



FIELD GUIDE

TO DRUG DEMAND REDUCTION PROGRAM DEVELOPMENT

THIRD EDITION

2018

DDR FIELD GUIDE III

ACKNOWLEDGMENTS

Many individuals contributed to the production of the third edition of the Field Guide to Drug Demand Reduction Program Development and their names are listed in various places throughout the document. Special thanks goes to Brian Harris, Director of the Office of Policy, Planning, and Coordination with the Bureau of International Narcotics and Law Enforcement Affairs (INL/PC), and also to Brian Morales, Division Director for Global Demand Reduction Programs within INL/PC for their leadership on addressing drug demand reduction challenges around the world. Appreciation is also owed to the entire INL/PC Drug Demand Reduction team of which Dr. Andrew Thompson served as lead for coordinating the project.

The production of the Third Edition of the Field Guide to Drug Demand Reduction Program Development would not have been possible without the efforts of the Colombo Plan's Drug Advisory Program (CP/DAP) team members, Nathalie Panabokke, Rasalingam Nagarajah, and Sajeewa Suresh Perera, under the guidance of CP/DAP Director, Ma. Veronica Felipe. Lastly, Nancy W. Dudley, consultant to CP/DAP, served as lead editor for this edition.

DDR FIELD GUIDE III

CONTENTS

Introduction to the Drug Demand Reduction Field Guide	
Foreword by Brian Harris	1
Drug Demand Reduction Team	2
DDR Global Implementing Partners	6
A Message from the Division Director for Global Drug Demand Reduction Programs	8
Program Area 1 – Developing the Drug Demand Reduction Workforce	
The Universal Treatment Curriculum	15
The Universal Prevention Curriculum	20
Credentialing Treatment and Prevention Professionals	24
Program Area 2 – Professionalizing Drug Treatment and Prevention Services	
INL Drug Demand Reduction Menu of Services	29
Global Treatment Standards Checklist	32
Treatment Capacity Survey	37
Research Systems Survey	40
Program Area 3 – Building Global Networks and Community Coalitions	
Fostering a Global Community of Professionals	43
Promoting Research and Education through Universities	46
Supporting Drug-Free Community Coalitions	49
Sharing Epidemiology Data on Drug Use	51
Tracking Toxic Adulterants	53
Addiction Studies Degree Programmes	55
Program Area 4 – Addressing Populations with Special Clinical Needs	
Providing Specialized Care for Women in Treatment	58
Supporting Drug-Free Living in Children	62
Removing Treatment Barriers for LGBT People	68
Providing Recovery Support	69
Promoting Treatment within the Criminal Justice System	71
Reducing the Risk of Fatal Overdose in Opioid Users	74
Features from the Global Drug Demand Reduction Community	
ISSUP Update	77
The Case for Credentialing	80
Biology of Decision Making and Drug Dependence	82
A PIRE Retrospective: INL Evaluations through the Years	86
INL Drug Demand Reduction Activities in 2017	
94	
Appendices	
Appendix 1: The International Drug Control Framework	115
Appendix 2: Roster of CADCA Coalitions By Country	119
Appendix 3: ICUDDR Member Universities	134

FOREWORD

Dear Colleagues:

I am pleased to share with you the *3rd Edition of the Field Guide to Drug Demand Reduction Program Development*. This document, developed by the Office of Policy, Planning, and Coordination within the Bureau of International Narcotics and Law Enforcement Affairs (INL), is meant to serve as a primer and quick reference guide to INL demand reduction programs and activities around the world.

The Third Edition of the Field Guide contains updates on centrally-managed programs, various tools that can be used to assess a country's demand reduction systems, and information about the global networks and coalitions that INL supports. This volume also contains a summary of drug demand reduction missions conducted by INL DDR during 2017 as well as several features by guest authors highlighting important elements of the global drug demand reduction community. It's our hope that you will use this Field Guide to help inform and shape your thinking as you work to overcome drug demand reduction challenges in your own work portfolio.

The *3rd Edition of the Field Guide to Drug Demand Reduction Program Development* is presented in the spirit of building a global community of knowledgeable professionals to combat the global problem of drug dependence. A comprehensive approach to the public health crisis of

“ “ *The Third Edition of the Field Guide contains updates on centrally-managed programs, various tools that can be used to assess a country's demand reduction systems, and information about the global networks and coalitions that INL supports.* ” ”



drug use cannot ignore demand, and our response to the crisis must involve strategies that have been proven to be effective across culture and context. While this Field Guide presents a thorough introduction to drug demand reduction, please know that the Drug Demand Reduction team within INL/PC can always be reached at DemandReduction@state.gov to answer your specific questions or talk about how to get involved with any of the projects presented here.

Brian Harris

Director of the Office of Policy, Planning, and Coordination
Bureau of International Narcotics and
Law Enforcement Affairs (INL/PC)
U.S. Department of State



DRUG DEMAND REDUCTION TEAM



BRIAN MORALES

Division Director for Global Drug Demand Reduction Programs in INL's Office of Policy, Planning and Coordination (INL/PC)

◀ Brian Morales is the Division Director for Global Drug Demand Reduction Programs in INL's Office of Policy, Planning and Coordination (INL/PC). He has worked on the issue of drug demand reduction for ten years, covering programs throughout the world. One of his most notable achievements was the establishment of the International Society of Substance Use Prevention and Treatment Professionals (ISSUP) in July 2015, bringing together the global treatment and prevention workforce into an association that promotes professionalization through training and credentialing. In March 2016, he collaborated with international partners to launch the International Consortium of Universities for Drug Demand Reduction (ICUDDR) to promote academic study around the world in the field of addiction science. Prior to INL/PC, Brian covered Afghanistan counter-narcotics issues and also served in the Bureau of Western Hemisphere Affairs at the U.S. Mission to the Organization of American States. Brian earned his Bachelor of Science in Foreign Service (2001) and a Master of Arts in Latin American Studies (2004), both from Georgetown University.

Charlotte joined the team in February 2016 as the Team Lead for Drug Demand Reduction in INL's Office of Policy, Planning and Coordination. She brought over 16 years of drug policy experience from working at the White House Office of National Drug Control Policy in the areas of drug supply and demand reduction. She earned her undergraduate degree from Virginia Tech and received a Master's Degree in International Policy and Practice from George Washington University in 2001. Charlotte is currently working on the development of a new curriculum aimed at building partnerships between public health and criminal justice sectors to increase access to treatment in the criminal justice system. She is also working to redesign and update INL's universal curriculum to treat women with substance use disorders.



CHARLOTTE SISSON



**BILL
MCGLYNN**

Bill is an experienced U.S. State Department professional. From 2008 to 2011, Bill was INL's Principal Deputy Assistant Secretary. In other assignments, he served as Deputy U.S. Permanent Representative to the Organization of American States and in the U.S. embassies in Haiti, Gabon, the European Union, Austria, and Portugal. Bill received his undergraduate degree in 1976 from the University of Virginia, studied law at William and Mary, and was a member of the Executive Education program at Princeton (1995-1996). Bill has been working on drug demand reduction programs in Africa, Asia, and Latin America. As part of the drug demand reduction team Bill has been instrumental in working with the African Union on an epidemiological project funded by INL.

Maria joined the Drug Demand Reduction team in July 2015, covering the Universal Prevention Curriculum development and training. She also supports the work of professionalizing the demand reduction workforce in Afghanistan and Pakistan. Her previous work at the U.S. Department of State includes creating and managing strategic communication campaigns and involvement in YSEALI (the Young Southeast Asian Leaders Initiative), YALI (the Young African Leaders Initiative), and forging partnerships with the private sector to strengthen the Department's ability to engage with youth communities around the world. Maria first joined the Department as a Presidential Management Fellow in 2011, which included a rotation at the U.S. Embassy in Jakarta. She earned her Master's in International Affairs from the George Washington University, is a native speaker of Lithuanian and is conversational in Spanish and Russian.



**MARIA
SKIRK**



**ALAN
PIRACHA**

Alan joined the drug demand reduction team in early 2017 and covers development of the Universal Treatment Curriculum, children's programming, and serves as the INL contact for the 2018 ISSUP workshop. Alan previously worked in several other capacities at the State Department, including in INL's Afghanistan and Pakistan office where he covered multilateral engagement for justice sector issues; as the Niger Desk Officer; in the Office of the Chief of Protocol; and in the Bureau of Overseas Building Operations. He completed his Master of Arts in public diplomacy at American University and his undergraduate education in political science and film production at Bowling Green State University.

■■■ DDR TEAM



**ANDREW
THOMPSON**

Andrew Thompson joined the Drug Demand Reduction team in October 2017 as a Science and Technology Policy Fellow of the American Association for the Advancement of Science. He earned a Ph.D. in Neuroscience from UCLA in 2016, focusing on drugs of abuse and the neurobiology of impulsive decision making following drug exposure. In addition to his scientific background, Andrew has experience in education and communication. He is responsible for several projects relating to scientific research and outreach, as well as for finding ways to use digital dissemination techniques and online learning to increase the reach of global drug demand reduction programs.

Jullion joined the DDR team in February 2017. He is a Foreign Service Officer with a B.A. in Criminal Justice from the University of Delaware and an M.A. in International Relations from Johns Hopkins' School of Advanced International Studies. Before joining the Department, Jullion assisted HIV+ incarcerated individuals in the Boston area with re-adjusting to life outside of prison. During his tenure at the U.S. Consulate in Guangzhou, he aided U.S. citizens in distress, promoted LGBT civil society and vetted prospective Chinese citizens for tourist visas. In 2017, he helped develop two new courses – one entitled The Intersection of Substance Use and Sexual Orientation and Gender Identity (SOGI) and the other focused on helping individuals in recovery acquire tools and training to assist others in recovery. He also lead efforts in the Western Hemisphere and West Africa working with the Colombo Plan, the United Nations Office on Drugs and Crime and the Organization of American States to increase the number of treatment professionals in the region. Jullion also is an asset to the drug demand reduction team speaking fluent Chinese, Spanish, Catalan and Italian, and is working on French and Haitian Creole proficiency.



**JULLION
COOPER**

VISITING MEMBERS

Allison Greenberg of Massachusetts is a student at The George Washington University pursuing her bachelor's degree in Criminal Justice and International Affairs, concentrating in Security Policy. Allison joined INL's Drug Demand Reduction team in the summer of 2017 as an intern, drafting memorandums for senior officials, providing support to interagency policy, editing drug treatment and prevention training modules for populations with special clinical needs, and contributing to the 3rd edition of the Field Guide.



**ALLISON
GREENBERG**



**JARED
FRANZ**



Jared Franz of Leonardtown, Maryland, is completing his BA in international relations, with a focus on foreign policy and global conflict resolution. Jared's studies focus on analyzing the impact of drug trafficking activities on various regions of the world as well as how the demand for drugs affects everyday life in communities in Latin America. While at INL-DDR, Jared contributed to the 3d edition of the Field Guide, coordinated with various posts and offices, and provided support in the creation of prevention and treatment training materials.

DRUG DEMAND REDUCTION GLOBAL IMPLEMENTING PARTNERS



AFRICAN UNION

AFRICAN UNION COMMISSION

The African Union (AU) works toward a vision of an integrated, prosperous, and peaceful Africa. It encourages international cooperation, democratic principles and institutions, good governance, research in science and technology, and the eradication of preventable diseases. In keeping with these objectives, the AU is engaged in a range of demand reduction efforts, including promoting the adaptation and implementation of minimum quality standards for treatment of drug dependence, organizing annual demand reduction technical focal point consultative meetings, strengthening research and data collection capacity for drug use prevention and treatment in Africa, and establishing and strengthening epidemiological networks.



THE COLOMBO PLAN

THE COLOMBO PLAN

The Colombo Plan for Cooperative Economic and Social Development, established in 1951, is one of the oldest intergovernmental organizations in the Asia-Pacific region with the goal of achieving socio-economic progress in its member countries. The Colombo Plan Drug Advisory Programme (DAP) has spearheaded drug demand and supply reduction solutions in the region since its inception in 1973, and provides technical assistance, training, and programming across five continents. The Global Centre for Credentialing and Certification (GCCC) of the Colombo Plan was established in 2009 to promote the professional development of the drug demand reduction workforce by offering training programs and credentials for prevention, treatment, and recovery specialists. In 2010 and 2017, project offices were opened in Kabul, Afghanistan and Santiago, Chile, respectively.

COMMUNITY ANTI-DRUG COALITIONS OF AMERICA



The Community Anti-Drug Coalitions of America (CADCA) is a leading U.S. substance abuse prevention organization, representing over 5,000 community-based coalitions across the United States and in 22 countries who work to create safe, healthy, and drug-free communities. CADCA is the recipient of INL's Anti-Drug Community Coalitions Grant, which supports coalition training and technical assistance to non-government organizations operating in developing countries around the world.



Inter-American Drug Abuse
Control Commission

ORGANIZATION OF AMERICAN STATES, INTER-AMERICAN DRUG ABUSE CONTROL COMMISSION

The Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS) is the Western Hemisphere's policy forum for dealing with the drug problem. The Demand Reduction Section of CICAD works with member states to build institutional and human resource capacity through training and certification programs. The Training and Certification for Drug Violence Prevention, Treatment, and Rehabilitation (PROCCER) model, developed by CICAD, supports prevention and treatment service providers, and ensures that they have the necessary competencies, knowledge, and aptitudes to provide appropriate interventions.



UNODC
United Nations Office on Drugs and Crime

THE UNITED NATIONS OFFICE ON DRUGS AND CRIME

The United Nations Office on Drugs and Crime (UNODC) operates in all regions of the world, through an extensive network of field offices, to assist Member States in responding to the world drug problem and dealing with crime, corruption, and terrorism. The three pillars of UNODC's work programme include field-based technical cooperation and capacity building, research and analytic work to increase knowledge and expand the evidence base, and normative work to assist States in the implementation of the relevant international treaties and the provision of secretariat and substantive services to the treaty-based and governing bodies. UNODC encourages a balanced approach between drug supply and drug demand reduction activities, and the approach to drug demand reduction is fundamentally based on respect for human rights, social protection, and cohesion. UNODC works directly with Member States to implement treatment, care, and rehabilitation for people affected by substance use disorders.



World Health
Organization

THE WORLD HEALTH ORGANIZATION

The World Health Organization (WHO) is the directing and coordinating authority on international health within the United Nations system. WHO carries out this role by providing leadership on matters critical to health, shaping the research agenda, stimulating the generation, translation, and dissemination of knowledge, setting and monitoring the implementation of norms and standards, and articulating ethical and evidence-based policy options. WHO is instrumental in identifying effective prevention and treatment interventions in its guidelines documents, and supports policymakers identify and implement effective treatment and public health focused drug policies. WHO also collaborates with UNODC to improve the coverage of drug dependence treatment in the UNODC/WHO Programme on Drug Dependence Treatment and Care.

A MESSAGE FROM THE DIVISION DIRECTOR FOR GLOBAL DRUG DEMAND REDUCTION PROGRAMS



BRIAN MORALES

Division Director of Global Drug Demand Reduction Programs
Office of Policy, Planning, and Coordination
Bureau of International Narcotics and Law Enforcement Affairs (INL/PC)

A warm welcome to all readers of the 3rd Edition of the Field Guide for Drug Demand Reduction Program Development. This Field Guide is produced annually by the U.S. Department of State’s Bureau of International Narcotics and Law Enforcement Affairs as a resource for U.S. Embassy personnel with a mission relating to drug demand reduction. It is meant as a handbook for assessing the substance use issue in your region and for developing effective responses which are comprehensive, well-coordinated, and in line with evidence-based practices. I hope you will find it a useful resource throughout the year.



How INL Views the Problem of Global Substance Use

The INL drug demand reduction team views the issue of global substance use in its broadest possible context, beginning with the costs of substance use to the U.S. and to the rest of the world. Wherever substance use occurs, it weakens the pillars of society: public health, economic growth, national

security, and the rule of law. Substance use undermines the strength and resilience of individuals and families across all social, economic, and cultural boundaries. It erodes the fabric of communities by destroying neighborhoods from the inside out, with often the most vulnerable of citizens—children and youth—being the first to fall prey to the use of addictive drugs. Those communities in which substance use is allowed to flourish, for even short

periods, are plagued by drug trafficking, violence, and the spread of HIV and other illnesses. And wherever substance use remains unaddressed over time, it breeds corruption, cybercrime, insecure borders, unemployment, black markets, overdose, and hopelessness. All of these negative forces, in turn, fuel the rise of disease, poverty, and terrorism in urban and rural settings, affluent and developing alike.

quantity, supply reduction that occurs without a corresponding reduction in demand can drive up the market value of drugs. This runs the risk of encouraging drug production by increasing the profits of producers and traffickers, while making up for the cost of drugs lost to interdiction. Additionally, this creates incentives for traffickers to use pharmaceutical products or dangerous synthetic drugs as cutting

agents, which increases the risk of unpredictable negative health effects, including fatal overdose. Drug demand reduction, on the other hand, aims to reduce the market value for drugs by preventing drug use and providing treatment to people who use drugs. A balanced approach to drug control incorporates both supply reduction and demand reduction strategies, with the goal of simultaneously increasing the risk and costs of producing drugs, and reducing the profitability of drug production.

Drug demand reduction is primarily delivered through three channels: prevention, treatment, and recovery support. In each of these areas, best practices and

effective techniques have been developed and deployed around the world. While the science of DDR is advancing rapidly, INL recognizes several major challenges to be tackled on the immediate horizon.

First, thousands of individuals who currently need treatment services do not, or cannot, access them; and of those who do access services, many do not receive adequate care. According to a study published in *World Psychiatry* in October 2017, only



There are two major approaches to the challenge of global substance use: drug supply reduction and drug demand reduction (DDR). The first attempts to reduce the quantity of drugs that are available on the market. The second attempts to reduce the willingness to purchase and use drugs. These two approaches are complementary, and work best in parallel as part of a balanced drug control strategy. Because of the economic forces that determine market value and

INTRODUCTION

39 percent of all the people diagnosed with substance use disorders around the world within the previous year recognized a need for treatment; only 24 percent made at least one visit to a service; and only seven percent received minimally adequate treatment (World Psychiatry 2017; 16:299-307). Strategies to increase awareness,

The ability to rapidly disseminate scientific knowledge to practitioners is a critical factor for ensuring quality substance use prevention and treatment programming. We need to shorten this time frame in the U.S. and around the world by building connections between scientists and practitioners.



Third, INL is focusing on the need for ensuring that treatment services are responsive to the specific needs of individuals, including vulnerable members of society who may experience extra barriers to effective treatment. This includes a range of populations with special clinical needs, such as women, children, people in recovery, and people involved in the criminal justice system. INL considers it vital to identify and support vulnerable or marginalized populations through the development and dissemination of specialized protocols, treatment modalities, and training packages. Furthermore, specialized curricula focusing on the unique clinical needs of certain populations must continually be updated with the latest evidence in which

reduce stigma, expand outreach, promote accessibility, and develop a trained and qualified workforce can help to ensure that those who need treatment receive quality services.

approaches work, for whom, and under what circumstances.

Second, the transfer time for scientific evidence to become operational in the field is, on average, seventeen years. This is far too long, and the delay is costing lives.

THE VALUE OF INTERNATIONAL DRUG DEMAND REDUCTION

International drug demand reduction efforts support the achievement of a broad range of U.S. foreign and domestic policy objectives. In the area of public health,

studies show that effective treatment programming has correlated with reductions in intravenous drug use, reductions in suicide attempts, and interruptions in the intergenerational cycle of drug use, violence, and crime. DDR programming has also been shown to reduce levels of crime and support the rule of law, with reductions in drug dealing among high-risk youth as well as reductions in arrests rates and incarcerations among gang members post-treatment. In the area of national security, safe and secure borders are critical, and a host of DDR efforts align with national security objectives, including programming to intervene on the recruitment of child soldiers, insurgents, and suicide bombers through the use of drugs. Finally, in the area of economic development, DDR programming benefits range from the macro-level, through the U.S. engagement of foreign partners, to the

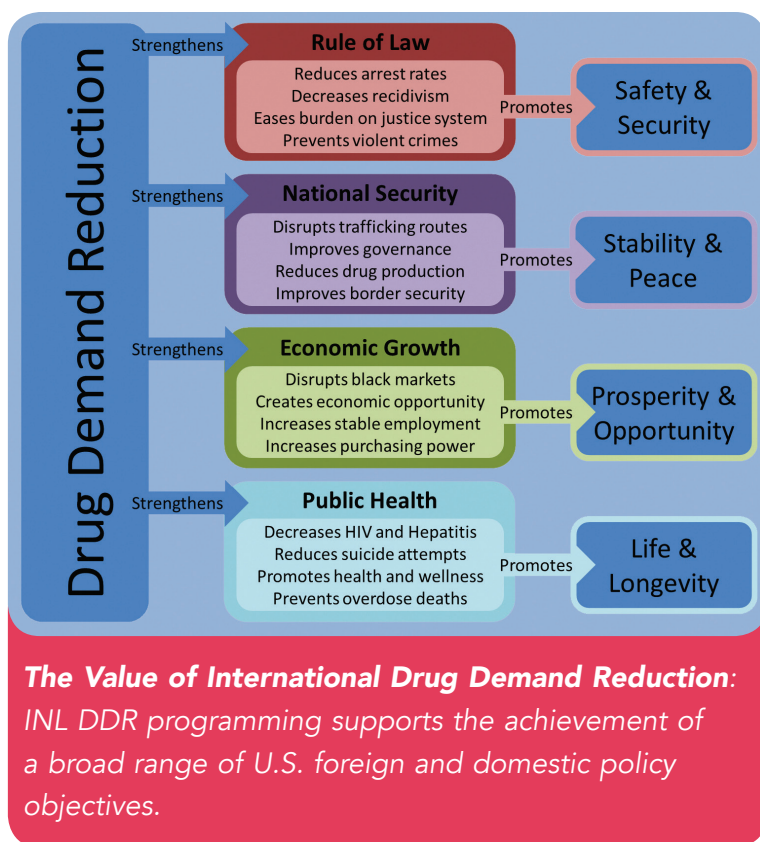
system-level with recovery oriented systems of care (ROSC) supporting economic development opportunities for persons in longer-term recovery, to the micro-level, in which individuals show increases in rates of employment after undergoing treatment.

In 2018, the INL DDR team is continuing to build on the progress that has been made thus far in reducing global substance use and its adverse public health and social consequences. For decades the U.S. has been funding more than 80 percent of the world’s addiction research. As a result, policymakers and DDR professionals around the globe have access to far more scientific knowledge and evidence on what works in addiction treatment and prevention than ever before. Moreover, the worldwide drug demand reduction community, with strong INL leadership and encouragement, is embracing the International Standards for

the Treatment of Drug Use Disorders and recognizing the importance of applying evidence-based practices (EBPs) in all prevention and treatment programming.

INL’S FOUR DRUG DEMAND REDUCTION PROGRAM AREAS

INL’s drug demand reduction efforts are focused in four key areas. These program areas reflect the revolutionary changes in our understanding of addiction during the past 70 years, and each is defined by distinct goals, objectives, and measureable and sustainable outcomes. Below are summaries of those program areas. Each of the four is highlighted in detail in the Field Guide.





**DEVELOPING THE DRUG
DEMAND REDUCTION
WORKFORCE**



**PROFESSIONALIZING
DRUG TREATMENT AND
PREVENTION SERVICES**



**BUILDING GLOBAL
NETWORKS &
COMMUNITY COALITIONS**



**ADDRESSING
POPULATIONS WITH
SPECIAL CLINICAL NEEDS**

PROGRAM AREA 1: DEVELOPING THE DRUG DEMAND REDUCTION WORKFORCE

The most fundamental component of an effective drug demand reduction system is a trained and professionalized workforce. The counselors and care providers who work directly with patients and people at risk for substance use disorders should be equipped with the tools and skills they need to implement prevention, treatment, and recovery support practices that are supported by strong scientific evidence of effectiveness. In support of this goal, INL's Program Area 1 aims to create a workforce that is professionally trained and proficient in universal best practices, and that can demonstrate these proficiencies through an internationally recognized credential. INL supports the development of this workforce by disseminating curricula on drug prevention, treatment, and recovery, as well as by supporting examination and credentialing for addiction professionals.

PROGRAM AREA 2: PROFESSIONALIZING DRUG TREATMENT AND PREVENTION SERVICES

An effective drug demand reduction system depends on high-quality treatment and prevention service providers that can deliver ethical, evidence-based programs. These services should be supported by well-integrated systems which link substance use

treatment with justice, health, and social support systems to ensure that treatment is accessible, effective, and comprehensive. In support of this goal, INL's Program Area 2 aims to develop and disseminate global standards for treatment and prevention systems and services. Additionally, INL supports the creation of tools that allow policymakers, researchers, and service providers to measure the performance of drug demand reduction systems and services relative to the international standards, and develop plans for continual assessment and quality improvement. These tools can be used to assess a national drug demand reduction system's level of development, and to identify areas where existing INL programming can fill gaps or improve systems and services.

PROGRAM AREA 3: BUILDING GLOBAL NETWORKS & COMMUNITY COALITIONS

In order to promote the rapid dissemination of best practices and emerging knowledge relating to substance use treatment and prevention, professionals in the drug demand reduction workforce should have the ability to freely collaborate and form networks with other professionals to share information, coordinate efforts, and connect with policymakers. In support of this goal, INL's Program Area 3 aims to establish and strengthen global networks, including

a professional membership organization for substance use professionals and a consortium of universities advancing the academic study of substance use disorders. Additionally, INL supports the development of task-focused networks and drug-free community coalitions to promote data sharing and to strengthen global cooperation to reduce the demand for drugs.

PROGRAM AREA 4: ADDRESSING POPULATIONS WITH SPECIAL CLINICAL NEEDS

In all cases, the specific needs of individual patients should inform treatment decisions. However, certain patient populations may experience unique conditions that affect their ability to access or benefit from treatment, and the special clinical needs of these populations should be considered throughout the treatment process. Specialized treatment protocols, interventions, and training programs must be developed and disseminated to ensure good clinical outcomes for these populations. In support of this goal, INL's Program Area 4 aims to identify and support vulnerable or marginalized populations through the development and dissemination of these specialized protocols, treatment modalities, and training packages. INL has supported specialized curricula to address the clinical needs of many of these populations, including women, children, people in recovery, and people involved in the criminal justice system.

The 3rd Edition of INL's Field Guide for Drug Demand Reduction Program Development closes with two additional sections of information on DDR programming: "Features from the Global Drug Demand Reduction Community," which includes several articles by guest authors, and a list of missions accomplished by INL DDR around the world.

As the leader of the INL-DDR team, I invite you to use the 3rd Edition of the Field Guide for Drug Demand Reduction Program Development to build on the progress that has been made thus far in reducing global substance use and its adverse public health and social consequences. Always bear in mind that your work is part of a larger comprehensive and balanced approach of supply and demand reduction strategies around the globe. Be confident that your efforts are grounded in an increasingly solid foundation of knowledge, not only about how the addicted brain functions, but also about how substance use disorders can be effectively prevented and treated, even among the most vulnerable populations.

The late Shimon Peres famously said, "Optimists and pessimists die the same way, they just live differently." Knowing this, I invite you to be an optimist. Together let us save lives. Let us take action now.



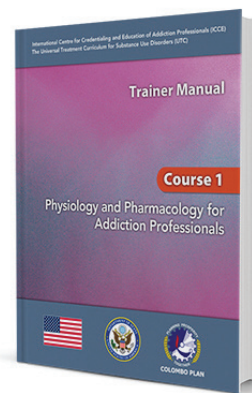
PROGRAM AREA 1 DEVELOPING THE DRUG DEMAND REDUCTION WORKFORCE

The most fundamental component of an effective drug demand reduction system is a trained and professionalized workforce. The counselors and care providers who work directly with patients and people at risk for substance use disorders should be equipped with the tools and skills they need to implement prevention, treatment, and recovery support practices that are supported by strong scientific evidence of effectiveness. In support of this goal, INL's Program Area 1 aims to create a workforce that is professionally trained and proficient in universal best practices, and that can demonstrate these proficiencies through an internationally recognized credential. INL supports the development of this workforce by disseminating curricula on drug prevention, treatment, and recovery, as well as by supporting examination and credentialing for addiction professionals.

THE UNIVERSAL TREATMENT CURRICULUM (UTC)

The devastating consequences of drug addiction to society's health, welfare, and economic development know no limit; this disease strikes people of all ages, genders, education levels, socioeconomic statuses, and ethnic and national backgrounds. However, over the past 70 years our scientific understanding of the phenomenon of addiction has been nothing short of revolutionary. The scientific research, over 80 percent of which is conducted by the U.S. Government through the National Institute on Drug Abuse (NIDA), indicates that drug treatment and drug prevention work! Success rates at treating the disease are on par with other chronic and relapsing diseases like heart disease and diabetes. Unfortunately, however, in too many cases the scientific research is not being translated into practice. When addiction is misunderstood and non-evidence-based practices are used, treatment fails, clients and families lose hope in rehabilitation and recovery, communities lose confidence in treatment as a viable measure, and governments begin considering policy alternatives that undermine a public health approach.

Recognizing both the challenge - and the necessity - of translating science into practice, INL assembled a panel of curriculum developers who were researchers, university faculty, and practitioners to develop a training series to "unlock" the science into step-by-step



training modules. The resulting series, the *Universal Treatment Curriculum (UTC)*, cover basic and advanced practices for dedicated substance use treatment professionals. The UTC has gained recognition internationally as an up-to-date, comprehensive, definitive, and recognized set of educational materials on substance use treatment. During development and again once every three years, each course within the series undergoes an exhaustive peer-review process and is then reviewed and endorsed by an international expert panel to ensure the materials remain consistent with the latest research and best practices. INL partners with international organizations, governments, universities, and civil society to adapt the materials to country and regional contexts, translate to local languages, and disseminate to the workforce.

UNIVERSAL TREATMENT CURRICULUM BASIC COURSES

The basic level UTC consists of a range of courses that cover the broad spectrum of treatment for substance use disorders. The content and methodology of the UTC training series is designed to ensure that addiction practitioners develop a balanced perspective of the principles relating to both the science and art of treatment. Each course is intended to enhance the knowledge, skills and competencies of treatment professionals, as well as promote evidence-based practice for the enhancement of service delivery and treatment outcomes.



Course 1: Physiology and Pharmacology for Addiction Professionals

20 training hours

This course presents a comprehensive overview of addiction; provides an understanding of the physiology of addiction as a brain disease; and describes the pharmacology of psychoactive substances.



Course 4: Basic Counselling Skills for Addiction Professionals

33 training hours

This course focuses on an overview of the helping relationship and the opportunity to practice core counselling including basic skills in motivational interviewing, group counselling and implementation of psychoeducation sessions.



Course 2: Treatment for Substance Use Disorders—The Continuum of Care for Addiction Professionals

33 training hours

This course provides the foundation for learning about substance use disorder treatment. It gives an overview of recovery and recovery management, stages of change, principles of effective treatment, components of treatment and evidence-based practices.



Course 5: Screening, Intake, Assessment, Treatment Planning and Documentation for Addiction Professionals

33 training hours

This course is a skills-based course that teaches effective and integrated intake, screening, assessment, treatment planning and documentation procedures to addiction professionals.



Course 3: Common Co-occurring Mental and Medical Disorders - An Overview for Addiction Professionals

20 training hours

This course offers an overview of the relationship between co-occurring mental and medical disorders and substance use disorder related treatment issues.



Course 6: Case Management for Addiction Professionals

13 training hours

This course provides a skill-based course that provides an overview of case management in substance use disorder treatment and provides skills practice in case management functions.

**Course 7: Crisis Intervention for Addiction Professionals**

13 training hours

This course addresses the concept of crisis as a part of life and provides guidelines for crisis intervention, including managing suicide risk. It also addresses ways counsellors can avoid personal crisis situations by providing information and exercises about counsellor self-care.

**Course 8: Ethics for Addiction Professionals**

26 training hours

This course focuses on professional conduct and ethical behavior in substance use disorder treatment. It also provides participants with the opportunity to learn and practice the use of an ethical decision making tool.

UNIVERSAL TREATMENT CURRICULUM ADVANCED COURSES

The advanced level UTC is a set of over fourteen courses which are reviewed on an ongoing basis to ensure that they reflect the latest science and evidence based approaches. These advanced offerings provide a more comprehensive and theoretical foundation in the clinical practice of substance use disorder treatment. It offers a specialized training provision that aims to provide an in-depth continuing education with skills-based activities to further enhance the capacity of the treatment workforce and standardize the quality of care and services they provide for their clients.

**Course 9: Pharmacology and Substance Use Disorders**

33 training hours

This course provides an overview of pharmacology through the identification of the classification of drugs into based on their effects on the central nervous system and addiction potential. It provides an understanding of the role of neurotransmitters in the development of addiction and the psychological implications on substance use disorders.

**Course 10: Managing Medication Assisted Treatment Programs**

33 training hours

This skills-based course is meant to provide an understanding of the importance of medication in substance use disorder treatment and it benefits when used in conjunction with psychosocial interventions.

**Course 11: Enhancing Motivational Interviewing Skills**

20 training hours

This course provides an in-depth understanding of the theory and application of Motivational Interviewing strategies and interventions for substance use disorder treatment.

PROGRAM AREA 01



Course 12: Cognitive Behavioral Therapy

20 training hours

This course offers an overview of Cognitive Behavioral Therapy goals and techniques and its application to treatment of people with substance use disorders and comorbid disorders.



Course 13: Contingency Management

20 training hours

This foundation course provides an understanding of the theories and principles of reinforcement-based treatment with a specific focus on the Contingency Management (CM) approach. The course covers the use of behavioral interventions in the treatment of substance use disorders, and the basic components of CM and its application.



Course 14: Working with Families

33 training hours

This course provides a comprehensive overview for substance use disorder treatment practitioners working with families dealing with substance use disorders. The discussion covers the impact of substance use disorders on the family, its coping mechanisms, recovery issues and interventions that can be implemented.



Course 15: Skills for Managing Co-Occurring Disorders

20 training hours

This skills based course is meant to enhance understanding of co-occurring disorders, substance-related disorders, and mental disorders. It aims to develop skills to identify and provide interventions for people with substance use disorders and other co-occurring medical and mental disorders.



Course 16: Advanced Clinical Skills and Crisis Management

33 training hours

This skills based course is meant to enhance understanding of the theories of counseling and the application of its therapeutic techniques in substance use disorder treatment.



Course 17: Case Management Skills and Practices

33 training hours

This course is designed to provide the opportunity to enhance competency in case management through a better understanding of the important roles and skills of case managers.



Course 18: Clinical Supervision for Substance Use Disorder Professionals

33 training hours

This course provides an overview of the fundamentals, principles, models and methods of clinical supervision. This includes laying out the roles, functions, skills and competencies of clinical supervisors.



Course 19: Enhancing Group Facilitation Skills

20 training hours

This course provides practitioners with the knowledge and skills to effectively facilitate group counseling in SUD treatment settings by reviewing the concepts of building, leading and ending a group within a treatment setting.



Course 20: Populations with Special Clinical Needs

33 training hours

This course introduces knowledge and concepts important in the provision of treatment services and interventions for individuals with SUD and special clinical needs with an emphasis on the development of skills for use in practice.



Course 22: Recovery Management and Relapse Prevention

33 training hours

This course provides an understanding of the concepts of relapse and recovery by shifting the paradigm for treating substance use disorders from an acute to a chronic illness management model.



Course 21: Trauma-Informed Care for Adults

26 training hours

This course presents substance use treatment practitioners with the skills to effectively address trauma in adults with SUD by enhancing the sensitivity and understanding required when dealing with trauma in a treatment setting.



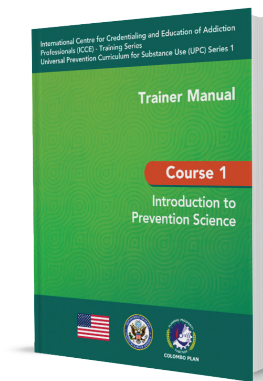
THE UNIVERSAL PREVENTION CURRICULUM (UPC)

Evidence-based prevention provides new tools for the prevention toolbox. Finding what works in prevention has been a challenge. Many approaches, which have been popular – e.g. “scare tactics” campaigns, information-only educational approaches, and former users’ testimonials have been found to be ineffective in rigorous research. But research has also found that there are effective interventions and strategies that recognize when, how, and with whom to intervene to make progress in addressing substance use.

In 2013, UNODC published a rigorous review of the results of over 20 years of research on effective drug use prevention strategies and interventions, The UNODC International Standards on Drug Use Prevention. In 2015, INL funded the creation of the Universal Prevention Curriculum for Substance Use (UPC), which is based on the International Standards and aims to train the full spectrum of the prevention workforce. The major role in the development of the UPC has been undertaken by Applied Prevention Science International (APSI) working with international experts in prevention from around the world.

THE DESIGN OF THE UPC

The UPC is designed to enhance the knowledge and skills of prevention professionals and enable them to implement evidence-based substance use prevention interventions and policies. Such standardized curricula will help ensure



that regionally and nationally-based prevention professionals obtain consistent science-based information and skills training. The primary emphasis of the curriculum is on evidence-

based interventions and policies and on implementation quality and sustainability.

The Universal Prevention Curriculum for Substance Use comprises two training series, each addressing the needs of different target groups. The underlying principles of UPC are to provide a way forward for prevention that is based on: scientific research and evidence; sound quality standards; and an ethical stance in how prevention should be undertaken. UPC was designed to meet the current demand for a comprehensive training package in the field of drug use prevention, based on evidence-based principles.

UNIVERSAL PREVENTION CURRICULUM COORDINATOR SERIES

UPC Coordinators Series is designed for those wishing to undertake a significant in-depth study of prevention. It is designed for coordinators, managers as well as for practitioners, or for those who wish to undertake a major program of study in prevention.



Course 1: Introduction to Prevention Science

33 training hours

This course provides an overview of the science that underlies evidence-based prevention interventions and strategies, and the application of these effective approaches in prevention practice.



Course 2: Physiology and Pharmacology for Prevention Specialist

20 training hours

This course presents an overview of the physiology and pharmacology of psychoactive substances and their effects on the brain to affect mood, cognition and behavior, and the consequences of such use on the individual, the family and the community.



Course 3: Monitoring and Evaluation of Prevention Interventions and Policies

33 training hours

This course gives an overview of primary evaluation methods used to measure evidence-based prevention interventions and guidance in applying them to “real-world” prevention settings.



Course 4: Family-based Prevention Interventions

26 training hours

This course explores the family as the primary socialization agent of children, the science behind family-based prevention interventions, and the application of such evidence-based approaches to help prevent the onset of substance use in children.



Course 5: School-based Prevention Interventions

33 training hours

This course presents an overview of the school in society, the science behind school-based prevention interventions, and the application of such evidence-based approaches in school settings around the world.



Course 6: Workplace-based Prevention Interventions

26 training hours

This course provides an overview of the role of work and the workplace in society, how stresses and other work-related influences affect people’s risk of substance use, the science behind workplace prevention interventions, and the application of such evidence-based approaches in work settings around the world.

PROGRAM AREA 01



Course 7: Environment-based Prevention Interventions

20 training hours

This course reviews the science underlying evidence-based substance use prevention environmental interventions, involving policy and community-wide strategies.



Course 8: Media-based Prevention Interventions

20 training hours

This course presents the science underlying the use of media for substance use prevention interventions.



Course 9: Community-based Prevention Implementation Systems

33 training hours

This course introduces the science underlying the systems approach to prevention interventions and guidance on developing such approaches, as well as exemplars of evidence-based drug use prevention systems.

**UNIVERSAL PREVENTION CURRICULUM
IMPLEMENTER SERIES**

UPC Implementers Series is written for implementers or practitioners who work with families, in schools, the workplace, and the community.



CORE Course: Introduction to the Universal Prevention Curriculum Series for Implementers

58 training hours

The CORE Course is composed of 10 modules representing different aspects of prevention science and its application to practice. It is designed to give participants a foundation in the knowledge and skills needed to undertake evidence-based prevention programming at the community level.

The course provides an overview of the basic processes that underlie addiction and the brain, basic pharmacology of psychoactive substances, and preventive mechanisms that have been found to be effective in more than 30 years of prevention science. It also provides skills-building in areas such as reviewing data needed to assess the substance use problem; working with a prevention implementation planning approach; and developing logic models to assist in that planning. It is required as a pre-requisite for participation in the seven specialty tracks.



Track 1: Monitoring and Evaluation of Prevention Interventions and Policies

60 training hours

This track presents primary evaluation methods with a focus on monitoring and process evaluation used to measure outcomes of evidence-based substance use prevention interventions and policies. It also provides experiential learning in planning and monitoring outcomes through exercises and a practicum completed at the end of the track. There are eight courses in this track.



Track 2: Family-based Prevention Interventions

54 training hours

This track gives an overview of the science inherent in family-based prevention interventions and the methods used to intervene effectively in order to prevent substance use in children and adolescents. It also provides experiential learning in some of the skills used in effective family-based intervention methods to prepare prevention implementers to participate in such programs. There are seven courses in this track.



Track 3: School-Based Prevention Interventions and Policies

72 training hours

This track introduces the science behind school-based prevention interventions and policies, and the methods used to improve school climate, strengthen policies, and intervene directly with classroom prevention interventions. It provides one track for administrators on effective planning and strategies for addressing school policy and climate; and a second track for teachers primarily on classroom interventions. There are eight courses in the track.



Track 4: Workplace-Based Prevention Interventions and Policies

76 training hours

This track presents the science underlying workplace-based prevention interventions and policies, and the methods and strategies workplaces can use to improve their environment and culture. It also provides experiential learning in planning for workplace policy changes and other substance use prevention efforts thus empowering employees to avoid substance use. It consists of seven courses.



Track 5: Environment-Based Prevention Interventions and Policies

59 training hours

This track reviews the science behind effective environment-based prevention interventions and policies – which focus on community-wide strategies to prevent tobacco and alcohol misuse; and illegal drug trafficking and use in various settings and the methods used to identify and successfully implement these interventions. It also provides experiential learning in planning for and implementing environmental policy changes and other community-wide substance use prevention efforts. There are seven courses in this track.



Track 6: Media-Based Prevention Interventions

81 training hours

This track discusses the science inherent in effective media-based substance use prevention interventions with a focus on developing successful persuasive communications. It also provides experiential learning in planning messages and media for reaching parents and youth in substance use prevention efforts. There are six courses in this track.



Track 7: Community-Based Prevention Implementation Systems

87 training hours

This track explores the science underlying the systems approaches to prevention interventions and presents the primary methods for planning community-wide implementation systems. It also provides experiential learning in planning and working with stakeholders to develop prevention intervention services. It consists of seven courses,

CREDENTIALING TREATMENT AND PREVENTION PROFESSIONALS



A key component of the DDR strategy is to not only train staff working in the field, but to raise the bar and establish minimum standards of knowledge, practice, and competence. Professionalization of staff is achieved through an examination and credentialing process. The Colombo Plan's Global Centre for Credentialing and Certification (GCCC) which was formerly the International Centre for Credentialing and Education of Addiction Professionals (ICCE) has developed an international standard, the International Credentialed Addictions Professional (ICAP). This standard, currently developed at 3 levels, offers countries the opportunity to endorse an evidence-based standard and agree to recognize reciprocity of the credential and adhere to an ethical standard. It also provides a professional the opportunity to earn a credential that is recognized in many other countries. As new curricula are developed, new exams are built to establish new ICAP levels or endorsements on current ones.

Credentialing ensures that organizations and their staff provide quality, evidence-based care to those in need of services. INL Credentialing of professionals is based on the knowledge that:

1. A common evidence-based standard for prevention, treatment, and recovery support services ensures consistent quality of care for people at-risk-for or who have developed substance use disorders;
2. An accreditation framework for all services will lead to a higher quality of care and improved patient outcomes; and
3. Licensing and/or accreditation informs colleges and universities on agreed upon standards needed for future students in the field.

GCCC VISION STATEMENT

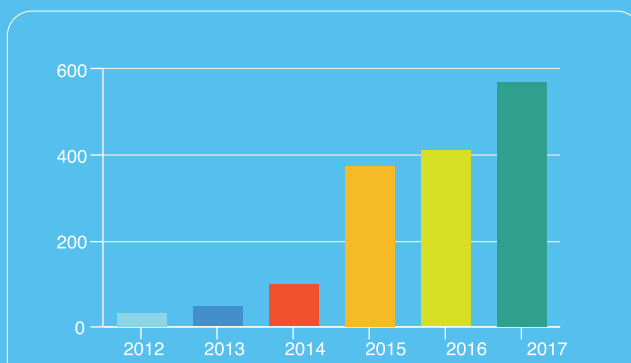
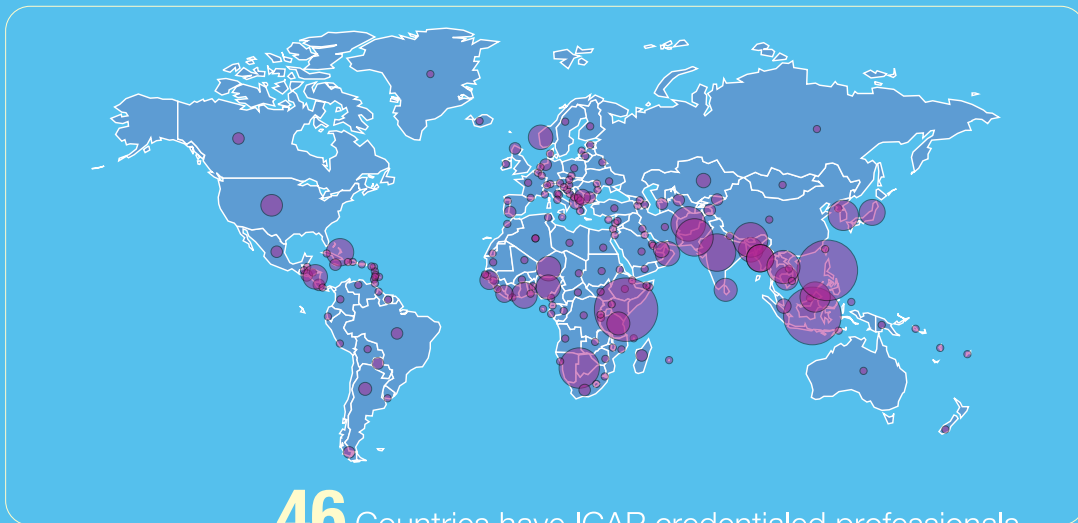
GCCC envisions a world where all persons have access to effective prevention programs, treatment modalities, and recovery support led by credentialed professionals.

GCCC MISSION STATEMENT

GCCC will support that vision by being the leading global credentialing organization of addiction professionals by training, professionalizing and expanding the drug demand reduction workforce who enhance the health, and well-being of individuals, families and communities.

Professionalizing the Addiction Workforce

Prevention, Treatment, Recovery Support



The number of credentialed addiction professionals has increased in the last six years.



72% of candidates
pass their exam

GCCC GOALS

1. To create a cadre of drug demand reduction professionals through the enhancement of their knowledge, skills and competence, enabling them to provide quality services
2. To provide a global standard that encourages drug demand reduction professionals to continue learning for the purpose of providing quality services
3. To develop individual professionals by providing a formal indicator of current knowledge and competence
4. To promote professional and ethical practice by enforcing adherence to a Code of Ethics

GCCC COMMISSION

The GCCC Commission was formed in 2012 to oversee and ensure the highest quality and standard of GCCC initiatives, inclusive of trainings, examinations and mode of administration, and credentials. Just as important, the Commission provides an engagement mechanism for the participating countries to improve the quality of prevention, treatment, and recovery support services at home and the region at large. Their expertise also ensures that all Universal Curricula remain globally applicable and supported by the most current evidence-based research and findings. Presently the Commissioners represent 22 countries who are participating in some way with the GCCC mission.

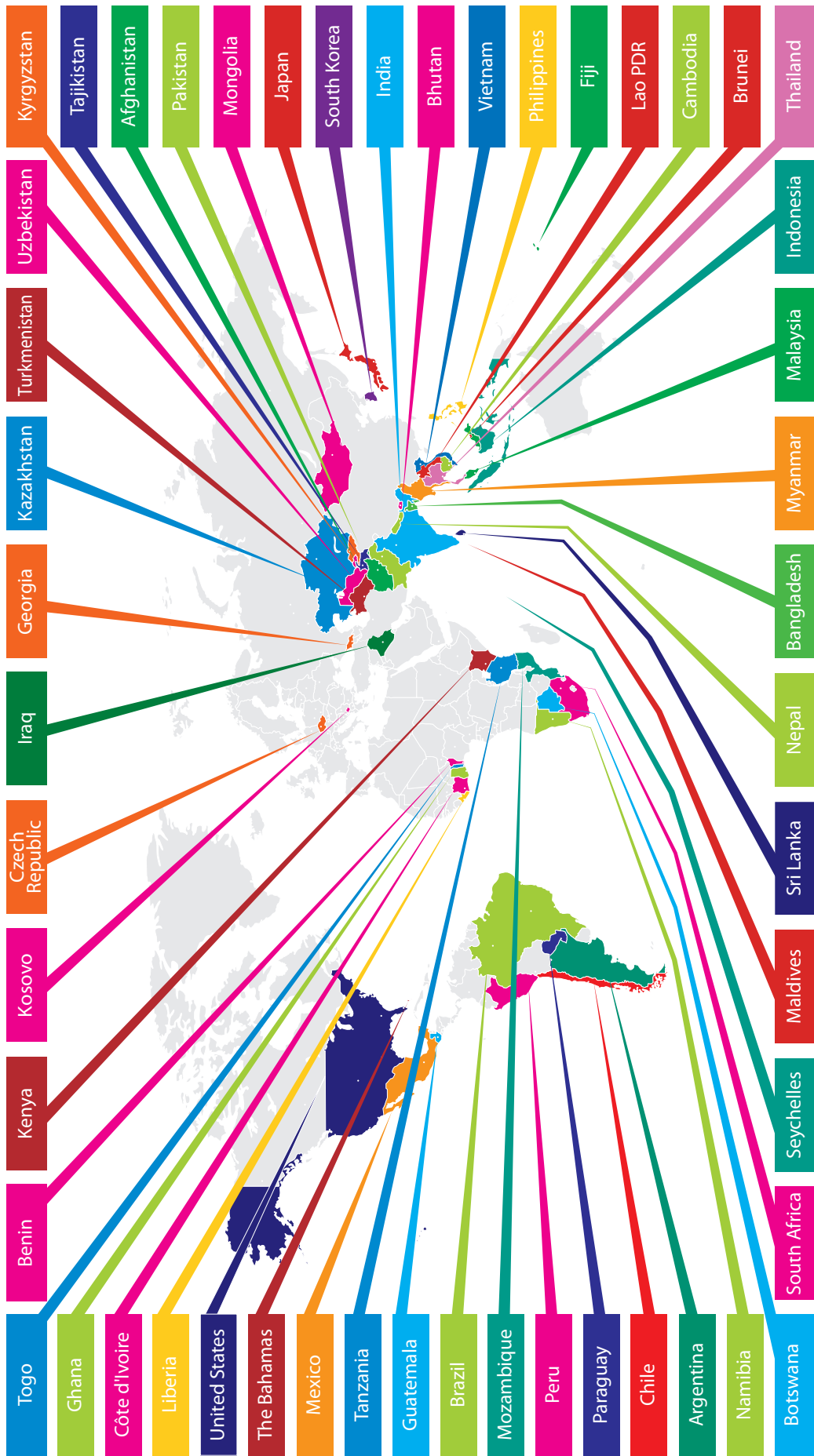
GCCC INITIATIVES

In response to the long-standing crisis of inadequate addiction treatment programs in many parts of the world and lack of adequately trained addiction professionals, the demand for credentialing has grown exponentially since the first exam was given in 2012. Many governments and other entities are recognizing the need for not only training, but a process for ensuring that the workforce meets minimum standards in the pursuit of positive outcomes for their citizens.

Since 2009, GCCC programs have become a specialized technical unit for addiction professionals. Since 2013, GCCC has been supporting 70 initiatives annually benefitting over 1,500 drug demand reduction professionals in 56 countries, reaching beyond the borders of Colombo Plan member countries. Currently, GCCC is in the process of credentialing nearly 200 national-level trainers and 1,000 addiction treatment practitioners in Afghanistan, as well as 400 treatment practitioners in Pakistan.

As the demand for training and credentialing increases, the scheduling of exams becomes more challenging. The current structure requires tremendous resources to process applications and proctor exams whether in an online or paper/pencil format. With a goal of expanding into more countries, these challenges will only become greater. At the same time participants deserve a user-friendly process and new ways to reduce barriers—particularly in areas outside of major cities. The following new initiatives are being pursued during 2018.

1. An online portal and database will be built so that applicants will be able to apply online and upload supporting documents to take any level credentialing exam. This will simplify the process for the applicant and reduce the GCCC resources needed to process each applicant for approval.
2. As an alternative to fixed dates for administering the exam at testing sites, remote proctoring will be offered in places with reliable internet access. This option would allow individuals to schedule their own exam at their home, office, or other appropriate location where a computer equipped with a camera would be used to “watch” the applicant while they take their exam. With this option, candidates would know immediately whether they passed or failed and could have the option to apply to retake the exam at a testing site or by the remote process again.



Countries implementing UPC, UTC, or other INL Curricula as of November 2017.

PROGRAM AREA 2 PROFESSIONALIZING DRUG TREATMENT AND PREVENTION SERVICES

An effective drug demand reduction system depends on high-quality treatment and prevention service providers that can deliver ethical, evidence-based programs. These services should be supported by well-integrated systems which link substance use treatment with justice, health, and social support systems to ensure that treatment is accessible, effective, and comprehensive. In support of this goal, INL's Program Area 2 aims to develop and disseminate global standards for treatment and prevention systems and services. Additionally, INL supports the creation of tools that allow policymakers, researchers, and service providers to measure the performance of drug demand reduction systems and services relative to the international standards, and develop plans for continual assessment and quality improvement. The four tools included in this section can be used to assess a national drug demand reduction system's level of development, and to identify areas where existing INL programming can fill gaps or improve systems and services.

INL DRUG DEMAND REDUCTION MENU OF SERVICES

The Drug Demand Reduction team within INL's Office of Policy, Planning, and Coordination has experience in developing and implementing a variety of programs to support national and regional demand reduction programs. These programs can assist a country's development of drug policies, support research and data collection, or improve a country's prevention and treatment systems. The INL demand reduction team is available for consultations on program design relating to the areas in the list below. We encourage you to reach out to DemandReduction@state.gov.

POLICY

1. Policy Framework

- a. National Drug Policy
- b. Master Plan for Drug Demand Reduction
- c. Development or revision of laws and regulations
- d. Development of National Quality Standards
- e. Development of National Quality Guidelines

2. Institutional Mandates

- a. Identified national institution with the lead on drug demand reduction
- b. Identified drug demand reduction focal point (position title and individual)
- c. Identified national drug demand reduction coordinating body that meets regularly

RESEARCH

1. Mapping

- a. Mapping of prevention organizations and the programs that they offer
- b. Mapping of treatment services

2. Assessments

- a. Rapid Assessment Survey of drug use situation, capacity, and needs
- b. Targeted drug use surveys of limited areas or populations (e.g. cities or schools)
- c. National drug use prevalence survey
- d. National drug observatory
- e. Regional drug observatory

3. Evaluations

- a. Outcome evaluations to determine the effectiveness of programs
- b. Prevention evaluations
- c. Treatment evaluations
- d. Peer review and publication of results

PREVENTION

1. Workforce Development

- a. Training of prevention specialists
- b. Credentialing of prevention specialists
 - i. Government agency responsible for regulating prevention workforce
 - ii. Availability of a national credential
 - iii. Recognition of international credential

- c. Development of National Professional Association for the prevention workforce

2. Diversity of Interventions and Policies

- a. Target Age
 - i. Prenatal and infancy
 - ii. Early childhood
 - iii. Transition to school and middle childhood
 - iv. Transition to adolescence
 - v. Late adolescence
- b. Setting
 - i. Family
 - ii. School
 - iii. Community
 - iv. Workplace
 - v. Healthcare
- c. Risk Groups
 - i. Universal (general public or population at large)
 - ii. Selective (groups at high risk for substance use)
 - iii. Indicated (Individuals at high risk for substance use)

3. Regulatory Systems for Prevention Programs

- a. Identified government agency for regulating prevention programs
- b. Government agency opts-in to international regulatory program based on International Standards on Prevention
- c. National inspection system
 - i. Inspection forms
 - ii. Establishment and training of inspection teams
 - iii. Policy and program
- d. Accreditation of programs

TREATMENT

1. Workforce Development

- a. Training of treatment specialists
- b. Credentialing of treatment specialists
 - i. Government agency responsible for regulating treatment workforce
 - ii. Availability of a national credential
 - iii. Recognition of international credential
- c. Training of recovery coaches
- d. Credentialing of recovery coaches
- e. Training of health practitioners (generalists)
 - i. Identification of substance use disorder
 - ii. Referral to specialized treatment
- f. Development of National Professional Association for the treatment workforce

2. Diversity of Providers

- a. Government
 - i. Specialized stand-alone centers
 - ii. Integrated public health facilities
- b. Civil Society
 - i. Non-governmental organizations
 - ii. Faith-based organizations
- c. Private Sector (fee-for-service programs).

3. Diversity of Settings

- a. Outreach (informal community care)
- b. Self-help groups (informal community care)
- c. Primary health care services (clinics/hospitals)
 - i. Screening
 - ii. Brief Intervention
- d. Specialized outpatient and drug dependence treatment
 - i. Assessment
 - ii. Case Management
 - iii. Treatment Planning

- iv. Detoxification
- v. Psychosocial Interventions
- vi. Medication-Assisted Treatment
- vii. Relapse Prevention
- e. Long-term residential treatment centers
 - i. Housing
 - ii. Vocational Training
 - iii. Protected Environment
 - iv. Life Skills Training
 - v. Ongoing Therapeutic Support

4. Evidence-Based Modalities

- a. Social Skills Training
- b. Contingency Management
- c. Motivational Interviewing
- d. Cognitive-Behavioral Therapy
- e. Therapeutic Community
- f. Group Therapy
- g. Family Therapy

5. Specialized Services for Populations with Special Clinical Needs

- a. Women
- b. Adolescents
- c. Children
- d. Criminal Justice Populations
- e. Gangs
- f. Child Soldiers
- g. Homeless Populations
- h. HIV Positive, Hepatitis B & C, Tuberculosis
- i. Sex Workers
- j. Trafficking Victims
- k. Refugees
- l. Rural Populations
- m. Culturally Distinct Populations (i.e. Indigenous)
- n. Lesbian, Gay, Bisexual, and Transgender Populations
- o. People with Disabilities or Chronic Pain

6. Diversity & Integration of Support Services

- a. Primary health care services
 - i. Basic health care
 - ii. Referral linkages between general medical services and specialized treatment services
- b. Generic social welfare
 - i. Housing/shelter
 - ii. Food
 - iii. Community-based treatment model
- c. Specialized health care services
 - i. Mental health treatment
 - ii. Internal medicine
 - iii. Dental treatment
 - iv. HIV and Hepatitis C treatment services
- d. Specialized social welfare services
 - i. Family support and reintegration
 - ii. Vocational training/education programs
 - iii. Income generation
 - iv. Leisure time planning
- e. One-stop shops (for advanced systems)

7. Regulatory Systems for Provision of Treatment Services

- a. Identified government agency for regulating treatment programs
- b. Government agency opts-in to international regulatory program based on International Standards on Treatment
- c. National inspection system
 - i. Inspection forms
 - ii. Establishment and training of inspection teams
 - iii. Policy and Program
- d. Accreditation of programs

INTERNATIONAL STANDARDS FOR DRUG TREATMENT CHECKLIST

Use this checklist to evaluate a nation’s treatment programs relative to UNODC’s international standards. This checklist should not be used to rate or rank treatment centers. Instead, these standards represent best practices for effective and safe substance use treatment, and should be used as a guide to identify areas where treatment programs can improve their services.

Part 1

Availability and Accessibility of Treatment Services

Are treatment interventions available at different levels, from primary health care to specialized treatment programs for drug use disorders?

Do available treatment services include brief interventions, diagnostic assessment, outpatient counseling, outpatient psychosocial and evidence-based pharmacological treatments, outreach services, and services for management of drug-induced clinical conditions (i.e. overdose, withdrawal, psychosis)?

Are treatment services within reach of public transport and available to people in both urban and rural areas?

Are low threshold (drop-in, same-day admission) and outreach services available to reach “hidden” or non-motivated populations?

Are there multiple entry points to treatment services (i.e. emergency room, clinic, community referral, central receiving center) and a “no wrong door” approach?

Do treatment center operating hours permit access to services for individuals with employment or family responsibilities?

Are essential treatment services affordable to clients at all levels of income with minimized risk of financial hardship?

Are treatment services gender-sensitive, including addressing specific child-care needs and needs in pregnancy?

Do treatment services provide access to social support, general medical care, and referrals to specialized health services for the management of complex health conditions?	
Are treatment service users involved in service design, development, and evaluation?	
Is information about the availability and accessibility of essential treatment services accessible through multiple sources, including the internet, printed materials, and other open-access information services?	

Part 2 Ethical Standards

Are the human rights and dignity of service users respected in treatment services (i.e. no humiliating or degrading interventions are used)?	
Do patients have the right to freely give and revoke their informed consent at any time?	
Is strict confidentiality of patient data ensured and protected by legislative measures, and supported by appropriate staff training and service rules and regulations?	
Is treatment staff properly trained in the provision of treatment and do they show respectful, non-stigmatizing, and non-discriminatory attitudes toward service users?	
Are service procedures in place which require staff to inform patients of treatment processes and procedures, including the right to withdraw from treatment at any time?	
If any research involving human subjects is conducted in treatment services, is this research subject to review of ethical committees, and do patients give informed written consent to participate in research?	

Part 3 Coordination Between the Criminal Justice System and Health/Social Services

Is treatment for substance use disorders predominantly provided in health and social care systems?	
Is treatment available as a partial or complete alternative to imprisonment for offenders with substance use disorders?	
Are appropriate legal frameworks in place to support treatment as an alternative to incarceration?	

Do criminal justice settings provide opportunities for individuals with drug use disorders to access treatment in health and social care systems?	
Are treatment interventions voluntary (i.e. not imposed on individuals in the criminal justice system against their will)?	
Are essential prevention and treatment services accessible to individuals in criminal justice settings, including pharmacological and psychosocial treatment services, rehabilitation services, and prevention of transmission of blood-borne infections?	
Are law enforcement and penitentiary system officers and court professionals appropriately trained to ensure recognition of medical and psychosocial needs associated with drug use disorders?	
Do treatment services in criminal justice settings follow the same evidence-based guidelines and ethical standards as in the community?	
Is continuity of treatment ensured by effective coordination of health and social services in communities and criminal justice settings?	

Part 4

Evidence-Based Treatment Methods

Is resource allocation guided by existing evidence of effectiveness and cost-effectiveness of prevention and treatment interventions?	
Is a range of evidence-based treatment interventions of different intensity in place at different levels of health and social systems, and are pharmacological and psychosocial interventions appropriately integrated?	
Are primary health care professionals trained to identify and manage the most prevalent disorders due to drug use?	
Are primary health care professionals supported by specialized services for substance use disorders, particularly for treatment of severe drug use disorders?	
Are specialized services organized based on multidisciplinary teams adequately trained in the delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology, and social work?	
Is the duration of treatment determined by individual needs (i.e. no pre-set limits of treatment that can't be modified according to patient needs)?	

Does training in identification, diagnosis, and treatment of substance use disorder occur at different levels of education, including university curricula and continuing education programs?	
Are treatment guidelines, procedures, and norms regularly updated in accordance with accumulated evidence of treatment interventions, knowledge about the needs of patients, and results of evaluation research?	
Are treatment services and interventions adapted for relevance to the socio-cultural environment in which they are applied?	

Part 5 Responding to the Needs of Special Subgroups and Conditions

Are the special clinical needs of women, adolescents, pregnant women, ethnic minorities, and other marginalized groups such as the homeless reflected in service provision and treatment protocols?	
Are special services and treatment programs in place for adolescents with substance use disorder, and are these services separated from patients in more advanced stages of drug use disorders?	
Are the location, staffing, program development, child friendliness, and content of treatment services and programs tailored to the needs of women and pregnant women?	
Are treatment services tailored to the needs of people with drug use disorders from minority groups, and are cultural mediators and interpreters available whenever necessary to minimize cultural and language barriers?	
Do treatment programs integrate social assistance and support in order to help people living in the street, unemployed, homeless, or rejected by their families achieve means of sustainable livelihoods?	
Are outreach services in place to establish contact with people who may not seek treatment because of stigma and marginalization?	

Part 6 Clinical Governance of Treatment Services

Are treatment policies based on the principles of universal health coverage, best available evidence, and developed with the active involvement of key stakeholders including the target populations, community members (families), and non-governmental organizations?	
---	--

Are written service policy and treatment protocols available and known to staff?	
Are staff working at specialized services adequately qualified, and do they receive ongoing evidence-based training, certification, support, and supervision?	
Are policies and procedures for staff selection, recruitment, employment, and performance monitoring clearly specified and known to all?	
Is a sustainable source of funding available at adequate levels and with proper financial management and accountability mechanisms?	
Are services for the treatment of drug use disorders linked with relevant general and specialized health and social services?	
Are adequate record-keeping systems in place to ensure accountability and continuity of treatment and care?	
Are service programs, rules, and procedures periodically revised on the basis of continuous feedback, monitoring and evaluation processes, and drug use trends in the population?	

**Part
7**

Integration, Monitoring, and Evaluation

Are links between drug use prevention services, drug dependence treatment, and prevention of health and social consequences of drug use established and operational?	
Is treatment planning based on estimates and descriptions of the nature and extent of the drug problem, as well as of the characteristics of the population in need?	
Are the roles of national, regional, and local agencies in different sectors well-defined?	
Are quality standards for drug treatment services established, and is compliance required for accreditation?	
Are mechanisms for good clinical governance, monitoring, and evaluation in place, including clinical accountability, continuous monitoring of patient health and well-being, and intermittent external evaluation?	
Is information on the number, type, and distribution of services available, and is it used within the treatment system for planning and development purposes?	

TREATMENT CAPACITY SURVEY

INL's Drug Demand Reduction team regularly collects data on treatment availability and capacity in countries around the world. This survey can be used to assess the treatment system of a country. To answer these questions, we recommend that you engage responsible government ministries, local university experts, and international organizations (e.g. UNODC, WHO). Please document any surveys you complete and return them to the INL/DDR team at DemandReduction@state.gov.

1 Treatment Facilities

1. How many government-run specialized stand-alone treatment centers are available?	
2. How many government-run treatment centers are integrated into public health facilities?	
3. How many secular non-governmental treatment centers are available?	
4. How many faith-based non-governmental treatment centers are available?	
5. How many private sector treatment centers are available?	
6. For each treatment center listed above,	
a. How many professional treatment staff are employed at each center?	
b. How many clients can the center serve per month (# of beds available)?	
c. How many clients does the center serve per month (# of clients actually served)?	
d. What is the average length of in-patient treatment (in days)?	
e. How many people are on the waitlist?	
f. What is the program cost for clients?	

2 Coverage

1. Are services available to low-income populations?	
2. Are services available to middle-income populations?	
3. Are services available to high-income populations?	
4. Are services available to rural populations?	
5. Are services available to urban populations?	

3 Diversity of Settings

1. How many of these types of interventions are offered?	
a. Outreach (informal community care)	
b. Self-help groups (informal community care)	
c. Primary health care services- screening and brief interventions (e.g. in clinics or hospitals- this total will come from "treatment facilities" above which include these services)	
d. Specialized outpatient treatment (these services may include assessment, case management, treatment planning, detoxification, psychosocial interventions, medication-assisted treatment, relapse prevention)	
e. Long-term residential services (this total will come from "treatment facilities" above to include only those where patients permanently reside in the treatment facility)	

4 Specialized Services for Populations with Special Clinical Needs

1. How many treatment centers offer specialized treatment services to the following populations?	
a. Women?	
b. Adolescents (ages 13-17)?	
c. Children (ages 0-12)?	
d. Criminal justice populations?	
i. Prison populations?	
ii. As an alternative to incarceration?	
e. Members of gangs?	
f. Homeless populations?	
g. HIV+, hepatitis B & C, and TB populations?	
h. Sex workers?	
i. Trafficked victims?	
j. Rural populations?	
k. LGBT people?	
l. People with physical disabilities?	

5 Continuum of Care Support

1. How many of these services are offered for persons in recovery:	
a. Peer support groups	
b. Family support and reintegration services	
c. Halfway houses	
d. Vocational training	
e. Income generation/micro-credits	
f. Crisis intervention	

6 Evidence-Based Treatment Modalities

1. How many of the following techniques and interventions are used in treatment settings?	
a. Social skills training	
b. Contingency management	
c. Motivational interviewing	
d. Cognitive-behavioral therapy	
e. Therapeutic community	
f. Group therapy	
g. Family therapy	

7 Workforce Development

1. How many hours of the UTC training have been completed in your country?	
2. Are treatment specialists credentialed by GCCC?	
a. If yes, how many people are credentialed in this country?	
3. Is there a national credential offered for treatment professionals?	
4. Is there a government agency identified as responsible for regulating the treatment workforce?	
5. Does the government recognize the international Colombo Plan GCCC Credential?	
6. Is there a training offered for recovery coaches?	
a. Is there a national credential offered for recovery coaches?	
b. Is there an international credential offered or recognized for recovery coaches?	
7. How many health practitioners have received training on the identification/referral of drug use?	
8. Is there a national professional association for the treatment workforce?	
a. If yes, how many members?	

8 Regulatory System for the Provision of Treatment Services

1. Is there a government agency identified for regulating treatment services/centers?	
a. If yes, who?	
b. If yes, has this government agency opted into the international regulatory program based on the International Standards on Treatment?	
c. Is there a national inspection system?	
i. If yes, is there a policy or program for treatment center inspections?	
ii. If yes, are there inspection forms?	
iii. If yes, are there inspection teams?	
iv. If yes, are the inspection teams trained?	
2. Do treatment centers have to be accredited/licensed to operate in the country?	

RESEARCH SYSTEMS SURVEY

INL's Drug Demand Reduction team regularly collects data on national drug use surveys conducted in countries around the world. This survey can be used to collect information on the most recent drug use surveys undertaken by a national or regional drug observatory. To answer these questions, we recommend that you engage responsible government ministries, local university experts, and international organizations (e.g. UNODC, WHO). Please document any surveys you complete and return them to the INL/DDR team at DemandReduction@state.gov.

1 List the national drug use surveys have been completed in the past seven years.

Title: _____
 Author: _____
 Publishing Date: _____
 Website for E-Version (or email to demandreduction@state.gov): _____

Note: National Drug Use Surveys adhere to a rigorous methodology and will provide nationwide drug use data figures for a given period of time (e.g. past year use, lifetime use).

2 List the targeted drug use surveys that have been completed over the past 7 years for specific areas within a country (e.g. cities, provinces/states)

Title: _____
 Author: _____
 Publishing Date: _____
 What cities are surveyed? _____
 What states or provinces are surveyed? _____
 Website for E-Version (or email to demandreduction@state.gov): _____

3 List the targeted drug use surveys that have been completed over the past 7 years for the following specific populations:

1. Drug use among Women _____
2. Drug use among Adolescents (ages 13-18) _____
3. Drug use among Children (under age 12) _____
4. Drug use among Rural Populations _____

5. Drug use among Low Income Populations
6. Drug users at risk of recruitment for violent extremism
7. Drug use among Gangs
8. Drug use among Refugees
9. Overdose in Opioid Drug Users
10. Drug users in the Criminal Justice System
11. Drug use among Culturally Distinct Populations (Indigenous)
12. Drug use among LGBT
13. Drug use among Peoples with Physical Disability and Chronic Pain Management
14. Drug use among Homeless Populations
15. Drug use among Child Soldiers
16. Drug use among Trafficking victims
17. Drug use among Sex workers
18. Drug use among people living with HIV+, Hep B & C, TB

Note: Drug Use Surveys adhere to a rigorous methodology that can provide drug use data figures, such as prevalence rates for a given population (e.g. women, children, people who inject drugs, sex workers). These studies are typically conducted by researchers or government agencies.

4 Name the regional observatory, if any, where your country participates:

Note: A regional drug observatory is an international research institution that is typically organized multilaterally which has a mandate to cross-country research on drug use patterns over time. They will receive data from participating countries within a geographic scope. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is an example of a regional observatory.

1. EMCDDA
2. OAS/CICAD
3. West Africa Epidemiological Network Drug Use Observatory (WENDU)
4. African Union Observatory

Note: A national drug observatory is a research center that can be housed within a government agency, academic institution, or private organization which has a mandate to research drug use patterns over time. They conduct surveys, rapid assessments, and more extensive research studies. An example of an observatory could be the U.S. Center for Disease Control (CDC) or the South African Community Epidemiology Network on Drug Use (SACENDU).

5 Does your country have a national drug observatory?

1. Yes, please provide the name of the institution:
2. N/A, No regional drug observatory exists.
3. No, a regional observatory exists but the country does not participate.

PROGRAM AREA 3 BUILDING GLOBAL NETWORKS & COMMUNITY COALITIONS

In order to promote the rapid dissemination of best practices and emerging knowledge relating to substance use treatment and prevention, professionals in the drug demand reduction workforce should have the ability to freely collaborate and form networks with other professionals to share information, coordinate efforts, and connect with policymakers. In support of this goal, INL's Program Area 3 aims to establish and strengthen global networks, including a professional membership organization for substance use professionals and a consortium of universities advancing the academic study of substance use disorders. Additionally, INL supports the development of task-focused networks and drug-free community coalitions to promote data sharing and to strengthen global cooperation to reduce the demand for drugs.

FOSTERING A GLOBAL COMMUNITY OF PROFESSIONALS



The International Society of Substance Use Prevention and Treatment Professionals (ISSUP) is a global, not-for-profit, non-government organization that supports the development of a professional substance use prevention and treatment network. It serves as a focal point for information, research, events and training for substance use professionals.

ISSUP's activities are informed by science and research, and promote evidence-based, high-quality standards and ethical approaches to substance use prevention, treatment, and recovery policy and practice. Through its **unique website**, ISSUP provides support and access to up-to-date information for the substance use prevention and treatment community. ISSUP also holds an **annual international meeting**, which offers training and networking opportunities that support the **professionalization of the workforce**.

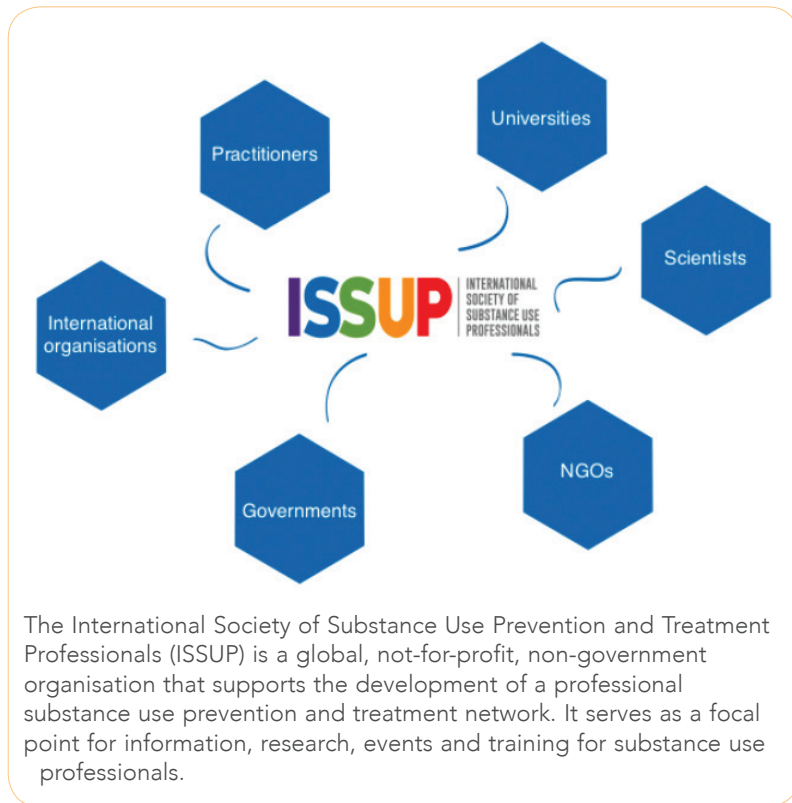


Fundamental contributors and key initiators of ISSUP's establishment and growth include the U.S. Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL), as well as the Colombo Plan and its Drug Advisory Programme (DAP).

THE NEED FOR ISSUP

- Substance use disorders are a major global problem. There is still an enormous unmet need for effective substance use prevention, treatment, and recovery support-particularly in developing countries.
- Many prevention and treatment interventions are not based on sound evidence and recovery support is often not recognised as a crucial part of the process.
- Those working in the field are not recognised as a 'professional'.
- The field can be fragmented, in need of collaboration and coherence.

ISSUP is a unique initiative offering a platform for an international professional society, bringing together, supporting and sharing knowledge from across the spectrum of the substance use workforce.



Office on Drugs and Crime (UNODC), and the World Health Organization (WHO). It was formally established and registered in the United Kingdom in February 2016.

VISION, MISSION & AIMS

ISSUP Vision

A connected, trained, knowledgeable, and effective international network of substance use prevention and treatment professionals undertaking and promoting high-quality, evidence-based, and ethical substance use prevention and treatment.

ISSUP was initiated in 2015 through the U.S. Department of State’s Bureau of International Narcotics and Law Enforcement Affairs (INL), working in consultation with the African Union, the Inter-American Drug Abuse Control Commission - Organization of American States (CICAD – OAS), Colombo Plan, the United Nations

ISSUP Mission

To establish Substance Use Prevention and Treatment as a unique and multidisciplinary field through the professionalization and development of its network of substance use prevention and treatment professionals.



ISSUP Members assembled in Cancun, Mexico in December of 2017.

ISSUP Aims

ISSUP Activities address the mission, promoting a membership organization committed to developing and supporting a professional workforce with the competencies and skills required to deliver high-quality, evidence-based, ethical services. In order to achieve this ISSUP:

- Provides knowledge for the implementation of evidence-based, high-quality, and ethical policy and practice
- Provides opportunities for and access to training, education, and credentials
- Facilitates the collaboration of professionals in digital and physical space
- Represents the international and national communities of substance use prevention and treatment professionals
- Provides the focal point for all who want to know more about and undertake prevention or treatment activities

THE THREE CHANNELS OF ISSUP

ISSUP Website

Through its website, www.issup.net, ISSUP acts as a catalyst and focal point to connect groups within the global substance use community. ISSUP provides support to all working in the international community of substance use prevention, treatment, and recovery support.

ISSUP Event

A major event that takes place annually in different regions of the world bringing



Through its website, www.issup.net, ISSUP acts as a catalyst and focal point to connect groups within the global substance use community. ISSUP provides support to all working in the international community of substance use prevention, treatment, and recovery support.

the global substance use prevention and treatment community and the major international organizations together to receive training, network, attain credentials and share knowledge.

ISSUP Chapters

ISSUP engages members on a national level through National Chapters, facilitating the formation of culturally relevant networks. A National Chapter represents a national ISSUP organization that is run by a group of substance use prevention and treatment professionals in a particular country or region.

Get involved with ISSUP!

Join ISSUP to link, share, talk, grow, meet, and learn!

Register for free online at www.issup.net

info@issup.net

www.issup.net

Twitter: @issupnet

Facebook: /issupnet

PROMOTING RESEARCH AND EDUCATION THROUGH UNIVERSITIES

ICUDDR

The International Consortium of Universities for Drug Demand Reduction (ICUDDR) was organized to encourage the development and rapid expansion of a skilled global workforce able to prevent and treat substance use disorders in order to reduce their human, social, and economic costs, which are borne by communities around the globe. Toward this end, the ICUDDR facilitates networking among Universities to promote high quality education and training in the field of addiction prevention, treatment, and public health interventions. Through its work, the ICUDDR stimulates improvement in competencies and skills among current and future generations of addiction professionals, to meet the increasing demand for prevention, treatment and public health services. The ICUDDR also pursues and promotes related applied addictions research, outreach and advocacy.

ICUDDR members have an opportunity to create and implement addiction studies programs with the support of a network of international colleagues and institutions. Members can access profiles of other university programs in addiction studies, and share information regarding course sequences, academic standards and requirements, and credentialing systems and international certificates for substance use professionals. ICUDDR promotes and supports research and scientific activities among its members. As a global initiative, ICUDDR members are part of an international body, which collaborates

and maintains relationships with other international organizations supporting the expansion of science-based education, research, prevention and treatment of substance use disorders. These include: the Colombo Plan, the U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs (INL), the International Society of Substance Use Professionals (ISSUP), the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the National Institute on Drug Abuse (NIDA), the Inter-American Drug Abuse Control Commission (CICAD) and Organization of American States (OAS), the International Society of Addiction Journal Editors (ISAJE), the Society for Prevention Research (SPR), and the European Society for Prevention Research (EUSPR).

MISSION

The ICUDDR supports the formation of academic programs in addiction studies at a time when demand is at an all-time high. Currently, many institutions are establishing addiction specialties in medicine due to the growing world drug problem, and many physicians and other health care professionals would benefit from continuing education to prevent and treat substance use disorders. Creation of effective academic programs in addiction studies hinges on the awareness that new and enhanced prevention and treatment systems and services require a

specialized and multidisciplinary workforce that is educated and trained to deliver these services.

We envision worldwide training and transformation of the addictions prevention and treatment workforce by harnessing the power of university networks to apply cutting-edge addiction science. ICUDDR will help organize a worldwide network of universities to implement academic programs in addiction studies, and to support applied research, outreach and advocacy, and dissemination of evidence-based practices in prevention and treatment of substance use disorders.

ICUDDR GOALS

- **Network Development.** Develop a network of universities that are engaged in the design and implementation of academic curricula and programs in addiction prevention and treatment studies.
- **Education.** Engage students and addiction professionals in academic programs of addiction studies and continuing education, promoting career opportunities in prevention and treatment.
- **Research.** Advance applied research in addiction prevention and treatment.
- **University-Community Outreach.** Enhance partnerships among university programs in addiction studies, addiction professionals, and the addiction science research and practice communities.
- **Advocacy.** Provide advocacy for policy change to support the development of academic programs in addiction studies and to enhance addiction prevention and treatment services. Advocate within universities for the development of academic programs in addiction studies. Develop and advocate for guidelines and standards for academic programs in addiction studies.

RECENT ACTIVITIES AND MAJOR ACCOMPLISHMENTS

Since its formation in March, 2016, ICUDDR has hosted three successful international conferences (Honolulu, Hawaii - 2016, and Prague, Czech Republic - 2017) that convened university and governmental leaders from around the world to share information and experiences related to implementation of academic programs in addiction studies. The Third Annual ICUDDR Conference was held in San Diego, California on June 4-5, 2018, at the University of California - San Diego. The ICUDDR website (www.icuddr.com) was launched in November 2017, and includes a brief history and overview of the ICUDDR, and a description of the organizational structure, university members and contacts, international partners, regional coordinating centers, the Universal Prevention Curriculum (UPC) and Universal Treatment Curriculum (UTC), procedures for accessing these curricula, and information about the annual ICUDDR conference,

ICUDDR surveys conducted in Europe and North America have identified universities with undergraduate, graduate, and certificate programs in addiction studies, yielding a database of over 400 universities, academic program titles, contact persons, and contact information. The ICUDDR leadership team has met on a regular basis and appointed officers and a Board of Directors, consisting of 15 members from 11 countries. A mission statement, an extensive set of goals and objectives, and plans for the 2018 ICUDDR Annual Conference were developed during a planning meeting in Washington, D.C. During the past two years, the leadership team has provided a range of presentations about the ICUDDR and global implementation of academic programs in addiction studies at prominent international conferences, including the 18th and 19th

PROGRAM AREA 03

International Congress on Addictions (Brazil, Mexico), the 2nd and 3rd Annual Conference of the International Society of Substance Use Professionals (ISSUP; Brazil, Mexico), and the Lisbon Addictions 2017 Conference (Portugal). In partnership with the U.S. Department of State/INL and the Colombo Plan, the ICUDDR leadership team has also convened planning meetings with CICAD/OAS, NAADAC, ONDCP, SAMHSA/CSAT, and other organizations to identify collaborative approaches to advance our mission and goals.

MEMBERSHIP

As of January 2018, the ICUDDR includes 85 university members from 33 countries and six major regions/continents. Membership has almost tripled from 2016-2017, due in large part to the ICUDDR conferences, participation in international meetings and conferences, initiation of the ICUDDR website, and networking among university colleagues in different regions of the world.

Member universities are located in the following regions/continents:

- Africa (4)
- Asia (27)
- Australia and Oceania (2)
- Europe (8)
- North and Central America (28)
- South America (16)

A full list of the 85 member universities is available in Appendix 3, which includes contact persons and websites for each university.

SUPPORTING DRUG-FREE COMMUNITY COALITIONS



Community Anti-Drug Coalitions of America (CADCA) defines a coalition as a formal arrangement for collaboration among groups or sectors of a community, in which each group retains its identity, but all agree to work together toward the common goal of a safe, healthy and drug-free community. Coalitions should have deep connections to the local community and serve as catalysts for reducing local substance abuse rates. As such, community coalitions are not prevention programs or traditional human service organizations that provide direct services. Rather, they are directed by local

residents and sector representatives who have a genuine voice in determining the best strategies to address local problems.

By bringing together different sectors of the community, a coalition can work effectively to develop a comprehensive solution to the community's unique substance abuse problems. The aim of these coalitions should be to achieve sustainable population-level reductions in substance abuse rates. This requires the implementation of communitywide strategies to change problem environments, not solely to develop prevention programs that focus

on serving individuals or groups of individuals. It also requires bringing the entire community together to achieve measurable results.

Local coalitions continue to change the way that American communities respond to the threats of illegal drugs, alcohol abuse and tobacco use. By mobilizing the entire community—parents, teachers, youth, police, health care providers, faith communities, business and civic leaders, and others—communities can transform themselves.



CADCA ASSISTS COMMUNITIES BY:

- Providing the support to become stronger, more effective, and better able to sustain population-level reductions in illicit drug use rates and related problems;
- Recognizing that illicit drug use is a multi-dimensional public health challenge that demands comprehensive, coordinated solutions;
- Connecting and engaging multiple sectors of the community – including businesses, parents, media, law enforcement, schools, faith organizations, health providers, social service agencies, and government – to collaborate and develop plans, policies, and strategies to achieve reductions in the rates of illicit drug use at the community level.

INTERNATIONAL PROGRAMS

CADCA works to reduce illicit drug use internationally through the establishment of multi-sector antidrug community coalitions. CADCA offers training, technical assistance, and other resources on how to build effective community coalitions to national

and local governments, non-government organizations (NGOs), and community groups in numerous countries affected by the cultivation, trafficking, and use of illicit drugs. CADCA's international trainings offer essential competencies and skills necessary to help create a culture of legality and bring about reductions – at the community level – in substance abuse rates. In carrying out all of the coalition-building activities, CADCA utilizes an evidence-based strategic planning process to foster community coalition development in selected countries. CADCA's trainings in coalition development promote community mobilization, civic engagement, and the development of social capital.

The training approach CADCA uses involves two parallel processes:

1. Providing local communities with evidence-based strategies to achieve population-level reductions in substance abuse rates;
2. Enabling and empowering local communities with the tools to develop the necessary social capital needed to solve their own problems through civic engagement.



SHARING EPIDEMIOLOGICAL DATA ON DRUG USE



AFRICAN UNION

Africa has become a major transit route in the global trade in narcotics. Both the United Nations Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB) 2013 reports indicated alarming trends with regard to the illicit drug situation in Africa, notably an increase in abuse of opioids, cannabis, amphetamine type stimulants and cocaine, and emerging New-Psychoactive Substances (NPS).

The African Union Commission Plan of Action on Drug Control (AUPA) 2013-2017 was adopted in 2013 as a robust framework for Member States to galvanize national, regional and international cooperation to counter the drug problem on the Continent over a five year period. The AUPA pays particular attention to capacity building in research, information collection and development of monitoring systems with a view to increasing monitoring of changing and emerging trends. It also emphasizes implementation of evidence-based responses and the ability to assess effectiveness of those interventions.

To pursue these goals, the AUC proposed a project -- Strengthening Research and Data Collection Capacity for Drug Use Prevention and Treatment in Africa (AUC Demand Reduction Project). The aims of the AUC Demand Reduction Project are to provide evidence for policy formulation and service delivery through establishment of national

and regional epidemiology networks on drug use in African Union Member States. It also seeks to strengthen technical assistance provided to Member States towards implementing evidence-based services for drug prevention and treatment.

The Project began in December 2015, with support from the Bureau for International Narcotics and Law Enforcement Affairs (INL). Drug demand reduction focal points from AU Member States attended the International Scientific Meeting on Drug Demand Reduction, held in Vienna. Organized by the World Health Organization and the UN Office on Drugs and Crime, the meeting brought together leading experts to share the most recent research findings and scientific understanding of evidence-based interventions to support Member States in the development of policies, strategies, and methods based on rigorous scientific evidence, to prevent and treat drug use disorders.

In August, 2016, at the African Continental Experts Meeting for Drug Demand Reduction (AU DDR Continental Consultation) in Cape Town, experts met to plan for the establishment of national and regional epidemiology networks. They reviewed and analyzed information on what data

PROGRAM AREA 03

is currently being collected; what data is most useful, challenges to starting a collection system, resource constraints, and how to scale up national networks to regional or continental levels. The meeting also proposed a process for selection of countries to participate in the Project. During the meeting the West Africa Epidemiology Network on Drug Use (WENDU), the Southern Africa Epidemiology Network of Drug Use (SENDU) and other partners shared their experiences.

Ten countries, distributed across all regions and on the basis of available information on the viability of an epidemiology network, were selected to participate in the project in 2016 and 2017 as follows: North Africa (Tunisia and Algeria), Southern Africa (Botswana and Zambia), East Africa (Tanzania and Uganda), West Africa (Ghana and Togo), and Central Africa (Cameroon and Angola).

Member States have actively participated in the Project and it is making excellent progress. The AUC has led on-site visits to each of these countries, meeting with host government, drug demand, non-governmental organization, treatment and prevention, medical, and law enforcement personnel. Each country has established a national network to collect data on drug use. Personnel from the ten countries have also received training in epidemiological data collection.

In November 2017, at the AU DDR Continental Consultation in Tunis, four countries provided their initial reports. The AUC and participating countries goal is to have a final report for all ten countries by late 2018. Also, the AUC and INL announced that 10 more countries will be added to the project.

TRACKING TOXIC ADULTERANTS

In recent years there has been an alarming upsurge in the use of pharmacologically active chemicals added as adulterants to drugs of abuse. Formerly, innocuous materials like diluent sugars or salts were added to drugs by dealers in target countries to increase their weight and market value. The growing popularity of synthetic drugs has left suppliers unable to compete, and in response many have begun adding psychoactive chemicals to drugs all along the supply chain to increase their potency. Many of these new adulterant chemicals pose serious public health hazards beyond the effects of the drug itself, including aminopyrine, an analgesic that reduces white blood cells; phenacetin, an analgesic and fever reducer banned in the U.S. that is linked to bladder cancer and kidney failure; and levamisole, a veterinarian deworming agent which depresses the immune system and reduces white blood cells in humans.



Medical doctors have noted that overdose and severe near-term health problems, even death, could occur due to synergistic and poisonous effects of multiple toxic adulterants, other controlled substances, and heroin impurities now routinely added to street drugs.



In 2010 due to a request from Brazilian treatment centers to find the cause of unusual infections, diseases, and health problems among cocaine using clients, INL began a project to test the composition of drug samples to specifically identify the cutting agents. Initial testing of thousands of cocaine samples (HCl & Crack) in Brazil showed that aminopyrine, phenacetin, and levamisole were new toxic adulterants being added to cocaine. By 2014, INL received reports of toxic adulterant expansion throughout the Andean and Southern Cone regions of South America, and along the cocaine trafficking route from South America to Africa and Asia. INL expanded the project in late 2015 to test street and wholesale drugs for toxic adulterants on a global basis in collaboration with the Colombo Plan.

Recognizing that source countries for Latin America, Asia, and Africa also supply U.S. markets, the Colombo Plan worked to test more than 500 U.S. street-level drug samples from drug testing labs in Vermont and Kentucky. Analysis showed that opioids, cocaine, and other drugs are adulterated with multiple, highly toxic adulterants

PROGRAM AREA 03

like other countries worldwide. Results of this analysis adds additional, unforeseen dimension to the U.S. opioid crisis.

The synergistic effects of these adulterants are significant and extend beyond the threat posed by fentanyl; the presence of fentanyl in the drug supply is likely masking the adverse health effects of other toxic adulterants.

As such, addressing the problem of fentanyl without simultaneously considering other toxic adulterants may lead to misrepresentation of the opioid or other drug epidemics, and may not lower health costs relating to substance use, as the remaining adulterants could in many

cases produce serious negative health consequences. The cutting of drugs with toxic adulterants happens at the source, transit, and consumer stages of the drug supply chain, compounding the challenge for law enforcement and public health agencies alike.

The United States, working with partners, has led the action to address this challenge, including by organizing the first international symposium of forensic drug lab directors to continue and expand analysis of samples for adulterants, linking forensic drug testing with the public health sector to track adulterants and develop early warning systems, and developing instant urine test kits for cutting agents which will allow health agencies to rapidly determine the adulterants to which patients have been exposed.



Pictured here are the participants and resource persons from the *First International Symposium of Forensic Drug Testing Lab Directors* held on December 4-7, 2017 in Cancun, Mexico. The Symposium, organized by the Colombo Plan Secretariat on behalf of INL, included toxicologists and lab directors from Argentina, Chile, China, El Salvador, Guatemala, Honduras, Indonesia, Jordan, Mexico, Nigeria, Paraguay, Saudi Arabia, Singapore, Thailand, Tunisia, Uruguay, and the United States.

ADDICTION STUDIES DEGREE PROGRAMMES

Historically, different professionals (medical doctors, social workers, psychologists, nurses, etc.) provided health, social and related services to substance users and their families (Conley, Schantz, Shea, & Vaillancourt, 2006). Substance use disorder is a complex and interdisciplinary subject, involving neuroscience, psychology, sociology, biology, medicine and many other fields. The multifaceted nature of substance use disorder, combined with growing demands for a well-trained workforce, has led to two viewpoints on how best to meet the needs of people with substance use disorder.

Professionals who do not work with substance users tend to believe that work in the addictions field should be carried out by professionals narrowly focused on addictions. On the other hand, professionals who work with substance users within their disciplinary training or who specialize in addiction tend to want more opportunities for education and specialisation in the addictions field for themselves. These two opposing attitudes contributed to the gradual development of new educational opportunities and narrow specialisation in addictions, including the newly emerging profession of an “addiction professional”. It is perhaps a reaction to this demand that we are observing increased educational activities in areas related to addiction. Specialised addiction study degree programmes (variously called addictology, narcology, alcoholology, addiction studies or addiction science) are being offered

by universities across the globe, such as addiction counselling (Taleff & Swisher, 2001), addiction medicine (Bell, 2008) and addictology (Miovský et al., 2015). Addictology is a transdisciplinary area of scientific research and clinical practice that is devoted to the understanding, management, and prevention of health and social problems connected with the use of psychoactive substances and other products (Miovský et al., 2015).

DEPARTMENT OF ADDICTOLOGY, CHARLES UNIVERSITY, PRAGUE

The Department of Addictology is a scientific and clinical workplace of the First Faculty of Medicine, Charles University in Prague and General Faculty Hospital in Prague. It was established on January 1st 2012, combining the Centre for Addictology of the Psychiatric Clinic, First Faculty of Medicine, Charles University in Prague and General Faculty Hospital in Prague and Unit for Addiction Treatment of the General Faculty Hospital in Prague. The department represents a unique merger of two separate workplaces that involve both clinical and paramedical professions that are involved in the recently established field of addictology.

The Department of Addictology is focused on inpatient clinical treatment and on teaching and research in addictology, a distinct field of transdisciplinary scientific inquiry into the risk environment of substance use and addictive behaviours.

PROGRAM AREA 03

The main activities of the clinic are split into four areas.

1. Clinical treatment involves 7 wards of the Unit for Addiction Treatment of the General Faculty Hospital in Prague:

- Inpatient ward (men)
- Inpatient ward (women)
- Detoxification unit
- Methadone maintenance unit
- Outpatient ward for alcohol addiction
- Outpatient ward for non-alcohol addiction
- Centre for psychotherapy and family therapy

2. Undergraduate teaching programmes (full- and part-time):

- Undergraduate bachelor's study programme in addictology
- Undergraduate master's study programme in addictology
- Teaching for students of general medicine and dentistry, and in psychiatry

3. Research and postgraduate teaching in addictology, including international cooperation in this area. Research activities are split into three separate centres:

- Centre for Primary Prevention of Substance Use

- Centre for Diagnostics, Therapy and Rehabilitation from Addictive Disorders
- Centre for the Study of Law Enforcement, Criminological Perspectives and Harm Reduction in Substance Use

4. Life-long learning in the field of addictology:

- Life-long learning of addictologists (classes accredited by the Czech Association of Addictologists)
- Life-long learning of other para-medical professions (classes accredited by the Czech Association of Nurses, Ministry of Health, et al.)
- Education of school prevention methodologists

The Department of Addictology consists of a multidisciplinary team of experts from the fields of addictology, psychology, psychiatry, law, epidemiology, sociology, social work, criminology, and special pedagogy, each with diverse experience in the drug field, including clinical work, research on the domestic and international level, developmental projects and university-level education.



PROGRAM AREA 4

ADDRESSING POPULATIONS WITH SPECIAL CLINICAL NEEDS

In all cases, the specific needs of individual patients should inform treatment decisions. However, certain patient populations may experience unique conditions that affect their ability to access or benefit from treatment, and the special clinical needs of these populations should be considered throughout the treatment process. Specialized treatment protocols, interventions, and training programs must be developed and disseminated to ensure good clinical outcomes for these populations. In support of this goal, INL's Program Area 4 aims to identify and support vulnerable or marginalized populations through the development and dissemination of specialized protocols, treatment modalities, and training packages. INL has supported specialized curricula to address the clinical needs of many of these populations, including women, children, people in recovery, and people involved in the criminal justice system.

PROVIDING SPECIALIZED CARE FOR WOMEN IN TREATMENT

Women: An Important Population of Focus

Women around the world who use drugs face challenges that increase their vulnerability to gender-based violence, economic discrimination, human rights violations, physical and mental comorbidities, high rates of incarceration, and intense stigma from many spheres of society. Such discrimination, as well as perceived and enacted stigma, act as significant barriers to treatment and encourage the continued victimization of women who use drugs. Traditionally, more men than women use drugs. In the last few decades, countries have recognized that the number of female drug users continue to increase as do the repercussions of

drug use for women. As the numbers of female drug users continue to expand, it is important to understand gender-specific etiological factors, phenomenology, course and outcome, and to implement effective prevention, treatment, recovery and social re-integration strategies on a national and international level.

Countries and policy-making bodies around the world recognize the issue of women's drug use and drug use disorders. For example, the Commission on Narcotic Drugs, a policymaking body of the United Nations for drug-related issues, adopted several resolutions regarding women and the world drug problem. The Commission highlighted the specific needs of women, most recently at its fifty-ninth session, held

Global data shows that females make up one third of the individuals who use drugs.

In 2010, the global estimated number of women dependent on drugs includes:

6.3
MILLION
dependent on
amphetamines

4.7
MILLION
women
dependent on
opioids

3.8
MILLION
women injected
drugs globally
(0.11% of the
world's females)

2.1
MILLION
dependent on
cocaine

Drug-use patterns among women around the world often reflect differences in access to drugs as well as other social and cultural environmental factors.

in March 2016, with adoption of resolution 59/5, “Mainstreaming a gender perspective in drug-related policies and programmes”. Further, the International Narcotics Control Board (INCB) devoted the first chapter of its 2016 annual report to the topic of women and drugs.



For over two decades, the United States government has been a global leader in identifying and responding to the unique needs of women who are in need of substance use disorder treatment.

Treatment Barriers and Clinical Needs Unique to Women

The reasons for women’s initiation of drug use include critical incidents such as coercion to use drugs by drug-using intimate partners, multiple family factors, the need for self-medication, multiple complex social/environmental factors, life stresses, sex work, relationship issues, physical, sexual and emotional abuse, and peer pressure.



Women tend to start using drugs at an older age than men, yet, women often develop a substance use disorder more quickly than men do.

Psychological factors, psychiatric comorbidities, especially childhood and more recent physical, sexual and emotional abuse are key issues that must be addressed in an integrated way during treatment. Sociocultural factors, including the fact that society expects a woman to be a wife, a mother, caretaker, sexual partner, and nurturer, can influence how women use

drugs and how they respond to treatment. Substance use by women is often linked with sexual behavior, multiple sexual partners, neglect of children and neglect of significant family and social responsibilities. Such behavior may lead to stigma and social discrimination.



Unlike men, women tend to experience greater medical, physiological and psychological impairment earlier in their drug use life course.

When women enter treatment for substance use disorders they often present with a more severe clinical profile than men, despite lesser frequency and quantity of substance use.

Certain structural, social, and personal barriers are considered responsible for low rates of treatment-seeking among women. While women comprise one third of individuals who use drugs, they comprise only one fifth of the in-treatment population. Women encounter significant systemic, structural, social, cultural and personal barriers to accessing substance use disorder treatment. At the structural level, obstacles for women include a lack of childcare services as well as prejudicial and stigmatizing attitudes from treatment providers and other societal members. Often, residential treatment programs do not allow women to bring their children to treatment; this can result in women having to make the gut-wrenching choice between parenting and treatment. Studies that have examined gender differences in substance use disorder treatment retention and completion show inconsistent results. On a social level, women’s roles as the economic provider, home tender, childcare giver or

PROGRAM AREA 04

other responsibilities may prevent women from seeking or engaging in treatment. On a personal level, the fear, guilt, stigma and shame may inhibit women for getting the help they need.

Generally, studies focusing on the association of treatment completion and outcome have indicated that treatment completion is associated with better outcomes, irrespective of gender. The sensitivity to women's special needs and problems is critical to treatment success and some of the specific issues related to outcome include: Co-occurring psychiatric disorders, history of victimization, therapist-patient gender matching, and social factors. Both men and women benefit from the substance use disorder treatment and gender alone is not a predictor of outcome. However, certain characteristics of individuals, sub-groups of individuals, and treatment approaches may have a differential impact on treatment-related outcomes by gender. Both the WHO and UN have given attention to the unique needs of women treated for substance use disorders while pregnant and while incarcerated.

Pregnant women in need of drug treatment may avoid treatment due to fear of involvement of legal authorities or other social consequences. However, if pregnant women remain untreated, there are risks for negative health outcomes for the mother and child. Some of the factors that motivate women to enter treatment are pregnancy, parenthood and a partner's entry into treatment. Overall, two factors that significantly aid in predicting the treatment outcome for women are co-occurring diagnoses and a trauma history. Thus, programs that address these issues have a better chance of helping women have meaningful positive drug treatment outcomes.

The unique issues of women for recovery and social re-integration include peer support groups, on-site 12-step meetings, and social outings. On-going social support, economic opportunity, parenting and child care support are needed to help provide women the tools to be successful in treatment and recovery.

Another issue that engenders women's success in treatment is the use of women-only programs. Women who participate in such programs report being better understood and can more easily relate to other female peers. Some women report that they feel unsafe or are harassed in mixed-gender programs.



In women-only programs, women report that the availability of individual counseling, the absence of sexual harassment and the provision of childcare services are important components for success.

In summary, women respond best to a women-centered approach to treatment, on-site childcare, co-occurring disorder treatment and trauma or sexual abuse counseling. Treatment programs should also provide women with skills, knowledge and support to enable them to maintain their change in substance use behavior when they return to their home and community. The ultimate goals of the treatment process are to enable women to take control of their lives, improve their physical and mental health, engage in healthy relationships with their children, families and communities, and finally, to engage in meaningful activities that help them feel connected to self, others, and community.

INL's Response



INL has been a pace-setter in addressing gender as part of a comprehensive, integrated and balanced approach to drug treatment.

INL created a women-centered treatment curriculum in 2009. Given the breadth and depth of the evolving science and emerging clinical evidence regarding women, it is necessary to now create a cutting-edge, skills-based curriculum that empowers practitioners with the most up-to-date practical knowledge and skills to provide the highest quality treatment to women. An international panel of experts will be developing this multi-volume course over the next year followed by pilot testing and refinement for world dissemination.

Potential Topics for INL's New Curriculum to Address SUDs in Women:

- Basic theories and concepts guiding the treatment of women who have substance use disorders
- Legal and ethical issues in providing treatment to women with substance use disorders
- Important aspects of creating a women-responsive therapeutic treatment context
- How to identify substance use disorders among women
- How to create and implement a comprehensive assessment of the female patient
- Creating and implementing Individualized care plans for women: Development, initiation, monitoring, and completion
- Methods to help female patients stabilize and withdraw from substances
- Components of a comprehensive drug treatment program for women
- Approaches to caring for the dually-diagnosed female patient
- Care in specialized circumstances (e.g., Obstetrical aspects of care of the pregnant woman with substance use disorders and helping women with substance use disorders care for their drug exposed newborn and caring for incarcerated women)
- Approaches to empower women to enhance parenting skills
- Trauma responsive treatment for women
- Case management for women
- Recovery oriented system of care for women
- Keys to developing a comprehensive care model for women

SUPPORTING DRUG-FREE LIVING IN CHILDREN

Today more and more young children around the world are living in drug-life circumstances and actively engaged in substance-using behavior. Recent data show that incidence and prevalence rates of substance use and substance use disorders among young children are increasing across a range of socio-economic strata. The World Health Organization reports that up to 90 percent of children living in street-life circumstances worldwide use some kind of substance. While previous studies of the effects of substances on children have traditionally focused on in utero drug exposure or on the social impact of family and community substance use, the newly documented presence of substance use disorders among very young children represents another frontier in INL's drug demand reduction challenges. Compounding the issue is the fact that treatment outreach programs often fail to engage this often "hidden" and highly vulnerable group, with a resulting serious gap in services for children with substance use disorders.

INL Spearheads Documentation of Child Substance Use Disorder

A range of verifiable toxicological test data have enabled INL to document alarming levels of substance exposure in infants, elementary school age and children up to 12 years old. For illustrative purposes, two of many examples throughout the world of the documented health crisis are provided below.

In 2010, with INL's support, child substance exposure and substance use disorder was



documented in Afghanistan. Children from newborns through 12 years old were observed to be dependent on opioids like heroin and opium. Many children were found to be prenatally opioid-exposed and then exposed to opioids throughout their childhood with parents giving them opioids to prevent withdrawal, stave off hunger and control their children's behavior.

INL and its partners provided the first scientific evidence that children were exposed to extremely high levels of opioids from first-hand (e.g., parents blowing opium smoke in their faces), second-hand (e.g., breathing the air where their parents are smoking opium) and even tertiary level exposure (e.g., touching walls, floors and toys with opioid residue and then placing their hands in their mouths). In some cases over 40% of all children in a village were

found to be opioid-dependent. Further, the Afghanistan National Urban Drug Use Survey (ANUDUS) published in 2012, is the largest laboratory-based substance use study in the world and shows that between 59,100 and 70,500 children in the country are affected by drug use. Over 80 percent of children testing positive for opioids are most likely not active substance users. Most are probably being provided opioids by adults or exposed to second-hand opium/heroin smoke and third-hand residues in the home. Most striking, when the results of the ANUDUS study are extrapolated to the total population of Afghanistan, the number of children affected by adult substance use is nearly 300,000. Toxicological tests performed by INL between 2010 and 2012 from a total of 242 Afghan children in residential substance use disorder treatment, reveal that the concentrations of opium products in children's bodies are striking; in some cases, they are higher than those observed in U.S. adult heroin/opioid users.

In the Southern Cone region of South America, crack cocaine is so abundant that it now sells for as little as one U.S. dollar per dosage unit (e.g., a rock like substance weighing approximately ten milligrams which is smoked). Widely available on the streets, crack is attracting thousands of children, who are turning to the stimulant as an alternative to the glue and solvents that many children living in street-life circumstances have traditionally used. Surges in the use of crack cocaine within Southern Cone countries are resulting in urban "cracolandas" (cracklands) where hundreds of users gather to smoke the drug and where children are frequently used as runners or decoys to avoid law enforcement.

Fifty-four treatment providers, representing eight regions within Brazil, were surveyed in 2012 about crack use by youth in the respective cities in which they work. When asked about the age of crack initiation

among males and females in their local "crackland," the mean age was reported as 9 and 11 years, respectively. In a 2013 survey of 32 youth attending a drug treatment prevention program in Campinas, Brazil, 84 percent reported seeing children 4-8 years old using crack in the city's open air drug markets; 44 percent reported "friends" using crack; and 47 percent reported a family member using crack. The developing brains and bodies of children are extremely vulnerable to the effects of toxic additives being identified in seizures of crack within the Southern Cone. Toxicological tests conducted in 2012 by the Brazilian Federal Police and the Drug Enforcement Administration (DEA) Special Testing Lab reveal that the current version of crack in the Southern Cone is being produced from raw unrefined cocaine base which often contains impurities and toxic cutting agents. These toxic adulterants include phenacetin, an analgesic banned in many countries due to linkage with bladder cancer/renal failure, and levamisole, a medication used by veterinarians for expelling worms that depresses immune systems and reduces white blood cells in humans.

Treatment Providers Need Tools to Respond

Treatment providers who work in countries where child substance use disorders are a growing concern are faced with a range of daunting challenges on the social, cultural and individual levels. Providers face a range of individual child's needs that requires responses from multiple agencies which must be coordinated and managed over time. Perhaps most challenging is how to effectively reach out to children whose substance use involvement is occurring against the background of intense socio-political stress, such as in conflict intense areas, where sustained violence and/or terrorism have impacted generations of children.

Thousands of young children in drug-life settings are clearly at high risk for trauma that includes physical, sexual, and emotional abuse as well as neglect. Treatment providers who intervene with such children are routinely faced with unraveling the complex relationship between substance use and trauma. More often than not they are doing so without the benefits of either trauma-specific programming or trauma-informed staff, a challenge made even more daunting since treating the extent and severity of the effects of trauma is a complex, recursive, and dynamic process. Furthermore, treatment providers must not only be capable of addressing trauma in relationship to substance use disorders, but also of understanding how to address it within the broader context of families and communities. Research indicates that to effectively treat the individual child, attention must be given to rehabilitating all relevant individuals from trauma and substance use disorder, as well as bolstering the entire community's capacity to prevent traumatic experiences and substance use disorder.

INL Supports the Development of Treatment Protocols for Children



To address the growing evidence of child substance use disorder and to support treatment providers in meeting the challenges, INL advanced a partnership with leading universities to implement and evaluate global child-substance use disorder prevention and treatment protocols.

In 2015, INL engaged an internationally recognized panel of experts to work together over eighteen months to develop a comprehensive evidence-based-training

curriculum that would offer practical tools and skills to prepare dedicated providers who are working on the front lines with children around the world. The INL expert panel was spearheaded by Hendree E. Jones, PhD., author of INL's global child substance use disorder treatment protocols, and an internationally recognized expert in the development and examination of both behavioral and pharmacologic treatments for pregnant women and their children in risky life situations. Dr. Jones was supported by an international panel of experts from Brazil, Paraguay, Pakistan, India, Afghanistan, Australia, the United States, and the United Nations. The experts represent a wide range of fields and specializations, including substance use prevention and treatment, psychology, education, pharmacology, public health, pediatric medicine, psychiatry, human rights, public policy, social integration, and community development. Experts were selected based on their prestige in the field and their first-hand experience in working directly with children with substance use disorder and their caregivers in a host of socioeconomic conditions and cultural settings.

The Child Intervention for Living Drug-Free (CHILD) Curriculum

INL's international expert panel's efforts have culminated in The Child Intervention for Living Drug-Free (CHILD) Curriculum, encompassing six courses, which empower providers to respond to the needs of children facing drug-life circumstances in varying social, cultural, economic, and political settings. The Curriculum represents the world's first evidenced-based training program for guiding treatment professionals on how to screen, assess and treat substance use disorder in children. The "realities" and underlying assumptions of working with children were integrated throughout the courses as cross-cutting themes and unifying perspectives.

All six courses are based on the critical premise that a child must be treated with a rich understanding of the context in which the child lives and experiences the world. The broader context that surrounds the child is considered as a part of this six-course Curriculum's approach to substance use disorder treatment. This context includes macro-factors such as culture,

region, country, community, and socio-economic standing. Micro-factors must also be considered such as family, caregivers, primary social networks, home and other living environments, as well as the child's "internal factors," such as how he or she interprets, responds to, and interacts with the outside world.

The Child Intervention for Living Drug-Free (CHILD) Curriculum

▶ **Course 1: Interventions for Children with Substance Use Disorders**

This first foundational course addresses the uniqueness of treating children with substance use disorder, beginning with the need for treatment professionals to alter intervention techniques to accommodate the child's level of cognitive and emotional development. It introduces major topics for expansion in later courses, including basic counseling skills, motivational interviewing, treatments for children exposed to trauma, pharmacological options as a part of treatment, and ethical considerations.

▶ **Course 2: Treating Children with Substance Use Disorders: Special Considerations and Counseling with Children**

Child substance use disorder is presented through the lens of health care in which substance use disorder is seen as a complex, but treatable disease in which co-occurring disorders are common. As the first critical step in developing an individualized treatment plan, participants learn how to perform screening and assessment procedures. This set of universal treatment tools can be adapted by treatment practitioners according to their specific settings, substances used by children, minority populations, culture, and other local needs.

▶ **Course 3: Motivational Interviewing for Children with Substance Use Disorders**

This course explores basic counseling skills and focuses on the development of the Motivational Interviewing (MI) technique, a skill which can permeate and bolster all of the practitioner's efforts in the field. MI is recognized as a practical technique for developing the critical quality of empathy in the treatment provider, a quality which guides the practitioner as he or she engages in assessing and determining the level of motivation in the child as well as how to respond to children in different stages of change.

▶ **Course 4: Attachment Theory and Principles of Treating Children with Substance Use Disorders Affected by Trauma and Distress**

This course explores the complex link between a child's "style of attachment" with his or her primary caregivers and subsequent substance use. The course offers specific interventions for working with children whose relationships are disrupted by trauma and distress as well as practical tools for providers to examine if their staff is trauma-informed and their program trauma-specific.

▶ Course 5: Principles of Pharmacological Treatments for Children with Substance Use Disorders: A Menu of Options

This course focuses on pharmacology as one part of a holistic and systems approach to managing substance use disorders in children. It is designed for both medically-trained individuals who are qualified to prescribe and supervise the administration of pharmacological agents to children as well as non-medically trained professionals who may benefit in their capacity to supervise and monitor children with SUDs. It offers practical guidance for identifying and responding to signs and symptoms of intoxication and overdose in children as well as pharmacological protocols for managing detoxification.

▶ Course 6: The Suitcase For Life Intervention Tool

This course offers practitioners a unique intervention tool for working directly with children in the field. The highly mobile and culturally adaptable Suitcase For Life consists of eight modules based on evidence-based approaches for developing strengths and skills in the child in eight areas of functioning: Artistic Expression; Communicating and Relating; Dealing with Stress; Understanding the Harms of Drugs; Keeping the Body and Mind Healthy; Keeping Yourself and Others Safe; How to Be a Good Citizen; and Dreaming and Planning for the Future. Each module can be tailored to each unique cultural context.

Implementation, Outcomes, and Evaluation



As of early 2018, the CHILD Curriculum has been piloted to treatment providers from South Africa, Kenya, Bangladesh, India, Pakistan, Afghanistan, Peru, Argentina, Brazil, Paraguay, and Chile.

Numerous follow up technical assistance visits by INL in 2016 and 2017 to India, Pakistan, Afghanistan, Argentina, and Paraguay indicate that providers are implementing the Curriculum in a range of program and community settings. The data from these technical assistance reports indicate that a range of CHILD curriculum techniques are being widely implemented, including in such critical areas as child protection and child's rights policies; documentation practices

(screening, intake, assessment, treatment planning, treatment sessions attended, and outcomes); confidentiality; and staff training in motivational interviewing and other counseling techniques.

One study of 783 children between 4 and 18 years of age in Afghanistan who received the Child Intervention for Living Drug-free (CHILD) protocol while in treatment for substance use disorders showed that CHILD had a sustained positive impact on children. This study appeared in the International Journal of Pediatrics (Volume 2017 (2017), Article ID 2382951, 10 pages, <https://doi.org/10.1155/2017/2382951>). The study showed that on average, children showed significant improvements from residential treatment entry to treatment completion for all scales examined such as anxiety, emotional symptoms, conduct problems, hyperactivity, peer problems, prosocial behavior, trauma symptoms and quality of life in terms of physical health, mental health, friends and home. These improvements remained when the children

were evaluated again after being back in the community 12 weeks later.

Another formal evaluation study is planned for 2018-2019 in which more data will be gathered through a co-supported effort by NIDA and INL. This 5 year randomized clinical trial will evaluate CHILD, the comprehensive substance use disorders treatment intervention, for substance-using children 7-12 years of age in Delhi, India. The intervention is intended to increase treatment retention and abstinence from solvent, opioid, and cannabis use, as well as reduce HIV-risk, psychiatric disturbance, anxiety-related emotional disorders, social problems, trauma, and improve quality of life relative to usual care. This intervention has the potential to reduce the impact of substance use on children and to provide a treatment program that can be scaled up for use throughout the USA and other countries.

A Tool for Measuring Addiction in Children

One of the major challenges in delivering effective substance use disorder treatment for young children concerns the lack of a tool for measuring substance use severity and related behaviors in such a young population. The field currently recognizes and employs formal tools for measuring substance use disorders in adults and also in adolescents. However, not until INL spearheaded the CHILD Curriculum did the need for an additional assessment tool come into sharp focus. This new tool is known as the Child Intervention for Living Drug-free (CHILD): Comprehensive Assessment of Risk, Resilience and Experience (CARRE) tool.



The CARRE tool provides the first-ever assessment of detailed information about substance use behavior and other life domains pertaining to child functioning that may need treatment.

The life domains examined in this tool include: physical health status, school adjustment, vocational status, family function, peer relationships, substance use, psychiatric status, leisure and recreation activities, and the child's legal situation. As of early 2018, practitioners in Argentina and Paraguay are being trained in the use of the ground-breaking CARRE tool, an assessment instrument which holds promise as a significant contribution to the substance use disorder treatment field.

REMOVING TREATMENT BARRIERS FOR LGBT PEOPLE

Sexual Orientation & Gender Identity (SOGI)

In 2016, INL identified the Lesbian, Gay, Bisexual, and Transgender (LGBT) community as a population with special clinical needs when addressing substance use treatment. Members of the LGBT community may be more likely to experience specific social factors which can negatively impact their health, including bullying, violence, social exclusion, and isolation. Additionally, they may face barriers to accessing treatment, such as fear of rejection, lack of provider experience, and discrimination in service provision. Social stigma and lack of understanding play a large role in creating these barriers, and many of these barriers can be removed by educating providers in the best ways to provide treatment to LGBT people with substance use disorders.

In order to address the special clinical needs of LGBT people in treatment, INL funded the creation of a new course to teach treatment providers the fundamentals of working with this population. The new course is entitled “The Intersection of Substance Use and Sexual Orientation and Gender Identity (SOGI).” The course uses interactive and experiential teaching

strategies to introduce concepts like minority stress, micro-aggressions, cultural humility and social determinants of health which can lead LGBT persons to substance use. The course also explores hands-on strategies for providers detailing ways to better interact with clients in addition to providing suggestions on how to create a more inclusive space for LGBT clients.

The course’s value was evident in the October 2017 pilot in Lima, Peru, where more than 35 participants from the Ministry of Women and Vulnerable Populations, the Ministry of Health, the National Commission on Development and a Life without Drugs (DEVIDA PERÚ), and LGBTQ civil society groups received the 5-day training.

The development, peer review and ultimate dissemination of the course represent a collaborative effort between INL's international DDR partners: the Colombo Plan, the UNODC and OAS/CICAD. Drug Demand Reduction counterparts at the U.S. Health & Human Services (SAMSHA) were also consulted and provided a preliminary trainer manual for review toward this project. The course is in its final stages of review and will be ready for global dissemination in 2018.

PROVIDING RECOVERY SUPPORT

Individuals in long-term recovery from substance use disorders can be extremely effective in helping those who are in early recovery. With a strong foundation in personal recovery they can be very instrumental in helping others to fully engage in a healthy regimen and lifestyle in which their SUD is effectively addressed. The individuals who provide recovery support are often called “recovery support service providers,” “recovery support specialists,” “peer support specialists,” “recovery coaches,” and other titles.

In addition, there are also individuals who can and do provide highly effective recovery support services without the benefit of being in recovery from SUDs or any other disease. While first-hand experience is a valuable resource in being a recovery support service provider, it is not a requirement. What is required-- and is considered essential for being an effective recovery support service provider-- is the capacity to support the recovery of an individual within the context of the science of substance use disorders, as well as with reference to the cultural and social realities of that individual’s community.

The troubling reality is that many of well-intentioned “recovery coaches” who are in recovery themselves can be ill-equipped to handle the challenges of sustained recovery and may put themselves at risk for relapse. People in recovery regularly encounter precarious situations that can make them vulnerable to relapse, homelessness, and interaction with the criminal justice system,



putting their health and well-being at risk. People in recovery who want to use their experience to help others recover from substance use can face additional issues such as exposure to drug-related cues, stress, and blurred boundaries. Indeed, people in recovery who are drawing upon their experience to help others overcome substance use disorders need to be prepared to face the unique challenges associated with their role.

To improve the skills and capabilities of recovery support service providers, the State Department’s Bureau of International Narcotics and Law Enforcement Affairs (INL) is now overseeing the completion of an eight-module course entitled “Delivery of Peer Recovery Support Services” This Course represents a first step towards

PROGRAM AREA 04

the creation of a possible broader multi-course Universal Recovery Curriculum (URC). The initial course was created with the guidance of an INL-selected Expert Working Group (EWG). Notably, the group tapped longstanding international partners for INL's overseas demand reduction programs, including the Organization of American States, the Colombo Plan, as well as government entities addressing the opioid epidemic in the U.S., namely the Substance Abuse and Mental Health Services Administration (SAMHSA) and the White House Office of National Drug Control Policy (ONDCP). The EWG focused its efforts around key recovery support service provider concepts, including self-care, problem-solving, community resource development, ethics, and boundaries. Further, they prioritized the following for inclusion in the course:

These modules will provide knowledge and practical skills allowing recovery coaches to:

1. *Understand and explain the nature of recovery support services and the roles of the service provider;*
2. *Manage and fulfill the core functions and responsibilities of the recovery support service provider;*
3. *Use the core values of recovery and recovery support services to guide their work and support relationships;*

4. *Use the core skills and the broader skills of recovery support service providers safely and effectively;*
5. *Use the broader skills of recovery support service providers safely and effectively;*
6. *Promote safety for the people they serve—and for themselves—by using the ethics of the field, an understanding of the risks, and the principles of self-care to guide their work;*
7. *Perform recovery support services within the context of the science of substance use disorders and recovery, respect for the cultural and social realities of their communities, and a grounding in the health of the community; and*
8. *Have an integrated concept of how these elements work together to support recovery.*

Delivery of Peer Recovery Support Services

The course will be piloted in late 2018. The final peer reviewed version of the course will eventually be trained in numerous regions around the world with the goal of strengthening the quality of recovery for thousands of individuals. In addition, the initial 8-module course will also be made available for U.S. towns and communities, especially those struggling with opioids.

PROMOTING TREATMENT WITHIN THE CRIMINAL JUSTICE SYSTEM

Science has confirmed that substance use disorders are reoccurring chronic, often relapsing diseases that affect the brain, and that they should be treated within the public health arena like other diseases such as diabetes and asthma.

The challenge, however, occurs when substance users engage in crime; at that moment, two distinct public systems are required to respond to “drug offenders.” Substance users are suffering from brain-based disorders characterized by compulsive cravings and other overwhelming obsessions. And while not all substance users are criminals, their substance use disorders frequently trigger behavior that is self-destructive, dishonest, predatory, and sometimes, violent.

Substance users who engage in crime present one of the greatest challenges we face: How is a culture, a country and a community to respond with both compassion and a duty to law enforcement? The criminal justice system in any setting is obligated to attend to its principal mission when responding to drug offenders, that is, to protect public safety and enforce the law. Nevertheless, the public health and treatment systems have their moral obligation: to respond on behalf of the drug user who may very well benefit from treatment in multiple ways that benefit the individual as well as the community to which he or she will return.

When treatment and criminal justice systems respond in coordinated manner, individuals and communities both benefit: public safety is maintained and many individuals who need treatment can receive it.



Effective linkages between the two systems offer valuable opportunities for treatment interventions to occur all along the justice continuum, from arrest, to prosecution, to sentencing, to incarceration, to release.

Studies show that systematic interventions that offer treatment in lieu of incarceration or further prosecution often result in reduced criminal activity and can thus increase opportunities for recovery. Simply put, when criminal justice and treatment systems cooperate, those individuals who have substance use disorders and engage in non-violent crimes can receive support to change their behavior, not only in the context of law enforcement, but in the context of public health which is committed to helping individuals with rehabilitation from their substance use disorder. Research shows that many individuals who receive help from a coordinated treatment and criminal justice response, such as drug courts and other alternative sentencing

options, return to their communities with new life skills by which to manage their disorders and become productive and responsible.

Unfortunately, far too often the criminal justice system becomes a repository for individuals with untreated substance use disorders. The public health sector and the criminal justice system must find creative and practical ways to address nonviolent offenders suffering from substance use. In response to this critical need, INL's drug demand reduction team has taken on creating curricula designed to help countries meet their respective challenges in determining what types of interventions may be possible to route nonviolent offenders with substance use disorders into treatment.

One of the main drivers of the INL-funded curricula is that the need for systemic treatment interventions to be based on best practices, including the following: *offenders must be screened for substance use disorder at every point of entry along the justice continuum.* Moreover, if the screening indicates the presence of a substance use disorder, a diagnostic assessment to determine the nature and severity of the substance use disorder should be performed, and the appropriate level of care (such as outpatient, inpatient, residential, and possibly medication-assisted treatment) needed to treat that disorder should be determined. Many nonviolent offenders with substance use disorders often have co-occurring mental health disorders and/or physical illnesses; these should be part of the diagnostic assessment, administered by trained clinicians.

One model intervention that has proven to be highly successful within the United States is drug courts. Drug courts are beneficial for countries that would like to target high-risk and high-needs users that require a great deal of services and support. Successful

drug courts are based on the best practices outlined above and have strong relationships with treatment organizations that deliver services based on best practices. However, reliance on drug courts alone misses opportunities for treatment interventions at other justice system junctures. In the United States, additional types of programs that target early phases the criminal justice continuum, such as the time of arrest or intake, have been implemented to rapidly begin treatment interventions for offenders with substance use disorders. In addition, opportunities to reduce criminality while on community supervised release, such as probation or parole, are enhanced by developing a system which provides information and referral opportunities to treatment.



Coordination and linkages between the criminal justice and treatment systems requires buy-in from policymakers.

Therefore, INL is developing training for policymakers and agency heads from both the public health sector and criminal justice sector to address critical areas of need within a particular country. In addition to receiving information on a number of alternatives to incarceration along the justice continuum, countries will also complete a pre-assessment survey which will help identify:

1. important stakeholders, decision-makers, policymakers, and others who should be involved in the training,
2. key junctures in the criminal justice system at which policymakers can develop alternatives to incarceration or improve existing services,

3. existing services, structures, and processes related to drug-involved persons who are involved in the criminal justice system, and
4. important gaps in services.

As the INL policymakers is course is developed, a second curriculum will be developed for both criminal justice personnel and public health practitioners to increase their knowledge regarding:

1. the nature of substance use disorders;
2. best practices for intervention and treatment; and
3. the need for service delivery coordination with the criminal justice system.

The intent of this training is to assist countries in the development and delivery of systematic treatment interventions as part of an integrated public health model.

REDUCING THE RISK OF FATAL OVERDOSE IN OPIOID USERS

In 2016, over 42,000 people in the United States died as a result of an opioid overdose. Worldwide, an estimated 33 million people use opioids, many of whom are at high risk of fatal overdose. Somewhat paradoxically, the risk of overdose markedly increases following a period of abstinence from opioids, due to the reduction of tolerance over time. This commonly occurs after release from incarceration, discharge from inpatient treatment, or cessation of drug dependence treatment, making people in these conditions vulnerable to fatal opioid overdose.

Opioids exert their intoxicating effect by activating the brain's opioid receptors; activation of these receptors both alleviates the perception of pain and induces euphoria. The ability of opioids to treat pain has led to their widespread medical use, however their effects on mood increase their potential for abuse and dependence. Additionally, opioid receptors are also involved in the regulation of breathing, such that high doses of opioids can cause fatal respiratory depression.

In cases of fatal overdose, the victim's breathing slows to the point where oxygen levels in the blood fall below the level needed to transfer oxygen to the vital organs. As the organs and the brain shut down from lack of oxygen, the individual becomes unresponsive, blood pressure decreases, and the heart rate slows, leading to cardiac arrest. Death can occur within minutes of opioid ingestion, or after a longer period of unresponsiveness lasting

up to several hours. Many opioid overdoses occur in private homes, and most of these are witnessed by close friends, a partner, or a family member. Additionally, healthcare workers, first responders, and outreach workers who regularly interact with people who use drugs are likely to witness an overdose. If recognized in time, opioid overdose is reversible. Naloxone is a safe and non-abusable substance that binds very tightly to opioid receptors, replacing other opioids that may be present, and blocking other opioids from binding. If administered during an overdose, naloxone can reverse respiratory depression and save the victim's life.

Though naloxone can save lives and has minimal adverse effects beyond the induction of opioid withdrawal symptoms, access to it is commonly limited to health professionals. Several countries have begun distributing naloxone to people likely to witness an opioid overdose. At the 2017 Commission on Narcotic Drugs, the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO) launched the Stopping Overdoses Safely (S-O-S) Initiative. The initiative's targets include making naloxone and training on overdose management available to all people likely to witness an overdose, including peers and family members. The initiative sets a global implementation target of 90-90-90 (90 percent of people likely to witness an overdose will have received training; 90 percent of those trained will have been given a supply of emergency naloxone; and

90 percent of those who have been given naloxone will be carrying the naloxone on them or close at hand).

In order to contribute to this target, INL is supporting a pilot study by UNODC and the WHO on the feasibility of community distribution of naloxone in four countries in Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, and Ukraine. The study aims

to estimate the public health outcomes of community management of opioid overdose, including the use of naloxone. The goals of this study will be to support the use of community naloxone distribution by demonstrating its feasibility in preventing opioid overdose deaths, and to establish guidelines for the distribution of naloxone and training within communities.

FEATURES FROM THE GLOBAL DRUG DEMAND REDUCTION COMMUNITY



ISSUP UPDATE

By Joanna Travis-Roberts



THE CASE FOR CREDENTIALING

By Becky Vaughn



THE BIOLOGY OF DECISION MAKING AND DRUG DEPENDENCE

By Andrew Thompson, Ph.D.



A PIRE RETROSPECTIVE: INL EVALUATIONS THROUGH THE YEARS

By Matthew Courser, Ph.D. and
Linda Young, M.A.



ISSUP UPDATE



JOANNA TRAVIS-ROBERTS

Acting Executive Director for the International Society of Substance Use Professionals (ISSUP)

In 2017, ISSUP was privileged to welcome over 2,500 participants from 71 countries for the 3rd ISSUP Workshop in Cancún, Mexico. Global experts, policymakers, health workers, and other professionals met to build networks and exchange knowledge and best practices. The 3rd ISSUP Workshop took place together with the 19th International Congress on Addictions organised by Centros de Integración Juvenil (CIJ) from December 4th - 8th.

ISSUP coordinated training from a range of international partners including the Colombo Plan, UNODC, WHO, PAHO, CADCA and OAS/CICAD. Attendees of the ISSUP training were also able to participate in the CIJ Congress. In addition to the

training courses and open panels, a range of expert group meetings were held to discuss best practices and the latest methods in substance use prevention and treatment. Highlights from the meeting include:

- The Colombo Plan organized the first meeting of directors of 17 national drug laboratories to share information on the growing transnational threat of toxic adulterants found in illicit drugs, which are causing widespread health problems in many countries.
- Over 400 international health practitioners and policymakers were trained in accredited drug prevention and treatment courses.



ISSUP UPDATE

- Expert working groups reviewed and updated the two fundamental tools used by those working on drug demand, the Universal Treatment Curriculum (UTC) and the Universal Prevention Curriculum (UPC).
- ISSUP held talks on creating National Chapters of ISSUP in Brazil, Chile, India, Kenya, Malaysia, Nigeria, Pakistan, the Philippines, South Africa, and the United Arab Emirates.

Representatives from Kenya’s National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) confirmed their commitment to partner with ISSUP to host the next annual meeting in Nairobi in December 2018. ISSUP looks forward to hosting another productive and successful event in Kenya.

ISSUP IN 2017 - HIGHLIGHTS

In addition to the highly successful 3rd ISSUP Workshop, 2017 saw a major expansion of ISSUP and the launch of many popular features on the ISSUP website.

- ISSUP’s membership more than doubled in 2017.



- ISSUP launched its Training Database recording UPC and UTC activity in March 2017.
- ISSUP launched its Forum in May 2017.







- ISSUP launched its website in Spanish in August 2017.
- ISSUP staff and members added over 700 new articles to the Knowledge Share.
- ISSUP published 30 country profiles on its website.
- ISSUP sent out a total of 21 newsletters.
- ISSUP held its annual Board Meeting in Prague in June 2017 and 3 Executive Committee Meetings in 2017.
- ISSUP attended a number of important international conferences including the Society for Prevention Research (SPR) Conference, the EU-SPR Conference, Lisbon Addictions 2017, the International Consortium of Universities for Drug Demand Reduction (ICUDDR) Conference as well as the WHO Forum on Alcohol, Drugs and Addictive Behaviours and the 60th Session of the Commission on Narcotic Drugs (CND).
- ISSUP offered expert advice and support on the UPC Adapt Project in Europe and took part in the African Union Continental Consultation on Drug Demand Reduction.


GET INVOLVED WITH ISSUP!


Join ISSUP to link, share, talk, grow, meet, and learn!

Register for free online at www.issup.net

 info@issup.net

 www.issup.net

 [@issupnet](https://twitter.com/issupnet)

 [/issupnet](https://www.facebook.com/issupnet)



THE CASE FOR CREDENTIALING



BECKY VAUGHN

Director of the Global Centre for Credentialing and Certification (GCCC)

Professional credentialing plays a key role in treatment and prevention efficacy. Like other chronic conditions, substance use disorders can be treated, and effective support can be provided to those who are managing their disease and their families. The last few decades have brought remarkable new information from research and evidence that is now providing effective prevention practices, treatment modalities, and recovery support models. More recently, important studies have pushed for new treatment paradigms as well as significant advances in psychopharmacological approaches to addiction. All of this has led to the need for higher levels of training and education for professionals to ensure that those impacted by the disease of addiction receive the best and most effective treatment possible.

First, professional credentialing of prevention and treatment providers complements INL’s worldwide training

efforts through the setting of recognized standards of competency and expertise for those working on the front lines with those suffering from substance use disorders. Second, professional credentialing is one of the best mechanisms to increase the delivery of evidence-based protocols, help ensure quality services, improve outcomes, and ultimately, save lives.

Not only does additional training and credentialing increase the availability of the best protocols and improve the likelihood of positive outcomes, it also decreases the chances of causing harm to the patient. In today’s environment of rising overdose episodes and often death, it has become even more crucial that professionals have the latest and best research information to drive cutting-edge protocols. Like any other medical condition, the goal is to do no harm while providing an accurate diagnosis, appropriate treatment, and recovery support.

A HISTORICAL NEED FOR CREDENTIALING

The evolution of the addiction treatment workforce in the U.S. occurred in part when those who had participated in treatment and/or entered recovery through the original 12-step program of Alcoholics Anonymous

“The professional credentialing of prevention and treatment providers is a keystone of INL’s global drug demand reduction effort.”

program were willing to help and support other individuals in need. This model was referred to as the “lay therapy” movement of the early 1900s (White, 1999).

By 1950, paraprofessionals/lay therapists had entered the field and the pre-eminent model of treatment, the Minnesota Model, was dependent on a group of professionals, many of whom had no formal training in the helping professions (Fisher & Harrison, 2009; Libretto, Weil, Nemes, Copland-Linger, & Johansson, 2004).

In 1967, the American Medical Association embraced the “disease concept” (Merta, 2001) which expanded the field’s overall understanding of the nature of addiction and the components of effective treatment. This greater understanding was followed by the creation of formalized training programs by the National Institute for Alcoholism and Alcohol Abuse (NIAAA) and the National Institute for Drug Abuse (NIDA). Over time, many other countries began to take notice of America’s growing reservoir of addiction research and adopted similar researched-based approaches and practices.

In the 1970s, formally educated and trained professionals began entering the addiction fields, particularly as counselors, based on their education and training, rather than on their recovery (Hosie, West, & Mackey, 1988). Those working in the helping professions began seeking minimal standards through the establishment of formal credentials and licensing. Since



When professional credentials for prevention and treatment providers are in place, then individuals, families, and communities all benefit.”

then, numerous credentialing bodies have emerged in the U.S., both at the national and state level, and in several other countries as a way of establishing standards for professionals to meet.

INL SUPPORTS PROFESSIONAL CREDENTIALING

The global DDR initiative funded by INL is committed to reducing the demand for drugs around the world through prevention, treatment, and recovery support. Research-supported curriculums are available to any country who wants to increase their services capacity with a well-trained workforce. Credentialing exams are available for any professional wanting to establish a basic minimal knowledge. Because of these new resources, governments, universities, and treatment centers can now improve their outcomes in preventing, treating, and supporting people in recovery.

INL’s DDR mission to professionalize the field is built upon its capacity to cultivate and ensure minimum standards for the prevention and treatment workforce. When prevention and treatment providers earn a professional credential that reflects those standards, the following benefits are within reach:

- Reduction in the possibility of harm by eliminating out-of-date modalities,
- Improvements in the lives of individuals, families, and communities with the latest best practices, and
- Passionate providers working in the field can earn the credibility they need and the recognition they deserve.

THE BIOLOGY OF DECISION MAKING AND DRUG DEPENDENCE



ANDREW THOMPSON, Ph.D.
Member of INL's Drug Demand Reduction Team

Substance use disorders are chronic, relapsing conditions characterized by preoccupation with acquiring or taking a drug, to the detriment of other healthy behaviors. Effective treatments for substance use disorders require long-term support and medical monitoring, because stress and cues related to the drug can trigger relapse even after long periods of abstinence. In fact, treatment success rates for substance use disorders are roughly the same as those for other chronic, relapsing diseases like asthma, diabetes, and hypertension.

These diseases also share similar patterns of causes and effects. In each case, genetic inheritance or exposure to certain environmental conditions causes a specific organ in the body to develop a defect or stop working properly, leading to widespread symptoms of the disease. For instance, diabetes can occur when a genetic dysfunction causes the immune system to destroy insulin-producing cells in the pancreas, or when a diet high in sugars and refined carbohydrates causes cells to become resistant to insulin. In both cases, the body loses its ability to automatically regulate blood sugar levels, and medical intervention and conscious behavioral and lifestyle changes are necessary. In substance use disorders, the organ that develops a defect is the brain, and as a result the body loses the ability to automatically make

appropriate decisions, requiring medical intervention and conscious changes to behavior and lifestyle.



In order to understand substance use disorders, it is necessary to understand how the brain normally learns about the world and makes decisions, and how genetic effects and exposure to drugs of abuse can lead to a defect in the decision-making apparatus within the brain.

THE HUMAN BRAIN AND DECISION-MAKING

The human brain is a 1.4 kilogram mass of approximately 170 billion cells. Roughly half of those cells provide nutrients, insulation, and defense to the other half, which perform most of the information processing functions of the brain. These 86 billion information-processing cells are called neurons. Neurons are specialized cells with the ability to receive signals from other neurons, make simple yes-or-no decisions, and transmit signals to other neurons across large distances. The simplest neural circuit

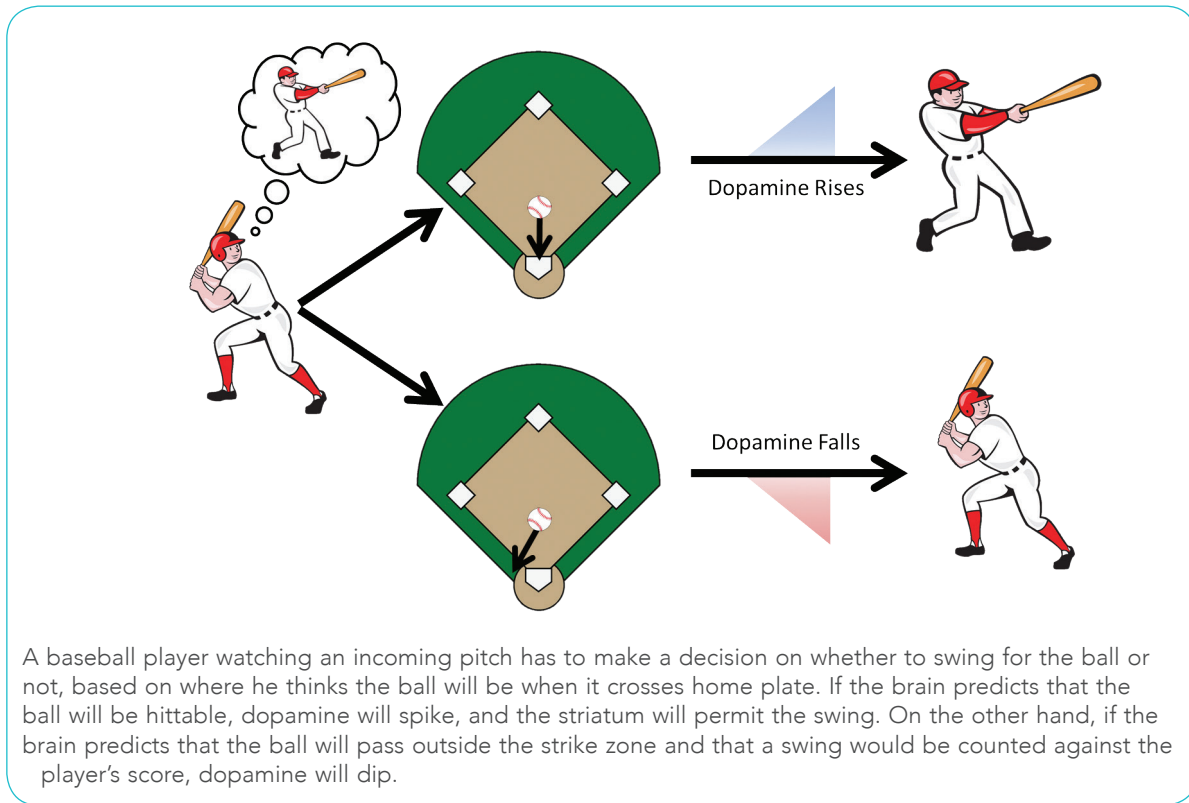
(a group of connected neurons that perform a function) is the reflex arc, which involves only 2 neurons: a sensory neuron which detects a stimulus and a motor neuron which moves a muscle in response. Slightly more complex neural circuits can involve other neurons between the sensory and motor neurons, and can make rudimentary decisions such as whether or not a stimulus is intense enough to meet a threshold for reaction. Adding more neurons into the circuit allows the system to detect more complicated stimuli, make more complicated decisions, and react with more complicated sets of actions. The entire human nervous system can be thought of as a scaled up version of these simple neural circuits: sensory neurons bring information about the outside world to the brain, the neurons in the brain make billions of tiny decisions about that information, and the instructions for how to react are sent out to the body. The output of this system is behavior.

While the human brain is complex organ, the neural process for decision-making is comparatively simple. It primarily involves two sections of the brain: the frontal cortex and the striatum. The frontal cortex is located on the surface of the front section of the brain, from just above the eyes to the top of the head. It is responsible for planning and estimating the value of potential actions, and for instructing the muscles to execute those actions. The striatum is a cluster of neurons deep inside the brain, and it is an intermediate stop for information between the planning and execution stages. The frontal cortex sends information about planned actions to the striatum, which returns a simple yes-or-no decision about whether the planned actions should be executed.

To make this yes-or-no decision, the cells in the striatum continuously track the levels of a chemical called dopamine, which is released in response to unexpected rewards

and to cues that predict expected rewards. Specialized molecules on the surface of neurons called dopamine receptors are activated by dopamine, and their level of activity determines the output of the striatum. When dopamine is high, indicating the potential for acquiring rewards, the striatum returns a “yes” signal, allowing planned actions to proceed. When dopamine is low, indicating that rewards are not available or that acting might prevent reward delivery, the striatum returns a “no” signal, preventing action. The “rewards” that are detected could be anything from a flavorful meal or a drink of water to academic achievement and social status. The magnitude of the reward is related to the level of dopamine, so opportunities for bigger rewards produce a bigger rush of dopamine and are more likely to be acted upon than smaller rewards.

Most of the time, dopamine rests at a neutral middle level, and small fluctuations in dopamine will affect behavior. For instance, a baseball player watching an incoming pitch has to make a decision on whether to swing for the ball or not, based on where he thinks the ball will be when it crosses home plate. His eyes register the location and direction of the ball and communicate that to his frontal cortex, which makes a prediction about where the ball will go and prepares to instruct the muscles to react with a swing. If the brain predicts that the ball will be hittable, dopamine will spike, and the striatum will permit the swing. On the other hand, if the brain predicts that the ball will pass outside the strike zone and that a swing would be counted against the player’s score, dopamine will dip and the striatum will arrest the planned action before it can be enacted. The brain relies on experience and expectations of the future to make that decision, and dopamine is the mediator that allows the decision to be enacted. This



same decision-making process is repeated thousands of times every second, with the striatum weighing in on every fidget, eye blink, and keystroke.

IMPULSIVITY AND DRUG USE

There is naturally occurring variation in sensitivity to dopamine fluctuations. Some people naturally have lower levels of the dopamine receptor which detects dips in dopamine, meaning that small dips in dopamine might be missed, and actions that might otherwise have been stopped will be carried out. Because of this, these people have a tendency to act even when it might not be appropriate, which may appear like an inability to control impulses or a tendency to act without thinking. This tendency to engage in reward pursuit and consumption despite associated risks or costs is called impulsivity, and it is a fairly common trait. Many impulsive people benefit from taking risks and making quick decisions. However, impulsive behavior can also be intrusive, harmful, and disruptive,

and impulsivity can be a risk factor for the development of substance use disorders.

In addition to the finding that impulsive people have naturally lower levels of this dopamine receptor, studies have shown that exposure to drugs of abuse can decrease the level of the dopamine receptor and increase impulsive behavior.

Impulsivity therefore serves as both a cause and a consequence of substance use disorder: some brains are naturally inclined to be more impulsive and therefore more likely to try drugs or less able to stop taking drugs, and drugs can rewire brains to increase impulsive behaviors and make continued drug use more likely despite negative consequences.

The reason that drugs of abuse are able to alter behavior is that many of them mimic or enhance the dopamine signal. Different drugs do this differently: for example, opioids cause the dopamine-releasing neurons to be more active, and cocaine prevents dopamine from being recycled after it is released. In both cases, dopamine builds up and the brain's ability to prevent actions is impaired. Like the baseball player making a decision about whether or not to swing the bat based on his prediction of the value of that swing, a person considering taking a drug of abuse must make a decision about executing the actions necessary to acquire and take the drug based on their predictions of the reward value of those actions. However, even if they appropriately weigh the value of sobriety vs. the reward value of taking the drug, they may still execute the drug-associated actions because striatum cannot detect the dopamine dips that would otherwise arrest those actions. The effect of drugs on the striatum is therefore like the effect of a magnet on a compass: the strength of the reward signal produced by the drug overrides the strength of the reward signals generated by other natural rewards, and long-term or repeated exposure can permanently alter the brain's ability to inhibit impulses and make appropriate decisions.

IMPLICATIONS FOR TREATMENT

The single most important thing we can learn from understanding the biology of substance use disorder is that it truly is a disease.

Additionally, a biological understanding of substance use disorder encourages recovery: dopamine receptor levels can recover after drug exposure over time and with training, and impulsive behaviors can be managed. Treatment strategies like contingency management, which takes advantage of



When we think of people with substance use disorders as patients with an impulsive decision-making tendency rooted in biology rather than as addicts or criminals with a moral failing, we are better able to empathize and form a helping therapeutic relationship.

impulsivity by directly rewarding healthy behavior, and cognitive-behavioral therapy, which can help patients recognize and manage impulsive tendencies, are very successful practices for treating substance use disorders. Medication-assisted therapy, by directly affecting the biological structures of decision-making, can also be an important part of a treatment program.

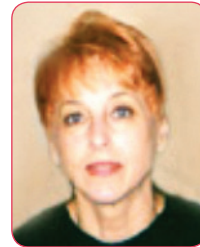
Regardless of the strategy used to promote abstinence and behavior change during treatment, it is vital that support and medical monitoring continue after the treatment has finished. Just like other chronic disorders, success in establishing symptom remission relies on long term adherence to a medication regimen and/or behavioral changes. Lapses and relapses occurring after treatment has ended should be considered evidence for the effectiveness of treatment, and for the need to retain patients in long-term medical monitoring following treatment. Understanding the fundamental biology of substance use disorder is critical for the development of an effective treatment workforce.

A PIRE RETROSPECTIVE: INL EVALUATIONS THROUGH THE YEARS



MATTHEW COURSER, Ph.D

Research Methodologist and Monitoring and Evaluation (M&E) Specialist



LINDA YOUNG, M.A.

Research Design, Data Collection and Project Implementation Specialist

The Pacific Institute for Research and Evaluation (PIRE) is a non-profit research organization that has worked as an evaluation partner of INL since 1997. PIRE staff members have conducted evaluations of prevention and treatment programs and of law enforcement training programs in countries such as Brazil, Thailand, Peru, El Salvador, and Afghanistan. The focus of this retrospective article is on the evaluation of treatment programs and treatment systems and highlights PIRE's experience in designing and implementing evaluations of treatment and training programs around the world.

WHY PROGRAM EVALUATIONS MATTER

Program evaluation is the systematic application of scientific research methods to assess the design, implementation, improvement or outcomes of a program (Rossi & Freeman, 1993; Short, Hennessy, & Campbell, 1996). Program evaluation is important for three key reasons:

- First, accountability. Many programs are funded with tax dollars. As a result, confirming program effectiveness and ensuring that the public investment

“Essentially, the results of specific evaluations can generate knowledge that provides new insight and moves researchers, policymakers, and practitioners forward in how they think about and address important public health issues.

provides real value to stakeholders and communities is important (Moore, 1997).

- Second, evaluation results can be used for developmental purposes--to help program staff understand how to improve or further develop a program, or to improve the performance of a program.
- Third, evaluation data generates knowledge. This knowledge can be used to improve the collective understanding and explanation of a problem or phenomena and can impact approaches used by practitioners to address it. Essentially, the results of specific evaluations can generate knowledge that provides new insight

and moves researchers, policymakers, and practitioners forward in how they think about and address important public health issues.

EVALUATING SUBSTANCE USE DISORDER TREATMENT PROGRAMS

Substance use disorder (SUD) treatment can be overwhelming for health systems, families and individuals struggling with addiction. Treatment program evaluations are intended to determine whether or not substance use treatment programs are reducing participants' use of substances and reducing involvement in problems related to substance abuse, such as criminal activity. Evaluations of treatment programs are designed to measure whether the specific goals and objectives of a treatment program are being reached and whether the program is having the intended impact on the population served by the treatment program. Many factors are considered when designing a treatment evaluation including the treatment environment, the community context, the treatment modality (i.e., whether the program provides inpatient/residential, outpatient or home-based treatment, and whether it functions as a drop-in center or shelter), characteristics of the population served (i.e., demographics such as age and gender), and whether the treatment program serves patients who enter voluntarily or if the center participates in mandatory treatment mandated by a court system. Additional factors often included in treatment evaluations include the characteristics of the staff of the treatment programs, their level of education and the amount of training they have received regarding substance abuse, the program model that is being implemented, the planned length of treatment, and whether the program offers follow up support and family involvement.

Evaluating a treatment program involves collecting data at multiple time points from patients (usually upon entering treatment or completing the detox process and then again when the planned treatment has been completed). Data collected from patients as part of treatment evaluations often includes questionnaire/survey data and may include biomarkers such as hair, blood, or saliva, depending on the substances most commonly used by the population served by the program. Evaluations of treatment programs often also include surveys of treatment program staff and administrators and may include data elements from operational records and from individual patient records.

EVALUATING TREATMENT SYSTEMS

Treatment evaluations often focus on assessing treatment outcomes for an entire treatment system within a country or for a set of treatment programs in a defined geographic area (such as a state or province). Although evaluations of treatment programs can be scaled up to include multiple programs, evaluating a treatment system brings special challenges. Depending on the number of treatment programs, the size of the geographic area, and the number of treatment modalities utilized by treatment programs, sampling procedures may be needed to ensure that the results of the evaluation can be generalized to the entire treatment system and/or participants of the treatment program. In addition, if a group of treatment programs or an entire treatment system is to be evaluated, buy-in of treatment program directors, stakeholders, and government officials is important.

SAFEGUARDING TREATMENT PATIENT RIGHTS AND PRIVACY

A critical aspect of any treatment evaluation involves ensuring that first, the rights of treatment patients are respected during the evaluation and second, that personally identifiable patient information is kept strictly confidential. Patients seeking substance use disorder treatment are vulnerable. Patients often manifest physical, mental, or emotional distress as a result of their drug use. In addition, drug use and addiction comes with stigma that can result in patients being ostracized by their families, employers, and communities. In many areas of the world, drug use is not only stigmatizing but also illegal. As a result, information about specific patients must be kept strictly confidential and safeguards must be taken to ensure that patient information is secured by the evaluation team--both during and after the evaluation--and not shared with government officials or anyone else outside of the research team. In addition, because patients may be in physical or emotional distress during and after treatment, researchers must take care to ensure that the research instruments, procedures, and protocols do not harm vulnerable patients. In many cases, the instruments, protocols and procedures in treatment evaluations must be reviewed and approved by an Institutional Review Board (IRB) or Research Ethics Committee (EC) prior to the evaluation being conducted.



A critical aspect of any treatment evaluation involves ensuring that first, the rights of treatment patients are respected during the evaluation and second, that personally identifiable patient information is kept strictly confidential.

DESIGNING AND CONDUCTING EVALUATIONS OF TREATMENT PROGRAMS

- Meet with the funder and stakeholders
- Determine the research questions and/or the key outcomes to be measured
- Map the treatment program (or treatment programs)
- Determine evaluability of the treatment programs or treatment system
- Identify constructs, key measures, and sources for those data
- Determine the research design
- Create instruments and data collection procedures
- Human subjects' protection review
- Identify a field team and collect data
- Report data to funder, stakeholders, and programs

The steps above illustrate the process of planning, designing, and conducting an evaluation of treatment programs or treatment systems. Depending on the context, the order of the steps below may shift or a number of steps may happen simultaneously.

01. *Meet with the funder and stakeholders.*

Evaluations of treatment systems often are expensive to conduct and take at least a year (often multiple years) to complete. Engaging the funder of the evaluation and stakeholders such as program managers, members of public health agencies, and staff from government drug demand reduction agencies is a critical first step in designing an evaluation of a treatment program or treatment system. This meeting will allow the evaluation team to understand the practical or policy need that is driving the need for an evaluation.

02. Determine the research questions and/or the key outcomes to be measured.

This step—often completed in conjunction with the meeting with funders and stakeholders—is key as the research questions and outcomes of interest will determine many other aspects of the design of the evaluation. Examples of important issues to consider:

- Is the evaluation focused just on changes in drug use?
- Is it also focused on related problems such as criminal behavior?
- Are there contextual factors (such as patient participation in treatment activities and whether the treatment program implements all activities as planned) that also are of interest?

Matching the scope of the evaluation to what is feasible given time and resource constraints is critical at this point in the design process.

03. Map the treatment program (or treatment programs).

If the evaluation is to focus on one treatment model or program, collect basic details about the program to create a “map” of the treatment program and the services it provides. If the evaluation includes multiple programs or an entire treatment system, then mapping becomes even more important. In many countries, there is no listing of treatment programs and no official records of the types of treatment provided to patients. Treatment maps allow the evaluators to collect basic information about the treatment programs within the larger treatment system. Both WHO and INL have developed mapping templates that can be used to collect and organize basic details about treatment programs.

04. Determine evaluability of the treatment programs or treatment system.

Once a treatment map has been completed, the next step is to assess whether the treatment program(s) included in the evaluation can be evaluated. Outcome evaluations require that a program being evaluated is well established and structured (i.e., there is a well-defined set of prescribed treatment strategies and activities) and that the program has the capacity to support planned data collection efforts. Sometimes, pilot studies or feasibility studies are needed to determine “evaluability” before a rigorous full-scale evaluation can be conducted.

05. Identify constructs, key measures, and sources for those data.

The next step is to identify key constructs or types of data to collect (such as drug use, criminal behavior) and measures (such as specific types of drug use, involvement in specific criminal behaviors, participation in treatment activities, etc.) to include in the evaluation. Constructs and measures should be linked directly to the evaluation’s guiding research questions and outcomes. In addition to identifying specific constructs and measures, it is important at this stage also to identify how each measure will be collected.

06. Determine the research design.

The research design is a key consideration and is determined by a number of factors, including funding, the amount of available time for the evaluation. In many cases, a pre-test/post-test design (in which patients are followed during and after their treatment) will be the best design for an evaluation of a treatment program.

07. Create instruments and data collection procedures.

The next step is to create data collection instruments and procedures to guide data collection. In many treatment evaluations,

■■■ A PIRE RETROSPECTIVE

a survey of patients is created as well as a survey of program staff. Because some data for the evaluation may come from treatment records or from drug tests with patients, it is important also to develop data collection forms and procedures for collecting and recording these data elements.

08. Human subjects' protection review.

Once instruments and data collection procedures have been developed, they should be submitted to an IRB or Ethics Committee for review. Depending on the country, there may be more than one committee that could require a review of human subjects' involvement in research and proposed protection strategies may need to be reviewed and approved at varying levels.

09. Identify a field team and collect data.

The next step is to determine how data will be collected and when to begin the data collection process. Although it is possible in some cases to rely on program staff to collect data, in many cases treatment programs will not have the staffing resources needed to collect data and outside data collectors will need to be used for the evaluation. It is important to monitor the data collection process and to integrate quality assurance checks into the data collection process.

10. Report data to funder, stakeholders, and programs.

The final stage of the evaluation is to analyze the data collected and develop a report on the outcomes of the evaluation. Typically, this report will answer the research questions developed during the design of the evaluation. If the results of the evaluation are being shared back with participating treatment programs, it is a good idea to create a short, non-technical report that can be easily understood.

HOW HAVE THE FINDINGS OF INL-FUNDED EVALUATIONS BEEN USED?

Findings from INL prevention and treatment evaluations have supported the work of INL in multiple ways. Evaluation results have helped INL meet its reporting requirements to the U.S. Congress. In addition, the findings from these evaluations have been used by INL to set policy and for program improvement. For example, in 2006 PIRE conducted an evaluation of the PROERD (DARE) program in Sao Paulo, Brazil. Our evaluation found that the program did not impact youth drug use rates or prevent youth drug use. As a result of the evaluation, INL decided not to continue funding for the PROERD program in Sao Paulo. In 2012, PIRE completed an evaluation of seven inpatient treatment centers in Afghanistan. We found that patients who completed treatment had reductions in illicit drug use and in criminal behavior. The evaluation results were most positive for patients who completed inpatient treatment and at least one year of outpatient treatment. Based in part on these evaluation results, INL has provided continuing support for the Afghan treatment system, has expanded the number of centers receiving funding, and worked with project partners to adjust the treatment map and monitoring program to help ensure that patients complete their planned course of treatment.

“Evaluation results have helped INL meet its reporting requirements to the U.S. Congress. In addition, the findings from these evaluations have been used by INL to set policy and for program improvement.”

The sections below that detail some of the findings from a few of PIRE conducted evaluations further highlight how the results from evaluations have been used.

BENEFITS TO THE UNITED STATES FROM CONDUCTING INTERNATIONAL TREATMENT EVALUATIONS

Although the evaluations that PIRE has conducted have been focused on specific countries and on prevention and treatment programs within those countries, the evaluations have brought significant benefits to the United States, including the following:

- The knowledge gained from PIRE's evaluations about what works (and how it works) has direct application to the U.S. treatment system and can be used to improve the effectiveness and reach of treatment services in the United States.
- The U.S. is a culturally diverse country and as such, the serious impact of substance use disorders is experienced by members of numerous ethnic groups who may seek treatment in the U.S. The INL evaluations conducted in other countries have provided important insights into how cultural contexts and experiences can influence prevention and treatment approaches and outcomes.
- INL-funded evaluations have created highly-skilled, cross-institution, multidisciplinary teams of U.S. researchers who have specialized experience evaluating treatment programs and systems.

It is worth noting that it is very difficult to conduct treatment evaluations in the United States due to most treatment programs being privately owned and funded on a fee-for-service basis by private insurance companies and/or the Medicaid program. This funding approach for treatment means

that most domestic treatment programs do not have the staff time necessary to cooperate with an evaluation. In addition, there are many different treatment models, modalities, and approaches in the United States (<https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/drug-addiction-treatment-in-united-states>). These practical constraints negatively impact the evaluability of the U.S. treatment system. Treatment programs and systems in other countries often are less complex and funded differently, meaning that it is often more feasible to conduct treatment evaluations in other countries.

Evaluations that could not be conducted practically in the United States often can be conducted in other countries.



EVALUATION PROJECT HIGHLIGHTS

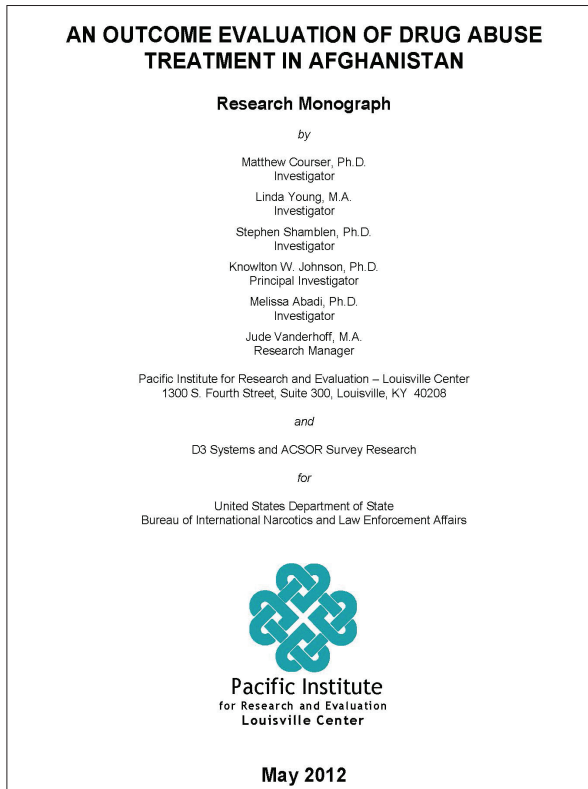
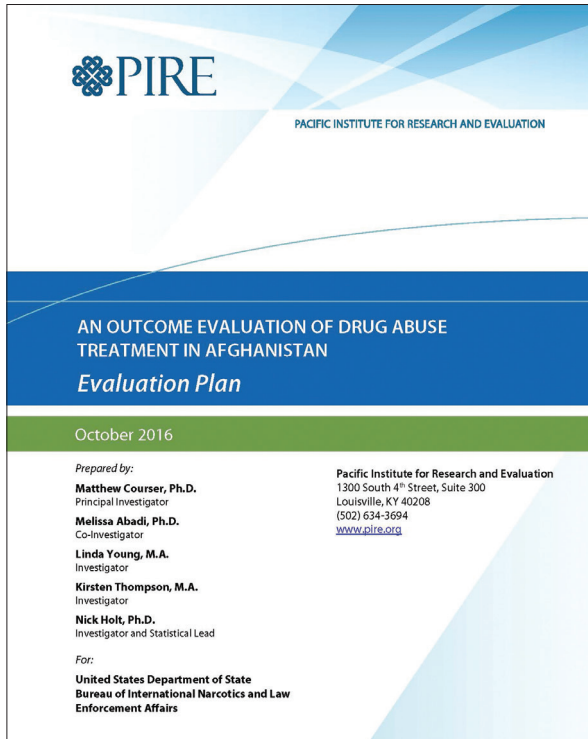
Afghanistan Treatment Evaluation

Between 2010 and 2012, PIRE conducted a pre-post evaluation of seven residential drug abuse treatment centers for men and women in Afghanistan. Primary aims of the evaluation were to assess patients' pre-post change in illegal drug use, alcohol use, and criminal behavior after completing outpatient treatment and to assess treatment implementation of the Colombo treatment model in the participating drug abuse treatment (DAT) centers. The seven centers participating in the evaluation were located in cities of Kabul, Wardak, Paktia, Takhar, Balkh, Bamyán, and Herat. Four of these DAT Centers served males exclusively, and three served women and children. Highlights of the evaluation included:

- In the 30 days prior to treatment, 85% of patients reported using at least one illegal drug (benzodiazepines, drugs

■ ■ ■ A PIRE RETROSPECTIVE

containing THC, opiates, oxycodone, or methamphetamines). At the time of the post-test interview, 75% of patients used at least one illegal drug, a 12% decrease relative to the baseline prevalence. This decrease was statistically significant.



- In the 30 days prior to treatment, 84% of patients reported using opiates. At the time of the post-test interview, 58% of patients used at least one illegal drug, a 31% decrease relative to the baseline prevalence. This decrease was statistically significant.
- The prevalence of self-reported serious crimes (such as robbery, arson, and violence against others) in the past month decreased from 13% at baseline to 8% at post-test, a 40% reduction relative to the baseline percentage. This reduction was statistically significant.
- Patients who completed outpatient treatment were six times more likely to have a reduction in any illegal drug use and almost five times more likely to have a reduction in opiate use from pre-test to post-test.
- Patients who reported completing prior drug treatment were twice as likely (OR=2.01) to have a reduction in opiate use from pre-test to post-test.

Evaluation of the International Law Enforcement Academy (ILEA)-Bangkok Supervisor Criminal Investigation Course (SCIC)

Established in 1998 through a Bilateral Agreement between the United States and Thailand, the ILEA-Bangkok training focuses on enhancing the effectiveness of regional cooperation against the principal transnational criminal trends in Southeast Asia - illicit drug trafficking, financial crimes, and alien smuggling. The U.S. Drug Enforcement Agency in collaboration with the Royal Thai Police serve as the coordinating leaders overseeing the implementation of the SCIC training which is presented by experts representing both U.S. and Asian law enforcement agencies.

The SCIC is a management course that provides thirty days of classroom instruction. In addition, specialized courses on counter-narcotics, computer crimes, facility security, intellectual property rights and other pertinent topics complement the training protocol. The PIRE evaluation conducted between 2000 and 2003 was designed to assess the quality and effectiveness of the training and involved, collecting data from law enforcement officers representing twelve Southeast Asian countries. Highlights of the evaluation findings included the following:

- More than 75 percent of ILEA-Bangkok students rated the training favorably with regard to trainers' performance, training content and methods, training environment, cultural sensitivity, perceived usefulness, time allocation per module, and level of module difficulty.
- Trainees maintained a high level of commitment to using the training information presented during the SCIC course six months after completing the course.
- In addition, there was a significant increase in students' actual use of the training information when comparing level of use before the training and at a six-month follow-up.

Works Cited

Moore 1997 *Creating Public Value: Strategic Management in Government*
Rossi & Freeman, 1993;
Short, Hennessy, & Campbell, 1996

INL DDR ACTIVITIES IN 2017



The INL DDR Team

CONDUCTED

46 MISSIONS

TO **30**

COUNTRIES

IN 2017

in an effort to deliver programmatic services, support Embassy personnel, participate in national and regional events, and complete assessments of emerging issues.

The following pages summarize the missions.

NORTH AMERICA

1 MONTREAL, CANADA

NIDA International Forum

The U.S. National Institute on Drug Abuse (NIDA) and Canada's Center on Substance Abuse and Addiction (CCSA) co-hosted NIDA's Annual meeting of international researchers, bringing together nearly 200 participants from around the world to present the latest studies and research on drug addiction. INL provided remarks during the opening evening, focusing on its partnership with international organizations to develop curricula using the latest evidence-based science to train and credential more addiction professionals globally. (June 16-19)



Steve Gust, International Director for NIDA, Charlotte Sisson, INL/PC Drug Demand Reduction Team Lead, and Antonius Riva Setiawan, ISSUP.

2 SAN DIEGO, CALIFORNIA

University of California at San Diego Addiction Studies Seminar

A group of addiction experts met to (1) share latest research findings in the field of DDR, including on the genetics of substance use disorders, (2) learn about the education of addiction professionals from Hazelton/Betty Ford Foundation, and (3) learn about research on marijuana. The Director of California's Prison System, Scott Kernan, also gave a presentation on the corrections system in California. INL briefed on INL's global DDR programs and encouraged the audience to become a member of the International Society of Substance Use Prevention and Treatment Professionals (ISSUP). Colombo Plan CEO and former Director of INL Demand Reduction Thom Browne gave a presentation on the public health effects of toxic adulterants found in drugs. University attendees are interested in the State Department's work in international drug demand reduction and would like to identify opportunities for future cooperation. (June 14-15)

3 WASHINGTON, D.C.

ISSUP Executive Committee Meeting

The Executive Committee met in Washington to develop their workplan for 2018. INL was invited to participate in the meetings. (September 17-19)

4 WASHINGTON, D.C.

International Consortium of Universities Creates an Executive Board

Leaders of the INL-supported International Consortium of Universities for Drug Demand Reduction (ICUDDR), met in Washington, D.C. to discuss formalizing their organization. Requests to join this group of universities continued to expand since the first meeting in May 2016, from 20 universities to over 100. Meeting participants agreed that the main goal should be to rapidly improve training of the substance use disorders workforce at the academic level, using the INL-developed Universal Prevention and Treatment Curricula. The meeting resulted in the nominations of an interim President from Charles University in Prague and nominations for an executive board composed of representatives from universities in North America, South America, Europe, Africa, the Middle East, South and Central Asia, East Asia and the Pacific. (September 28)



5 WASHINGTON, D.C.

Development of a New “Universal Recovery Curriculum” Training Series

INL chaired an Expert Working Group (EWG) meeting to review existing curriculum and develop a new series for recovery support workers. A panel of 12 recovery experts from North America, Europe, Latin America, and Africa developed an outline for the first hands-on, interactive course entitled, *Recovery Support Services*. The course will train peer mentors to effectively engage with others in varying stages of recovery from substance use disorders. The curriculum represents a collaborative effort between INL’s international drug demand reduction partners: Colombo Plan, UNODC, OAS/ CICAD, SAMHSA, and ONDCP. (August 7-8)



6 MIAMI, FLORIDA

OAS/CICAD Demand Reduction Expert Group Meeting:

INL participated in a Demand Reduction Expert Group Forum organized by the Organization of American States’ (OAS) Inter-American Drug Abuse Control Commission (CICAD). Sixteen member states, as well as the UNODC, the EU and

WHO, sent representatives to identify and address current obstacles in applying drug prevention and treatment programming in the region. Following INL's presentation highlighting its support for CICAD, UNODC and the Colombo Plan activities in the Hemisphere, several states expressed interest in integrating these programs into their national strategies. (March 7-8)

7 MEXICO CITY, MEXICO

Building Support for Mexican Government and Civil Society Participation in a Global Event:

INL's Mission in partnership with the Embassy Mexico City's was focused on building a common vision with CONADIC (Mexico's National Anti-Drug Addiction Commission) and Mexican NGO CIJ (the Youth Integration Center) on planning for the International Society of Substance Use Professionals (ISSUP) training event. The ISSUP event was co-organized with a scheduled Mexican international congress in Cancun in December and this mission resulted in a partnership between CONADIC and CIJ to conduct a joint training of trainers who would co-train at the ISSUP event. (April 3-5)

8 & 9 CANCUN, MEXICO

ISSUP-3 Workshop:

The annual global conference for the addictions workforce took place together with the 19th International Congress on Addictions organized by Centros de Integración Juvenil (CIJ), with over 2,500 participants from 71 countries. The event included 20 concurrent trainings, expert meetings, and special events. One of those events was the first global Lab Director's meeting to review toxic adulterants found in illicit drugs and was held with over 17 countries in attendance resulting in the agreement to develop a database for an early warning system for toxic adulterants. (April 6-7 preparatory mission, Dec. 4-8 event)



Acting Assistant Secretary Walsh delivers remarks at ISSUP Opening Ceremony with ISSUP Executive Director, Mexico's Youth Integration Centers (CIJ) Director, Mexico's General Director of Services and Treatment, CONADIC, Mexico's Secretary of Health and General Director of the State Health Services in Quintana Roo and international organizations from UNODC, Colombo Plan, the World Health Organization, and the Organization of American States.

SOUTH AMERICA

10 BOGOTA, COLOMBIA

DDR Children’s Project Site Visit

INL/PC visited Semillas de Amor (Seeds of Love), a residential treatment center in Bogota which houses more than 100 girls aged 10 to 18. Substance abuse, prostitution and family abandonment leads them to the 9 to 12-month program where they learn to increase their self-esteem levels and cultivate interpersonal, social and professional skills. Center staff have received training from INL in the past and prominently display their certificates. The center was invited and welcomed to join the INL-supported Latin American children’s network.

(May 26)



11 CARTAGENA, COLOMBIA

Western Hemisphere Experts Meet to Develop a Curriculum for Public Health Professionals

CICAD hosted an Expert Working Group (EWG) meeting with the Spanish government in Cartagena, Colombia. Health professionals and bureaucrats from more than 30 Western Hemisphere countries attended. International organizations COPOLAD, UNODC and Cooperación Española also participated. Delegates discussed challenges of providing substance use treatment services in Latin America and solicited feedback on a CICAD-drafted trainer manual to enhance medical providers’ knowledge of treating individuals with problematic substance use. (May 30-June 2)

12 LIMA, PERU

Meeting on Universal Prevention Curriculum Evaluation

INL met with embassy and host government counterparts, visited a children’s treatment center, and met with INL training implementers. Peruvians expressed enthusiasm to collaborate with INL to expand the demand reduction workforce development in four areas: 1) women’s treatment - INL grantee CARE Peru disseminated INL’s 10-week women’s treatment training to 468 public health professionals in Lima using their network of 41 national trainers. Soon they will train an additional 360 professionals in 6 regions beyond the nation’s capital; 2) LGBTQI training – Peru’s new drug strategy mandates drug treatment access for LGBTQI individuals. INL prepared for the piloting of its new LGBTQI course in Peru; 3) prevention training and evaluation – Cayetano Heredia University will teach

INL's Universal Prevention Curriculum (UPC) to a number of public schools in Lima, and an evaluation will determine whether the training of teachers/administrators has a measurable impact on youth drug use and risky behaviors; and 4) children's treatment training - Instituto Mundo Libre, a children's drug treatment center which received INL support throughout the 1990s and 2000s, will now be included in INL's child treatment training program to improve clinical practice and better reintegrate vulnerable children in recovery into society. (May 22-23)



13 QUITO AND GUAYAQUIL, ECUADOR

Demand Reduction Assessment

INL conducted its first mission to Ecuador to explore opportunities for collaboration in addressing addiction. All actors from national to local governments, civil society actors, and university representatives were enthusiastic about the potential for collaboration with the U.S. Embassy on INL programming. Consumption in Ecuador varies by region, with the most widespread consumption in Guayaquil, particularly with the toxic substance known as "H." The visit was timely given the development of Ecuador's new National Drug Control Strategy. (November 13-16)



14 SANTIAGO, CHILE

Development of Drug Treatment Curriculum for LGBTQI Populations with Special Clinical Needs

INL chaired an Expert Working Group (EWG), hosted by Chilean government's anti-narcotics agency, SENDA. The five LGBTQI drug treatment experts from Argentina, Chile, and the United States outlined a hands-on, interactive course entitled, *The Intersection of Substance Use and Sexual Orientation and Gender Identity (SOGI)*. The course trains clinicians in specific considerations when providing drug treatment to the LGBTQI community. The development, peer review and ultimate dissemination of the envisioned course represents a collaborative effort between the Colombo Plan, UNODC, OAS, and U.S. Interagency counterparts at the Department of Health and Human Services. (May 22-24)

15 SANTIAGO, CHILE

CICAD DDR Experts Meeting

INL represented the United States at the August 22-24 Organization of American States (OAS) Inter-American Drug Abuse Control Commission (CICAD) Drug Demand Reduction Expert Group. Participants at the DDR expert meeting, chaired by the CICAD Executive Secretary, Chile's National Service for the Prevention and Rehabilitation of Drug and Alcohol Consumption (SENDA), and the European Union Cooperation Programme on Drugs Policies (COPOLAD) identified three key themes: 1) the need to focus on the cause of use, rather than the substance; 2) the continued need to address recovery in addition to drug use prevention and treatment; and 3) the need to identify and track indicators of success. (August 22-24)

16 ASUNCION, PARAGUAY

Children's Program Site Visits

INL reviewed implementation of an INL-supported children's prevention and treatment program, and toured four interconnected treatment centers funded by Paraguay's Ministry of Health and Ministry of Children and Adolescents, which already have or are slated to receive Universal Treatment Curriculum (UTC) and Universal Prevention Curriculum (UPC) training. INL also engaged for the first time with the Paraguay National Police (PNP) Center of Education, which maintains eight educator-trainers. These specialized officers conduct prevention outreach in public elementary, middle, and high schools nation-wide and reached an impressive 35,000 students and teachers in 2016. INL introduced the UPC and invited PNP to participate in future training, which was enthusiastically welcomed. (June 15-16)



Children aged 8-12 participate in an INL-supported afterschool UPC program.

17 SAO PAULO & CAMPINAS, BRAZIL

DDR Mission Identifies New Drug Prevention Partner

INL-trained NGO and government partners at the both the state and city levels displayed excellent demand reduction coordination. Sao Paulo State Secretary for Social Development, Floriano Pesaro, agreed that his ministry will translate the Universal Prevention Curriculum (UPC) to Portuguese, which will support INL efforts to expand drug use prevention work in Brazil with civil society organizations and to other Portuguese-speaking countries. Furthermore, Consulate General Sao Paulo was actively engaged during the visit and is an advocate for DDR equities. (June 12-14)

WEST AFRICA

18 DAKAR, SENEGAL

Exploring Training Opportunities to Strengthen Treatment and Prevention

INL met with several Senegalese government officials and NGO staff to learn about current drug consumption trends and drug use challenges. In addition to the rise in the consumption of cocaine, heroin and opioids, like tramadol and codeine, Senegal's DDR partners also lament the effects of car exhaust inhalation among its street kid population (locally known as Talibé). While Senegalese government and NGO partners are motivated to address addiction, they described their lack of drug prevention and treatment training materials as a major obstacle. INL also explored a partnership with the University of Dakar in developing a treatment professional university program. Further, several NGOs that specialize in helping prevent and treat drug use among children expressed interest in INL's specialized curriculum for children. (September 7-8)



19 ABIJAN, COTE D'IVOIRE

Cote d'Ivoire Government to Expand on DDR commitments

INL meetings in Cote d'Ivoire (CDI) retraced the 2014 launch of the UTC in francophone West Africa through a partnership with Cote d'Ivoire. Collaboration since has produced three UTC Master Trainers in CDI who have in turn trained more than 40 public health professionals in CDI, Togo and Benin. In a roundtable meeting with the Ministry of Health and other DDR stakeholders, UTC Master Trainers committed to working with all relevant parties to devise a UTC national dissemination strategy. General Krouma Mamadou, Secretary General of CDI's drug secretariat, emphasized his agency's commitment to not only treat and prevent drug use with evidence based practices, but also to make formal policy changes that buttress the fact that addiction is a brain disease. For example, a draft law was under development for CDI's legislative body to drastically reduce minimum prison sentences for drug possession for personal use (currently 3 years). (September 1-6)



20 ABUJA, NIGERIA

Nigeria Commits to Large-Scale UTC Training Initiative

INL strategized with Nigerian counterparts on the nationwide dissemination of the Universal Treatment Curriculum (UTC). The Federal Neuro-Psychiatric Hospital Yaba, Nigeria’s largest psychiatric health unit with drug treatment services, signed an Education Provider Memorandum of Agreement with the Colombo Plan to work with seven partnering organizations to cost-share and train the curriculum. Nigeria’s National Drug Law Enforcement Agency (NDLEA) has promised to dedicate resources for training as part of its drug demand reduction strategy. While Yaba hospital organizes trainings from Lagos, NDLEA and UNODC will coordinate training for the rest of Nigeria via six regional training centers spread throughout the country, operated by the Federal Ministry of Health. This ambitious effort to ratchet up drug demand initiatives complements INL’s strong record of assisting the Nigerian government with drug supply reduction initiatives. (August 28-31)



EAST AFRICA

21 NAIROBI, KENYA

Preparation for the ISSUP-4 Annual Workshop

INL began working with international partners in late 2017 on preparations for the fourth annual workshop in African, December 10-14, 2018. Given existing partnerships and a strong drug demand reduction models on the continent, ISSUP, the African Union (AU), and INL identified Kenya as the leading location for the Africa event. From November 13-17, INL joined representatives from the AU and the ISSUP Board for meetings in Nairobi with potential ISSUP-4 partners. The team met with Kenya's National Authority for the Campaign Against Drug and Alcohol Abuse (NACADA); Ministry of Health; Ministry of Public Service, Youth, and Gender Affairs; UNODC; Kenyatta University, the Supreme Council of Kenya Muslims; and, Community Anti-Drug Coalitions of Kenya. All interlocutors offered tangible commitments so that Kenya could serve as the location of ISSUP 4. INL also briefed U.S. Embassy Nairobi. (November 13-17)



The ISSUP-4 planning team meets with Kenyan Ministry of Public Service, Youth, and Gender Affairs officials.

22 ADDIS ABABA, ETHIOPIA

African Union Ministers Meeting and Project Training

Member states focused on the AU Plan of Action for Drug Control, cited progress in expanding treatment and prevention, but called for more resources in these and other areas of drug policy. The AU Epidemiology Project was praised and received strong support. The first training session for experts of countries participating in the project took place. There was also interest in the International Society of Substance Use Prevention and Treatment Professionals (ISSUP). AU Commission officials said they would support global meeting of ISSUP in Africa in 2018. (March 20-24)



African Union, Colombo Plan, and INL participants and observers of AU meeting.

NORTH AFRICA

23 TUNIS, TUNISIA

African Union Continental Consultation – Progress on Improving Drug Use Information and Workforce Development

At its annual meeting, the AU’s Drug Demand Reduction Experts Meeting decided to expand the INL-funded epidemiology project to improve data on drug use in Africa. This decision follows a pilot phase for Angola, Cameroon, Tanzania, Uganda, and Zambia to combine information from four countries that already have good epidemiological systems in place (Kenya, Nigeria, Senegal, and South Africa). AU countries also showed strong interest in joining the Universal Treatment Curriculum and the Universal Prevention Curriculum programs. The Colombo Plan and INL estimated that 10 countries are serious about making formal requests. Currently 13 of the 54 member states of the African Union have participated in these programs. (November 1-3)



Dr. Isidore Obote briefs AU countries on AU Epidemiology Project

24 TUNIS, TUNISIA

Epidemiology Site Visit

Tunisia’s National Drug Authority, Ministry of Health, non-governmental organizations, and demand reduction experts have excellent systems of drug demand information and expressed strong interest in the AU project, the UTC and other Colombo Plan curricula. Dr. Nabil Ben Salah, Director General of the Center and President of the Tunisian Society on Addiction; Dr. Hajer Skhiri, Director of the National Health Institute, Hafidha Okbi, Director, National Narcotics Office, and Dr. Hedili Abderrazek, Head of Tunisia’s National Laboratory, described the situation in Tunisia. Tunisian authorities and experts believe the the AU project will improve its ability to identify drug use and support the goals of the new Tunisian Drug Observatory. (November 6-8)



Senior AU and Tunisian drug demand officials during site visit to Tunis.

EUROPE

25 VIENNA, AUSTRIA

Commission on Narcotic Drugs (CND)

INL participated in the 60th Convention on Narcotic Drugs from March 13-17 in Vienna, Austria. Together with U.S. interagency partners, INL helped secure international control of the two most prevalent fentanyl precursor chemicals, and helped to raise awareness of the threats posed by the opioid crisis and synthetic drugs. (March 13-17)

26 PRAGUE, CZECHIA

2nd Meeting of the International Consortium of Universities for Drug Demand Reduction (ICUDDR)

A network of 57 universities from around the globe, hosted by historic Charles University (established 1348), met in Prague to promote the development of addiction studies programs and explore how best to incorporate INL training materials into their programs. This ICUDDR movement, which was established by INL last year, has stimulated enthusiasm and generated ideas by more than 130 universities. By joining efforts through international and regional networks, they are better able to advocate for the professionalization of the addictions field in order to prevent drug use and help those who are addicted enter long-term recovery. University of California-San Diego (UCSD) offered to host the 2018 meeting and HHS/Substance Abuse and Mental Health Services Administration (SAMHSA) expressed interest in supporting this consortium domestically in order to strengthen U.S. university education in addiction studies. (June 20-21)



27 PRAGUE, CZECHIA

Board Meeting of the International Society of Substance Use Professionals (ISSUP)

The ISSUP Board of Trustees met to discuss improvements in the ISSUP website, guidelines for national chapters, and administrative issues. INL was invited to participate as an observer. (June 22-23)

28 VALENCIA, SPAIN

INL Explored Spanish University Prevention and Treatment Initiative for College Students, Provided Briefings with University Representatives

INL met with an outpatient treatment program in Valencia called BioNexum which provides treatment services for U.S. students studying abroad in Spain. They also provide drug and sexual violence prevention programs and demonstrated various tools that they have developed. The center’s director noted that many American college students initiate drug use for the first time when studying abroad. INL could work with the U.S. interagency to develop training resources and a network of universities that develop drug prevention and treatment services for American students globally.

Additionally, INL met with the president, deans, and faculty of CEU-Cardenal Herrera University in Valencia, the largest non-profit private university in Spain with more than 50,000 students educated from elementary school to doctoral programs throughout the country. The group expressed interest in creating an addiction studies program within the Faculty of Psychology. (June 28)

29 LISBON, PORTUGAL

Lisbon Addictions Conference

The European Conference on Addictive Behaviors and dependencies held its second Bi-Yearly conference in Lisbon, Portugal October 24-27 nearly doubling its size from 600 to 1200 attendees since it was first organized. The Conference had seventy-one countries represented and featured presentations from INL partners, including United Nations Office on Drugs and Crime (UNODC), World Health Organization (WHO), International Consortium of Universities on Drug Demand Reduction (ICUDDR), International Society for Substance Use Professionals (ISSUP), and the Colombo Plan, which engages in training professionals to use best practices through their Universal Prevention and Treatment Curricula (UPC/UTC).

MIDDLE EAST

30 ABU DHABI, UNITED ARAB EMIRATES

Strengthened Partnership between National Rehabilitation Centre and INL

Dr. Hamad al-Ghaferi, the Director General of the UAE's National Rehabilitation Centre hosted an INL delegation to discuss opportunities for expanded collaboration over the coming years.

The two parties agreed to develop a Memorandum of Understanding recognizing the NRC's new complex as a training hub for addiction counselors in the Middle East utilizing INL's Universal Curricula. NRC has already been training the package nationally and translated the courses into Arabic. (May 7)



31 ABU DHABI, UNITED ARAB EMIRATES

Pilot Training for Quality Assurance Mechanism Advances First Ever International Drug Treatment Accreditation System

A key pillar of INL's drug demand reduction framework is professionalizing services through the credentialing of practitioners and accreditation of drug treatment centers. INL supported development and global recognition of international treatment standards, as well as the pilot testing for accreditation to the standards in Afghanistan. From July 10-14, INL participated in a UNODC pilot training at the National Rehabilitation Centre (NRC) in Abu Dhabi, UAE for 12 Afghan assessors on the newly developed tool to evaluate and rate the quality of services with the international treatment standards. With UNODC support, these assessors will conduct pilot assessments of drug treatment centers in Afghanistan over the next year. Feedback will be used to finalize the assessment tool and training regime for assessors, at which time the International Quality Standards will become available for world-wide use. (July 10-14)



Afghan assessors utilize the assessment tool and rubric to evaluate a hypothetical treatment center during pilot training.

32 DUBAI, UNITED ARAB EMIRATES

Afghanistan Drug Demand Reduction Stakeholders Reaffirm Commitment to Countering the Deadly Epidemic of Drug Use in Afghanistan

Representatives, including five deputy ministers and a minister advisor to President Ghani, from a wide spectrum of Afghan Government ministries, the Colombo Plan, UNODC, civil society implementers as well as INL met over three days to discuss workforce professionalization, Drug Treatment Centers (DTC), and prevention programming sustainability, as well as the continued transition of programs to the Government of Afghanistan. Key commitments include: vowing to work towards integrating drug treatment into the broader health system; exploring cost-saving initiatives; and strengthening evidence-based drug use prevention across settings such as family, media, and school. (May 8-10)



33 ABU DHABI, UNITED ARAB EMIRATES

19th International Study of Addiction Medicine (ISAM) Conference

The 19th International Study of Addiction Medicine (ISAM) collaborated with the UAE National Rehabilitation Center (NRC) in Abu Dhabi October 26-29 to host medical doctors and others in the field of addiction medicine for their annual conference. The conference was sponsored under the patronage of H.H. Sheikh Mansour bin Zayed Al Nahyan, who is the Deputy Prime Minister and Minister of Presidential Affairs of the UAE. The next conference will be in South Korea in 2018 followed by India in 2019. INL presentations included "Promoting Treatment within the Criminal Justice System" and "Translating Research into Practice to Increase the Drug Demand Reduction Workforce." (October 28-29)

34 MANAMA, BAHRAIN

Expanding DDR Cooperation

On October 30 INL met with University of Bahrain Chairman of the Psychology Department Dr. Mohammad Mokdad and Professor and Psychiatrist Ramon Alfulaij on efforts to teach on addictions and support rehabilitation to the community. INL shared its efforts to develop and implement the Universal Treatment (UTC) to train professionals on best practices. Bahrain University is interested in incorporating the UTC curriculum into their coursework and on learning more about best practices for security waiver forms to have coverage for student practicums. INL also met with Dr. Charlotte Kamal at the Psychiatry Hospital, which partners with the University of Bahrain for student practicums and employment opportunities. The Hospital was interested in learning more about the curriculum and on ways of utilizing the UTC for current staff. (October 30)



SOUTH ASIA

35 NEW DELHI, INDIA

India Site Visits to Explore Opportunities for Further Partnerships

INL conducted site visits to children's treatment centers in Delhi, India that have received INL support and training. In particular, INL reviewed the status of Outreach Drop In Centers (ODICs), which aim to bridge a gap between substance using children and access to appropriate treatment and social services. INL also met with senior officials from the Indian Ministry of Social Justice and Empowerment, which in 2015 covered the costs to travel all of their regional trainers to Delhi for two consecutive months of Universal Treatment Curriculum (UTC) training. Discussion focused on future advanced series training, Indian's interest in adopting the INL-supported credentialing regime, and Indian participation in Colombo Plan's October Focal Points Meeting. (July 17-18)



Photo 1: Street children with substance use disorders participate in a confidence-building exercise at an ODIC in Delhi, India. Photo 2: Street children with substance use disorders play cricket during a break at a different ODIC in Delhi, India.

36 COLOMBO, SRI LANKA

Program Review

INL serves as the primary donor to Colombo Plan, undertaking a robust drug demand reduction program in more than 60 countries related to training and workforce professionalization. (January 23-February 3)

37 COLOMBO, SRI LANKA

Colombo Plan Council Meeting and Program Meetings

The Colombo Plan Council, comprised of the diplomatic missions of member states in Colombo, takes place once a quarter. The INL and IO bureaus participate periodically to cover equities which are discussed and affect project implementation. (April 7-14 – 290th meeting; July 31 - 291st meeting; Dec. 11-12, 293rd meeting)

38 COLOMBO, SRI LANKA

Pilot Training of the New Drug Prevention Core Curriculum for Implementers

Lead substance use prevention scientists from Applied Prevention Sciences International (APSI) held a pilot training for the newly developed Universal Prevention Curriculum (UPC) Implementers Series funded by INL. The training engaged Colombo Plan's Global Master Trainers from Afghanistan, Bhutan, Kazakhstan, Kenya, Malaysia, Myanmar, Pakistan, Philippines, and Uganda in prevention content and training skills. The pilot training was a follow-up to a seven-week online training which included pre- and post-tests, quizzes, as well as individual and group work. (May 15-20)

SOUTHEAST ASIA

39 NAY PYI TAW, MYANMAR

Southeast Asian Drug Focal Points Meeting

This is one of three “subregional” meetings of drug focal points for Southeast Asia who are members of the Colombo Plan. (The other two are for South Asia and the Pacific.) This meeting was attended by Brunei, Indonesia, Myanmar (co-host with Colombo Plan), the Philippines, Singapore, Thailand, and Vietnam. Attendees broke up into three groups, and in the demand reduction area recommended more research, particularly on prevention. The law enforcement group expressed strong interest in training on precursors and New Psychoactive Substances. Their recommendations led to the invitation to the International Law enforcement Academy (ILEA) Bangkok to attend the next subregional meeting in Singapore. (February 22-24)



40 BANGKOK, THAILAND

UPC Implementers Series Specialized Track Training

Lead substance use prevention scientists from Applied Prevention Sciences International (APSI) as well as curriculum developers for the special prevention setting tracks in media, school, environment, family, and workplace, held an in-person pilot training for Colombo Plan’s Global Master Trainers. The training included trainers from 12 countries in Asia and Africa. The global master trainers gained extensive content knowledge and are equipped to train specialty tracks of the UPC-Implementers Series. (August 30-September 7)

41 HO CHI MINH CITY, VIETNAM

ATTC Conference and University Meetings

INL presented on its efforts to develop curricula for addiction treatment professionals at the 4th National Conference on Substance Use Disorders and HIV hosted by the Ho Chi Minh University for Medicine and Pharmacy and South Vietnam Addiction Technology Transfer Center (ATTC). In Vietnam, the number of patients with substance use disorders has increased dramatically in treatment centers from 584 in 2008 to over 44,000 patients in 2016. The meeting included roughly 400 participants from multiple universities, faculty, students, practitioners and government representatives from Vietnam. INL met separately with Ho Chi Minh University for Medicine and Pharmacy which has been teaching the Universal

SOUTHEAST ASIA

Treatment Curricula (UTC) to students in the past year with INL support. INL also met with other Vietnamese universities to discuss how they can adapt the treatment curriculum to their coursework. (August 3-5)



From Left to Right: Charlotte Sisson, INL/PC Drug Demand Reduction Team Lead; Dr. Nguyen Cuu Duc, Deputy Director General, Department of Science, Education, Culture, and Social Affairs; Nadine Rogers, PhD, MS, PMP – Substance Abuse and Mental Health Services Administration (SAMHSA) Vietnam Country Team Lead; Hoang Vu, MD, MPH, Medical Officer, SAMHSA, Vietnam PEPFAR Team.

42 KUALA LUMPUR, MALAYSIA

DDR Program Meeting

INL held meetings with multiple stakeholders. Activities included a visit to the INL-funded Cyberjaya University College of Medical Sciences (CUCMS) Colombo Plan Fellowship Program. The first of its kind, the Colombo Plan Fellowship Program trains a cohort of drug demand reduction professionals from Africa and Asia in substance abuse treatment using INL's Universal Treatment Curriculum (UTC) materials. INL also met with Malaysia's National Anti-Drugs Agency (AADK) and treatment NGO PENGASIH to discuss plans for Malaysia's ISSUP National Chapter which is scheduled to be formed in 2018.

43 SINGAPORE

DAP Focal Points Meeting

INL represented the United States at the October 23-25 Colombo Plan Drug Focal Points Meeting, where representatives from Colombo Plan member states reviewed drug policies and interventions with a particular focus on demand reduction. INL overviewed the U.S. approach to DDR and conducted numerous sideline bilateral engagements to generate additional interest among the delegates on INL's prevention and treatment programming. (October 16-20)

44 JOGJAKARTA, INDONESIA

6th Commission Meeting of the International Centre for Credentialing and Education of Addiction Professionals (ICCE)

The Government of Indonesia hosted the ICCE Commission, which included 18 countries that recognize the ICCE credential (ICCE is now officially known as GCCC for Global Centre for Credentialing and Certification). The Commission welcomed two new countries from the Western Hemisphere, the Bahamas and Argentina. Commissioners discussed priorities for the coming year from expanding testing opportunities to lowering the cost of the credentialing exam. (April 2-5)

45 INDONESIA**ODIC Site Visits**

From October 16-20, INL conducted an Indonesia program review to tour three U.S.-established drug Outreach Drop-In Centers (ODICs) in Kawarang (West Java), Kendari (Southeast Sulawesi), and Palembang (South Sumatra); to engage with community leaders in the drug-ravaged Jakarta neighborhood of Pengangsaan, where the U.S. has established a Community Anti-Drug Coalition; and to meet with the Indonesian National Narcotics Board. This trip laid the groundwork for the second U.S.-Indonesia Drug Demand Reduction Workshop which will commence in 2018. (October 23-27)

46 DILI, TIMOR-LESTE**Demand Reduction Assessment**

The joint Colombo Plan-INL mission to East Timor included meetings with the Ministry of Public Health, National Youth Council, Ministry of the Interior, Ministry of Social Solidarity, University of Timor-Leste, and local NGOs. East Timor is facing increased drug use and local partners are particularly interested in introducing drug use prevention. Some of INL's substance use treatment training also generated interest by health care professionals working in the area of trauma and child abuse. (April 6-8)

APPENDICES



Appendix 1

The International Drug Control Framework

Appendix 2

CADCA'S Network of International Coalitions By Country 2017

Appendix 3

ICUDDR Member Universities and Contacts

APPENDIX 1

THE INTERNATIONAL DRUG CONTROL FRAMEWORK

International drug control is primarily accomplished through three major treaties adopted by the United Nations. The purpose of these treaties is to ensure that drugs are available for medical and scientific purposes while preventing abuse and diversion of those drugs into illicit channels.



THE SINGLE CONVENTION ON NARCOTIC DRUGS (1961)

The Single Convention on Narcotic Drugs was adopted in 1961 in an attempt to consolidate existing international drug control agreements and provide a mechanism for adding new substances to the list of those under international control. The Single Convention is administered by the United Nations Commission on Narcotic Drugs and the World Health Organization, while the United Nations Office on Drugs and Crime (UNODC) conducts most of the day-to-day work of ensuring compliance and the International Narcotics Control Board (INCB) administers the controls on drug production, international trade, and distribution.

Under the 1961 Single Convention, countries are required to provide yearly estimates to the INCB of the quantity of controlled substances that will be a) consumed for medical and scientific purposes; b) used for the manufacture of other drugs, of Schedule III preparations, and of substances not covered by the Convention; c) held in stocks; and d) produced or manufactured. The INCB establishes quotas for each country on the manufacture and import of controlled substances based on these estimated quantities, and monitors actual production, trade, and consumption. Additionally, the INCB is empowered to deduct from each year's quotas any excesses left over from the

previous year's quotas, and to punish failures to control illicit production or diversion by deducting from a nation's quotas. Countries are therefore obligated to not exceed the amounts of the estimates confirmed or established by the INCB.

The Single Convention establishes four categories, or Schedules, for drugs, each with its own levels of controls. The initial list of drugs to be controlled under these Schedules was established with the Convention. Of note, the Single Convention only deals with drugs derived from plants, namely cocaine, opioids, and cannabis, and their derivatives. The Commission on Narcotic Drugs is empowered to add new substances to a Schedule based on their similarity to drugs already scheduled or their ability to be converted into drugs already scheduled, at the recommendation of the World Health Organization.

The least restrictive classification under the 1961 Single Convention is Schedule III. Drugs in this Schedule do not require government authorizations for import or export, and countries only need to furnish estimates of the quantities of drugs to be utilized for the production of preparations in Schedule III. The next level of control is Schedule II. Drugs in this schedule require government authorizations for import and export, and require estimates and statistical reports to be furnished to the INCB, but governments are not bound to prevent the accumulation of these drugs

by retail distributors, medical prescriptions are not obligatory to obtain these drugs, and the retail label of these drug are not required to show the exact drug content by weight or percentage. Schedule I involves the full control structure of the convention, notably: a) requirements for governmental authorization for each international transaction, b) obligations to keep detailed records of all transactions, c) a requirement of medical prescriptions for dispensation to individuals, and d) yearly estimates and statistical reports furnished to the INCB, which limits the quantities of drugs available to those needed for medical and scientific purposes. The most restrictive

category under the 1961 Single Convention is Schedule IV, which contains a subset of drugs which are also classified under Schedule I, but are deemed by the World Health Organization to be “particularly liable to abuse and to produce ill effects” that is “not offset by substantial therapeutic advantages”. These drugs are subject to all the control provisions under Schedule I, but also to special measures that can be set by individual nations. Under certain circumstances, nations may prohibit the production, trade, and use of Schedule IV drugs to medical and scientific research only. The Schedules and applicable controls are shown in the table below.

Schedule	Control Measures
IV (most restrictive)	<ul style="list-style-type: none"> ■ Limit use to medical and scientific purposes ■ Require government authorization for all imports and exports ■ Keep detailed records of all transactions ■ Require medical prescriptions for supply or dispensing ■ Furnish estimates and statistical reports on production, trade, and use to INCB ■ Comply with INCB quotas for production and trade ■ Comply with special measures of control, as appropriate ■ Limit use to medical and scientific research only, as appropriate
I	<ul style="list-style-type: none"> ■ Limit use to medical and scientific purposes ■ Require government authorization for all imports and exports ■ Keep detailed records of all transactions ■ Require medical prescriptions for supply or dispensing ■ Furnish annual estimates and statistical reports on production, trade, and use to INCB ■ Comply with INCB quotas for production and trade
II	<ul style="list-style-type: none"> ■ Limit use to medical and scientific purposes ■ Require government authorization for all imports and exports ■ Keep detailed records of all transactions ■ Furnish annual estimates and statistical reports on production, trade, and use to INCB ■ Comply with INCB quotas for production and trade
III (least restrictive)	<ul style="list-style-type: none"> ■ Limit use to medical and scientific purposes ■ Furnish limited annual estimates and statistical reports on use in manufacturing other Schedule III preparations to INCB ■ Comply with INCB quotas for production and trade

THE CONVENTION ON PSYCHOTROPIC SUBSTANCES (1971)

The second major international drug control agreement was established in response to the increased range and diversity of drugs that were not covered by the 1961 Single Convention. Amphetamine-like stimulants, barbiturates, benzodiazepines, and hallucinogens were not sufficiently similar to substances controlled under the 1961 Single Convention, and thus a new treaty was necessary to address illicit use of those drugs. The 1971 Convention included a robust scheme for scheduling new drugs that did not rely on similarity to previously scheduled drugs, but rather on the potential for abuse and therapeutic usefulness.

Under the 1971 Convention on Psychotropic Substances, substances are evaluated for scientific and medical considerations by the Expert Committee on Drug Dependence (ECDD). The ECDD deliberates on documents provided by the Secretariat of the World Health Organization, including a critical scientific review of the substance, the results of a questionnaire sent to member countries, and any comments on the critical review received by the Secretariat. The substance is first assessed to determine whether it falls under the scope of the 1961 Single Conventions. If so, it is scheduled according to its similarity

to an already scheduled substance. If the substance is determined to not fall under the terms of the 1961 convention, then the ECDD evaluates it under the 1971 convention. Specifically, the ECDD considers the *extent of abuse or the degree of likelihood of abuse*, as well as the *degree of seriousness of the public health and social problem* to determine whether the substance constitutes a public health and social problem warranting the placing of the substance under international control. Additionally, the ECDD assesses the *degree of usefulness of the substance in medical therapy*. The ECDD developed specific criteria for inclusion in each schedule under the 1971 Convention, as outlined in the table below.

If the ECDD does not find that there is a scientific or medical basis for international control, the CND may not place the substance under international control. However, if the ECDD finds that there is a scientific or medical basis for control, the CND may take legal, administrative, social, economic, and other factors into account and decide not to control the substance, or to control it at a different level than recommended by the ECDD.

Schedule	Abuse Potential/Public Health Risk	Therapeutic Usefulness
I (most restrictive)	Especially serious	Limited, if any
II	Substantial	Little to moderate
III	Substantial	Moderate to great
IV (least restrictive)	Smaller but significant	Little to great

Under the 1971 Convention, the following control measures apply to each of the schedules:

Schedule	Control Measures
I (most restrictive)	<ul style="list-style-type: none"> Require licenses for manufacture, trade, and distribution Require medical prescriptions for supply or dispensing Comply with obligations relating to the control and monitoring of export and import Furnish regular statistical reports on use and distribution to the ICNB Adopt punitive measures to repress acts contrary to law
II	<ul style="list-style-type: none"> Require licenses for manufacture, trade, and distribution Require medical prescriptions for supply or dispensing Comply with obligations relating to the control and monitoring of export and import Adopt punitive measures to repress acts contrary to law
III	<ul style="list-style-type: none"> Require licenses for manufacture, trade, and distribution Require medical prescriptions for supply or dispensing Comply with obligations relating to the control and monitoring of export and import Adopt punitive measures to repress acts contrary to law
IV (least restrictive)	<ul style="list-style-type: none"> Require licenses for manufacture, trade, and distribution Comply with obligations relating to the control and monitoring of export and import Adopt punitive measures to repress acts contrary to law

CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES (1988)

The third and final major international treaty dealing with drug control was created to combat organized crime and trafficking in drugs of abuse. It deals with chemicals which are frequently used in the manufacture of drugs by establishing two tables of chemicals and controlling their

trafficking. This treaty is administered by the CND, and the INCB is responsible for assessing scientific evidence for or against control. Substances may be considered for control simultaneously under all three treaties.

APPENDIX 2

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

CADCA's Network of International Coalitions by Country 2017

Summary: 22 countries, 240 communities, 234 international community coalitions established, 47 coalitions created in 2017, comprised of approximately 6,675 volunteer members

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Bolivia	La Paz	Cotahuma	1. Coalición Comunitaria Obatahuira	Carolina Becerra	caribece@gmail.com caribece@hotmail.com	4/13/2014	17	Although N.A.S financing ended do to political reasons, the coalition continues to carry out activities to prevent alcohol/ drug consumption in the community. The meetings are held every two months under the direction of its Board of Directors. The members are still receiving some technical support from the former CAD-CAs in-country point of contact.
	São Paulo state	Pindamonhangaba city	1. Coalizão Comunitária Anti-drogas de Pindamonhangaba	Eliane Prado Marcondes	Coalizaopinda.br@gmail.com	2008	195	The coalition has successfully worked with local schools in order to engage youth in drug prevention activities. The coalition has created the "Prevention Week", which has been incorporated to the municipality's calendar of events. The members continue to work with merchants in partnership with local police, in order to maintain the low rate of sales of alcohol to minors achieved in the city. The coalition members have also paid a visit to their representatives in the Brazilian congress in order to advocate for public policies focused on drug prevention.
Brazil	São Paulo state	Pompéia city	2. Coalizão Comunitária Anti-drogas de Pompéia	Maria de Fátima Souza	coalizaopompéia@gmail.com	2013	45	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently.
	São Paulo state	Taubaté city	3. Coalizão Comunitária Anti-drogas de Taubaté	Sandra Maria Duarte	Coalizaobrasil.taubate@bol.com.br	2011	80	Coalition conducted several activities during the carnival festivities in the city. Coalition has worked closely with the municipality, and is part of the city's planning committee. Coalition has also incorporated the "Prevention week against alcohol and other drugs" to the municipality's calendar of events.
	São Paulo state	Ubatuba city	4. Coalizão Comunitária Anti-drogas de Ubatuba	Nelson Medeiros	medsurf@uol.com.br	2013	22	Coalition graduated and established partnership with the Ubatuba Municipal Secretariat of Education in projects directed at reducing the drug use rates among youth. Coalition has also worked to implement prevention activities during carnival, and enjoys the support of a house of representative on the Federal level.
	São Paulo state	Bragança Paulista city	5. Coalizão Comunitária Anti-drogas de Bragança Paulista	Juliano Marcel	coalizaobp@outlook.com	2015	60	Coalition has worked closely with the municipality and implemented specific rules regarding the sales of alcohol to minors during some of the main public events in the city. Coalition has partnered with a local university and the local education secretariat to finalize their data collection. Their assessment report was presented during the 1st Municipal Conference about Alcohol and other drugs in the city.
	São Paulo state	Santos city	6. Coalizão Santos	Cristhiane Neves Saraiva	crissaraiva@uol.com.br	2015	55	Coalitions members participated in a meeting with SENAD (Secretaria Nacional De Políticas Sobre Drogas), in partnership with Associação Pro Coalitions of Brazil, in order to advocate for more prevention policies in the Federal level. The coalition has also organized several activities among the youth, promoting a healthy lifestyle without drugs. The coalition also partnered with a local business, and played an important role presenting at their "SIPA" (Internal week of work accidents prevention).
	São Paulo state	São Paulo city - CIC West	7. Coalizão Comunitária Anti-drogas CIC Oeste	Leandro Guilherme Gabriel	coalizaopiritubajaragua@gmail.com	2015	35	Coalition has worked diligently to increase the number of adolescents in their membership base. Coalition is working to finalized their community assessment, through a survey that was conducted in private and public schools of the community in partnership with a local university.
	Rio de Janeiro state	Itaiaia city	8. Coalizão de Itaiaia	Leonardo Seixas	leiseixas14@hotmail.com	2013	20	Coalition has promoted a "Prevention week" against drugs, with lectures and activities focused on drug prevention among youth. Coalition has also worked intensively with local law enforcement in order to ensure compliance of local merchants with alcohol sales laws. Coalition had a strong presence in some of the main festivities/events in the city, creating awareness among vendors and recruiting new members.
	Rio de Janeiro state	Porto Real/Quatis city	9. Coalizão Comunitária Anti-drogas de Porto Real	Maicon Oliveira	maikongofe@gmail.com	2014	30	In partnership with the municipality, the coalition has announced a public action plan for comprehensive drug prevention actions in 2018.
	Pernambuco state	Recife city - Santo Amaro	10. Coalizão Comunitária de Santo Amaro	Roziane Santana	roziane@taxanuma.com.br	2015	25	Brasília Itamosa/Phia and Santo Amaro coalitions have merged into a single coalition. The coalition has developed a strategic plan to reduce the use of inhalants among students between 10 and 18 years old, as per official GOB assessment dated 2010. The coalition plans to finalize their assessment report with the findings of a survey conducted in local schools by the first quarter of 2018.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Brazil	São Paulo state	Cruzeiro city	11. Coalizão Comunitária de Cruzeiro	Carina Franqueira	carinfranqueira@hotmail.com	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will start working on its assessment in the next months.
	São Paulo state	Itanhaém city	12. Coalizão Comunitária de Itanhaém	Elizabeth de Souza	lelady@hotmail.com	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will start working on its assessment in the next months.
	São Paulo state	Jacaré city	13. Coalizão Comunitária de Jacaré	Maria Isabel Soares	isabelcomunidade@hotmail.com	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will begin working on its assessment in the next months.
	São Paulo state	São José dos Campos city	14. Coalizão Comunitária de São José dos Campos	Patrícia Minari Silva	patriciaminari@igmail.com	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will begin working on its assessment in the next months.
	São Paulo state	São Paulo city	15. Coalizão Comunitária de São Paulo	José Manoel de Souza Aguiar	jpgalate@prefeitura.sp.gov.br	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will begin working on its assessment in the next months.
	São Paulo state	Sorocaba city	16. Coalizão Comunitária de Sorocaba	Maria Clara Suarez	dra.clara@gmail.com	2017	10	Coalition trained and graduated under the TOL (Trainer of Leaders) initiative. The coalition has been officially launched in the community, in partnership with municipal and state governments. Coalition is now working on recruiting new members and mobilizing all 12 sectors. Coalition will begin working on its assessment in the next months.
	Santiago Island - Prata city	Achada São Filipe	1. Coalizão Antidroga de Achada São Filipe	Odete Correia	odete.correia@mdc.gov.cv	2012	40	Coalition has organized the "Walk against drugs" during the activities observing the International day against drugs. Coalition has also conducted prevention activities in local schools and with parents. Coalition has worked closely with the local health department and has had important presence during the "Health fair" promoted by the municipality every year. Coalition continues to work with the other coalitions in the country towards the creation of a Cape Verdean Network of coalitions.
	Santiago Island - Prata city	Ponta D'água	2. Coalizão Antidroga de Ponta D'água	Celestino Lobo	clodino@gmail.com	2012	25	Coalition has promoted "door-to-door" activities in the neighborhood of Ponta D'água, in order to create awareness among parents and increase their membership base. Coalition has secured radio time in a local radio station, where coalition members now have a radio show on a weekly basis. Coalition has organized a soccer championship for kids and adolescents, emphasizing the importance of a healthy lifestyle and bringing awareness against drug use. Coalition continues to work with the other coalitions in the country towards the creation of a Cape Verdean Network of coalitions.
	São Vicente Island - Mindelo city	Mindelo	3. Coalizão Antidroga de São Vicente	Jessica Fonseca	fonseca.jessica@platonos.org.cv	2013	35	Coalition graduated has forged relationships with local leaders and local partners to sustain activities and efforts. Coalition is currently developing strategic and action plans and is working with the other coalitions in the country towards the creation of a Cape Verdean Network of coalitions.
	Santiago Island - Prata city	Calabaceira	4. Coalizão Antidroga de Calabaceira	Jessica Fonseca	fonseca.jessica@platonos.org.cv	2015	30	Coalition graduated has forged relationships with local leaders and local partners to sustain activities and efforts. Coalition is currently developing strategic and action plans and is working with the other coalitions in the country towards the creation of a Cape Verdean Network of coalitions.
	Santiago Island - Prata city	Achada Grande Frente	5. Coalizão Antidroga de Achada Grande Frente	Paulino Delgado	frchada2000@gmail.com	2015	30	Coalition graduated has forged relationships with local leaders and local partners to sustain activities and efforts. Coalition is currently developing strategic and action plans and is working with the other coalitions in the country towards the creation of a Cape Verdean Network of coalitions.
	Sal Island	Espargos	6. Coalizão Antidroga de Espargos	Dr. Quella Monteiro	achamafias@hotmail.com	N/A	0	New coalition (still under training).
	San Jose	Pavas	1. Coalición Comunitaria de Pavas	LIC. Haydee Ace Grujalba	arcegrujalba@hotmail.com cel.8301-3908.	10/13/2014	55	The coalition is working on the evaluation of last year action plans' results in the Metropolis committee. The Pavas Centro committee has been reorganized and it is maintaining the same plan of action. A new coallitnary committee is being organized in the community of Villa Esperanza, they held 4 preliminary meetings with 15 members. The coalition is focusing on reducing the use of marijuana among the youth in the community.
	San Jose	Alajuelita	2. Coalición Comunitaria de Alajuelita	Daniel Umata Najera	najera1701@gmail.com cel. 6052-9467	9/1/2015	40	The Alajuelita Coalition is being reorganized due to the death of its leader. The coalition is working with the municipality support, focusing on reducing the use of marijuana among the youth in Alajuelita's downtown.
	San Jose	Desamparados	3. Coalición Comunitaria de Desamparados	Ronald Muñoz	ronald1234@hotmail.com 8500-9482	9/1/2015 reorganized in 10/1/2016	19	The coalition is getting reorganized due to problems of its leaders with the local mayor. The new program is aiming to coordinate the infiltrated political deviations with the help of the municipal police chief and focusing on reducing the use of marijuana among the youth in the community.

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Costa Rica	San Jose	Escazu	4. Coalición Comunitaria de Escazu	Guillermo Fonseca Picado 8323-3959	guillermofns@gmail.com	10/1/2016	15	The coalition coordinator was changed due to the municipal organization restructuring in which several officials were removed. The new group is on track with the TOI plan and focusing on reducing the use of marijuana among the youth in the community.
	San Jose	Moravia	5. Coalición Comunitaria de Moravia	LIC. Geannina Zuñiga Z	geannina.zuniga@hotmail.com cel. 8695-5297	10/1/2016	6	The current leadership is under observation. They have not been able to connect with the mayor's office and its internal committees to work on prevention. They are working on their Logic Model and strategies to reduce the use of marijuana among the youth in the community.
Ghana	Accra	La-Nkwantanan Madina Municipal	1. West Madina Coalition for Development (MEMCODE)	Hashim Abdulai	abdulai.hashim@yahoo.com	8/22/2013	52	The Coalition has organized educational campaigns on drugs and substance abuse prevention to sensitize the community, reaching over 5300 young. They have created a one-on-one outreach program for membership drive, and working on looking for support to sustain the coalition.
	Accra	La-Nkwantanan Madina Municipal	2. East Madina Coalition for Development (EMACOD)	Kamal Razak	rakanni@yahoo.com	03/06/2014	49	The coalition organized outreach programs for community members and opinion leaders reaching about 4500 people to mobilize support for drug abuse prevention as a strategy to sustain intervention programs.
	SWEDRO	Agona West: Municipal	3. Agona West Coalition for community development (AWCCOD)	Dorcas Apronti	dorcasapronti@gmail.com	9/22/2015	43	The coalition has set up and inaugurated school clubs to institutionalize drug abuse prevention programs in 25 schools reaching over 7000 school children, teachers and opinion leaders. The members held a meeting with the Paramount Chief and his sub-chiefs to elicit support and encourage them to commit financial resources to drug abuse prevention programs within their jurisdiction. The members are working to change physical structures of places with drug pushers, obscure corners, and weedy that are conducive for trade and drug abuse. So far, they have been able to made at least 3 places available for community use.
	CAPE COAST	Cape Coast Metropolitan	4. Cape Coast Community Coalition for Change (C5)	Daniel Deladem Kissel	dannycentralpress@yahoo.co.uk	9/22/2015	74	The in-school educational programs provided by the coalition, reached out to about 8000 people and have been organized for students and teachers to provide them with basic facts about drugs and substance abuse and their prevention. The members of the coalition provided advocacy programs targeting opinion and community leaders to mobilize their support. Radio discussions and phone-in programs continue to be a major outlet for the dissemination of information on drugs and substance abuse prevention. Through this intervention over 20,000 people within Cape Coast and its environs have been reached with messages on drug and substance abuse prevention.
	BEGORO	Fanteakwa District	5. Community Anti-Drug coalition of Fanteakwa (GADCOF)	Samuel Darfour	samueldarfour@gmail.com	9/24/2015	61	The coalition developed capacity building programs to equip and train selected students to serve as peer educators; this was organized in collaboration with Narcotics Control Board, and it was done for about 250 students. The intervention of the coalition had impacted about 9 people who used to sell and use marijuana and now have been referred to the psychiatric unit of the District Hospital for support.
	SOMANVA	Yilo Krobo Municipal	6. YiloKrobo Community Coalition for development (YKCCOD)	Cynthia Miamle Teitoh	Cynthiamietteh@gmail.com	9/25/2015	33	The coalition organized educational campaigns on drug abuse prevention in 5 schools reaching out to about 2300 students. The Advocacy meetings have been held with school authorities to scrutinize those who sell in schools or come to work within the school since some couriers and peddlers.
	DODOWA	Shai Osudoku District	7. Safe Haven	Robert Mensah Kwaku Gbley	bobbybley@gmail.com	9/28/2015	70	The Coalition organized the following: 1)School outreach and educational campaign programs including counseling of drug users. A total of about 7650 in-school and out of school youth were reached. 2)Community violence prevention training for 150 community youth leaders in hot spot areas to prevent gang violence in the communities. The coalition has changed the physical structure of some areas to make them an open space for public used. They are also engaging in sustainability strategy to incorporate the coalition's activities into their work plan, so they can have a budget to support the coalition's activities in the years ahead.
	ASESENA	Upper Manya Krobo	8. The Upper Focus Group Action for Aseseva (TUFGAA)	Joseph Kyel Baifour	kyeloseph@yahoo.com	5/12/2017	25	The coalition was established on May of this year and has created a name, logo, letterhead and set its vision, mission, and objectives to start working on the selected community. The members are planning the Kick-off event.
	ODUMASE	Lower Manya Krobo	9. Coalition for Lower Manya Krobo Development (CLO-MAKD)	Godfried Caesar	gc2caesar@yahoo.com	5/13/2017	28	The coalition was established on May of this year and has created a name, logo, letterhead and set its vision, mission, and objectives to start working on the selected community. The members are planning the Kick-off event.
	ELMINA	Komenda Edina Aguado Adirem	10. Elmina for Change (E4C)	Owusu Boahen	Samuel.oguaffh@yahoo.com	5/26/17	31	The coalition was established on May of this year and has created a name, logo, letterhead and set its vision, mission, and objectives to start working on the selected community. The members are planning the Kick-off event (scheduled for tuesday 12/12/17). The In-Country Coordinator will be present at the event.
Guatemala	San Lucas Sacatepéquez	San Lucas Sacatepéquez	1. Coalición Comunitaria de San Lucas	Evelyn Galvez	evelyn.319@hotmail.com	11/1/2014	17	The coalition is working on researching its local conditions. They are also in the process of changing leaders, and creating a new poll to verify if the marijuana consumption and sale have been lowered. They are in the intervention, evaluation, and sustainability process.

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Guatemala	Secatepequez	San Bartolome	2. Coalición Comunitaria de San Bartolome	Jose Morales	josesmo@gmail.com	2/2/2015	12	The leadership is strengthening in the community. The coalition improved the neighborhood park by providing illumination, and the members are currently working on determining their local conditions and planning next year activities. They are in the problem prioritization and strategies planning process to reduce the use of marijuana among the youth.
	Quezaltenango	Salcaja	3. Coalición Comunitaria de Salcaja	Glendy	glendyb2506@hotmail.com	11/7/2016	7	The coalition is in the process of verifying and collect the surveys to create their logic model. They are also working on increase their capacity, board of director and members. The coalitions is in the community assessment and building capacity process.
	Quezaltenango	Cantel	4. Coalición Comunitaria de Cantel	Feliza Garcia	rosalina_garcia10@hotmail.com	11/7/2016	16	The coalition is working on prioritizing the strategies with the municipality support and Cantel fabrics and associations. The members are working on defining their implementation plan and annual action plan for the interventions in the community.
	Quezaltenango	Totonicapan	5. Coalición Comunitaria de Totonicapan	Carlos Alvarado	arcavarado09@gmail.com	11/7/2016	25	The members are working on informing the community about CADCA's works and developing connections with new sectors to bring more members to the coalition. The coalition is planning to provide illicit substance prevention talks to the community as a means of seeking additional allies in the community.
	Port au Prince	Carrefour	1. Coalition Anti-Drogue de La Commune de Carrefour	Lucinda Cassagnol-Laquerre 509-368-68423	faeta2008@yahoo.fr	11/1/2014	40	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Coalition is also working on the strategic and action plans and has a non-profit status.
Haiti	Choloma	Lopez Arelano	1. Coalición Comunitaria Lopez Arelano	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	5/1/2013	35	The political advocacy is training more than 100 alcoholic beverage merchants throughout the municipality. The community is working on membership expansion and received webinar training on comprehensive strategies for the 2018 plan. Three members participated in CADCA Mid-year Training. Currently working on developing their implementation plan to address marijuana use on youth.
	La Lima	La Lima	2. Coalición Comunitaria La Lima	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	7/6/2014	30	The coalition has the goal to provide training to 75 merchants with in the municipality. They were part of CADCA's webinar on integral strategies to help them work in their 2018 plan. Currently working on developing their implementation plan to address marijuana use on youth.
	El Progreso	El Progreso	3. Coalición Comunitaria El Progreso	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	7/6/2014	63	The coalition is working on their Action Plan to reduce marijuana consumption among youth. They also worked on recovering physical space (a soccer field where marijuana was sold) this was achieved with the strategy of "family field days" coordinating with institutions to improve the soccer field.
	Villanueva	Villanueva	4. Coalición Comunitaria de Villanueva	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	1/16/2017	11	The coalition is working on the Community Assessment, Membership, and Logic Model. They participated in CADCA's webinar training on Integral Strategies.
	Puerto Cortes	Puerto Cortes	5. Coalición Comunitaria de Puerto Cortes	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	1/16/2017	12	The coalition is working on the Community Assessment, Membership, and Logic Model.
	Ormoa	Ormoa	6. Coalición Comunitaria de Ormoa	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	1/16/2017	11	The coalition is working on the Community Assessment, Membership, and Logic Model. They participated in CADCA's webinar training on Integral Strategies.
	San Pedro Sula	San Pedro Sula	7. Coalición Comunitaria de San Pedro Sula	Lesy Castillo Delmis Chacon Rubio	lessycastillo@gmail.com dchaconrubio@yahoo.es	1/16/2017	14	The coalition is working on the Community Assessment, Membership, and Logic Model. They participated in CADCA's webinar training on Integral Strategies.
Indonesia	Jakarta	Pengasaan	1. Pengasaan Community Coalition	Tony Parbudi	tony_parbudi@granat.or.id	May, 2017	35	Coalition established as a result of the Training of Leaders initiative (TOL). The coalition is working on collecting appropriate data, finalize the logic model, plan for officer elections and draft coalition bylaws.
	Surabaya	Putat	2. Putar Community Coalition	Jemmy Lim	plato.found@gmail.com	May, 2017	26	The scarcity of local data poses a challenge for coalition work. The available data sets such as police reports may not capture true local conditions as they are collected at the regional level. Another challenge we are facing is the reassignment of both Lurahs in October 2017. Based on lessons learned in the Philippines which has similar structure of local government like Indonesia, the changes of a local chiefstain may impact the future work, success, and existence of the coalition.
Iraq	Erbil	Ankawa	1. Ankawa Community Coalition	Saadiah F.Hassoon (chair person), Ghatia Hassoon (logistics)	saadiaasahy@gmail.com ghaydahassoon2004@yahoo.com	9/5/2013	40	Coalition has worked with local authorities to enforce local laws related to drug use and is currently working on environmental strategies to change the design of their community.
	Erbil	Ari	2. Ari Community Coalition	Kawa Pardaood (Project Manager)	kawapardaood@hotmail.com	9/5/2013	40	Coalition has build a strong relationship with the community, government agencies and religious leaders.
Kenya	Mombasa	Mombasa	1. Mombasa Community Anti-Drug Coalition of Kenya (MISCADCK)	Mrs. Farida Rashid	farida-rashid2000@hotmail.com mrsacadck01@gmail.com	2011	50	Coalition has enhanced the access between drug users and local treatment centers.
	Kwale	Kwale	2. Kwale Community Anti Drug Coalition (KWACDCO)	Coalition Chair (Mr. Kariba Mkungu) and Secretary (Mrs. Meriam Kasiba)	kanidrug@gmail.com kasbatm@yahoo.com	2012	45	Coalition has advocated for the improvement of systems in place, in order to provide more opportunities for the local community to access to prevention services.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Kenya	Nairobi	Nairobi	3. Community Anti-Drug Coalitions of Kenya (CADCKE)	Dr. Catherine Gachutha (Coalition Chair) Mr. Patrick Okwarah (Coalition Secretary and Coordinator)	cadcke@cadcke.org pokwarah@cadcke.org pokwarah@gmail.com cgachutha@gmail.com	7/5/2013	45	Coalition has launched a website (www.cadcke.org) and has officially become the umbrella coalition for all the others Kenyan community coalitions.
	Nairobi	Nairobi	4. Nairobi Community Anti-Drug Coalition (NOCADC)	Dr. Catherine Gachutha (Coalition Chair) Mr. Patrick Okwarah (Coalition Secretary and Coordinator)	pokwarah@cadcke.org pokwarah@gmail.com cgachutha@gmail.com	7/5/2013	45	Coalition has advocated for the revision of local laws that would increase local drinking age from 18 to 21 years old.
	Bishkek	Bakai-Ata	1. Bakai-Ata Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	9/1/2014	32	Coalition conducted compliance checks of local retailers. Held meetings educating the retailers on the current alcohol and tobacco laws. Worked on removing spice advertisements in the community. Finalized coalition by-laws and developed coalition logo.
	Bishkek	Kelechek	2. Kelechek Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	9/1/2014	30	Coalition installed signs informing about alcohol and tobacco laws at the local stores. Conducted compliance checks of local retailers. Coalition installed a video camera at one of the "hot spots." Coalition utilized community resources to renovate a soccer field.
	Mady	Mady	3. Mady Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	2/1/2017	21	Established as a result of the Training of Leaders Initiative. Graduated in January 2017. Currently in the process of conducting community assessment and recruiting new members. Working with the retailers that sell tobacco and alcohol informing about the law.
	Gulcho	Gulcho	4. Gulcho Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	2/1/2017	30	Established as a result of the Training of Leaders Initiative. Graduated in January 2017. Currently in the process of conducting community assessment and recruiting new members. Training of teachers, nurses, young leaders on prevention efforts. Placed signage informing about the law in the retail locations.
	Tokmok	Tokmok	5. Tokmok Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	1/15/2017	15	Established as a result of the Training of Leaders Initiative. Graduated in January 2017. Currently in the process of conducting community assessment and recruiting new members.
Kyrgyzstan	Kara-Balta	Kara-Balta	6. Kara-Balta Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	2/1/2017	30	Established as a result of the Training of Leaders Initiative. Graduated in January 2017. Currently in the process of conducting community assessment and recruiting new members. Conduct regular clean-up campaigns of the identified hot spots.
	Sokoluk	Sokoluk	7. Sokoluk Coalition	Guljama Sultanalleva	sultanallevag@gmail.com	2/1/2017	25	Established as a result of the Training of Leaders Initiative. Graduated in January 2017. Currently in the process of conducting community assessment and recruiting new members. Marijuana eradication campaign.
	Tijuna	Colonia 10 de mayo	1. Coalición Comunitaria 10 de Mayo	LC: Miquel Khamwonga President: Mrs. Maria de la Luz Valdovinos	miquel@coaliciones.org marluzvaldovino@hotmail.com	12/12/2012	49	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening and their third implementation plan development.
	Tijuna	Colonia Sanchez Taboada	2. Coalición Comunitaria de Sanchez Taboada	LC: Miquel Khamwonga President: Mrs. Noheми Rodriguez	miquel@coaliciones.org mlareme5y10@gmail.com	12/12/2012	73	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on membership strengthening, directors board reinforcement and their third implementation plan development.
	Tijuna	Colonia Camino Verde	3. Coalición Comunitaria de Camino Verde	CL: Miquel Khamwonga President: Mr. Apolonio Sixtos	miquel@coaliciones.org salesito_rg@hotmail.com	12/12/2012	98	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on membership strengthening, their third implementation plan in process and to address the community problems associated with the use of crystal meth as well as recuperating public spaces.
	Tijuna	Colonia Valle Verde	4. Community Coalition of Valle Verde	LC: Miquel Khamwonga President: Mrs. Alejandra Garduño Salazar	miquel@coaliciones.org petezvaldez7@gmail.com	8/1/2014	42	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening and their third implementation plan development.
	Mexico	Ciudad Juárez	Colonia Águilas de Zaragoza	5. Coalición Comunitaria de Águilas de Zaragoza	LC: Mrs. Gabriela Fierro President: Yuliana Pérez	gferro@coaliciones.org yuly29k2u90@gmail.com	11/12/2012	41
	Ciudad Juárez	Colonia Altavista	6. Coalición Comunitaria de Altavista	LC: Mrs. Gabriela Fierro President: Mrs. Vela Martínez	gferro@coaliciones.org Chiquis_12.ktty@hotmail.com	11/12/2012	41	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on membership strengthening and their second implementation plan development.
	Ciudad Juárez	Colonia Felipe Angeles	7. Coalición Comunitaria de Felipe Angeles	LC: Mrs. Gabriela Fierro President: MR. Andrés Muñoz	gferro@coaliciones.org Jesus_muñoz@hotmail.com	11/12/2012	41	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening and their second implementation plan development.
	Ciudad Juárez	Colonia Aztecas	8. Coalición Comunitaria de Aztecas	LC: Mrs. Gabriela Fierro President: LC: Miguel Angel Gonzalez	gferro@coaliciones.org Angelphisy30@hotmail.com	8/1/2014	41	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening and their second implementation plan development.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Mexico	Agua Prieta	Colonia Alarmitos	9. Coalición Comunitaria de Alarmitos	LC: Mrs. Martha Escobar Ayala. President: Mr. Rosendo Sichel Rubio	mesobar@coaliciones.org coalicionalarmitos@gmail.com	7/12/2012	58	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening, the board of directors renewal and their second implementation plan development.
	Agua Prieta	Colonia Ferrocarril	10. Community Coalition of Ferrocarril	LC: Mrs. Martha Escobar Ayala. President: Mr. René Espinoza Sidar	mesobar@coaliciones.org pastor-remne@hotmail.com	11/17/2014	43	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on capacity strengthening, the board of directors renewal and their second implementation plan development.
	Nogales	Colonia Luis Donaldo Coloso	11. Coalición Comunitaria de Olotso	LC: Mrs. Genesis Rodriguez President: Mrs. Alma Jessica Flores Trujillo	grodiguez@coaliciones.org almasaryesk@gmail.com	6/12/2012	70	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working on strengthening the membership and community needs assessment reinforcing.
	Chihuahua	Colonia Revolución	12. Coalición Comunitaria de Revolución	LC: Lic. Liliana Nevarez President: Mrs. Aracely Martínez Villegas.	inevarez@coaliciones.org aracelymartinez959@gmail.com	08/28/2014	40	Graduated coalition meets weekly. Focuses on marihuana consumption among youth. Currently working on capacity strengthening and their second implementation plan development.
	Chihuahua	Colonia Villa Juárez	13. Coalición Comunitaria de Villa Juárez	LC: Liliana Nevarez President: Mrs. Sonia Graciela Pérez Trejo	inevarez@coaliciones.org Soniagpt30@gmail.com	08/26/2014	42	Coalition graduated and meets regularly at the local community center. This coalition is focusing on marihuana use by youth and works closely with the local Center on Prevention of Addiction (CAPA) to deliver a training on marihuana for community parents and Youth. In addition to raising awareness this coalition is working to recover public spaces. Currently working on capacity strengthening and their second implementation plan development.
	Ecatepec	Colonia Chamizal	14. Coalición Comunitaria de Chamizal	LC: Lic. Belem PeñaFlor President: Mrs. María G. Fernández.	bpenaflor@coaliciones.org donchamizal@gmail.com	10/23/2014	39	Coalition graduated and currently focuses on addressing the use of inhalants by community youth. Planned on taking back and rehabilitating community hot spots by cleaning up, painting murals, and placing signs in problem areas. Currently working on capacity strengthening, their second implementation plan development, coalition sectors adding and developing their second community needs surveys.
	Nezahualcoyotl	Colonia Pirules	15. Coalición Comunitaria de Pirules	LC: Lic. Belem PeñaFlor President: Mrs. Patricia Franco	bpenaflor@coaliciones.org llicastelan319@gmail.com	11/27/2014	37	Coalition graduated and focuses on marihuana use among youth. Currently working on strengthen the membership, their second implementation plan development, coalition sectors adding, public space refurbishment and action plan activities follow up.
	Durango	Colonia Villas Guadiana	16. Coalición Comunitaria de Villas Guadiana	LC: Lic. Aracely Morales President: Mrs. Alejandra Canales G.	amorales@coaliciones.org	08/29/2014	44	Graduated coalition completed its logic model and decided to focus on the problem of crystal consumption among youth. Currently working on capacity strengthening, the board of directors renewal and their second implementation plan development.
	Durango	Colonia Division del Norte	17. Coalición Comunitaria de División del Norte	LC: Lic. Aracely Morales President: Mrs. Silvia Erika Silva Ontiveros	amorales@coaliciones.org	08/22/2014	44	Coalition graduated and forged relationships with local leaders and partners to sustain DDR activities and efforts independently. Currently working to addresses the community problems associated with marihuana use among youth, membership strengthening, the board of directors renewal and their second implementation plan development.
	Hermosillo	Colonia Las Arboledas	18. Coalición Comunitaria de Las Arboledas	LC: Leonarda Lugo President: Mrs. Skarlet Andreea Gomez Plata	llugo@coaliciones.org andy_321@hotmail.com	10/15/2014	46	Coalition graduated and currently hosts several community events including: summer camp, classes and workshops for community youth to recruit new members. Works closely with key sectors such as local civic group, fire fighters, and health department to address community conditions centered on underage drink. Currently working on capacity strengthening, the board of directors renewal and their second implementation plan development.
	Monterrey	Colonia San Bernabé 8	19. Coalición Comunitaria de San Bernabé 8	LC: Lic. Beatriz Abrego President: Mrs. Della Cruz	babrego@coaliciones.org dellaacruz@hotmail.com	11/8/2014	33	Coalition graduated and holds regular community meetings to address marihuana consumption among teens. This coalition is working closely with elected officials, judges, law enforcement and other local authorities electing a coalition member as the community judge, a local authority to address this issue. The coalition also works closely with the local prevention center CAPA to conduct workshop for community residents on the issue. Currently working on capacity strengthening and their second implementation plan development.
	Monterrey	Colonia Fomerrey 110-105	20. Coalición Comunitaria de Colonia Fomerrey 110-105	LC: Lic. Beatriz Abrego President: Mrs. Blanca Ortiz.	babrego@coaliciones.org bety.tristan@hotmail.com	10/29/2014	40	Graduated coalition holds weekly meetings to address the problem of marihuana consumption among teens. The coalition also works closely with the local prevention center CAPA to conduct workshop for community residents on the issue. Currently working on capacity strengthening and their second implementation plan development.
	Nuevo Lareto	Colonia Colinas del Sur	21. Coalición Comunitaria de Colinas del Sur	LC: Sandra Torres President: Mrs. María Leocadia Pecina Martínez	stores@coaliciones.org valeriarn@gmail.com	04/15/2015	47	Graduated coalition is composed of mostly women and enjoys the support of a CAPA organization and of CAJ, a youth-serving organization. Also has the support on coalition projects from dozens of local professionals. Coalition addresses alcohol consumption among youth. Currently working on membership strengthening and implementation plan in process.
	Tabasco	Villa Hermosa	22. Coalición Comunitaria de Macuspana	Mr. Moises Gadena	mcadena@coaliciones.org	May, 2016	25	The board is in the process of holding an election. Coalition planning an official and public launch, after which it will begin a community assessment. The coalition has meetings regularly.

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Mexico	Tabasco	Villa Hermosa	23. Coalición Comunitaria de Pino Suarez	Mr. Moises Cadena	mcadena@coaliciones.org	May, 2016	12	The coalition launched publicly in May of 2016. Has a board of directors and has almost completed an assessment. Organized a community clean up force comprised of police officers and students, asked with cleaning and painting of an athletic field. The coalition has meetings regularly and they are about to start their community needs assessment.
	Hidalgo	Pachuca	24. Coalición Comunitaria de Los Jobs	Mr. Moises Cadena	mcadena@coaliciones.org	December, 2016	11	The coalition has not launched to the public yet. The members are conducting an initial community assessment. The Main illicit substance is alcohol.
	Hidalgo	San Felipe Orizatlan	25. Coalición Comunitaria Los Cubitos	Mr. Moises Cadena	mcadena@coaliciones.org	December, 2016	32	The coalition had their pledge of allegiance to the Mexican flag and kick off event. Comprised mostly of very active female residents who meet 3x/week. Launched publicly. Completed community assessment, mapped the community and hotspots and conducted knock and talks. Formed a youth group. Will begin working on the logic model.
	Quintana Roo	Playa del Carmen	26. Coalición Comunitaria de Solidaridad	Mr. Moises Cadena	mcadena@coaliciones.org	February, 2016	11	Coalition has selected an area of intervention and is focusing on marijuana. Working on securing the support and participation of municipal authorities. The coalition has meetings regularly, with a tremendous community support, they are about to finish their community needs assessment.
	Quintana Roo	Cancun	27. Coalición Comunitaria 221	Mr. Moises Cadena	mcadena@coaliciones.org	October, 2016	10	Coalition launched publicly, established a board of directors, almost completed its community assessment, identified the target area and mapped the community with hotspots
	Quintana Roo	Cancun	28. Coalición Comunitaria 516	Mr. Moises Cadena	mcadena@coaliciones.org	October, 2016	11	Coalition in early stages of development. Members have just begun to meet. Have not developed a structure or products yet.
	Jalisco	Lomas Verdes	29. Coalición Comunitaria San Juan de los Lagos	Mr. Moises Cadena	mcadena@coaliciones.org	January, 2016	11	Coalition launched publicly. Meet weekly. Developed vision, mission, objectives, and working on chronogram. Following its own action plan / activities believed to deal with the problem identified, consumption of marijuana by youth. Currently working on membership strengthening
	Jalisco	Tonala	30. Coalición Comunitaria El Rosarito	Mr. Moises Cadena	mcadena@coaliciones.org	January, 2016	5	Coalition in early stages of development. Members have just begun to meet. Have not developed a structure or products yet. Currently working on membership strengthening
	Jalisco	Tonala	31. Coalición Comunitaria Santa Ana de Petatlan	Mr. Moises Cadena	mcadena@coaliciones.org	January, 2016	5	Coalition in early stages of development. Members have just begun to meet. Have not developed a structure or products yet. Currently working on membership strengthening
	Jalisco	Tonala	32. Coalición Comunitaria Rey Xolotl	Mr. Moises Cadena	mcadena@coaliciones.org	January, 2016	5	Coalition in early stages of development. Members have just begun to meet. Have not developed a structure or products yet. Currently working on membership strengthening
	Jalisco	Tonala	33. Coalición Comunitaria Jovenes del Vergel	Mr. Moises Cadena	mcadena@coaliciones.org	January, 2016	5	Coalition in early stages of development. Members have just begun to meet. Have not developed a structure or products yet. Currently working on membership strengthening
	Chiapas	Tuxtla Gutiérrez	34. Coalición Comunitaria San Pedro Progreso	LC: Mtro. Jose Cleber Gonzalez President: Mrs. Maribel Trejo Martinez	cgonzalez@coaliciones.org tao7@hotmail.com	November, 2016	21	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on marijuana use by youth, found to be the main problems in the community. Also, finished their community needs assessment and logical framework. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Chiapas	Tuxtla Gutiérrez	35. Coalición Comunitaria Infonavit Grijalva	LC: Mtro. Jose Cleber Gonzalez President: Mr. Carlos Torres Nava	cgonzalez@coaliciones.org cartonav@hotmail.com	November, 2016	19	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by minors, found to be the main problems in the community. Currently working on strengthen the membership and on their community needs assessment and logical framework. The coalition had their Third CADCA SPF training session.
	Chiapas	San Cristobal	36. Coalición Comunitaria Prudencia Moscoso	E.C: Lic. Rosa Luz Morales President: Mrs. Bertha Roblero Pérez	morales@coaliciones.org Huyil2205@gmail.com	November, 2016	40	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and two logic models on inhalant use by minors, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Puebla	San pedro de Cholula	37. Coalición Comunitaria Tepontla	LC: Lic. Arelly Grande President: Mr. Ciro Juarez Lope	agrande@coaliciones.org tepontla@gmail.com	November, 2016	15	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on marijuana use by youth, found to be the main problems in the community. Also, finished their community needs assessment and logical framework. Currently working on strengthen the membership and on their implementation plan.
	Puebla	Puebla de Zaragoza	38. Coalición Comunitaria San Bartolo	LC: Arelly Grande Garcia President: Mrs. Gregoria Romero Mones	agrande@coaliciones.org santbarolo@gmail.com	November, 2016	18	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on inhalant use by youth, found to be the main problems in the community. Currently working on strengthen the membership, developing their community needs assessment and Logical framework. The coalition had their Third CADCA SPF training session.
	Puebla	San pedro de Cholula	39. Coalición Comunitaria Infonavit San Pedro	LC: Arelly Grande Garcia President: Mrs. Gpe. Balandras de la Fuente	agrande@coaliciones.org	November, 2016	22	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on inhalant use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthen the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Mexico	Guanajuato	Leon	40. Coalición Comunitaria León II	LC: Lic. Arturo Barajas President: Mrs. Silvia Milena Martínez	abarajas@coaliciones.org hotmail.com	December, 2016	34	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on inhalant use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Guanajuato	Leon	41. Coalición Comunitaria Soledad / La Joya	LC: Lic. Arturo Barajas President: Mrs. Francisco Javier Velázquez Cervantes	abarajas@coaliciones.org javier@hotmail.com	December, 2016	34	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Guanajuato	Leon	42. Coalición Comunitaria Chapallita	LC: Lic. Arturo Barajas President: Mrs. María Carmen Mena García	abarajas@coaliciones.org la181845@gmail.com	December, 2016	26	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Veracruz	Veracruz	43. Coalición Comunitaria Buena Vista	LC: Lic. Betzabe Méndez Cruz President: Mrs. Lucía Gutiérrez Velázquez	bmendez@coaliciones.org slykamor@hotmail.com	December, 2016	14	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on marijuana use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week.
	Veracruz	Veracruz	44. Coalición Comunitaria Colonia Playa Lirida	LC: Lic. Betzabe Méndez Cruz President: Mr. Abiud Joaquín Villanueva	bmendez@coaliciones.org dfemamp@gmail.com	December, 2016	18	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week.
	Veracruz	Boca del Río	45. Coalición Comunitaria Villa Rica	LC: Betzabé Méndez Cruz President: Mr. José Manuel Ortiz Torres	bmendez@coaliciones.org el_o_t@hotmail.com	December, 2016	11	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on inhalant use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week.
	Zacatecas	Ciudad de Zacatecas	46. Coalición Comunitaria Minera	LC: Dan Alejandro Acuña de la Torre President: Mr. José Antonio Ayalá Bahuelos	dacuna@coaliciones.org coalicionminera@gmail.com	November, 2016	23	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Zacatecas	Fresnillo	47. Coalición Comunitaria Sector Lagunilla	LC: Lic. Ana Verónica García President: Mrs. Irma Martínez	agarcia@coaliciones.org irmaa-05@hotmail.com	November, 2016	28	This coalition was created to replace the Alma Obrera coalition. The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and two logic models on inhalants and marijuana use by minors, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Zacatecas	Felipe Angeles	48. Coalición Comunitaria Felipe Angeles	LC: Dan Alejandro Acuña de la Torre President: Mrs. Ruth Dueñas Esquivel	dacuna@coaliciones.org coalicionminera@gmail.com	November, 2016	15	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition had their Third CADCA SPF training session.
	Morelos	Cuernavaca	49. Coalición Comunitaria Alta Vista	LC: Lic. Noe Chávez President: Mrs. Ivonne Arce García	nchavez@coaliciones.org black03@hotmail.com	November, 2017	31	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model. Even though the earthquake from September 19th and all the community difficulties just event, the coalition has finished their community needs assessment and logic models. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week. After the earthquake, it is important to mention that the coalition is evaluating the opportunities to keep working in that neighborhood or the possible relocation.
	Morelos	Cuernavaca	50. Coalición Comunitaria Ciudad Chapultepec	LC: Lic. Noe Chávez President: Mrs. María Cristina Tovar Salgado	nchavez@coaliciones.org tobart10@hotmail.es	November, 2017	27	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week.
Morelos	Juetepec	51. Coalición Comunitaria Los Pinos de Tejalpa	LC: Lic. Noe Chávez President: Mrs. María Del Carmen Avila Bustos	nchavez@coaliciones.org coalicionespinos@gmail.com	November, 2017	45	The coalition had their pledge of allegiance to the Mexican flag and kick off event, completed the community mapping and logic model on alcohol use by youth, found to be the main problems in the community. Also, finished their community needs assessment and Logic Model. Currently working on strengthening the membership and on their implementation plan. The coalition is about to have their Third CADCA SPF training session in this week.	

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Paraguay	Asunción	San Antonio	1. Coalición Comunitaria San Antonio	Geradine Willim Angel Cristaldo	Gwillim2014@gmail.com angelcristaldonavarro@gmail.com tel: 0986967742	N/A	14	The Coalition is developing the 2018 action plan and chronogram on the prevention, sale, and consumption of alcohol by minors. One of the goals is to ensure that alcohol and cigarette sellers comply with regulations to prevent underage sales.
	Asunción	Santa Ana, Barrio Obreiro y Roberto L. Petit	2. Coalición Santa Ana, Barrio Obreiro y Roberto L. Petit	Geradine Willim Oscar Gonzalez	Gwillim2014@gmail.com oga-2011@hotmail.com tel: 0981481001	N/A	16	The Coalition's members will be working on mapping the risk zone, and collecting data for the community underage drinking and drugs used issue.
	Asunción	Barrio Petrossi	3. Coalición Barrio Petrossi	Geradine Willim Blanca de Añara	Gwillim2014@gmail.com tel: 981555879	N/A	23	The coalition is planning to hold a meeting to form the core group. The leader of the group, is not able to completely participate on the coalitions activities due to the government elections process, and personal reasons.
Peru	Callao	Districto de Callao	1. Coalición Comunitaria Callao Norte	Rolando Salazar	rsalazar@cefro.org.pe		28	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Callao	Districto de Callao	2. Coalición Comunitaria Car-men de la Legua	Rolando Salazar	rsalazar@cefro.org.pe		28	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Callao	Districto de Callao	3. Coalición Comunitaria Villa Señor de los Milagros	Rolando Salazar	rsalazar@cefro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Callao	Districto de Callao	4. Coalición Comunitaria La Chalaca	Rolando Salazar	rsalazar@cefro.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Callao	Districto de Callao	5. Coalición Comunitaria Mli Peru	Rolando Salazar	rsalazar@cefro.org.pe		24	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Callao	Districto de Callao	6. Coalición Comunitaria Villa Los Reyes	Rolando Salazar	rsalazar@cefro.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Cercado de Lima	7. Coalición Comunitaria Conde de la Vega	Carolo Sivas	csivas@cefro.org.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Cercado de Lima	8. Coalición Comunitaria Mirones	Carolo Sivas	csivas@cefro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Cercado de Lima	9. Coalición Comunitaria Barrios Altos	Carolo Sivas	csivas@cefro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Cercado de Lima	10. Coalición Comunitaria Lima Cuadrada	Carolo Sivas	csivas@cefro.org.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	La Victoria	11. Coalición Comunitaria Balconcillo	Carolo Sivas	csivas@cefro.org.pe		28	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	La Victoria	12. Coalición Comunitaria Matute	Carolo Sivas	csivas@cefro.org.pe		32	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	El Rimac	13. Coalición Comunitaria El Rimac	Carolo Sivas	csivas@cefro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	El Rimac	14. Coalición Comunitaria El Manzano	Carolo Sivas	csivas@cefro.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	15. Coalición Comunitaria Sector 2 Grupo 5	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	16. Coalición Comunitaria Sector 3 Grupo 8	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	17. Coalición Comunitaria Sector 7	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	18. Coalición Comunitaria Pichacamac	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		38	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	19. Coalición Comunitaria Sector 1	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Villa El Salvador	20. Coalición Comunitaria Asociación Distrital VES	Gabriela Montoya Ponce de Leon	gmontoya@sumbi.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Peru	Lima	San Juan de Lurigancho	21. Coalición Comunitaria Ciudadela Mariscal Cáceres	Carolo Sivas	csivas@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	22. Coalición Comunitaria Inca Manco Capac	Carolo Sivas	csivas@cedro.org.pe		38	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	23. Coalición Comunitaria San Hilarión	Carolo Sivas	csivas@cedro.org.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	24. Coalición Comunitaria Santa Elizabeth	Carolo Sivas	csivas@cedro.org.pe		28	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	25. Coalición Comunitaria José Carlos Mariátegui	Carolo Sivas	csivas@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	26. Coalición Comunitaria Caja de Aguas	Carolo Sivas	csivas@cedro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Lurigancho	27. Coalición Comunitaria Asociación Distrital S.J.L.	Carolo Sivas	csivas@cedro.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Santa Anita	28. Coalición Comunitaria Coop La Universal	Rolando Salazar	rsalazar@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	Santa Anita	29. Coalición Comunitaria Asociación Distrital Sta Anita	Rolando Salazar	rsalazar@cedro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Lima	San Juan de Miraflores	30. Coalición Comunitaria Pampas de San Juan	Giovanna Vargas	gvargas@craser.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Lima	San Juan de Miraflores	31. Coalición Comunitaria Pampas de San Juan II	Giovanna Vargas	gvargas@craser.pe		20	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Lima	Villa María del Triunfo	32. Coalición Comunitaria Tablada de Lurin	Giovanna Vargas	gvargas@craser.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Lima	Villa María del Triunfo	33. Coalición Comunitaria José Carlos Mariátegui	Giovanna Vargas	gvargas@craser.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Lima	Comas	34. Coalición Comunitaria La Libertad	Edda Perez	eperez@craser.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Lima	Comas	35. Coalición Comunitaria Año Nuevo	Edda Perez	eperez@craser.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Lima	Los Olivos	36. Coalición Comunitaria Santa Ana	Edda Perez	eperez@craser.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community.
	Lima	Los Olivos	37. Coalición Comunitaria Chavarría	Edda Perez	eperez@craser.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community.
	Lima	Los Olivos	38. Coalición Comunitaria Villa del Norte	Edda Perez	eperez@craser.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	East of the Andes	Tingo María	39. Coalición Comunitaria Casillo Grande	Carola Sivas	csivas@cedro.org.pe		28	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	East of the Andes	Tingo María	40. Coalición Comunitaria José Carlos Mariátegui	Carola Sivas	csivas@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Peru	East of the Andes	Tocache	41. Coalición Comunitaria Villa Mercedes	Carola Sivas	csivas@cedro.org.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	East of the Andes	Tocache	42. Coalición Comunitaria Cercado Tocache	Carola Sivas	csivas@cedro.org.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	East of the Andes	Ayacucho	43. Coalición Comunitaria Las Nazarenas	Liubentka Obrenovich	slube@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	East of the Andes	Ayacucho	44. Coalición Comunitaria Miraflores - San Juan Bautista	Liubentka Obrenovich	slube@cedro.org.pe		35	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Pucallpa	Yarmacocha	45. Coalición Comunitaria Las Palmeras	Edda Perz	eperz@creser.pe		40	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Pucallpa	Yarmacocha	46. Coalición Comunitaria Roberto Ruiz Vargas	Edda Perz	eperz@creser.pe		20	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Huánuco	Huánuco	47. Coalición Comunitaria Los Profundos	Edda Perz	eperz@creser.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Huánuco	Amarilis	48. Coalición Comunitaria Matonga	Edda Perz	eperz@creser.pe		38	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Cusco	Huaro	49. Coalición Comunitaria Huaro	Edda Perz	eperz@creser.pe		16	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Arequipa	Cerro Colorado	50. Coalición Comunitaria Ceerro Colorado	Giovanna Vargas	gvargas@creser.pe		25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Trujillo	Victor Larco Herrera	51. Coalición Comunitaria Victor Larco Herrera	Edda Perz	eperz@creser.pe		20	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce marijuana consumption in the community based on their annual implementation plan.
	Chiclayo	Lambayeque	52. Coalición Comunitaria Lambayeque	Mitchael Allaga	maliaga@creser.pe		20	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce alcohol consumption in the community based on their annual implementation plan.
	Plura	Castilla	53. Coalición Comunitaria Castilla	Giovanna Vargas	gvargas@creser.pe		30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. The members are implementing activities to reduce PBC (crack cocaine) consumption in the community based on their annual implementation plan.
	Cusco	Urco	54. Coalición Comunitaria Urco	Edda Perz	eperz@creser.pe		20	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Arequipa	Miraflores	55. Coalición Comunitaria Chapi Chico	Giovanna Vargas	gvargas@creser.pe		25	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Trujillo	Huanchaco	56. Coalición Comunitaria Huanchaco	Edda Perz	eperz@creser.pe		30	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Chiclayo	José Leonardo Ortiz	57. Coalición Comunitaria Ausparia	Mitchael Allaga	maliaga@creser.pe		28	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Plura	Castilla	58. Coalición Comunitaria Los Médanos	Giovanna Vargas	gvargas@creser.pe		30	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Lima	Independencia	59. Coalición Comunitaria El Ermitaño	Mitchael Allaga	maliaga@creser.pe		20	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.
	Lima	Lurigancho, Chosca	60. Coalición Comunitaria Nicolás de Piérola	Álvaro Sánchez	asanchez@creser.pe		20	The coalition was established this year, and had his constitution meeting. The members are working on the Community Assessment.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Philippines	Angono, Rizal	Angono, Rizal	1. CAISA CA - Community Against Illegal Substance Abuse Coalition of Angono	Angelo San Juan, Lorelei Cambaliza-Corre	angelsanjuan.84@gmail.com leL_cambaliza04@yahoo.com	9/15/2015	24	Coalition has conducted a drug prevention education workshop in partnership with local government, local schools and youth leaders. The Coalition also pioneered a Community- Based Prevention, Intervention and Treatment Program for the city which is now known as GABAY sa Pagbabago. They are recognized as the NGO representative of the City's Anti Drug Abuse Council.
	Bacolod City	Bacolod City	2. Community Anti-Drug Coalition of Bacolod - CADCoB	Israel Salanga, Richard Nessa	l_salanga2011@yahoo.com richard_nessa@yahoo.com.ph	9/12/2015	13	Coalition continue its school-based program in partnership with Department of Education and recently sponsored the celebration of the IDADAIT with the DDB. They also launched a Story-telling program for the grade school students. The Coalition was also recognized as NGO representative of the City's Anti Drug Abuse Council.
	Basco, Batanes	Basco, Batanes	3. Batanes Anti-Drug Abuse Coalition	Demetrius Paul Narag, Eleanor Abad	bascomayor@gmail.com eleanor_abad@yahoo.com	10/23/2015	22	The Coalition started with Anti Drug Awareness Campaign and Education in all public schools in Basco (Grade 6-12) in partnership with the Department of Education and Vice Governor's Office.
	Calapan, Mindoro	Calapan, Mindoro	4. Calapan City Anti-Drug Coalition	C. Voltaire Brucal, Michelle Luzon	bongbrucal.bb@gmail.com zhe_luzon@yahoo.com.ph	10/6/2015	39	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Calumpit, Bulacan	Calumpit, Bulacan	5. CABISIG - Calumpitang Bisig-la Kontra Droga	Erlinda P. Pahate, Jose Arnel Faustino	erindapahate6@gmail.com josearnel-faustino@yahoo.com	8/10/2015	18	The Coalition works in partnership with Dep Ed in providing Preventive Education Seminar to Public School Junior and Senior Highschool. They are recognized as the NGO representative of the Barangay Anti Drug Abuse Council
	Markina City	Markina City	6. CADCA-Kalumpang	Arnel Santos	scoutnoel@yahoo.com	2/10/2013	60	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Markina City	Markina City	7. Coalitions Anti-Drug @ Malanday	Arnel Santos	scoutnoel@yahoo.com	1/24/2013	70	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Muntinlupa City	Muntinlupa City	8. COSAPE - Coalition for Substance Abuse Prevention and Education (formerly CADCOP)	Dr. Raquel P. Tolentino	quelly923@yahoo.com	12/2013, reorganized and registered on 7/10/14	98	The Coalition has forged partnership with the Rotary Club of Muntinlupa for the implementation of school-based anti drug abuse program for Private schools.
	Muntinlupa City	Muntinlupa City	9. CADCOP Tunasan - Community Anti-Drug Coalition of Muntinlupa	Dr. Raquel P. Tolentino	quelly923@yahoo.com	01/2013, re-organized and registered on 05/2014	353	Coalition has developed a successful partnership with the Criminology School of Muntinlupa focused on at-risk youth in Tunasan Muntinlupa.
	Quezon City	Quezon City	10. Tandang Sora Anti-Drug Coalition	Liybeth Seida	liybethseida18@gmail.com	11/10/2015	30	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. Their coalition was recognized as NGO representative of the BADAC.
	Quezon City	Quezon City	11. Barangay Sto. Cristo Anti-Drug Coalition	Liybeth Seida	liybethseida18@gmail.com	5/21/2015	55	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. Recognized by their BADAC as NGO representative.
	Quezon City	Quezon City	12. Greater Lagro Community Anti-Drug Coalition	Liybeth Seida	liybethseida18@gmail.com	8/28/2015	65	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently. Recognized by BADAC as NGO representative
	Taray, Rizal	Taray, Rizal	13. Community Anti-Drug Coalition of Taray - CADCOT	Diosdado Baquiran, Rodolfo Santanigo	madampo@yahoo.com olansuperman@yahoo.com	8/17/2015	42	The Coalition just finished their Drug Free Workplace Program for Public establishments/Barangays and will start next year with the private establishments. They also have Barkada Kontra Droga Program for the youth wherein they organize and mobilize youth groups. They work in partnership with the Municipality's Anti Drug Abuse Office
	Tayabas, Quezon	Tayabas, Quezon	14. Community Anti-Drug Coalition of Tayabas - CADCT	Maide Jader, Faustino A. Silang	m_obdianale@yahoo.com donid_522@yahoo.com	9/3/2015	50	Graduated coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	San Pedro, Laguna	San Pedro, Laguna	15. SPADAC - San Pedro Anti-Drug Abuse Coalition	Lolito Marquez, Edwin Matunog	lmarquez8888@yahoo.com edwinmatunog18@gmail.com	8/21/2015	125	SPADAC continue their Drug Awareness Program on Private Schools in Barangay San Vicente in partnership with Kwanis Club and Rotary Club. They recently joined the Drug Abuse Prevention and Control Week exhibit in Quezon City wherein the Coalition set a booth selling handcrafted products, laundry and dishwashing soap for fund raising.
	Valenzuela City	Valenzuela City	16. CICALA Valenzuela - City Coalitions of Anti-Drugs Advocate	Ibarra Salonga, Antonio Espiritu	salongairra@yahoo.com vadaac_fm-tary@yahoo.com	9/5/2015	68	The Coalition works with the Local Government of Valenzuela in the implementation of their Drug Free Workplace Program by conducting Anti Drug Abuse Seminars for the employees of the Private Business establishments in the City. They also continue their Drug Education Program for the youth and organize youth groups in public schools in partnership with the Department of Education.
	San Juan City	San Juan City	17. San Juan Anti-Drug Abuse Coalition	Ferdinand Marcelo Norie Ann Sanchez Beverly Joy Baldivino	ferdinandmarcelo@gmail.com norieann_sanchez@yahoo.com b_baldivino@yahoo.com	11/23/2017	15	Coalition established as a result of the Training of Leaders initiative (TOL). Recently organized their coalition. Oath taking of Officers on January 29, 2018
	Makati City	Barangay Poblacion Makati (CADMAK)	18. Community Anti-Drug of Makati (CADMAK)	Stephen Mojica Rosalide Dedeo	stephen_mojica_11@yahoo.com rosalidedeo@gmail.com	12/12/2017	25	Coalition established as a result of the Training of Leaders initiative (TOL). Recently organized their coalition. Oath taking of Officers on January 30, 2018

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Philippines	Santa Rosa	Laguna	19. Community Anti-Drug Coalition of Santa Rosa (CADSTAR)	Manuel Alijon Romwel Tan	nealijon@gmail.com ramztan24@gmail.com	8/21/2017	38	Coalition established as a result of the Training of Leaders initiative (TOL). Oath taking of Officers on January 31, 2018. Done with Community Assessment, Committee assignments and Planning
	Calamba City	Calamba City	20. Community Anti-Drug Coalition of Calamba City (CADCC)	Carmelita Revano Rhodora Agoncillo	militrevano@yahoo.com ms_dorisagoncillo@yahoo.com	8/5/2017	33	Coalition established as a result of the Training of Leaders initiative (TOL). Kick Off activity on February 1, 2018. Done with Oath taking of Officers, Community Assessment and Planning
	Palawan	Puerto Princesa	21. Communities Against Drug Abuse in Puerto Princesa and Palawan (CADAPP)	Roselyn Adornado Rebecca Alqueiro	roselynavarezfabro@gmail.com beckyquero09@gmail.com	11/4/2017	40	Coalition established as a result of the Training of Leaders initiative (TOL). Done with Oath taking of Officers, Community Assessment, and Planning. 1/A on Feb. 2, 2018
Senegal	Pikine	Pikine-Dagoudane	Coalition Communautaire de Djiddah de Thierno Kao	Mayoro Samba	mayorosamba@gmail.com 221-775-392-018	8/1/2012	105	The coalition is holding office meetings quarterly. The members are participating in activities with the inter-ministerial committee against drugs. They organized conference in collaboration with the community sports and cultural association to inform and sensitize the population on drugs used. The members performed door-knocking activities in the neighborhoods with community relays to inform and educate families about the problems of substance abuse.
	Dakar	HLM/Grand Dakar	2. Coalition Communautaire des HLM	Abdoulaye Gueye	abdoulayekara@hotmail.fr 221-773-594-675 221-709-461-585	4/1/2013	135	The coalition has been holding office meetings every two months. The members are participating in the national week of mobilization against drugs activities, organizing the football tournament against drugs. - Organization of a conference at the Madieye SALL school in collaboration with the HLM justice center to raise awareness among the school community about drug use and its misdeeds - Organization of a like pedestrian partnership with the House of Justice HLM to mobilize and educate the HLM communities on the use of drugs and related harm - Participation in the study on violence among young people in urban areas in the Dakar region, particularly in HLMs and Guédiawaye in partnership with the African Institute of Urban Management and the financing of the Research Center for International Development of Canada - Organization of activities monthly thematic exchange as part of the capacity building of coalition members
	Dakar	La Biscuiterie/ Grand Dakar	3. Coalition Communautaire de la Biscuiterie	Vincent Gomis	vincentmoudoucarpoulgomis@gmail.com 221-777-978-315	6/1/2015	92	Office meeting attire every six months is 02 meeting in the year 2017; - Participation in activities of the national anti-drug week organized by the interministerial committee for the fight against drugs; - Organization of a conference at "Ben Tally" primary school in the context of raising the awareness of the local population about the use of drugs and its misdeeds;
	Pikine	Dalfort/ Pikine Dagoudane	4. Coalition Communautaire de Dalfort	Astou NDAYE	astou139@yahoo.fr 221-77-504-469-117	11/7/2016	77	Holding two meetings of office and an information meeting on the TOL initiative; - Realization of a diagnosis whose data are still being used; - Holding a meeting information on the TOL initiative with the Jacques Chirac Center; - selected by Jacques CHIRAC to be one of community concerned by the TOL initiative; - Selection of 05 leaders to participate in the TOL initiative; - Meeting with trainers and CADCA Program Officer for pre-training on the TOL initiative.
	Cape Town	Khayelitsha	1. Kayelitsha Community Coalition	Thembeke	Cell: 0719781287	2013	30	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Cape Town	Delft	2. Belhar Community Coalition	Michelle Adonis	michelle@hojaysass.co.za	2012	25	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Cape Town	Elsie's River	3. East River Community Coalition	Tonio Gantana	t.gantana@gmail.com	2013	20	Graduated Coalition has forged relationships with local leaders and local partners to sustain activities and efforts independently.
	Klerksdorp	Jouberton	4. Community Coalition of Jouberton	Marina De Lange	sanparkmarina@iattic.net	3/1/2015	28	Coalition graduated in January 2017. Coalition conducted community assessment and finalized coalition by-laws. Coalition developed Logic Models, Strategic and Action plans. Currently in the process of developing Sustainability Plan.
South Africa	Johannesburg	Eldorado Park	5. Community Coalition of Eldorado Park	Terrence Makaanisa	Terrence@sancacentral.co.za	3/30/2015	123	Coalition graduated in January 2017. Coalition conducted community assessment and finalized coalition by-laws. Coalition developed Logic Models. Currently in the process of developing Strategic and Action Plans and Sustainability Plan.
	Buffalo City Municipality	Duncan Village	6. Community Coalition of Duncan Village	Roger Weimann	rogerweimann@hotmail.com	May, 2017	5	Coalition established as a result of the Training of Leaders initiative (TOL) in May 2017. They are in the process of conducting community assessment, solidifying coalition structure and informing their respective communities of their work.
	Buffalo City Municipality	Buffalo Flats	7. Community Coalition of Buffalo Flats	Roger Weimann	rogerweimann@hotmail.com	May, 2017	5	Coalition established as a result of the Training of Leaders initiative (TOL) in May 2017. They are in the process of conducting community assessment, solidifying coalition structure and informing their respective communities of their work.
	Buffalo City Municipality	King Williams Town	8. Community Coalition of King Williams Town	Roger Weimann	rogerweimann@hotmail.com	May, 2017	5	Coalition established as a result of the Training of Leaders initiative (TOL) in May 2017. They are in the process of conducting community assessment, solidifying coalition structure and informing their respective communities of their work.

CADCA'S NETWORK OF INTERNATIONAL COALITIONS BY COUNTRY 2017

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
South Africa	Buffalo City Municipality	Scenery Park	9. Community Coalition of Scenery Park	Roger Weimann	rogerweimann@hotmail.com	May, 2017	5	Coalition established as a result of the Training of Leaders initiative (TOL) in May 2017. They are in the process of conducting community assessment, solidifying coalition structure and informing their respective communities of their work.
	Buffalo City Municipality	Mzamonmhle	10. Community Coalition of Mzamonmhle	Roger Weimann	rogerweimann@hotmail.com	May, 2017	5	Coalition established as a result of the Training of Leaders initiative (TOL) in May 2017. They are in the process of conducting community assessment, solidifying coalition structure and informing their respective communities of their work.
	Dushanbe	Somoni	1. Somoni Community Coalition	Rajabova Zamigor	zamigorrajabova@gmail.com	12/5/2013	24	Collected data from relevant organizations in Jan. 2017 - 16% decrease in the # of drug users in the last 3 years. Proposed \$5000 project supported by INL in Jan. 2017.
	Dushanbe	Shohmansur	2. Shohmansur Community Coalition	Dadabaeva Meliuba	matlubad@gmail.com	12/7/2013	23	Collected data from relevant organizations in Jan. 2017 - an 18% decrease in the # of drug users in the last 3 years.
	Sogd Oblast	Kayrakkum	3. Qatroqum Community Coalition	Iskandarov Akmal	akmal.iskandarov64@gmail.com	3/1/2014	12	Trainings sessions with 26 community leaders, 1 in Jamoat in Jan. 2017. Training of 10 alcohol and tobacco vendors in Jan. 2017. Identified and closed for a while 2 hot spots in house basements. There is a plan to open sport and child facilities.
	Sogd Oblast	Gaturov	4. Bobojon Gaturov Community Coalition	Dzarkinzoda Roziya	jarkinzodaroziya@rambler.ru	3/1/2014	25	Surveyed 500 teens and youth in Oct. 2016. Surveyed 24 alcohol and tobacco product vendors in Oct. 2016. Football tournament in Nov. 2016 for 125 players and 360 fans; speeches and EIC materials dissemination. Mass awareness campaign with the participation of more than 430 people on Dec. 1, 2016. Proposed \$5000 project supported by INL in Jan. 2017.
	Khatlon Oblast	Farkhor	5. Farkhor Community Coalition	Abdulloeva Farishtamoh	abubakr_2004@mail.ru	4/1/2014	20	Collected data from relevant institutions in Jan. 2017 - 5.4% decrease in # of drug users in the last 3 years. Planted trees in 3 hot spots in Feb. 2017
	Khatlon Oblast	Kumsangir	6. Kumsangir Community Coalition	Gulchehra Safarova	fofodusty7777@gmail.com	4/1/2014	21	Collection of data from relevant institutions in Jan. 2017 - decrease of number of drug users for the 3 last years per 25.2%.
	Khatlon Oblast	Pyanj Reyon	7. Pyanj Community Coalition	Ganieva Barfino	barfinoh@mail.ru	12/13/2014	21	Collected data from relevant institutions in Jan. 2017 - a 16% decrease in the # of drug users in the last 3 years.
	Republican Suboridnat	Vahdat	8. Vahdat Community Coalition	Saidov Safarali	vahdat_youth@inbox.ru	12/13/2014	18	Collected data from relevant institutions in Jan. 2017 - 6.2% decrease in the # of drug users in the last 3 years.
	Khatlon Oblast	Shurabad	9. Shurabad Community Coalition	Sunatulloev Iskandar	kharullo-69@mail.ru	9/1/2015	22	Collected data from relevant institutions in Jan. 2017 - a 17% decrease in the # of drug users in the last 3 years.
	Khorog	Ghorog	10. Khorog Community Coalition	Aziznamatov Maram	volunteer70@mail.ru	9/1/2015	21	Police visits to 4 store owners to collect penalties in Jan. 2017. Collected data from relevant institutions in Jan. 2017 - a 14% decrease in the # of drug users in the last 3 years. Proposed \$5000 project supported by INL in Jan. 2017.
	Republican Suboridnat	Tursunzade	11. Tursunzade Community Coalition	Kurbonov Jahongir	rmjahongir@mail.ru	9/1/2015	23	Proposed \$5000 project was supported by INL in Jan. 2017.
	Republican Suboridnat	Shahrinai	12. Shahrinai Community Coalition	Kholov Manuchehr	manuchehr.bazhov@bk.ru	9/1/2015	19	
	Republican Suboridnat	Hissar	13. Hissar Community Coalition	Radiyova Khayriniso	gulshan.dur@mail.ru	9/1/2015	22	A report meeting with the participation of 22 people in Jan. 2017.
	Republican Suboridnat	Rudaki	14. Rudaki Community Coalition	Abobov Zairiddin	musceva83@mail.ru	9/1/2015	23	A report meeting with the participation of 24 people in Jan. 2017.
	Sogd Region	Penjikent	15. Penjikent Community Coalition	Jalolov Furkat	malikasd@yandex.ru	11/15/2017	18	Training with the 16 members of the community coalitions on Nov. 15, 2017. Surveyed 15 alcohol and tobacco product vendors in Nov. 2017.
	Sogd Region	Ayni	16. Ayni Community Coalition	Bahiddinov Fahridin	ustbd1@mail.ru	7/1/2017	19	As a result of TOL. Surveyed 150 teens and youth in Oct. 2017. Surveyed 12 alcohol and tobacco product vendors in Nov. 2017. Training of 21 Jamoats leaders on DDRP in November 2017.
	Dushanbe district	Sino	17. Sino Community Coalition	Ramazonov Eraj	n/a	7/1/2017	16	As a result of TOL. Surveyed 6 "hot spots" in November 2017 and the strategy of "Physical design change" with 2 ones has been implemented.
Dushanbe district	Firdavsi	18. Firdavsi Community Coalition	Majidov Saidumar	boklnca@gmail.com	7/1/2017	21	As a result of TOL. Surveyed 250 teens and youth in Oct. 2017. Scientific and practical conference on DDRP with the 125 students of 4 schools. Surveyed 20 alcohol and tobacco product vendors in Nov. 2017.	
GBAO	Darvaz	19. Darvaz Community Coalition	Shekhova Guljahan	pochohonum026@mail.ru	7/1/2017	18	As a result of TOL. Meetings on DDRP in 3 schools were conducted in November 2017. Surveyed 4 "hot spots" in November 2017	

Country	City	Neighborhood / District	Coalition Name	Name of Point of Contact	Email Address for Point of Contact	Date Established	# of Members	updated information Nov 2017
Togo	Lomé	Kegbé	1. CCADK Community Coalition	Togbui Komlan ALI V	011 228 (90 02 37 11)	July, 2017	40	Coalition members have made commendable efforts to improve the local conditions of their communities and bring about change. The group organized a study group to review the modules learned during the last training (Modules 6 and 7), focusing mostly on knock-and-talk and capacity building. During the community meetings organized by the coalitions, they decided to conduct a community clean-up every first Saturday of the month, in order to continue to change the physical design of their community
	Lomé	Agbalépédogan	2. CCADA Community Coalition	Togbui AWOUADORGbonfou	011 228 (90 18 92 00)	July, 2017	40	Coalition members have made commendable efforts to improve the local conditions of their communities and bring about change. The group organized a study group to review the modules learned during the last training (Modules 6 and 7), focusing mostly on knock-and-talk and capacity building. During the community meetings organized by the coalitions, they decided to conduct a community clean-up every first Saturday of the month, in order to continue to change the physical design of their community
Uganda	Nansana	Nansana	1. Nansana Community Coalition	Mutaawe Rogers	mutaawe2@gmail.com	N/A	48	This community begin the training process on October 31. Currently working toward recruiting all 12 community sectors to gain support from residents, representatives from institutions and organizations to form the coalition.
	Kawempe	Kawempe	2. Kawempe Community Coalition	Mutaawe Rogers	mutaawe2@gmail.com		40	This community sectors to gain support from residents, representatives from institutions and organizations to form the coalition.
Uruguay	Montevideo	La Unión	1. Coalición Comunitaria La Unión	Haydée Toledo	cel +59 8 95 348 808	3/24/2015	11	The coalition is working on the consumption of Pasta Base (crack) as the main problem. The members are painting a 100 meter wall in the community, and contacting printing press and radio to raise awareness on addictions, and publicize the coalition work. They are also participating in joint work with state agencies in order to solve problems arising from people living on the street and safety/security issue that the coalition is addressing. The coalition is participating in meetings with different sectors and the Municipality to elaborate rules for the good use of public spaces. A survey application process is under way to evaluate the results of the strategies developed in the logic model.
	Maldonado	Maldonado Nuevo	2. Coalición Comunitaria Maldonado Nuevo	Ricardo González	cel +59 8 410 007	9/15/2016	14	The coalition is in the process of collecting data from the community assessment to create the Logic Model. The members are organizing events to introduce the coalitions efforts to the community. The coalition is planning to host a marathon, be part of the city's Carnaval on February 2018 and offer expert conferences to inform the community about substance addictions. The members obtained commitment and interest from the city halls of San Carlos, Piriápolis and Pan De Azúcar to visit them and explain the coalition vision and how they can use the government support to reduce the substance abuse in the community.
22			0				6675	

APPENDIX 3

ICUDDR MEMBER UNIVERSITIES AND CONTACTS

Continents	Country, City	University	Contact person	Website
Africa	Botswana, Gabarone	Boitekanelo College	Mopedi Caesar Lesolame	www.boitekanelo.ac.bw
	Kenya, Nairobi	Kenyatta University	Beatrice Kathungu	www.ku.ac.ke
	Kenya, Nairobi	SAPTA - Support for Addictions Prevention and Treatment in Africa	William Sinkele	www.sapta.or.ke
	Uganda, Kampala	Makerere University	Paul Nyende	www.mak.ac.ug
Asia	Afghanistan, Kabul	Kabul University	Hamidullah Farooqi	ku.edu.af
	Bhutan, Thimphu	Samtse College, Royal University of Bhutan	Dorji Thinley	www.rub.edu.bt
	Kazakhstan, Astana	Astana Medical University	Timur Jakubaliyev	www.amu.kz
	Malaysia, Cyberjaya	Cyberjaya University College of Medical Sciences	Mahmood Nazar Mohamed	cybermed.edu.my
	Myanmar, Yangon	University of Medicine 1	Nanda Myo Aung Wan	um1ygn.edu.mm
	Philippines, Bacolod	University of St La Salle	Ramon Lachica	www.usls.edu.ph
	Philippines, Manila	Philippine Women University	Lina B Laigo	www.pwu.edu.ph
	Philippines, Manila	University of Santo Tomas	Claudette A. Agnes	www.ust.edu.ph
	Philippines, Manila	Ateneo de Manila University	Maria Isabel Melgar	www.ateneo.edu
	Philippines, Manila	College of Saint Benilde - De La Salle	Geronio Ulayao	www.benilde.edu.ph
	South Korea, Cheonan	NamSeoul University	Sejin Ju	www.nsu.ac.kr
	South Korea, Daejeon	Chungnam University	Yoo, Chai-Young	plus.cnu.ac.kr
	South Korea, Seongnam	Eulji University	Young-Ho Kim	www.eulji.ac.kr
	South Korea, Seoul	Sahmyook University	Sung Ik Kim	www.syu.ac.kr
	South Korea, Gwangju	Gwangju University	Hyun-dong Son	www.gwangju.ac.kr
	South Korea, Seoul	Seoul National University	Sungjae Kim	www.useoul.edu
	South Korea, Seoul	Yonsei University	Chul-Hyung Park	www.yonsei.ac.kr
	South Korea, Incheon	Inha University	Choe, Soonja	eng.inha.ac.kr
	South Korea, Gangwon-do	Kwangwon National University	Hye-Sun Kim	www.kangwon.ac.kr
	South Korea, Osan	Osan University	Hyosoon Lee	www.osan.ac.kr
South Korea, Busan	Catholic University Pusan	Yeong Kyu Kim	www.cup.ac.kr	
South Korea, Seoul	Chongshin University	Cho Hyun Seob	www.chongshin.ac.kr	
South Korea, Seoul	Hanyoung Theological University	Eun Hye Kim	www.hytc.ac.kr	
Thailand, Bangkok	Chulalongkorn University	Rasmon Kalayasiri	www.chula.ac.th	

Continents	Country, City	University	Contact person	Website
Asia	Thailand, Bangkok	Mahidol University	Prapapun Chucharoen	www.mahidol.ac.th
	United Arab Emirates, Abu Dhabi	Abu Dhabi University	Smitha Dev	www.adu.ac.ae
	Vietnam, Ho Chi Minh City	Ho Chi Minh City University Of Medicine and Pharmacy	Do Van Dung	yds.edu.vn/yds2
Australia and Oceania	Fiji, Suva	Fiji National University, College of Medicine, Nursing & Health Sciences	Alisi T Vudiniabola	www.fnu.ac.fj
	New Zealand, Auckland	University of Auckland	Peter Adams	www.auckland.ac.nz
Europe	Czech Republic, Prague	Charles University	Michal Miovský	www.cuni.cz
	Italy, Rome	University of Rome Tor Vergata	Carla Rossi	web.uniroma2.it
	Slovenia, Ljubljana	University of Ljubljana	Andrej Starc	www.uni-lj.si
	Spain, Barcelona	Universitat de Barcelona	Xavier Ferrer	www.ub.edu
	Spain, Valencia	University of Valencia	Maria Zarza	www.uv.es
	Spain (Balearic Islands), Palma	University of the Balearic Islands	Carmen Orte	www.uib.eu
	Ukraine, Kramatorsk City	Donetsk National Medical University	Olena Petryayeva	dnmu.com.ua
	Ukraine, Kyiv	Ukraine Research Institute of Social and Forensic Psychiatry and Drug Abuse	Iryna Pinchuk	undisspn.org.ua
North America	Costa Rica, San José	Universidad de Costa Rica	LIGIA MURILLO CASTRO	www.ucr.ac.cr
	El Salvador, San Salvador	Universidad Evangélica	CRISTINA JUÁREZ DE AMAYA	www.uees.edu.sv
	El Salvador, San Salvador	Universidad Centroamericana "José Simeón Cañas"	CAROLINA PAZ	www.uca.edu.sv
	El Salvador, San Salvador	Universidad Jose Matías Delgado	REYNALDO FLORES	www.ujmd.edu.sv
	Grenada, St. George's	St. George's University	Damian Greaves	www.sgu.edu
	Guatemala, Guatemala City	Universidad Da Vinci de Guatemala	NURIA ELIZABETH MALDONADO	www.udv.edu.gt
	Guatemala, Guatemala City	Universidad Galileo	Ana Schneider	www.galileo.edu
	Honduras, Tegucigalpa	Universidad Nacional Autónoma de Honduras	LINA MARÍA MENDOZA RECARTE	www.unah.edu.hn
	México, Mexico	Universidad Anáhuac	PAULINA HUERTA	www.anahuac.mx
	México, Mexico	National Autonomous University of Mexico	Silvia Morales Chaine	www.unam.mx
	Nicaragua, Managua	Universidad Nacional Autónoma de Nicaragua (UNAN)	ROSA CELINDA ZAMORA BELLORIN	www.unan.edu.ni

ICUDDR MEMBER UNIVERSITIES

Continents	Country, City	University	Contact person	Website
North America	Panamá, Panamá	Centro de Estudio de Adicciones	CARLOS SMITH	www7.uc.cl
	Panamá, Panamá	Universidad de Panamá	ENRIQUE LAU CORTES	www.up.ac.pa
	U.S., California, San Diego	University of California-San Diego	Igor Koutsenok	ucsd.edu
	U.S., Kent, Ohio	Kent State University	Peggy Stephens	www.kent.edu
	U.S., Washington, Cheney	Eastern Washington University	Grace Creasman	www.ewu.edu
	U.S., Illinois, Chicago	Governors State University	Cheryl Mehta	www.govst.edu
	U.S., New Mexico, Albuquerque	University of New Mexico	Tim Condon	www.unm.edu
	U.S., Erie, Pennsylvania	Lake Erie College of Osteopathic Medicine	Javier Cordova	lecom.edu
	U.S., Florida, Tampa	University of South Florida	Roger Peters	www.usf.edu
	U.S., Iowa, Ames	Iowa State University	Richard Spoth	www.iastate.edu
	U.S., California, Claremont	Claremont Graduate University	Eusebio M. Alvaro	www.cgu.edu
	U.S., North Carolina, Greensboro	University of North Carolina at Chapel Hill	Hendree Jones	www.unc.edu
	U.S., California, San Diego	San Diego State University	María Luisa Zúniga	www.sdsu.edu
	U.S., New York, Syracuse	Syracuse University	Ignatius Nnamdi Ijere	www.syracuse.edu
	U.S., Richmond, Virginia	Virginia Commonwealth University	J. Randy Koch	www.vcu.edu
	U.S., Pennsylvania, Pittsburgh	Institution for Research, Education and Training in Addictions	Holly Hagle	ireta.org
U.S., Arizona, Tucson	University of Arizona	Kris Bosworth	www.arizona.edu	
South America	Argentina, Buenos Aires	Universidad Nacional de San Martín (UNSAM)	Gustavo Mausel	www.unsam.edu.ar
	Chile, Antofagasta	Universidad de Antofagasta	LUIS BARRA	www.uantof.cl
	Chile, Santiago	Universidad de Chile	FERNANDO IVANOVIC	www.uchile.cl
	Chile, Antofagasta	Universidad Católica del Norte	NÉSTOR MERCADO	www.ucn.cl
	Chile, Valparaíso	Universidad de Playa Ancha	VERÓNICA PASTÉN VALENZUELA	www.upla.cl
	Chile, Santiago	Pontificia Universidad Católica de Chile	KATIA GYSLING CASELLI	www.uc.cl
	Chile, Santiago	Universidad Central	PAULO EGENAU	www.ucentral.cl
	Chile, Concepcion	Universidad de Concepción	JACQUELINE SEPULVEDA	www.udec.cl
	Chile, Temuco	Universidad de la Frontera	RICARDO PEREZ LUCO	www.ufro.cl

Continents	Country, City	University	Contact person	Website
South America	Chile, Punta Arenas	Universidad de Magallanes	EDUARDO PINO ASTETE	psu.umag.cl
	Chile, Santiago	Universidad de Santiago	HUMBERTO GUAJARDO	www.usach.cl
	Chile, Santiago	Universidad Alberto Hurtado	ELIZABETH LIRA	www.uahurtado.cl
	Paraguay, Asunción	Universidad Metropolitana de Asunción	MARIA LIZ GARCIA	uma.edu.py
	Paraguay, Asunción	Universidad Católica "Nstra. Sra. De la Asunción"	DIANA LESME ROMERO	www.universidadcatolica. edu.py
	Perú, Lima	Universidad Peruana Cayetano Heredia	FERNANDO SALAZAR	www.cayetano.edu.pe
	Perú, Lima	Universidad Autónoma	JOSÉ ANICAMA GÓMEZ	www.autonoma.pe

