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Volume Six: Current Trends, Continuing Issues and New Challenges

Introduction

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Re-thinking the policy response

Volume six presents papers with data on current trends in use of alcohol and drugs and associated problems globally. It looks at current issues regarding use of alcohol and drugs, including of substances like synthetic drugs and painkillers, and problems related to ageing. Current debates on drugs and alcohol policy are considered. As noted in volume one, the trend is towards viewing alcohol, tobacco and other drugs (ATOD) together.

The impact of the link between illicit drugs, crime and violence has led Latin American leaders to speak openly about the need for policy change. Mexico is a country which has been at the forefront of concerns about the failures of the *war on drugs* policy. Following an attempted crackdown by the government, there have been ever-spiralling turf wars over smuggling routes. Some in Latin America have argued the problem originates in the United States with its persistent demand for drugs and from the flow of guns from the United States to Mexico. Based on fieldwork in Mexico in 2009 and 2011, *Felbab-Brown 2011* offers some lessons for policy-makers from Mexico's battle against organized crime and drug trafficking. Building on a series of case studies, the extract included here pulls the policy lessons together and provides a set of recommendations for reshaping interdiction approaches and improving law enforcement policies in Mexico, not only to weaken the criminal groups but also to reduce the violence, arguably a greater problem than drug trafficking *per se*. Suggestions for policy which she discusses include:- prioritization of interdiction actions against the most violent groups; interdiction operations that target the middle layer of drug trafficking organisations; and establishing a community policing capacity that is accepted by the local community. Over time, what is needed in Mexico, she argues, is a deepening of police reform, institutionalizing the rule of law, and strengthening socioeconomic development in marginalized communities.

Some of these themes are present in *Scenarios for the drug problem in the Americas 2013 – 2025 (2013)* outlined by a group of outstanding, knowledgeable and experienced individuals appointed by the Organization of American States (OAS) under a mandate given by the Heads of Government of Member States at the 2012 Summit of the Americas in Cartagena de Indias. The leaders of the OAS had agreed on the need to analyze the results of the current policy in the Americas, explore new approaches and make policy more effective. They emphasised two basic points: that the drug problem is one of the most important challenges facing the hemisphere, with its impact on public health and the cost incurred by States, especially due to the violence that it brings; and that the current approach has not been successful and is not working well enough. A first analytical report looked at current trends, best practices, and policy challenges. This was followed by a second report, reproduced here. The purpose of constructing these scenarios was to provide a common framework and language to support dialogue, debate, and decision-making within and across countries. Four possible future responses to the drug problem in the Americas are described – *Together, Pathways, Resilience, and Disruption*. These scenarios are outlined and compared.

In *Together*, the emphasis would shift from controlling drugs to preventing crime, violence, and corruption. Like-minded countries would be determined to launch – *together* – a sustained campaign against transnational criminal organizations and their violence, traffic in drugs, weapons, and corrupting influence. Here the single most important goal would be to reduce the violence associated with illicit drug trafficking by reducing the power of criminal organizations.

In *Pathways* a number of countries would begin experiments that, in effect, lead them to diverge from current policies. The result would be different responses, where some countries would pursue a path of gradual, evidence-based experimentation and reform, while others maintained current legal, regulatory and policy frameworks and focused their energies on demand reduction programs through prevention and alternatives to incarceration. Others would push for major changes in high-consuming countries. Non-problematic use of cannabis would often begin to be seen as a special case. The variety of approaches in the pathways scenario reflects a perception that while every country experiences the drug problem, they do not do so in the same way, and public opinion varies widely. This set of responses argues that countries should be allowed to develop diverse strategies to protect their people.

The *Resilience* approach would focus on building strong and healthy communities, able to resist the attractions of drugs, alcohol and tobacco: there would also be a parallel, pragmatic harm reduction response for the significant portion of people incapable of complying with abstinence-based treatment objectives and who develop chronic and problematic use. The aim would be a comprehensive health and social inclusion set of policies. Resourcing these would however be a key challenge.

Each of these three scenarios has potential but all face obstacles. The fourth scenario *Disruption* is one where, increasingly frustrated by the ineffectiveness of current approaches, some countries implement a policy that allows them to opt out of international agreements and disregard the production and transit of drugs – particularly cocaine – to focus on issues of most concern to them domestically. The Scenarios Report predicts that such a policy would lead to an increase in international tensions and conflicts over drugs and organized crime throughout the hemisphere.

These four scenarios effectively encapsulate the key issues and choices facing science and policy today regarding controlled substances. The articles which follow in volume six look in detail at some of these key trends and challenges.

Although some South American leaders have dared to say that *a drug free world* is impossible, breaking the taboo against questioning the international regime, there is as yet little consensus about the direction of policy change. And worldwide, attitudes in some other countries (such as Saudi Arabia regarding alcohol and Russia regarding illicit drugs) remain firmly against relaxing controls. Public health specialists take heart from what has been achieved in regulating tobacco in recent years and see potential in developing shared frameworks to control all psychoactive substances. But significant contradictions exist globally between neo-liberal values of mass consumption, with the promotion of alcohol and tobacco in emerging economies, and pressures towards prohibition on health grounds. Some argue that traditional drugs should be allowed in their appropriate cultural context, such as coca leaf and khat, but questions arise around what exactly is a traditional drug and what is traditional use, especially in a context of social change and migration (cf Odenwald et al 2007; Beckerleg 2010).

Latin American leaders point out that the main problem lies with the demand for drugs in the USA. If major change is to happen, it will need to begin in America. Already there are signs of a shift with reforms at state level with regard to marijuana (cf Cerda et al 2012). The War on Drugs announced there by President Nixon in 1971, and influencing international policies ever since, is now in its fifth decade and many are questioning whether it has been effective. Criticisms of existing policy are that it does not deter and does not rehabilitate. Problems that cannot be ignored include sentencing disparities which lead to longer sentences for Black than White offenders. Prison numbers in the US have soared to the point where the US now accounts for 25 per cent of the world's prisoners while having only 5 per cent of the world's population: most of this is driven by drug-related offences. However there are signs of change: for example 17 US states are currently directing money away from prison construction toward programmes and services such as treatment and supervision designed to reduce the problem of repeat offenders.

The underlying issue is the endemic and ubiquitous nature of use of psychoactive substances. As soon as one is controlled another pops up. Currently there is growing debate about a perceived problem of addiction to prescription opioid medication, a side-effect of the increasing production and consumption of pharmaceutical drugs in contemporary societies (cf Conrad 2007). Many are useful medicines, for example in helping with pain relief as part of cancer treatment and for chronic pain in an ageing population. But social side-effects are observed: 12 million people in US aged over 12 years have used prescription opioids non-medically; and celebrities are seen to go in and out of treatment programmes, with some notorious deaths bringing attention to the issue.

Global assessments of harm and disease

Drugs and alcohol are important global issues, with incontrovertible evidence of the burden of disease, especially from alcohol, of the link between IDU and HIV/AIDS, and of the harms caused by drug trafficking. Five per cent of the global burden of disease is due to alcohol and rates are even higher for those under 65 years of age. Rates are higher in Europe and Eastern Europe than in other regions of the world but countries with emerging markets, like India and South Korea, are beginning to show evidence of alcohol problems (cf Chung et al 2012). Worldwide 16 million people inject drugs and East Europe and Central Asia are two key regions where this problem is present (Todd et al 2009). With the current economic crisis, especially in the euro zone, there have been cutbacks in services and some fear that everything built up over the past thirty years with regard to harm reduction may be at risk.

Globally, new drugs and new patterns of drug use are attracting increasing political, media and public attention. *The EMCDDA report on The Drug Problem in Europe: New drugs and emerging trends 2012* draws on data from the European Union's early warning system, which was developed as a rapid-response mechanism to the emergence of new psychoactive substances. (Other terms used loosely in this context are *designer drugs* and *herbal highs*). Between 2005 and 2011, 164 new psychoactive substances (NPS) were formally notified through the early warning system. In 2011, for the third consecutive year, a record number of substances (49) were detected for the first time in Europe, up from 41 substances in 2010 and 24 in 2009. Sometimes referred to as *legal highs*, these NPS are substances which have not been scheduled under the 1961 and 1971 United Nations international drug control Conventions but may pose a threat to public health (cf Hughes and Winstock 2011). Most new psychoactive substances appearing on the European illicit drugs market

are reported to be synthesised outside Europe, with China and, to a lesser extent, India being identified as the primary source countries. These may be acquired via the Internet and in smart and head shops. Substances involved include ketamine, mephedrone, *spice* and synthetic cannabinoids. They may be marketed with misleading names such as *bath salts* and often on examination are found to contain controlled substances. Drugs acquired over the internet are untested and unregulated and deaths have occurred with some people suffering adverse toxic reactions, including to substances purchased as diet pills.

Along with new problems relating to new substances such as NSP/ legal highs- 280 new drugs are currently being monitored in the EU - and opioid medication, and new patterns of availability, e.g. through internet sales and new trafficking routes (such as West Africa) - are continuing problems with familiar substances, with HIV/AIDS and alcohol dependence in Russia (cf McKee 1999; Redmond and Spooner 2009), with co-morbidity, ageing substance misusers, and with neglected, marginalized and underprivileged groups in general. In China today, a recognized problem is use of amphetamines and other stimulants and there are worries about drugs coming into China from Afghanistan and links between injecting drug use and HIV/AIDS (cf Macdonald 2007; Chu and Levy 2005). Mozambique and Kenya now show evidence of problems of injecting heroin use. In South Africa, alcohol and cannabis are the most commonly reported drugs used in treatment populations and tobacco use is a major problem (cf Herrick 2012). In Latin America there has been an increase in drug use since 1998, although in many countries, like Brazil, alcohol is still the main problem (cf Pantani et al 2012). There are hidden populations and street populations. While official policy may argue for harm reduction, there can be strong resistance to this in the general population and among staff in health agencies. For countries like Mexico, Argentina and Colombia, drug use is primarily a crime issue. Legalization has been debated in Guatemala, Bolivia and Uruguay and in the latter country, a major policy shift has occurred regarding legalization of marijuana production.

The picture then is of use and misuse of alcohol and drugs that has by no means been effectively controlled, takes various forms and is spreading into many countries of the world. There is lively debate about options for alternative policies and evidence that some interventions and policies work better than others. However there remain huge variations in perceptions and explanations of the issue and both continuities and changes in responses - not surprising perhaps given the complexity and variety of human activities contained under the umbrella of drug and alcohol studies.

Understanding how much disability and death a particular disease causes (known as the *burden of disease*) is important. In 1990, a special World Health Organization (WHO) project was launched, the Global Burden of Disease Project. In 2002, on the basis of updated information from this ongoing project, the WHO estimated that 91 million people were affected by alcohol use disorders and 15 million by drug use disorders.

In their article, *Degenhardt et al 2008* describe data from the first 17 countries participating in the WHO World Mental Health (WMH) Survey Initiative. Countries covered by the survey were Colombia, Mexico, United States, Belgium, France, Germany, Italy, Netherlands, Spain, Ukraine, Israel, Lebanon, Nigeria, South Africa, Japan, People's Republic of China, and New Zealand. This paper focuses on lifetime use and age of initiation of tobacco, alcohol, cannabis, and cocaine. The key finding was that globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones.

In general, the US had among the highest levels of use of all drugs. Much lower levels were observed in lower income countries in Africa and the Middle East, and lower levels of use were reported in the Asian locales covered. The use of drugs seems to be a feature of more affluent countries. In the Americas, Europe, Japan, and New Zealand, alcohol had been used by the vast majority of survey participants, compared to smaller proportions in the Middle East, Africa, and China.

The US, which has been driving much of the world's drug research and drug policy agenda, stands out with higher levels of use of alcohol, cocaine, and cannabis, despite punitive illegal drug policies, as well as (in many US states), a higher minimum legal alcohol drinking age than many comparable developed countries.

Rehm et al 2009 quantify the burden of mortality and disease attributable to alcohol, both globally and for ten large countries: 3.8 per cent of all global deaths and 4.6 per cent of global disability-adjusted life-years are attributable to alcohol. The disease burden is closely related to the average volume of alcohol consumption, and, for every unit of exposure, is strongest in poor people and in those who are marginalised from society. Even though most adults worldwide abstain from drinking alcohol, consumption is common in many parts of the world. The consequences attributable to alcohol account for large costs to societies: they are not limited to health-care costs but also include costs related to social harm.

The countries with the highest overall consumption of alcohol are in Eastern Europe around Russia, but other areas of Europe also have high overall consumption. There are some difficulties in attempts at measurement and comparison, including the fact that more than 25 per cent of global consumption is estimated to be unrecorded. Alcohol is linked to many disease categories, but alcohol-use disorders, cancer, cardiovascular disease, liver cirrhosis, and injury are the most important disease categories causally affected by alcohol. Global consumption is increasing, especially in the most populous countries of India and China.

The article by *Wilsnack et al 2009* draws attention to gender- and age-specific alcohol consumption from a review of 35 countries from 1997 to 2007. The article considers whether there are consistent differences between how men and women drink. They found that drinking *per se* and high-volume drinking were consistently more prevalent among men than among women and lifetime abstention from alcohol was consistently more prevalent among women. Among drinkers, the prevalence of high-frequency drinking was consistently greatest in the oldest age group, particularly among men. Interesting it appears that aging does not consistently reduce high volume and heavy episodic drinking outside Europe and English-speaking countries.

From a review of 18 countries, China, India, the United States, Brazil, Russia, Colombia, Mexico, Turkey, the Czech Republic, Hungary, Russia, Australia, the Netherlands, Switzerland, Sweden and South Africa and covering four drugs in detail, cannabis, cocaine, heroin, and amphetamine-type stimulants, *Reuter and Trautmann 2009* point to the continuing issue of harms, especially drug-related deaths, HIV/AIDS and crime. While the number of cannabis users may have declined, the sudden and substantial rise in cannabis treatment-seeking suggests that consumption and harms related to cannabis may have gone up. The main concern of their study, however, is to review the global drug trade. They found no evidence that the global drug problem was reduced during the UNGASS period from 1998 to 2007. The drug problem generally lessened in rich countries and

worsened in a few large developing or transitional countries. A serious epidemic of opiate use occurred in the Russian Federation and Central Asia. Profits from the drug trade went mostly to traffickers in consuming countries not in source or transit countries. They conclude that enforcement of drug prohibitions has caused substantial unintended harms, many of which were predictable.

Drugs, alcohol, development and deprivation

While the bulk of research has drawn its data from affluent rich countries, and theories and policies have been shaped by this focus, insufficient attention has been paid to what is happening in middle income and low income countries. There is a need for scholars and policy makers concerned with development to take seriously the issue of drugs and alcohol (cf Keefer and Loayza 2010). *Singer 2008* provides a wide ranging review of the situation in developing countries. This article highlights barriers to development emanating from the drug trade including: interpersonal crime and community violence; the corruption of public servants and the disintegration of social institutions; the emergence of new or enhanced health problems; the lowering of worker productivity; the ensnarement of youth in drug distribution and away from productive education or employment; and the skewing of economies to drug production and money laundering.

Large sectors of the world's population suffer from the intertwined plagues of poverty, inequality, and health disparities. While the rate of new HIV infections has slowed in some developing nations, rates of infection overall are still growing and the number of people living with HIV has continued to grow. Influences on these trends and explanations include modernisation, urbanisation and migration - the majority of people on the earth now live in cities. Conditions of poverty and inequality potentially encourage use of drugs and alcohol, as in the slum areas of cities where rural-to-urban migrants face poverty, lack of housing, overcrowding, inadequate water and sanitation, disease, street violence and youth unemployment.

Tajikistan has become an important corridor for heroin from Afghanistan intended for European and Russian markets (cf Latypov 2011). Products manufactured and distributed internationally by the global tobacco and alcohol industries have caused significant health problems in developing nations. Cocaine use in developing countries is concentrated in Latin America and the Caribbean, but there has been increased use in recent years in western and southern Africa, also spreading to Kenya and other parts of Africa. So while trends in use in developed countries are largely stabilising or falling, increasing problems are being experienced in developing countries, especially where poverty and ready access to drugs of addiction collide. Along with this remains the older problem of inhalation of solvents and various commercial aerosols by street children.

A range of measures have been suggested or attempted in recent years, including: offering drug crop farmers alternative livelihoods by providing them with skills and opportunities to engage in other economic activities; harm reduction efforts that lower the health risk among those who choose to use drugs, avoid demonizing drugs users, and insure their inclusion as full societal members; and effectively controlling the legal drug industry, both in terms of promotional efforts and product diversion. To this list, Singer adds the critical need for controlling demand by addressing the inequitable social and economic conditions that lead to compensatory drug use in the first place and

the health benefits that could be derived from prioritizing prevention and treatment over interdiction.

Klein 2011 reports that African policy makers find themselves confronted by a phenomenon of rising substance use, particularly in urban areas. Responses are largely driven by imported models advocated by drug control agencies and development partners. There are many unintended consequences of drug control policies (as outlined in other articles in this collection). However Klein points out that the corrosion of governance related to the drug trade hits particularly hard where remuneration of law enforcement is low, supervision poor, and the capacity for internal reform is limited. He argues that harm reduction should be the overarching policy principle for African drug policy. This rests on recognition that drugs play a part in most societies but acceptance that there are definite problems associated with certain patterns of use.

Mohindra et al 2011 describe alcohol consumption in India and note that it is disproportionately higher among poorer and socially marginalised groups, notably Scheduled Tribes. This supports a common finding of problematic substance use in severely deprived groups like Australian Aborigines, First Nation and Native Americans, linking to exclusion and poverty and loss of power and cultural autonomy. These features of deprivation and social collapse are found also in ghettos and urban areas in South America, the USA and elsewhere (see volume two and Perlman 2010).

The article by *Johnston and Boyle 2012* focuses on an issue attracting increasing attention - fetal alcohol spectrum disorder (FASD). They describe the experiences of northern British Columbian (BC) Aboriginal mothers raising adolescents with FASD: (on the advice of elders they consulted, the term Aboriginal is used in the article to refer to those people who may be First Nations as characterized within the Constitution of Canada). Although FASD is not unique to them, it has had a devastating impact on many Aboriginal people and their families in BC. Rather than characterising sub-groups as pathological or deviant, these researchers use the insights of postcolonial theory to frame their analysis. Aboriginal mothers of children with FASD are faced with societal blame for consuming alcohol during pregnancy. In explaining the phenomenon of FASD, Johnston and Boyle refer to the historical and collective emotional injury Aboriginal peoples have experienced as a result of colonialism. This injury manifests itself in various behaviours, including the abuse of alcohol. Unhealthy ways of behaving or coping are seen as ways to protect against pain and *trauma*. They note that FASD can be a hidden disability. Not all individuals who have it share the marked physical characteristics attributed to FASD. The authors develop the concept of *Mothering from the Margins* to explain how marginalization contributes to the vulnerability of children and mothers alike. This study is a step toward developing nursing interventions that could prove useful for mothers raising adolescents with FASD.

Murphy and Rosenbaum 1998 show that this issue of personal and social *trauma* is shared among excluded groups in both rich and poor countries. Features of extreme social exclusion and experience of trauma are part of the lives of many of those with the most severe problems of substance misuse. The drug using women described here had had early lives full of brutal experiences, including sexual exploitation, often as children. Recognition of this is only now becoming clearer but is an underlying problem in many women who come to drugs services. Murphy and Rosenbaum focus on the issue of alcohol and drug use and motherhood and the place of state intervention in policy and practice. They give particular attention to the impact of stigma. *Stigma* is a

key condition of relationships involving drug or alcohol dependent people but the most stigmatised and abhorred are pregnant drug using women. They point out that even in rich countries poverty and inequality are increasing and provision for the poor and in need has been cut back in recent years and/or is increasingly set about with conditions, including especially conditions placed on mothers. Media images of Black crack smoking mothers in USA played a key role in encouraging more hostile attitudes to welfare, a set of policies since exported to other countries. Racism exacerbates the situation in America. Living in a violent neighbourhood is a key fact of life in American housing projects as it is in parts of Mexico, Kenya or Brazil (cf Gutiérrez and Atienzo 2011). Services rarely meet the needs of women. Murphy and Rosenbaum argue for women-sensitive services and better recognition of the importance of trauma as a background to problematic drug use among both males and females - but women with children need extra special attention and dedicated services.

New issues and perspectives

Degenhardt and Hall 2006 note that while there are moves to reduce controls on cannabis in some countries, at the same time, there has been rising concern about a possible link between cannabis consumption and mental illness. They review evidence from six longitudinal studies in five countries to show that regular cannabis use predicts an increased risk of a schizophrenia diagnosis or of reporting symptoms of psychosis. They conclude that it is most plausible that cannabis use precipitates schizophrenia in individuals who are vulnerable because of a personal or family history of schizophrenia (cf Arsenault et al 2004; Gage et al 2013).

Rich et al 2011 continue the theme found in many studies of the unintended consequences of drug policy looking at the harms caused to particular groups, in this case African American men in USA. Over the past 40 years, the number of people in U.S. prisons has increased by more than 600 per cent. An estimated 10 million Americans are incarcerated each year. No other country locks up more of its citizens. This has significant impact on the life-chances of Black American men. It is a pronounced effect of the War on Drugs and, they say, of America's failure to treat addiction and mental illness as medical conditions, pointing out that more than half of inmates have symptoms of a psychiatric disorder.

However *Williams et al 2008* make the point that not all drug users are mentally ill. There is very common use of substances as recreational drugs. The context for this is the *pharmaceuticalisation* of everyday life. They focus on the new issue of cognitive enhancers, taking us back to one of the long-standing questions in this field about what are legitimate and what are illegitimate uses of any substance? They also raise the question whether certain substances fit better with certain societies and economies, citing the role of stimulants in *fast capitalism*.

Jayne et al 2012 discuss the important issue of tourism in our increasingly globalised world: tourism is important for local economies but also has implications for both tourists and locals. In particular, they look at the role of alcohol, drinking and drunkenness as an aspect of tourist behaviour, especially in backpacking holidays. Drawing on empirical research undertaken in Australia, they build on a key insight from human geography that space and place are not passive backdrops to drinking but are active constituents in the practices and experiences bound up with alcohol consumption.

Their article offers 'rich and vivid insights into the emotional and embodied materialities and performativities of backpacking'.

Van Zee 2009 presents an in-depth analysis of the promotion and marketing of OxyContin (Purdue Pharma, Stamford, CT), a sustained-release oxycodone preparation. By 2002, unintentional overdose deaths from prescription opioids surpassed those from heroin and cocaine nationwide in the USA. Issues identified here regarding marketed prescriptions include the need to check that drug promotion is truthful, balanced, and accurately communicated. One lesson that could be drawn from this study by those considering alternative approaches to drug regulation is that information on any substances that might be made available through controlled outlets would need to stand up with respect to truthfulness, accuracy, balance, and scientific validity.

The continuing lack of certainty or agreement about what is the problem of drug and alcohol use – raised by the distinction between less harmful use of less harmful substances for pleasure versus the appearance of dependence or addiction and other health problems in heavy or severe users of more dangerous substances – is relevant to the issues raised in the article by *Hall and Carter 2011*. They ask 'if the problem is addiction then is there a role for pioneering *futuristic* treatments'? With what some have seen as the return of the brain disease model, there have been calls for more experimentation in treatments including the use of deep brain stimulation. Hall and Carter conclude that evidence suggests that the very uncertain benefits of deep brain stimulation in alleviating the symptoms of addiction do not outweigh the known harms associated with the procedure.

The *Royal College of Psychiatrists 2011* report *Our Invisible Addicts* looked at the neglected issue of substance misuse by older people. They argue that this is now a growing public health problem. The proportion of older people in the population is increasing rapidly, as is the number of older people with substance use problems. Older people may show complex patterns and combinations of substance use (e.g. alcohol plus inappropriate use of prescribed medications). While the young may use substances for pleasure, the old seem more likely to use them for relief from pain. A related question is what will happen to cohorts of drug-using populations as they get older?

Conclusion

A number of simple conclusions emerge from our reading: that use of mind and body altering substances is ubiquitous and seems to be a feature of all human societies; that the range of substances available is wide and increasing; that current controls do not seem to be sufficiently effective or appropriate; and that with globalisation many of the problems found in high income countries are spreading to low and middle income countries (cf Coomber 1998; Andreas and Nadelmann 2006). Our responses are however complicated and agreement is absent. Many interventions by psychiatrists, psychologists, social workers, educationalists and police can be shown to be effective and have value. Other policies and practices (often those most favoured) are less effective and have unintended consequences. Our responses can be improved by engaging in calm deliberations, informed by the best evidence and respect for the understandings built up over many years through the research, scholarship and experience of those who have committed time and effort to drug and alcohol studies. It is hoped that the articles collected in these six volumes,

together with further reading, will help to support much needed improvements in understanding and in policy.

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