A COMPARATIVE ANALYSIS OF THE IMPACT OF DRUG LEGISLATION, POLICY AND EDUCATIONAL PROGRAMMES ON YOUNG PEOPLE

FINAL REPORT

PREPARED FOR WALSALL HEALTH AUTHORITY

SEPTEMBER 2002

THIS PROJECT WAS FUNDED BY THE DIRECTORATE FOR PUBLIC HEALTH AND SAFETY AT WORK OF THE EUROPEAN COMMISSION
(Contract Number: S12.308257 (2000CVG2-223) )
1. Introduction

The primary aim of the research was to better understand the way in which drug legislation, policies and educational; programmes were understood and internalised by young people between the ages of 10 and 13. The key issue was to elicit the views of young people themselves through a structured questionnaire and to analyses them in the context of national legislation regarding illicit substances in Italy, the Netherlands, Sweden and the UK as well as the way the legal framework was interpreted and preventative measures taken in Bologna, Rotterdam, Stockholm and Walsall.

The intention was to identify common themes across the four participating cities and any local differences in attitude that might result from the different approaches taken nationally or locally. This, in turn, would directly inform prevention programmes and practice at the local level and contribute to national and the Europe wide debate on drugs and substance misuse.

The collection and use of the data collected for this report have some very clear limitations. Their value therefore are principally in what they indicate and rather than in producing ‘absolute conclusions’.

The first of these methodological constraints was the difficulty in making cross-country comparisons given the uneven split across the different sample cities. This was as a result of a combination of factors including the time limitation of the project that did not allow for sufficient lead-time in participating cities where approaching individual schools was ‘politically’ more risky than others; the limited number of schools willing to participate; and local issues such as the move to a more devolved school system in Bologna.

The second involved the difficulty of weighting age groups for cross-country comparisons, as the youngest and eldest groups were too small to use percentage figures. The result was a more superficial analysis that, nevertheless, yielded valuable information for policy makers and the developers of new interventions.

The report that follows sets out the national and local context in each country. Section 3 contains the analysis of the data and Section 4 sets out conclusions stemming from that analysis. A copy of the questionnaire is attached as an appendix.
2. National and Local Context

2.1 ITALY

Legal Framework

Main reference law: D.P.R. (Decree of the President of the Republic) 309 of 9 October 1990.

Single Text of the Law concerning the regulation of the use of psychoactive substances and drugs; it defines guidelines for prevention, treatment and rehabilitation of substance addiction; it also establishes the system of services active in the field.

As regards substance users, the law established sanctions, both administrative and penal, of which the latter have subsequently been repealed by a constitutional referendum in 1993.

In case an individual is found in possession of illegal substances (substances are classified on the basis of their harmfulness) in a quantity that is consistent with the assumption that they are intended for personal consumption, the Prefecture (Prefettura) is responsible for offering the person in question two options: undergoing treatment at a Centre on addiction and substance abuse (Servizio Tossicodipendenze), or accepting an administrative sanction (e.g.: suspension of driving licence, passport, etc.).

The Ministry of Social Affairs is responsible for distributing resources earmarked for the National Fund for Combating drug abuse to the Regional governments which, in turn, will allocate funds, to the projects presented by public services, local authorities, subsidiary organisations (therapeutic communities), voluntary associations.

The Law gives the Ministry of Health the power to issue general guidelines in the areas of prevention of substance use, epidemiological surveys, as well as the inspection, authorisation and control of activities involving the cultivation, processing, trading, importing and exporting of drugs.

The Ministry of the Interior is charged with the supervision of law-enforcement services co-ordinated by the central Anti-drugs Agency (Servizio Centrale Antidroga).

Regional authorities are given the task of co-ordinating action at local level.

Local Health Authorities set up Centres on Addiction and Substance Abuse, which are responsible for the definition of criteria for diagnosis, treatment and rehabilitation, in collaboration with the private social sector, on a contract-based approach.

Local Authorities (Municipalities) are given responsibility for prevention work and for all initiatives aimed at combating social exclusion and deprivation.

At the moment the Government has established the DNA (Dipartimento Nazionale Antidroga, Anti-Drugs National Department), which should be responsible for all initiatives aimed at combating drug dependence, although the specific fields of action of the department have not yet been clearly defined.
Furthermore, Public Services are currently under attack, and their work is contrasted with that of therapeutic Communities which, in Italy (in particular religiously inspired communities), have been the first to design residential rehabilitation services using a drug-free approach, without recourse to substitute drugs (methadone).

References:

- D.M. 30 November 1990, n.444 – Regulation concerning the definition of human resources, organisational and functional characteristics of addiction and drug abuse services to be established by local health authorities.
- Law no.45 of 18 February 1999 — Regulations regarding the national Fund for combating drug abuse and the personnel of addiction and drug abuse services.
- Deliberation of 5 August 1999 – Permanent conference for the relations between the State, Regional governments and the autonomous Provinces of Trento and Bolzano. Draft agreement between the State and the Regions, based on a proposal by the Ministries of Health and Social Solidarity, on the: "Definition of minimum standard requirements for the authorising and licensing of private care providers for substance abusers ".

**Regional Project on substance abuse**

Law no. 45 was ratified on 18/2/99 – Regulations concerning the national fund for combating drug abuse and personnel for centres on addiction and substance abuse. The law establishes general criteria for the evaluation and funding of projects, which must pursue the following aims:

1) Primary, secondary and tertiary prevention, including harm reduction, provided the measures are aimed at the psychological and physical rehabilitation of the individual;

2) Employment placement of substance abusers;
3) Dissemination of social and health care outreach services over the territory, such as street units, “low threshold” services, counselling and help-phone services;
4) Health education.

Substance abuse in Bologna

Within an essentially stable context in terms of the incidence of drug abuse and of service provisions data highlight changing trends potential development areas for action.

Elements of stability

- General stability in the number of heroin users in the city of Bologna, estimated to be around 4000 people, around fifty per cent of whom are registered with the services. The stable number of heroin abusers is probably due, among other factors, to the attraction the city exerts on addicts from the surrounding area, who buy and consume their supplies here.
- The improvement in the number of people who complete treatment, namely a decrease in the number of people who drop out of various treatment programmes.
- The progressive ageing of the substance abusers’ population registered with the services. The average age of SerT users is 33.
- Essentially stable male/female ratio: women account for about 25% of the overall number of users.

Elements of change

- The emerging of new heroin addicts in the poorest and most marginal fringes of the population, who often have difficulties in accessing services.
- An increase in the number of foreign drug addicts, and of their proportion on the total number of substance abusers.
- The merging of new modes of consumption for different, sometimes very risky, substances (alcohol, cocaine, stimulants) among the younger population, who often do not exhibit other forms of specific social or personal problems.
- A significant increase in the number of users among prison inmates, partly due to the full implementation of Dlgs 230/99. In 2000, the SerT team worked with 419 prison inmates. Among these, the number of foreigners - and in general of people from outside Bologna – has increased, while the number of Bologna residents in the care of the SerT while in prison is decreasing.
- Cocaine users. There is a cyclical increase in the flow of cocaine on the market and in the use of this substance, whose harmfulness is often underestimated. There has also been an increase in cocaine use among heroin addicts registered with SerT, who often inject cocaine as they do with heroin, with extremely serious health and social risks.
- Positive changes have also been registered, in terms of an improved social “compatibility” of registered substance abusers. Thanks to the generally positive economic outlook, the percentage of those who are regularly employed has also increased.
- However, there is a hard core of people who find it extremely difficult to find unprotected employment placement, even where addiction is well compensated.
- The number of users who do not have a police record is increasing.
The “Underground”. Specific research conducted on substance abusers who are not registered with the services indicate the presence of three broad groups:

- "Weekenders", occasional substance users, who consume heroin or other drugs at weekends or in particular circumstances (disco, raves, parties). Often these people use "designer drugs", in particular MDMA or ecstasy.
- “Social exclusion” area: substance abusers who are homeless and have no stable relational ties, living in situation of severe social exclusion and poverty. Most of these are not city residents, and have difficulties accessing the care system.
- Foreigners: "Foreign drug addicts “ are potential service users who are difficult to classify; whose specific needs are not easily charted by available tools (existing information systems), and whose identity is often incorrectly or only partially recorded, so that it is not possible to monitor them by following existing procedures (with follow-up studies). Their contact with services is generally a result of dramatic or traumatic events (imprisonment, hospital treatment, overdose).

Local Policies and Service System

In 1995 the Regional government issued a directive setting up the “Services System” at provincial level, and its management board, the Territorial Technical Co-ordination Unit (CTT), which includes all agencies working in the field of substance abuse: SERT, Municipalities, Provinces, Communities, Prefecture, Voluntary associations. The CTT started to identify tools for the analysis and evaluation of the phenomenon; therefore making it possible to identify problem areas or priority projects, which became the focus of activities for a number of working groups formed by operators of the public and private services of the city and province of Bologna. Since 1999 activities have focussed on the design and management of projects to be financed by the national fund for Combating Drug Abuse (Law 45/99). All projects were examined, amended and given a priority rating by the working groups; all projects explicitly established links with other initiatives and, in many cases, their management was allocated jointly to different agencies.

The comparative, shared analysis of emerging needs, the review of data processed by epidemiological Observatories and the expertise of CTT working groups produced significant changes in the organisational setting and activities of individual services.

In Bologna there are 5 Centres for addiction and substance abuse (Ser.T.) which are run by the local health Authority (U.S.L.).

There are also 5 therapeutic residential centres operating under contract with the U.S.L agency: La Rupe, Il Pettiroso, Casa Gianni, Il Quadrifoglio, Cooperativa L'Arcoveggio.

The SerT were established in compliance with D.P.R. 309/90 (before 1990, substance abusers were cared for by socio-medical teams located within USL) whose functions, tasks and organisational structures are detailed by D.M. 444/90.

Ser.T is a general service, whose specific task consists in providing social and health care services; access is either by voluntary registration by users themselves or by referral. Ser.T is also responsible for designing therapeutic treatment programmes, including the prescription of drug substitutes, following adequate observation and diagnosis.
As for voluntary associations, three should be mentioned here: Asat, SAT, ABAD-ALAMO.
The Municipality has activated collaboration projects with some of these associations, though they are not yet operational.

Active collaboration links also exist with the Standing Committee against social exclusion, formed by representatives of voluntary associations working in the field of social exclusion, rather than specifically with substance abusers (Red Cross, Caritas, trade unions, social co-operatives).

Some of these organisations have been contracted by the local administration to manage various facilities according to the principle of subsidiarity, i.e. where public services cannot be activated, voluntary organisations and the private social sector can act autonomously. The local administration must then provide partial financial support for the activities undertaken, and must co-operate to ensure that activities are as effective as possible.

The Municipality also pursues its primary objective of orientating and co-ordinating the activities envisaged by policies on substance abuse. Within the services system, the Municipality manages the following "harm reduction" measures:

- a mobile street unit
- a day centre
- a social counselling service
- 5 night shelters

The Municipality has a primary role within the framework of the Services System, in identifying and stressing local priorities, co-ordinating resources and monitoring activities.

The Municipality of Bologna considers the reorientation of the services system on users and their families as a priority, intervening wherever necessary and possible to focus services and interventions by all other providers in that direction.

Actually, it is necessary to co-ordinate interventions in order to ensure equal dignity to all public and private subjects and to pursue the goals of integration and co-operation in the framework of subsidiarity.

Special significance has been attributed to prevention measures among young people, focusing in particular on "New Drugs", providing various forms of support to families concerning education, their relationship with children who are at risk or in difficulty, in the field of information, vocational training and counselling for teachers and educators.

The Municipality of Bologna regards Schools and their relation with it as central in the implementation of prevention and awareness raising actions, and intends to promote jointly any initiative deemed necessary and useful.

Relationship with Law Enforcement Agencies

DPR 309/90 contains two clauses that refer specifically to the phenomenon of substance abuse:
• Art. 75 (administrative sanctions), which does not regard personal consumption as a crime, but sanctions drug dealing, the purchasing or possession of narcotic or psychoactive substances in quantities exceeding the average daily dose, as established by criteria set out in article 78, paragraph 1. Therefore, sanctions apply to selling and possession, not to personal use. Clearly this attitude belies a merely administrative, rather than preventative perspective. However, users of psychoactive substances, who are found in possession of such substances, are referred to the SerT where a therapeutic treatment is initiated; if the person refuses treatment, he/she will be given an administrative sanction (rather than a penal one), such as the temporary withdrawal of one’s driving licence or passport.

• Art. 121 (referral to the public service for addiction and substance abuse) “Any GP or medical practitioner visiting or caring for a person using narcotic or psychoactive substances must report him/her to the local public service for drug addicts. Such reporting is subject to regulations on privacy and confidentiality”. Operators then contact the referred person in order to elaborate a treatment-rehabilitation programme.

Currently, prevention and harm reduction actions do not actively involve law-enforcement agencies, except in specific situations, on request from individual operators (either from social services or law enforcement agencies) outside any specific institutional framework.

Prevention in Bologna

Current and future projects

New consumption styles– new drugs
In this area, the main problem derives from the need to identify better co-ordination procedures for the many existing initiatives, which should be supervised by Local Authorities. From this viewpoint, in the territorial context represented by CTT (Territorial Technical Co-ordination Unit) many differences exist with respect to territorial specificity. In the town of Bologna prevention is a complex and difficult task due to the lack of co-ordination in the different initiatives.

The Municipality of Bologna initiates and manages either directly or in co-operation with the Social Private sector and social Co-operatives several prevention initiatives. Priority projects are:

• The implementation of a family counselling service, in order to establish initial contact with parents and children in problematic situations. Projects: “SOS parents” and “Direct link with parents of substance abusers”.
• Extension of the Project for discotheque managers and staff, in co-operation with the Night-club Trade Union, to prevent the use of psychoactive drugs on their premises.
• Collaboration with all the educational agencies located in the Municipal territory (Sports Associations, Federations, Youth Groups, etc.) to design joint prevention projects with special reference to emerging problem areas, such as the recreational use of psychoactive drugs; the constantly increasing consumption of performance-enhancing substances, often presented as an easy means to success in sports.
As regards the school context the following initiatives have been launched:

- Involving junior high schools in the European project EU Drugs, to identify needs in respect of substance use prevention;
- Involving primary schools, junior high schools and High Schools in the general definition of a programme of primary prevention (students, teachers, parents).

Within schools C.I.C.'s (Centri di Informazione e Consulenza, Information and Counselling Centres) are open to students who can use them to talk about any problems and difficulties they experience to the staff (teachers and psychologists).

**The Services for Drug Addicts (SerT)** participates in prevention initiatives that are planned at Health Authority level by the Co-ordination of Health Education Services of the local Health Authority (CSES) and implemented in high schools; it also collaborates with Spazi Giovani (Youth Centres) in the provision of counselling services and treatment of young people at risk.

In 2001, the Local Health Agency implemented the project "Significant adults": theme-based educational workshops for high school teachers and students' parents; in 2002 the project will involve the setting up of an educational counselling service in a community clinics as well as in various schools.

As far as secondary prevention is concerned, in relation to synthetic drugs and multiple substance abuse, a project has been activated by the Local Health Authority in co-operation with a Community Centre in places of social aggregation and during events that attract large numbers of young people (such as raves parties and street raves).

The Local Health Authority has also initiated an area-based project in a suburban area (Casteldebole) where the risk of social exclusion and delinquency among young people is high. Here, a social centre has been set up in co-operation with SerT, with recreational, sports and cultural facilities.

At national level several awareness-raising campaigns have been launched:
- DrogaTel service (tel. number: 800-016600), a help-line providing information on the nearest services for drug addicts available to caller;
- Information campaign on the risks connected with substance use and abuse (see Internet website. <http://www.iononcalo.it>);
- TV advertising campaign "Io dico No" (I say no);
- TV advertising campaign for a therapeutic community (perhaps the most famous in Italy) and website: www.sanpatrignano.it

These initiatives have been implemented by the Presidency of the Council of Ministers – Department of Social Affairs.
2.2 Sweden

Sweden has three political and administrative levels: the primary is government; the secondary is the county council and the third is the municipality / local authority. The Riksdag (parliament) institute laws, but the county council and the local authority can prescribe unique regulations (e.g., not allowed to drink alcohol in public places).

Sweden has a long tradition to try to regulate the Swedes consumption of different drugs. The first known legislation is from 1698, an act that prohibits the production of alcohol for household use. According to a new Swedish doctoral dissertation that compares drug policies in Sweden and the Netherlands (Tops, 2001) the comparably tough attitude of Sweden is rooted in the institutionalised traditions of formal control, encapsulated in the idea of the “good state” and the right of the state to interfere in the private sphere of its citizens.

In Sweden, normally drug means all kinds of drugs, including tobacco, alcohol and narcotics. The Swedish drug prevention take part on three levels, all more or less publicly funded. The first level represents of ten national institutes (Folkhälsoinstitutet, Centralförbundet för alkohol- och narkotikaupplysning, Skolverket, Socialstyrelsen, Ungdomsstyrelsen, Rikspolisstyrelsen, Svenska Kommunförbundet, Landstingsförbundet, Tullverket and Systembolaget), that are to (1) improve the national health, (2) supervise the work of the local authorities and (3) develop the knowledge in order to improve the national health. They all have different focus, but all in one way or another deal with drugs (primarily primary prevention). The Swedish council for information on Alcohol and drugs (Centralförbundet för alkohol- och narkotikaupplysning) does for instance annually drug inventories on tobacco, alcohol and drug use in all of Sweden.

The second level comprises of different organisations within the local authority. The level consists of some 30 voluntary organisations (if you’re interested I will send you the names) and eight “other organisations” (e.g., Drugsmart.com, Mentor) that deal with drug prevention.

According to Statskontoret (1998) the drug preventive work annually costs the Swedish state approximately 230 million SEK (24 million EUROs).

The legislation. There are numerous acts that in one way or another regulate the attitudes and consumption of different types of drugs. Trying to get a survey of the Swedish legislation, my impression is that there are two opposing trends. The first is an adaptation / adjustment to the European legislation for alcohol – since Sweden joined the EU. For instance, the tax on beer and wine is lowered, the possibility for restaurants to get an alcohol license is easier, the Swedish Alcohol Retailing Monopoly (Systembolaget) lost their monopoly for wholesale trading alcoholic products. In 1975 there were 281 establishments that were licensed to sell alcohol in Stockholm, in 1987 the number increased to 843 and in the year of 2000 it was 1562.

However, Systembolaget is still the only company that is allowed to sell alcoholic products to individuals. The second – and opposing trend – is more prevention. For instance, the age limit for buying tobacco is increased to 18 years of age, the penalty for using narcotics are moving from light to severe.
Some of the relevant acts or national regulations that today regulate drug use in Sweden are:

The Tobacco Act of 1993. This act prohibits all under the age of 18 of purchasing tobacco. There is also a ban for smoking in school, day care et cetera. Since the start of statistics in 1981, there is downward trend in smoking tobacco among the adult population (18 – 73 years of age); from about one third in 1981 to one fifth in 1998 (Folkhälsoinstitutet och Centralförbundet för alkohol- och narkotikaupplysning, 2000). The situation is probably the same for younger persons.

The Alcohol Act of 1995. You are not allowed to consume beer, wine or hard liqueur before the age of 18, and not purchase before the age of 20. The Swedish Alcohol Retailing Monopoly lost their monopoly for wholesale trading of alcohol, but continues to be the only to sell to individuals. The act of 1995 also established a new local authority to license and control those establishments that are to sell alcohol (e.g., pubs, restaurants).

There are no clear indications of increased alcohol consumption among young Swedes (Folkhälsoinstitutet och Centralförbundet för alkohol- och narkotikaupplysning, 2000). The average total annual consumption given as centilitres of pure alcohol was about 2,3 litres 1979/80 (girls 16 – 19 years of age) respectively 5,2 litres (boys 16 – 19 years of age) and 2,7 litres in 1998 (girls) and 4,8 litres (boys).

The Narcotic Act. The first Narcotic act is from 1923. Since then at least 20 new acts or regulations has been passed. The general trend is to successively add new narcotic substances to the law and to increased the penalties for narcotic distribution. On the same time, the view on “private possession” has changed. From 1968 to 1972 larger quantities were allowed without prosecution. After 1980, this trend was changed and from 1988 substance abuse was made an criminal offence. First, possession was imposed by fine, and then since 1993 by (possible) imprisonment for 6 months. In 1993 the Narcotic legislation was also changed so that blood and urine test can be made when consumption is suspected. An evaluation of the enforcement of this new legislation (Brottsförebyggande rådet, 2000) show that the number of individuals that were arrested for private possession increased with 40% between 1993 and 1998. Young people under the age of 20 and not earlier known to the police (for narcotic related crimes) increased from 265 (1991) to 804 (1997), an increase of 300%. The situation is equal for young people (15 – 19 years of age) that were known to the police; from 324 to 934, as well as older individuals. In Stockholm the number of positive blood and urine tests (for all ages) increased from approximately 1.270 (1994) to 1.980 (1998). Of course, there is no way to disentangle to what extent those increases really depends on the changed legislation and to changes in the consumption.

The Smuggling of Goods Act. The second half of the 1990th meant a clear increase of identified smuggling; the number of cigarettes that was confiscated increased from 5,1 million 1994 to 45,0 million 2000. The same goes for alcohol: 254 thousand litres in 1994 to 811 thousand litres in 2000; and narcotics: 338 kilo 1994 to 959 kilos 2000.

The Prohibition of Unhealthy Goods Act. This is a new act that includes items that not yet is included into the Narcotic act, but assumed to be dangerous.
The Traffic Act. From 1999, all consumption of alcohol and narcotics is banned by drivers (zero-tolerance).

The Social Welfare Act. This act, that came into effect 1982, is a general law pertaining to such services as financial assistance, child welfare, and facilities for the aged. The fundamental principles of this act is that the need of the individual must be focused, that the assistance that is offered is voluntary, a holistic view must be applied, and that individuals should not be subjected to unwarranted special treatments. This is the primary act that regulates support to young people, but does also regulate the preventive efforts by the society.

Care of Young Persons Act. The compulsory care of young people is made in accordance with the Care of Young persons act. This is provided by state driven institutions, run by the National board of Institutional care.

The Care of Substance Abusers Act. Regulates the possibilities of compulsory care of adults, that is persons 18 years or older.

The Education Act. All compulsory and Upper secondary schools are according to the educational act responsible to monitor and develop the health of the students.

The Compulsory School (Upper Secondary) Regulation. These regulations control the schools disciplinary options towards students that use tobacco, alcohol or drugs.

The Compulsory School Curriculum. The curriculum mandate each school to have drug education (ANT); during grade 5 (approx. 12 years of age) each student should know the physical and psychological consequences of drugs.

Drug use. In an international perspective, evidence indicate that the Swedes are fairly low in alcohol and narcotic consumption. At grade 9 has approximately 25% of British young persons been drunk, 17% of the Swedish and 5% of the Italian school kids; Narcotics: 42% in Britain, 21% Italy, 6% Sweden (Folkhälsoinstitutet och Centralförbundet för alkohol- och narkotikaupplysning, 2000). Regarding tobacco, the situation is more equal: 28% Sweden, Great Britain 27%, Italy 25%.

Stockholm

The city of Stockholm has 750.000 inhabitants, annually increasing with about 7000 inhabitants. It is the commercial, financial and political centre of Sweden. Greater Stockholm has about the 1.600.000 inhabitants, which is about one sixth of all Swedes. Although the immigration has increased during the last decades, still 90% are Swedish citizens and 80% are born in Sweden. The unemployment was 2000 2,1%. A high proportion (54%) of the inhabitants are living in one-person households. 20% of the populations is 20 years or younger.

In Stockholm, there is about 6.000 identified drug addicts. That equals about 1% of the population. Of those 2.000 are intravenous drugs addicts. There are about 1.300 youth (20 years of age or younger) known to abuse alcohol or other substances.

The political and administartional authority of Stockholm is partly centralised to the policy and finance committee of the city council (Kommunstyrelsen) and partly
decentralised to 18 city Districts, each on responsible for their own schools and child welfare.

Centralised preventive work

The County Council. The present political majority of Stockholm is a conservative coalition. One of the foci of the majority is to prevent crime and drug abuse. Note that all consumption of tobacco, alcohol or narcotics is to be considered abuse, since no consumption of tobacco and alcohol is allowed before the age of 18, and none of narcotics. The official message is that of “zero-tolerance”.

The County Council also has the responsibility for medical attendance. There are three separate organisations that are working to help those with drug problems, including young persons: (1) Centre for alcohol and drug prevention, (2) Drug addiction centre north, and (3) the Maria Youth Clinic, which helps young people that are acutely intoxicated.

Police. The police force is an important agent in the actual drug use. The enforcement of the different laws directly and indirectly influence the attitudes and consumption of drugs. According to a study by the National council for crime prevention, the number of blood and urine tests that are made annually are steadily increasing, now up to 12,000 a year. The police resources devoted to fighting drug use have more than doubled in the 90ths.

Prevention Centrum Stockholm (Precens). The Precens (the Preventive Centre) is founded under the direct support of the Social welfare minister of Stockholm. It is an organisation that aims to prevent crime and drug abuse among young people. It should (1) support the city parts in the drug preventive work, (2) initiate information campaigns, (3) continuously monitor the increase of decrease of drug abuse (which is done biannually in surveys to all students in grade 9), and (4) educate different personnel working with drug prevention.

Decentralised preventive work

School. All compulsory and upper secondary schools are according tot the educational act responsible to monitor and develop the health of the students. The compulsory school regulation / Upper secondary schools regulation regulates the schools disciplinary options towards students that use tobacco, alcohol or drugs. The compulsory school curriculum mandates each school to have drug education; during grade 5 each student should know the physical and psychological consequences of drugs. According to an evaluation by the Skolverket (2000), the “anti-drug education” is generally of poor quality. Others have found (Andersson, 1997) that many schools lack all “anti-drug education”, or that it is very fleeting in time.

Social service administration. When it comes to minors, the most important agent is the Social welfare administration. They should prevent the occurrence of drug consumption, as well as when identified, prohibit further use. Child welfare exists in all Europe. However, the extent varies dramatically, from about 2 children per 1000 annually in England, Netherlands, Belgium and Germany, to more than 20 in Sweden and Norway. According to a new study from Stockholm (Andrée Löfholm, Nyman, & Sundell, 2001) the enforcement of drug use is not always harsh. Of those young persons under the age of 20 that were reported (according to a mandatory law)
because of drug use, 65% were investigated. This means that one third of the cases were just dropped without any further acts from the authority.

**Private organisations.** As stated above, there are several private non-profit organisations that are devoted to preventing drug problems. The European cities against drugs are lobbying among politicians et cetera, and the Mentor Sweden is distributing money to local initiatives against alcohol and drug use. Mentor Sweden also has the Swedish queen in its board.

**References**


2.3 Britain

History of British Legislation Concerning Drug Misuse

During the First World War, it was rumoured that British soldiers were using cocaine to enhance their performance and help them cope with the trauma of war. This resulted in the introduction of the first piece of primary legislation to control the possession of heroin and cocaine and the Defence of the Realm Act (1916) was introduced to prohibit their use. The law on possession of certain drugs was reinforced by the Dangerous Drugs Act (1920).

The Misuse of Drugs Act 1971 is the main legislation controlling the misuse of drugs in this country and is the basis of the legislation that underpins the current government strategy. The Advisory Council on the Misuse of Drugs (ACMD) was set up under this Act to “keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem.”

Current National Policy

By 1994 the government had realised that to tackle the growing drug misuse problem in the country would require a co-ordinated approach in addition to the laws regarding possession and dealing.

Tackling Drugs Together (1995) was the White Paper, which was driven by this statement of purpose:

To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:

- increase the safety of communities from drug related crime;
- reduce the acceptability and availability of drugs to young people; and
- reduce the health risks and other damage related to drug misuse


The strategy recognised the need for stronger action on reducing the demand for illegal drugs and that multi-agency co-ordination, both at national and local levels, would be required in order to make systematic progress to these aims. There were three main areas to the strategy: crime; young people; and public health.

To address the issue of reducing the level of drug related crime the strategy attempted to broaden the approach that statutory agencies take by using secondary prevention methods as well as enforcement. The introduction of Arrest Referral schemes across the country is an example of this new approach. The engagement of local communities with statutory and voluntary agencies in a shared agenda of improving community safety is an attempt to reassure people that effective action is being taken to tackle the drugs problem and reduce the fear of crime.

Young people were a key focus of the new strategy and attempts were made to strengthen the approaches taken by education whilst at the same time recognising that there are a range of influences on young people to take drugs and that youth
services and other agencies need to be more involved in the education and prevention process.

The most significant aspect of the strategy however, was the requirement of districts to set up local Drug Action Teams (DATs) to work together in producing local strategies and delivering effective solutions to the drugs problem in their area. The make up of each Drug Action Team is left to each area to decide, but would normally include Chief Executives of Health and Local Authorities, senior Police Officers, Directors of Education, Social Services and Public Health as well as the manager of the Prison Service and the Probation Service. Drug Reference Groups were also established to provide local expert advice to Drug Action Teams and to involve broad representation from the local community and voluntary groups as well as statutory agencies.

In May 1997, a Labour Government was elected and, as part of their election manifesto, a ‘Drugs Czar’ was appointed to set about drafting a new national strategy to build upon the previous government’s Tackling Drugs Together. The White Paper, ‘Tackling Drugs to Build a Better Britain’ was published in April 1998.

This strategy has four elements:

- Young people – to help young people resist drug misuse in order to achieve their full potential in society
- Communities – to protect our communities from drug related anti-social and criminal behaviour
- Treatment – to enable people with drug problems to overcome them and live healthy and crime free lives
- Availability – to stifle the availability of illegal drugs on our streets

*Tackling Drugs to Build a Better Britain (May 1998)*

This strategy builds upon the previous one but has an even greater emphasis on coordinated activity, both at central government level and at a local level. Extra funding has been made available to support the key areas of the strategy. The Drugs Prevention Advisory Service (DPAS) has been tasked with providing advice and support to local Drug Action Teams and monitoring their progress and effectiveness against national and local targets to achieve the aims of the government’s strategy.

**Walsall’s Response to the National Strategy**

Walsall is a town in the West Midlands, approximately twelve miles northwest of Birmingham. It has a population of approximately 263,000 (1991 census) and at one time was an important engineering and lock-making centre. Much of the engineering base has disappeared to be replaced by service industries. It was also well known for its leather industry and there are still a small number of family run businesses in the town specialising in high quality leather goods. Walsall Football Club is still known as ‘The Saddlers’ because of the town’s connection with making saddles and harnesses.

Unemployment reached a peak in Walsall in 1993 with 18% of the population who ‘had not undertaken any work for pay or profit in the week of the Survey’ (Griffiths 1998). By 1998 the estimated unemployment rate had fallen to 7.4% (Griffiths 1998). The pattern for unemployment across the borough closely follows other
indices of deprivation and demonstrates the East-West divide in Walsall with areas of poor health, poor nutrition and high rates of smoking (Ramaiah 1998). A scoping report into drug use in the borough also identified that the ‘hotspots’ for crime and chaotic drug use were also to be found in the areas of high unemployment and poor health outcomes (Spence 2000).

A report undertaken by two local parliamentary candidates to understand the nature and extent of the drug problem in Walsall (George and Geary 2001) highlighted the links between reported crimes in the Borough. In 1999-2000 out of a total of 36,000 crimes committed in Walsall, an estimated 50% were linked to drugs and in particular, heroin. More recently, an increase in the use of crack cocaine has been observed by street workers and police. The geographical location of Walsall may help to explain why drugs are so prevalent in the area. Walsall has a major motorway (M6) running through the western part of the Borough connecting the north of the country with London. Another major motorway junction (M5) in Walsall connects the area to the south west of the country and another junction (M54) connects the area to the west and Wales. This motorway network makes Walsall an ideal distribution point for drugs moving around the country. Inevitably, as drugs are transported through the area, a quantity of them end up on the streets of the town. The affordability and availability of heroin and other drugs makes them an acceptable alternative to cigarettes and alcohol for a small, but increasing, number of young people.

Walsall also has a significant ethnic minority population who live mainly in the south and west of the borough. Approximately 10% of the population is from black and ethnic minority communities, made up of:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>0.9%</td>
</tr>
<tr>
<td>Indian</td>
<td>4.7%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.6%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

(Source: 1991 Census)

Some research has recently been undertaken to examine the issues that concern the Black and Ethnic Minority Communities around drugs. Among a range of issues raised through the research were the concerns that drug education in schools is delivered by predominantly white teachers and does not reflect the cultural diversity of the pupil audience. The issues raised are not considered to be relevant for them so many of the key drug education messages may be lost. Drug education needs to take place in settings other than schools and be delivered by credible workers for the target audience (Garratt 2001).

The local Health Action Zone Steering Groups also commissioned research into drugs issues in their areas. These findings have been built into the Drugs Action Plan for 2001-02 and some of the HAZ funding has been used to support the work in schools. All of the HAZ areas highlighted the need to work with the most vulnerable and at risk young people and also to raise awareness of the drugs issue amongst all members of the local community.
Structures in Walsall

Walsall set up its own Drug Action Team in 1995 following the recommendations of Tackling Drugs Together, consisting of the senior representatives from the designated organisations and other relevant bodies. A Drugs Reference Group was created at the same time. A Drug Action Co-ordinator was appointed to develop the local strategy and Action Plans and oversee their implementation.

The aims of the local Action Plans broadly reflected the national strategy with additional local targets to take account of the nature of the drugs problem within Walsall. In 2000 the Drug Action Team was restructured to make it more focused and at the same time the Drug Reference group was disbanded and reformed into four smaller groups representing the four key aims of the 1998 strategy. A joint commissioning forum was set up to work alongside the DAT to commission drug treatment services and prevention activities across the Borough.

The local structures in Walsall that have an impact on the implementation of the government’s strategy ‘Tackling Drugs to Build a Better Britain’ include:

- The Drug Action Team
- Education Services
- Social Services
- West Midlands Police Force
- Probation Service
- The Local Authority
- Walsall Health Authority
- Walsall Community Health Trust
- Primary Care Groups
- Health Action Zones
- Addaction
- Youth Offending Team
- WALKWAYS
- Black and ethnic minority groups
- ESCAPE

The above groups are either represented at senior manager or Director level on the Drug Action Team or on one of the four sub-groups feeding in to DAT. All of the organisations and agencies delivering work that is related to tackling the drugs misuse problem in Walsall is now linked into the strategic decision making process to enable co-ordination of the strategy to take place at all levels.

Education Policy, Curriculum and Preventative Practice in Walsall

The delivery of drug education in schools is driven by the national legislative framework and current trends in health education. This results in a variety of approaches largely based on attempting to dissuade young people from using drugs. This has resulted in a number of different approaches being used. Many of the programmes have an American influence, such as DARE (Drugs Abuse Resistance Education) or the abstinence campaign of ‘Just say ‘No’.

The main approaches that have been tried are:
• The shock/horror approach that includes hard-hitting videos and publicity, including users talking about the horrors of drug use

• Giving young people information about drugs on the assumption if they are properly informed they will not use drugs

• Developing attitudes and values that promote a drug free lifestyle and strong moral beliefs to misuse drugs

• ‘Just say no’ campaigns whereby young people develop skills to say ‘no’ to peer pressure

• Giving young people the opportunity to develop decision-making skills to make informed choices

• Displacement activities where young people are encouraged to try other risk taking activities such as abseiling or white water rafting to replace the highs that they might experience from taking drugs

• Programmes to develop self esteem which are based on the assumption that young people with high levels of self-esteem will not use drugs

• Life-skills programmes that incorporate elements of all of the above and are developmental, start at an early age and build upon the knowledge, skills and attitudes of the young people involved.

Cohen (1996) concluded that research evidence shows that appropriate drug education can increase drug knowledge, develop decision-making skills and make young people more discerning about what they actually do. It does not stop young people using drugs but it can play a role in reducing drug related harm.

Primary prevention programmes that try to prevent young people from using drugs in the first place can cause harm and may exacerbate drug problems amongst young people (Cohen, 1996). He goes on to argue that school based programmes should emphasise what happens to them if they choose to use drugs rather than not to use them in the first place. However harm reduction programmes have been given little official support. Their use in schools and youth settings is known to be widespread and practitioners believe this approach is more realistic for young people who may already be engaging in risk taking behaviour.

The key piece of government guidance influencing the delivery of drug education in English schools is Circular 4/95 Drug Prevention and Schools. It was produced as a result of the Tackling Drugs Together Strategy (1995) and based on the recommendations of a report by the Advisory Council on the Misuse of Drugs (1993), Drug education In Schools: The Need for New Impetus. The new guidance set out the statutory position on drug education in schools; described the principles which should inform the teaching of drug education; offered guidance to schools to help them develop drug education programmes; made suggestions on how to deal with drug related incidents within schools; and also focused on tobacco, alcohol and volatile substances in addition to illegal drugs.
This Circular has been supplemented by, but not replaced by, a more recent publication called 'Protecting Young People' (1998) which responds to the newer government strategy, 'Tackling Drugs Together to Build a Better Britain' (1998). The document looks at the evidence for good practice in drug education in schools and the youth service.

The approaches that it advocates constitute good drug education are based on the conclusions of the OFSTED report (1997), 'Drug Education in Schools'. This states that "the effective teaching of drug education should increase pupils' knowledge about alcohol, tobacco and other drugs and also enable young people to:

- improve their self-esteem
- make informed choices and decisions
- develop personal initiative and be able to take responsibility
- recognise personal skills and qualities in themselves and others
- maintain and develop relationships
- develop self-confidence
- develop assertiveness in appropriate situations
- develop the motivation to succeed"

(Protecting Young People DfEE (1998))

Drug education in schools is delivered as part of the Personal, Social and Health Education curriculum (PSHE). This is not a statutory subject in the same way as the rest of the National Curriculum, but drug education forms part of the inspection process of OFSTED (Office for Standards in Education). Schools are expected to have a drug education policy in place, which includes the handling of drug related incidents. The National Curriculum 2000 that was introduced in all English schools in September 2000 included a PSHE and Citizenship Curriculum. Citizenship does not become statutory until Key Stage 3 at Secondary school.

Although the government has not made PSHE a statutory requirement, it has introduced a framework for its implementation in schools. The National Healthy Schools Standard has been developed from the original European Health Promoting Schools initiative in 1995. A variety of local schemes developed based on the Health Promoting Schools Principles. A number of local schemes have been accredited to agreed National Standards. Walsall's local scheme was accredited in April 2001. Drug Education features as a target within the framework with key performance indicators that the school is expected to achieve.

Walsall was one of thirty-five Local Authorities in England to receive additional consultancy and training to implement Quality Standards in Drug education in its schools. These standards are based on 'The Right Approach' and the 'The Right Response' produced by Drugscope. These standards are currently being piloted in six Secondary Schools and a number of Primary Schools have also undertaken the
necessary training. As part of the attempts to improve the quality of support offered to schools, some of the local voluntary organisations have also taken part in this training.

The government has a target of all schools having planned programmes of drug education in place by July 2003. (DfES 1999). Walsall is working towards this target and is likely to achieve 100% of schools with programmes and policies in place by the end of 2002.

In addition to the recommended drug education curriculum, Walsall has introduced Early Years’ Personal, Social and Emotional Goals. This effectively means that drug education begins at three years of age. To provide the evidence for taking this approach in Walsall a piece of research was commissioned by the Drug Action Team in 1996. This took place in Lane Head Nursery School in Walsall and used a puppet called Nathan to elicit responses from the pupils aged 3-5 years on subjects such as smoking, drinking alcohol and using medicines. The results demonstrated that pupils already have attitudes and opinions on smoking and drinking and that it is very relevant to begin work on developing emotional literacy and simple decision-making skills with this age group.

The teaching methods used to deliver PSHE vary from traditional teacher led classroom discussions, group work, use of a variety of resources, including videos and CD-ROM. The most significant change to the way PSHE is delivered in Walsall is through the introduction of an Art into Personal, Social and Health Education Coordinator. Walsall has been designated as a Health Action Zone (HAZ) because of its poor health outcomes based on a range of indicators. Some of this funding has been used to support the local Healthy Schools Initiative and develop innovative projects to improve the health and well being of children in Walsall. An important feature of the whole programme is the way it works with local communities to identify their health needs and develop imaginative ways of providing solutions to these problems. ‘Arts into Health’ is the vehicle that is used to tackle these issues. Using this principle an arts worker was appointed to consult with 5-11 year olds on their health concerns. This led to a post being established which ensures that young people’s voices are taken into account when planning PSHE. The drug education programmes that are being developed in schools taking part in the Healthy Schools programme are developmental, use life skills methodology and include interactive techniques, including Quality Circle Time, Theatre in Health Education and a variety of arts media to achieve their aims.

Preventative Practice – Working with Vulnerable Young People

Walsall’s Drug Action Plan (2000-2001), recognises the fact that schools are not the only place where young people receive education about drugs and includes targets on working with excluded and disaffected young people as well as those young people looked after by the Local Authority or involved with the Youth Justice system. The affordability and availability of heroin in the town suggests that a growing number of young people may be using this drug as their first drug of choice rather than cannabis. The recent Young People’s Lifestyle Survey (Exeter University 2001) shows a small increase in the number of under 16’s admitting to using heroin compared with the 1995 survey (Birmingham University 1995) i.e. <2% cf <1%.
There were a number of highly publicised deaths in Walsall, attributed to heroin overdoses during 2000. This led to accusations in the press by the local Coroner that schools were not doing enough to address the dangers of heroin. A co-ordinated plan has been drawn up, including training, drug awareness, needle exchange, Hepatitis C awareness and a campaign to raise awareness of the dangers of heroin. (Walsall DAT Action Plan 2000-01)

Programmes designed to work with the most vulnerable young people include the Youth Inclusion Project; Positive Futures; Drugs, Empowerment, Action, Learning (DEAL); and the Jigsaw project. These programmes draw their funding from a variety of sources and use sport, physical activity and engagement in music or video projects to divert young people from engagement in drug taking situations.
2.4 Netherlands

**DRUG POLICY IN THE NETHERLANDS**

The main aim of the drugs policy in the Netherlands is to protect the health of individual users, the people around them and society as a whole. Priority is given to vulnerable groups, and to young people in particular. Policy also aims to restrict both the demand for and supply of drugs. Active policies on care and prevention are being pursued to reduce the demand for drugs, while a war is being waged on organized crime in an attempt to curb supplies. A third aim of policy is to tackle drug-related nuisance and to maintain public order. The Netherlands now has twenty years experience of working with these policies on drugs.

Given the importance of an integrated approach, responsibility for drugs policy is borne by a number of ministries. The Ministry of Justice is responsible for matters falling within the scope of criminal law and the Ministry of Health, Welfare and Sport for policy on prevention and care services and for coordinating drugs policy as a whole. The Ministry of the Interior is responsible for matters relating to local government and the police. An integrated approach to drugs policy has been adopted at local level too.

**Dutch Society**

In order to appreciate the Dutch approach to the drugs problem, certain characteristics of Dutch society must be kept in mind. The Netherlands is one of the most densely populated, urbanized countries in the world. It has a population of 15.5 million, occupying an area of no more than 41,526 km². The Netherlands has a long history as a country of transit: Rotterdam is the largest seaport in the world, while the country has a highly developed transport sector. The Dutch firmly believe in the freedom of the individual, with the government playing no more than a background role in religious or moral issues. A cherished feature of Dutch society is the free and open discussion of such issues. A high value is attached to the well-being of society as a whole, as witness the extensive social security system and the fact that everyone has access to health care and education.

**Indictable Offences and Maximum Penalties**

The maximum penalty for importing or exporting hard drugs is 12 years imprisonment and a fine of 100,000 guilders. Anyone found in possession of a quantity of hard drugs for personal use is liable to a penalty of one year imprisonment and a fine of 10,000 guilders. The maximum penalty for importing or exporting soft drugs is four years imprisonment and a fine of 100,000 guilders.

Habitual offenders are liable to a maximum penalty of 16 years imprisonment and a fine of 1,000,000 guilders. Moreover, offenders may be deprived of any advantage gained from the offence.
The basic principles of the Opium Act

Regulations on drugs are laid down in the Opium Act. The Act draws a distinction between hard drugs, (e.g. heroin, cocaine and XTC) which pose an unacceptable hazard to health, and soft drugs (e.g. hashish and marihuana), which constitute a far less serious hazard. The possession of drugs is an offence. However, the possession of a small quantity of soft drugs for personal use is a minor offence.

Importing and exporting drugs are the most serious offences under the provisions of the Opium Act, although manufacturing, selling and attempting to import drugs are also offences. As is the case in other countries, the cultivation of hemp is prohibited, except for certain agricultural purposes (e.g. to form windbreaks, and for the production of rope). New legislation is currently being drafted to raise the maximum penalty for commercial hemp production from two to four years imprisonment. On the principle that everything should be done to stop drug users from entering the criminal underworld where they would be out of the reach of the institutions responsible for prevention and care, the use of drugs is not an offence.

Investigations and Prosecutions Policy

As is the case in many other countries, the expediency principle is applied in Dutch policy on investigations and prosecutions. This means that the public prosecutor may decide not to institute prosecution proceedings if it is in the public interest. The highest priority is given to the investigation and prosecution of international trafficking in drugs; the possession of small quantities of drugs for personal use is accorded a much lower priority.

Anyone found in possession of less than 0.5 grams of hard drugs will generally not be prosecuted, though the police will confiscate the drugs and consult a care agency.

The expediency principle is applied to the sale of cannabis in coffee shops in order to separate the users’ markets for hard and soft drugs and keep young people who experiment with cannabis away from hard drugs.

The sale of small quantities of soft drugs in coffee shops (which are not allowed to sell alcohol) is therefore technically an offence, but prosecution proceedings are only instituted if the operator or owner of the shop does not meet the following criteria:

- no more than five grams per person may be sold in any one transaction;
- no hard drugs may be sold;
- drugs may not be advertised;
- the coffee shop must not cause any nuisance;
- no drugs may be sold to minors (under the age of 18), nor may minors be admitted to the premises;
- The mayor may order a coffee shop to be closed.

While the Opium Act is designed to tackle drug trafficking directly, a number of measures have been taken to counter the problem indirectly, such as legislation which makes it easier to investigate and confiscate the proceeds of drug trafficking and prevent money laundering. Dutch banks, for instance, are obliged to report any unusual financial transactions. Since 1995, legislation has been in force which enables monitoring of the trade in precursors (i.e. substances which are not in themselves illegal but which may be used in the manufacturing of drugs).
Safety and Public Order

Until 1995 the number of coffee shops increased, and some have given rise to considerable nuisance, while some have links with criminal organizations. For these reasons, the Dutch government has decided to tighten up controls.

Policy on coffee shops is largely decided at local level by the local authorities, the police and the public prosecutions department. The municipalities have gained wider powers to tackle the problem of nuisance by limiting the number of coffee shops operating within their district. As a result, the past 18 months have witnessed an 11% drop in the total number of coffee shops. This vigorous policy will continue to be pursued until the number of coffee shops has reached the minimum at which the objective of separating the markets can be achieved.

Liveable conditions and safety are a high priority in the major cities. In the past four years, the Netherlands has invested an extra 60 million guilders in projects to tackle drug-related nuisance and in facilities for the treatment and rehabilitation of the addicts who cause it. Addicted offenders are now given the option of detoxification treatment or serving a prison sentence.

Drug tourism gives rise to serious nuisance, and efforts to counter it have been accorded a high priority. Agreement has been reached with France on a simplified transfer procedure for drug tourists, while foreign drug tourists may be expelled from the country. One of the objectives of reducing the number of coffee shops and the quantity of cannabis that may be sold is to counter drug tourism. From time to time, investigations will be conducted targeting foreigners who export quantities for sale in their own countries.

Care

The protection of the health of drug users is a major priority, and a wide range of facilities are available. The Netherlands spends more than 300 million guilders a year on facilities for addicts. Over half of this amount is spent on the drug problem. There are 12 clinics for the treatment of addicts, and their capacity has been increased, from 500 places in 1980 to 1961 in 1995.

In the past ten years accessibility of care services has improved considerably. These services now reach an estimated 75% of all addicts. Their aim is to reach as many addicts as possible to assist them in efforts to rehabilitate, or to limit the risks caused by their drug habit. Social rehabilitation is an essential element.

To achieve these aims, an extensive network of services has been established. Methadone-programs enable addicts to lead reasonably normal lives without causing nuisance to their immediate environment, while needle exchange programs prevent the transmission of diseases such as AIDS and hepatitis B through infected needles. The services also provide counselling.

Prevention

Prevention plays an important role in Dutch drugs policy. Schools in particular are targeted in efforts to discourage drug use, while campaigns are conducted in the mass media to reach the broader public. In late 1996, a campaign was launched to
counter the use of cannabis, while XTC will be the subject of a similar campaign in early 1997.

The objective of these campaigns is to discourage the use of cannabis and XTC. The use of XTC is particularly popular among young people attending raves and discos. In 1995, to prevent accidents occurring during such large-scale events, municipalities were issued with guidelines on ways of maintaining public order and safety and limiting health risks, which many now apply when issuing licenses. As a result, far fewer accidents now occur during these events.

### Results of Public Health Policy

There were 2.4 drug-related deaths per million inhabitants in the Netherlands in 1995. In France this figure was 9.5, in Germany 20, in Sweden 23.5 and in Spain 27.1. According to the 1995 report of the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, the Dutch figures are the lowest in Europe. The Dutch AIDS prevention-program was equally successful. Europe-wide, an average of 39.2% of AIDS victims are intravenous drug-users. In the Netherlands, this percentage is as low as 10.5%. The number of addicts in the Netherlands has been stable at 25,000 for many years. Expressed as a percentage of the population, this number is approximately the same as in Germany, Sweden and Belgium. There are very few young heroin addicts in the Netherlands, largely thanks to the policy of separating the users markets for hard and soft drugs. The average age of heroin addicts is now 36.

In most EU countries, such as the United Kingdom, Germany, France, Sweden and the Netherlands, the use of cannabis has increased in the past few years. A similar trend is, unfortunately, discernible with regard to synthetic drugs. Evidently, international youth culture has more influence on the use of these substances than government policies. International cooperation is therefore vital in tackling this problem.

### Research and Monitoring

Though Dutch policies in the field of health protection have been relatively successful, some adjustments are needed. The nature of the drugs problem is constantly changing and a ceaseless effort must therefore be made to seek the best means of limiting the damage drugs can cause to health. Monitoring (following and recording trends) as well as scientific research are therefore essential if an adequate response is to be given when new risks emerge.

The Netherlands occupies a leading position internationally in research and monitoring, as witness the 1995 report of the European Monitoring Centre for Drugs and Drug Addiction in Lisbon. A national drugs monitoring system will be set up in the course of 1997.

To supplement the European Monitoring Centre’s work, a number of international comparative studies have recently been conducted to analyse the extent of the drugs problem and the policies pursued. Studies were published on the policies pursued on cannabis in the Caribbean, Germany, France and the United States, and these were compared with Dutch policy. A study was also conducted of policy on hard drugs in
France. A bilateral study of the situation in Sweden and the Netherlands is currently under preparation.

An extensive study has been launched of the nature and extent of XTC use, the results of which will be published in the spring of 1997. The study will examine factors such as the pharmacological and toxicological effects of this drug, as well as its social and epidemiological impact.

Policies are continually amended in response to such studies.

**Marijuana as Medicine**

On August 26, 1996, the Minister of Health, Welfare and Sport requested the Health Council of the Netherlands to inform her, as soon as possible, about the scientific situation relating to the medical use of marijuana and its active constituents. The response to the Minister's request is embodied in this summary.

Marijuana has been known for several thousand years in herbal medicine. Its active substances are the cannabinoids, especially tetrahydrocannabinol (THC). Over the years, Cannabis sativa, as the herb is officially known, has been claimed to increase appetite, relax the muscles, sharpen the mind, improve mood, have a sedative effect, relieve anxiety and combat pain and nausea. The literature cites dozens of ailments and disorders that have allegedly responded to treatment with marijuana. With the emergency of standardized medications, the medical use of marijuana sank into obscurity. During the Sixties, the increasingly widespread use of marijuana as a stimulant was accompanied by a burgeoning interest in its medicinal properties. During this period also, synthetic preparations of marijuana's active constituents (such as THC) were developed. While marijuana is usually smoked, it is also traditionally added to certain foods and drinks (marijuana tea). The THC content of marijuana preparations varies from 0.5% to 15%. Outside the Netherlands, two synthetic cannobinoids are marketed as medications: dronabinol (THC) in the United States (Marinol) and nabilone in the United Kingdom (Cesamet).

A study of the literature highlights four applications for which marijuana and cannabinoids in particular are alleged to be effective:

- Chemotherapy-induced nausea and vomiting
- As an appetite stimulant in AIDS patients and cancer patients
- As a muscle relaxant and tremor-suppressor in multiple sclerosis (MS)
- Intraocular pressure lowering in glaucoma.

In order to assess the efficacy of marijuana and cannabinoids for these indications, the Committee has studied the literature published during the past 25 years. On the basis of this literature survey, the Committee has concluded that evidence is insufficient to justify the medical use of marijuana.

Furthermore, with regard to marijuana, the Committee believes that physicians cannot accept responsibility for a product of unknown composition that has not been subjected to quality control. This is not restricted to smoking, but also applies to other forms of consumption, such as tea.
In saying this, the Committee does not wish to judge patients who consume marijuana (in whatever form) because it makes them feel better. As with alcohol and tobacco, this is a matter for individual patients.

The Committee is presently unable to respond to the Minister’s request for a comparison between the use of marijuana, or any other preparations of the hemp plant, and the active ingredient tetrahydrocannabinol (THC), or other constituents, since there are no published reports of systematic research on this topic.

**Drug use among high school pupils**

On June 19, 1997, the Trimbos Institute published the core data of the sentinel surveys on alcohol, tobacco and drug use and gambling among high school pupils.

The use of cannabis has continued to increase, as was expected. Both the lifetime prevalence and current use have risen. In 1996, 11% of all high school pupils had taken cannabis at least once during the four weeks leading up to the study. In 1992 this figure was 7%. These current users often do not 'blow' more than once or twice a month. However, 2.5% had taken cannabis more than 10 times in the previous four weeks.

However, in many other Western European countries, and in the United States, we see an increase in the use of cannabis. A review of studies carried out among high school pupils in various countries will be published at the end of 1997. From the data that is available so far, it is striking that young people in the Netherlands do not differ significantly in either a negative or positive sense from young people in other countries. Where, in the latest Trimbos survey, 13% of Dutch high school pupils had used cannabis in the preceding month, the corresponding figures for England and the United States were 24% and 21% respectively. From the figures of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDDA) in Lisbon it appears that, as far as cannabis use is concerned, high school pupils in France and Spain are not (very) far behind their Dutch peers either.

XTC was and is the most popular hard drug in the Netherlands. Among high school pupils, 5.6% have had experience with this substance and 2.2% had taken it in the four weeks preceding the survey. Although amphetamines are taken less frequently than XTC (1.8% had taken it in the past four weeks), the rise in use is striking; in 1992 the percentage was 0.6%. XTC users in particular, are increasingly taking amphetamines, often in combination with XTC. The number of young people who have ever tried hallucinogenic mushrooms is 4.2%, and those who had taken them in the past four weeks was 1.5%.

The use of tobacco and alcohol among high school pupils is increasing. In 1996, 28% of high school pupils smoked, which is 4% more than in 1992. It would seem that smoking has become more popular among young people than it was a few years ago. Given the fact that hashish and marijuana are usually smoked, an increase in the number of young people who smoke tobacco leads to a larger number of potential cannabis users. Alcohol use in the past four weeks prior to the study had also risen from 42% in 1992 to 52% in 1996. It is striking and alarming that one out of three high school pupils consumed more than four glasses of alcohol at the last available opportunity, whereas in 1992 that was only 12%.
Conclusions for policy

The gradual increase in the use of drugs - and also in alcohol and tobacco - among high school pupils is an alarming development. Notably, this development is also seen in many other countries, including countries with a much more repressive policy than ours. International trends in youth culture appear to have a significant influence on use patterns. Public information about the dangers of drug use is the most important policy instrument that can be used to try to reduce drug use. The message must be that all drug use is discouraged, including drugs that - apparently - do not cause extensive damage and degeneration. It is precisely with respect to the use of cannabis, XTC and the 'new drugs' such as mushrooms that this misunderstanding can occur in young people. For this reason, high priority is given to intensifying and improving the quality of prevention work.
3. Drug Survey: Analysis

Overview

The sample of children aged between 10 and 14 was undertaken in four countries – Netherlands, Italy, England and Sweden - and involved 56 schools. 1805 children responded to the survey questions and these comprised:

- 509 children from Sweden
- 559 children from the Netherlands
- 467 children from England
- 270 children from Italy

Age and Gender Profile

Although the survey drew its results from a range of ages between 10 and 14 the vast majority of the sample – 1707 out of 1805 – were aged 11 or 12. The low numbers in the sample age range 10, 13 and 14 can provide interpretational problems because very small numbers produce disproportionate percentage variables and this needs to be borne in mind at later stages of the analysis.

The gender split slightly favoured boys over girls – 921 to 884.

Home Circumstances

A high percentage of children [85%] came from households where the father was in work and 72% of the sample also had a working mother. A similar figure, 72%, live with both parents. Almost half of the sample was unable to say what type of work their father did but of those who did respond 50% classed their father’s occupation as a skilled or unskilled worker. Similarly, those with a mother at work struggled to identify what kind of work they did but the majority of those responding [23%] said it was some kind of white-collar work.

92% of the sample said they got pocket money from their parents but the way in which they got the money varied. Regular payment – daily, weekly or monthly – was most common [65%] although a significant 26% were able to get money on demand or as needed.

National / Ethnic origins

91% of the sample said they were born in the country they currently live in but, significantly, only 63% came from families where both parents were also born in the country. 24% of the sample came from families where both parents were born outside the current country of residence.

The sample were asked whether they identified with their country of residence by posing the question ‘Do you consider yourself Dutch/Swedish/ English/Italian?’ In three cases the responses were overwhelmingly positive but in the case of the Netherlands there was a significant difference. Here only 58% of the sample from Dutch schools said they considered themselves Dutch – a result that is in marked contrast to the 80 and 90% responses from the other three countries.
Awareness of and Attitudes Towards Tobacco

The health messages about tobacco have clearly been absorbed by the survey sample. Almost all had been told about the dangers of smoking and 91% stated they believed it was harmful to health.

Understanding of the legal position in respect of children and tobacco use was less well understood but that may be explained by the fact that almost half the sample said they had no means of getting hold of tobacco. However, given that over 80% said they knew someone who smoked it might be sensible to treat the idea that they have no access to tobacco with caution.

However, the results clearly indicate a high level of resistance to the idea of smoking. The vast majority claim not to have used tobacco and have a stated intention never to do so. They are equally firm on the view that people under the age of 18 should not be legally allowed to smoke and there was a small majority view that adults were right to impose this view on young people.

Attitudes towards tobacco as a tool of personal and social image enhancement are also given short shrift with the majority feeling that the use of tobacco would not make you feel more confident, grown-up or part of the group.

Interestingly, given the view that tobacco advertising has focussed heavily on young women, there is very little variation in the percentage responses to these questions when the figures are analysed by gender.

Awareness and Attitudes Towards Alcohol

Again levels of awareness were high but there was less uniformity over the health message. A greater number were prepared to take the view that alcohol could be used – as long as it was in moderation. Very many more had tried alcohol and had access to it and in a significant number of cases the source was within the family itself. Over half the sample believed they knew people who drink ‘a lot of alcohol’ and over 20% had said they had, at some time, felt drunk. Interestingly, of this 20%, virtually all have been drunk with the knowledge of their parents.

Unlike the case with tobacco, the sample is evenly split on whether they are likely to drink in the future and there are more who believe the social benefits of drinking are positive. This greater willingness to tolerate alcohol appears to echo the messages coming from within their families where the sample is split on whether their parents have forbidden the use of wine, beer and spirits.

As with tobacco, money does not seem to be the key factor which determines whether the sample group want to use alcohol or not. They are, however, very aware that adults are often hypocritical in their attitude towards drink – using it themselves but warning off your people.

There is a slight gender bias towards drinking amongst males but it is marginal. Boys who had tried alcohol tended to favour beer and spirits and more females preferred wine – again this reflects marketing trends. Interestingly however, slightly more girls said that drinking was an aid to confidence.
Awareness and Attitudes Towards Illegal Drugs

Awareness varies somewhat depending on the named drug but it is clear that the overall health messages about the danger of drugs has penetrated to the majority of this sample. Those believing any of the drugs named in the survey would be safe to use only rose out of single figures when certain prescription medicines such as Prozac were considered.

Most of the sample got their information from family, school and media sources and 70% believed that children of their age could be arrested for the use of drugs. However, only 11% [ 13% boys and 9% girls] said they had been offered drugs whilst 26% said they knew someone who takes them. Only 4% of the sample said that they had ever tried drugs themselves and yet despite this there was sufficient evidence to track low level instances of the use of marijuana, crack, glue, heroine and ecstasy.

Only 3% of the sample said they might be tempted to use illegal drugs in the future and the vast majority agreed with their prohibition.

The use of drugs to enhance personal and social prestige and to aid social interaction revealed some interesting variables. Given that attitudes towards the danger of drugs are firmly set and there is an overwhelming acceptance of the need for their prohibition, the sample should relatively high levels [10%-13%] of belief that drugs made you one of a group, enhanced confidence or made you feel more grown up. There was also a similar level of support for the view that young people themselves should be able to make decisions about the use of drugs for themselves – with a surprising 18% saying that their parents had not forbidden the use of drugs.

On the whole the boys were more inclined towards being tolerant and receptive to the use of drugs than girls and a small percentage more of girls believed that the use of drugs would lead them into serious trouble.

As with smoking and alcohol, lack of money was not cited as a reason for not getting into the use of drugs and it seems likely that parental disapproval and fear of consequences, combined with an inability to buy or access drugs, are greater deterrents.

Happiness at School and Self-Image

A small majority of the sample [but significantly more girls than boys] said they liked school although 9% said they felt lonely or socially isolated in that environment. Most said they tried hard at school and a large minority said that they were likely to challenge and contradict their teachers.

A hefty 40% of the sample said they thought there were things about themselves they would want to change and this reflects the onset of adolescence. However, despite the inner turmoil felt by some, levels of truancy are low overall [only 8%] although instances of bullying in school do seem worryingly high at 12%.

At home parental involvement in the lives of the children seems, in overall terms to be positive. However, 10% of the sample has parents who do not seem to care
about the development of the child’s intellectual or social life and keep no track on either. A relatively high 13% said they have no family or friends with whom they can talk about problems in their everyday life.

Variations by Age

As mentioned earlier, the sample is heavily weighted towards the age s of 11 and 12. Only small overall numbers were contacted in the 10, 13 and 14 age groups and this makes the use of percentage figures in these categories unrepresentative and unreliable. However, it is possible to say some things about the age range variables uncovered in the sample.

- In general terms the figures show that as the age of the sample rises so does their demand for decision-making independence and their preparedness to tolerate experimentation with the range of substances identified in this survey.

- On the issue of smoking however there is a very strong homogeneity of response regardless of age. This may reflect the fact that children are seen as almost universally prohibited from smoking and the opinions of the sample group are formed more by health and education messages on tobacco than they are by advertising and commercial pressures.

- Both awareness and the use of alcohol is influenced by the age of the respondent. Tolerance towards the use of alcohol and awareness of its social prevalence and the role it plays seems to show a demonstrable step upwards between the ages of 11 and 12.

- Awareness of drugs is variable and may owe a good deal to popular awareness and media attention. All the age groups seemed to be equally aware of headline drugs like cocaine, heroine and cannabis but in the areas of steroids, tranquilisers, Prozac and the less well-known drugs, awareness increases from the 11 year old group to the 12 year olds.

- There was a slight tendency for older children to believe some drugs to be safer. These variables are small but they clearly exist between the two main age groups sampled here – 82% of 11 years thought the use of marijuana unsafe compared to 78% of 12 year olds for example.

- Older children were also more likely to have tried drugs and to have tried a greater variety of drugs. They are also much more likely to believe that drugs perform an important role in their social development – making them part of a group, conveying confidence and making them feel more grown up.

However, having noted these points it has to be said that they are small variables within a relatively small sample across a very limited age group and it would be unsafe to draw any long-term conclusions from the figures. What seems to be undeniable is the fact that common messages about the health impact of using substances and the legality of their use appear to have been universally and commonly understood. It would be entirely consistent with other issues of child development to see a developing tendency towards experimentation and independence developing year on year throughout these transitional years. Nothing
in this sample however suggests that an ‘age step’ exists as a threshold which separates relative naivety on substance use from greater understanding and wisdom.

**Variations by Nationality**

There was a strong uniformity of response to the issue of tobacco use across all four countries. There were no significant variations on attitude to the understanding of the health impact or to the general undesirability of smoking despite the fact that in all cases the numbers of adults they knew who smoked was also consistently fairly high.

There were also few significant variations in attitudes towards the use of tobacco as a tool to aid social interaction with all countries rejecting the idea that it made someone seem more grown-up. However, ideas about whether people were likely to take up smoking in the future did differ somewhat – 70% of the Netherlands sample ruled out ever smoking whilst only 60% of the English sample did the same. The Swedish and Italian samples fell within this range in the mid 60s.

Attitudes to the use of alcohol are largely consistent across Sweden, Italy and the Netherlands but vary considerably in England. The sample of children from the English schools were much likelier to have drunk, at least once, to the point of being intoxicated and professed themselves much more likely to drink regularly as they got older.

However, across all countries it was clear that there was much more recognition of the use of alcohol as a socially acceptable phenomenon as long as its use is moderated.

Awareness and attitudes to illegal drug use is, like the issue of tobacco, remarkably statistically consistent across all four countries. No identifiable social or cultural attitudes emerge from this data that might lead anyone to conclude that attitudes towards drug taking are significantly different.

In all cases access to drugs seems very limited, there is no large-scale intent to try drugs in the future expressed anywhere. Notions that drugs are a social event or promote your individual confidence are found in fewer than 10% of all respondents and there seems to be no one country in which toleration or the desire for greater legality is being expressed.
4. Conclusions

In many ways the results of the survey mirror both the results of other academic studies and a good number of common sense or popular perceptions around the issue of the use of substances. The health promotion and educational messages relating to smoking and the use of tobacco seem to have hit home amongst the children in all countries. The vast majority see smoking as undesirable, harmful and anti-social and express a view that they will never start the habit despite living around adults who use tobacco. However, we have to acknowledge that these views may well be the result of the fact that the age group forming the sample are not the targets of the tobacco manufacture and marketing industries. At the ages of 10-14 children are much more influenced by the school, parental and media messages about the dangers of smoking than they are by the blandishments and image based promises of cigarette companies. As children grow older however, the evidence seems to support the view that the impact of advertising becomes more important and influential on their decision-making.

Despite the damage that is caused by the excessive or uncontrolled use of alcohol, it is clear that drinking is a much more socially acceptable drug of choice. This is reflected in the survey sample where attitudes reflect a certain official ambivalence towards alcohol use – uncontrolled it can be dangerous but it is also a legitimate drug in the context of social enjoyment and interaction. It is also, in certain circumstances, a substance whose moderate use is endorsed by the family. However, amongst the sample we were able to identify something of a national or cultural difference in the attitude towards alcohol – amongst the children sampled in England there was a much more liberal or even aggressively positive attitude towards drinking with more children doing it and more saying they are likely to do it in the future.

Attitudes towards other illegal and prescription drugs were very similar to that of smoking. There was a widespread acceptance of the harm and damage it can cause along with a rejection, by and large, of the idea that drugs have a role to play in helping individuals find their identity or assisting in otherwise difficult social circumstances.

The availability or affordability of substances seemed to play very little part in the formation of attitudes towards them. The notion that children are inhibited from experimentation simply by their inability to afford substances is not borne out by the findings of this report. It is clear that the majority reject substance use at this age on the grounds of awareness and principle rather than economic prohibition.

However, having said that there remains a consistent 10-13% of the sample who do see themselves as open to the possibility of using substances now or in the future. In these cases it is clearly not a failure of the health promotion messages or a lack of exposure to the issues that has created this minority. This small group seem to be temperamentally and more deliberately intent on exploring the substance use options – whether this is a triumph of curiosity, personal despair, a counter-cultural statement etc. is impossible to say from the results of this work but it does seem evident that their position is not driven by a lack of information.

It is also worth noting that a similar 10-13% of our sample expressed a general dissatisfaction with school life and with the support they get in their family. This
group clearly find coping to be an issue and have no support structure to fall back on. Clearly it is not possible to say that the 10% who find the idea of substance use worth considering are the same 10% who struggle emotionally and socially but there is a question to ask about the degree of correlation and crossover in these groups.
APPENDIX – Questionnaire

Introductory text: Why we do it ... who we are

Please try to answer the following questions as honestly and as completely as you can. Remember, there are no right or wrong answers. All the answers you give are strictly private.

Do not write your name on the paper.

Mark your chosen answer with a tick (✓).

If you can’t read something, put your hand up and someone will help you.

When you have finished, read through the questions again and sit quietly until everyone has finished or you are told to stop.

After you have completed the questionnaire, put it in the envelope and seal it. The envelopes will be collected by: and sent unopened to the researchers. Neither teachers, nor parents will ever see your answers. The researchers, who will be working with the questionnaires, will not be able to identify any individuals who filled in the forms. You will be the only one who will ever know how you answered the questions.
1 How old are you today?  10  11  12  13

2 Are you a:
   Boy
   Girl

3 Do you live with:
   Your mother and father
   Your mother
   Your father
   Part-time with mother, part-time with father
   Foster parents/guardian (someone who looks after you who is not your parent)
   Other

4 How many people (not animals) live in your home (including yourself)? If you have two homes, select the place where you live the most time:

5 How many bedrooms are there in your home (select the place where you live the most time)?

6 Does your father work?
   Yes (please write what does he do)
   No
   Don't know

7 Does your mother work?
   Yes (please write what does she do)
   No
   Don't know

If you don't live with either your mother or your father, answer question 8. Otherwise, go to question 9.

8 Does your guardian work?
   Not applicable
   Yes (please write what does he/she do)
   No
   Don't know

9 Do you usually get pocket money? Please mark one box
   No, I don't usually get any
   Yes, I get money each day
   Yes, I get money every week
   Yes, I get money once a month
   How much pocket money did you get last time?
   Yes, I get money as I need it
10 Which ethnic group do you consider yourself to be a member of?

**ENGLAND**
- White
- Irish
- African Caribbean
- Pakistani
- Bangladeshi
- Indian
- Sikh
- Other

**THE NETHERLANDS**
- White
- Turkish
- Moroccan
- Surinamese
- Antilles/Auban
- Other

**ITALY**
- Italy
- EU citizens
- Non-EU citizens (African)
- Non-EU citizens (Asian)
- Non-EU citizens (North-American)
- Non-EU citizens (Latin or South-American)
- Other

**SWEDEN**
- Sweden
- Norway, Denmark, Finland, Iceland
- Europe (except the Nordic countries)
- Africa
- Asia
- Latin or South American
- North-America
- Other

11 Were you born in the country you live in?
   - Yes
   - No

12 Were your parents born in the country you live in?
   - Both parents were born there
   - One parent was born there, one in another country
   - Both my parents were born in another country

13 Do you consider yourself as a Swede/ Italian/English/ Dutch (only answer for the country you live in)?
   - Yes
   - No
   - Don’t know
Here are some questions about TOBACCO (cigarettes, cigars, snuff, chew tobacco)

14 Have you been told about tobacco? You may tick more than one box.
   No
   Yes, in school
   Yes, by parents
   Yes, by brothers, sisters
   Yes, by friends
   Yes, on TV, radio, cinema, newspapers
   Yes, in other ways
   Don’t know

15 Do you think using tobacco can be healthy or unhealthy?
   Very dangerous to your health
   A bit dangerous to your health
   Not at all dangerous to your health
   It depends on the quantity
   Don’t know

16 Can a child of your age be arrested by the police for using tobacco?
   No
   Yes,
   Don’t know

17 Could you get tobacco if you wanted to? You may tick more than one box.
   No, I can’t get tobacco
   Yes, in a shop
   Yes, in an automatic vending machine
   Yes, from brothers or sisters
   Yes, from friends
   Yes, from parents (with permission)
   Yes, from parents (without permission)
   Yes, in other ways
   Don’t know

18 Do you know anyone who smokes or chews tobacco? You may tick more than one box.
   No
   Yes, parents
   Yes, brothers or sisters
   Yes, relatives or other carers
   Yes, friends
   Yes, others
   Don’t know
19 Have you ever used tobacco?
   No, never.
   I have tried it once or twice  
   I use it occasionally  
   I use it regularly  
   I used to, but I don’t now  
   How old were you the first time you used tobacco? ______ years old

20 Do your parents know that you use tobacco?
   I don’t use tobacco
   Yes
   No
   Don’t know

21 Do you think you will use tobacco when you are older?
   No
   Yes
   Don’t know

22 Do you agree or disagree with these statements about smoking?
   Agree Disagree Don’t know
   Please mark one box on each line
   a) Life is more fun when you smoke
   b) People under the age of 18 should be allowed to smoke
   c) Smoking helps you to be one of the group
   d) Smoking helps people to feel more confident
   e) Smoking makes you feel more grown up
   f) My parents have forbidden me to smoke
   g) Adults should let young people decide themselves about smoking
   h) If I had enough money I would start smoking
   i) Smoking would get me into serious trouble
   j) Adults tell you not to smoke but use tobacco themselves

Here are some questions about ALCOHOL (Beer, Cider, Wine, Wine coolers, Spirits)

23 Have you been told about alcohol? You may tick more than one box.
   No
   Yes, in school
   Yes, by parents
   Yes, by brothers, sisters
   Yes, by friends
   Yes, on TV, radio, cinema, newspapers
   Yes, in other ways
   Don’t know
24 Do you think using alcohol can be healthy or unhealthy?
   Very dangerous to your health
   A bit dangerous to your health
   Not at all dangerous to your health
   It depends on the quantity
   Don’t know

25 Can a child of your age be arrested by the police for drinking alcohol?
   No
   Yes,
   Don’t know

26 Could you get alcohol if you wanted to? You may tick more than one box.
   No, I can’t get alcohol
   Yes, in a shop
   Yes, in a pub / restaurant
   Yes, from friends
   Yes, from parents (with permission)
   Yes, from parents (without permission)
   Yes, in other ways
   Don’t know

27 Do you know anyone who drinks a lot of alcohol? You may tick more than one box.
   No one
   Yes, parents
   Yes, brothers or sisters
   Yes, relatives or other carers
   Yes, friends
   Yes, others
   Don’t know

28 Have you ever felt drunk on alcohol?
   No, never.
   Yes, once
   Yes, 2 – 4 times
      How old were you
   Yes, 5 – 10 times
      the first time you
      were drunk? ______ years old
   Yes, more than 10 times

29 What have you drunk? You may tick more than one box.
   I don’t drink alcohol
   Beer, lager
   Wine
   Spirits or liqueurs (e.g., Martini, Cinzano, sherry, whisky, gin, vodka, limoncelo, nocino)
   Don’t know

30 Do your parents know that you have been drunk?
   I have never been drunk
   Yes
   No
   Don’t know
31 Do you think you will drink alcohol when you are older?
   No
   Yes
   Don’t know

32 Do you agree or disagree with these statements about drinking alcohol?
   Please mark one box on each line
   Agree Don’t know Disagree

   a) Life is more fun when you drink alcohol
   b) People under the age of 18 should be allowed to drink alcohol
   c) Drinking helps you to be one of the group
   d) Drinking helps people to feel more confident
   e) Drinking helps people feel grownup
   f) My parents has forbidden me to drink alcohol
   g) Adults should let young people decide themselves about drinking
   h) If I had enough money I would drink alcohol
   i) Drinking would get me into serious trouble
   j) Adults tell you not to drink but use alcohol themselves

33 Which of the following words do you know or think refer to drugs? You may tick more than one box

Amphetamine Tranquillisers
Cannabis    Potsy
Marijuana   Hashish
Ecstasy     Cocaine
Flick       Crack
Hallucinogens Metabolita
Compulsione Heroin
Glue        Gas
Steroids    Setting
Valium      Prozac

34 What do you think about the drugs you have indicated above? Please circle the answer you think is correct

A Amphetamine safe unsafe don’t know
B Tranquillisers safe unsafe don’t know
C Cannabis safe unsafe don’t know
D Potsy safe unsafe don’t know
E Marijuana safe unsafe don’t know
F Hashish safe unsafe don’t know
G Ecstasy safe unsafe don’t know
H Cocaine (snow) safe unsafe don’t know
I Flick safe unsafe don’t know
J Crack safe unsafe don’t know
K Hallucinogens safe unsafe don’t know
L Metabolita safe unsafe don’t know
M Compulsione safe unsafe don’t know
N Heroin (junk, smack) safe unsafe don’t know
O Glue safe unsafe don't know
P Gas safe unsafe don't know
Q Steroids safe unsafe don't know
R Setting safe unsafe don't know
S Valium safe unsafe don't know
T Prozac safe unsafe don't know

35 Who told you about drugs? You may tick more than one box.
I don't know them
School
Parents
Brothers, sisters
Friends
TV, radio, cinema, newspapers
Other ways
Don't know

36 Can a child of your age be arrested by the police for using drugs?
No
Yes, some drugs
Yes, all drugs
Don't know

37 Have you ever been offered drugs?
No
Yes
Don't know

38 Do you know anyone who takes drugs?
No
Yes
Don't know

39 Have you ever used drugs?
No (go to question 40)
Yes
Don't know

If you have, please choose the nearest answer:

during during more than
last month last year a year

A Amphetamine
B Tranquillisers
C Cannabis
D Potsy
E Marijuana
F Hashish
G Ecstasy
H Cocaine
I Flick
J Crack
K Halluciongenes
L Metabolita
40 If you have ever taken any of these drugs, how old were you the first time you used any of them? _______ years. Which one was it? __________________

41 Do your parents know that you have used drugs?
   I have never taken drugs
   Yes
   No
   Don’t know

42 Do you think you will use any drug when you are older?
   No
   Yes
   Don’t know

43 Do you agree or disagree with these statements about drugs?
   Please mark one box on each line
   Agree Disagree Don’t know
   a) Using drugs makes life more fun
   b) People under the age of 18 should be allowed to use these drugs
   c) Using drugs helps you to be one of the group
   d) Using drugs makes you feel more grown up
   e) Taking drugs helps people to feel more confident
   f) My parents have forbidden me to use drugs
   g) Adults should let young people decide themselves about drugs
   h) If I had enough money I might buy drugs
   i) Using drugs would get me into serious trouble
   j) Taking drugs makes problems easier to handle

44 Have you used any in list below during the last 7 days?
   A Tobacco   No  Yes, how many days _______
   B Alcohol  No  Yes, how many days _______
   C Drugs  No  Yes, how many days _______

Finally, here are some questions about SCHOOL and your LEISURE TIME

45 These questions are about school, relationships and feelings. Please circle one answer on each line

A Do you like school?               Yes  No  Don’t know
B Do you often feel lonely at school? Yes  No  Don’t know
C Do you often have to find new friends because your old ones are with someone else? Yes  No  Don’t know
D Do you do your best at school-work?  
E Are there a lot of things about yourself you would like to change?  
F Do you use to contradict your teachers?  
G Have you ever played truant / cut classes in the last month?  
H Do you ever feel afraid of going to school because of bullying?  
I Do you do well at school work?  
J Do you think others may fear going to school because of you?  
K Do your parents usually like to hear about your ideas?  
L Do your parents know what you do in your leisure time?  
M Do your parents know what friends you associate with in the leisure time?  

46 How many days a week do you normally spend **all** evening at home?  
____________

47 When you spend the evening at home, who stays normally with you?  

No one  
Parents  
Brothers or sisters  
Friends  
Relatives  
Other adults

48 With whom do you talk about things that really bother you?  

You may tick more than one box.  

No one  
Parents  
Brothers or sisters  
Friends  
Teachers or other school personnel  
Other adults
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