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Group of Experts on Demand Reduction

FIFTH MEETING OF THE
GROUP OF EXPERTS IN DEMAND REDUCTION
October 22-24, 2003
Buenos Aires, Argentina

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FINAL REPORT
OF THE
GROUP OF EXPERTS IN DEMAND REDUCTION
AND
PLAN OF ACTION 2004-2005

FINAL REPORT

1. BACKGROUND

The establishment of a Group of Experts on Demand Reduction was approved at the twentieth regular session of CICAD. During its twenty-first regular session, the Commission convened the first meeting of the CICAD Group of Experts, to be held in conjunction with the Argentine Secretariat of Programming for the Prevention of Drug Addiction and to Combat Drug Trafficking (SEDRONAR) and under the chairmanship of Argentina, in Buenos Aires, Argentina, on July 29 - August 1,1997.

The twenty-first regular session of CICAD established the following mandate for the Group of Experts on Demand Reduction:

> "The purpose of the Group of Experts on Demand Reduction would be to provide technical expertise, facilitate cooperation among countries, and submit recommendations to the Commission on implementing the lines of action that derive from the ***Anti-drug Strategy in the Hemisphere.***
>
> The Group will be made up of national experts in different aspects of demand reduction, and hence the experts may vary with the subject considered.
>
> The priority subjects of demand reduction are:
> a) Performance of a diagnosis of drug use, epidemiological studies, systems of information (such as SIDUC) and of surveillance and monitoring, and bio-medical, clinical, psychosocial, epidemiological, ethnographic and anthropological research.
> b) Prevention and education models and programs involving community participation, designed both for the population at large and for specific groups at special risk of becoming users.
> c) Models and programs of intervention to address the adverse health and social consequences of drug abuse.
> d) Measures for the treatment and rehabilitation of persons addicted and their reintegration-into the community."

The second meeting of the Group of Experts was held in Mexico on March 3-6, 1998. One of the experts' most important recommendations was the need to establish minimum standards of care in drug treatment centers, in order to improve the quality of care and respect for the human rights of addicts receiving treatment.

The third meeting of the Group of Experts was held in Santiago, Chile on October 3-5, 2000, under the chairmanship of Chile. The main area of priority identified by the Group of Experts was the need to expand programs to address the rising use and abuse of synthetic drugs.

The fourth meeting of the Group of Experts was held in Montego Bay, Jamaica, on August 8-10, 2001, under the chairmanship of Jamaica. The main area of priority identified by the Group of Experts was effective treatment for substance abusers.

II. PROCEEDINGS

A. PARTICIPANTS

Delegates from Argentina, Barbados, Belize, Brazil, Canada, Chile, Costa Rica, Commonwealth of Dominica, El Salvador, Haiti, Jamaica, Mexico, Panama, Paraguay, Peru, the United States, Uruguay, and Venezuela took part in the Fifth Meeting of the Group of Experts on Demand Reduction. In addition, observers were present from the Cayman Islands, Japan, the European Commission (EC), the United Nations Office on Drugs and Crime (UNODC), the World Health Organization (WHO), and the Ibero-American Network of NGOs working in Drug Addiction (RIOD). (See List of Participants, Annex I)

B. SESSIONS AND ORGANIZATION OF THE MEETING

The inaugural session took place at 9:30 a.m. on October 22, 2003 at the National Library in Buenos Aires, Argentina. Dr. Wilbur Grimson, Secretary of Programming and Coordination for Drug Abuse Prevention and the Combat of Narcotics Trafficking (SEDRONAR) of Argentina, inaugurated the meeting, in the presence of the following dignitaries*:* Dr. Juan Carlos Romero, Attorney General; Dr. Mariano Ciafardini, Sub-Secretary for Criminal Policy, representing the Minister of Justice, Security, and Human Rights; Dr. Juan Manuel Sotelo, of the Pan-American Health Organization (PAHO/WHO); Ambassador Domingo Cullen, Director of International Organizations, representing Vice-Chancellor Dr. Jorge Taiana; Dr. Pedro David, Judge, National Court of Penal Cassation; Dr. Atilio Alvarez, Juvenile Public Defender for the National Capital; Dr. Gabriela Hamilton, Executive Coordinator of the National Program to Combat HIV/AIDS and STDs, representing the Minister of Health; Carlos Mauro, Advisor to the Secretary of National Security; Dr. Alicia Lopez, President of the Financial Intelligence Unit; Major Commissioner Daniel Carusso, Second in Command of the Argentinean National Police; Advisor Daniel Berazay, International Narcotics Affairs of the Chancellery; Major Commissioner Juan Carlos Bottallo, Superintendent for the Department on Dangerous Drugs, Argentinean National Police; Major Commander Héctor Schenone, Department on Dangerous Drugs, National Gendarmerie; Head Prefect Albino Gatti, Department on Dangerous Drugs for the Argentinean Naval Prefecture; Vice-Commodore Roberto Gentile, representing the Director of the National Aeronautical Police; Dr. Daniel Pazos, Customs; Dr. Néstor Marchant, Director of the Braulio Moyano Hospital and President of the Argentinean Association of Psychiatrists; Juana Ricci, President of the Argentinean Federation of Drug Abuse Treatment and Prevention NGOs (FONGA); Colonel of Division Christian Barbot, Police Attaché of the Embassy of France; and Dr. Peter Tinsley, Chief Secretary for Criminal Affairs of the Embassy of the United States of America.

Maria Eugenia Perez, Demand Reduction Representative from the Inter-American Drug Abuse Control Commission (CICAD/OAS), welcomed all those present on behalf of the Secretariat, and proceeded to give an overview of topics on the agenda for the meeting, and looked forward to successful completion of the work entrusted to the Group of Experts, which is charged with discussing the issues at hand in order to generate a set of recommendations for CICAD and its member states that will then serve as a framework for plans and policies for most effectively reducing drug demand. Dr. Grimson offered reflections on the drug problem and a consideration of causes and consequences, emphasizing aspects of the situation in Argentina and the deterioration of drug use problems in that country in recent years.

1. WORKING SESSIONS

Dr. Wilbur Grimson, in his capacity as Chair of the Group of Experts, opened the session with an invitation to all delegates to introduce themselves and their work. Ms. Perez then followed with a *Report from the CICAD Executive Secretariat on Activities since the Fourth Meeting of the Experts in Jamaica* (CICAD/DREX/doc.15/03), providing an update on CICAD achievements in demand reduction during the past year, as well as stating the aims of this fifth meeting of the CICAD Group of Experts. The Schedule of Activities was adopted without modification (CICAD/DREX/doc.02/03, Annex II).

Dr. Luis Alfonzo presented to the group a document elaborated by a small group of treatment specialists, ***A Practical guide to the organization of a comprehensive drug treatment system: a***

proposal (CICAD/DREX/doc.03/03), after which discussion between participants centered around the following topics:

- The document was very well received by the delegates, who commented that it serves to fill a critical gap in terms of organizing the provision of treatment services, and clearly indicates both the technical and political steps that need to be taken;
- The need to identify the demand for treatment, by type of drug most commonly used as well as the appropriate form of treatment required, in order to determine what treatment services need to be developed in each country;
- The importance of providing gender-appropriate treatment services;
- The goals of substance abuse treatment are:
    - to stop drug use
    - to prolong abstinence
    - to restore the individual's ability to function
    - to assist the individual's social reintegration into family, studies, work, etc.;
- The enactment of supporting legislation for a National Treatment System, which should assign responsibility to each institution involved in treatment;
- The accreditation of service providers through systematic training;
- Before a country moves to implement a National Treatment System, it is necessary to consider:
    - What is the severity of the problem nationally that merits financing a Treatment System?
    - How much will it cost to implement such a system?
    - How many substance users do we have, and is this number substantial?
    - What are the political and social advantages of implementing or not implementing such a system?
- It is necessary that the health care system **recognize addiction as a disease**, that is, as a medical condition that merits treatment, especially in cases of severe intoxication or when it is detected in emergency rooms, so that the system can ensure proper diagnosis and appropriate referral.

In the afternoon, all delegates and participants were received in the **Casa Rosada** (the Presidential Palace) in a meeting granted by the Office of the President of Argentina at the request of Dr. Grimson. The group met with the **Minister of the Interior, Dr. Alberto Fernandez**, and the **Secretary General of the Presidency, Dr. Oscar Isidro José Parrilli**. Participants introduced themselves, and Dr. Grimson and Ms. Pérez provided a brief explanation of the objectives of this Group of Experts meeting. The two Ministers responded by confirming the necessity of supporting governmental measures to address drug use and demand reduction, as well as the objectives of this Fifth Meeting of the Group of Experts.

During the second, third and fourth sessions, a series of presentations was delivered on current practices in drug abuse treatment and prevention. The second session began with **Linda Montanari of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)**, describing the ***Treatment* Demand *Indicator: the work of the EMCDDA*** (CICAD/DREX/doc.14/03). She presented:

- The difficulty of collecting treatment data in Latin America, since the health care system is often not the entity keeping track of such information;
- The European Monitoring Centre takes fingerprints to prevent against counting the same patient twice;
- A case is considered "new" when the drug user is accessing services for the first time, or if he or she has not sought services within the past year;
- The EMCDDA does not measure the "demand for treatment" per se; rather it creates a client profile, the drug of choice, the age of first-use, and whether they are male or female, and also does an inventory of existing treatment centers in order to determine treatment needs, or the demand for treatment services in a specific country;

- The WHO representative commented that the judicial system is generating an artificial demand, because when it detains an offender who is using, they send him or her to treatment regardless of whether this person has a medically diagnosed dependency;
- Measuring the demand for treatment is a complicated task. For example, populations at high risk for substance use, such street children or adults who are homeless or living in the streets, are not reflected in the numbers of substance users counted through household or other surveys, precisely because they are on the street.

This was followed by the "Panel on substance abuse prevention: promising methodologies." First at hand was the topic of school-based prevention, with a presentation from **Dr. Giselle Amador, Technical Area Coordinator for the Costa Rican Institute on Alcoholism and the Addictions (IAFA)**. She described IAFA's school-based prevention program ***Learning to Value Myself*** (CICAD/DREX/doc.13/03), and presented results of the evaluations of school-based prevention programs during the 1999-2000 and 2001-2002. The findings indicated the following:

- The evaluation process should be continued in order to truly be able to understand the program's preventive impact on students;
- It is necessary to have a control group in order to carry out the evaluation process;
- Students who abstain from use tend to demonstrate more advanced life skills, while active users tend to score lower in these skill areas;
- Male and female students acquire skills differently, indicating that preventive programs should take into consideration gender-appropriate approaches;
- It is necessary to establish both qualitative and quantitative evaluations in order to better measure the impact of school-based preventive programs.

This was followed by a three-part presentation on the CICAD project to include **substance abuse prevention in 14 nursing schools in Latin America** (CICAD/DREX/doc.09/03). Dr. Gloria Wright of CICAD opened by outlining *Challenges and Perspectives* within the overall project. Then **Dr. Margarita Abdala de Tomas**, Vice-Director of the Nursing School at the National University of Cordoba, and **Dr. Teresa Micozzi**, Director of the University of Rosario Medical School Nursing School, each described their experiences in integrating substance abuse content within their own schools, as well as the results of outreach activities and research studies. During these presentations, participants received copies of the five books published about the project, as well as the final technical report from the University of Cordoba Nursing School, whose program is no longer financed by CICAD, but continues to receive technical support.

Dr. Guillermo Castaño, Coordinator of the Online Masters in Drug Addiction Studies for the Luis Amigo University Foundation (FUNLAM) in Medellin, Colombia, delivered a presentation on the ***Practical aspects of implementing policies and programs for the prevention of the use of alcohol and other psychoactive substances in the workplace*** (CICAD/DREX/doc.12/03).

- He emphasized the need to sensitize the business community as well as the labor unions as to why they should step in and offer substance abuse prevention programs for their workers. What are the benefits for the company?
- The importance of carrying out more research to measure or characterize substance use problems in the workplace;
- Work particularly with the most vulnerable corporations where public safety is at stake, (airlines, ground transport, railroad, assembly-line factories such as *maquiladores*, and others);
- Acknowledgement of the work that has been done by the International Labour Organization (ILO) in the field of workplace prevention.

The final panelist for this session, **Mike Buscemi, Senior Youth Advisor for the Lions Club International Foundation**, introduced ***Skills for Adolescence: a substance abuse prevention***

program (CICAD/DREX/doc.10/03), which Lions has developed and implemented in countries around the world.

He described the Lions Club International Foundation and what it is doing in the area of substance abuse prevention for adolescents. The program's emphasis lies in five components:

- Introducing drug-related information into the curriculum;
- Training teachers;
- Involving parents in the prevention process;
- Bringing in the community as an active player in prevention.

The presentation was very well received by the group, who accepted Mr. Buscemi's offer to form a strategic alliance between the Lions Club International Foundation and CICAD in order to develop school- and community-based prevention programs, especially with youth in targeted communities.

The third session opened with a demonstration by **Mr. Alfonso Abarca, of the Salvadoran Anti-drug Foundation (FUNDASALVA)**, of the Foundation's ***Software to monitor the progression of patients through drug treatment programs***.

- Many participants commented on the utility of a program such as this, and asked about the possibility of sharing this software with other countries in the region;
- The experts emphasized the importance of having intake and registration forms which are compatible between institutions, for example, the SIDUC survey with FUNDASALVA's computerized patient tracking program. This will require that suitable computer programs be developed that permit simplified and compatible data collection during the patient intake process.

Following this, **Ornel Brooks, Executive Director of the Belize National Drug Abuse Control Council (NDACC)**, gave an overview of ***Alternatives to custodial sentencing: the experience in Belize*** (CICAD/DREX/doc.11/03), after which the Group agreed upon the importance of considering alternative sentencing, such as community service and parole, when combined with treatment in cases of addiction, as an alternative to incarceration for minor drug-related infractions. Such methods could also serve to relieve prison overcrowding in the region, where many prisons are full of drug users.

Dr. David Deitch, Head of the Addiction Treatment Center of the University of California at San Diego, made a presentation on ***In-custody Treatment: Rationale, Outcomes, and Directions*** (CICAD/DREX/doc.04/03). Participants reacted very favorably to the presentation and to the methodology used, and recognized the importance of being able to provide treatment or other rehabilitative assistance to drug-dependent inmates. The meeting recommended the creation of Treatment Centers or Therapeutic Communities within the prison but apart from the general inmate population, thus enabling individual treatment for these drug-dependent individuals.

To close the session, **Dr. Juana Tomas-Rosello, Treatment Advisor to the United Nations Office on Drugs and Crime (UNODC)**, introduced participants to recently released UNODC documents dealing with the need for policies to finance drug abuse treatment, as well as treatment planning in ***Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide***.

- Dr. Tomas-Rosello commented that the American hemisphere is the only one with a group of experts for Demand Reduction that is discussing issues at this level of detail. She offered CICAD and the Group of Experts use of the three UNODC documents listed below, with hopes that they could complement CICAD's own treatment document:
    - Drug Abuse Treatment and Rehabilitation: A Practical Planning and Implementation Guide
    - Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers
    - Contemporary Drug Abuse Treatment: A Review of the Evidence Base
- She also let the group know that UNODC is ready and willing to work collaboratively with CICAD and this Group of Experts.

The final presentation was given by **Dr. Héctor Shalom, National Coordinator of the Youth Action Centers in Argentina**, a project of the Ministry of Education, Science, and Technology. He spoke on the ***Creation of National Community Prevention Programs*** (CICAD/DREX/doc.16/03), describing this community-based prevention model and how it functions:

- The program takes in-school adolescents and uses them as agents to organize life skills development activities. The program is run by the young people themselves, and is open to other youth from the community, thus incorporating out-of-school children.
- Evaluations of the more than two hundred youth centers have shown that the program has:
  - Reduced the school drop-out rate by 12%
  - Incorporated youth that had been expelled from the school system, allowing them to enter school again
  - Lowered the suicide rate among adolescents.

At the end of each of these presentations, there was a period of open discussion, during which the experts could offer their conclusions and recommendations, which were then elaborated on the conference screens in both English and Spanish, thus compiling the set of recommendations which are presented below (see Section III).

The closing session was held at 3:30 p.m. on Friday, October 24, 2003. Maria Eugenia Perez addressed the delegates on behalf of the Executive Secretariat of CICAD, congratulating them on their productive efforts. Dr. Grimson, in his capacity as Chair of the Group of Experts, made a few words recognizing the commitment displayed by each of the participants, and after highlighting the excellent technical execution of the meeting, marked its official conclusion.

III. RECOMMENDATIONS OF THE GROUP OF EXPERTS ON DEMAND REDUCTION

The Fifth Meeting of the Group of Experts on Demand Reduction agreed to submit the following recommendations to the Commission and to the member states for consideration and possible adoption:

General recommendations:

Proposes

1. To recognize and understand the complexity of problems arising from drug use, which requires an approach rooted in a broad participation and commitment on the part of many sectors, both governmental and non-governmental, trade unions, industry, civil society and multilateral cooperation agencies, so that, in coordination, they are able to plan and execute effective and timely measures to overcome the difficulties identified.[1]

2. To establish a balance between national policies on Supply Control and Demand Reduction, thus enabling member states to invest the necessary resources and efforts towards reducing the significant economic and social costs resulting from problems relating to drug use.[2]

I. ORGANIZATION OF A NATIONAL SUBSTANCE ABUSE TREATMENT SYSTEM[3]

Recommendations to the member states

1. **To establish a National Treatment System** for drug use disorders and to identify the **national agency** that will be responsible for coordinating the system.[4]

[1] Relating to MEM Indicators 1, 2, 3 and 4.
[2] Relating to MEM Indicator 1.
[3] Relating to MEM Indicators 13, 14, and 15).

2. **To ensure that national drug treatment programs and centers are integrated into a continuum of care**, with adequate patient matching and referrals, and to make specific plans to fill gaps detected in treatment services and modalities.

3. To use as reference the **Practical Guides** for the organization of a comprehensive national drug treatment system developed by **CICAD** and by the **United Nations Office on Drugs and Crime (UNODC)**.

4. **To allocate the necessary resources for implementation of a National Treatment Plan**, so that existing treatment services will meet **standards for quality, efficiency, cost-benefit and evidence-based impact evaluations**.[5]

5. The **National Treatment System** developed by the member states should take into account the following **key aspects**:

   a. A **commitment on the part of the health sector** to a comprehensive approach to problems arising out of drug use, integrated within the current health system, and including the active participation of the primary care system and the overall health network.[6]

   b. To include, as a priority, **timely care for vulnerable population groups**, especially those in particularly difficult circumstances, such as **children and teenagers, women, indigenous populations, workers, people living with HIV/AIDS, prison populations and intravenous drug users, among others**.[7]

   c. To create the conditions in which all individuals requiring treatment services can have **access to treatment**.[8]

   d. To develop a **national registry and accreditation system for treatment programs**, based on continuous evaluation and on maintaining minimum operational standards, providing the national observatories on drugs with the information compiled.[9]

6. If they have not yet done so, member states will establish **"Minimum Standards of Care in Drug Treatment."**

7. To strengthen mechanisms for gathering up-to-date data on the **national capacity to provide treatment services**, including information on the number of existing institutions, service accessibility, type of interventions available, as well as the characteristics of the population seeking said services, such as socio-demographic traits and drug use profiles.[10]

8. To include, within the **social security system, HMOs (health insurance)** and related systems, **coverage for problems arising from drug use, avoiding any exclusion or discrimination which may adversely affect people's inalienable right to healthcare**.[11]

Recommendations to CICAD, the United Nations Office on Drugs and Crime, PAHO and other international donor agencies

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[4] MEM Indicators 1 and 3.
[5] MEM Indicators 1, 2, 12 and 15.
[6] MEM Indicators 1 and 3.
[7] MEM Indicators 8 and 14.
[8] MEM Indicators 12 and 14.
[9] MEM Indicators 12 and 13.
[10] MEM Indicators 12, 13, 14, 16, 17, 18, 19, 20, 21 and 22.
[11] MEM Indicators 1 and 2.

1. Provide technical and financial assistance for the development of comprehensive national drug treatment systems to those countries who so request.

II. COMPUTERIZED SYSTEMS FOR PATIENT TRACKING[12]

Recommendation to member states

That they continue to pursue and enhance data collection on the admission and treatment of patients in both public and private institutions and NGOs within their respective countries.

Recommendation to CICAD's Executive Secretariat

That it provide support to encourage mutually compatible registration methods, for example, the Inter-American Drug Use Data System (SIDUC) with patient tracking software presented by FUNDASALVA. This will require the development of appropriate information systems that can serve to simplify and harmonize patient registration.

III. DRUG ABUSE PREVENTION FOR SPECIFIC POPULATIONS[13]

A. SCHOOL-BASED

Recommendations to member states

1. That they adopt the first recommendation of the 2002 MEM hemispheric report and seek to introduce **comprehensive health promotion, healthy lifestyles, and substance abuse prevention programs into the educational setting**, utilizing age-appropriate materials and training for teachers, school counselors, and other agents of prevention.

2. That they adopt, among other programs of proven effectiveness, a **life skills** strategy as an effective, proven approach for school-based substance abuse prevention.

B. WORKPLACE

Recommendations to member states

1. That research be conducted in order to measure or characterize the extent of drug use in the workplace.

2. To foment **collaboration between Ministries of Labor and trade unions** to create employee assistance programs to prevent drug use in the workplace.

3. To **reach out to private companies and business leaders in vulnerable sectors where public safety is at stake** (for example, transportation, automobile manufacturing plants and other line-production industries such as textile factories and *maquiladoras*) so they are alerted to the need to **invest resources in prevention programs**.

Recommendation to CICAD's Executive Secretariat

1. The **Inter-American Observatory on Drugs** should develop, within the SIDUC system,

[12] MEM Indicators 13, 14, 15, 18, 20 and 27.
[13] MEM Indicator 8.

methodologies to gather **information on drug use in the workplace**.

2. That it promote **cooperation with the International Labour Organization** (ILO) in order to disseminate prevention strategies developed by the ILO for drug use in the workplace.

C. PENAL DETENTION CENTERS[14]

Recommendations to member states

1. In order to reduce the large number of **drug users in prison**, to develop, in the case of minor offenses, mechanisms offering **alternatives to custodial sentencing, such as community service work and probation, offered in conjunction with treatment or counseling in cases of addiction**.

2. For drug users in prison, implement treatment programs, such as **therapeutic communities, inside the prisons**, keeping addicts apart from other inmates so that they can receive treatment tailored to their particular needs.

D. YOUTH-BASED COMMUNITY AND SCHOOL PREVENTION

Recommendations to member states

1. To promote **youth participation** through the organization of activities and the creation of centers seeking to give youth an active and leading role in making their own interests and preferred ways of working known. The value of these projects should be emphasized in furthering outreach to **marginalized populations which -- often left out of the formal education system – might thus be reintegrated**.

2. It should be noted that the sustainability of these projects requires both they they be carried out and that they be evaluated both qualitatively as well as quantitatively, that there be follow-up with the specific populations, and that information about the projects be disseminated through published materials.

IV. TRAINING OF HUMAN RESOURCES[15]

Recommendations to member states

1. To **incorporate the training of specialized professionals within existing human resource development programs for the health and social development sectors**, using strategies and resources already allocated for such purposes, as well as developing new alternatives.

2. Appreciating the impact of the **International Online M.A. in Addictions Studies** in preparing specialized professionals in this field, to promote the program nationally, and to seek fellowships and educational loans for students (EDUCREDITS).

3. To seek to include representatives of the nursing profession in their respective national drug commissions or councils.

4. Consider that the nursing school model can be advantageously applied to **include content about substance abuse in similar training in other disciplinary areas**.

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[14] MEM Indicator 22.
[15] MEM Indicator 9.

5. To establish a system for the **accreditation of drug treatment counselors** and other treatment workers at centers offering programs at a variety of levels.

Recommendation to CICAD's Executive Secretariat

1. To develop, with the assistance of nursing schools currently participating in the project, a core or "model" curriculum for health promotion and substance abuse that additional nursing schools may adopt.
2. To utilize online distance education methodology, thus incorporating new technologies to Demand Reduction projects with the goals of broadening coverage, making access to substance abuse prevention and treatment knowledge more democratic, and giving CICAD training activities a greater impact.

FINAL CONSIDERATIONS

1. It is recommended to the thirty-fourth regular session of CICAD that the **Chairmanship of the Expert Group on Demand Reduction be extended from one to two years**, given the complexity of the topics being dealt with.
2. It is recommended that the Expert Group on Demand Reduction continue to be associated as a group, that it assist in the implementation of these recommendations, and that it **meet again in October 2004**.
3. The Expert Group requests that the **CICAD Executive Secretariat prepare an action plan**, based on the recommendations of this group, to arrange tasks and allocate responsibilities and necessary resources for their implementation, and finally to submit said plan to the Commission at its thirty-fourth regular session.

ACTION PLAN 2004-2005

I. ORGANIZATION OF A NATIONAL SUBSTANCE ABUSE TREATMENT SYSTEM[1]

1. **MINISTERIAL-LEVEL MEETING**
The CICAD Executive Secretariat, UNODC and PAHO will organize, in 2004, a **high-level meeting with the participation of the Ministries of Health, the National Drug Commissions, congressional and parliamentary representatives, and non-governmental treatment providers** to promote and increase awareness as to the necessity of organizing comprehensive substance abuse treatment systems.

2. **FINANCIAL AND TECHNICAL ASSISTANCE**
The CICAD Executive Secretariat, UNODC, and PAHO will provide **technical and financial assistance** to those countries who so request it in order to establish **Minimum Standards of Care in Substance Abuse Treatment**. Countries who have already established Minimum Standards of Care will cooperate in this effort, sending their own experts to assist other countries. To these ends, the CICAD Executive Secretariat will establish a fund to facilitate such horizontal cooperation.

II. INFORMATION EXCHANGE

1. Recognizing that in demand reduction, it is essential that there be broad exchange of information on effective and evaluated experiences, research about the bio-psychosocial roots of addiction, and so on, the CICAD Executive Secretariat, in collaboration with UNODC and PAHO, will establish an online community so that the members of the Group of Experts and other interested colleagues can share information and materials and remain in contact with each other.

III. COMPUTERIZED REGISTRATION SYSTEMS FOR PATIENT TRACKING

1. The Executive Secretariat, in the first quarter of 2004, will facilitate the adaptation of FUNDASALVA's patient tracking software, so that patient intake forms include the information asked for in the SIDUC surveys, as well as that required by the MEM, in order that it may be useful to member countries for the registration and tracking of substance abuse treatment patients. Once these changes have been made, the Secretariat will be able to offer the software to interested countries, along with the financial and technical assistance needed to secure implementation.

IV. PREVENTION TAILORED TO SPECIFIC POPULATION GROUPS[2]

A. SCHOOL-BASED PREVENTION

1. **Guidelines for a Regional Plan for School-based Prevention:** Experts from the Demand Reduction Expert Group will be responsible for developing, during the half of 2004, a Regional Plan for School-Based Prevention, utilizing a combination of strategies of proven effectiveness: health promotion, healthy lifestyles, developing life skills, and substance abuse prevention.

2. These guidelines will be oriented towards identifying content that should be included in a school-based program, outlining how to train teachers, defining which primary school ages should be covered, how to evaluate the program's impact, how to cooperate with the Ministry of Education,

[1] MEM Indicators 13, 14 and 15.
[2] MEM Indicator 8.

etc. The ultimate objective of school-based prevention should fundamentally be to expand coverage nationwide.

3. A working group, composed of members of the Group of Experts in Demand Reduction, will develop these guidelines at a meeting to be held in the first half of 2004.
4. CICAD's Executive Secretariat, PAHO, and UNODC will seek to provide technical and financial assistance to member states to implement these guidelines, in addition to promoting horizontal cooperation among countries that have made greater advances in the realm of school-based prevention.

B. YOUTH-BASED COMMUNITY AND SCHOOL PREVENTION

1. The CICAD Executive Secretariat will request that the Government of Argentina circulate the document and share its experience with the Creation of Youth Action Centers, which propel the integration of marginalized youth through prevention activities -- run out of the schools -- as a base for targeting youth in the community, thus providing a way to re-direct dropouts back into the education system. This exchange of experiences will pave the way for implementation of pilot versions of the Youth Action Center program in at least one or two member states that so request.

V. PENAL DETENTION CENTERS AND ALTERNATIVES TO CUSTODIAL SENTENCING

1. Noting that **Guatemala, Peru, and St. Vincent and the Grenadines** are carrying out projects to provide drug treatment in prisons under the MEM assistance scheme, the CICAD Executive Secretariat will promote horizontal cooperation and interchange. It will also do follow-up and evaluation during the implementation period, in order to be able to expand this experience to other interested member states. **The Executive Secretariat will finance these horizontal cooperation activities during 2004 and 2005.**

2. For prison treatment projects, the offer made by the University of California to share its Therapeutic Community model for prison intervention is gratefully accepted.

3. Regarding **alternatives to custodial sentencing,** Belize will circulate documentation of its experiences to expert group members, and a **Caribbean meeting will be held in the first semester of 2004 with the support of the CICAD Executive Secretariat**. Based on results of the meeting, CARICOM will be asked to present the topic to the most appropriate body for action and implementation in Caribbean states.

VI. SPECIALIZED HUMAN RESOURCES TRAINING IN THE ADDICTIONS[3]

1. Creation of an International EDUCREDIT Fund, designed to enable human resources to receive specialized training through scholarships or long-term low-interest loans. Initially these will be directed towards students in the International Online M.A. in Addictions Studies, and will later be broadened to include other training programs run by CICAD.

2. The Executive Secretariat, in conjunction with other donor agencies, commits to contribute resources into the fund during its first three years of existence, after which time the Fund will become self-financing, generating its own resources.

A. INTERNATIONAL ONLINE M.A. DEGREE IN ADDICTIONS STUDIES

[3] MEM Indicator 9.

1. The graduation ceremony for the first class of the Online M.A. will take place September 24, 2004, at the OAS Headquarters in Washington, in the Hall of the Americas, in the presence of the eight Rectors, coordinators, and those students, professors, and tutors who are able to attend.

2. In March 2004, the Rectors of the eight universities that make up the University Network UNIREDDROGAS will meet to evaluate the progress of the Online M.A. in its second year of execution, to approve the academic and administrative regulations, and to work on the agreement between the universities for future promotion and operation of the program.

3. To request the National Drug Commissions of the member countries to consider serving as Internship Sites for the On-Line M.A. students who are interested in drug policy formulation and planning.

4. The representative from the Ibero-American Network of NGOs working in Drug Addiction (RIOD) confirmed the commitment made at the recent RIOD meeting in Guatemala regarding the incorporation of pertinent RIOD institutions as Internship Sites for students of the Online M.A. This brings with it strengthened ties between governmental and non-governmental organizations performing substance abuse work in the region.

B. SCHOOLS OF NURSING

1. The Executive Secretariat as well as the members of the Group of Experts commit to promoting and circulating the nursing school model so that other disciplines linked to drug use issues are inspired to **include drug-related content in their own courses of study**.

2. The Executive Secretariat, in coooperation with the nursing schools currently participating in the project, will develop a core or "model" curriculum about health promotion and substance abuse prevention, so that other nursing schools can adopt it.

3. In the second half of 2004, the Executive Secretariat, in conjunction with the National Distance Education University of Spain (UNED) and the University of Sao Paulo-Riberao Preto, will begin the process of putting the Drug Research Methodology Course onto the internet, so that it will be available as an online training tool for nursing students and other health professionals.

C. INTERNATIONAL ONLINE M.A. DEGREE IN PEACE STUDIES AND CONFLICT RESOLUTION

1. In February 2004, the CICAD Executive Secretariat, in conjunction with the National Distance Education University of Spain (UNED) and the Metropolitan University of Caracas-Venezuela (FUNDAMET), will meet with universities that have a speciality in the area of peace studies and conflict resolution, in order to propose the need for an M.A. to train professionals specialized in peace studies and conflict resolution, given the strong overlap between narcotics and drug production and problems of governability, corruption, and democracy in countries in the region.

VII. IMPACT EVALUATION OF DEMAND REDUCTION PROGRAMS[4]

1. The Government of Uruguay has offered to serve as host to carry out a workshop for **Training in Evaluation Methods appropriate to measuring the impact of prevention and treatment programs on their target populations, in order to help member states to more fully comply with MEM indicators numbers 11 and 16**. Training is to be carried out in the first semester of 2005.

VIII. IBERO-AMERICAN NETWORK OF NGOs WORKING IN DRUG ADDICTION (RIOD)

[4] MEM Indicators 10 and 15.

1. CICAD reconfirms its commitment to continue to support activities and actions taken by RIOD.

ANNEX I: LIST OF PARTICIPANTS

FIFTH MEETING OF THE
GROUP OF EXPERTS IN DEMAND REDUCTION
October 22-24, 2003
Buenos Aires, Argentina

OAS/Ser.L/XIV.4.5
CICAD/DREX/doc.08/03
October 24, 2003

QUINTA REUNION DEL GRUPO DE EXPERTOS EN REDUCCIÓN DE LA DEMANDA
22-24 Octubre, 2003, Buenos Aires, Argentina

LISTA DE PARTICIPANTES

ARGENTINA

Dr. Wilbur R. Grimson
Secretario de Programación y Coordinación para la
Prevención de la Drogadicción y la Lucha contra el Narcotráfico (SEDRONAR)
Buenos Aires, Argentina
Telf: (5411) 4320-1290
Fax: (5411) 4320-1182
Correo Electrónico: rgrimson@sedronar.gov.ar

Dr. Camilo Verruno
Director Nacional de Asistencia, Secretaría de Programación y Coordinación para la
Prevención de la Drogadicción y la Lucha contra el Narcotráfico (SEDRONAR)
Telf: (5411) 4320-1290
Fax: (5411) 4320-1182
Correo Electrónico: cverruno@sedronar.gov.ar

Lic. María Marta Herz
Directora de Prevención, Secretaría de Programación y Coordinación para la
Prevención de la Drogadicción y la Lucha contra el Narcotráfico (SEDRONAR)
Buenos Aires, Argentina
Telf: (5411) 4320-1290
Fax: (5411) 4320-1182
Correo Electrónico: prevencion@sedronar.gov.ar

Lic. Manuel Díaz
Jefe de Auditorías, Secretaría de Programación y Coordinación para la
Prevención de la Drogadicción y la Lucha contra el Narcotráfico (SEDRONAR)
Buenos Aires, Argentina
Telf: (5411) 4320-1290
Fax: (5411) 4320-1182

Dr. Ernesto Eduardo González
Asesor de Relaciones Institucionales, Secretaría de Programación y Coordinación para la
Prevención de la Drogadicción y la Lucha contra el Narcotráfico (SEDRONAR)
Buenos Aires, Argentina
Tel: (5411) 4320-1290
Fax: (5411) 4320-1182
Correo Electrónico: info@trabajosindrogas.com.ar

BARBADOS

Mr. Ishmael Morris
Deputy Manager
National Council on Substance Abuse
Bridgetown, St. Michael
Barbados
Tel: (246) 429-6272 Cell: (246) 427-8962
Fax: (246) 427-8966
E-mail: imorris@ncsa.org.bb

BELIZE

Mr. Ornel Brooks
Executive Director
National Drug Abuse Control Council
Ministry of Health
Belize City, Belize, C.A.
Tel: (501) 223-1106
Fax: (501) 223-1121
E-mail: ndacc@btl.net

BRAZIL

Dra. Luciana Gonçales
Coordenadora Geral de Tratamento
Secretaria Nacional Antidrogas - SENAD
Palacio do Planalto Anexo II
Brasilia, Distrito Federal, Brazil
Tel: (55-61) 411-2097 / 411-2902
Fax: (55-61) 411-2110
E-mail: lucianag@planalto.gov.br

CANADA

Ms. Halina Cyr
Acting Director
Office of Demand Reduction, Drug Strategy and Controlled Substances Programme
Health Canada
Ottawa, Ontario, Canada
Tel: (613) 957-8337
Fax: (613) 957-1565
E-mail: halina_cyr@hc-sc.gc.ca

CHILE

Sra. Selva Careaga Nuñez
Encargada del Area de Capacitación y Proyectos
Consejo Nacional para el Control de Estupefacientes (CONACE)
Telf: (562) 510-0816
Fax: (562) 699-4462
Correo Electrónico: scareagan@CONACE.gov.cl

COSTA RICA

Dra. Eugenia Mata Chavarría
Instituto Costarricense sobre Drogas
Apartado 7311-100
San José, Costa Rica
Telf: (506-2) 411-850
Fax: (506-2) 411-911
Correo Electrónico: mataeugenia@costarricense.cr

EL SALVADOR

Dra. Margarita Chávez Escobar
Directora Ejecutiva
Comisión Salvadoreña Antidrogas (COSA)
San Salvador, El Salvador
Telf: (503) 2-211-721
Fax: (503) 2-211-721
Correo Electrónico: margarita.chavez@gobernacion.gob.sv

COMMONWEALTH OF DOMINICA

Mr. Mervin Paul
Acting Director
National Drug Prevention Unit
Government Headquarters
Roseau, Commonwealth of Dominica, W.I.
Tel: (767) 448-2401 Ext. 3343/3446
Fax: (767) 448-6086
E-mail: merv_paul@hotmail.com

HAITI

Dr. Marie Ghislaine Adrien
Director
Commission Nationale de Lutte contra la Drogue (CONALD)
National Psychiatric Center in Haiti
Port-au-Prince
Telf: (509) 413-3644
E-mail: ghislaineadrien@yahoo.com

JAMAICA

Professor Frederick Hickling
Chairman, National Council on Drug Abuse
Kingston 5, Jamaica
Tel: (876) 927-2492 / Mobile: (876) 399-1809
Fax: (876) 927-2116
E-mail: frederick.hickling@uwimona.edu.jm

MEXICO

Lic. José Manuel Castrejón Vacío
Secretario Técnico
Consejo Nacional contra las Adicciones (CONADIC)
Secretaría de Salud
Av. Paseo de la Reforma 450 Piso 9
CP 06600 México, DF
Telf: (525) 5207-9382
Fax: (525) 5207-9333
Correo Electrónico: mcastrejon@salud.gob.mx

PANAMA

Sra. Soraya Cano
Ministro Consejero de la Embajada de Panamá en Argentina
Ave. Santa Fé 11461 Piso 1
Buenos Aires, Argentina
Telf: (5411) 4811-1254 / 4814-3655
Fax: (5411) 4814-0450
Correo Electrónico: consejeropanama@fibertel.com.ar

Sr. Juan Pablo Mora
Agregado de la Embajada de Panamá en Argentina
Telf: (5411) 4811-1254 / 4814-3655

PARAGUAY

Dra. Lis Kreitmayr de Mallwitz
Cooperación Internacional
Secretaría Nacional Anti-Drogas (SENAD)
Telf: (595-21) 942-563 Particular Cel. (595-981) 445-950
Tel/Fax: (595-21) 214-731
Correo Electrónico: lis_kreitmayr@hotmail.com

Cnel. DEM Angel Benitez Cáceres
Agregado Militar
Embajada de Paraguay en Argentina
Telf: (5411) 4804-4192
Fax: (5411) 4802-0981
Correo Electrónico: abenitezc@hotmail.com; agregaduriamilitar@hotmail.com

PERU

Sr. José Luis Peña Vega
Coordinador de Tratamiento y Rehabilitación de la Gerencia de
Prevención y Rehabilitación del Consumo de Drogas
Comisión Nacional para el Desarrollo y Vida sin Drogas (DEVIDA)
Lima, Perú
Telef/Fax: (511) 449-0007 / 449-0057 / 449-0528
Correo Electrónico: jpeña@devida.gob.pe

UNITED STATES

Ms. Rachel Romsaas
Program Assistant
Bureau of International Law Enforcement and Narcotics Matters (INL)
U.S. Department of State
Washington, D.C.
Tel: (202) 647-7843
Fax: (202) 647-5603
E-mail: Romsaasr@state.gov

URUGUAY

Dra. María Lorenzo y Losada
Asesora Técnica de la Secretaría Nacional de Drogas
Montevideo, Uruguay
Telf: (598-2) 622-6022 Int. 1241
Fax: (598-2) 150-3952
Correo Electrónico: Mlorenzo@presidencia.gub.uy

VENEZUELA

Lic. Luis Alfonzo
Médico Psiquiatra
Comisión Nacional contra el Uso Ilícito de Drogas (CONACUID)
Caracas, Venezuela
Tel/Fax: (58-212) 753-1538 / (58-414) 252-2723
Correo Electrónico: alfomeza@telcel.net.ve; alfonzo4457@hotmail.com

INVITADOS ESPECIALES / PRESENTADORES

Lic. Alfonso Abarca
Fundación Antidrogas de El Salvador (FUNDASALVA)
San Salvador, El Salvador
Telf: (582) 793-4016
Tel/Fax: (582) 753-1538
Correo Electrónico: Aabarca@fundasalva.org.sv

Dra. Margarita Abdala de Tomás
Vice-Directora
Escuela de Enfermería
Universidad Nacional de Córdoba
Córdoba, Argentina
Telf: (54-351) 433-4028
Fax: (54-351) 433-4043
Correo Electrónico: margaritaabdala@hotmail.com; enfermeria@fcm.unc.edu

INVITADOS ESPECIALES / PRESENTADORES

Lic. Giselle Amador
Coordinadora del Área Técnica
Área de Rehabilitación
Instituto sobre Alcoholismo y Farmacodependencia (IAFA)
San José, Costa Rica
Telf: (506-2) 24-40-96
Fax: (506-2) 24-67-62
Correo Electrónico: giselleamador@costarricense.cr

Mr. Michael Buscemi
Senior Youth Advisor to the Lions Clubs International Foundation
1984-B Coffman Rd., Newark OH 43055, U.S.A.
Tel: (740) 522-6404
Fax: (740) 522-6580
E-mail: mikeb4kids@yahoo.com

Dr. Guillermo Castaño
Coordinador Maestría On-Line en Drogodependencias
Fundación Universitaria Luis Amigó (FUNLAM)
Medellín, Colombia
Telf: (574) 260-6666 Ext. 122
Fax: (574) 260-8074 Cel: (574) 420-8590
Correo Electrónico: gcastano@sembrador.amigomed.edu.co; azapata@funlam.edu.co

Dra. Alejandra Chervo
Vice-Directora, Escuela de Enfermería
Universidad de Rosario
Ovidio Lagos 480
Rosario, Argentina 2000
Telf: (54-3461) 436-963
Fax: (54-341) 480-4579
Correo Electrónico: mchervo@fmedic.unr.edu.ar; machervo@hotmail.com

Dr. Catherine Chestnut
Chief Executive Officer
National Drug Council of the Cayman Islands
P.O. Box 10007APO
Grand Cayman, Cayman Islands, BWI
Tel: (345) 949-9000
Fax: (345) 949-6264
E-mail: cathyndc@candw.ky

Dr. David A. Deitch, PhD
University of California, San Diego
Department of Psychiatry
La Jolla, CA 92037-5051, U.S.A.
Tel: (858) 551-2957
Fax: (858) 534-3877
E-mail: rvignati@ucsd.edu (assistant)
Website: www.atc.ucsd.edu

INVITADOS ESPECIALES / PRESENTADORES

Dra. Derma Fassi de Grenat
Directora, Escuela de Enfermería
Universidad Nacional de Córdoba
Córdoba, Argentina
Telf: (54-351) 423-4043 (Escuela)
Telf/Fax: (54-351) 433-4028
Correo Electrónico: enfermeria@fcm.unc.edu.ar

Dr. Yasuyo Kajimoto
First Secretary, Japanese Embassy in Argentina
Tel: (54-11) 4318-8200
Fax: (54-11) 4318-8210
E-mail: yasuyo.kajimoto@mofa.go.jp

Dra. Teresa Micozzi
Directora Escuela de Enfermería
Universidad Nacional de Rosario
Ovidio Lagos 480
Rosario, Argentina 2000
Telf: (54-341) 439-2655
Fax: (54-341) 411-1457
Correo Electrónico: teresamicozzi@hotmail.com; tmcozzi@fmedic.unr.edu.ar

Lic. Héctor Shalom
Responsable Nacional de los Centros de Actividades Juveniles
del Ministerio de Educación, Ciencia y Tecnología
Buenos Aires, Argentina
Telf: (5411) 4129-1000 ext. 7443
Correo Electrónico: hshalom@me.gov.ar

ORGANIZACIONES INTERNACIONALES/ INTERNATIONAL ORGANIZATIONS

OFICINA DE LAS NACIONES UNIDAS CONTRA LA DROGA Y EL DELITO/ UNITED NATIONS OFFICE ON DRUGS AND CRIME (UNODC)

Dr. Juana M. Tomás-Rossello
Drug Abuse Treatment Adviser
United Nations Office on Drugs and Crime (UNODC)
Vienna International Centre
P.O. Box 500
A 1400 Vienna, Austria
Tel: (43-1) 26060-5284
Fax: (43-1) 26060-5928
E-mail: juana.tomas@unodc.org

ORGANIZACIONES INTERNACIONALES/
INTERNATIONAL ORGANIZATIONS

ORGANIZACION MUNDIAL DE LA SALUD (OMS)/
WORLD HEALTH ORGANIZATION (WHO)

Dra. Maristela G. Monteiro
Coordinator
Management of Substance Dependence
World Health Organization
20 Avenue Appia
1211 Geneva, Switzerland
Tel: (41-22) 791-4791
Fax: (41-22) 791-4851
E-mail: monteirom@who.int

UNION EUROPEA-COMISIÓN EUROPEA/
EUROPEAN UNION-EUROPEAN COMMISSION

Ms. Linda Montanari
European Monitoring Centre on Drugs and Drug Addiction (EMCDDA)
Rua Cruz de Santa Apolonia 23-25
P - 1149-045 Lisbon, Portugal
Tel: (9351-21) 811-3081
Fax: (351-21) 813-7943
E-mail: Linda.Montanari@emcdda.eu.int

Dr. Marcos Langbehn
Asesor Político
Comisión Europea
Delegación en Argentina
Ayacucho 1537
Buenos Aires, Argentina
Telf: (011-5411) 4805-3759
Fax: (011-5411) 4801-1594
Correo Electrónico: marcos.longbehn@cec.eu.int

ORGANISMOS NO GUBERNAMENTALES/
NON-GOVERNMENTAL ORGANIZATIONS

Lic. Roberto Gallinal
Red Iberoamericana de ONG que Trabajan en Drogodependencias (RIOD)
Gregorio Suarez 2818 Ap. 101
Montevideo, Uruguay
Tel: (5982) 708-1845
Fax: (5982) 708-1845
Correo Electrónico: encare@adinet.com.uy

Lic. María de Lourdes Valdés Abascal
Asesora
Fundación Montefénix
México, DF
Telf: (525) 56116-0402
Fax: (525) 5406-5308
Correo Electrónico: kyva_abascal@yahoo.com

COMISION INTERAMERICANA PARA EL CONTROL DEL ABUSO DE DROGAS (CICAD)/ INTER-AMERICAN DRUG ABUSE CONTROL COMMISSION (CICAD)

Dr. Anna McG. Chisman
Chief, Demand Reduction Program
Tel: (202) 458-6221
Fax: (202) 458-3658
E-mail: Achisman@oas.org

Lic. María Eugenia Pérez-Madrigal
Specialist
Demand Reduction Program
Tel: (202) 458-6920
Fax: (202) 458-3658
E-mail: Mperez@oas.org

Dr. Gloria Wright
Specialist
Demand Reduction Program
Tel: (202) 458-3788
Fax: (202) 458-3658
E-mail: Gwright@oas.org

Mrs. Amparo Hernández
Demand Reduction Program Assistant
and Travel Coordinator
Tel: (202) 458-6321
Fax: (202) 458-3658
E-mail: Ahernandez@oas.org

Ms. Emily Holman
Program Assistant
Demand Reduction Program
Tel: (202) 458-6104
Fax: (202) 458-3658
E-mail: Eholman@oas.org

ANNEX II: SCHEDULE OF ACTIVITIES

V MEETING OF THE GROUP OF EXPERTS
IN DEMAND REDUCTION
October 22-24, 2003
Buenos Aires, Argentina

OEA/Ser. L.XIV.4.5
CICAD/DREX/doc.02/03rev.3
21 October 2003
Original: English

DRAFT SCHEDULE OF ACTIVITIES

Date and Time		Place
Tuesday, October 21, 2003		
5:00 –7:00 pm	**Participant Registration**	Hotel Las Naciones
Wednesday, October 22, 2003		
9:15 am	Transfer by bus to the National Library:	
10:00 am	**Inaugural Session**	National Library
	Remarks by:	
	Mrs. María Eugenia Perez, Executive Secretariat, Inter-American Drug Abuse Control Commission (CICAD)	
	Dr. Wilbur R. Grimson, Secretary of Programming and Coordination for the Prevention of Drug Dependence and the Control of Drug Trafficking (SEDRONAR) of Argentina	
	Followed by:	
	Musical interlude by Cuarteto Tango	
12 noon	Return to Hotel Las Naciones	
12:30 pm	**Lunch** hosted by SEDRONAR	Hotel Las Naciones
1:45 pm	**First Plenary Session**	Hotel Las Naciones

1. Update from the Executive Secretariat on activities since the fourth meeting of the Expert Group

2. Practical guide to the organization of a comprehensive drug treatment system: a proposal (CICAD/DREX/doc.03/03)
Introduction by Dr. Luis Alfonzo, M.D.

4:00-4:15 pm **Coffee break**

4:15-6:30 pm Organization of a comprehensive national drug treatment system: a proposal (contd.)

DISCUSSION AND RECOMMENDATIONS

6:30 p.m. Adjournment

7:30 pm Reception hosted by the Executive Secretariat of CICAD — Hotel Las Naciones

Thursday, October 23, 2003

Second Plenary Session

9:00 a.m.

Demand for treatment indicator: the work of the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). Presentation by Ms. Linda Montanari, EMCDDA

Panel on substance abuse prevention: promising approaches

1. School-based drug abuse prevention: Presentation on Costa Rica's school-based prevention program "Learning to Value Myself", by Dr. Giselle Amador, Technical Area Coordinator, Costa Rican Institute on Alcoholism and the Addictions

2. CICAD's project to introduce substance abuse prevention into the curriculum of 15 nursing schools in Central and South America: Presentation by Dr. Gloria Wright, Executive Secretariat of CICAD, and by Dr. Derma Fassi de Grenat, and Dr. Margarita Abdala de Tómas, Director, and Deputy Director respectively of the nursing school of the University of Córdoba, Argentina

11:00-11:15 am **Coffee break**

4. Practical aspects of implementing policies and programs for the prevention of the use of alcohol and other psychoactive substances in the workplace. Presentation by Prof. Guillermo Castaño, Luis Amigó University, Medellín, Colombia

5. Skills for adolescence – a substance abuse prevention program. Presentation by Mr. Mike Buscemi, Senior Youth Advisor to the Lions Clubs International Foundation, Ohio, United States

DISCUSSION AND RECOMMENDATIONS

1:00 pm **Lunch**

Third Plenary Session

2:00 p.m. 1. Software to monitor progression of patients in drug treatment programs: a demonstration by Mr. Alfonso Abarca of FUNDASALVA , El Salvador
Discussion of the utility of the software, possible adaptation to other countries, and recommendation

2. Alternatives to sentencing for minor offenses: the experience in Belize. Presentation by Mr. Ornel Brooks, Executive Director, National Drug Abuse Control Council of Belize
   Discussion of potential expansion to other countries

3:30-3:45 pm **Coffee break**

3. Treatment programs for drug abusing prisoners: current practices and recommended approaches

   In-Custody Treatment: Rationale, Outcomes and Directions.
   Presentation by Dr. David Deitch, University of California, San Diego (CICAD/DREX/doc.04/03)

4. Drug abuse treatment and rehabilitation: A practical planning and implementation guide.
   Presentation by Dr. Juana Tomás-Rossello, Drug Abuse Treatment Adviser, United Nations Office on Drugs and Crime (UNODC)

   DISCUSSION AND RECOMMENDATIONS

5:30 pm Adjournment

Friday, October 24, 2003

9:00 am **Fourth Plenary Session**

1. Socialization and Change: A Journey through Crime, Drugs, and Recovery. Presentation by Dr. David Deitch, University of California, San Diego (CICAD/DREX/doc.05/03)

2. Creation of national social prevention programs
   Presentation by Mr. Héctor Shalom, Youth Action Centers, Argentina

3. Recommendations to CICAD and to the OAS General Assembly on the agenda topics (working groups)

4. Work plan for the Expert Group on Demand Reduction for 2004-2005

4:00 pm **Closing Session**

ORGANIZACIÓN DE LOS ESTADOS AMERICANOS

COMISIÓN INTERAMERICANA PARA EL CONTROL DEL ABUSO DE DROGAS

THIRTY-FOURTH REGULAR SESSION
November 17-20, 2003
Montreal, Canada

OEA/Ser.L/XIV.2.34
CICAD/doc1262/03 add 1
13 November 2003
Original: English

PRACTICAL GUIDE TO THE ORGANIZATION OF A COMPREHENSIVE DRUG TREATMENT SYSTEM
EXECUTIVE SUMMARY

ORGANIZACIÓN DE LOS ESTADOS AMERICANOS

COMISIÓN INTERAMERICANA PARA EL CONTROL DEL ABUSO DE DROGAS

cicad

V MEETING OF THE GROUP OF EXPERTS
IN DEMAND REDUCTION
October 22-24, 2003
Buenos Aires, Argentina

OEA/Ser. L.XIV.4.5
CICAD/DREX/doc.03/03
14 October 2003
Original: Spanish

PRACTICAL GUIDE TO THE ORGANIZATION OF A COMPREHENSIVE DRUG TREATMENT SYSTEM

EXECUTIVE SUMMARY

Introduction

Drug use is a complex, multidimensional, and dynamic problem that adversely affects the population's quality of life and integrity, and requires priority attention. Accordingly, the member countries of the Organization of American States undertook, in the ***Antidrug Strategy in the Hemisphere***, to continuously review and improve their national policies in this area, emphasizing the importance of developing the supply of quality, timely, and accessible treatment services for drug users and dependents, in a context of limited resource availability.

In most countries of the hemisphere, the supply of these treatment services in a manner that meets the population's needs is hindered by a number of problem areas as well as the lack of any political, legal, or technical guidelines, depriving the state of necessary resources and administrative control mechanisms.

To find solutions to these problems, those responsible for designing and executing drug dependency treatment policies must be sufficiently aware of the various factors that determine the quality of services received by users, able to accurately characterize their needs, and knowledgeable about the availability of treatment alternatives and about how best to organize such services.

In recent decades, efforts in the region to improve the quality of drug-use and dependency treatment services have included the establishment of hemispheric guidelines for demand reduction policies, expert group recommendations, institutional strengthening activities, and publications on quality in the treatment of drug dependency, in conjunction with activities to develop the necessary legal and regulatory framework. The recommendations generated by this activity to improve the quality of treatment services include the following:

- Integrate drug dependency treatment services into the general healthcare system, establishing a network of services to ensure a "continuum of care".

- Define minimum standards of care in the areas of treatment, rehabilitation, and social reintegration.

- Provide orientation for professional and auxiliary teams with respect to the essential organizational and regulatory aspects of providing these treatment services.

This document, prepared by a CICAD/OAS Task Force, proposes an organizational framework for quality drug dependency treatment services based on systematic evaluation and the establishment of minimum standards and criteria for good clinical practice and user satisfaction. The following subjects will be covered:

I. Drug use disorders
Definition of the problem. Diagnostic criteria

II. General principles of treatment
Evaluation of drug users and dependents. Treatment planning

III. Organization of a drug use disorder treatment system
- General design of a treatment system
- Modalities and levels of care
- Patient placement criteria

In covering these subjects, this document will summarize relevant experience gained in recent decades and the valuable contributions made by national and international organizations, such as the World Health Organization (WHO), the Inter-American Drug Abuse Control Commission of the Organization of American States (CICAD/OAS), and the American Society of Addictive Medicine (ASAM), in helping member countries develop national policies and treatment alternatives.

I. Drug use disorders

These are disorders that can manifest themselves immediately or over a short, medium, or longer timeframe, as a function of the user's physiological response to drugs – especially as they affect the nervous system – and the psychological, social, and cultural circumstances in which the drugs are used. This group of disorders includes acute intoxication, abstinence syndrome, abuse, dependency, and the physical, psychological, and social complications associated with dependency.

Drug-use disorders, and dependency in particular, are complex, often chronic illnesses that tend to be prolonged in duration, with frequent relapses and repeated attempts at treatment. Their most striking characteristic is a pattern of behavior focused on finding and using the substance concerned, at the expense of the user's customary behavior and leading him to neglect family, professional, academic, and social obligations, persisting in his drug use though fully aware of its harmful effects. All of this creates a burden for the user, his family, and the community in general, adversely affecting the quality of their lives.

The coexistence of drug use disorders together with general medical and psychiatric problems creates a more complex panorama for treatment, calling for the design and implementation of therapeutic strategies usually beyond the response capacity of traditional dependency treatment services. Such services must therefore be

adapted to improve their response capacity, develop new options, and coordinate with services in different areas.

II. General principles of treatment for drug use disorders

The approach to and treatment of drug use disorders is a function of demand for care and requires various levels of complexity from public or private organizations responsible for providing treatment services to the affected population. In the effort to meet this demand a variety of treatment options have been designed and used, ranging from the minimal complexity of a counseling session with nonprofessionally trained personnel to intervention by professionals specializing in high technology procedures.

Treatment is designed to achieve three fundamental goals:

- Stopping drug use
- Prolonging drug abstinence
- Restoring full capacity to function personally, socially, and economically

To achieve these goals, services must:

- Be available and accessible to users for as long as they require them.
- Take a comprehensive approach to drug use, including biomedical and psychosocial aspects as well as community support.
- Motivate patients to seek and commit to treatment.
- Adapt to particular user needs.
- Ensure respect for the human condition of persons in treatment and protection for their fundamental rights.
- Work in coordination with other services, forming a treatment network.

The best treatment system is one that provides timely services to meet the needs of the greatest number of persons, in the least restrictive, freest, safest, and most effective manner possible, with the flexibility needed to move patients from one level of care to another, according to their needs, and linking different drug dependency treatment services together and with the network for healthcare and other community services.

III. Organization of a drug use disorder treatment system

In order for a drug-use disorder treatment system to provide quality care for the affected persons, its various components must coordinate with and complement each other and the network of services in general.

In the organization of these services, therapeutic interventions are structured to occur simultaneously or in sequence, constituting what is referred to as the treatment process, with varying degrees of technological intensity and complexity, determining the levels of care and treatment modalities to be applied.

Therapeutic process. Set of activities carried out within a defined setting, program, or establishment, corresponding to a specific level of care, to meet needs detected in the patient.

Level of care. Institutional or programming framework for treatment activities. The operations and complexity of some establishments may correspond to a single level of care, while others may have components corresponding to several levels.

Treatment modality. The combination of technologies used to treat a problem or set of similar drug-use-related problems characterized by the fact that they can be managed using resources of similar levels of complexity; or in other words, the treatment activities or processes carried out at a given level of care. The following are examples of treatment modalities:

- Residential treatment community.
- Medically managed residential treatment.
- Psychiatric unit of a general hospital.
- Methadone, buprenorphine, or other substitution program under medical supervision.
- Day hospital
- Outpatient

The development and application of standardized criteria for placing patients under a particular treatment modality will help to increase the potential benefit to be obtained from therapeutic intervention, which depends largely on finding the right match between patient needs and available services. These placement criteria must be based on systematic evaluation procedures, permitting the treatment needed by the patient in various functional areas to be identified and the corresponding competencies required at each level of care to be determined. The aim in applying these criteria is to place the patient at the most appropriate level of care, i.e. with the lowest level of intensity required to achieve therapeutic objectives with the highest degree of safety.

To assist countries in developing these criteria, the annexes to this document illustrate how various dimensions of treatment can be assigned to specific levels of care.

IV. Conclusions

- The treatment of drug use disorders should receive priority attention in the design and execution of national demand reduction policies; it is up to the governments of the Americas, individually and collectively, to develop guidelines ensuring a systematic approach to supplying treatment services that meet the population's needs.

- Strategies can be defined to organize the structure and operation of services to ensure optimum effectiveness and quality in the care and treatment of drug use disorders.

- To the extent that treatment needs can be properly understood, the resources available to meet them can be identified, and mechanisms to balance supply and demand for such services can be established, the level of care provided will be improved and the social burden borne by countries as a result of drug use disorders and their effect on quality of life will be diminished.

- A fundamental element of drug demand reduction policy is the development and strengthening of a technical and legal framework to support the delivery of treatment services to the affected population. It is essential that this framework encompass, in a meaningful way, the work performed by governments in regulating and controlling treatment programs.

V. DRAFT CICAD RECOMMENDATIONS FOR A NATIONAL DRUG ABUSE TREATMENT POLICY

- Each government should make it the goal of the substance dependency (abuse) treatment system to return persons with substance use disorders to their full personal, social, and economic functional capacity.
- Each government should enshrine a body of human rights to protect the privacy and confidentiality of individuals seeking care from the continuum of substance abuse treatment services.

- Working through its coordinating agency for demand control and reduction, or its National Drug Commission, each government should establish a national policy on substance abuse treatment and designate a National Treatment Agency responsible for implementing this policy.
    - The designated National Treatment Agency should develop and implement the National Treatment Plan. This plan should:
        - Introduce the use of an internationally accepted diagnostic classification system for substance abuse disorders.
        - Promote the expansion of treatment capacity, ensuring that every principal population center has access to the five fundamental levels of care and treatment (broadly defined in Annex I):
            - Crisis management setting
            - Outpatient treatment
            - Intensive outpatient treatment
            - Inpatient treatment
            - Hospital treatment
        - Promote linkage among the five fundamental levels of care and treatment to form a complete continuum with diversified modalities.
        - Include public and private resources (NGOs).
- The designated National Treatment Agency should develop professional qualification standards for substance abuse treatment providers and provide opportunities for relevant training by designating a national training center.
- The National Treatment Agency should accept responsibility for maintaining Minimum Standards of Care in the Treatment of Substance Abuse.
- The National Treatment Agency should develop a register of substance abuse treatment establishments and keep it up to date.

VI. Annexes

Levels of Care in the Treatment of Drug Abuse

Level of Care: The institutional or programmatic framework within which the treatment activities take place; some establishments provide only one level of care, while others offer integrated programs for several levels.		
Level I **Outpatient**	Treatment in a nonresidential setting Limited stay (hours) Frequency: (weekly or interdaily). Example: Outpatient consultation	Patients diagnosed with degrees of severity that can be managed with available resources or who have been receiving treatment at a more intensive level and have improved to the extent where they can benefit from this level of care; or patients who could require more intensive care but are not prepared to commit fully to treatment. Patients with "dual diagnoses", mental disorders of mild severity, or more severe but stable.
Level II **Intensive outpatient** **Partial hospitalization**	Treatment in a nonresidential setting Stay of several hours, morning, afternoon, or both. Frequency: daily. Example: Day Hospital	Patients diagnosed with degrees of severity that can be managed in an outpatient program, which, however, requires reinforcement in terms of intensity of care; can be provided on a daily basis during visits of several hours. This level may involve components normally found in residential, more structured programs.
Level III **Residential Treatment Community**	Inpatient treatment Stay of 24 hours Residential, structured emphasis. Includes care typically provided in residential settings, professional medical, psychiatric, psychosocial care, control of medications, evaluation, treatment, rehabilitation, family-based approaches, etc.. Example: Medium-term treatment community	Time and structure are required to integrate recovery with the development of coping skills in the case of patients in denial about their drug problem. The effects of substance use disorders are evident and very significant, with a very high level of damage, making motivation and relapse prevention strategies impossible or ineffective in an outpatient setting. Cognitive disorders, temporary or permanent, interfere with interpersonal relations or the patient's emotional coping skills. Certain serious medical, psychological, and social problems may be present requiring comprehensive, multidimensional, and long-term treatment. Living space is unprotective or toxic, interpersonal relations chaotic or even abusive, offering little support. Long histories of treatment. Law enforcement problems, poor job or school performance, an antisocial system of values.
Level IV **Hospital**	Inpatient treatment. Stay of 24 hours Emphasis on general and specialized medical care Includes care typically provided in residential settings, professional medical, psychiatric, psychosocial care, control of medications, evaluation, treatment, rehabilitation, family-based approaches, etc., under the supervision of an accredited team of healthcare professionals. Example: Short- or medium-term medically-managed residential setting.	Needs deriving from drug use disorders with moderate and severe mental health and medical complications. Subacute medical and mental disorders requiring all of the resources available in a general or specialized hospital.
Emergency/Crisis	Immediate care services that must be available, at all of the levels, for the treatment of acute complications from drug use, where the most important concern is imminent risk to the patient's life; the technology involved is therefore of the general or specialized medical type. Example: The Emergency Room of a General Hospital.	Patients displaying decompensation for a biological, psychological, or social condition of a severity requiring immediate medical and nursing care. Patients with symptoms of intoxication or severe abstinence syndrome, posing a high risk of complications and requiring attention from a team of properly trained healthcare professionals (doctors and nurses), providing care on a continuous (24-hour) basis based on specific intervention protocols that require all of the resources provided by hospitals for intensive medical care.

Treatment Process

Treatment Process: A series of activities conducted in a defined setting, program, or establishment, corresponding to a particular level of care, as part of the treatment and for the purpose of meeting the patient's diagnosed needs.	**Pharmacological Interventions:** Under the control and responsibility of the medical team, for the purpose of restoring the user's equilibrium through the use of various pharmaceutical products. **Psychosocial Interventions:** Responsibility of a multidisciplinary team, for the purpose of addressing problem issues related to the subject's addictive disorder.	Management of: Acute intoxication Acute Abstinence Syndrome Dependency Biomedical complications Psychological complications Social complications Dual disorders Social reintegration

Evaluation Dimensions in the Detection of Treatment Needs

Evaluation dimensions		Description of aspects to be evaluated
Dimension 1	**Potential Acute intoxication or abstinence syndrome**	Risks associated with the patient's current level of acute intoxication or severe symptoms of abstinence or convulsions, based on: The patient's prior history. Amount, frequency, chronic nature, or recency of the reduction or discontinuation of alcohol and other drug use. Current signs of abstinence syndrome. Sources of external support for an outpatient detoxification program.
Dimension 2	**Biomedical disorders and complications**	The existence of some current physical illness unrelated to abstinence syndrome or intoxication. The illness requires treatment because it poses risks or complications for recovery from the drug dependency problem. The existence of chronic disorders affecting the evolution of the dependency disorder or its treatment.
Dimension 3	**Psychological or psychiatric Disorders and complications**	The existence of current psychological or psychiatric disorders posing a risk to or complications for treatment; chronic problems that may affect treatment progress. Explore whether the psychiatric or psychological problems are a consequence of drug use, form part of the drug use problem, or are unrelated to drug use, and whether the condition is sufficiently severe to warrant specific mental health treatment. The patient's current capacity to effectively manage his daily activities and cope with any psychological problem.
Dimension 4	**Treatment acceptance/resistance**	The patient's willingness to commit to treatment as a tool for change and improved functioning.
Dimension 5	**Potential for relapse, Continued drug use or other problems**	Immediate danger of severe problems as a result of drug use. The patient's capacity to recognize and confront his dependency problem or mental disorder, making the changes necessary to avert relapses, discontinue use, or prevent the continuation of problems. The severity of the problems to be confronted and the additional stress loads that could result from the patient's failure to successfully commit to treatment at this time. The patient's level of awareness about the mechanism that triggers his relapses, alternatives for coping with intense desires to use drugs, and control over his impulses to use drugs or to harm himself or others.
Dimension 6	**Recovery environment Living environment**	Potential dangers to the patient's safety or commitment to treatment (living situation, relations with family and significant others, employment or academic situation, among other aspects of the patient's living environment. Sources of support, individuals, economic resources, educational or employment possibilities that could help strengthen motivation for treatment and increase the possibilities of therapeutic success. Availability of community support for the recovery process.

Disorders stemming from psychoactive substance use and dependency

Criteria for the Placement of Adult Patients

Evaluation dimensions	Outpatient	Intensive Outpatient Partial Hospitalization	Residential Treatment Community	Hospital
Dimension 1: Intoxication or risk of abstinence syndrome	Negligible or minimal	Moderate risk of severe abstinence syndrome	Minimal. Moderate or severe but manageable abstinence syndrome	High risk. Manageable. Hospital resources required.
Dimension 2: Biomedical disorders	Negative or very stable, in control	Negative or not posing an obstacle. Manageable.	Negative or stable; under medical supervision	24-hour medical supervision, nursing services, and hospital resources required
Dimension 3: Psychological disorders	Negative or very stable, or the patient is under mental health supervision	Mild to moderate severity, potential obstacle to recovery; the patient needs to be stabilized.	Negative or minimal and posing no obstacle; or mild to moderate severity. Behavior modeling structure required.	Unstable moderate or high severity. 24-hour psychiatric care. Parallel treatment for drug dependency.
Dimension 4: Treatment acceptance/resistance	Disposed toward recovery but requiring motivation and control; or high severity in this dimension but not in others.	Poor commitment. Significant ambivalence, lack of awareness about the problem. Structured, almost daily program or intensive service required.	Open to recovery but requiring a structured environment or residential setting; or high severity in this dimension but not in others. Motivational strengthening required. Serious difficulty with or opposition to treatment, posing imminent dangers	Resistance to treatment, poor impulse control; requires motivational strategies in 24-hour structured settings or a motivational strengthening program.
Dimension 5: Risk of relapse, Continued use or problems	Capable of maintaining abstinence or controlling use,. Persistent progress toward recovery or in achieving motivational goals, with minimal support.	Intensification of the problems, despite active participation in an outpatient program. High probability of relapse, continued use or problems without close supervision and almost daily support.	Understands the relapses; needs structure to maintain therapeutic progress. Relatively unaware of the problem and requiring residential intervention to prevent continued use, with imminent, dangerous consequences; cognitive and functional deficits.	Patient does not qualify for less intensive services
Dimension 6: Recovery environment	Patient is receiving support. He has the tools to cope successfully with the situation.	Patient requires support. With structure, support, and removal from the home environment, the patient can cope successfully.	Dangerous. Patient requires a 24-hour structure to learn to cope successfully.	Dangerous. Patient does not qualify for less intensive services.