Volume four: POLICY APPROACHES

Introduction

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Key perspectives and concepts

The articles in volume four demonstrate that the shape of a policy reflects the way the problem is defined. We have seen that these perceptions are influenced by historical and cultural forces (volume one), theoretical and conceptual frames (volume two) and approaches to providing evidence (volume three). As Deborah Stone explained:

> 'Problem definition is a process of image-making, where the images have to do fundamentally with attributing cause, blame, and responsibility. Conditions, difficulties, or issues thus do not have inherent properties that make them more or less likely to be seen as problems or to be expanded. Rather, political actors deliberately portray them in ways calculated to gain support for their side.. . . political actors use narrative story lines and symbolic devices to manipulate so-called issue characteristics, all the while making it seem as though they are simply describing facts' (Stone 1989: 282).

There are a range of policy approaches to the use of and harms associated with different substances (cf Hall 2001; Crombie et al 2007). One issue is whether use is seen as a medical or a criminal justice responsibility - or neither. Changes in attitudes can be observed over time – as we see with the dramatic change in attitudes to tobacco and increasingly perhaps to alcohol. Over time, changes can be observed in the ideas governing policy, for example from seeing the problem as one of *inebriety* to identifying distinct approaches to specific substances to the current concern with the category *ATOD+* (Berridge 2013). Increasingly today, the focus among experts is on poly-substance use but this has not been reflected in the shape of policies.

Change is not just a response to changing perceptions: changing realities are also influential, with policies often developing in response to a crisis or change in conditions. We can see the influence of heroin epidemics, new routes in smuggling and trafficking (Fazey 2007), take up of use by specific groups (such as young people taking cannabis or women drinking) and changes in price and availability. And priorities change over time, with varying concern at different times and in different countries with, for example, HIV/ AIDS prevention, the reduction of acquisitive crime, city centre disorder or abstinence and individual recovery. At times, advocacy coalitions are formed where a diverse range of actors, including politicians, civil servants, pressure groups, journalists, academics, think tanks and others, come together to promote a particular policy. Each advocacy coalition interprets and uses research to advance its policy goals in different ways. Those aiming at policy change formulate strategies to affect the balance of power among stakeholders and to influence perceptions of the problem and of the best solutions.

Overall the main goals of contemporary policies regarding drugs and alcohol fall into three areas: the prevention of crime and disorder; the prevention of public nuisance; and the prevention of harm, especially to young people and children. Decisions are made whether to focus mainly on *supply* or

demand. While the objectives of policies may look the same, a key difference can lie with the way they are implemented. In many countries, one fundamental question is whether the state has the capacity to institutionalise controls or sufficient health services to provide treatment and care. The numerous policies in existence have been comprehensively evaluated by experts in three important publications (Edwards et al 1994; Babor et al 2010a; Babor et al 2010b).

Modern industrial societies typically regulate a large proportion of all marketed products, including food and pharmaceuticals, in terms of such factors as purity, safety, strength/ size, and labelling and advertising claims made. Room has concluded that alcohol and tobacco are under-controlled and cannabis is over- controlled, in terms of relative harm, (Room 2000; Room n.d.) - a situation explained by some by reference to substantial vested interests (Klein 2008; Bewley-Taylor 2012).

With regard to illicit drugs policy, some observers see a process of convergence across countries. *Harm reduction* seems to have been accepted in a growing number of countries, albeit implemented in an inconsistent fashion. Globally, methadone treatment has become more widely available, although the form in which it is delivered can vary greatly, from punitive to compassionate and compulsory to voluntary.

Magnus Israelsson reviewed laws on compulsory care of adult substance misusers (CCC) through a survey of 38 countries in Europe. He found that a majority of the countries have a law concerning CCC either within criminal justice legislation or in civil law. The choice lies between moral (criminal justice system) and medical (health) approaches. Israelsson found that CCC under criminal law is widespread across Europe from Spain to Russia whereas civil CCC is the dominant type in north - west Europe. Nordic countries in particular are characterised by restrictive public health policies concerning alcohol consumption and distribution (Israelsson 2011).

Seddon 2007 notes that in many western countries the criminal justice system is increasingly used to channel and coerce drug users into treatment and in Britain coerced treatment has become a key part of drug policy and practice. In the United States, the idea can be traced from the *narcotic farms* of the 1920s through to the California Civil Addict Program in the 1960s. There are three key assumptions in such approaches: that there is a strong causal connection between drug addiction and acquisitive crime; that treatment is effective in reducing this *drug-related crime*; and that coerced treatment is effective. Seddon reviews the conceptual and evidential issues associated with these assumptions. Some studies suggest coerced clients do no worse than those entering treatment voluntarily and that legal pressure can aid treatment retention but others show negative effects. It is important to note the distinction between *coerced* and *compulsory* treatment, with the latter neither involving nor requiring consent. Importantly, Seddon notes, the distinction between voluntary and coerced treatment is too crude, as there are many informal, extra-legal influences on the decision to enter treatment. Similarly it cannot be assumed that people who enter treatment under pressure lack motivation. *Ambivalence* has been observed by treatment professionals to be commonly present in both voluntary and coerced patients.

Seddon also discusses a number of ethical issues that arise around the idea of coerced treatment. He highlights what he terms the *paradox of freedom*- the inherent contradiction in many policies (especially in neo-liberal societies) between the assumption of freedom of choice in the definition of individuals as rational calculators (who may choose to be treated) while at the same time those

individuals are viewed as *addicted consumers* under the control of a powerful substance. He argues persuasively that the issues raised by coerced treatment go to the heart of debates about the notions of *risk* and *freedom* within crime control practices today.

Policy responses vary not just with the type of substance but with the manner of use and the status of the user. Responses vary across countries too, partly reflecting the customary place of substances in each country. For example, as regards alcohol, Europe is the heaviest drinking area in the world. This links directly to trade: Europe is the source of a quarter of the world's alcohol and over half the world's wine production. In Europe, most countries have education and public awareness campaigns, drink driving restrictions, restrictions on the sale of alcohol and age limits on purchase. The Nordic countries have had retail monopolies and most countries have controls on marketing.

Ten areas have been identified as priorities for action in European alcohol policy: pricing, availability and marketing; illegally and informally produced alcohol; drink–driving; drinking environments; health care interventions; public awareness-raising; community and workplace action; and monitoring and evaluation. There are five priorities: to protect young people, children and the unborn child; to reduce injuries and death from alcohol-related road accidents; to prevent alcohol-related harm among adults and reduce the negative impact on the workplace; to inform, educate and raise awareness of the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns; and to develop and maintain a common evidence base at EU level (CEC 2006).

To capture these variations and explain differences across time and place, the concept of *policy regimes* has emerged. Distinctions have been made between those characterised as libertarian, regulatory or prohibitionist. Crucial distinctions are often made between illicit (or controlled) versus legal (freely available) substances and between acceptable and unacceptable forms of use.

Policies often consider *risks* and *harms* associated with a substance. These may not always be caused by the substance itself: the problem may be overuse, the way it is taken in (e.g. by injecting), how it was obtained and the impact of distribution systems, supply routes, markets and how they operate, how they are produced and the effect of these on local economies . When this wider range of risks and harms are taken into account, attention is often drawn to the *unintended consequences* of policies: for example, the involvement of organised crime where policies of prohibition are in place, the impact of smuggling to avoid taxation, the location of markets (as where problems arise in city centres as a result of regeneration efforts and specific licensing policies) or the impact on local communities of *coffee shops* or drug dealing.

Policies can operate at local, national or international level: increasingly the three levels are interconnected, raising the question of how much autonomy each has. The role of international Treaties and Conventions has been a key area of study. Julia Buxton argues that international drug control policies have been intertwined with US foreign policy goals since the launch of the control system a century ago and that the US controls the international drug policy institutions (Buxton 2006).

The question for analysts is how *appropriate, effective* and *sustainable* are any existing set of institutional arrangements? MacCoun and Reuter have said that drug policy proposals should meet a *political standard* - that is, they should not offend the fundamental cultural or political values of a

society (MacCoun and Reuter 2001: 12-13). Public health and criminology researchers in particular study what policies are effective as well as looking at policy failure. They examine how policies are chosen by governments and how they are implemented in practice. Criteria have been selected on which to evaluate policies – *efficiency, equity, quality* and *responsiveness* – considering *who benefit* and *who lose* from policies. Other important questions are: should the *substance* or the *individual* be the target of policy? Should policies focus on the *general population* or on *heavy consumers*? Treatment responses focus on individual patients who are alcohol or drug dependent: population level responses aim to change the drinking environment or setting and change behaviour through public health or psychological interventions or use of criminal justice sanctions. Which policy levers are most effective – e.g. penal sanctions, taxation, treatment or education? Can the field of illicit drug policy learn from the experience of policies on tobacco and alcohol? While in high income countries like Europe there are attempts to restrict access to tobacco and alcohol, pressures for increased consumption of alcohol in emerging economies are great (Diageo expects 50 per cent of its activity to be in emerging economies in future (Ahmed 2013)) and sharp contradictions exist between the neo-liberal value of consumer choice and prohibition of use of tobacco, alcohol and drugs.

Reviews and critiques of policy regimes

MacCoun and Reuter 2002 review the experiences of eleven nations: Australia, Canada, Colombia, Denmark, France, Iran, Jamaica, Mexico, Portugal, Russia, and Sweden. They point out some basic analytical challenges for cross-national drug policy analysis: the fact that data is often scarce or of poor quality and difficult to compare across countries. They observe that various public health and public safety problems are caused both by domestic drug consumption and by the legal prohibition of these substances. Some countries confront a second drug problem as well, one that can dwarf the first: they are home to major drug trafficking organizations. And several of these countries must contend with the direct and indirect effects of an aggressive U.S. campaign to stem the flow of drugs.

Periodically, there have been new initiatives to try to deal with the ever present problem of the human inclination to take psychoactive substances, such as acceptance of medical use of marijuana, decriminalization of use by individuals, heroin maintenance therapy and a range of harm reduction interventions. Examples are the Swiss trials in heroin maintenance, the Dutch cannabis regime (separating markets for soft and hard drugs), and de-penalisation policies in a number of countries.

Galston and Dionne 2013 observe how, over recent years in the USA, public opinion has shifted dramatically toward support for the legalization of marijuana. A recent national survey there showed a narrow majority in favour of legalization, and its supporters translated this sentiment into ballot initiative victories in Colorado and Washington State in 2012. In their paper, these authors seek to explain the forces behind the move toward legalization. One feature is that attitudes cut across political party lines. Being religious influences views, where marijuana use is seen as a moral issue. Support for legalisation does not however equate with a belief that use is harmless: rather it is influenced more by practical doubts about the ability of the law to enforce a prohibition against it. A large majority seem to have been persuaded that there is evidence for marijuana having a legitimate medical use. Galston and Dionne conclude that it is at least a plausible hypothesis that changing

public sentiment on medical marijuana helped transform attitudes on marijuana altogether. Attitudes are also influenced by generational experiences – coming of age in the years of the 1960s counter culture versus the Reagan years, for example.

We have seen that the issue of whether to focus attention on supply or demand is a constant theme in discussions of drugs policy. Arguably, if conventional economic laws of supply and demand were to apply, a measure of the effectiveness of supply reduction would be indicated by a rise in prices. *Caulkins and MacCoun 2003* explore this issue in their article. They focus on the apparent paradox that, in recent decades, the prices for cocaine and heroin in the U.S. have fallen despite increasingly stringent enforcement. They comment that the risks and prices paradigm views drug enforcement as working through deterrence. Deterrence depends on the object of the enforcement threat behaving with some degree of *rationality* (a point also discussed by Seddon as we have seen). Caulkins and MacCoun present evidence to question whether rational actor models adequately describe drug dealers' behaviour and conclude that they do not do so thus explaining why deterrence does not work out as implied by the risks and prices theory.

Another critical review of policy is presented in the article by *Reinerman et al 2004.* They note that proponents of criminalization attribute to their preferred drug-control regime a special power to affect user behaviour. By comparing the situation in two cities with different policy regimes, their findings cast doubt on the core empirical claim made by criminalization proponents that, in the absence of a threat of punishment, the prevalence, frequency, and quantity of cannabis use will increase and will threaten public health. The *separation of markets*, in which lawfully regulated cannabis distribution reduces the likelihood that people seeking cannabis will be drawn into deviant subcultures where hard drugs are also sold is one public health objective of Dutch decriminalization. The irrelevance of the policy context is indicated by their data which suggest that most experienced users organize their use according to their own sub-cultural etiquette—norms and rules about when, where, why, with whom, and how to use—and less to laws and policies.

Hughes and Stevens 2010 consider the case of Portugal, often cited in contemporary debates as an exemplar. Portugal established Commissions for the Dissuasion of Drug Addiction (CDTs) whose primary aim is to dissuade drug use and to encourage dependent drug users into treatment. They conclude that the major perceived success of the Portuguese reform has been its contribution to changes in public health problems, with significant referrals—particularly in the early years—by the CDTs of heroin users to treatment. There were also significant reductions in mortality, HIV, HCV and TB. This research concludes that decriminalization reduced the burden on the Portuguese criminal justice system: reductions in opiate-related deaths are likely to reflect the large increase in the provision and uptake of treatment, particularly low-threshold opiate substitution treatments, and not simply the effect of decriminalization.

Modern efforts to prevent alcohol problems through public policy received wide recognition with the publication of a 1975 monograph, *Alcohol Control Policies in Public Health Perspective*, sponsored by the World Health Organization. This report led to a World Health Assembly recommendation that countries design national alcohol policies emphasizing preventive measures. The World Health Organization places a high priority on controlling alcohol-related problems through effective economic and public health measures.

In 2004, WHO produced two key publications: the *Global Status Report on Alcohol* (WHO, 2004a) attempts to give a global overview of alcohol (alcohol consumption and use, prevalence rates and patterns of use). The *Global Status Report: Alcohol Policy* (WHO, 2004b) describes the status of alcohol policies worldwide. In May 2010, at the sixty-third session of the World Health Assembly, the 193 Member States of WHO reached a consensus on a global strategy to reduce the harmful use of alcohol. The global strategy aims to give guidance for action at all levels, set priority areas for global action and to recommend a range of policy options and measures that could be considered for implementation (with the necessary adjustments for the specific contexts of individual nations).

To explore how far these ambitions have been implemented, *Brand et al 2007* developed a composite indicator—the *Alcohol Policy Index*—to gauge the *strength* of a country's alcohol control policies. This referred to five regulatory domains: physical availability of alcohol, drinking context, alcohol prices, alcohol advertising and operation of motor vehicles. They found that the strength of alcohol control policies, as estimated by the Alcohol Policy Index, varied widely among 30 countries located in Europe, Asia, North America, and Australia. The study revealed a clear inverse relationship between policy strength and alcohol consumption.

Wagenaar et al 2010 also review public health policies with regard to alcohol, specifically considering the effects of alcohol taxes and prices on alcohol-related morbidity and mortality. Public policies affecting the price of alcoholic beverages have significant effects on alcohol-related disease and injury rates. Arguments for regulation through increasing prices by adding taxes have been influenced by the positive experience with tobacco tax increases. This study observes that the link between alcohol tax and price levels and drinking (including heavy drinking) is well established, along with the association of individual and population drinking levels with several indicators of morbidity and mortality. The aggregated results from the fairly large set of studies which they review showed clearly that beverage alcohol prices and taxes were significantly and inversely related to all outcome categories examined: alcohol-related morbidity and mortality, violence, traffic crash fatalities and drunk driving, rates of STDs and risky sexual behaviour, other drug use, and crime. They conclude that doubling the alcohol tax would reduce alcohol-related mortality by an average of 35 per cent, traffic crash deaths by 11 per cent, sexually transmitted disease by 6 per cent, violence by 2 per cent, and crime by 1.4 per cent. In most developed countries, alcohol is second only to tobacco as a consumer product that causes death.

In spite of this evidence, policies regarding minimum unit pricing have been hotly debated, with politicians appearing to submit to pressure from the alcohol industry in withdrawing proposals for reform. In their paper, *Hawkins et al 2012* ask what is the influence of the alcohol industry on alcohol policy? Babor et al. (2010b) had defined alcohol policy broadly as those measures aimed at minimising the harms which result to both individuals and society as a result of alcohol use. Recent initiatives in Scotland have argued for a role for minimum pricing as an effective targeted public health policy. The experiences of reformers highlight the importance of issues of governance - how decisions are made – in explaining why some policies gain support while others are rejected. Hawkins et al point out the significance of the fact that alcohol production is now concentrated amongst a handful of multinational corporations. Their study illuminates how research might begin to answer questions around the influence of industry on policy.

In Sweden, the alcohol retail monopoly and the national alcohol policy are seen by some as threatened by the EU project of a single market. Traditional alcohol policy instruments like heavy alcohol taxes have been brought into question. Alternatives which have existed in Sweden include prohibition and ration books. Another response has been compulsory care for those who presented a problem to their families or society. This is the subject of the article by *Edman 2005,* a historical study of compulsory care of alcohol abusers in Sweden during the period 1940–1981. This research brings out the important distinction between perceptions as encapsulated in policy documents, and activities as actually practised on the ground. He found that the actual treatment of alcohol abusers was shaped by class and gender. The method of treatment most commonly used within Swedish institutional care during the 20th century was work, focusing on character building. The people who were detained were perceived as workshy men and immoral women, as deviants, and were mainly poor and working class.

Harm reduction

Following the recognition of HIV and its links to injecting drug use and AIDS, between 1988 and 1993, innovative public health projects increased the ability to target vulnerable populations through syringe distribution, expansion of methadone treatment and outreach to hard-to-reach populations. *Stimson 1995* explores this shift in policy and practice, noting that there were major changes in service philosophy and practices, as ideas of harm minimization, accessibility, flexibility and multiple and intermediate goals were developed. There is evidence that these public health projects encouraged extensive changes in the health behaviour of injecting drug users (IDUs), arguably averting an epidemic of AIDS among IDUs. One conclusion here is that drug users can behave rationally when in a supportive environment.

The HIV/AIDS epidemic in the 1980s had a huge impact on thinking about drug policy in many parts of the world. The concept of harm reduction entered into discussion. Lessons were learnt from overseas, for example from Amsterdam where syringe distribution had started in 1984, and political leadership was important in effecting policy change. The experience showed that major shifts in policy can occur in a context of perceived crisis. The principle of harm minimisation legitimized behavioural targets other than abstinence and encouraged attention to prevention. Stimson refers to this as a paradigmatic shift in UK drugs policy, with the main focus being on injecting behaviour and general health rather than on mental health. In this conception, drug users were viewed as more like other patients and not necessarily irrational and irresponsible.

The article by *Hedrich et al 2008* continues the story told by Stimson explaining how ideas spread in Europe and shaped a distinctive approach to policy in the region. There are two key elements in harm reduction policies - opioid substitution treatment and needle exchange programmes. Although large differences in provision remain between west and east Europe and between southern and northern Europe, these authors think they can detect elements of convergence in policy in Europe towards a distinct model. Influential features of this process which they identify include the role of strategic guidance and target-oriented action plans in shaping policies. They point to the role of intergovernmental collaboration and information exchange, prompted by concern with international drug-related crime but also regarding health indicators such as drug-related deaths or HIV+ rates among IDUs/PWUDs. Over time, written European drugs strategies

translated into four-year Action Plans. They conclude that European strategy can provide a framework for national policies, shaping and guiding it. They recognise that the actual implementation of policies may vary, noting variations in the scale and coverage of OST and NSP and that there are certain organizational aspects in healthcare delivery which are also essential for accessibility of treatment. However they remain relatively positive about the direction of policy travel in Europe over time.

International context

National policies are thus constrained by their embedding within supra-national arrangements such as the European Union which limit the room for manoeuvre in both alcohol and illicit drugs policy. Above this level are international agreements, most evident in the field of illicit drug control. The document by *Rolles et al 2012* offers a critique of this international regime, assessing its *unintended consequences,* which include the creation of a huge criminal market, the displacement of production and transit to new areas (the balloon effect), the diversion of resources from health to enforcement, the displacement of use to new drugs and the stigma and marginalisation of drug users. For many countries, there are also negative development costs. Criminalisation encourages high-risk behaviours, such as injecting in unhygienic, unsupervised environments. Enforcement tilts the market towards more potent but profitable drug products. It can also fuel the emergence of high-risk, new *designer drugs*: illegally produced and supplied drugs are of unknown strength and purity, increasing the risk of overdose, poisoning and infection. In most countries, it is minorities who are over-represented in arrests and prison populations.

This publication from an advocacy organisation supports moves towards the legal regulation of drug markets. Drawing on experiences from alcohol, tobacco and pharmaceutical regulation, Rolles et al argue that increasingly sophisticated models have now been proposed for regulating different aspects of the market – production, vendors, outlets, marketing and promotion, and availability – for a range of products in different environments - and these should be taken seriously. Noting the fact that the consequences of policies fall most heavily on the poorest and most marginalised, these arguments for reform rest not least on reference to human rights - an approach to policy which has gained strength in the 21stC at the international level.

Gallahue et al 2012 consider issues of human rights when reviewing the use of the death penalty for drug offences. In most jurisdictions, a distinction is made between purchasing drugs for personal use versus possession for distribution. Trafficking of illegal drugs is dealt with especially harshly in a number of countries. Those arguing for harsh punishments refer to the evil and profitable nature of drug trafficking. These researchers found that, in practice, death sentences are often commuted to life imprisonment. However this leaves large numbers of people incarcerated on death row in gaols around the world.

There are thus, as we have seen, two major policy approaches to drugs: a non-punitive and pragmatic health-oriented approach and a zero-tolerance punitive approach. Almost all nations are currently parties to the UN international drug control Conventions of 1961, 1971 and 1988, treaties that, taken together, form what has been called the global drug prohibition regime. *Bewley-Taylor 2013* observes that, within this, there is space for national discretion but the

prohibitive norm remains at the regime's core. Bewley-Taylor notes that recent years have seen a growing unwillingness among increasing numbers of states to fully adhere to a strictly prohibitionist reading of the UN drug control Conventions. In his 2012 book, Bewley-Taylor coined the term *soft defecting* states, to refer to those choosing to deviate from the prohibitive ethos of the Conventions whilst remaining within the confines of their treaty commitments. Softer approaches include harm reduction interventions, aiming to lessen the link between injecting drug use and HIV/AIDS (particularly drug consumption rooms/safe injection facilities), medical cannabis schemes and the decriminalization of drug possession for personal use.

Bewley-Taylor's article illustrates research on the policy process at international level. It notes the role of like-minded groups and coalitions and shows the complexities of both inter- and intra-group dynamics as they operate in these arenas. The complexities and constraints of reaching decisions at international level are exemplified by recent attempts by Bolivia to effect change with regard to coca chewing.

The document *WHO 2010* identifies alcohol use as the third leading risk factor for poor health globally. WHO see alcohol as having implications not only for public health but also for social and economic development. In high-income countries, people are protected by a range of laws and interventions but this is not always the case in low- and middle-income countries. The global strategy to reduce the harmful use of alcohol provides a portfolio of policy options and strategies for consideration by member states and identifies areas for priority action. Policies should involve not only the health sector but a range of others, such as transport, trade, social welfare and education. WHO recognise that conflicting interests are at work, since alcohol provides employment and tax revenue as well as causing harm. There are five main objectives in the global strategy: to raise awareness of the harms linked to alcohol; to strengthen the knowledge base; increase capacity in member states to respond effectively; strengthen partnerships and encourage cooperation and coordination; and improve monitoring and evaluation systems.

Recommendations for policy are offered but hedged around with due sensitivity to variations in culture and resources in different countries. These cover ten areas which are discussed in detail: leadership, awareness and commitment; health services' response; community action; drink-driving policies and countermeasures; availability of alcohol; marketing of alcoholic beverages; pricing policies; reducing the negative consequences of drinking and alcohol intoxication; reducing the public health impact of illicit alcohol and informally produced alcohol; and monitoring and surveillance.

Concluding comments

The main themes which have emerged in the literature on drug and alcohol policy are of the existence of disproportionate responses to different substances; that policies can have perverse impacts and unintended consequences; that disputes remain about the relationship between policy and patterns of use; and that there is variable evidence on the effectiveness of policies (cf Kleiman et al 2011). There is no single problem across countries and there are no magic bullets. However changes do occur over time.

There is growing acceptance among informed groups of many of the criticisms of international drug policy. In a much cited essay for the Commission on Narcotic Drugs meeting in 2008, *Costa 2008*, the Executive Director of the UNODC discussed how to make drug control 'fit for purpose'. He identified five broad classes of unintended consequences of prohibition as implemented that should play a role in discussions of policy: creation of huge criminal black markets; policy displacement (from health to enforcement against those markets); geographic displacement; substance displacement (to less controllable drugs); and displacement in the way we perceive and deal with the users of illicit drugs.

The argument of the article by *Amsterdam and Brink 2013* is that alcohol abuse is more harmful for public health and society than illicit drug use and the balance of attention in public policy should reflect this. Their key message is that policy-makers unjustifiably focus on the harm of illicit drugs, whereas they underestimate the harm of alcohol use. Policy makers should consider alcohol to be at least as harmful as illicit drugs and invest more in prevention and harm reduction strategies for alcohol abuse and dependence. They note that worldwide policy makers are primarily concerned about the public health effects of illicit drug use and the prohibition of illicit drugs, whereas there is little political interest in the reduction of societal costs due to alcohol use. They describe the findings of a Dutch harm ranking study (similar in concept to that of Nutt et al described in volume three). The paper mobilises a huge range of evidence to demonstrate the health harms associated with alcohol consumption urging much more awareness of this and higher priority in public policy.

However it is also evident that international agreements are very difficult to change and that reform is a time-consuming process demanding the input of many people. But successes regarding tobacco show it is possible to change. The WHO Framework Convention on Tobacco has been seen as a step change: 192 member states of WHO unanimously adopted what was seen as the world's first public health treaty – the first legal instrument designed to reduce tobacco-related deaths and disease globally. (However, since 2005, only 11 per cent of countries have fulfilled their legally binding commitments).

As populations urbanize and grow, tobacco and alcohol use, poor diet and inactive lives will drive up deaths globally (cf Jernigan et al 2000). A coherent response would prioritize tobacco and alcohol control and child nutrition, focus innovation on efficient community-based models of care, and ensure access to basic off-patent medicines (cf Chand 2012*).* There is a need for more research on effective forms of regulation of drugs and alcohol and consideration of the links between these broad regimes and the specific interventions which are the focus of articles in volume five.

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