Dalgarno Drug & Alcohol Resource Team

D.A.R.T Member Paper

'The Rights of the Child' – *Ensuring a 'Child-centred' drug policy is a vital Human Rights issue for those who influence Drug Policy*

An experienced educational and child safety advocate, the author presents an evidence-based paper on children's rights to a healthy life to enable them to reach their full potential. This complex topic makes interesting and powerful reading and is relevant to those who influence drug policy within their own regions and world-wide.

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Introduction

Global drug issues (including manufacture and trafficking of illicit substances) have been controlled through cooperative efforts of many countries, within the framework of the **United Nations Drug Control Conventions** for 100 years. They are designed to ensure that drugs are available only for legitimate *medical* and *research* purposes.

These are the:

- **1961, Single Convention on Narcotic Drugs**.
- **1971 Convention on Psychotropic Substances**.
- **1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances**

Parties to these conventions are required to:

First - take all practicable measures for the prevention of the abuse of narcotic drugs or psychotropic substances.

Second - take steps "*for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved",* who may have become dependent upon these substances.

One hundred years of Drug Control has largely been a success. The evidence includes, but is not limited to the following:

- In 2007 drug control had reduced the global opium supply to 1/3rd the level in 1907.
- During the last decade world output of cocaine and amphetamines has stabilised; Cannabis output has declined since 2004; Opium production has declined since 2008.

However, for our drug policies to be even more effective, governments and community leaders must re-visit a Convention that they have almost unlaterally endorsed. In fact, it is a Convention which is the most universally ratified of all Conventions and which unequivably addresses our obligations to our future generations – those children and young people who will determine the health and viability of our world. This is the United Nations Convention on the Rights of the Child or CRC.

Nowadays, much is being said about Human Rights. There are, indeed, some horrendous examples of human rights violations across the globe. However, if the CRC is implemented, particularly with regards to drug issues, it will make vast inroads into such violations and even the most serious of human rights violations could be eliminated. The following will serve to demonstrate this point.

According to UNICEF 'the Convention on the Rights of the Child is an international treaty that recognises the human rights of children, defined as persons up to the age of 18 years old' to include:

- the right to survival;
- to develop to the fullest;
- to protection from harmful influences, abuse and exploitation;
- and to participate fully in family, cultural and social life.

In particular, the CRC is very specific about the devastation caused by illicit drugs and the associated need for child protection.

There are a number of sections (or Articles) which explicitly require Member States to focus their policies on how they will impact on current and future generations. In particular:

- **Article 33 states that they** : "*shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances*".

- **Article 3 says***: 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'*.

- **Article 6 of the CRC states that "***every child has the inherent right to life and that Member States shall ensure to the maximum extent possible the survival and development of the child"*

- **Article 27** *states that Member States "recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development".*

Most importantly, the CRC was ratified by the majority of Member States in 1989; thus the CRC is deemed to be the most universally accepted UN convention globally. In fact, Colleagues, the CRC directly complements the UN Drug Control Conventions and gives emphasis to the importance of protecting an emerging generation.

There is now an urgent need for governments and community stakeholders to take the lead and revisit this vital Convention. Over the last 20 years, it has been overlooked in many jurisdictions.

Over time, this has resulted in drug policy that has become a 'user-centred' harm reduction model. This has brought with it an unintended consequence of a culture of 'drug-use acceptability' and an increase in drug use.

For instance:

- The 2010 National Household Drug Survey has revealed an increase in illicit drug consumption and use since 2007.
- **I**n 2008, research compiled by the Australian Institute of Family Studies found that a substantial number of Australian children are living in households where adults routinely misuse alcohol and other drugs. The AIFS research further shows that in cases of substantiated child abuse or neglect, 33 per cent of parents experienced significant problems with substance abuse and 31 per cent with alcohol abuse. And disturbingly, it is estimated that 30 per cent of abused or neglected children go on to maltreat children in some way when they are adults. It also warns that existing data underestimates the impact of drug and alcohol abuse on children, because current national surveys do not collect information on parental status or child care responsibilities.

- An Australian Institute of Health and Welfare (AIHW) report released in January 2011, entitled , ***Child protection Australia 2009-10,*** showed that - 'In the last 12 months, the number of children on care and protection orders has increased by 7% to just over 37,700 and the number of children in out-of-home care has risen by 5% to around 35,900'. Aboriginal and Torres Strait Islander children remain over-represented in all areas of the child protection system, with Indigenous children almost 8 times as likely to be the subject of substantiations as their non-Indigenous counterparts.

- A report from the Victorian State Government, released in October 2011 shows an alarming trend – which could well be a reflection of other communities in Australia. Here is some of the information revealed:
  'Child protection workers received a staggering 5828 complaints of neglect in 2010-11. In the worst substantiated cases, overworked investigators found children left in conditions so bad they had to remove their rotted teeth and teach them how to sit at a table. Shocking revelations of abuse included incidents of toddlers being left to starve among human waste, rat infestations and used syringes in their toy boxes

The saddest reality of all is that there is **a correlation between child abuse and drug abuse – with a multiplier effect, which is now intergenerational.** This has huge ramifications for drug policy makers and our emerging generation.

According to a report compiled by UNICEF Malaysia Communications entitled *Drug abuse & its impact on children and young people* (2007): 'Drug abuse by a family member will have a significant and enduring impact on the family dynamics and functioning. For instance:

- A child's basic needs - diet and nutritional intake, health and schooling - may become neglected if a parent is more preoccupied with drugs.
- A child is at risk of emotional and physical neglect as they grow. These children also risk developing emotional and social problems later in life.
- A child could be the victim of violence – both physical and mental from a family member who is abusing drugs.
- A child may lose out on childhood to adopt adult responsibilities having to provide both practical and emotional care for their parents who abuse drugs. This includes protecting their parents from harm.
- Older siblings may be expected to look after their younger brothers and sisters – to ensure they continue to go to school, to keep the home in order.
- A child may develop drug problems as a result of being exposed to drug culture in the family.

While it is true that, in many developed countries there is now greater awareness of the need for child protection, unfortunately, all too often, the priority has reverted to intervening with protective measures after the fact - that is after instances of abuse have been identified. In too many cases, this is far too late – and has had very serious repercussions. It is like the scenario of placing an ambulance at the bottom of a cliff, instead of a fence at the top to prevent the fall in the first place.

A second reason to re-visit the CRC is the very concerning reality of the lack of robust and consistent reporting in child abuse cases in many regions.

For instance:

- The World Health Organization (2002) estimated that worldwide, 57,000 children were victims of homicide in 2000, but stated that many child deaths were not routinely investigated (WHO, 2002). and more recent data are not available. *(Source National Crime Prevention Council (NCPC) Resource Sheet, December 2010)*
- According to Australia's National Crime Prevention Council (NCPC) 'It is difficult to obtain accurate statistics about the numbers of children who die from child abuse or neglect in Australia because comprehensive information is not currently collected in every jurisdiction' It appears that some states in Australia are making good progress in their reporting on the correlation of drug abuse and child abuse, while others are not doing so at all.

If drug policy gave priority to implementing the principles of the CRC, we would put effective protective factors in place much earlier

There are some very good examples already in place. This paper will discuss two – the drug strategies of Sweden and the United Kingdom.

Sweden remains a world leader in implementing a successful drug policy. While it has many facets, its main focus is on primary drug prevention.

The combination of resources for preventive activities such as information to school children, different types of treatment programs, both community based and in correctional institutions, and an efficient control policy within the Criminal Justice system, has resulted in Sweden having one of the lowest per capita drug use rates in Europe.

The Swedish Action Plan on Narcotic Drugs 2006–2010 states that **'long-term preventive work to achieve a drug-free society must continue. The work at local level is crucial to achieving successful results. At the same time cooperation within the EU and internationally must increase, as almost all illegal drugs consumed come from outside Sweden. Children, young people and parents will be given special priority as target groups in the coming years'.**

In particular, preventive work in schools is a top priority. School is one of the most important environments in the community for promoting the health of children and young people and preventing drug abuse and other risks to which young people are exposed. The National Institute of Public Health was assigned the task of spreading knowledge to decision-makers and civil servants in local authorities and to schools concerning effective methods of strengthening anti-drug efforts in schools.

In March 2011 at the UN's Commission on Narcotic Drugs, in Vienna, Maria Larsson, Swedish Minister Children and the Elderly, confirmed Sweden's commitment to the CRC. To quote part of her speech: 'Children and young people must be our focus. Prevention directed towards young people is a key to a successful drug-policy. The Convention on the Rights of the child is a commitment we all share, as well as useful tool in this work'.

Since then a stronger alliance has formed between Sweden and a number of countries including the United States, to find common ground in drug policy priorities.

The second example of a drug strategy that has turned towards primary prevention is that of the UK Drug Strategy - 2010 :

This strategy has taken a new direction with its completely new focus on drug prevention and the special needs of young people. One of its overarching objectives in its current drug strategy is: '**Reducing demand**. **It also recognises that** young people's drug use is a distinct problem and can have a major impact on young people's education, their health, their families and their long-term chances in life.

The Drug Strategy in the UK has specific and measurable objectives are in place that will aim to:

- break inter-generational paths to dependency by supporting vulnerable families;
- provide good quality education and advice so that young people and their parents are provided with credible information to actively resist substance misuse;
- intervene early with young people and young adults;
- consistently enforce effective criminal sanctions to deter drug use; and
- support people to recover under the 'Building recovery in communities' initiative.

Specific initiatives are aimed at targeting young people. They are the recognition that:

- All young people need high quality drug and alcohol education so they have a thorough knowledge of their effects and harms and have the skills and confidence to choose not to use drugs and alcohol.
- Schools have a clear role to play in preventing drug and alcohol misuse as part of their pastoral responsibilities to pupils. Teachers are to be empowered to provide information, advice and accurate information on drugs and alcohol through drug education and targeted information, using the FRANK service.
- Tackle problem behaviour in schools, with wider powers of search and confiscation. in school.
- Work with local voluntary organisations and the police to prevent drug or alcohol misuse and to support approaches to best meet the needs of excluded students.
- Those from disadvantaged backgrounds will be assisted by the 'pupil premium'.
- Initiatives such as Healthy Schools will also have a key contribution to make to improving the health and wellbeing of pupils.

In addition, there is a new initiative to help young people remain in school, education or training until the age of 18, with financial support for the most disadvantaged.

Of importance is the fact that, while the Government is challenging people to be responsible for their actions, it will also ensure that they are aware of the consequences of those actions.
One of the critical success factors of the Strategy is an initiative to support people living a drug free life. Provision is being made to access reliable information on the effects and harms of drugs, including new substances. They will be able to access advice, information and support if they, their children, or someone they know is at risk of drug misuse.

The UK Strategy also recognises that there is a target group of young people who face an increased risk of developing problems with drugs or alcohol. Vulnerable groups - such as those who are truanting or excluded from school, looked after children, young offenders and those at risk of involvement in crime and anti-social behaviour, those with mental ill health, or those whose parents misuse drugs or alcohol - need targeted support to prevent drug or alcohol misuse or early intervention when problems first arise.
Developing responses to these needs is best done at the local level, supported by consistent national

evidence and advice on effective approaches. Funding at a local level will be simplified and will include the creation of a single Early Intervention Grant, worth around £2 billion by 2014–15. This will draw together a range of funding streams for prevention and early intervention services, allowing local government the flexibility to plan an approach to reach vulnerable groups most effectively.

Some family-focused interventions have the best evidence of preventing substance misuse amongst young people. Local areas are already using a range of family-based approaches. These have led to significant reductions in risks associated with substance misuse, mental ill health and child protection and have led to reductions in anti-social behaviour, crime, truanting and domestic violence.

With 41% of the young people in in the UK seeking support for drug or alcohol misuse also being within the youth justice system, new funding arrangements for youth justice services will incentivise local government to find innovative ways to reduce the number of young people who commit crime, including tackling drug or alcohol misuse where this is part of the reason for their offending. Directors of Public Health and Directors of Children's Services will be empowered to take an integrated and co-ordinated approach to determine how best to use their resources to prevent and tackle drug and alcohol misuse.

While the above is only a snapshot of the initiatives of Sweden and the United Kingdom's approach to drug policy and their primary focus on children and young people, it is hoped that they will serve as examples to other governments which seem to have priorities centred differently – with more focus on treatment, rather than on prevention. While this is probably an unintended consequence of dealing with a burgeoning problems of increasing illicit drug use, the issues will never be resolved, if we fail to effectively our emerging generation of young people.

Conclusion

It is important to note that a 'child-centred' drug policy does not exclude assistance to people who are drug dependent. It does, however recommend greater emphasis on the need for a 'recovery-based' treatment approach, so that people will have more chance of returning to a productive and fulfilling lifestyle, than is currently on offer in a number of jurisdictions. As there is evidence of earlier onset of drug use, recovery-based treatment also extends to those children and young people who have become addicted at an early age**.**

The solutions for governments and communities are quite simple.

Firstly, review national and jurisdictional drug policy so that it becomes child-centred, with a focus on demand reduction, prevention and early intervention of initial uptake of drugs. If children have become drug addicted, their treatment must be recovery-focussed.

A good place to start would be at the strategic level – with the country's national drug strategy. Ensure that the spirit of the relevant Articles in the Convention on the Rights of the Child are documented in a prominent place, preferably in the introduction, and then detailed in relevant sections. Where national Child Protection strategies are in place, ensure that similar principles are cross referenced in other policy areas – critical one being education policy. Where such national strategies are yet to be established, ensure that this becomes a high priority.

At operations level (whether national or under a regional jurisdiction) the following is recommended:

Step 1 – Review all existing drug policies.
Step 2 - highlight all areas in existing illicit/illegal drug policy that relates to children.
Step 3 – Ensure that the articles within the spirit of the CRC are included as a matter of priority.

Finally, and as previously stated, one of the gaps to close in our current methodology when implementing drug strategies and policy is that of establishing **more robust reporting mechanisms related to child abuse and associated drug use.** In particular, when reflecting on the spirit of the CRC, we need to ensure more robust national and ideally, inter-country (regional) mandatory reporting mechanisms, with effective and timely follow through. There is evidence of pockets of good practice in this regard and Drug Free Australia will be working towards identifying these and sharing any jurisdictional systems that are well implemented.

Now is the ideal time for each and every country to re-confirm their commitment to the CRC.
Drug policy that prevents harms caused to children, including the unborn, can be the much needed 'circuit-breaker' in the escalating demand for drugs world wide.

References:

1. *Cohort trends in the age of initiation of drug use in Australia*, Degenhardt L, Lynskey M, Hally W. Australian and New Zealand Journal of Public Health. Volume 24, Issue 4
2. *Drug Affliction(What you need to know)* - Dr Ian Oliver, 2006
3. *The Right of Children to be Protected from Narcotic Drugs and Psychotropic Substances* – Stephan Dahlgren and Roxana Stere, WFAD 2010
4. UNICEF – CRC - http://www.unicef.org/crc/
5. Summary of CRC Articles http://www.unicef.org/photoessays/30556.html
6. *Drug abuse & its impact on children and young people* - UNICEF Malaysia Communications, *2007*
7. *Hidden Harm,* AMCD 2003 Report
8. *Child protection Australia 2009-10, AIHW*
9. *Illicit Drug Use among Women with Children in the United States: 2002–2003*, Simmons, Havens, Whiting et al
10. *Australian Institute of Family Studies Research Report*, 2008
11. *National Framework for Protecting Australia's Children 2009-2020* - http://www.pollyandme.com.au/documents/PromotingSharedResponsibility.pdf
12. *National Crime Prevention Council (NCPC) Resource Sheet, December 2010*
13. *Child Maltreatment 2008* - US Department of Health and Human Services (2010)
14. *Child Abuse in Sweden***,** Joan E. Durrant, Ph.D. 2003
15. *Swedish Action Plan on Narcotic Drugs 2006-2010* http://www.politicheantidroga.it/media/327726/swedish.pdf
16. UK Drug Strategy 2010 http://www.homeoffice.gov.uk/drugs/drug-strategy-2010
17. Lancet Report on Australia and New Zealand high drug use rates – editorial summary http://www.perthnow.com.au/news/high-society-australia-tops-list-of-drug-users/story-e6frg12c-1226238240177