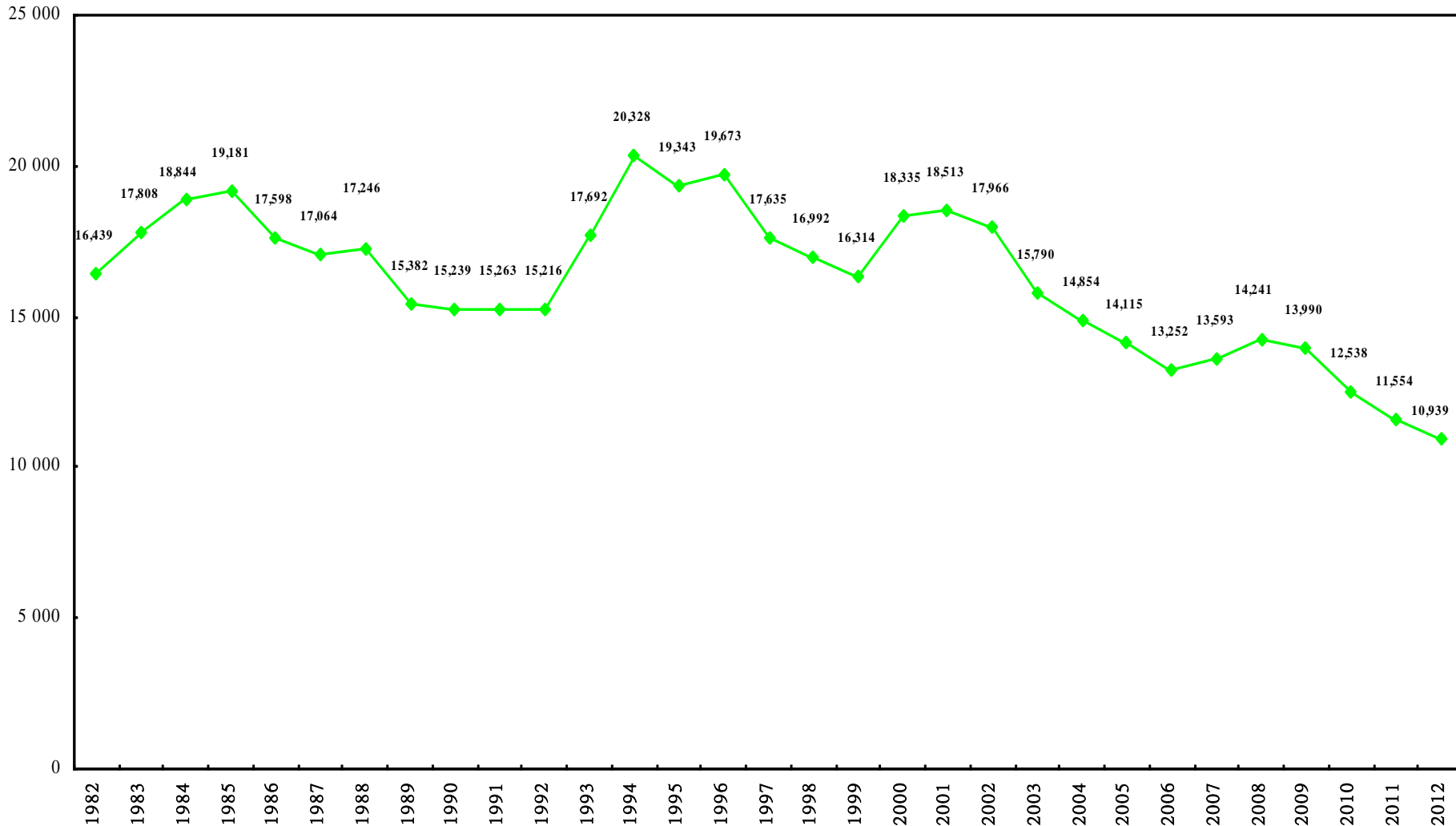
The Hong Kong Scene

- CRDA is the only source of data for us to observe the drug abuse situation in Hong Kong. It is updated every year.
- School Drug Survey

The first school drug survey in Hong Kong was conducted in 1987. Thereafter, it was carried once in four to six years. The latest one was conducted in 2012.

No. of reported drug abusers by type of drug abused, 1982 - 2012

No. of persons



Trends of drug abuse in Hong Kong

- LHC charts: 4 trends: 1. from opiates to psychotropic substances; 2. The average abuser gets younger; 3. Increase in female drug abusers; 4. The popularity of drug pushing.

The Harms of Drug Abuse

Home Office Online Report 24/05

Measuring the harm from illegal drugs using the Drug Harm Index

Ziggy MacDonald

- Louise Tinsley
- James Collingwood
 - Pip Jamieson
- Stephen Pudney

The **Drug Harm Index** captures the harms generated by the problematic use of any illegal drug by combining robust national indicators into a single-figure time-series index. The harms include drug-related crime, community perceptions of drug problems, drug nuisance, and the various health consequences that arise from drug abuse (e.g. HIV, overdoses, deaths etc.).

The relative importance of each of the harm indicators in the DHI is captured by the economic and social costs that they generate. This follows from work to estimate the economic and social costs of class A drug use, published by the Home Office in 2002.

From year to year, the change in the DHI will be due to the growth in the volume of harms (e.g. the number of new HIV cases or the number of drug-related burglaries) and the growth in the unit economic or social cost of the harms (e.g. the rise in the expected cost per new HIV case or the average victim cost of a domestic burglary).

The harms included in the DHI

Health impacts

- New HIV cases due to intravenous drug use (IDU), including those infected through heterosexual sex with someone who contracted the disease through IDU
(Communicable Disease Surveillance Centre (CDSC))
- New Hepatitis B cases due to intravenous drug use (CDSC)
- New Hepatitis C cases due to intravenous drug use (CDSC)
- Drug-related deaths (Office for National Statistics)
- Drug-related mental health and behavioural problems (Hospital Episode Statistics)
- Drug overdoses (Hospital Episode Statistics)
- Drug-related neonatal problems (Hospital Episode Statistics)

The harms included in the DHI

Health impacts

Community harms

- Community perceptions of drug use/dealing [e.g. local availability] as a problem (British Crime Survey)
- Drug dealing offences (Recorded Crime Statistics)

Domestic drug-related crime

(All British Crime Survey, calibrated with NEW-ADAM/Arrestee Survey)

- Burglary
- Theft of vehicle
- Theft from vehicle
- Bike theft
- Other theft
- Robbery

The harms included in the DHI Health impacts

Commercial drug-related crime

(Calibrated with NEW-ADAM/Arrestee Survey and Crime Statistics (for trend))

- Shoplifting (Crime & Justice Survey & Arrestee Survey)
- Burglary (Commercial Victimization Survey)
- Theft of vehicle (Commercial Victimization Survey)
- Theft from vehicle (Commercial Victimization Survey)

Professor David Nutt



David Nutt and his studies

The one published in Lancet in 2007:

Development of a rational scale to assess the harm of drugs of potential misuse.

3 factors of harm:

- Physical harm to the individual user
- The tendency of the drug to induce dependence
- The effect of the drug use on families, communities, and society

Another study published in 2010

- David Nutt and his colleagues have studied the *relative* harm of drugs. In one of [Nutt's studies](#) that were published in *the lancet*, members of the British *Independent Scientific Committee on Drugs* was asked to rate 20 drugs on 16 criteria such as drug-specific damage, mortality, dependence and international damage. Drugs were scored on a 100-point scale.

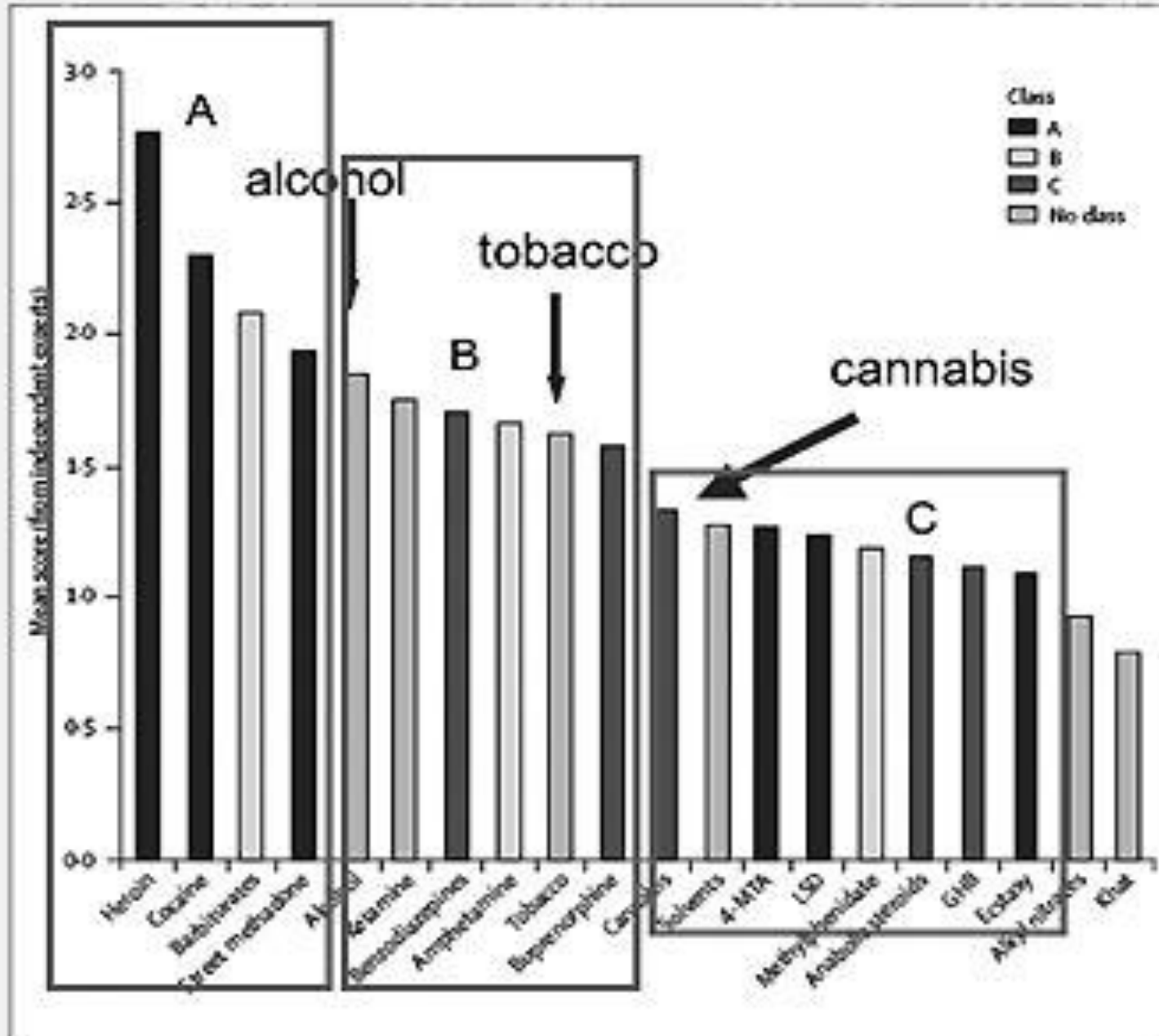


Figure 1: Mean harm scores for 20 substances

The respective classification under the Misuse of Drugs Act, where appropriate, is shown above each bar. Class A drugs are indicated by black bars, B by dark grey, and C by light grey. Unclassified substances are shown as unfilled bars.

David Nutt's Top 20 most harmful drugs

1. Heroin (Class A)
2. Cocaine (Class A)
3. Barbiturates (Class B)
4. Street methadone (Class A)
5. Alcohol (Not controlled)
6. Ketamine (Class C)
7. Benzodiazepine (Class B)
8. Amphetamine (Class B)
9. Tobacco (No class)
10. Buprenorphine (Class C)

David Nutt's Top 20 most harmful drugs

11. Cannabis (Class B)
12. Solvents (Not controlled)
13. 4-MTA (Class A)
14. LSD (Class A)
15. Methylphenidate (Class B)
16. Anabolic steroids (Class C)
17. GHB (Class C)
18. Ecstasy (Class A)
19. Alkyl nitrates (Not controlled)
20. Khat (Not controlled)

毒後駕駛的傷害

樂協支援專線 2127 4252



明愛樂協會



毒駕風險高
你我齊 Say No!

「High 壓上路·自掘墳墓」
「毒駕高危·智者不為」



撞車 昏睡 飄移
被捕 傷人 險大爆炸



編者本報:《高島日報》



1961 Single Convention on Narcotic Drugs

- A major achievement in the history of intern'l efforts to control narcotics
- Today, one of 3 treaties that define the intern'l drug control system.
- The other two are the 1971 Convention on Psychotropic Substances and the 1988 UN Convention vs Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
- As of March 2008, 183 parties, 95% of the 192 UN States Members

1961 Single Convention on Narcotic Drugs

Consists of 51 articles, covering:

- Definitions of the substances under control;
- The framework for the operations of the intern'l drug control bodies;
- reporting obligations of States Members
- Obligations regarding the production, manufacture, trade and consumption of controlled substances
- Actions to be taken against illicit traffic and penal provisions

1961 Single Convention on Narcotic Drugs

- Key Provision found in Article 4:
- The parties shall take such legislative and administrative measures ... to limit exclusively to medical and scientific purposes the production, manufacture, export, import distribution of, trade in, use and possession of drugs.

1961 Single Convention on Narcotic Drugs

3 objectives:

1. Codification of existing multilateral treaty laws into one single document;
2. Streamlining of the intern'l drug control machinery;
3. Extension of the existing controls into new areas.

1971 Convention on Psychotropic Substances

- For the first time a no. of amphetamine type stimulants, Hallucinogens (such as LSD), sedative hypnotics and anxiolytics (benzodiazepines and barbiturates), analgesics and antidepressants are placed under control.
- A significant no. of additional substances were added in subsequent decades
- It was a major step ahead for intern'l drug control

1971 Convention on Psychotropic Substances

- Again, as of March 2008, 183 countries were party.
- The parties agreed that all listed substances only be supplied with a medical prescription, no advertisement to the general public.
- Appropriate cautions and warnings added on labels and leaflets.

1971 Convention on Psychotropic Substances

- Parties must also take, according to Article 20,1 “measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved.

1971 Convention on Psychotropic Substances

- Introduce a system of licensing for manufacture, trade and distribution.
- Maintain a system of inspection of manufacturers, exporters, importers, wholesalers, distributors and medical and scientific institution.

1971 Convention on Psychotropic Substances

Schedule I: MDA, MDMA

Schedule II: amphetamine-type stimulants, including methamphetamine, amphetamine, methylphenidate and fenerylline, Phencyclidine, methaqualone and secobarbital.

Schedule III: barbiturates, flunitrazepam, buprenorphine, pentazocine

Schedule IV: diazepeam, phenobarbital

1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

- A powerful instrument in the international struggle against drug trafficking. As of March 1008, 183 parties.
- Obliges parties to make trafficking activities a “criminal offences.” instead of “punishable offences” in the 1961 Convention.
- Unique in its focus on the prevention of money laundering.

1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

- A major achievement: establishing precursor control at the intern'l level
- Tends to promote the concept of extradition
- Endorsement of “controlled deliveries”
- Addresses the concept of alternative development
- Requires Parties to adopt appropriate measures to eliminate illicit demand for narcotic drugs and psychotropic substances

World Drug Policy Trend

according to the World Drug Report

From Supply control in own country,
to international cooperation in supply control,
to demand control – address to treatment
needs, and then to harm minimization, and
Against money laundering and organized
crime

The Hong Kong Drug Policy

The 5-fold strategies adopted by the government

1. Law Enforcement
 2. Treatment and Rehabilitation
 3. Preventive Education and Publicity
 4. Research
 5. International Cooperation
- ~~(Harm Reduction)~~

香港戒毒康復工作廿年大事 回顧 (1992-2011)

〈十大事件選舉〉

Singapore Anti-drug strategies

Four-folded policy

1. (Tough legislation), Rigorous enforcement
 2. Preventive Drug Education
 3. Treatment and Rehabilitation for addicts
 4. Aftercare & Continued Rehabilitation for ex-addicts
- Classifying drugs into Classes A, B, and C
 - Imposing long-term imprisonment, caning and capital punishment

Switzerland National Drug Policy

Four pillars drug policy:

Prevention, therapy, harm reduction, and prohibition.

- Illegal drug use and sales permitted in Platzspitz park, Zurich 1987-92; park closed when situation grew increasingly out of control
- Introduced heroin-assisted treatment and supervised injection rooms in 1994

- In 2008 a popular initiative by the right wing Swiss People's Party aimed at ending the heroin program was rejected by more than two thirds of the voters. A simultaneous initiative aimed at legalizing marijuana was rejected at the same ballot.

Swiss Drug Policy

RISIKOARMER KONSUM

PROBLEMATISCHER KONSUM

ABHÄNGIGKEIT

ALKOHOL

CANNABIS

DESIGNERDROGEN

HEROIN

KOKAIN

MEDIKAMENTE
mit psychoaktiver Wirkung

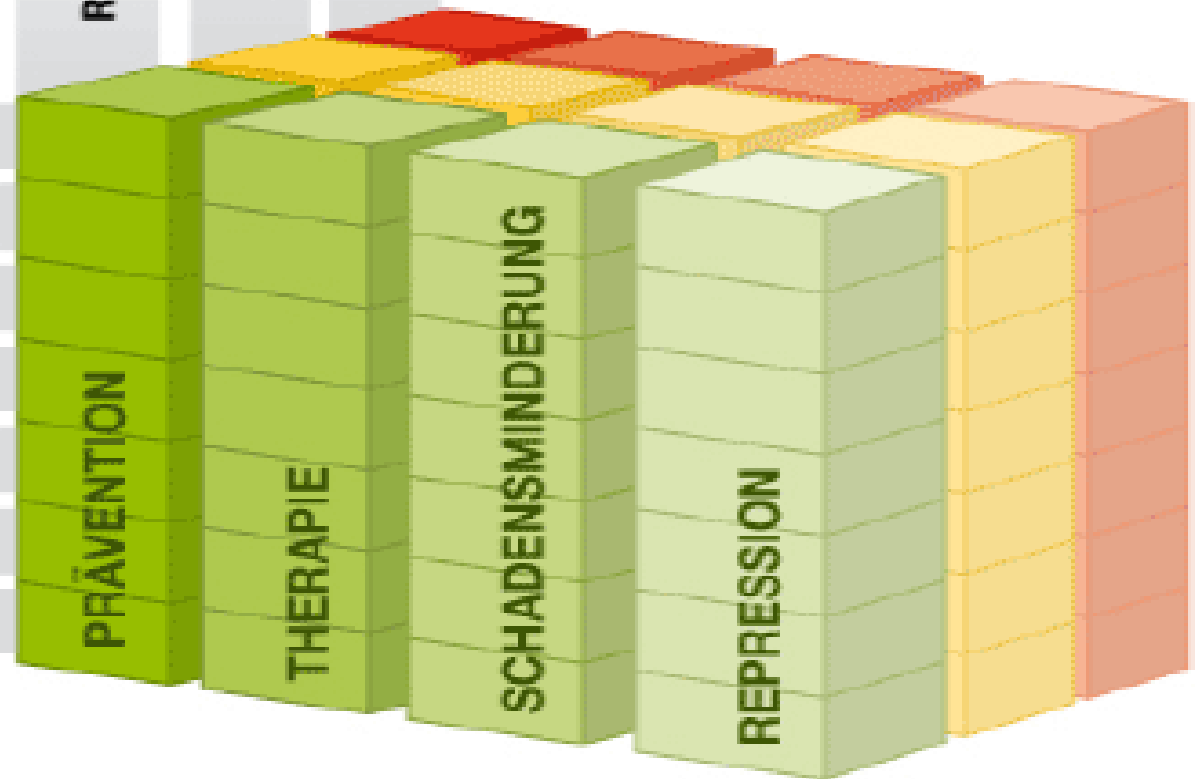
TABAK

PRÄVENTION

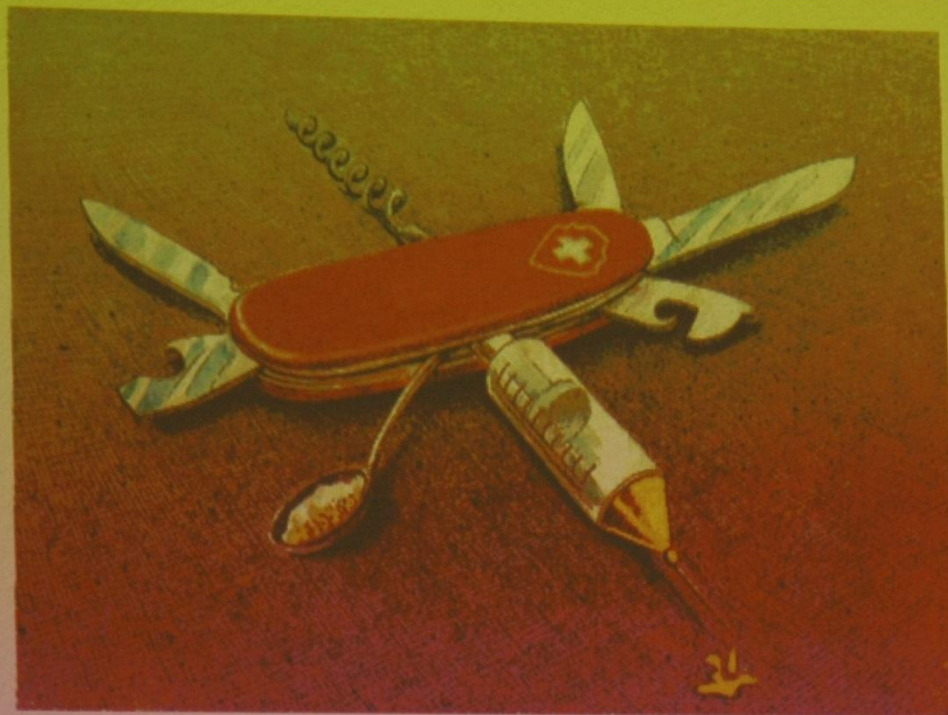
THERAPIE

SCHADENSMINDERUNG

REPRESSION



JOURNEE HEGEBE



Heroin prescription is part of an integrated health delivery system in Switzerland

The Netherlands

Drug policy in the Netherlands is based on the two principles that drug use is a health issue, not a criminal issue, and that there is a distinction between hard and soft drugs. The reported number of deaths linked to the use of drugs in the Netherlands, as a proportion of the entire population, is one of the lowest of the EU. The Netherlands is currently the only country to have implemented a wide scale, but still regulated, decriminalisation of marijuana. It was also one of the first countries to introduce heroin-assisted treatment and safe injection sites.

UK Drug Policy

2011-2012 Used an illegal drug

- Adult 8.9%
- Youngsters 16-24 19.3%

Actions:

- Reduce the number of people misusing illegal drugs
- Increase the number of people who successfully recover from drug dependence
- Reduce harmful drinking
- Preventing young people from becoming drug misusers

Drug Policy implications

There is little evidence from the UK, or any other country, that drug policy influences either the number of drug users or the share of users who are dependent. There are numerous other cultural and social factors that appear to be more important. It is notable that two European countries that are often used as contrasting examples of tough or liberal drug policies, Sweden and the Netherlands, both have lower rates of overall and problematic drug use than the UK.

An Analysis of UK Drug Policy

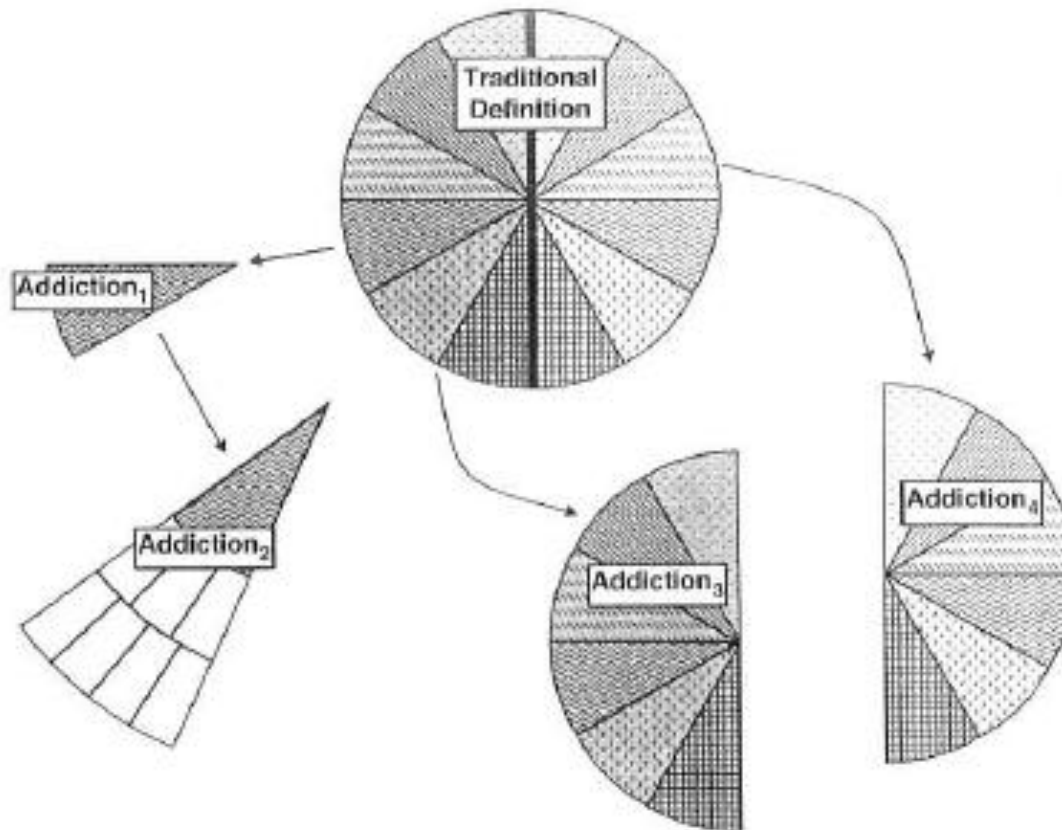
A Monograph Prepared for the UK Drug Policy Commission

Peter Reuter, University of Maryland
Alex Stevens, University of Kent

April 2007

Some more concepts

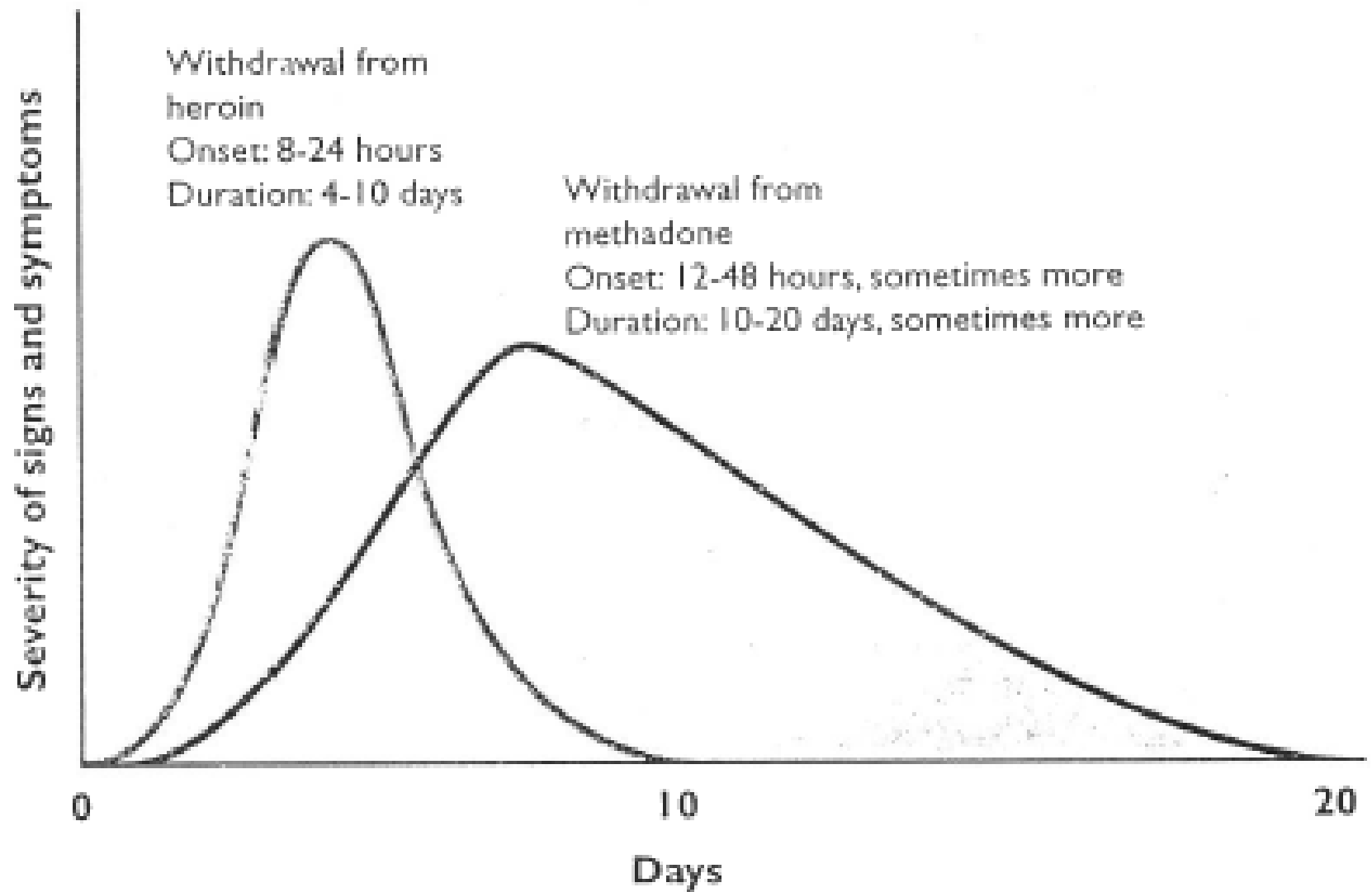
- Addiction
- Opioid withdrawal
- Lapse and Relapse
- Relapse Rates



- Addiction₁*: Overwhelming involvement with drugs or alcohol that is harmful to the addicted person, to society, or to both.
- Addiction₂*: Encompasses addiction₁ and non-overwhelming involvements with drugs or alcohol that are problematic to the addicted person, society, or both.
- Addiction₃*: Overwhelming involvement with any pursuit whatsoever (including, but not limited to, drugs or alcohol) that is harmful to the addicted person, to society, or to both.
- Addiction₄*: Overwhelming involvement with any pursuit whatsoever that is not harmful to the addicted person or to society.

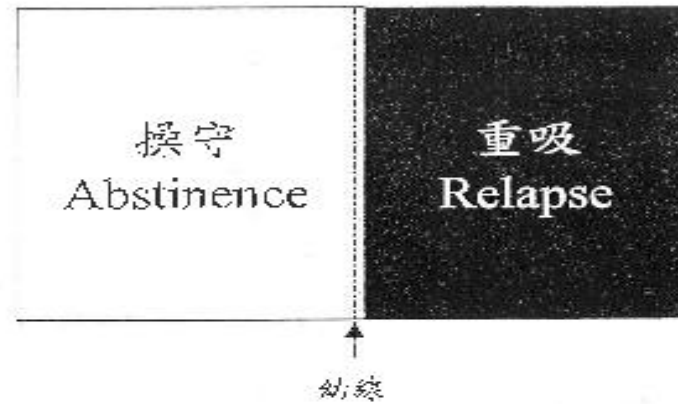
Figure 2.1 Four contemporary ways of using the word 'addiction' derived from the traditional definition.

Progress of the acute phase of opioid withdrawal

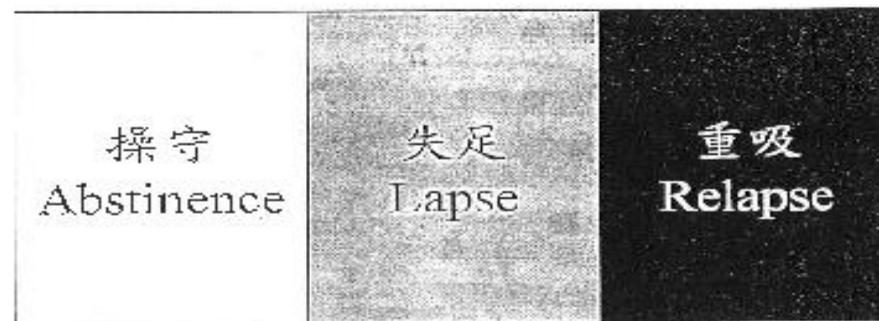


對重吸的兩種看法

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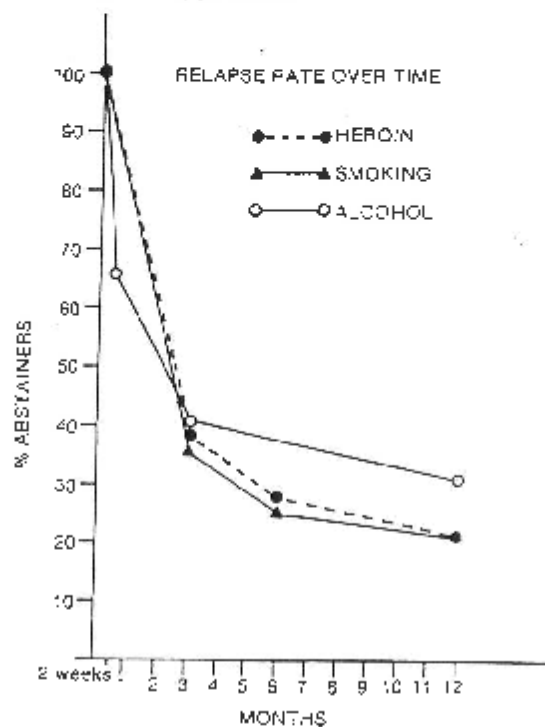
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THE RELAPSE PROCESS: A COMMON DENOMINATOR IN ADDICTIVE BEHAVIORS?

Recidivism rates are notoriously high across the spectrum of addictive behaviors. In addition to high relapse rates, the temporal patterning of the relapse process also shows considerable consistency for a variety of addiction problems. This consistency is strikingly apparent from an examination of the relapse curves depicted in Figures 1-3. This graph, first published in the early 1970s (Hunt, Barnett, & Branch, 1971), shows the temporal pattern

Figure 1-3. Relapse curves for individuals treated for heroin, smoking, and alcohol addiction. From "Relapse Rates in Addiction Programs" by W. A. Hunt, L. W. Barnett, and L. G. Branch. *Journal of Clinical Psychology*, 1971, 27, 355. Copyright 1971 by the Clinical Psychology Publishing Co., Inc. Reprinted by permission.



Wars on Drugs: different views

- UNODC affirming wars on drugs
- Critics say Wars on drugs are not working
- Many advocate: Support, not punish;
Legalization
- Many argue that drug abuse is a public health issue