

# *The Challenge of Addiction*

*Foundations for a Future Oriented Policy  
on Addiction in Switzerland*



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## Foundations for a Future Oriented Policy on Addiction in Switzerland



The *Report on the Challenge of Addiction* is intended as a contribution towards an integrated understanding of addiction policy on the basis of a public health approach. From a health policy perspective, the Report proposes broadening the scope of addiction policy in Switzerland and changing its strategic focus and direction. It recommends ten principles. These are intended to contribute to a coherent policy response to the problematic consumption of all psychoactive substances and to behaviours with addictive potential.

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# Foreword

Current addiction policy in most European countries including Switzerland consists primarily of a range of separate policies on alcohol, tobacco and illegal psychoactive substances. There is little or no coordination of these policy sectors. In point of fact, for each of the substances or spheres of activity, quite specific requirements must be taken into account, such as social acceptance or the distinction between legal or illegal substances. In recent years, demands for a coherent approach to addiction policy have gained increasing support. Such a demand was put forward with great clarity in the expert report “psychoaktiv.ch” by the Federal Commission for Drug Issues (FCDI), which in 2005 emphatically recommended the development of an addiction policy framework.



The present Report may be regarded as an important step in this direction. It was commissioned by the Federal Office of Public Health and prepared by a common steering group drawn from members of the three federal commissions in the field of addiction: the Federal Commission for Alcohol Issues (FCAI), the Federal Commission for Drug Issues (FCDI) and the Federal Commission for Tobacco Control (FCTC).

The proposals presented in this Report are intended to provide the desired framework for the discussion of a future oriented addiction policy in Switzerland. It broadens the perspective, going beyond the responsibilities of the existing commissions in order to expand the area of enquiry and propose new strategic approaches. In doing so, it calls into question the very concept of addiction policy as it is narrowly defined. The *Report on the Challenge of Addiction* deliberately leaves room for manoeuvre for the various stakeholders. Specialists, as well as practitioners and people from administration and politics will be able to take part in the process resulting from this Report and to shape the way in which the recommendations of the Report are implemented with their specialist knowledge and experience.

The *Report on the Challenge of Addiction* is aimed at a broad and diverse group of stakeholders in the political arena, academia and practice, and in organisations that deal with issues of addiction. It is, however, also aimed at all those persons who are affected in one way or another. The proposed approaches in terms of scope and strategy represent the agree-



ment of the three Commission delegations and are deserving of a broad discussion. Addiction policy can ultimately only be taken to the next level when it is in step with society's prevalent understanding of addiction, the scientific evidence and the experiences of those affected.

This also implies revisiting more general issues such as the social value of health and human well-being, as well as the cultural question that arises from the consumption of stimulants for pleasure. Some observers argue for a rediscovery of the culture of enjoyment and pleasure, as opposed to the culture of excess and rapid consumption. The path to such a destination, however, stretches out before us – the *Report on the Challenge of Addiction* is designed to help make the journey shorter and easier.



Pascal Strupler  
Director of the Federal Office of Public Health

# About this Report

## The Authors

The *Report on the Challenge of Addiction* has been produced jointly by delegates of the three Federal Commissions for Alcohol-related Issues (FCAI), for Drug-related Issues (FCDI) and for Tobacco Control (FCTC). As these Federal Commissions had previously worked separately from each other, working together on this Report made it possible for them to compare their approaches and exchange their experiences over a period of two years. In view of the need for a coherent addiction policy, they gave priority to the common ground offered by a public health approach, despite differences on certain issues specific to their areas of responsibility. This made it possible to agree on a joint policy framework.



## Aim and target group

The *Report on the Challenge of Addiction* aims to stimulate a broad debate on the subject of addiction from a health policy perspective and to prepare the way for a future oriented addiction policy. It does so in full recognition that this view competes with other approaches in politics, society and in business that frequently gain more attention. The Report does not simply focus on issues related to dependence on psychoactive substances, i. e. the routine subject matter for addiction policy. It provides an evidence-based expansion of its scope as well as a strategic reorientation. The Report introduces a policy framework which summarises a set of ten guiding principles that can contribute to a coherent policy on the **problematic and high-risk consumption** of all psychoactive substances or behaviours with addictive potential.

The *Report on the Challenge of Addiction* is aimed not only at stakeholders in academia, professional practice and in organisations that deal with addiction issues. It is also specifically aimed at politicians and the public: the Report and in particular the guiding principles inherent in the policy framework represent the joint basic health policy objectives as devised by delegates of the three commissions. ***The intention is for the principles of the policy framework to become the subject of an ongoing debate*** – recognising that the key elements and objectives of addiction policy are subject to the outcomes of political negotiations. Ultimately, the proposed principles can only prevail if the measures correspond to the predominant understanding of addiction in society. This Report intends to contribute to this in-depth discussion on the basis of scientific knowledge and evidence.

# Summary

Current addiction policy in Switzerland concentrates primarily on the three areas of alcohol, tobacco and illegal drugs, which until now have demonstrated few points of intersection. For each of these areas, the Federal Council has set up a respective commission of experts, the Federal Commissions for Alcohol Issues (FCAI), Drug Issues (FCDI) and Tobacco Control (FCTC). Earlier, these Commissions, independently of each other and to a different extent, had begun to pursue a *public health strategy*, or at least elements of such a strategy. The delegates from these Commissions, who were requested by the Federal Office of Public Health (FOPH) to develop a coherent addiction policy framework, have accordingly based their work on a *public health approach*. They have used this approach as an instrument to *assess what has been achieved and to identify the present and future need for action*. The result is this Report with its accompanying policy framework.

*The Report and the policy framework aim to reduce the burden on individuals, their direct environment and on society. To achieve this, the Report proposes three changes to the scope and three changes to the strategic direction of Swiss addiction policy.*

*The scope* of addiction policy in Switzerland should be expanded so that:

- it not only takes account of dependence as narrowly defined, but above considers all problematic consumption, together with the constantly changing patterns of consumption ("*more than dependence*"),
- it assesses all substances according to the burden of disease they cause, and not merely according to whether they are legal or illegal, or licit or illicit ("*more than legal status*"), and
- it also covers behaviours with addictive potential ("*more than substances*").

*The strategic reorientation* of addiction policy in Switzerland should:

- help make the healthy choice become the simpler, more attractive and more beneficial option (“*more than personal responsibility*”),
- retain a strong emphasis on the protection of young people, but also do justice to the fact that problematic consumption and dependence are not restricted to young people (“*more than youth protection*”), and
- refrain from staking everything on policy measures within the health sector, but include those policy arenas that also have a decisive influence on addiction policy, and involve other stakeholders (“*more than health policy measures*”).

This expansion in terms of scope and strategy of a policy which until now has been divided into separate areas is reflected in the policy framework. On the basis of a public health approach, the Report sets out *ten guiding principles for an effective future policy on addiction*. The key orientations are the same as for the Report: the prevention of problems arising from substance abuse and problematic modes of behaviour and the reduction of the harm suffered by individuals, their social environment and society as a whole.



# 1 Introduction

## The problem of defining addiction

The word “*addiction*” does not fully capture the content of this Report, and the term is also burdened by its almost inflationary overuse in everyday speech. However, there is no other word that can adequately cover the many different dimensions discussed in this Report either. When the Report speaks of the *Challenge of Addiction*, it refers to the patterns of psychoactive substance use or the behaviours that have the potential for addiction and which warrant *action in the area of health policy*. This means that the most important objective of addiction policy lies in various forms of harmful use, habitual consumption and problematic consumption; this new form of addiction policy does not deal primarily (or exclusively) with dependence.

In the literature on addiction, the concept of *dependence* is used to designate symptoms that may include mental, physical and social harm and other consequences arising from consumption of substances. The same term may be applied to forms of behaviour, such as gambling, that are not substance-related but which can equally lead to dependence. The most recent findings in the neurosciences regard dependence as a process combining biological, mental and social factors in which the brain adapts itself biologically to the act of consumption. Dependence is described as a consequence of repeatedly disrupted regulatory events in the reward system.<sup>1</sup> The effects perceived as positive by the individual cause similar processes in the brain regardless of the substance or behaviour.<sup>2</sup> A typical effect is the recurrent urge to have the substance when it is no longer present in the body, which increases when the substance is within easy reach or the person concerned is exposed to the substance or reminded of it in some way.

It must be borne in mind, though, that while no society is free from stimulants and addictive substances,<sup>3</sup> the manner in which the various substances are consumed is subject to change in all societies and all time



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periods; both attitudes and the available substances can change. Certain stimulants which at a certain time are perceived as addictive later become acceptable and are regarded as a source of enjoyment, and vice versa. The history of coffee or opium illustrates this clearly.

The consumption of addictive substances always fulfils a diversity of social and individual needs, ranging from pleasure to culturally and socially bound behaviours and rituals, the conscious breaking of rules, and inducing intoxication and euphoria. Consumption can increase psychological functions such as feelings of well-being and relaxation. It can also help reduce inhibitions, alleviate anxiety and pain, and suppress unpleasant memories; it may also be intended to sustain or increase performance. For these reasons alone, it would not be appropriate to declare all consumption to be addictive or to seek to regulate every potentially harmful form of behaviour.

Many substances are consumed without causing any problems in the majority of cases, although in some cases even a very small quantity can affect a person's health. *From a public health perspective, however, the focus is on those patterns of consumption that are called substance-related disorders.* These patterns – with differing levels of frequency and seriousness depending on the substance – concern consumption with undesirable physical, mental or social consequences. Habitual consumption in particular can, depending on the substance, lead to dependence with the corresponding consequences for the individual and his or her environment. And it is not always the substances themselves that are harmful to health; often harm is also caused by accompanying components or circumstances. In the case of tobacco, for example, addiction is due to the substance nicotine, but regular consumption of tobacco products exposes smokers to other harmful substances (including tar and carbon monoxide) that damage their health.

## The choice of a public health approach

Based on the fact that the problems arising from the consumption of psychoactive substances and from potentially addictive behaviours are highly relevant to the health of the population, the delegates of the three commissions agreed that a public health approach constituted the most appropriate framework for their deliberations. Such an approach provides a common foundation for an addiction policy that can be applied to all psychoactive substances and potentially addictive behaviours, and in particular to problematic patterns of consumption and the environments which induce them. There are three major characteristics of a public health approach in particular that facilitate common approaches in many different areas of addiction policy:

1. A public health perspective requires a focus that goes beyond the identified health problem to include and ***promote healthy behaviour combined with broad structural interventions***. While structural interventions incorporate social and environmental measures, and measures relating to social inequalities, the promotion of healthy behaviour seeks to strengthen the resources and skills that enable individuals to assume responsibility for their own health more readily. The public health view also includes, where this is useful, a reduction of harm and access to therapy.
2. From a public health perspective, the nature and extent of government action are determined for each health problem according to a number of factors: the common good, the burden of health problems on the public at large and the individuals concerned, the social and economic consequences, and the responsibility for protecting vulnerable groups.
3. From a public health perspective, a precise observation of social development is indispensable in order to ensure successful implementation. Healthy forms of behaviour derive from and are formed as a component of social and cultural change processes; they are ever more closely connected to the world of consumption and the media, and they reflect processes of individualisation and differentiation in society.

The use of a public health approach in addiction policy therefore means reconsidering the responsibility of the state. This applies in particular in relation to the prevention of problems arising from the consumption of and risky exposure to psychoactive substances and potentially addictive forms of behaviour. Too frequently the debate focuses on the pros and cons of banning substances or restricting forms of behaviour and neglects the very broad scope of government action in relation to addiction. Depending on the situation, the state may provide information, engage in prevention measures, set up task forces, provide incentives, introduce statutory regulations and enforcement procedures (law enforcement), regulate markets and limit harm. All these measures also fall within the purview of this Report.

A public health approach includes one further important characteristic that links it closely to the challenges of a future oriented addiction policy: it draws early attention to important trends in the health of the population and thus enables action based on foresight, and not merely reaction.

## The building blocks

In Switzerland, a great deal has already been achieved in addiction policy, and some of these achievements have come to be recognised internationally as models of their kind. The work that went into this Report accordingly builds on the important addiction policy advances of recent decades, such as the *psychoaktiv.ch* Report,<sup>4</sup> the national programmes on alcohol (NPA)<sup>5</sup> and tobacco (NPT)<sup>6</sup> and on the third package of measures introduced to reduce the problems connected with drugs (MaPaDro III);<sup>7</sup> there are also significant approaches at cantonal level and at local level. All these factors have stimulated a lively social and political debate on addiction, dependence and problematic consumption in Switzerland, and in doing so they have contributed to a change in the landscape of addiction policy.

Recent decades have shown that new principles can certainly be introduced into addiction policy in Switzerland. An example with a high international profile is the *move from an exclusively abstinence-oriented approach in policies related to illegal drugs to an approach that includes harm reduction*. Harm reduction has now gained social acceptance and has been codified in Swiss law since a referendum in 2008.<sup>8</sup> Harm reduction acknowledges that besides the immediate harm caused by the consumption of substances, there can also be subsequent harm that is preventable. That this approach can be used not merely in relation to illegal substances is demonstrated by an example from the area of alcohol: the early identification of a *designated driver* or the provision of means of transport home at events involving high alcohol consumption. By doing this it is possible to prevent traffic accidents as harmful consequences of alcohol consumption.

In relation to tobacco, a certain reorientation of policy has consisted of a move away from an approach aimed solely at smokers towards the protection of third parties, the passive smokers. The associated policy is aimed at local bans on smoking in certain environments as a means of limiting the harm to third parties and also of cutting back on smoking generally.

Many of the goals, models and principles developed up to now in Swiss addiction policy are still highly relevant. These include the Four Pillars Policy on drugs and the principle of harm reduction in illegal drug policy. They have in the meantime become firmly established as a mindset in political thinking and drug policy action and are not presented in detail in this Report. What is significant is the extent to which they are also valid for other areas of addiction. Many of the health policy proposals in the areas of prevention, health promotion and market regulation have not yet received the political go-ahead for their implementation, despite the fact that experts are largely in agreement on the importance of precisely these areas of action. Accordingly, these areas will be closely dealt with in this Report.

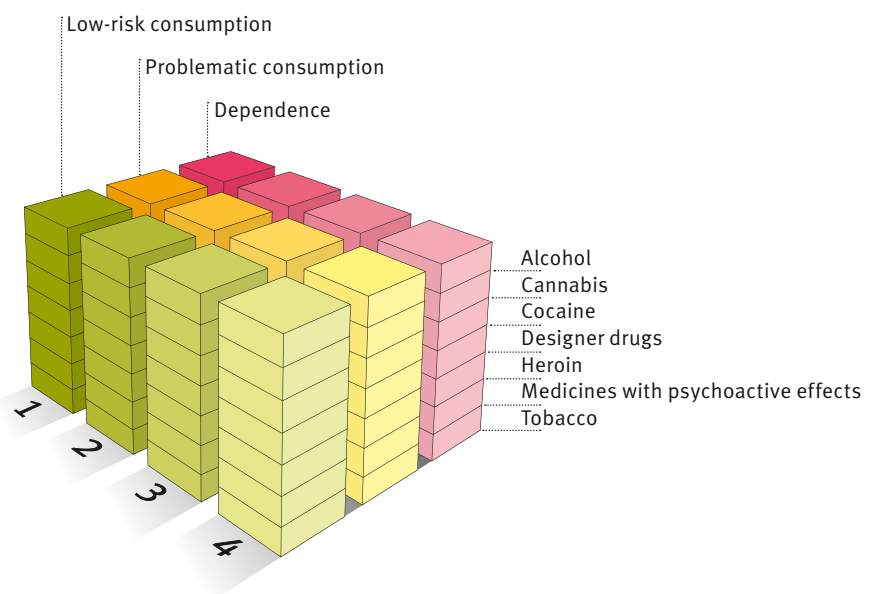
In Swiss drugs policy, the cube model (s. Figure 1) of *psychoaktiv.ch* has been useful in explaining the complexities of substance-related strategies to a public that extends far beyond the world of specialists. The cube establishes the relationship between the **three dimensions of an addiction policy**, whereby the various elements may be weighted differently, depending on the type of substance or problematic behaviour:

- the Four Pillars of Swiss addiction policy (prevention and health promotion, therapy, harm reduction and market regulation/law enforcement),
- the various psychoactive substances irrespective of their legal status, and
- the patterns of consumption, which, depending on the substance, are divided up into low-risk consumption, problematic consumption, and dependence.

Even though these classifications do not apply equally for all substances, this model has helped towards a major advance in understanding.

**Figure 1**

The cube model from the *psychoaktiv.ch* Report by the Federal Commission for Drug Issues (FCDI, 2006; slightly amended). The model does not represent any specific form of drugs policy, but should rather be used for testing and improving individual measures or even the entire addiction policy of a country. The substances are listed in alphabetical order.



- 1 Comprehensive prevention: Health protection, health promotion and early recognition
- 2 Therapy: Therapy with various treatment options; social integration
- 3 Harm reduction: For individuals and for society
- 4 Law enforcement: Market regulation and youth protection

## Areas of tension involving Individual – Society – State – Market

For the public health perspective of this Report, it is particularly significant that the protection of health is considered a duty of the state by Article 118 of the Swiss Federal Constitution. Narcotic substances are explicitly mentioned in this article, at the same time as foodstuffs, therapeutic products, organisms, chemicals and products that may damage health. The policy makes a clear distinction, however, between narcotics (banned under criminal law) and other substances or products (subject to a whole range of market regulations, including total prohibition).

In the area of addiction policy, this constitutional principle of *health protection* repeatedly comes into conflict with the constitutional principle of *economic freedom*, guaranteed in Article 27 of the Swiss Federal Constitution and in the cantonal constitutions. Economic freedom is a fundamental right in Switzerland, but despite this, a restriction of economic freedom may be justified provided it is based on an overriding public interest, is based on appropriate legal provisions and goes only as far as is absolutely necessary.

This is the exact point at which the arguments start. First of all, with regard to the relationship between the state and the economy: where does economic freedom end and where exactly does the state's responsibility for health begin? Secondly, with regard to the relationship between the state and the individual, there is on the one hand the issue of the freedom and the responsibility of citizens, and on the other the extent to which the state may encroach on these by enacting laws. Is the state authorised to intervene in a supportive or regulatory manner, and if so to what extent? How the state acts in this area of tension is largely dependent on the concept of the state and of the values prevalent in a diverse society. Modern societies, it is true, have largely accepted that persons suffering from dependence are ill and entitled to medical help and treatment. There



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is a markedly lower acceptance, however, of many of the preventive measures that would be required in order to curb the problems of addiction at an earlier point of intervention.

In addiction policy therefore, there is a constant need to consider the complex dynamic between individual, society, the state and market forces. The dangers or harm induced by a substance, for example, must always be assessed against its utility as perceived by individuals; or consideration must be given to the extent to which it is necessary to intervene on health grounds in the market or to restrict the choices of a majority with low risk patterns of consumption. Since state interventions touch on a wide number of interests, the debate on health policy proposals sometimes makes a provocative reference to a culture of prohibition or to a “nanny” state. In addition, such considerations and assessments are rendered even more difficult as a result of the largely historical but scientifically unfounded distinction between legal and illegal substances.<sup>9</sup> They are, however, also frequently reinforced for ideological reasons. In Switzerland moreover, many government interventions on health must be voted on politically, either in Parliament or in popular votes or referendums. This process is time-consuming and occasionally has a delaying effect. Precisely for this reason, however, it can also constitute a social learning process, as was demonstrated by the one step at a time acceptance of the Four Pillars approach in drugs policy over two decades or so of extensive discussions.

As a result, the boundaries in this area of conflicting interests have to be renegotiated over and again, and cannot – on account of substantial economic interests – simply be shifted for the benefit of health protection. In Switzerland, the long tradition of liberal thought has helped bring about harm reduction as a firm element of illegal drugs policy, but it is also precisely on account of this tradition that it is exceedingly difficult to impose restrictions on the legal market. It is also the case that the criminal law approach with regard to illegal drugs is more readily accepted and has more political support at present than an approach that would regu-

late the market. The public debate, however, often neglects to consider just how powerfully the individual's freedom of choice is influenced by environmental and market factors, even though entire research institutes are devoted to exactly this source of influence (s. Chapter 5).

From a public health point of view, it is undeniable that certain patterns of consumption and behaviour can have major negative consequences, both in the short and long term. This means that they lead not only to costs to the health care system, but also to additional social costs. The state and the mechanisms of social solidarity (health insurance companies, invalidity insurance and accident insurance schemes, organisations at local level) cannot by themselves deal with the risks and the externalities of products and services, without also influencing how they are designed and made available. A coherent addiction policy is therefore required, which will also need to enlist the responsibility of other stakeholders: the actors in the marketplace, social organisations and associations and other official bodies and institutions. There is a growing awareness that there is a need to regulate products and services that pose a risk to health, at the level of production and advertising, and in relation to the modalities of distribution. Both the pricing and the marketing of legal addictive substances such as alcohol and tobacco are increasingly coming under scrutiny. In some European countries for example, it has been possible to use pricing policy in order to cut back sharply on the consumption of alcopops.<sup>10</sup>

### **Contradictions and conflicts of interest in addiction policy**

A public health perspective on addiction, dependence and problematic consumption impinges upon many interests, players and policy arenas (s. Chapter 2 and 5). Accordingly, reactions are frequently contradictory, and not merely in Switzerland. Something that is unacceptable from a health point of view may enjoy considerable support when seen from a law-and-order perspective. It is for example difficult for society to accept that certain products like tobacco or alcohol are not consumer goods like any others, but are substances which can carry a high potential for addiction. From a health

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perspective, the production and marketing of such products requires regulation appropriate to the risks they pose to health. In liberal societies, this contrasts with standpoints that use enjoyment, freedom of choice and personal responsibility as arguments against state intervention.

At the same time, there is a steady increase in demands for greater state intervention in the law-and-order domain. These are heard in relation to the close connection between excessive alcohol consumption and violent behaviour in the context of public safety at sports events, for example. Restrictions on smoking for the protection of non-smokers – for example in restaurants – are often criticised as infringements of the personal freedom of smokers and restaurant proprietors. They are far less frequently accepted as measures to protect fellow human beings, as applies for example in the case of the prohibition of driving under the influence of alcohol. In the Swiss context, it is also not recognized that such measures have been introduced following democratic referendums in which they have received a high level of public support. But due to social and political attitudes, the personal freedom demanded for smokers does not extend to cannabis users. When it comes to new phenomena, such as the use of brain performance-enhancing drugs or so-called internet addiction, the positions are not yet clearly apparent, but here too similar fields of conflict are emerging.

In conclusion, it may be said that from the public health perspective, current addiction policy in Switzerland tends to be characterized by entrenched positions. These are frequently based on misjudgements and prejudices, rather than on the evidence of the actual health burden for those directly involved, for third parties and for society as a whole. This means that the policy cannot be said to be well prepared for the future. If the evidence base of the disease burden was accepted as the decisive factor for policy formulation, the political priorities would be different.



## 2 Public Health as the Basis for a Future Oriented Addiction Policy

The *Report on the Challenge of Addiction* follows the approach that is prevalent in today's public health science in its explanation of the causes of dependence and the ensuing consumption patterns, as well as with regard to understanding problematic and risky behaviour.<sup>11</sup> Such an approach starts from the assumption that the behaviour patterns involved have many different components which relate to individual factors and social influences as well as to the nature of the substance involved. Similar to the multiple-cause model in the drug area, a public health approach takes account of the relationship between the individual, the social environment and the substance or the addictive behaviour. Because of the impact on health and the consequential disease burden, however, it includes in its activities not only dependence but also problematic consumption. Health experts are in broad agreement with a coherent public health approach to addiction policy, and have repeatedly called for its introduction in Switzerland.

### What constitutes a public health approach?

A public health approach is an approach to health policy, "that has the objective of improving health, longevity and the quality of life for entire populations through the promotion of health, the prevention of illness and other health related interventions."<sup>12</sup> In addiction policy, a public health approach is gaining in importance throughout Europe,<sup>13</sup> not least because it can offer a common foundation for areas of activity that have hitherto remained separate. In what follows, some of the central dimensions of this approach will be presented briefly in order to show how relevant such an approach is to addiction policy. In the area of addiction, it facilitates approaches that are related to substances as well as substance non-specific interventions. The key dimensions of such an approach are: *the burden of health disease, social determinants, government action for the common good, the integration of structural prevention and behavioural prevention as well as health in all policies.*

*The burden of disease:* the starting point for any public health strategy is the burden of disease for society. This can be measured in various ways. The mortality rate is no longer the only measure; it is now complemented by the metrics of the frequency and distribution of disease and by the consequent burdens incurred by society. The measurement known as “DALY” is being used increasingly: it measures not only mortality, but disability free life years (see Table “The ten most important risk factors for disease in Switzerland”). Public health research shows that the severe health consequences caused by day by day and problematic substance abuse and by certain problematic behaviour patterns affect far greater numbers of the population<sup>14</sup> and thus on the whole have greater health consequences than the smaller numbers affected by dependence as defined in medical terms.

**The ten most important risk factors facing health care in Switzerland**

Risk Factor	In percent of all DALYs*
Tobacco consumption	11,2
Hypertension	7,3
Alcohol consumption	7,2
High body-mass-index	6,0
High cholesterol	5,1
Consumption of illegal drugs	2,7
Physical inactivity	2,4
Low consumption of fruit and vegetables	1,6
Unprotected sexual contacts	0,7
Sexual abuse in childhood	0,6

\* DALY = Disability Adjusted Life Years = the sum of prematurely lost years of life (before the age of 70) and years that are physically or mentally impaired.<sup>15</sup>

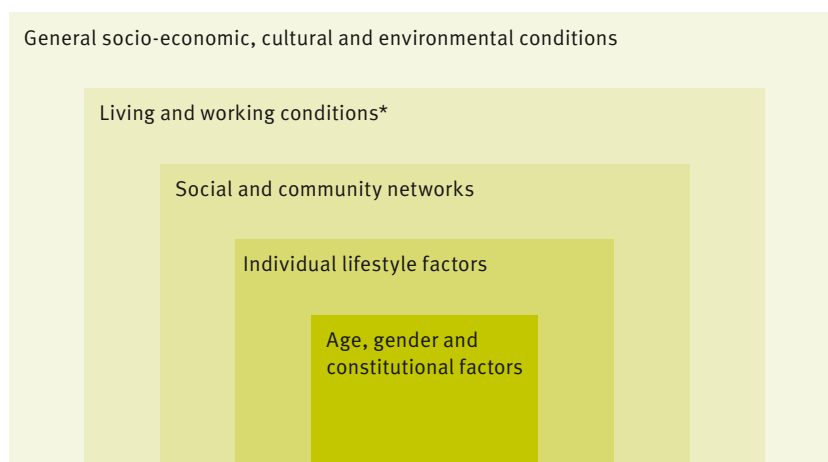
***Social factors of influence:*** This subsequent burden on health and society, (which can sometimes also have economic consequences) should not be blamed unilaterally on individuals and their health damaging behaviour. A population's and an individual's state of health is determined positively and negatively by a host of protective and harmful factors – not only by behaviour. These factors are called health determinants. Four levels of influence are particularly important:

- the lifestyle and behaviour patterns of the individual,
- the support and influence provided by the social environment, which can be beneficial or harmful to health,
- living and working conditions and access to institutions and services,
- the economic, cultural and physical conditions of the environment, such as the standard of living or the employment market.<sup>16</sup>

Public health research clarifies the health and illness-related connections between cause and effect in the social environment, for example the importance of social inequality or gender specific differences, but also important factors of social influence such as media or marketing. Public health measures are concerned with the effect of these factors on health, to the extent that they can be modified and influenced. The social determinants thus represent significant points of departure for initiatives in the health sector aimed at health improvement and prevention.<sup>17</sup>



**Figure 2**  
Overview of the main health determinants  
(Health in Switzerland. National Health Report 2008. Bern 2009).



\* Agriculture and food production; Education; Work environment; Unemployment; Water and sanitation; Healthcare services; Housing

**Government activity for the common good:** It is the duty of public health bodies, specialists and organisations to suggest that measures be implemented where the evidence shows that they will help alleviate the severity of health and social problems. Such measures should predominantly be designed to improve health, create more healthy years of life, avoid chronic illness and thereby increase the quality of life. Government measures influence supply and demand, reduce aggravating factors, secure the protection of certain population groups, especially those who are socio-economically disadvantaged, and regulate access to treatment and therapy. Depending on the problem area or type of addiction, policing and public order measures as well as various forms of harm reduction are also among the tools available to the state. In some circumstances, state measures restrict the individual's consumption options or freedom of action, or they impose requirements on economic players, for example through

regulation of access and sales. They thereby also make it possible for many of the persons concerned to enjoy better health and to have access to therapy as well as to have the chance of rehabilitation and social reintegration.

*Integration of structural prevention and behavioural prevention:* Public health measures always strive for a correspondence between structural measures (“structural prevention”) and individual measures (“behavioural prevention”). This type of integrated public health approach reflects the health problems of today’s societies; people can develop their health potential fully only when they themselves can influence the factors that determine their health.<sup>18</sup> The central areas of activity include:

- a supportive social environment,
- access to all essential information,
- the development of practical skills, and
- the opportunity for individuals to make their own decisions in respect of their health.

In this connection, the measures that are considered to be especially important are those mostly aimed at strengthening resources and means for maintaining health. When this Report speaks of integrated public health measures, it is referring to this dynamic between measures of structural prevention and measures designed to improve individual responsibility for health. In the area of addiction, for example, this means that the focus must not only be on the consumers (ban on driving when under the influence of alcohol), but must also include the producers (market regulation, as is the case, for example, with the ban on the advertising of medicines that are frequently misused or which lead to habitual use and dependence). The balance between these measures must always be adapted with respect to the problem area that is to be addressed.

**Health in all policies:** Just as is the case with causative factors, approaches to solutions are also situated in many political arenas. An addiction policy based on a public health approach must therefore take account of decisions made in many political arenas. These can be implemented in full awareness of their health impacts, as in taxation policy and customs and excise law, or through market regulation and the criminal law. They can also, however, have negative impacts on addiction policy, such as the deregulation of cross-border television advertising. In health policy, an approach such as this is designated health in all policies.<sup>19</sup> This proximity to political decisions means that many public health measures can be put into practice successfully only when a political majority based on a social consensus on priorities and approaches can be found.

## The social context

The interplay between the individual, the social environment and psychoactive substances or problematic behaviour must be clearly understood as it constitutes a central premise for an addiction policy based on a public health approach. In what follows, three key socio-political developments will be singled out on account of their crucial importance to the development of a future oriented policy framework. They are: **availability, acceleration and virtuality**. Their influence in shaping new patterns of consumption is obvious. For each of these trends, there is detailed scientific analysis which can only be presented briefly here.<sup>20</sup>

### Availability: the omnipresence of consumption options

Switzerland is one of the most prosperous countries in the world. It offers its inhabitants a high quality of life, high life expectancy and a multiplicity of life options. A highly relevant factor when considering an addiction policy is a specific characteristic of everyday life: the wide availability of

goods and services. The 24/7 principle is becoming increasingly prevalent; everything is available everywhere 24 hours a day and seven days per week, Switzerland is no exception. Coupled with technological developments like the Internet or cash-free shopping, this leads not only to the rapid and simple gratification of needs, but also to a constant incitement to consume.

Modern society is geared towards growth and increased consumption. Marketing, sponsorship, events, media, advertising and pricing mechanisms are structured and designed as far as possible to induce repeat consumption and to make consumption as instantly accessible as possible.<sup>21</sup> Examples can readily be found in events where participants can consume as many drinks as they wish for a flat-rate price, the trend towards liberalising gambling, special offers on alcohol and tobacco products, and the 24/7 availability of alcohol at motorway service stations.<sup>22</sup> For all addictive substances, accessibility plays a decisive part in the extent of their use.

#### **The Boom in Convenience Shops**

Small retail outlets with long opening hours such as petrol station shops, railway station and airport shops and newsagent kiosks produced a turnover in 2009 of around 4.5 billion Swiss francs. This corresponds to 10 % of the retail foodstuff trade. The sector leaders achieved growth rates of between 10 % and 40 %. They are planning to further expand the range of their merchandise.<sup>23</sup>

In a society with such a diversity of consumption options, and a consumption landscape that is becoming ever more confusing to navigate, individuals are increasingly expected to regulate themselves. This applies both to personal everyday life and to consumer choices in the omnipresent marketplace. Through no fault of their own, many people are unable to cope with this situation. While the choice between as many products

as possible is frequently presented by suppliers as an expression of freedom and prosperity, recent studies show that in modern affluent societies an increase in choice does not necessarily imply an increase in individual well-being.<sup>24</sup>

Not only individuals, but also governments face a new challenge: not all measures can continue to be taken purely at national level. On the one hand, the liberalisation and globalisation of markets have required certain countries to withdraw measures and regulations originally introduced for reasons of public health. This is what happened in Sweden and Finland on their accession to the EU when they were obliged to guarantee free market access. The relaxation of advertising restrictions in Switzerland is based on similar economic motives. On the other hand, countries are increasingly required to align their health policies with international or European agreements, such as the World Health Organization (WHO) Framework Convention on Tobacco Control, or with international agreements in the area of illegal drugs policy. In addition, the opening of borders and the existence of the internet create new opportunities for extending the grey and illegal markets. A further development is that legal, illegal and grey markets are increasingly blending together, to some extent with consequences for health: the WHO has drawn attention to the fact that international trade agreements do not take adequate account of the health repercussions of the global trade in goods.<sup>25</sup> The anti-drug agency of the United Nations is warning of a further fall in the prices of illegal drugs; new routes to Europe are being used by smuggling gangs and are bringing down the price of transporting drugs.

#### Acceleration: consequences of a faster pace of living and high mobility

In many studies, the acceleration in the entire pace of life in conjunction with greater mobility and digitalisation is also increasingly regarded as a factor encouraging substance abuse.<sup>26</sup> When people can no longer keep up with the growing pace, addiction problems often increase. This is true in respect to pressure at work,<sup>27</sup> but applies equally where there is fear of unemployment. In order to be effective and to be able to cope with as large

# *The challenges in relation to the virtual world will grow larger*

a workload as possible, people increasingly turn to substances such as caffeine, alcohol and nicotine as well as medicines and other psychoactive substances. Alongside soporifics, sedatives and analgesics, anti-depressives are now among the most commonly taken medications among employees.<sup>28</sup> A characteristic of substances in demand during periods of increased stress is their short-lived effect. People dependent on nicotine for example often feel an extra compulsion to smoke a cigarette when they are under pressure. A new trend is the use of medicines as a means of increasing performance or “neuroenhancement”.<sup>29</sup> On the whole, however, the data base on the use of such substances is still inadequate.

## **Virtuality: the expansion of anonymous space**

The significance of the mass media with regard to the use of addictive substances has been researched in detail.<sup>30</sup> We know less about the influence on use and behaviour exerted by the development of the internet with its constant and seemingly anonymous availability of content and services. Among the things typical of internet experiences is a high degree of stimulation.<sup>31</sup> The challenges related to the virtual worlds of the internet and computer will grow larger over the next 20 years, while the ramifications for health policy of this development are not yet clear.<sup>32</sup> A variety of developments already give grounds for concern from the viewpoint of health policy: the excessive use of the medium itself, for example, for playing online games. This includes the expansion of online opportunities for gambling, such as poker games, which are potentially highly addictive. They also include internet-based marketing of medicines, which simplifies access to prescription medication, which can then be used improperly. According to estimates made by the World Health Organization (WHO), moreover, around 50 per cent of medicines purchased online are fake, which makes any abuse even riskier.<sup>33</sup>

*An effective  
addiction policy  
must take  
account  
of specific social  
environments*

Developments in the area of internet addiction are as yet not clear. Estimates in Switzerland suggest there are over 70,000 internet addicts and 110,000 persons at risk.<sup>34</sup> More exact studies giving reliable numbers of persons affected, or research into causes and consequences, are for the most part not yet available.

## **Outlook**

In any society there is always a broad spectrum of consumption and behaviour, ranging from low risk to harmful and high risk. The patterns of consumption are affected by media influences and new sales techniques and incentives. The increase in availability and consumption options for all kinds of products, the growing pace of daily life and work and the all-embracing development of virtuality, both in relation to consumption and to everyday communication, all of these represent a completely new socio-political context for addiction policy. It will only be possible to provide an effective pathway and structure for addiction policy if it takes account of these social changes and the new social environments. It must also confront the newly emerging ethical issues in relation to these developments.







### 3 The Starting Position in Switzerland

#### **An addiction policy split up according to substances**

The basis for Switzerland's present addiction policy can be found in the provisions of the Federal Constitution,<sup>35</sup> in particular the three articles on alcohol (Article 105, which mentions the harmful effects of alcohol consumption), on special consumption taxes (Article 131, which is the basis for the tax on tobacco), and on the protection of health (Article 118, which covers narcotic substances). This division is a reflection of how Swiss addiction policy came into being historically (s. Chapter 1), and why it is split up into three policy sectors related to substances. For each of the three problem areas of alcohol, tobacco and narcotic substances, the Federal Council set up a separate Federal Commission. The recommendations of these Commissions meet with political support to a very mixed degree, for they not only impinge on a number of economic interests, but they also enjoy varied levels of acceptance on account of the divergent attitudes of the political players. This frequently makes it difficult to approach a given problem impartially and rationally, despite the existence of scientific findings on risks to health and potential for addiction. In addition, many important decisions with implications for addiction policy are made in other policy sectors (s. Chapter 5).

**Alcohol:** In relation to alcohol, the federal government must pay special attention to its harmful effects. For spirits a framework is provided by the Alcohol Act.<sup>36</sup> A portion of the revenues from alcohol taxes (the "alcohol tenth") goes to the cantons to support measures for combating alcohol dependence and the abuse of narcotic substances and pharmaceuticals, as well as the problems arising from the consumption of other substances. Beyond this, various acts and ordinances (such as the Foodstuffs Act,<sup>37</sup> the Radio and Television Act<sup>38</sup> and the Road Traffic Act<sup>39</sup>) contain provisions on alcoholic beverages. The cantons are responsible for the regulation of the bar and restaurant trade and for stipulating opening hours. With the deployment of a National Programme on Alcohol (NPA) 2008–2012, the Federal Council is attempting to give strategic orientation to Switzerland's alcohol policy and to coordinate the activities of the bodies, organisations and federal institutions involved.

*Many decisions  
with  
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policy  
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in other  
policy sectors*

**Tobacco:** In relation to tobacco, there is similarly a National Programme on Tobacco (NPT). On the other hand, there is no separate constitutional duty to pay heed to the harmful effects of consumption of tobacco, such as exists in the case of alcohol, or to the protection of health as is the case with illegal drugs. Nor is there a Tobacco Act. The individual tobacco regulations can be found in a wide variety of other acts and ordinances (for example in the Foodstuffs Act,<sup>40</sup> the Radio and Television Act,<sup>41</sup> the Employment Act<sup>42</sup> or in the Tobacco Ordinance<sup>43</sup>). In parallel to international developments, however, over the past ten years the discussion on the harmful effects of smoking has also been gathering force in Switzerland. This discussion has addressed the harmful effects both on smokers and on third parties or passive smokers. Referendums and parliamentary proposals have curtailed the practice of smoking in numerous cantons. In consequence, the Federal Assembly approved a Federal Act on Protection against Passive Smoking,<sup>44</sup> which permits stricter regulation at cantonal level. This came into force on 1 May 2010.

**Illegal drugs:** The policy framework for dealing with illegal drugs is set out in the Narcotics Act.<sup>45</sup> The topic of illegal drugs sparked off a controversial political debate in the early 1990s, especially in connection with the open drug scenes in various Swiss cities. Since then the Four Pillars model for drugs policy has met with social acceptance in various referendums at local, cantonal and federal levels. The current policy priorities of the Federal Council are specified in the government's third package of measures for reducing drug-related problems (MaPaDro III) 2006–2011.

Despite the broad social debate, the status of illegal drugs still remains the same, even following the revision of the Narcotics Act of 2008. This does not imply, however, that all prohibited substances carry a greater potential risk to health than legal drugs do. Nonetheless, the illegality of certain substances sets in motion specific consequences for those who consume them, in comparison with those who consume legal substances. These consequences include the threat of criminalisation and the stigmatisation and ostracism that this may bring. In a fundamentally illegal market, moreover, regulatory measures other than consistent penalties for production, trafficking and consumption are not possible. In particular there is



no possibility of influencing the quality of the substances in illegal markets and thus their potential to do harm. Prevention, treatment and harm reduction moreover are made far more difficult because the consumers are very hard to contact.

**Addictions not specific to substances:** The area of non-substance related addictions has gained political attention only to a limited extent. A case in point is gambling, for instance, which is mentioned in the Federal Gambling Act<sup>46</sup> or in the inter-cantonal agreement on the supervision and the authorisation of, and application of proceeds arising from lotteries and betting. At present, there are no laws at federal level, nor are there programmes or measures on addictions that respond to addictions related to behaviours rather than substances. There are, however, initiatives at cantonal and city level and there is a growing awareness and debate in specialist circles.

**Medication Addiction:** In the area of addiction to medicines, there is no federal policy addressing the topic in any depth, despite the fact that there is a growing turnover of medicines with a potential for abuse and dependence in Switzerland.<sup>47</sup>

## Separate political structures

These sharply divergent starting points and developments are reflected in various structures; the individual substances are mostly treated separately in Swiss policy. This separateness relates to administrative units as well as to the panels of experts and specialist organisations. Within the various federal structures, the individual policy sectors are embedded in different networks of social associations, specialist organisations and administrative units. These act in unison only rarely, if at all. Geographical and cultural differences are also significant within Switzerland. And in addition there are multiple conflicts of interest blocking the way to a coherent and unified method for moving ahead. The consequence is that legal and illegal substances and the four pillars of drugs policy are at times played off against each other. The challenge is to change this by means of a shared and coherent political approach.

## Strategic common ground

In point of fact, the existing programmes in the areas of alcohol, drugs and tobacco already reveal a range of common interests in respect of strategy and content. This is especially the case in relation to a public health approach comprising both structural and individual measures. All three Commissions take a clear stand. It will be possible to build a future oriented addiction policy on this common ground.

For all programmes it can be stated:

- At present they are already pursuing a common public health approach; they do not exclusively address the individual and her/his personal responsibility. Structural measures and a heightened sense of cross-society responsibility are considered to be equally valuable and just as necessary.
- The programmes also have a shared public health perspective in relation to the role of the state and the need for government action. This is especially the case in respect of measures in other sectors of policy. Nor do the programmes consider action necessary only at the point of consumption – they all recognise the importance of prevention.
- They do not delay action until the onset of actual dependence, for the harm and damage inflicted on the individual and society arise in accordance with the substance or behaviour, and can be present with or without addiction. Any use of tobacco, for example, is fundamentally linked to health risks, whereas in the case of alcohol the risks primarily emerge in connection with problematic consumption.
- They all pursue a mix of measures and in doing so emphasise the importance of a coherent course of action.

### **The public health approach of Switzerland's three Addiction Policy Commissions**

#### **National Programme on Tobacco 2008–2012**

*“Overall social responsibility: Smokers put not only their own health at risk, but also that of other persons (passive smoking). Tobacco consumption is not simply a private matter – it represents a general social challenge.”*

#### **National Programme on Alcohol 2008–2012**

*“It is the *broad social acceptance* of alcohol as a supposedly ordinary consumer good that leads many people to lose their sense of distance and their ability to make a clear-headed judgement. The real risk potential of alcohol goes unrecognised all too often.”*

*“Alcohol policy should concentrate more firmly on reducing the negative effects of alcohol consumption on both *personal environment and on society*.”*

#### **Third package of measures taken by the federal government in order to reduce drug-related problems 2006–2011**

*“Both the path to addiction and its consequences are individual. In general, however, it can be stated that addiction leads to a loss of control over certain aspects of one's own behaviour, which leads in turn to physical, mental, social or economic problems both for the affected person and for her or his *immediate and broader environment*.”*

*Scientific  
findings and  
political  
perceptions  
remain  
incongruent*

### **Towards a coherent addiction policy**

Addiction policy in Switzerland, currently split up according to three substances, has had different impacts in the respective areas of alcohol, tobacco and illegal drugs. Independently from each other, however, the federal government's three addiction policy Commissions have increasingly pursued a public health approach. But the Swiss addiction policy is not truly coherent, and this weakens both its impact and its credibility. In particular, the policy is not based on an understanding of the disease burden and societal consequences arising from substance abuse or potentially addictive behaviours. In Switzerland there is still no congruence between the scientific findings and the expert recommendations on the one hand, and perception and implementation at a political level on the other. Addiction policy so far shows also that new developments and scientific evidence do not readily find their way into political action on addiction.

Clear differences between the three areas must also be taken into consideration. The concepts of the Four Pillars Policy, for example, are understood and applied differently in the separate policy sectors, or simply not applied at all. In the case of tobacco and alcohol, the predominant discourse is about regulation, not law enforcement, and in these areas the emphasis is on prevention through market regulation. Enforcement or police action comes into play in respect of legal substances when they are sold to minors, or when their consumption is inappropriate, such as when someone is driving under the influence of alcohol. Police action is also deployed in the maintenance of public order, for example at sports events where alcohol is consumed. In the case of tobacco, the concept of harm reduction is not used, while for the area of illegal drugs, it is a key concept and is also gaining in importance in the context of alcohol policy.

There are contradictions, moreover, in the political discussion (s. Chapter 5): a high degree of scepticism comes from special interest groups that oppose all forms of market regulation on the grounds that this is a restriction of the freedom of the individual. At the same time, however, the argument of freedom is immediately rejected when there is a proposal to



abolish the separation between legal and illegal substances. This represents a further obstacle to coherent action for dealing with problematic and risky consumption. This obstacle is magnified even further when it comes to new areas of addiction policy such as behavioural addictions.

The changing patterns of consumption are leading to a shift in the disease burden (s. Chapter 4). Current addiction policy is not adequately prepared for this. A public health approach will be able to recognise this shift in problems and respond to them in a targeted, coherent and therefore credible manner. This could improve the addiction policy's impact on health as well as enhance its credibility.



## 4 Scope of the Policy Framework for the Challenge of Addiction

Current addiction policy in Switzerland, just like the public perception of addiction, has been characterised by focusing on dependence and its consequences (s. Chapter 3). However, the consequences of the problems arising from the consumption of stimulants and addictive substances affect a far larger percentage of the population than those that are defined as medically dependent. As a result of the findings of the research on both addiction and on public health, the *Report on the Challenge of Addiction* proposes a broader approach to addiction policy. Addiction policy should be expanded in its scope to encompass three reference points: **more than dependence, more than legal status, and more than substances**. These are explained below. “More than” is intended to convey the expanded scope of the policy – the aim is not to declare every pleasurable activity to be a form of dependence, nor is it to make every potentially harmful act the subject of regulation.

### More than dependence

Changing patterns of consumption, different groups  
of affected persons, new products and markets

*Most health-related and social consequences of the use of addictive substances are not due to dependence in the medical sense, but to problematic consumption. A public health approach expands the scope of addiction policy to go beyond the narrow definition of dependence. As a result, the focus moves to the diversity of patterns of consumption, groups of persons affected, temporary fads and fashions, or trends in the legal and illegal markets.*

### Changing patterns of consumption

No society is free of stimulants and addictive substances. The consumption of various substances fulfils a range of personal and social needs (s. Chapter 1) and the corresponding behaviour patterns always involve an interplay between the individual, society and the addictive substance.

These findings are supported by research into the brain: addiction is the result of a process in which many biological, psychological and social factors interact (s. Chapters 1 and 2).

Patterns of consumption are constantly changing, both in the legal and the illegal markets. The *World Drug Report 2009*<sup>48</sup> for example points out that the global demand for cocaine, opiates or cannabis in the largest markets is stagnating or falling. On the other hand, the production and consumption of “designer drugs” made in the laboratory are on the rise. These include for example amphetamines, which in various combinations are known as “speed”, the party drug ecstasy or the stimulant known as “crystal”. The individual motivation for the consumption of legal and illegal substances is also changing, with an increasing trend currently being to consume two or more substances, either alternately or together. For example, a new pattern of consumption has emerged in the form of non-alcohol-dependent “risky drinkers”. They are predominantly young and male, although the number of female risky drinkers is increasing.<sup>49</sup>

These new patterns of consumption not only reflect broad availability: in a pluralistic society, personal identity is also defined by the products and substances that a person consumes, by the market, by the group in which a person moves (the “peer group”), or by social expectations. Psychoactive substances are normally taken by users with a specific aim in mind: they have become commonplace in the culture of the workplace and of fun and leisure, and a factor in belonging to a group.

Both legal and illegal suppliers as well as the government influence patterns of consumption, suppliers by providing and advertising certain substances and the government by regulating and prohibiting these substances and providing related information. Consequently, advertising, due to its influence on consumption and patterns of consumption, has become a key issue in health policy. The entertainment industry also contributes to the spread of problematic and high-risk consumption. The situation is not always helped by the media’s regular trivialization of the

# Many attitudes to addiction are outdated or wrong

problems involved. An interaction between supply, the incentive to consume, user groups and patterns of consumption emerges. Addiction policy measures must therefore always target the environment and supply as well as consumers and demand.

A wide variety of patterns has developed with regard to the consumption of psychoactive substances, in conjunction with a changing profile of consumers. Many attitudes to “addiction” are therefore outdated or wrong. These include expectations as to the background, gender or age of consumers (s. Chapter 5). Thus in many societies there is evidence of an increase in alcohol dependence and drug use among older people – on the one hand, consumers are getting older, on the other new life events lead to new patterns of consumption. In relation to gender, what once seemed to be certainties no longer look so certain: thus almost as many 15-year old girls smoke in Switzerland as boys of the same age. Alcohol consumption among girls has also increased in recent years, and at the same time anorexia among young men has become more common.<sup>50</sup> Many consumers no longer use only one substance, but (particularly in their leisure time) take two or more psychoactive substances at once, even in connection with sporting activities. Increasingly, there is a combination of behavioural dependencies and problematic or dependent substance abuse; examples include the taking of stimulants to stay awake in order to keep playing an online game, or the high proportion of casino gamblers who are smokers.<sup>51</sup>

Examples of new patterns of consumption are:

- episodic or chronically excessive alcohol consumption among a certain minority (in certain cases in conjunction with new social forms of drinking in public such as “botellones” or “Harassenläufe” (drinking contests)) as well as the increase in the number of very young binge drinkers; on the other hand, alcohol consumption among young people in general is on the decline,
- the increase in the consumption of drinks containing caffeine and taurine, occasionally mixed with alcohol,



- new nicotine products and patterns of nicotine consumption as a result of the changed acceptability of tobacco smoking,
- new patterns in the consumption of illegal drugs due to the decline in the price of substances such as cocaine and heroin,
- the import and the use of naturally occurring, psychoactive substances such as the plant *Salvia Divinorum* (salvia),
- the medicalisation of everyday life due to the increasing use of analgesics, soporifics, sedatives and stimulants, appetite suppressants, anti-depressants, anti-psychotics and other psychiatric medication,
- problems arising from the consumption of anaesthetics and central nervous system stimulants in the party scene,
- the use of substances to enhance performance during the working week and, in contrast, the use of psychoactive substances to shape leisure and winding down activities at the weekend,
- the consumption of easily available and cheap industrial substances such as solvents (for example GBL/GHB ) to induce a state of euphoria.

#### **New Developments – Different Challenges**

##### **Alcohol consumption**

Around one million Swiss people drink in a problematic way, a good three-quarters of these only occasionally (“episodic drinkers”). Some 100,000 men and women drink too much alcohol chronically and a further 155,000 are not only chronic drinkers, but also engage in binge drinking on occasion. However, overall per capita alcohol consumption in Switzerland is falling.<sup>52</sup>

The number of young binge drinkers (five or more glasses alcohol at one time, at least three times in the past month) fell slightly between 2003 and 2007 for the first time in many years, but still remains high, particularly among 16-year old boys, where the level is just under

18 % (girls 8 %). In addition, in 2007, three quarters of 13-year-olds had consumed alcohol at least once in their lives, and more than half of these within the 30 days prior to being questioned.<sup>53</sup>

#### **Smoking**

The number of smokers has fallen since 2001 and currently lies at around a quarter of all 14 to 65-year-olds.<sup>54</sup> Almost one half of 14-year-olds admit that they have smoked a cigarette at least once in their lives (around 50 % of boys and 47 % of girls).<sup>55</sup>

#### **Illegal drugs**

The consumption of cannabis, cocaine and ecstasy has increased in the past ten years. At present, around 20 % of the population over 15 years of age have consumed cannabis (24 % of men and 15 % of women). Experience of consumption has also risen in the case of cocaine (from 1.6 % to 2.8 %) and ecstasy (from 1.0 % to 1.8 %).

Among young people, it is clear that more boys consume cannabis than girls (current consumers number 11.5 % and 5.1 % respectively). However, here consumption has stabilised and has recently begun to fall among school pupils.<sup>56</sup> The number of young men who have experience of hard drugs has increased, whereas the number of young women with such experience has remained stable.<sup>57</sup>

#### **Consumption of medicines**

The use of soporifics and sedatives increased slightly among the Swiss population from 2002 to 2007 (soporifics: from 2.3 % to 2.8 %; sedatives: from 2.4 % to 2.6 %). There was an especially pronounced rise in the consumption of soporifics in the case of women aged 70 or over (2002: 11.3 %, 2007: 14.2 %).<sup>58</sup>

#### **Compulsive gambling**

For 2007, the percentage of people in Switzerland who gamble or have gambled pathologically (“lifetime prevalence”) was estimated at 1.1 % of the population between 18 and 98, and the number of players whose behaviour is problematic at 2.2 %.<sup>59</sup> In 1998 the estimated percentages amounted to 0.8 % and 2.2 % respectively.<sup>60</sup>

*Many  
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### The diversity of consumers

Society is not simply divided into consumers and non-consumers of substances. In between dependence and abstinence, there is a multitude of different patterns of consumption in relation to many substances and forms of behaviour with a potential for dependence. These patterns are – as a reflection of our pluralistic society – spread among various social groups (s. Chapter 5) and are certainly not encountered solely among social problem groups. Thus in everyday life, certain forms of behaviour and forms of consumption – for example drinking alcohol – are expected as part of traditional rituals.

Many patterns of consumption are closely linked with the process of growing up and development in adolescence, which is why persons in this age group are particularly vulnerable.<sup>61</sup> Some of the patterns of consumption allow the consumer to identify with a particular group. Others, however, are partly shaped and promoted in modern societies in a special way by producers and suppliers, the media and new means of communication. A survey by the youth advisory service “Streetwork” in the city of Zurich showed that only 5 per cent of interviewees never consumed psychoactive substances at parties, while 50 per cent took them occasionally and 45 per cent on a regular basis.<sup>62</sup> In relation to forms of consumption, risk behaviour, availability of substances or incidence of forms of behaviour and also with regard to the addictive behaviour itself, clear differences and clear shifts between the sexes are apparent. Special attention must be given to this. For example, men and not women are more likely to be affected by internet addiction, while young women are more commonly affected by eating disorders (such as anorexia) than young men.

Attention must also be paid to especially vulnerable consumer groups: children growing up in families affected by dependence, or older people whose problematic consumption or dependence is less visible and who are embarrassed and therefore less likely to admit to it.



## New markets and products

What is on offer – both in the legal and the illegal markets – influences the patterns of consumption and creates new trends. One example is the increase in the number of poker tournaments on offer (including those online), where poker is occasionally classified not as a game of chance, but as a game of skill, in the hope of attracting a broader public.<sup>63</sup> Often there are no legal provisions to deal with these new offers, it is unclear who is responsible, and this is immediately exploited to hasten the spread. The pressure of new markets and products means that a fresh start has to be made in each case to draw up legal provisions; this in turn makes it appear as if the state is introducing an excess of regulation. Such a perception underscores the arguments of the producers and providers and is in some cases actively encouraged by them.

Examples of new markets or products include:

- cocktails such as alcopops and beer-mix drinks (shandies) that seek to attract new consumer groups, such as young women,
- the accessibility or availability of alcoholic drinks due to the sale of alcohol in 24/7 petrol station shops and the bargain offers of alcoholic drinks in discount supermarket chains,
- new products that permit the consumption of nicotine,
- new party drugs,
- the unregulated internet sales of pharmaceutical products, which encourages the abuse of medicines,
- the increasing misuse of therapeutic products to enhance brain performance, and the abuse of medicines used in the treatment of dementia and Parkinson's.

## More than legal status

The everyday potential for harm and dependence

*The potential to do harm and the actual amount of harm that may be done have no correlation with whether a psychoactive substance is legal or illegal. The overall harm to health caused by legal substances is clearly higher than that caused by illegal substances. The same applies to the social and economic harm to families and society. A public health approach therefore avoids making a distinction between legal and illegal substances, which is of little help in formulating health policy. A future oriented addiction policy also needs to take account not only of the misuse of alcohol, tobacco and illegal drugs but also the abuse of medicines and of new pharmacological products designed to optimise physical and mental capabilities. Basically, this means facing up to new regulatory issues.*

## The distinction between legal and illegal substances

With its pragmatic Four Pillars Policy, Switzerland is playing a successful pioneering role internationally in relation to illegal drugs policy. But today in society as a whole and in relation to health policy, the major challenge primarily lies in the problems arising from the consumption of substances that are legally available. In this area, Switzerland has some catching up to do as far as addiction policy is concerned, both in relation to legislation on tobacco and alcohol. A legal substance like alcohol is widely available in everyday life, is advertised as a lifestyle and luxury product, and, regardless of its risk and dependence potential, enjoys widespread social acceptance. Generally speaking, politicians, manufacturers and retailers and a large proportion of consumers are reluctant to regard or even opposed to regarding such substances as the object of addiction policy. These legal substances can however lead to a broader spectrum of negative physical, psychological and social effects among consumers and related persons than the illegal substances that are the subject of so much attention in the media.<sup>64</sup> The burden of disease arising from legal substances is also greater (s. Chapter 2).

*A coherent  
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substances*

**Reorientation of addiction policy abroad**

The European Monitoring Centre for Drugs and Drug Addiction points out that in Europe, some countries have already broadened their addiction and drugs policy approach. They consider legal and illegal drugs together, take account of behavioural dependencies as well, and also include a multitude of different patterns of consumption. These countries also call for a public health approach and cite the findings of research into addiction.<sup>65</sup>

In every country, the debate on the distinction between legal and illegal substances flares up from time to time.<sup>66</sup> In parallel to this, public attitudes to addiction and drugs change. In Switzerland in 2008, 68 per cent of citizens approved the revised Narcotics Act in a referendum. As a result, the Four Pillars Policy and the heroin prescription programme, which was highly controversial at the beginning the 1990s, became part of the law. Since then, numerous cantonal referendums have seen measures introduced to protect passive smokers, moves that have now been incorporated in new federal legislation (s. Chapter 5). In the case of alcohol, it is the public order dimension accompanying or related to consumption (violence in stadiums, drinking alcohol in public) that has fuelled the debate on the availability of alcohol.

There is a broad social consensus that at an individual and social level, depending on the situation, harm reduction should be offered in addition to therapy and treatment. However, there is no consensus on the issue of whether the legal status of psychoactive substances should be decided according to their respective potential for doing harm or on the basis of attitudes founded on historical or moral arguments (s. Chapter 1). A coherent addiction policy must however go beyond a policy on illegal drugs and take account of all psychoactive substances – both legal and illegal.

*Medicines  
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policy*

### Abuse of medicines

In addition to the familiar legal and illegal substances that cause addiction, the abuse of medicines means that the perspective must be expanded to take in medicines, both those available on prescription and without prescription. Three groups of drugs are of particular concern: sedatives, analgesics (painkillers) and stimulants. Benzodiazepines have a relaxing-sedating effect and form the most commonly prescribed active ingredient group of all the psychoactive medicines. They have a comparatively high dependency potential. Analgesics are the most used group of medicines with the potential for misuse. At present, the problematic use of prescribed and over-the-counter drugs is primarily a problem seen among women, although there are signs that cases involving men are on the increase. In Switzerland, however, there has been no study to date that has investigated aspects of the abuse of medicines in specific relation to men.

Here again the approach to addiction has to take account of more than just the defined dependence on medicines. In a Swiss study on the consumption of medicines conducted in 1999, a relatively high number of interviewees (39 per cent) taking medication had at the same time a basically healthy profile (90 per cent of the interviewees regarded themselves as in good health). The prevention of illness is becoming an ever more important motivation for using medicines. In addition, a variety of indispositions are cited as the reason for taking medication: these include difficulties in sleeping, digestive complaints as well as stress and personal tension.<sup>67</sup>

The effects of the problems arising from the consumption of medicines have hitherto not been emphasised in the debate on addiction policy, a state of affairs that is further complicated by the existence of a grey area between the legal and the illegal dispensing of medicines. This aspect of a future oriented addiction policy, moreover, runs counter to powerful economic interests. A look at the figures shows however that this field of activity must form an integral element of any addiction policy.

### **Problematic consumption of medicines in Switzerland**

In 2002, 7 % of Swiss adults consumed analgesics, soporifics or sedatives every day.<sup>68</sup>

Women of all age groups consume medicines on a daily basis considerably more frequently than men of the same age. Among the elderly, this difference increases markedly: whereas 8.1% of men over the age of 75 admitted having taken a sleeping aid every day in the seven days prior to questioning, 16.9 % of women, almost twice as many, said they had done so.<sup>69</sup>

In the period from 2005 to 2007, the main or secondary problem for around 15 % of patients in an in-patient addiction therapy unit was medicines. In most of these 180 or so cases the drug involved was a form of benzodiazepine (a soporific or sedative).<sup>70</sup> Here again it is clear that problematic consumption by far exceeds the level of actual dependence.

### **Performance-enhancing substances**

Alongside the legal use of medicines prescribed by physicians and sold by pharmacists, a trend towards using therapeutic products for reasons not originally intended is becoming apparent: the consumption of substances in order to improve and adapt physical, sexual and mental performance. These forms of abuse are not new, but have taken on new dimensions in modern societies due to major advances in pharmacology and the marketing of pharmacological products. Potency-enhancing drugs, for example, are no longer taken solely in cases where there are medical indications of impotence, but are now taken by healthy young people as general way of enhancing performance and enjoying new experiences: the aim is no longer therapy, but optimisation.<sup>71</sup>

A further example is “doping”. Doping has not only found its way into international top-class sport. The use of banned substances and the misuse of legal substances with the aim of achieving top performances or changing the shape of the body are also prevalent in amateur sport and

in the fitness market. The potential harm that these substances can do to a person's health is considerable. This applies in particular to anabolic steroids, which, according to a German study, are consumed in gyms, primarily by men, in high doses and without medical supervision.<sup>72</sup>

**The effects of selected psychoactive and performance-enhancing substances<sup>73</sup>**

**Alcohol:** causes relaxation, euphoria, lowering of inhibition, but may also increase aggression, and can bring about a higher tendency towards violence<sup>74</sup>

**Amphetamines:** have a stimulant effect on the central nervous system (release of adrenalin, norepinephrine and dopamine), increase self-esteem, lower the aggression threshold, increase the ability to concentrate, and suppress fatigue

**Caffeine:** has a stimulant effect on the central nervous system, raises the pulse rate, and improves concentration

**Methylphenidate (brand name in Switzerland: Ritalin):** has a stimulant effect on the brain, improves attention span, increases concentration, reduces motor hyperactivity and impulsivity by enabling improved impulse control, increases heart rate and blood pressure, at the same time suppressing fatigue

**Modafinil:** suppresses fatigue, increases concentration; improves physical and mental performance

**Nicotine:** causes the release of chemical messengers and hormones in the brain. Once tolerated, it has a stimulant effect in low doses, while in higher doses it has a sedative effect, increases the attention span to the level of persons not dependent on nicotine,<sup>75</sup> suppresses anxiety, anger and aggression, helps relaxation, and reduces fatigue. It also causes a higher heart rate, higher blood pressure and various other effects

The debate surrounding the various methods of enhancing mental performance is growing and the issue is becoming increasingly controversial. However, at present no truly comprehensive data covering this field is available in the EU or in Switzerland. In the USA, there are indications that around 25 per cent of all students use medicines to enhance their performance and to function better. These drugs not only increase moti-

vation but also attention span, concentration and self control. There is evidence of a similar use of medicines in Switzerland. In 1999, a fifth of interviewees admitted that they had also used medicines to enhance their performance in everyday life.<sup>76</sup> There is too little scientific knowledge at present of the health-related effects of this form of doping, using pharmaceuticals for unapproved indications (“off label use”). In particular, there is no reliable data on the long-term side effects. There is also need for a discussion of social effects that result from the increasingly fluid boundaries between therapy and optimisation. Experts assume that in the long-term there will be a large market, both legal and illegal, for “neuroenhancement” drugs.<sup>77</sup> The development of preparations for the treatment of Alzheimer’s disease and dementia, for example, already points to this potential usage in respect of enhanced cognitive performance.<sup>78</sup>

All these developments must be monitored closely as part of a forward-looking addiction policy.

#### **Performance enhancement, smart drugs and doping**

A survey in German gyms conducted in 1998 showed that 24 % of men had experience of misusing anabolic substances.<sup>79</sup>

A survey carried out by research journal *Nature* of 1400 academics in 60 countries revealed that 20 % had at some time taken pharmaceuticals in order to improve their ability to concentrate, and of these 25 % had done it on average once a week, and a further 25 % every day.<sup>80</sup>

Some 5 % of workers take pharmaceutical products to enhance their mental performance (DAK survey of 3000 workers aged between 20 and 50). Women tend to resort to mood-lifters such as anti-depressants, while men prefer drugs that increase their powers of concentration, like Ritalin. Around 75 % of those questioned claimed to have taken the drugs for medical reasons, while the remainder admitted there was no medical necessity for seeking a boost. 17 % of the interviewees admitted having taken drugs to enhance their mental abilities or to improve their mental state.<sup>81</sup>

The worldwide production of Ritalin quintupled between 1990 and 1997; in Switzerland, the quantity of Ritalin used between 1996 and 2000 rose from just under 14 kg to over 100 kg.<sup>82</sup>

## More than substances

Potential for addiction and harm of certain forms of behaviour

*Studies and practical experience have shown that certain forms of behaviour, such as gambling, carry a risk of addiction and can also be harmful to health. In addition, behavioural and substance dependencies often exist alongside each other (“co-morbidity”). The related research is still in its infancy – but there appears to be a need to develop both preventive and therapeutic measures in this field. A coherent and future oriented addiction policy must include non-substance related addictions (“behavioural addictions”, “behavioural dependencies”).*

The term “addiction” is used in everyday language not only for substance dependencies, but also for a wide variety of forms of behaviour that are regarded as excessive, out of control or abnormal (s. Chapter 1). Not every behaviour pattern of this type is a form of addiction, but such behaviour can be highly problematic and be a symptom of other disorders.<sup>83</sup>

## Criteria for behavioural dependencies

In its ICD-10,<sup>84</sup> the World Health Organisation sets out clearly defined diagnostic criteria for a dependency syndrome or traditional substance dependence (s. Chapter 1). In the foreground, there are three main characteristics of dependence: loss of control, physical dependence and social and health-related effects. In relation to behavioural dependencies, there is still a lack of scientific consensus on such criteria. To date, only “pathological gambling” has been clinically defined and recognised as dependence-type behaviour. However, even in this field, which has been the subject of research for a longer period, we now face entirely new challenges, due to the virtual world. Here there is a need for further clarification and research in the field of addiction.

Existing studies on internet habits show, however, that behavioural dependencies are characterised by specific patterns: an obsessive desire or strong pressure to behave in a certain way, limited control that may



verge on loss of control, development of increased tolerance, withdrawal symptoms, neglect of professional, educational or social obligations and the desire to continue the behaviour despite its negative effects. Based on these criteria, there is a trend to refer to “internet addiction” or “online addiction”. In the field of nutrition and exercise, certain excessive forms of behaviour are comparable with substance-related addictions in their processes: behavioural dependencies trigger similar processes in the brain to substance addictions. In particular, the natural reward processes in the brain, such as the release of dopamine, intensify, both in the case of psychoactive substances and in the case of dependent forms of behaviour such as shopping or gambling addictions or an addiction to work (ergomania).<sup>85</sup>

#### **Estimates of the prevalence of behavioural dependencies**

According to estimates, 5 % of Swiss people are addicted to shopping, with women at 6 % being twice as frequently affected as men at 3 %. In addition, 33 % of the population have a tendency towards uncontrolled buying behaviour.<sup>86</sup>

In the USA and the German-speaking area, the number of sex addicts is estimated at between 3–6 % of the population, with men being clearly more often affected than women (ratio of 4:1).<sup>87</sup>

According to estimates, between 1 % and 2.3 % of Swiss people are addicted to the internet, and as many people are thought to be at risk of such addiction.<sup>88</sup>

In 2007, 0.5 % of Swiss people between the ages of 18 and 98 were pathological gamblers, and a further 0.8 % had a problem with gambling.<sup>89</sup>

The *Report on the Challenge of Addiction* aims to give consideration to non-substance related dependencies, both in relation to prevention and market regulation and to therapy and harm reduction. Initial research results indicate that behavioural dependencies can also have negative health-related and social effects, in the same way that dependence on psychoactive substances does. Problematic patterns of consumption also develop, with substance-related and non-substance related dependencies reinforcing each other. In the area of non-substance related dependencies, there are signs of a similar interaction between structural and behaviour-related prevention, as there are for legal substance-related dependencies. Easy availability is an important factor. Significant global markets are now developing for online gambling, and they are pressing for recognition and liberalisation in order to become easily accessible. Accordingly, there is also a need here for various forms of regulation, including statutory measures such as legalisation, age limits and a system of taxation that aims to influence what is offered. Interestingly, in many countries, revenues from state monopolies in the gambling market are used for social projects that also serve to prevent addiction.

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## 5 Strategic Direction

### of the Policy Framework for the Challenge of Addiction

Broadening the scope of addiction policy (s. Chapter 4) is only worthwhile if changes are also made to the way in which the policy is implemented. This requires a change to the strategies employed in Swiss addiction policy. The health policy goal is to reduce the disease burden or to keep it at a low level (s. Chapter 2). This is to be achieved through a combination of behaviour-related and structural prevention measures, supplemented where appropriate with harm reduction measures. It is also necessary to strengthen protective factors and to reduce harmful ones.

Here again, a public health approach makes systematic and evidence-based action possible: it includes measures that relate both to supply and demand. It also takes account of measures that are beneficial to health and that are applied before specific addiction-related policies take effect. Furthermore, it ensures the inclusion of other policy sectors that have an influence on addictive behaviour. On this basis, the *Report on the Challenge of Addiction* proposes three strategic directions under the headings *more than personal responsibility*, *more than youth protection*, and *more than health policy measures*. Here again, the use of the word “more” points to the expanded scope of the policy.

#### **More than personal responsibility**

##### Structural measures and the promotion of skills

*Individual measures are important, but on their own they are not sufficient to reduce the burden of disease, as public health research has shown. A future oriented addiction policy therefore also strives to influence both demand and supply. If appropriate, it will also aim to achieve harm reduction. In addition, it will focus on the promotion of protective factors by creating supportive environments. People with a dependency are entitled to treatment and care – addiction is an illness, not a personal failing. Relatives, partners and children must also be able to count on receiving support. Children and adolescents have their own personal needs on their way to*

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*becoming adults; they must be protected against the abusive exploitation of these needs and desires by specifically targeted advertising and marketing measures.*

### Structural measures

There is an imbalance in much of the addiction policy debate. Problem patterns of consumption and their consequences – such as binge drinking, alcohol-related domestic violence, the harm caused to others by passive smoking or drug-related crime – are normally attributed by the general public and by politicians to individual (mis)conduct rather than to patterns of behaviour that have in part been structured by society. Indeed, the common approach is to point to the responsibilities of the immediate family – while less attention is paid to other factors, such as the influence of the marketing and sale of legal psychoactive substances. Rather than stressing the negative health-related, social and economic harm, the positive aspects of creating economic prosperity are emphasised. There is of course a certain logic to this: where there is consumption of addictive substances or addictive behaviour, there is always at least one supplier who stands to profit from it. This also applies in the case of compulsive gambling and increasingly to new internet or computer-related behavioural dependencies. A future oriented addiction policy must therefore always look to devise measures that target both the consumers and the suppliers. Public health strategies in the field of addiction must therefore constantly act to influence both supply and demand.

In the debate on addiction, this gives rise to a conflict between individual and collective responsibility. This same conflict arises between the state's duty to protect its citizens' health and its duty to ensure economic freedom. In protecting economic freedom, the state permits products that are harmful to health to be sold in the market. In some cases it even encourages the production of these products by granting subsidies. At the same time, the state pursues an active health policy in order to protect the common good, which is aimed at preventing the consumption of the self-same

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products (as in the case of smoking) or the consequential harm that they cause (as in the case of alcohol). On the one hand, this dynamic sees the individual being granted a high degree of freedom of choice, in accordance with the basic requirements of any democratic system; on the other, disregard is shown for the fact that the decision-making abilities of individuals vary considerably and that the supply structures are of course tailored towards encouraging consumption.

**CHF 16 million spent on the tobacco control –  
CHF 16 million spent on the domestic cultivation of tobacco**

In 2008, the fund for preventing smoking benefited to the tune of just under CHF 16 million from revenues from sales of cigarettes. This money financed prevention measures designed to stop people from starting to consume tobacco products, to help people stop smoking and to protect the public from the risks of passive smoking. In the same year, however, a similar sum of just under CHF 16 million in revenue from cigarette sales was used to promote the cultivation of tobacco in Switzerland, providing financial support to the 350 or so farms in Switzerland that grow tobacco.<sup>90</sup>

When a person is suffering from a medical condition, a similar conflict emerges between allocating the blame to the individual and making access to treatment available on a non-discriminatory basis. This conflict is especially relevant to the discussion around health insurance premiums and the reimbursement of medical costs. If we look beyond the individual case, the question arises of the overall costs to society.

### **The social costs of the consumption of addictive substances and compulsive gambling**

Tobacco consumption each year gives rise to social costs of CHF 10 billion. 12 % of these costs are direct costs (health care, police and court proceedings), while 38 % are indirect costs (invalidity benefits, absence from work), and 50 % are intangible costs (loss of quality of life for those concerned and others).

Every year, alcohol consumption brings social costs of CHF 6.5 billion. Of these 11 % are direct costs, 23 % indirect and 66 % intangible.

The consumption of illegal drugs each year brings social costs of CHF 4.1 billion francs. 34 % of these costs are direct, while 56 % are indirect and 10 % intangible.<sup>91</sup>

Gambling in Swiss casinos gives rise to annual social costs of CHF 70 million (direct and indirect, not including intangible costs), although it is estimated that only 20 % of problem or pathological gamblers play in casinos.<sup>92</sup>

In a liberal society, it is neither possible nor desirable for every risk to be eliminated. The right of citizens to organise their lives as they wish has to be respected, even if this means that some do harm to themselves. And the interests of the economy must be recognised. But when the health of the population is put at risk, a liberal and social state must act, even if this means imposing limits. This form of intervention is regarded as far more acceptable in transport policy or accident prevention, for example, than in addiction policy. But the pragmatic HIV/AIDS policy pursued in Switzerland, and measures like the heroin prescription programme are good examples that show public health initiatives in controversial areas can give impetus to a social learning process and contribute to a de-emphasis of ideological aspects.

The debate over personal responsibility and its political and ethical dimensions relates not only to addiction policy, but to all forms of prevention and health promotion. The simple fact is that the issue of personal responsibility in relation to addiction policy is particularly apparent. Freedom in society is too readily equated with the freedom of choice enjoyed by consumers. In this way, access to alcohol around the clock or the right

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health

to consume it in public places is transfigured into a fundamental right, while in fact it primarily relates to an increase in options for consumption and availability. This is in line with the reality that in the current health-policy debate, freedom is normally defined in terms of contractual, commercial or economic freedom, which has to be maintained or even extended in every respect.

### Encouraging health literacy

The *Report on the Challenge of Addiction* therefore proposes to depart from a very one-sided concept of personal responsibility. In society, in relation to health, the aim must always be to achieve **shared responsibility**. No one person alone can ensure their own good health. It requires a broad range of key skills, as concluded by the OECD in its *International Adult Literacy Survey*.<sup>93</sup> The ability of the individual to make sound health-related decisions in everyday life, known as health literacy, is therefore gaining considerably in importance. This applies to skills required in the context of the home, in society more broadly, in the workplace, in the health system and in the political debate. Society and politicians should consistently encourage the abilities of the public to exercise shared responsibility in relation to health. Policy should move beyond the confines of health policy in order to encourage action in other political sectors as a means of supporting responsible health-related behaviour through structural measures.

*From a public health point of view, action is needed that goes beyond “personal responsibility” in various ways that complement each other, as the health of an individual is an issue that also affects society as a whole. Each individual’s health literacy must therefore be complemented by a general health awareness in society:*

In structural prevention:

- What is needed is a social environment that makes it easier for people to engage in behaviours that are positive for their health. Other responsible social players must increasingly live up to their responsibility to the common good. This is especially pertinent in relation to compliance with legal requirements, such as the regulations on selling alcohol to minors. However, this responsibility must go beyond simple compliance with legal regulations, as is exemplified by measures to control fans at football matches. Some projects also attempt to appeal to fathers as the key male role models and thus to make inroads into family structures.
- Private sector players also have numerous opportunities to shoulder responsibility. These include, for example, voluntary product labelling, quality assurance, more restrained advertising and sponsorship measures or limits on supply. Unfortunately, in relation to addiction, experiences with the self-regulation of the private sector are not encouraging. For various suppliers, such as those in the tobacco industry, their efforts are a sham. Nevertheless, harm reduction can be pursued directly, as is the case in New Zealand, where bar owners have taken on the role of guarantors and make sure that persons under the influence of alcohol do not drive. A further example is the organisation of schemes for driving people home when they have been drinking. In this way, the social strategy of arranging for designated drivers in the USA has brought about a change in behaviour that reduces the harm done by alcohol consumption.

In behaviour-related prevention:

- People need personal resources to support what they do for their health. More of these resources must be made available. This is taken into account in behaviour-related prevention based on the life skills model, which encourages the development of personal responsibility.<sup>94</sup> International effectiveness studies have shown life skills training programmes to be a successful approach to behaviour-related prevention.<sup>95</sup> These programmes are also conducted under the headings of risk literacy and health literacy: in addition to the acquisition of general life

skills, it is also important to develop a critical approach and attitude towards using psychoactive substances and new media such as the internet. Such models can increasingly be offered as unspecific addiction prevention and early intervention programmes in schools and youth facilities, in associations and organisations.<sup>96</sup> In certain Swiss cantons, this has already been done and this approach should therefore be extended and regularly evaluated.

Training in life skills is especially useful in that it can reach those pupils who are not well integrated into day-to-day school life and who do not abide by the rules or stay within the limits. A survey of teaching staff involved in one programme of this type showed that 62 per cent of young people who have attended the course demonstrate a positive change in behaviour.<sup>97</sup> A nationwide investment in these skills-promoting prevention programmes would also be welcome in Switzerland. But it should be noted that there has been a debate about this type of programme for quite some time: it relates to the issue of whether the programme should primarily address “use prevention” (prevention of consumption) or “abuse prevention” (prevention of problematic consumption).<sup>98</sup> In the course of the Swiss debate, which recognises the importance of harm reduction in relation to the use of illegal drugs and alcohol, it must be assumed that both approaches will be covered and will prove useful. The epidemiological data, however, indicate clearly that there is a need to focus on preventive education in primary school. The creation of the required general conditions and the provision of the resources that are needed is a political issue.

## More than youth protection

Appropriate approaches for different sections of society

*Youth protection is also considered important and beyond dispute from a public health standpoint: the data indicates that problematic substance use has especially serious effects at this stage of life. The same may also be plausibly assumed in relation to behavioural dependencies. The strong focus on youth protection, has however, in view of the burden of disease, led to too narrow a strategic outlook for a future oriented addiction policy. This is particularly due to the major demographic changes that are underway.*

Data indicates that many patterns of problematic substance consumption originate in childhood or adolescence and that, depending on the substance concerned, they may have particularly serious effects in this phase of life.<sup>99</sup> In the case of tobacco, for example, over 80 per cent of adult smokers were already dependent before they had reached the age of 20.<sup>100</sup> Therefore a priority goal of any addiction policy must be to protect children and young people. But no policy can simply be allowed to stop there – a policy primarily directed towards young people does not tackle the health challenge in its entirety. In addition, many of the youth protection measures that are needed would already be covered if the consumption and the supply of substances were regulated in accordance with public health requirements. This applies for example in the case of smoking bans in public places. Due to the easy availability of many legal and illegal substances – even for young people – the consistent implementation of the existing regulations is not the only decisive factor in protecting young people. Harm reduction measures, such as those employed at festivals and other events, together with integrated youth development programmes are also important as preventive measures. Addiction policy must not define young people per se as a problem group and must understand their special characteristics – the desire to take risks and to overstep the limits is one of the defining features of this age group.

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The current focus on young people, especially in relation to problematic alcohol consumption, is a too narrowly-defined objective for future strategic measures. The statistical data indicates that the burden on society caused by problematic consumption among adults is far more severe than that caused by consumption by adolescents (for example in relation to healthcare costs and accidents). In addition, the focus on young people often lacks credibility, as the proposed measures in most cases are directed at the young consumers and not at the supply structures, and nor do they pay regard to adults in their capacity as role models: for young people, the credibility of measures is very important. For example, there is far more discussion about young people who engage in botellones (a form of binge drinking in public places) than of the problems arising from alcohol consumption that takes place at adult events. The youth focus disregards the fact that harmful consumption of alcohol and risk-carrying alcohol-related behaviour is found everywhere in society. A differentiated addiction policy will therefore be aimed at a wide variety of groups of consumers and affected persons. The measures must be tailored to different age groups, social classes, genders and other relevant social criteria if they are to be successful.

#### Measures related to age and addiction

The figures for Switzerland show that 29 per cent of 65–74 year-olds consume alcohol every day, that almost 20 per cent of persons over 74 years of age take analgesics, soporifics and sedatives, and that 20 per cent of the 55–65 year-olds smoke.<sup>101</sup> The changes in demographics have also led – and not only in Switzerland – to the growth of an older clientele in support centres for people with alcohol and drug-related problems. Among older people, addiction problems are also commonly associated with social problems, although in most cases these are less visible than in the case of young people. Usually they take place behind the closed doors of their homes.<sup>102</sup> Personal difficulties and life changes (retirement, the deaths of relatives and friends, loss of independence) lead to an increased risk, with the abuse of alcohol and of various types of medicines being the

main problem areas.<sup>103</sup> Here too there are considerable economic and social costs: accidents – such as falls due to substance abuse – and the resultant premature admission to a nursing home not only burden the healthcare system, but also have a highly detrimental effect on the independence and quality of life of the persons concerned. The issue of systems-induced (iatrogenic) addictive behaviour must also be discussed. Economic considerations combined with a lack of suitably trained staff may contribute to the pressure to dispense sedatives.<sup>104</sup>

#### **Different age groups – different patterns of consumption**

In 2007, the age group with the highest percentage of smokers at around 37 % was the 25–34 year-olds, while almost 34 % of 15–24 year-olds also smoked. The tendency is for the percentage of smokers to fall with age. While 31 % of 45–54 year-olds smoke, the level falls to 25 % among 55–64 year-olds and 17 % among 65–74 year-olds. The lowest number of smokers is found among the over 75 year-old age group, at 8 %.<sup>105</sup>

15–24 year-olds are the most frequent high-risk binge drinkers (20.6 %). This form of consumption declines steadily as people grow older. On the other hand, although abstinence and low-risk consumption increase as people grow older, so does chronic high-risk consumption.<sup>106</sup>

The consumption of medicines increases drastically with age: whereas only 3.3 % of the 25–34 year-old women (and 3.2 % of men) had taken analgesics every day in the seven days before questioning, in the case of the 45–54 year-old women this figure has already risen to 7.0 % (men: 4.7 %) and in the case of over 75 year-olds, it is 16.9 % (men: 7.2 %). The statistics on the use of soporifics are similar.<sup>107</sup>

The numbers of people affected by a shopping addiction decline gradually with age.<sup>108</sup>

## Measures in relation to socially disadvantaged groups

Many illnesses and health disorders occur more frequently in the socially disadvantaged sections of society, in some cases with far-reaching consequences for the quality of life of the persons concerned and of their families. The socio-economic class to which a person belongs is particularly significant.<sup>109</sup> Clear social differences are visible, for example, in the German figures on tobacco smoking: socially disadvantaged children and young people are not only more likely to smoke, they also begin at an earlier age.<sup>110</sup> Explanatory models relate to the risk environment and the accumulation of problem situations, such as the wide diversity of psychosocial problems and aggravating environmental factors that these children and young people are exposed to. In relation to alcohol too, the frequency of risky patterns of consumption – such as binge drinking – is significantly higher among school pupils in lower academic ability groups than among pupils studying for the university entrance certificate. The same applies to the consumption of cannabis. At particularly high risk are young unemployed men. Furthermore, according to the latest epidemiological studies, the mental health of young people in all social classes has deteriorated.<sup>111</sup> The experience of soft factors such as friendship, relationships, emotional attachments, love, warmth and time is a further factor that determines whether young people will tend to use drugs. Social work measures for young people that help them to integrate and also address their emotional needs are therefore of great importance.

## Measures in relation to people with an immigrant background

Studies on the prevention of substance addiction among immigrants indicate where useful measures should be taken. In particular, they emphasise that in many immigrant groups there is little or no awareness of the risk that legal substances (tobacco, alcohol, medicines) pose. The term “addiction” is almost exclusively understood as relating to the consumption of illegal substances (e. g. heroin, cocaine). Information, early recognition and treatment in good time are made more difficult because many families are not prepared to talk openly about a drug related problem, but

instead try to solve it within the family. The situation is exacerbated by language and more general integration problems. There is inadequate knowledge of what support is available, and in many cases there is a lack of understanding of how the Swiss health system works. Experiences at local (communal) level in Switzerland show that it is especially important to be able to gain access to women and mothers and to explain the problems of addiction to them.<sup>112</sup> These types of programmes must be tailored to the realities of the lives of the groups of persons concerned.

### Measures in relation to gender-specific differences

Women and men still differ considerably when it comes to social and health-related matters, in the way they use substances, and in relation to behavioural dependencies. Generally speaking, there are higher rates of problematic substance use among men, while women normally have a higher consumption rate for various types of medication. In several countries, more girls smoke than boys.<sup>113</sup> The reasons for consuming addictive substances also differ between women and men. For women, they often relate to excessive role expectations and the burden of dealing with many different responsibilities, but regular experiences of violence and feelings of helplessness can also be a cause. Among men, the reasons are often connected to the pressure to succeed at work and in their personal lives, or with the inability to cope with family obligations, such as fatherhood. To an increasing extent, restrictive and over-demanding role expectations and male stereotypes are also considered important factors. For both men and women, a variety of gender-specific realities, experiences, resources and needs must be taken into account.

Special consideration must also be given to the fact that more women live with men who have an addiction problem than vice-versa (in Germany, the ratio is around 3:1). For this reason, they often have to share the burden and suffer the consequences of their partner's addiction (such as debts, physical violence, and isolation). In most cases, women stay in a



relationship with a partner who has an addiction for much longer than men would in the same situation.<sup>114</sup> Special problems also arise in the event of pregnancies, as the consumption of various substances can be harmful to the child. In most programmes, far too little account is taken of the gender-specific aspects – this needs to be changed.

#### **The influence of the socio-economic status and of gender**

Immigrants from the former Yugoslavia, Portugal, Kosovo, Turkey and Sri Lanka are far more likely to consume soporifics, analgesics or sedatives on a daily basis than immigrants from Italy, Germany, Austria or France. The latter are virtually identical to the Swiss in their consumption patterns for medicines.<sup>115</sup>

20 % of men consume alcohol every day, a substantially larger percentage than women (9 %).<sup>116</sup>

A person's own assessment of their state of health shows a positive correlation with the education they have received: 72 % of people with a basic school leaving certificate regard their state of health as good to very good, while in the case of persons with an upper secondary school certificate the level is 88 %, and for those with a tertiary level certificate, it is 93 %.<sup>117</sup>

Women, and older and less well-educated people more frequently suffer from a chronic disease or a chronic health-related problem: 26 % of men and 28 % of women are affected. Whereas among 15–24 year olds, 14 % are affected, in the case of people who are 75 or over, the figure is 48 %. While 26 % of people with a tertiary level certificate suffer from a chronic disease, two thirds of those with a basic school leaving certificate are similarly afflicted, a considerably higher proportion.<sup>118</sup>

## Conclusions

The *Report on the Challenge of Addiction* therefore proposes to focus on the special protection needs, protection requirements and risks in relation to a variety of age groups and cohorts combined with socio-economic and socio-cultural criteria, without discriminating against the persons concerned. The various forms of behaviour and addiction and the distinct patterns of consumption of specific groups must be tackled by a series of tailored addiction policy measures. In addition, the supply structures must be analysed and presented in a transparent way – particularly in relation to the factors encouraging consumption. The task will be made easier by adopting a procedure that includes the persons affected.

Addiction policy has to pay special attention to the risks affecting children and young adults, without labelling them as a problem group per se. This applies not only in the case of illegal substances, but also for the access to, the supply and the advertising of legal products (such as alcohol and tobacco) and increasingly also to the virtual world.

For all groups, it is important to guarantee access to programmes for health promotion, prevention, early diagnosis, therapy and if applicable harm reduction, without attributing blame. This is a key requirement for an addiction policy based on a public health approach, even if it requires the provision of additional financial resources.

Lastly a future oriented addiction policy will also attempt to bring about a change in social norms. The aim, for example, is to make it the social norm not to smoke, or to encourage new forms of behaviour when drinking alcohol. Although educational campaigns contribute to this, the most important element will be structural measures relating to society as a whole. Thus, for example, the lifting of the ban on the television advertising of wine and beer gives the wrong health policy signal. Such signals reduce the credibility of other prevention measures.

*Failure to act  
politically  
can constitute  
addiction policy  
by default*

**More than health policy measures**

The need for an inter-sectoral addiction policy

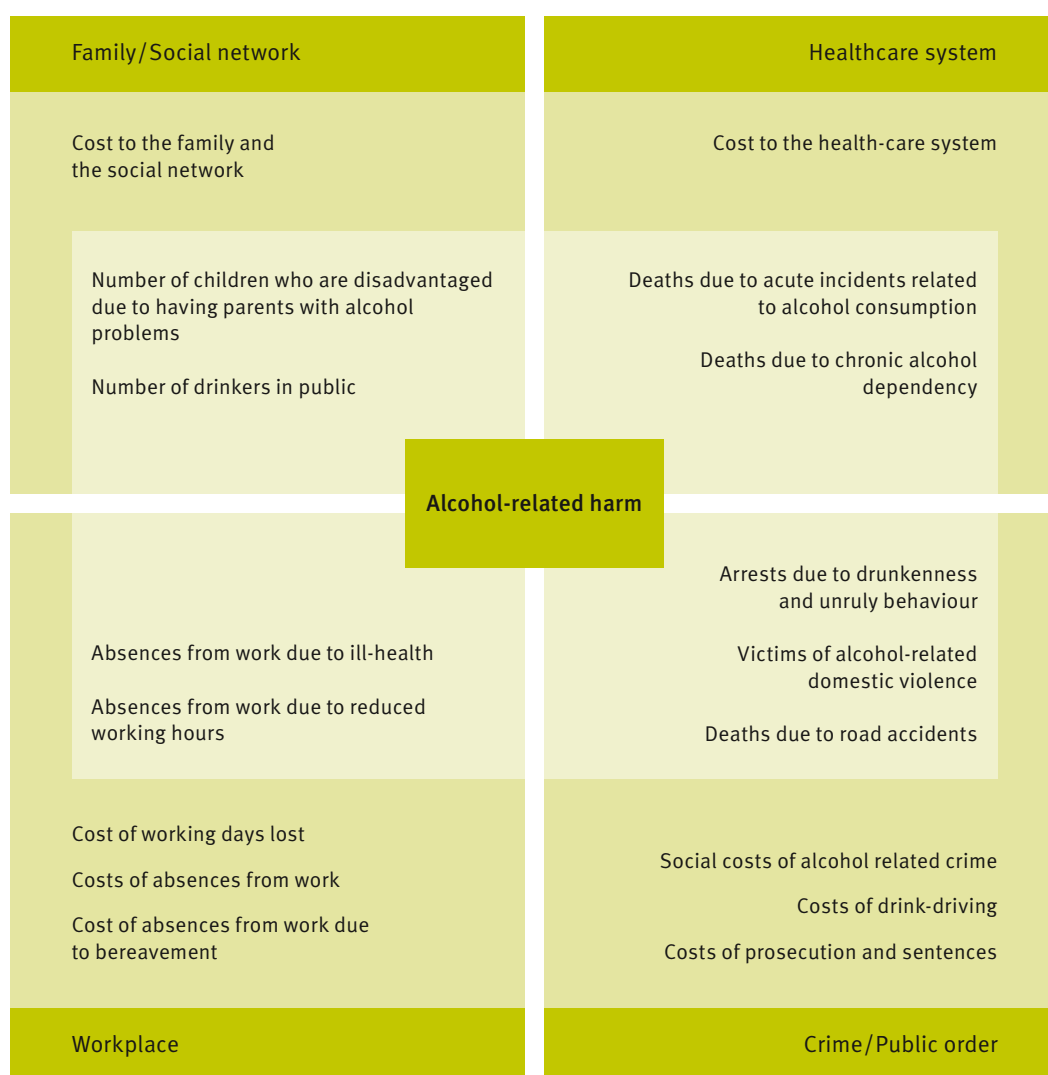
*In order to attain its health goals, a future oriented addiction policy must incorporate other policy sectors and encourage collaboration between the various federal levels. It must be prepared for a broadening of scope (s. Chapter 4) and it must strive for a strategic merger of the policies on addiction, which so far have been kept separate. Additional stakeholders such as civil society and businesses should likewise be enlisted in the efforts when it is appropriate to do so.*

Addiction policy is firmly established in the health sector, which is where it should be centred. Notwithstanding this, critical components of addiction policy are located in other policy sectors, including price and taxation policy, excise and customs tariffs, road safety legislation, restrictions on access and sales, and in measures designed to influence behaviour. Measures such as these are only rarely taken with any direct influence on the part of those responsible for health. Failure to act politically, though, can constitute addiction policy by default. The close connection between patterns of consumption and the structuring of supply makes it clear that an addiction policy must always find the most effective interplay between public education and the exertion of influence on production, supply and consumption. In a society offering multiple consumption options, addiction policy must attach greater importance to precisely those measures that have a bearing on supply; this is the only way of making the healthier choice into the more attractive, cheaper and simpler option. Today it is mostly the opposite, especially in the case of alcohol. In the policy on alcohol, there is still a reluctance to apply in a consistent manner the lessons learned from tobacco policy, where price is recognised to be one of the most important factors causing a reduction in consumption. Only slowly, and on account of a marked increase in the availability of low-price beer, have we witnessed the emergence of a similar discussion on alcohol. In the meantime, arguments based on health policy and on the grounds of protecting young people have been advanced for fixing a minimum price for beer. This is designed to counter the erosion of prices brought about by price wars between the breweries and the discount stores.

The other policy sectors should have an interest in addiction policy, because the major part of the costs arising from problematic patterns of consumption is reflected not only in health expenditures, but also in the social costs suffered by families, in economic costs incurred by businesses and in expenditure for public safety. Figure 3 uses the example of alcohol consumption in order to show the areas that may have to incur costs. In a similar way the consumption of other substances or certain behaviours have cost implications in the four areas of “family/social network”, “health system”, “workplace” and “crime/public order”, even though the costs here may differ in their nature and severity.

From the public health perspective, it is essential to have a coordinated and balanced approach between individual measures and the various policy fields illustrated here. *Successful public health measures in the area of addiction rely on the right mix of interventions combined with a coordinated approach.* These potential interventions encompass measures in health and social policy which aim to reduce supply and demand, as well as market regulation, and criminal sanctions and law enforcement; they also comprise supportive social, educational and family policies, including social reintegration. They are complemented by treatment and harm reduction. Depending on the substance, behaviour or consumer group, they will have to be adapted in different ways. In the European discussion, this is known as a “balanced approach”).<sup>120</sup>

**Figure 3**  
Possible effects of the consumption of alcohol on the health system,  
the workplace, crime and public order, and on families and the social network.<sup>122</sup>



**Regulation:** From the public health perspective, it is the disease burden that is the key criterion for action. A future oriented addiction policy will have to propose different mechanisms for regulation, depending on a substance's potential for harm or with regard to specific areas of behavioural addictions. Regulation can range from shaping the conditions prevalent in the legal market, bolstered by the threat of fines in the case of violations, to the comprehensive regulation of production, supply and consumption, which can be reinforced by the threat of custodial sentences for violations by suppliers. Even in the case of very dangerous substances, the refusal to allow a legal market can be justified only when such a refusal contributes efficiently to the protection of minors. That is possible only when a major reduction in supply is feasible; if it is not, it must be asked whether legal market regulation might not better protect young people from the harmful consumption of substances that are currently illegal.

**Law enforcement:** Depending on a substance's potential for causing harm, addiction policy will also require policing and law enforcement measures; no addiction policy can work without measures for enforcement, for even market regulation (and not only a ban on production, supply and consumption) has to be buttressed by criminal provisions and sanctions. And these must moreover be aimed not only at consumers, but also at distributors and manufacturers.

**Supportive measures:** It is also crucial to take into account aspects of social, educational and family policy as well as to provide for measures in the working environment or the leisure sphere, for aggravating and protective factors are unequally distributed in society. Children and young people from the lower socio-economic levels are affected more severely by harmful factors than are those from the higher strata.<sup>121</sup> The linking of structural measures, together with the strengthening of social resources for health and protective factors at the family and local level, must occupy a more powerful central position in the efforts to improve addiction policy. This is especially the case with respect to school and leisure policy as well as the individuals' responsibility for their own health. In order

# *An effective future addiction policy will place the accent on evidence and effectiveness*

to achieve this, the skills and competencies of the stakeholders that are essential to implementing a coordinated and integrated policy must be improved.<sup>122</sup> At a local level, this can mean the training of staff in the health and social services departments, in schools, in local authorities, and in the police.

## **Outlook**

The public health debate on addiction policy is a political debate, which is often adversarial as the stakeholders support different models of society. Today many social problems are considered from a health perspective. This enables an evidence-based discussion in relation to the disease burden. But on the other hand, it leads to an increasing politicisation of the discussion on public health measures. Among the diverse influences bearing on addiction policy, the following are the most prevalent: public opinion, political Ideology, theoretical concepts, experience and empiricism, science and evidence, and effectiveness.<sup>123</sup> A future oriented addiction policy will place the accent on evidence and effectiveness.

Social and demographic change and changing patterns of consumption have led to manufacturers and service providers adopting a defensive position as they consider their sales to be increasingly threatened by state regulation. They argue against a “nanny state” that uses legal instruments which increasingly intrude into the private lives of its citizens. This poses difficulties for the shaping of a future oriented addiction policy, even though changed (healthier) consumption patterns could provide opportunities for entrepreneurial action. The sales and consumption of alcohol-free beer, for example, have seen substantial increases globally. In the addiction policy discussion therefore, there must always be equal emphasis on the responsibility of manufacturers and suppliers, and not only on the personal responsibility of individual consumers.

Addiction policy must be pragmatic and realistic and geared to the realities of life. Its priority goal is an improvement of public health through an effective and measurable reduction of the *problematic consumption* of psychoactive substances and through forward looking action in relation to behaviours *with potential for addiction*. The resultant reduction in the disease burden and social problems will lead to a decrease in costs not only for the health sector but also for other political and social sectors.

At European level, we are also witnessing a movement towards integrated and coherent addiction policies. The identifying features for this are a focus on evidence, the support of differentiated interventions and decriminalisation, all with the aim of improving health. It would be a welcome move if political decision-makers distanced themselves from simplistic notions about addiction policy. We hope that the guiding principles for a future oriented policy approach offered in this Report will contribute to this.

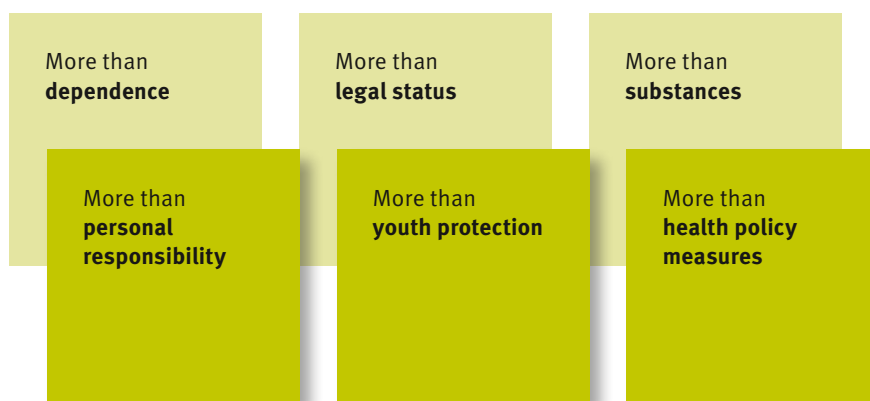






## 6 The Challenge of Addiction:

### A Framework for a Future Oriented Policy



This policy framework for addressing the challenge of addiction has a new understanding of addiction policy as its point of departure. It recommends that such a policy should consider *broadening its scope* as well as *changing its strategic focus and direction*. The policy framework for addressing the challenge of addiction considers the challenge to be a social phenomenon that must be addressed by taking a coherent and comprehensive approach. The framework encompasses not only psychoactive substances but also addresses potentially addictive behaviours not related to substances, and it is based on a *public health approach*. Guidelines for proceeding in accordance with this approach include the *prevention of problematic consumption and problematic behaviours* as well as the *reduction of the harmful effects on health and the impact they have*, both on the individual and his or her environment, and on society.

### **Principle 1 A coherent policy**

Through a *public health approach*, Switzerland will pursue a *coherent policy* in relation to the *harmful and risky use* of psychoactive substances and potentially addictive behaviours.

### **Principle 2 Objective determined by potential harm and the disease burden**

Action arising from addiction policy in Switzerland will be shaped and determined by the *potential harm and the burden of disease* caused by substances or potentially addictive behaviours affecting the individual, his or her environment and society. Such an approach thus distances itself from a simplistic distinction between legal and illegal substances and an exclusive emphasis on dependence.

### **Principle 3 Broader scope**

Swiss addiction policy will focus not only on alcohol, tobacco and illegal drugs, but will also include *medicines, addictions not related to substances* and *products aimed at physical and mental enhancement*. The specific characteristics of the different types of addiction will need to be recognised by the policy.

### **Principle 4 Securing treatment and care**

Addiction is an illness. People afflicted by problematic consumption, problem behaviour or dependence have a right to receive treatment and care. Their family members, partners and children are also entitled to support. There must also be access to *measures for early diagnosis and consultation, support in achieving withdrawal and being reintegrated into society*. The aim is to create and consolidate an integrated approach to services.

### **Principle 5 Harm reduction**

Effective harm reduction measures relate to consumers and their environment. *They are provided where they constitute an option from a public health perspective*. In relation to tobacco, the current evidence does not support harm reduction measures.

#### **Principle 6 Prevention through structural measures**

Addiction policy in Switzerland will put the emphasis on structural measures aimed at environments, with the objective of making the healthier choice the attractive option. To achieve this, *different policy sectors will increasingly be involved in addiction policy measures.*

#### **Principle 7 Obligations for producers, distributors and retailers**

*Producers, distributors and retailers* of products with potential for harm or addiction will be obliged to contribute through *legal measures specifically designed to control supply and demand.* This applies at all federal levels in Switzerland.

#### **Principle 8 Differentiated approach to target groups**

The protection of young people will continue to be an important area of addiction policy and will require consistent implementation. Addiction policy instruments must, however, be broadly directed at all *target groups.* Special attention must be paid to ensuring that no one should be discriminated against on the grounds of *social inequality or social diversity.* In addition, *health literacy* should be encouraged through specific training programmes aimed at prevention and early intervention.

#### **Principle 9 Civil society**

Responsible *societal actors*, such as sports and trade associations or professional organisations, need to become increasingly active, especially in prevention and harm reduction.

#### **Principle 10 Research, training and monitoring/evaluation**

Switzerland will increase its commitment to *addiction research* and to the *training of the workforce.* To this end, an efficient and integrated *system of addiction monitoring* will be developed reflecting the approach of the model put forward in this policy framework. The Federal Council should initiate a *national research project into addiction.* Addiction research will be further consolidated at university level through the inclusion of medicine and psychiatry.

# Outlook

## The continuation of process relating to the challenge of addiction

The delegates of the three federal Commissions on addiction, the FCAI, FCDI, and FCTC, who participated in this Report *request the Federal Office of Public Health (FOPH)*, following the publication of the present document, *to initiate and implement a targeted action plan*.

The priorities of this action plan will be the

- *dissemination*,
- *consolidation* and
- *integration and mainstreaming*

of the essence of the present Report and its policy framework.

The *dissemination* of the content will provide information to broader groups in society and serve to stimulate discussion of the points raised. The Report can thus serve as a reference paper for stakeholders at all federal levels and in specialist and social organisations. By disseminating the Report in this way, the FOPH will commit itself to ensuring the consideration of the policy framework in policy formulation as well as in current discussions relevant to addiction policy.

In tandem with its dissemination, the *consolidation* of the Report's findings will define the further need for action and launch appropriate sub-processes. It will consistently take account of the *expansion of the scope of the policy under the headings of "more than dependence", "more than legal status", and "more than substances"*. This means that a greater degree of strategic collaboration and exchange will be encouraged in the areas of tobacco, alcohol and drugs. At the same time the basis will be created for integrating the challenges of non-substance related addictions and enhancement into the discourse on addiction.

The *strategic expansion* of *"more than personal responsibility", "more than protection of youth", "more than health policy measures"* should be increasingly *integrated and mainstreamed* in political decisions that have an impact on the harmful consumption of substances and non-substance related addictions, as well as on the supply of products and services. In this context various methods of market regulation are of high significance.



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