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International Drug Policy Consortium

A global network promoting objective and open debate on drug policy

Drug Policy Guide

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Introduction

The International Drug Policy Consortium (IDPC) is a global network of non-governmental organisations (NGOs) and professional networks that specialises in issues related to the production and use of controlled drugs. We aim to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and support evidence-based policies that are effective in reducing drug-related harms. We produce occasional briefing papers, disseminate the reports of our member organisations about particular drug-related matters, and offer expert consultancy services to policy-makers and officials worldwide. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates.

This drug policy guide was compiled in 2009 through research and consultation with our network of experts. It aims to provide our regional and national partners with a resource that they can use to conduct reviews of the national drug policies and programmes in their areas, and engage with policy-makers to work towards policy and programme improvements. The guide will be updated annually to reflect changes in global evidence and experience.

These chapters will also guide the consultancy work of the IDPC during 2010. Through its global network of members and experts, IDPC can provide policy-makers with specialist advice and support to develop policies and strategies that are appropriate for their country. This can be organised through submitting written materials, presentations at events, meetings with key officials, arranging study tours, or introducing consultants. If you are interested in any of these services, please contact Ann Fordham at afordham@idpc.net to discuss.

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Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HIV	human immunodeficiency virus
IDPC	International Drug Policy Consortium
IDU	injecting drug user
IHRA	International Harm Reduction Association
NGO	non-governmental organisation
NSP	needle and syringe programme
OST	opioid substitution therapy
TB	tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Chapter 1
Core Principles

Core Principles

Most national governments have faithfully followed the model of drug policy promoted since 1961 by United Nations (UN) drug control conventions, with a focus on laws and enforcement operations to stifle and eventually eradicate the supply of illegal drugs. However, many policy-makers have been forced to re-evaluate their previous commitment to these strategies because:

- it has proved impossible to reduce significantly and sustainably the overall scale of illegal drug markets[1]
- it is increasingly clear that there are significant negative consequences of implementing the current global drug control system (for example, the increased profits and reach of organised crime)[2]
- the growth of drug-related health problems has forced a review of the effects of the criminalisation and marginalisation of drug users[3]
- the United Nations (UN) system has drawn attention to concerns about the breach of fundamental human rights and freedoms in the pursuit of drug control objectives.[4]

In this context, governments need to conduct meaningful reviews of their national drug control laws, strategies and programmes to make the most effective use of resources and achieve the fundamental objective of drug policy: to maximise human security, health and development.[5]

Governments should conduct meaningful reviews of their national drug control laws and strategies to make the most effective use of resources to maximise human security, health and development.

1 European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 1998-2007 (European Communities)*, http://ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf: This study found no evidence that the global drug problem was reduced during the UNGASS period from 1998 to 2007.

2 UKDPC (2009), *Refocusing drug-related law enforcement to address harms – Full review report* (London: UKDPC), http://www.ukdpc.org.uk/resources/Refocusing_Enforcement_full.pdf ; Bewley-Taylor, D., Hallam, C., Allen, R. (2009), *Beckley Report 16 – The incarceration of drug offenders, an overview.* (The Beckley Foundation Drug Policy Programme), http://www.idpc.net/sites/default/files/library/Beckley_Report_16_2_FINAL_EN.pdf; Transnational Institute (2008), *Drug Policy Briefing 28 – Crops for illicit use and ecocide,* http://www.tni.org/sites/tniclone.test.koumbit.net/files/download/brief28.pdf.

3 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2009), *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva: WHO), http://www.who.int/hiv/idu/TechnicalGuideTargetSettingApril08.pdf ; Ball, A., Rana, S. and Dehne, K.L. (1998), 'HIV prevention among injecting drug users: responses in developing and transitional countries'. *Public Health Reports* **113**(1):170 –181, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1307739/.

4 United Nations Press Release (10 March 2009), *High Commissioner calls for focus on human rights and harm reduction in international drug policy,* http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument ; International Harm Reduction Association Press Release (9 February 2009), *UN Special Rapporteur on the Right to Health calls for government action on harm reduction in new IHRA report,* http://www.ihrablog.net/2009/02/un-special-rapporteur-on-right-to.html ; United Nations Office on Drugs and Crime Press Release (12 March 2009), *Political Declaration and Action Plan map out future of drug control,* http://www.unodc.org/unodc/en/press/releases/2009-12.03.html.

5 Preamble of the 1961 UN Single Convention on Narcotic drugs: 'The Parties [are] concerned with the health and welfare of mankind'.

There is now a wealth of evidence and experience worldwide on how to develop and review national drug strategies, and on what activities and programmes are most effective. This IDPC guide has drawn on this evidence and experience to offer accessible advice to policy-makers and guide them to develop effective policies and programmes relevant to the problems and challenges in their country.

High-level principles for an effective drug policy

We propose that national drug strategies should always be based on five core principles:

1) Drug policies should be developed through a structured and objective assessment of priorities and evidence.

2) All activities should be undertaken in full compliance with international human rights law.

3) Drug policies should focus on reducing the harmful consequences rather than the scale of drug use and markets.

4) Policy and activities should seek to promote the social inclusion of marginalised groups.

5) Governments should build open and constructive relationships with civil society in the discussion and delivery of their strategies.

Each chapter of this guide fully integrates these five core principles.

1.1 A structured approach to strategy development and review

Since 1961, most countries have developed drug policy by framing laws to control drug production, distribution, and use that complied with their obligations under the UN Drug Conventions. As policy-makers have come to recognise the complexity of the factors that affect levels and patterns of drug production, supply and use among their populations, it has become clear that comprehensive and integrated national strategies were required, and that drug laws and their enforcement were just one of many areas of government activity that could be used to achieve these strategic objectives.

This area of social and health policy has long been characterised by ideological debates and political and diplomatic sensitivities. It is particularly important that governments take a highly structured approach to developing and reviewing their drug policies and strategies. Simply focusing on law enforcement issues or viewing drug policy decisions through the lens of being 'tough' or 'soft' on drugs is not enough. Ideally, the process for good drug policy-making at the national level should include the following normative framework:

It is particularly important that national governments take a highly structured approach to developing and reviewing their drug policies and strategies.

- **A statement of high-level objectives** These will flow from an assessment of which consequences of drug markets and drug use are most harmful to society. Communities and civil society can be positively engaged in a discussion on what aspects of the drug problem matter most to them. For example, depending on specific circumstances in a country, priorities may focus on reducing organised crime and violence, the impact of drug use on families and communities, or the transmission of HIV and other infections. There will probably be a combination of objectives covering the scale of the market and its consequences. As will be explained below, operational objectives, such as the number of drug seizures or arrests, do not constitute appropriate fundamental outcomes for a national strategy.

- **A description of the activities that the government will pursue and support to help meet these objectives** There is growing evidence worldwide to guide policy-makers on which activities and programmes would be most effective in achieving their objectives. For example, there is clear evidence of the impact of

drug dependence treatment on reducing street crime,[6] or of the implementation of harm reduction programmes on reducing HIV infections.[7] Clearly, the range and extent of activities will be constrained by available resources. However, investing in effective drug strategies and programmes will lead to greater savings by reducing the cost of health, social and crime problems (for example, drug dependence treatment programmes are less costly than responding to the crimes that these programmes would prevent[8]).

- **The involvement and collaboration of departments or agencies responsible for these activities** A society's drug problems cannot be solved by one government department or agency alone. A comprehensive and integrated strategy requires co-operation and co-ordination between many government bodies, including the departments of health, social affairs, justice, education and foreign affairs. Successful programme delivery should take place through the local offices of these departments, in partnership with local municipal authorities, community and faith groups, and civil society organisations, including affected communities such as drug users and growers. It is important to set up strong co-ordination mechanisms locally and nationally to encourage these diverse organisations to pull together behind the agreed strategy and make sure that resources are used efficiently. A robust accountability mechanism should also be established to assess how well the strategy is working.

- **The amount of resources made available by the government to support these activities** National drug strategies have diverged substantially on the issue of resource attribution. Some countries (notably the USA) spend billions of dollars every year on planned actions within their national drug strategy. Others invest very little in activities designed to reduce drug problems. Expenditure may be hidden in general health, justice or law enforcement budgets, where its impact on achieving drug strategy objectives may not be explicitly evaluated. It is important that policy-makers clearly assess what is spent 'proactively' on drug policies and programmes (for example, on enforcement, prevention and treatment) in relation to the savings made on 'reactive' expenditure (for example, responding to drug-related problems such as crime, loss of economic activity or treatment of diseases).

6 Ball, J.C. & Ross, A. (1991), *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcome.* (New York: Springer-Verlag) ; National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998), 'Effective medical treatment of opiate addiction'. *JAMA* **280**:1936–1943, http://consensus.nih.gov/1997/1998TreatOpiateAddiction108html.htm ; Gossop, M. (2005), *Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study (NTSOR)* (National Treatment Agency for Substance Misuse), http://www.nta.nhs.uk/publications/documents/nta_drug_treatment_crime_reduction_ntors_findings_2005_rb8.pdf

7 Hunt, N. (2003), *A review of the evidence-base for harm reduction approaches to drug use* (Forward Thinking on Drugs, A Release Initiative), http://www.ihra.net/Assets/23/1/HIVTop50Documents11.pdf

8 National Treatment Agency for Substance Misuse (2009), *The Story of Drug Treatment* (London: NTA), http://www.nta.nhs.uk/publications/documents/story_of_drug_treatment_december_2009.pdf ; Godfrey, C., Stewart, D. & Gossop, M. (2004), 'The economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)'. *Addiction* **99**(6):697–707, http://cat.inist.fr/?aModele=afficheN&cpsidt=15796344

- **A clear articulation of the scope and timescale of the strategy, and how and when its progress will be measured** If we are to learn from our drug policy successes and failures, strong arrangements need to be put in place to review the impact of drug strategies, activities and programmes. This involves setting clear goals and timescales, and committing to an objective and properly structured review at an agreed point. Many countries created comprehensive national drug strategies in the 1990s that they have now refined and updated. However, with a few exceptions such as in Portugal, Hungary or Australia, the review of these strategies has been insufficiently systematic and objective. This has led to activities continuing that are clearly ineffective, and opportunities being lost to introduce new and potentially more successful approaches. Since no country has managed to resolve fully the problems associated with drug markets and drug use in its territory, policy-makers should be constantly searching for new and better objectives and responses, based on evidence and experience rather than ideology and political rhetoric.

1.2 Ensuring compliance with fundamental rights and freedoms

According to the UN drug control conventions, the primary concern of the drug control system is the 'health and welfare of mankind'[9]. Drug control bodies and measures are also bound by the overarching obligations created under Articles 55 and 56 of the 1945 UN Charter, which promote universal respect for, and observance of, human rights and fundamental freedoms[10].

Human rights and fundamental freedoms stem from the dignity and worth of the individual.[11] They are universal, interdependent, interrelated, indivisible and inalienable,[12] which means that they cannot be taken away from a person because they might be a drug user or grower, or a person living with HIV. This has been explicitly endorsed by UN High Commissioner for Human Rights, Navanethem Pillay, who stated that 'individuals who use drugs [did] not forfeit their human rights'.[13]

'Individuals who use drugs do not forfeit their human rights'.
Navanathem Pillay,
UN High Commissioner
for Human Rights

Human rights are not only a statement of principle. States also have binding obligations under international law to respect, protect and fulfil them.[14] This means that they should not interfere with the human rights of their citizens, including drug users and growers, nor allow third parties such as law enforcement officers to do so. It also means that they should adopt appropriate legislative, constitutional, budgetary and other measures so that the human rights of all their citizens are fully realised.

Concerns have been raised by Anand Grover, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, about current drug policy practices. Sadly, human rights abuses continue to proliferate under the auspices of drug policy, while progress in realising human rights has never been at the heart of those policies. Examples of common human rights violations include:[15]

9 Preamble of the 1961 UN Single Convention on Narcotic Drugs, available at: http://www.incb.org/pdf/e/conv/convention_1961_en.pdf

10 According to article 103 of the UN Charter, the obligations contained in the Charter prevail upon every international agreement, including the three Drug Conventions.

11 1948 Universal Declaration of Human Rights.

12 World Conference on Human Rights (1993), *Vienna Declaration and Programme of Action* (A/CONF.157/23), 12 July 1993, para.1

13 United Nations Press Release (10 march 2009), 'High Commissioner calls for focus on human rights and harm reduction in international drug policy', http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument

14 Office of the High Commissioner for Human Rights website: *International human rights law*, http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx

15 Human Rights Watch, Open Society Institute & International Harm Reduction Association, *UNGASS Ten year drug strategy Review: Ten ways drug policy affects human rights*, http://www.ihra.net/Assets/1512/1/UNGASSReviewFactSheet-DrugPolicyIHRAHumanRightsWatchandOSI.pdf

- the violation of the right to life,[16] with the use of the death penalty[17] or extrajudicial killings for drug offences

- the violation of the right to be free from torture, cruel and inhuman punishment,[18] with the arbitrary detention of drug users and abuses in compulsory drug treatment centres [19]

- the right to be free from slavery – some compulsory treatment centres are still using such practices as forced labour [20]

- the violation of the right to health,[21] due to restricted access to essential medicines and drug or HIV prevention, treatment, care and support[22]

- the violation of social and economic rights,[23] with the implementation of forced crop eradication campaigns

- the violation of the right to be free from discrimination[24], with the discriminatory application of drug control laws, notably towards minority ethnic people, indigenous people and women.[25]

Today, these human rights abuses are receiving greater attention from the public, and NGOs engaged in human rights work have become more active in scrutinising states' performance.[26] The UN drug control bodies are also becoming more conscious of this issue. For instance, the Executive Director of the United Nations Office on Drugs and Crime (UNODC), Antonio Maria Costa, recently declared: 'Our work is guided first and foremost by the UN Charter that commits signatories to fundamental freedoms, and by the Universal Declaration of Human Rights… As we emphasise the health aspects of drug control, it stands to reason that the implementation of the drug Conventions must proceed with due regard to human rights. Thus far, there has been little attention paid to

16 1948 Universal Declaration of Human Rights, and 1966 International Covenant on Civil and Political Rights.

17 Over 30 countries retain the death penalty for drug offences.

18 1975 UN Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment.

19 Open Society Institute & International Harm Reduction Development Program (2009), *Human rights abuses in the name of drug treatment, reports from the field,* http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/treatmentabuse_20090318/treatmentabuse_20090309.pdf ; Richard Pearshouse (2009), *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*, (Canadian HIV/AIDS Legal Network), http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=917 ; Human Rights Watch (2010), *Skin on the cable – The illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia*, http://www.hrw.org/en/reports/2010/01/25/skin-cable-0

20 1948 Universal Declaration of Human Rights

21 1945 Constitution of the World Health Organisation, and the 1966 International Covenant on Economic, Social and Cultural Rights

22 The World Health Organisation estimates that approximately 80% of the world's population has either no or insufficient access to treatment for moderate or severe pain: World Health Organisation, Access to Controlled Medications Programme (2008), *Improving access to medications controlled under international drug conventions,* http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf.

23 1966 International Covenant on Economic, Social and Cultural Rights.

24 1960 Convention on the Elimination of All Forms of Racial Discrimination, and 1979 Convention for the Elimination of All Forms of Discrimination against Women.

25 For example, Human Rights Watch research indicates that in the USA, African-Americans are ten times more likely than whites to enter prison for drug offences: Human Rights Watch (2008), *Targeting Blacks: drug law enforcement and race in the United States*, http://www.hrw.org/en/node/62236/section/1.

26 The Beckley Foundation Drug Policy Programme, International Harm Reduction Association, Human Rights Watch & The Canadian HIV/AIDS Legal Network (2008), *Report 13 - Recalibrating the regime: The need for a human rights-based approach to international drug policy*, http://www.idpc.net/php-bin/documents/BFDPP_RP_13_Recal_Regime_EN.pdf.

this aspect of our work. This definitely needs to be amended'.[27] Additionally, both the UN Special Rapporteur on Torture, Professor Nowak, and the UN High Commissioner for Human Rights, Navanethem Pillay, have called for a human rights-based approach to drug policy.[28]

It is clear that governments and law enforcement authorities have paid scant attention to fundamental rights and freedoms in their enthusiasm to design and implement national drug control policies and programmes. A paradigm shift is needed, where human rights law is recognised as a core element of the national legal framework for drug policy.[29] This new legal framework should focus on:

- public health, in order to improve access to essential medicines and develop harm reduction, prevention, treatment and care programmes

- development, in order to refocus not only on alternative development but also on poverty reduction, education, employment, social security, etc.

- human security, in order to refocus law enforcement efforts on those most responsible for the drug-related issues, rather than low-level and non-dangerous dealers, drug users and vulnerable farming communities.

27 UNODC Executive Director Antonio Maria Costa (10 March 2008), 51st Session of the Commission on Narcotic Drugs, Vienna, http://www.unodc.org/unodc/en/about-unodc/speeches/2008-03-10.html

28 United Nations Press Release (10 March 2009), *High Commissioner calls for focus on human rights and harm reduction in international drug policy*, http://www.unhchr.ch/huricane/huricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument

29 Barrett, D. & Nowak, M. (2009), 'The United Nations and Drug Policy: Towards a Human Rights-Based Approach', *The Diversity of International Law: Essays in Honour of Professor Kalliopi K. Koufa* (Constantinides and Nikos Zaikos eds., Brill/Martinus Nijhoff): 449-477, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1461445.

1.3 Focusing on the harms associated with drug markets and use

Over the past century, countries have focused much of their drug control efforts on reducing the scale of drug markets, primarily through punitive means, believing that this would reduce drug-related harms.[30] These attempts have been largely unsuccessful. While theoretically reductions in scale might lead to a reduction in harms, the opposite has often occurred in practice. For example, successful operations against a dealing network can increase violence as competing gangs fight over the vacant 'turf';[31] and an action against a particular drug can lead drug users to switch to substances that may be more dangerous.[32]

> Policies that explicitly focus on specific harms are more effective than those that attempt to create a drug-free society.

Moreover, these policies have often resulted in additional harms. Laws criminalising drug use and the possession of injection 'paraphernalia' encourage the police to harass drug users at needle-exchange sites, keeping them away from disease-prevention services.[33] Similarly, fear of being added to a government registry of drug-dependent people deters dependent drug users from seeking drug treatment, since registration can result in loss of employment, driver's license, or even child custody. These policies can also increase risky behaviours associated with drug consumption, and therefore increase associated diseases.[34] Ultimately their impact on public health is often negative, both in terms of disease prevention and control, and financial expenditure. Simply affirming the long-term objective of a drug-free society, or the eradication of illegal drug markets, is no longer a sustainable policy.

Evidence shows that policies and programmes that explicitly focus on specific harms are more effective than those that attempt to eradicate the market for a specific drug or seek to create a drug-free society. Harm reduction measures aim to reduce the harmful consequences of both drug use and drug markets. While, the principle of harm reduction

30 Preambles of the 1961, 1971 and 1988 UN Drug Conventions.

31 Roberts, M., Trace, M. & Klein, A. (2004), *Beckley Report 3 – Law enforcement and supply reduction* (DrugScope & Beckley Foundation), http://www.beckleyfoundation.org/pdf/report_lawenforce.pdf

32 American Civil Liberties Union (1999), *Drug testing: a bad investment* (New York: ACLU), http://aclu.org/FilesPDFs/drugtesting.pdf ; Westermeyer, J. (1976), 'The pro-heroin effects of anti-opium laws in Asia'. *Archives of General Psychiatry* **33**:1135–1139.

33 World Health Organisation (2009), *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles* (Manila: WPRO), http://www.wpro.who.int/NR/rdonlyres/4AF54559-9A3F-4168-A61F-3617412017AB/0/FINALforWeb_Mar17_Compulsory_Treatment.pdf

34 Open Society Institute (2009), *The effects of drug user registration laws on people's rights and health: key findings from Russia, Georgia and Ukraine* (New York: OSI), http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/drugreg_20091001/drugreg_20091001.pdf

is often used to refer to health promotion measures such as needle exchange programmes, drug prevention, treatment and other social support programmes, it also encompasses measures that reduce a wide range of drug-related harms for the individual, the community and the overall population. Harm reduction is therefore often described as a pragmatic approach; one that seeks to improve public health, community welfare and human rights by whatever method is most effective. Importantly, harm reduction involves the recognition that the overall reduction of the scale of drug markets and drug use is not the only, or even the most important, objective of drug policy (for additional details, see Section 3.3 on Protecting the Rights of Indigenous People).

A greater contribution to the 'health and welfare of mankind'[35] can be achieved by designing and implementing policies and programmes that seek to reduce disease transmission and petty or organised crime, and increase the inclusion and productivity of drug users in society. Governments should start by assessing the drug-related harms that have the most negative impact on their citizens. Then they are in a better position to design and implement strategies to tackle those specific problems.

This broad concept of harm reduction should be considered as a guiding principle in the design of all drug policies and programmes.

35 Preamble of the 1961 UN Single Convention on Narcotic Drugs, available at: http://www.incb.org/pdf/e/conv/convention_1961_en.pdf

1.4 Promoting the social inclusion of marginalised groups

The distribution of drug use among different social groups varies from country to country. In some it can be evenly distributed geographically, across social classes and different races or cultures; in others it can be concentrated within particular areas or groups.

However, one trend seems to persist in all societies: the prevalence of dependent drug use is strongly concentrated among the most marginalised. This is unsurprising, as it is well documented that harsh living conditions, and the associated trauma and emotional difficulties, are major factors in developing drug problems.[36] Those living in harsh social conditions will always be more vulnerable to regular drug use and its related harms.

Much of the work of social affairs departments and agencies in national governments is focused on improving the living conditions of poor and marginalised groups and integrating them more strongly into the social and economic mainstream. However, many aspects of national drug control policies have had the opposite effect on drug users. For example:

- Disapproval of drug use stigmatises individuals, groups and sometimes entire communities, restricting their ability to engage in social and economic activity.
- Programmes that identify and punish young people caught using or possessing drugs often result in their exclusion from education or employment, increasing the risk that their problems will worsen.
- Programmes that focus on arrests and harsh penal sanctions towards drug users have little deterrent effect. Instead they remove them from positive social influences and increase their exposure to health risks and criminal groups.
- Law enforcement and other activities that push dependent drug users underground make it harder for health and social programmes to reach them.

Policies should be adopted that challenge and minimise the social marginalisation and stigmatisation of individuals and groups who are most at risk.

36 Graubner, C. (2007), *Drugs and Conflict: how the mutual impact of illicit drug economies and violent conflict influences sustainable development, peace and stability* (GTZ Development-oriented Drug Control Programme, General Ministry for Economic Cooperation and Development in Germany), http://www2.gtz.de/dokumente/bib/07-0470.pdf ; UK Home Office (2007), *Online Report 04/07: Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences*, http://www.homeoffice.gov.uk/rds/pdfs07/rdsolr0407.pdf ; Smyth, N.J. & Kost, K.A. (1998), 'Exploring the nature of the relationship between poverty and substance abuse: knowns and unknowns'. *Journal of Human Behaviour in the Social Environment* **1**(1): 67–82, http://www.informaworld.com/smpp/content~content=a904453311&db=all ; Breslau, N. (2002), 'Epidemiologic studies of trauma, posttraumatic stress disorder and other psychiatric disorders'. *The Canadian Journal of Psychiatry* **47**(10): 923-929, http://www.ncbi.nlm.nih.gov/pubmed/12553127 ; Western Pacific Regional Office of the World Health Organization (2009), *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*, (Manila: WPRO), http://www.wpro.who.int/NR/rdonlyres/4AF54559-9A3F-4168-A61F-3617412017AB/0/FINALforWeb_Mar17_Compulsory_Treatment.pdf.

If governments wish to have a significant and sustained impact on the level of drug dependence among their citizens, they need to adopt policies and programmes that challenge the social marginalisation and stigmatisation of individuals and groups at higher risk. Many of these approaches will not necessarily be drug policy specific, but will be part of a wider health, social and economic policy.

Social marginalisation can also be minimised by reducing the reliance on treating all forms of drug use as criminal offences under national laws, and applying widespread arrest and harsh punishments to drug users. These punitive approaches are increasingly recognised as causing more harm than good. The UN Secretary-General, in his message on World AIDS Day 2009, declared: 'I urge all countries to remove punitive laws, policies and practices that hamper the AIDS response... In many countries, legal frameworks institutionalize discrimination against groups most at risk... We must ensure that AIDS responses are based on evidence, not ideology, and reach those most in need and most affected'.[37] Indeed, many countries are now turning away from harsh punishment for drug use towards reforms involving depenalisation (the reduction of the level of penalties associated with drug offences) or decriminalisation (the repeal of laws that define drug use as criminal, or transferring the process to administrative or health services) in order to avoid worsening the social exclusion of drug users.[38] Decriminalisation presents a major advantage over depenalisation: it facilitates social reintegration.

This is a significant departure from historical approaches to drug policy based on the principle of deterrence. This is the idea that if drug users are condemned, shunned and subjected to harsh punishments, then other potential users will be deterred. The drug market will contract and eventually disappear. Evidence suggests that deterrence is not a significant factor in the level of drug dependence among a particular population, whereas availability, the price of drugs, poverty, inequality and harsh living conditions definitely are.[39]

The principle of social inclusion can be considered at two levels: drug policy and wider social and economic policy.

37 The Secretary General of the United Nations (1 December 2009), *Message on World AIDS Day,* http://data.unaids.org/pub/PressStatement/2009/20091201_SG_WAD09_message_en.pdf

38 This approach has notably been recently successfully adopted in Portugal (see section 2 of this on Criminal Justice for additional details).

39 Example: Comparative study of the impact of drug policy in Amsterdam and San Francisco on drug use: Reinarman, C., Cohen, P.D., & Kaal, H.L. (2004), 'The limited relevance of drug policy: cannabis in Amsterdam and San Francisco'. *American Journal of Public Health* **94**(5):836-842, http://www.ncbi.nlm.nih.gov/pubmed/15117709; Boyum, D. & Reuter, P. (2001), 'Reflections on Drug Policy and Social Policy'. In Heymann, P. and Brownsberger, W. (eds.) *Drug Addiction and Drug Policy: The Struggle to Control Dependence* (Cambridge: Harvard University Press): 239-264; MacCoun, R. & Reuter, P. (2002), 'The Varieties of Drug Control at the Dawn of the Twenty First Century', *Annals of the American Academy of Political and Social Sciences* (Issue co-edited by Reuter and MacCoun).

Drug policy Law enforcement, prevention and treatment programmes should all have a social inclusion element:

- Drug laws and enforcement tactics should avoid measures that worsen the marginalisation of drug users and farmers, and focus instead on encouraging them to engage in re-integration or alternative development programmes. As the UNODC declared, we should be treating dependent drug users as citizens in need of help, not as criminals deserving punishment.[40]

- Prevention and education programmes should be carefully designed to avoid processes that inhibit dependent drug users' healthy transition to adulthood (such as exclusion from school or denial of services).

- Drug dependence treatment programmes should be focused on enabling dependent drug users to re-integrate successfully and live independently as constructive members of the community.

- Representatives of the groups most affected by drug policies, such as drug users and growers, should be included in the design of drug policies and programmes. This will create better informed policy and help avoid unintended negative consequences on these communities.

Wider social and economic policy Analyses of international prevalence figures[41] and studies on individual populations[42] all point to the conclusion that overall levels of poverty, inequality and social cohesion have a greater long-term impact on the prevalence of drug use and related problems in any society than do specific national drug policies. The example most often quoted is in Europe, where Sweden and the Netherlands both share relatively low levels of drug use, despite pursuing very different drug policies. What these countries have in common are relatively affluent and egalitarian societies, with strong communities and social programmes. If a government's priority is to reduce the overall level of drug dependence, then it is better advised to focus on addressing these wider social policy challenges rather than deepening social exclusion through tough drug policies. These themes are further developed in Section 3.1 on drug prevention and Chapter 4 on strengthening communities.

40 United Nations Office on Drugs and Crime (2009), *World Drug Report 2009*, http://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

41 Compare the UNDP Human Development Index world maps: http://hdr.undp.org/en/statistics/data/hd_map/hdi_trends/, with data compiled in the UNODC World Drug Report, 2009: http://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf.

42 Wilkinson, R. & Marmot, M.G. (2003), *Social determinants of health: the solid facts* (WHO), http://www.euro.who.int/InformationSources/Publications/Catalogue/20020808_2 ; March, J.C., Oviedo-Joekes, E. & Romero, M. (2006), 'Drugs and social exclusion in ten European cities', *European Addiction Research* **12**(1): 33-41, http://www.ncbi.nlm.nih.gov/pubmed/16352901 ; Buchanan, J. (2004), 'Missing links? Problem drug use and social exclusion', *Probation Journal* **51**(4):387-397, http://prb.sagepub.com/cgi/content/abstract/51/4/387.

1.5 Building open and constructive relationships with civil society

All too often, political sensitivities have led policy-makers to view civil society as a problem to be avoided. However, if constructive mechanisms can be created for respectful engagement, NGOs – including user and grower representatives – are an invaluable source of expertise because of their understanding of drug markets and drug-using communities.

In this guide, the term 'civil society' encompasses several groups, in particular people and communities most affected by drug policy such as drug users, people living with HIV, growers of crops deemed illicit, and indigenous people and their communities. Civil society organisations are composed of NGOs, networks and associations that aim to represent the interests of these groups, provide them with services and assistance, and encourage positive changes in policies that affect them.

The positive role of civil society in the design and implementation of policies and programmes should be recognised, and conditions should be created to encourage their engagement.

Civil society groups and organisations play a key role in all sectors of public policy-making and represent a valuable source of information, experience and expertise. Meaningful and constructive engagement with civil society is premised on the principles of participation, transparency and accountability.

The HIV/AIDS response recognised at an early stage that the participation of those most affected by the virus was critical for an effective response. Policies and programmes designed to prevent or reduce the spread of HIV have proved to be most effective and sustainable when developed in partnership with people and communities most affected by the epidemic.

In the field of drug policy, civil society organisations play a major role in analysing the drug phenomenon and in delivering programmes and services. They have extensive experience and expertise on these issues that is particularly useful to governments and international agencies. The positive role of civil society in the design and implementation of effective and appropriate policies and programmes should be recognised, and structures and conditions should be created to encourage positive and meaningful engagement with affected groups.

The UN drug control system is starting to recognise the added perspective and value that civil society organisations have brought to the policy debate, especially those composed of representatives most affected by the policies. For example, a structured mechanism of NGO engagement was created at the Commission for Narcotic Drugs through the 'Beyond 2008' initiative. This was a two-year project that brought together thousands of civil society representatives from around the world to discuss the impact of the drug control system in their countries and to agree on recommendations to put forward at the Commission. Additionally, the Global Fund Board offers three seats to civil society organisations with full voting powers, while the Global Fund Country Coordinating Mechanisms organise partnerships between civil society actors and government bodies to make sure that all relevant actors are included in the decision-making process.

There are many benefits of positive, strong and strategic engagement with civil society. These include strengthening political support and ensuring appropriate policies; formulating better-informed policy; widening support for policy implementation; promoting stronger public policy networks for consensus building and action; and increasing monitoring and evaluation capability.

The main objectives of positive engagement with civil society are:

- supporting appropriate policy formulation and priority-setting based on practical advice and experience

- facilitating effective communication between policy-makers and key civil society stakeholders, making sure that people and communities are involved in planning interventions that will impact on them

- seeking mutually beneficial partnerships with civil society organisations to undertake joint programming and/or act as programme implementers

- stimulating a vibrant network of civil society organisations that can continue to support effective policy and programme design and implementation.

Civil society is important for effective monitoring and evaluation of the situation on the ground and new policies adopted by governments. It can work with the state to identify problems and consider appropriate responses. Groups working in this area will often be able to mobilise responsive resources, such as being able to target hard-to-reach groups.

Clear and open lines of communication should be created between governments and civil society representatives in order to engage in meaningful and respectful exchanges of information and perspectives.

Chapter 2
Criminal Justice

2.1 Drug law reform

IN THIS SECTION

Key message

A shift of focus from criminalising and punishing drug users to promoting human rights, public health and socio-economic development will bring better results and be more consistent with other areas of social and health policy.

Why is it important?

Since the start of the international drug control system in the early 20th century, the creation of tough laws prohibiting the production, distribution and use of certain psychoactive substances, and their widespread implementation by law enforcement agencies, has been the main strategy for reducing the scale of drug markets and drug use. It was believed that this strategy would eventually reduce the associated health and social problems. The strategies and activities of law enforcement agencies have been the single most important influence on how drug problems have been managed in any given country.

Current supply-led drug policies have had little impact on the scale of the global drug market and have led to a number of negative consequences.

Many studies have now acknowledged that this enforcement-led drug policy has had little impact on the scale of the global drug market, and has led to a number of negative consequences. Increasingly, governments are starting to realise that drug laws should primarily seek to contribute to the overall national strategy objectives of reducing crime, preventing HIV and other blood-borne diseases and promoting public health and economic development.

Drug laws should primarily contribute to the overall national strategy objectives of reducing crime, preventing HIV and other blood-borne diseases and promoting public health and economic development.

The United Nations drug conventions

The global drug control regime consists of three complementary conventions that have been signed and ratified by most UN member states. While these conventions impose obligations on national governments, it is often forgotten that the main concern behind these obligations is the protection of the 'health and welfare of mankind'.[43] In practice, signatory states have much discretion as to how drug laws should be framed and implemented.

The 1961 convention details drugs within schedules, requiring that stringent controls be placed upon them because of their inherent harmful characteristics, risks of dependence and/or limited therapeutic value. The primary objective of the 1961 Single Convention is to control drugs by restricting their use to 'medical and scientific' purposes. Drug use outside these contexts is prohibited. However, the convention also obliges governments to pay special attention and take all practicable measures to provide treatment, education, aftercare, rehabilitation and social reintegration for dependent drug users (article 38). It stipulates that these services may be offered either as an alternative or in addition to conviction or punishment (article 36, para. 2). Over the years, several inconsistencies have been pointed out, including by the World Health Organization (WHO) and the International Narcotics Drug Board; for example, the inclusion of cannabis and the coca leaf in Schedule I (the strictest control regime, similarly applied to heroin) of the 1961 convention.

The 1971 convention introduced a broadly equivalent control regime for newly developed psychotropic drugs such as hallucinogens and tranquillisers, restricting their use to 'medical and scientific' purposes. This convention similarly imposes obligations to identify and treat dependent drug users, as well as to promote public understanding of drug dependence, train personnel and conduct research (article 20). The convention also affirms that states should provide dependent drug users, as an alternative or in addition to punishment, access to treatment, care, rehabilitation and social reintegration (articles 22, para. 1b and 20, para. 1). Finally, the convention addresses drug trafficking through international co-operation (article 21).

43 Preamble of the 1961 UN Convention on Narcotic Drugs, http://www.incb.org/pdf/e/conv/convention_1961_en.pdf.

Decriminalisation: repeal of laws that define drug use as a criminal offence, or that transfer the process to administrative or health services.

Depenalisation: reduction of the level of penalties associated with drug offences.

In both cases, drug use remains illegal.

The 1988 convention also promotes co-operation among its signatories in order to address drug trafficking effectively, having been introduced to counter the transnational organised crime groups that became increasingly powerful and sophisticated in the 1980s. Signatory countries are compelled to adopt such measures as may be necessary to establish as criminal offences under their domestic law any activities related to the production, sale, transport, distribution or purchase of the substances included in the 1961 and 1971 conventions (articles 3, para. 1 and 21).

Additionally, the 1988 convention aims to criminalise the purchase or cultivation of illicit drugs for personal consumption (article 3, para. 2). However, article 3, para. 4(d) stipulates that in the case of possession, purchase or cultivation for personal consumption, a state may adopt measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender, either as an alternative or in addition to conviction or punishment. Hence, article 3 (paras. 4b-c-d) of the 1988 convention does allow signatory states to engage in depenalisation and a certain level of decriminalisation in cases of personal drug possession. The convention also enables states to adopt laws focusing on medically appropriate treatment for drug dependence as an alternative to criminal sanctions, as was already the case in the previous two conventions. Finally, the 1988 convention emphasises the importance of taking into account 'factual circumstances' when imposing sanctions on offenders, which includes their involvement in organised crime, the victimisation of minors and the use of violence or arms (article 3, para. 5).

The United Nations human rights system

Drug users, like any other citizen, should benefit from human rights protections at all times.

Human rights and fundamental freedoms apply in the context of drug policy, and drug users, like any other citizen, should benefit from these rights at all times. They include:

- the right to life[44]
- the right not to be subject to torture or other cruel or inhuman punishment,[45] which includes the right to be free from coerced and degrading forms of treatment
- the right to dignity[46]

44 Article 1 of the 1948 Universal Declaration of Human Rights

45 1984 UN *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* ; 1950 European Convention on Human Rights

46 Preamble of the 1948 Universal Declaration of Human Rights

- the right to non-discrimination;[47] for example, for access to healthcare services or employment

- the right to health,[48] which includes the right to informed consent for drug treatment

- the right to due process of law and of proportionality of sentences.[49]

When designing drug laws, policy-makers are obliged to respect, protect and fulfil these basic human rights. Whether reviewing or updating existing drug laws or policies in the framework provided by the UN conventions, governments should consider drugs and their classification, drug control sanctions, a new drug punishment system, and how to support health and social programmes. These are discussed below.

Drugs and their classification

Most current laws regroup drugs into classes according to their perceived danger, with different penalties for each class. It is difficult for governments to maintain a truly scientific approach to classification, as knowledge of the wide range of factors that impact on these dangers is constantly changing.[50] However, the principle that different substances should attract different levels of control can be useful, provided that scheduling is not the only determinant of sentencing. There should be a form of judicial discretion that takes into account a range of other factors relating to the offence and the offender to determine the sentence (for example, the quantity of drugs involved, the nature of supply, previous criminal history, treatment needs). When reviewing national classification, several elements have to be taken into account:

Law enforcement resources should be targeted at the most harmful and anti-social aspects of the drug market, while encouraging the social integration of drug users.

Several countries have turned to decriminalisation or depenalisation in an attempt to achieve this.

- Whether the current drug classification system should be maintained or replaced by an alternative process for judging the seriousness of offences (for example, the articulation of aggravating or mitigating factors). If the current drug classification system is retained, is the current placement of substances evidence based, and is the system widely understood?

- Which substances should the legislation cover (when considering UN obligations) and how should they be distributed across classes?

47 Article 5(e)-iv of the 1965 Convention on the Elimination of all forms of Racial Discrimination

48 Preamble of the 1945 Constitution of the World Health Organization

49 Article 9 of the 1966 International Covenant on Civil and Political Rights

50 The schedules within the UN Conventions themselves contain some glaring inconsistencies. For instance, despite the fact that morphine has been used by physicians for about 150 years for pain relief, it is included in Schedule I – which enlists the most harmful drugs.

- Should the quality (purity and strength), quantity or street-value of the drug substance be taken into account when determining its class?

- Through what process should new psychoactive substances be scrutinised and incorporated? Similarly, if a substance falls into disuse, or evidence emerges that its harms are greater or lesser than previously understood, what is the process for reviewing its place in the classification system?

- What framework is most suitable to reflect the link between illicit drugs and other drug substances (alcohol, tobacco and pharmaceuticals)?

Several evidence-based examinations have been conducted on the respective harms associated with the availability and use of different drugs.[51] These studies can provide governments with a more recent and reliable guide to appropriate classification.

Drug control and sanctions

An explicit view should be taken on how widely laws should be enforced, how enforcement actions should be targeted and how harsh punishments should be. In the absence of a proactive approach, drug laws are often implemented in an unplanned and arbitrary manner, which can lead to a misdirection of scarce resources and unfair or discriminatory practices. No country is capable of taking action against every individual that produces, distributes or uses drugs. This is why strategic judgments are needed to set priorities for law enforcement and the extent to which the risk of arrest and punishment should be used as a deterrent to restrict supply or use.

Governments have generally reacted to concerns about the level of drug use with an increase in the scope of their laws and in the severity of associated punishments. A wide variety of evidence now demonstrates the limited effects of deterrence as a drug policy instrument.[52] For example, the UK's Sentencing Guidelines Council recently published a public consultation paper on sentencing for drug offences in which the panel questioned the effectiveness of the current penalty system in deterring offending.[53]

As a result, some governments have developed alternative strategies. They have de-prioritised widespread arrest and punishment, and started to focus enforcement resources on the most harmful and anti-social aspects of the market, while encouraging the social integration of dependent drug users.

51 World Health Organization (2000), *Guidelines for the WHO review of dependence-producing psychoactive substances for international control* (EB105/2000/REC/1, ANNEX 9, with appendices), http://apps.who.int/medicinedocs/en/d/Jwhozip40e/ ; United Nations Office on Drugs and Crime (2005), *Coca cultivation in the Andean Region – A survey of Bolivia, Colombia and Peru*, http://www.unodc.org/pdf/andean/Part1_excutive_summary.pdf ; United Nations Office on Drugs and Crime (2005), *Myanmar – Opium survey 2005,* http://www.unodc.org/pdf/Myanmar_opium-survey-2005.pdf ; Ritter, A. (2007), *Monograph No. 15: Priority areas in illicit drug policy: Perspectives of policy makers*. DPMP Monograph Series (Sydney: National Drug and Alcohol Research Centre), http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/DPMP+Monographs3/$file/DPMP+MONO+15.pdf; Nutt, D., King, L., Saulsbury, W. & Blakemore, C. (2007), 'Development of a rational scale to assess the harm of drugs of potential misuse'. *The Lancet* **369**: 1047–1053 ; Sellman, J.D. & Adamson, S.J. (2007), *Proposed scale for rationally assessing the risk to public health from using a drug* (Draft, unpublished) ; Australian Federal Police (2004), *Research Note 7: The impact of AFP drug law enforcement on the availability of heroin*, http://www.afp.gov.au/__data/assets/pdf_file/3929/rn7.pdf.

52 European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 1998-2007 (European Communities)*, http://ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf; Roberts, M., Trace, M. & Klein, A. (2004), *Beckley Report 3 – Law enforcement and supply reduction* (DrugScope & Beckley Foundation), http://www.beckleyfoundation.org/pdf/report_lawenforce.pdf

53 Sentencing Guidelines Council (2009), *Consultation on Drug offences*. http://www.sentencing-guidelines.gov.uk/docs/drug_offences.pdf

To achieve this, several countries have recently turned to depenalisation or decriminalisation to focus enforcement resources on the most serious drug-related crimes and to avoid overcrowding prisons and court systems with low-level drug offenders.[54]

Decriminalisation entails the repeal of laws that define drug use as criminal, or transferring the process to administrative or health services. Portugal has been the most innovative country in that regard, with the adoption of a nationwide law in 2001 that decriminalised all drugs, including heroin and cocaine. Under the new legal regime, drug trafficking is still prosecuted as a criminal offence. However, although drug possession for personal use is still legally prohibited, violations of this prohibition are deemed to be exclusively administrative rather than criminal. The law introduced a system of referral to multidisciplinary commissions for each person arrested in possession of drugs. These commissions impose sanctions such as community service, fines or suspension of professional licences, and recommend treatment or education programmes for those in need.[55] It is still too early to assess the real impact of the Portuguese strategy, especially on the prevalence of drug use in the country. However, the 2001 law seems to have unblocked the hopelessly overcrowded Portuguese court and prison systems. The numbers of people accessing treatment have increased, and drug-related pathologies, such as sexually transmitted diseases and drug-related deaths, have decreased dramatically.[56]

Other countries have also moved in this direction. Western Australia adopted a law in 2005 decriminalising cannabis. In 2008, Mexico, which has long fought without success against drug trafficking through tough law enforcement measures, also passed legislation decriminalising personal use. In 2009, the Argentine parliament was also discussing legislation to implement a Supreme Court decision preventing the prosecution of those arrested in possession of marijuana. In Europe the Czech government is decriminalising minor possession cases.

Depenalisation involves reducing the level of penalties associated with drug offences. The UK has adopted this approach to cannabis offences. Individuals caught in possession of cannabis can receive a warning or fine from the police. This does not result in a criminal record but is recorded as an offence locally. Those caught in possession a third time, or where there are certain aggravating conditions, will potentially face prosecution.

54 Various strategies can be considered by governments, including a policy of non-prosecution and the use of formal or informal cautions (combined with the forfeiture of the drugs involved) as an alternative; diversion programmes involving the imposition of informal sanctions such as donations to charity or community work with the consent of the offender; treatment and rehabilitation as an alternative to prosecution or punishment; civil or administrative sanctions; or the use of non-custodial punishment as an alternative to prison.

55 Greenwald, G. (2009), *Drug decriminalisation in Portugal – Lessons for creating fair and successful drug policies* (Washington DC: CATO Institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

56 Hughes, C. & Stevens, A., *Beckley Briefing Paper 14 – The effects of decriminalization of drug use in Portugal* (Beckley Foundation Drug Policy Programme), http://idpc.net/sites/default/files/library/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf

A new drug punishment system

The design of these new approaches raises some difficulties for policy-makers. Traditional prosecution guidelines have distinguished individuals according to the amount and classification of the drugs found in their possession, and any evidence of intent to supply them to others. Over time, governments have found that these factors alone have been insufficient to distinguish accurately between different actors in the drug market, or to focus enforcement resources on the people who are causing the most harm.

It is helpful to consider four types of drug law offenders, and develop different ways in which they can be dealt with under the law:

- recreational or casual users
- dependent drug users
- social or low-level dealers
- serious or organised dealers.

For this purpose, it is helpful to consider four broad types of drug law offenders, and suggest ways in which they can be most effectively dealt with under the law:

- **'Recreational' or casual users** These can be defined as individuals arrested in possession of small amounts of drugs, where there is no evidence of drug dependence (for example, repeated convictions for possession, other related offences or medical history) or related criminal behaviour. Evidence demonstrates that harsh punishment of this group is not effective to reduce prevalence through deterrence.[57] Drug laws therefore need to be structured so that this group receives little priority and take up a minimum amount of resources from the criminal justice system. Some countries have achieved this objective by formally decriminalising drug possession or by issuing guidance to police authorities to de-prioritise this group. Others have introduced simple procedures such as spot fines or informal warning systems. In designing these systems, governments must be careful to minimise opportunities for low-level police corruption.

- **Dependent drug users** These can be defined as individuals arrested in possession of drugs, where there is evidence that their use is part of a wider pattern of behaviour that causes harm to themselves and others, and who can be helped by attending treatment programmes. They are often arrested for drug possession as well as for other offences such as property crime, prostitution or low-level dealing. Governments need to create mechanisms within their drug laws to divert this group into treatment programmes. Many countries have found that identifying, assessing and directing this group into treatment has achieved great savings, since the crime and health problems

57 Bewley-Taylor, D., Hallam, C. & Allen, R. (2009), *Beckley Report 16 – The Incarceration of Drug Offenders, An Overview* (The Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/BF_Report_16.pdf

associated with their drug use were reduced through the treatment process.[58] However, compulsory drug treatment centres are ineffective in tackling drug dependence and reducing drug-related harms. They have also led to numerous human rights violations, including ill-treatment, torture or forced labour. This form of treatment should not be implemented (see Section 3.2 on Drug Dependence Treatment for additional information on the negative consequences of compulsory drug treatment centres).

Diversion to treatment can easily be incorporated into national drug laws. However, these interventions must respect due process and appropriate screening mechanisms must be available to divert people to adequate services. Many of these interventions have been successfully implemented through drug courts, diversion and decriminalisation models. When dependent drug users are sent to prison for a criminal offence, they should be provided with appropriate drug treatment services (see Section 3.2 on drug dependence treatment).

- **'Social' or low-level dealers** In many countries, most of the people arrested and punished for dealing offences are those at the bottom end of the retail drug market. This is because their activities are more visible to law enforcement authorities. Most laws define a dealing offence on the basis of the amount of drugs in possession, and any evidence of intent to supply them to others. Some of these groups are purely social suppliers, who deal for little profit. Others are 'mules', who have been pressed into getting involved through intimidation or desperation. The concentration of law enforcement resources and punishment on these people is problematic for two reasons. First, once arrested and removed, they are easily replaced, meaning that this policy only has a limited impact on the market. Second, these low-level dealers are often under the power of those who truly control the drug market. Drug law mechanisms that rely solely on the amount in possession and evidence of supply tend to result in widespread arrests and overly harsh punishments. Drug laws should re-focus on high-level drug dealers rather than low-level offenders, and take into account the circumstances under which the drug crime was committed.

- **Serious or organised dealers** This group refers to the organised and violent crime gangs that control the large-scale drug markets and are responsible for the majority of harm to the law-abiding community. The most powerful individuals within these groups are often the most difficult to apprehend, but they should be the primary target of law enforcement resources and punishment. It is possible to introduce clear aggravating factors that would make it easier to distinguish between the levels of seriousness of the different types of dealing and the punishments applied. These include possession of weapons, use of violence, indicators of organised crime

58 National Treatment Agency for Substance Misuse (2009), *The story of drug treatment* (London: NTA), http://www.nta.nhs.uk/publications/documents/story_of_drug_treatment_december_2009.pdf; Godfrey, C., Steward, D. & Gossop, M. (2004), 'The economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment outcome Research Study (NTORS)'. *Addiction* **99**(6):697-707, http://cat.inist.fr/?aModele=afficheN&cpsidt=15796344; Ball, J.C. & Ross, A. (1991), *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcome.* (New York: Springer-Verlag) ; National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction (1998), 'Effective medical treatment of opiate addiction'. *JAMA* **280**:1936-1943, http://consensus.nih.gov/1997/1998TreatOpiateAddiction108html.htm; Gossop, M. (2005), *Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study* (National Treatment Agency for Substance Misuse). http://www.nta.nhs.uk/publications/documents/nta_drug_treatment_crime_reduction_ntors_findings_2005_rb8.pdf

involvement, dealing in public places, or involving children, in addition to the measures of scale and value of drug possessed. Carefully designed and implemented drug laws can truly influence the nature of the drug market and create incentives for dealing networks to be less violent, less public and less harmful to the community.

Drug laws need to strike a balance between responding to illegal markets and facilitating the delivery of health and social care programmes targeted at drug users.

Supporting health and social programmes

Drug laws need to strike a balance between responding to the illegal market and facilitating the delivery of health and social care programmes targeted at dependent drug users. There have been many instances where aspects of drug laws or their enforcement impeded the delivery of public health (such as efforts to prevent HIV infection), or social reintegration programmes (such as drug dependence treatment).[59]

Fear created by widespread arrest and harsh punishment drives drug use underground, stigmatises users and encourages more risk-taking. Specific legal pitfalls should also be avoided:

- Laws that have a blanket prohibition on the possession or distribution of drug 'paraphernalia': these clauses can have the effect of criminalising the distribution of items such as clean needles or filters that make certain forms of drug use less hazardous and that are essential for HIV and hepatitis prevention strategies.

- Laws that undermine harm reduction services through 'incitement' or 'facilitation of drug use' clauses: this has the effect of undermining harm reduction efforts and stigmatising drug users.

- Laws that remove flexibility in sentencing, forcing courts to imprison all offenders irrespective of the circumstances of individual cases: this often has the effect of undermining the diversion of appropriate offenders into drug dependence treatment programmes, but can also (as in the case of mandatory minimum sentences) lead to disproportionately long prison terms for relatively minor offences.

- Laws that inhibit legitimate access to controlled medicines for medical or research purposes: while the UN conventions emphasise the need to ensure the availability of drugs for legitimate uses, many national laws and regulations prevent or inhibit this access. In terms of research, the process of examining the potential medical benefits

59 World Health Organisation (2009), *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles* (Manila: WPRO), http://www.wpro.who.int/NR/rdonlyres/4AF54559-9A3F-4168-A61F-361741201 7AB/0/FINALforWeb_Mar17_Compulsory_Treatment.pdf; Open Society Institute (2009), *The effects of drug user registration laws on people's rights and health: key findings from Russia, Georgia and Ukraine* (International Harm Reduction Development Program), http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/drugreg_20091001/drugreg_20091001.pdf

of drugs such as cannabis and ecstasy has been massively undermined by drug control restrictions. Similarly, tight regulations around methadone and buprenorphine, and access to palliative care and treatment (for example, morphine), have contributed to a situation where these essential medicines are unavailable to 80 per cent of those in need.[60] Some governments have understood this problem and are now adopting laws that provide for the legal medicinal use of certain illicit drugs. For example, in the case of medicinal marijuana, governments such as Canada have amended their laws to allow for the possession and distribution of this drug using domestic medicinal control legislation. Other regions (notably in a number of states in the USA) are granting immunity in law to cannabis users who have a dispensation from a suitably qualified medical professional.

Recommendations

- A comprehensive review of national drug laws is needed in the light of changing patterns of drug use and experience of previous law enforcement strategies.
- Governments and international agencies should conduct human rights impact assessments of current drug laws and their implementation as part of this process.
- When creating or revising drug laws, governments should clearly determine which aspects of the drug market are most harmful to society (high-level drug traffickers, rather than drug users, small dealers and couriers) and target their laws accordingly.
- New or revised drug laws need to be clear on the range of substances covered. They should provide a structured and scientific approach to the relative seriousness with which different substances are treated, and a simple process for adding, moving or removing particular substances.
- New or revised drug laws should contain provisions that draw a clear distinction between the different actors operating in the market, and that facilitate the adoption of appropriate responses for each of these groups. Alternatives to imprisonment, such as fines, or referral to treatment and care services, should be designed for low-level drug dealers and dependent drug users.
- New or revised drug laws need to be carefully drafted to support instead of undermine health and social programmes. They should not inhibit harm reduction interventions, and should officially sanction the use of opioid substances for substitution therapy.

60 World Health Organisation, Access to Controlled Medications Programme (2008), *Improving access to medications controlled under international drug conventions*, http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf

Key resources

Bewley-Taylor, D., Hallam, C. & Allen, R. (2009), *Beckley Report 16 – The Incarceration of Drug Offenders, An Overview*, (The Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/BF_Report_16.pdf

Canadian HIV/AIDS Legal Network (2006), *Legislating for Health and Human Rights: Model Law: Model Law on Drug Use and HIV/AIDS,* http://www.aidslaw.ca/EN/modellaw/english.htm

EMCDDA (2003), *The role of the quantity in the prosecution of drug offences: an ELDD comparative study* (Lisbon: European Legal Database on Drugs), http://eldd.emcdda.europa.eu/attachements.cfm/att_5738_EN_Quantities.pdf

Galbally, R. (2000), *The Review of Drugs, Poisons and Controlled Substances Legislation: Final Report Part A.* (A Council of Australian Governments Review), www.tga.gov.au/docs/pdf/rdpfina.pdf

Greenwald, G. (2009) *Drug Decriminalisation in Portugal: lessons for creating fair and successful drug policies*, (Washington D.C.: The CATO institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

House of Commons Science and Technology Committee (2006), *Drug classification: making a hash of it?* Fifth Report of Session 2005–06, http://www.publications.parliament.uk/pa/cm200506/cmselect/cmsctech/1031/1031.pdf

Nutt, D., King, L., Saulsbury, W. & Blakemore, C. (2007), 'Development of a rational scale to assess the harm of drugs of potential misuse'. *The Lancet* **369**:1047–1053, http://www.thelancet.com/journals/lancet/article/PIIS0140673607604644/abstract

Pain & Policy Studies Group (2009), *Do International Model Drug Control Laws Provide for Drug Availability?* (World Health Organisation Collaborating Centre for Policy and Communications in Cancer Care; the Paul P Carbone Comprehensive Cancer Centre, School of Medicines and Public Health, University of Wisconsin), http://www.painpolicy.wisc.edu/internat/model_law_eval.pdf

Release (2009), *Response to the Sentencing Advisory Panel's Consultation Paper on Sentencing for Drug Offences*, http://www.release.org.uk/images/stories/pdf/SGC%20submission.pdf

Ritter, A. (2009), 'Methods for comparing drug policies – the unity of composite drug harm indexes'. *International Journal of Drug Policy* **20**(6):475–479, http://www.ijdp.org/article/S0955-3959(09)00049-8/abstract

Room R., *et al.* (2008), *The Global Cannabis Commission Report – Cannabis: Moving Beyond Stalemate* (Oxford: The Beckley Foundation), http://www.idpc.net/sites/default/files/library/BF_Cannabis_Commission_Rpt2008_EN.pdf

World Health Organization (2000), *Guidelines for the WHO review of dependence-producing psychoactive substances for international control.* EB105/2000/REC/1, ANNEX 9, with appendices, http://apps.who.int/medicinedocs/en/d/Jwhozip40e/

2.2 Effective drug law enforcement

IN THIS SECTION

Key message

Law enforcement agencies need to focus on a broader and more balanced set of objectives and activities designed to target drug-related crime, health and social problems, instead of simply seeking to reduce the overall scale of the drug market.

Why is it important?

The UN drug control conventions and national legislation worldwide are based on the idea that the strong enforcement of laws prohibiting drug production, distribution and use will eventually lead to the elimination of supply and demand, and therefore eradicate the illegal market. Local and national police forces, specialised drug enforcement agencies, and even in some countries the military, have therefore played prominent roles in drug policy implementation. So far, law enforcement activities against drug demand and supply have mainly consisted of:

- production controls, including eradication and harsh law enforcement against manufacturers and growers
- interdiction of drug smuggling
- investigation and incarceration of people accused of high-level trafficking
- arrest and punishment of people involved in retail drug markets
- arrest and punishment of people charged with possession or use of illicit drugs.[61]

61 European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 1998-2007 (European Communities)*, http://ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf

Strategies relying on widespread law enforcement and punishment have been unsuccessful in reducing the overall scale of the illegal drug market.

The actions against producers and traffickers have been focused on physically preventing the supply of drugs to consumers, and the actions against consumers have aimed to deter potential users through the threat of arrest.

It is time to acknowledge that strategies that rely on widespread law enforcement action and harsh punishments against growers, dealers and users have been unsuccessful in reducing the overall scale of illegal drug markets, and many of the activities behind these strategies have had serious negative consequences. A change in the focus of law enforcement strategies is needed if we are to succeed in reducing the impact of drugs on the health and social welfare of communities.

Problems with current strategies and tactics

In social and policy contexts worldwide it has become clear that traditional policies and strategies have been unable to achieve a significant and sustained reduction in the overall scale of drug markets. On a global scale, successive UN campaigns and commitments to eliminate or significantly reduce drug markets have failed to achieve their objectives, despite widespread political and financial support. Operational successes in particular countries, or against particular trafficking groups, have quickly been offset by the 'balloon effect'. The illegal activities that have been eradicated by law enforcement efforts are quickly replaced in different areas, by different groups or with different substances, often creating greater problems than those that existed before.

The 'balloon effect': successful action against a particular aspect of the drug market – for example, an area of cultivation or a local dealing spot – just pushes the activity to another area where the consequences may be more harmful.

In addition, many national strategies and tactics themselves have negative consequences, and can sometimes be counter-productive. The UNODC describes these dilemmas as 'unintended consequences', which include:

- The creation of a **massive and lucrative black market** that is exploited by organised crime, significantly increasing their power and reach. Law enforcement actions against these markets can create the conditions that favour the most violent and ruthless criminals.

- **The 'balloon effect'** Analysts have noted that a successful operation against a particular trafficking network can lead to an upsurge in violence as new trafficking groups fight over the 'turf' left vacant.

- **Policy displacement** This is the opportunity cost of using finite resources on ineffective strategies and tactics. As a result, fewer resources are available for more effective actions.

- **Marginalisation of drug users** Law enforcement action against drug users and social disapproval of their behaviour is often counterproductive, hindering their reintegration back into society. Criminalising, arresting and imprisoning drug users do not deter drug use. Instead, it breaks up positive family and community ties and undermines access to health services, jobs and education. Minority groups are particularly affected because they are often the primary target of law enforcement interventions. For example, in the USA the majority of those incarcerated for drug-related offences are African-American or Hispanic. Criminalising them creates additional stigma and discrimination towards these minority groups.[62]

These strategic dilemmas do not mean that law enforcement agencies should give up their attempts to control drug markets, but policy-makers do have to think and plan differently.

A new law enforcement focus

At the heart of this issue is the need to reconsider appropriate objectives and priorities for law enforcement action against drug markets and drug use. At a fundamental level it is the duty of police and other law enforcement agencies to serve and protect the health and welfare of citizens. The assumption among policy-makers and law enforcement managers has been that the best way to protect citizens from drug-related harm was to focus on the battle to eradicate illegal drug markets and their related crime, social and health problems. Operational objectives have therefore focused on measuring success in terms of steps towards the goal of eradication. These have included the area of crops destroyed, the amounts of drugs or precursors seized, and the number of production facilities destroyed, trafficking operations disrupted and drug users or small-scale traffickers arrested.

It is the duty of law enforcement agencies to serve and protect the health and welfare of citizens.

Law enforcement objectives should be more focused on the consequences of the drug market, rather than on its scale.

Unfortunately, none of these indicators has been shown to be an accurate guide to whether the overall scale of the drug problem is being reduced. For example, successful operations to disrupt trafficking groups have not led to sustained reductions in drug availability, and widespread crop eradication has not led to a

62 Kleykamp, M., Rosenfield, J. & Scotti, R. (2008), 'Wasting Money, Wasting Lives: Calculating the hidden costs of incarceration in New Jersey' (Drug Policy Alliance), http://www.scribd.com/full/14196183?access_key=key-qf6eya66qholley5hy0

reduction in overall drug production. Similarly, there is no correlation between the number of drug users arrested in a given country and trends in drug use prevalence.[63]

Strategies should focus on curtailing the operations of those groups and individuals whose actions are causing the most harm to society.

It is no longer possible to rely on the claim that tactics focusing on seizures, arrests and punishments will solve the drug problem. Instead, more attention and resources should be targeted at reducing associated crime and health harms. Law enforcement objectives should be more focused on the consequences – whether positive or negative – of the drug market rather than its scale. For example:

- **Objectives related to the market should focus more on outcome indicators** Have law enforcement operations reduced the availability of a particular drug to young people (measured by the level of use or ease of access indicators)? Have law enforcement operations affected the price or purity of drugs at the retail level? If so, has this had positive or negative effects on the drug market and drug users?

- **Objectives measuring drug-related crime should be given more prominence** Have the profits, power and reach of organised crime groups been reduced? Has the violence associated with drug markets been reduced? Has the level of petty crime committed by dependent drug users been reduced?

- **Objectives measuring the law enforcement contribution to health and social programmes should be included** How many dependent drug users have law enforcement agencies referred to treatment services? How many people have achieved a sustained period of stability as a result of treatment? Has the level of overdose deaths been reduced? Is the level of HIV infection and viral hepatitis among dependent drug users down?

- **Objectives related to drug use and dependence should be included** How did law enforcement activities impact on affected communities' socio-economic environment? Have patterns of drug use and dependence changed as a result of law enforcement actions?

These are much better indicators of law enforcement's contribution to wider drug policy objectives, and also provide a more realistic basis for achievement. If strategies and activities are to be guided by a different set of objectives, this does not mean a retreat from law enforcement on drug markets, but rather a different way of looking at options and tactics. These are some examples of how new approaches can involve different law enforcement agency activities:

63 Lenton, S. *et al.* (2005), *An Evaluation of the Impact of Changes to Cannabis Law in Western Australia: Summary of the Year 1 Findings*. Monograph Series No. 12. (Australia: NDLERF & NDRI), http://www.ndlerf.gov.au/pub/Cannabis_WA.pdf

Tackling organised crime groups Law enforcement will never be able to fully eradicate the illegal drug market (long and costly operations to disrupt one group only leads to its replacement by another). So strategies and interventions should focus on curtailing the operations of those groups and individuals whose actions are causing the most harm to society, whether it be through the corruption of officials and institutions, violence and intimidation against law-abiding citizens, or the distortion or undermining of legitimate economic activities. Actions against organised crime groups need to be based on quality intelligence, focusing on how their operations impact on society. This may lead to difficult decisions on priorities, focusing on the most harmful aspects of their operations rather than solely on seizures and arrests, and encouraging markets to be conducted away from public places[64] or be dominated by nonviolent friendship networks. Intelligence-led policing has been adopted in the UK, Northern Ireland, Canada, New Zealand and Australia,[65] although some criticisms have recently been raised by supporters of harm reduction about the impact of this strategy on drug users' health and human rights.[66]

Tackling the problems associated with retail markets Retail drug markets can operate in many different ways: in public or private spaces; concentrated or dispersed; and controlled by a small number of dominant groups or a large number of social networks. Different types of retail market can have vastly differing impacts on the levels of harm caused to the community through their visibility, violence or intimidation. Law enforcement efforts that focus indiscriminately on any visible aspect of the market can result in changes to the market that actually increase community harms. The most common example is where a successful operation against one trafficking group leads to increased violence through battles over the vacated 'turf', or the rise to prominence of a more violent group. Similarly, a raid on private premises where drug trafficking is concentrated can lead to the market moving to a more public or dangerous location. While the circumstances in each area are unique, retail markets are generally more harmful when they take place in public areas, are concentrated and involve groups and individuals who are prepared to use violence, intimidation and corruption to protect their trade. Law enforcement strategies against retail markets therefore need to be based on good intelligence about the local market, and seek to influence the shape of the market so as to minimise consequential harms.

Law enforcement against retail markets must be based on good intelligence about the local market and seek to influence the shape of the market to minimise consequential harms.

64 Closed retail markets are often associated with a reduced level of drug-related harms. Law enforcement efforts do have the potential to 'train' markets to become closed.

65 McSweeney, T., Turnbull, P.J. & Hough, M. (2008), *Tackling drug markets and distribution networks in the UK* (London: UKDPC), http://www.ukdpc.org.uk/resources/Drug_Markets_Full_Report.pdf

66 Lister, S., Seddon, T., Wincup, E., Barrett, S. & Traynor, P (2008), *Street policing of problem drug users* (York: Joseph Rowntree Foundation), http://www.jrf.org.uk/sites/files/jrf/2170-policing-drugs-crime.pdf

The 'Boston Miracle' is a good illustration of such an approach. At the end of the 1980s, Boston (USA) experienced a rapid upsurge in its murder rate, from about 15 per 100,000 in the mid-1980s to 25 in 1990. These numbers were heavily concentrated among young, black men, often using semi-automatic weapons, and many were members of street gangs involved in the expanding crack market. After a deadly incident in 1992, a coalition of faith groups was constituted and started to organise forums gathering gang-involved offenders, police officers, church ministers and social service personnel. Gang offenders were given the choice either to accept help with education and training or be targeted by the police for their violent activities. The project also sought to prevent weapon trafficking. An evaluation of the operation in 2001 found a 63 per cent decrease in the monthly rate of youth murders.[67]

Reducing availability to young people While it is not realistic to expect law enforcement authorities to stifle the overall availability of drugs in a particular country or city, it may be possible to influence the retail market in ways that minimise the risk of young people who are potential new drug users coming into contact with the market. Law enforcement agencies must focus their actions on shaping the local drug market so that it is less likely to be accessible to young people. For example, they can crack down on dealing in parks and playgrounds, or encourage markets to be run from private premises. They can also consider drug supply to children or involvement of minors in dealing as an aggravating factor in sentencing. That approach was adopted in the Czech Republic, Estonia, Denmark and the USA, but it has often led to increasingly disproportionate sentencing. For example, in the USA, people most likely to deal near schools are usually poor and black, because they usually live in highly populated urban areas where large numbers of schools happen to be concentrated. The costs and benefits of these 'aggravating factors' therefore need to be carefully considered.

The retail drug market must be influenced in ways that minimise the risk of young people coming into contact with the market.

Reducing petty crime committed by dependent drug users The most common forms of drug-related crimes are theft, fraud, prostitution and robbery offences committed by dependent drug users to raise money to pay for drug purchases.[68] Many countries have found that dependent drug users account for a significant proportion of overall rates of certain petty crimes. Those who have implemented initiatives that identify the most active offenders and refer them to drug dependence treatment programmes have found that it is a cost-effective mechanism for reducing individual crime rates.[69] As law

67 Stevens, A. & Bewley-Taylor, D. (2009), *Beckley Report 15 – Drug markets and urban violence: Can tackling one reduce the other?* (Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_15.pdf

68 These drug-related crimes are usually specific to the different types of illicit drugs: Bennet, T. & Holloway, K. (2009), 'The causal connection between drug misuse and crime', *The British Journal of Criminology* **49**:513-531, http://bjc.oxfordjournals.org/cgi/content/abstract/azp014

69 However, this approach has not yet been effective in reducing the overall crime rates. This suggests that the latter will be more influenced by wider social factors (such as inequality, poverty, or social marginalisation) than by the drug markets.

Identifying the most active offenders and referring them to drug treatment has been a cost-effective mechanism for reducing individual crime rates.

enforcement agencies come into regular contact with these offenders, they are well placed to play this identification and referral role. Arrest referral schemes, court diversion schemes and prison drug treatment programmes have all been effective in moving dependent drug users away from a lifestyle of petty offending and drug dependence. Law enforcement agencies should therefore put greater emphasis on referring these people to treatment rather than on the more expensive process of prosecution and imprisonment. Many different forms of this identification and referral process exist worldwide, but Portugal is the country that has probably gone furthest in incorporating this principle into its national drug strategy. All those arrested for drug possession are passed by the police to multidisciplinary panels, who refer them on to appropriate treatment services (see Section 2.1 on drug law reform). Several studies on the effects of the 2001 drug law have demonstrated that the law had already shown a positive impact on the recidivism[70] and social reintegration of dependent drug users.[71]

Supporting health and social programmes Problematic drug users generally live on the margins of society. Poverty and alienation are often contributing factors in the development of drug dependence (harsh living conditions and emotional trauma can increase vulnerability to drug dependence), and in turn, drug dependence exacerbates these problems. Many policies and programmes increase social exclusion. Arresting and punishing dependent drug users or denying them access to employment and education can make it more difficult to rehabilitate or reintegrate them into society. In these circumstances, drug use often involves significant health risks, including overdose or blood-borne infections such as hepatitis or HIV. In many countries the HIV pandemic is driven by the sharing of infected needles for drug injection, and public health authorities are engaged in a global response to scale up preventative measures targeted at dependent drug users. Many of these measures, such as the distribution of clean needles, work within the context of continuing drug use, and solely seek to keep drug users alive and healthy, and encourage them to consider treatment options. Many law enforcement agencies have been reluctant to support these initiatives, as they see them as condoning or perpetuating drug use. This lack of clear support and partnership work is disappointing. Law enforcement agencies should support the referral of dependent drug users to appropriate health and social services in order to improve public health, specifically in efforts to reduce HIV transmission and overdose deaths. Police and court officials in particular come into regular

Law enforcement agencies should become key partners in the design and delivery of strategies to improve public health.

70 Recidivism can be defined as the reversion of an individual to criminal behaviour, after he/she has been convicted of a prior offense and sentenced.

71 Hughes ,C. & Stevens, A. (2007), *Beckley Briefing Paper 14 – The effects of decriminalization of drug use in Portugal* (Beckley Foundation Drug Policy Programme), http://idpc.net/sites/default/files/library/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf; Greenwald, G. (2009), *Drug decriminalisation in Portugal – Lessons for creating fair and successful drug policies.* (Washington D.C.: CATO Institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

contact with groups at higher risk. They can play an important role in the distribution of advice and information, making needles and other materials available for safer use, and facilitating rapid responses to overdoses.

In cases where law enforcement and health agencies have worked together towards common objectives, they have been able to demonstrate clear success in reducing HIV transmission and overdose death rates. In 1994 the Swiss government adopted a new drug strategy centred on public security, health and social cohesion, which included prevention, therapy, harm reduction and law enforcement. The new policy involved prescribing opiates (notably heroin) to treat drug dependence. The progressive implementation of this policy resulted in a significant decrease in problems related to drug consumption. First, heroin use plunged radically between 1990 and 2005. Second, the policy brought about a significant reduction of overdoses and deaths indirectly related to drug use, such as from AIDS-related illnesses and hepatitis. Between 1991 and 2004 the drug-related death toll fell by more than 50 per cent. Finally, levels of drug-related HIV infections were reduced by 80 per cent within ten years.[72]

72 Savary, J.F., Hallam, C. & Bewley-Taylor, D. (2009), *Briefing Paper 18 – The Swiss four pillars policy: An evolution from local experimentation to federal law* (Beckley Foundation Drug Policy Programme), http://www.idpc.net/sites/default/files/library/Beckley_Briefing_18.pdf

Recommendations

- Law enforcement strategies should be reviewed and refocused with a change of objectives, moving away from a singular focus on seizing drugs and arresting users towards a partnership approach to reducing health and social problems.

- Actions against organised crime groups must be based on quality intelligence. States must focus their resources on the most harmful aspects of organised criminal groups' activities rather than solely on seizures or arrests.

- Law enforcement strategies against retail markets must be based on good intelligence to assess the dynamics of local drug markets, and seek to influence the shape of these markets so as to minimise their consequential harms.

- Policies that minimise the potential for young people to come into contact with the illicit drug market need to be developed. This can be achieved if enforcement actions are implemented against local drug markets in a way that shapes the market so that it is less accessible to young people.

- Evidence-based and cost-effective referral mechanisms of drug offenders to appropriate services are needed. Law enforcement agencies can identify and refer dependent drug users to these facilities.

Key resources

European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 1998-2007* (European Communities), http://ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf

European Monitoring Centre for Drugs and Drug Addiction (2007), *Drug use and related problems among very young people (under 15 years old)* (EMCDDA), http://www.emcdda.europa.eu/attachements.cfm/att_44741_EN_TDSI07001ENC.pdf

Lenton, S. *et al.* (2005), *An Evaluation of the Impact of Changes to Cannabis Law in Western Australia: Summary of the Year 1 Findings*. Monograph Series No. 12. (Australia: NDLERF & NDRI), http://www.ndlerf.gov.au/pub/Cannabis_WA.pdf

McSweeney, T., Turnbull, P.J. & Hough, M. (2008), *Tackling drug markets and distribution networks in the UK* (London: UKDPC), http://www.ukdpc.org.uk/resources/Drug_Markets_Full_Report.pdf

Stevens, A. & Bewley-Taylor, D. (2009), *Beckley Report 15 – Drug markets and urban violence: Can tackling one reduce the other?* (Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_15.pdf

UK Drug Policy Commission (2009), *Refocusing drug-related law enforcement to address harms – Full review report* (London: UKDPC), http://www.ukdpc.org.uk/resources/Refocusing_Enforcement_Full.pdf

2.3 Reducing incarceration

IN THIS SECTION

- Why is it important?
- Problems associated with high rates of incarceration
- Alternative strategies to incarceration
- Recommendations
- Key resources

Key message

Reducing incarceration rates through decriminalisation, depenalisation, and/or alternative mechanisms of diversion is a cost-effective way to reduce the harms associated with the overcrowding of prisons and the criminal justice system, and to promote the social reintegration of drug offenders.

Why is it important?

In an attempt to reduce illicit drug markets, many governments rely on the incarceration of drug users. The rationale behind the need to maintain and often increase police activity and penal sanctions for drug users is the belief that strong law enforcement and widespread incarceration will deter potential users and dealers from becoming involved in the drug market. Incarceration therefore plays an important part in the drug policy of most countries, although its use varies widely from one country to another.

Increasing numbers of people arrested for drug-related offences are being sent to prison. The steepest rise has been in the USA, where over half of federal prison inmates are kept in custody for a drug charge. Less spectacular rises have also taken place throughout Europe, Asia, Africa, Oceania and the Americas.[73]

Increasing numbers of people arrested for drug-related offences are being sent to prison.

The UN drug control system itself remains ambivalent in its attitude to punitive measures for drug offences. In its 2007 Annual Report, the International Narcotics Control Board devoted a whole chapter to the need for proportionality in sentencing for drug-related offences. However, this recommendation was made within an international legal

73 Bewley-Taylor, D., Hallam, C. & Allen, R., (2009), *Beckley Report 16 – The incarceration of drug offenders, an overview* (The Beckley Foundation Drug Policy Programme), http://www.idpc.net/php-bin/documents/Beckley_Report_16_2_FINAL_EN.pdf

framework that still strongly encourages a penal approach, particularly in the 1988 drug convention, which compels governments to adopt all necessary measures to establish every drug-related activity as criminal offences under their domestic law (article 3). As governments have introduced increasingly tough laws and penalties to comply with the letter and 'spirit' of these conventions, concerns have grown that the widespread incarceration of drug users has been expensive, ineffective and has increased health and social problems, while failing to prevent and deter drug use. This is despite considerable flexibility in the treaty provisions, including the 1988 Trafficking Convention, which (like its predecessors) allows social and health measures to be used in addition to, or instead of, penal measures for drug possession offences.

Problems associated with high rates of incarceration

Evidence shows that tough law enforcement approaches focusing on high incarceration rates for drug offenders have led to negative consequences, not only for the drug offenders themselves but also for state institutional structures.

Financial costs According to the calculations of Harvard economist Jeffrey Miron, $12.3 billion were spent to keep state and federal drug law offenders in prison in the USA in 2006. In the early 1990s it was even estimated that the yearly cost of a prison place was more than the cost of tuition, room and board at Harvard. Such high expenses are not limited to the USA. North of the border, the Canadian custodial service expenditure totalled almost $3 billion in the 2005–2006 period. The UK spent proportionately more on law and order than any other state of the Organisation for Economic Cooperation and Development, including the USA.

Overload for the criminal justice system The use of mandatory minimum sentences and pre-trial detention, and the associated increase in incarceration of non-violent offenders, can damage the reputation and good functioning of a country's criminal justice system. Sentencing statutes that result in low-level drug offenders serving longer sentences than bank robbers, kidnappers and other violent offenders (such as rapists or murderers) undermine the notion of proportionality and fairness of the law. Overloading the criminal justice system with low-level offenders may also weaken its ability to administer justice efficiently and to focus resources on higher-level criminals.

Limited impact on the reduction of drug use Some governments argue that law enforcement reduces drug consumption by directly lowering demand. This assertion is based on the premise that if drug users are incarcerated they are not contributing to the illicit drug market, and that the deterrent effect of heavy sentences will reduce overall levels of use. However, in practice it is difficult to find a correlation between the incarceration of drug users and a reduction of the illicit drug market. For example, US states with higher rates of drug-related incarceration have experienced higher not lower rates of drug use. A 2004 study comparing marijuana use in Amsterdam and San

Francisco also demonstrated that relative risks of punishment make no difference to levels of drug use. Despite significantly different law enforcement regimes in these two cities – Amsterdam having legalised marijuana use and San Francisco having focused its efforts on a harsh law enforcement approach – the research found remarkable similarities in drug use patterns.[74] While the threat of imprisonment may deter some groups from using drugs, research suggests that punishment generally has a limited impact on all types of illicit drug use, especially for drug dependent people.

The argument linking high incarceration rates with the reduction of drug use also ignores the existence of sizeable drug markets in many prisons worldwide. A 2003 European Monitoring Centre for Drugs and Drug Addiction report estimated that 12 to 60 per cent of inmates in European prisons had used drugs during incarceration,[75] and a 2006 study in Germany found that 75 per cent of imprisoned injecting drug users continued to inject drugs in prison.[76]

Other governments have justified their incarceration policies by citing the positive effect of prison on the rehabilitation of drug offenders. However, it is widely accepted that imprisonment in itself does not have a reformative effect. If appropriate drug treatment is offered to drug dependent detainees, it can have an impact on drug use and re-offending rates after release. However, drug treatment in prisons should always be considered as a last option. Evidence shows that better results can be achieved through treatment in the community. For example, the Drug Treatment Alternative to Prisons programme in New York found that only 26 per cent of offenders diverted into treatment were reconvicted, compared to 47 per cent of comparable offenders who had been sent to prison.[77]

Socio-economic consequences The diversion of funds to prisons is likely to impact negatively on many other areas of public expenditure. It may even help create the very social conditions that lead some people to use illicit drugs in the first place. These social conditions are overwhelmingly concentrated among demographic groups that are already largely socially and economically disadvantaged, such as minority groups. Mass incarceration can also impact negatively on the informal social controls that exist within these afflicted communities. Research in the USA correlating community crime rates to imprisonment rates among African-American people found that crime tended to fall with mild increases in imprisonment rates due to offenders being taken out of the community. Crucially, however, the research suggested that when the rate of imprisonment reached

74 Reinarman, C., Cohen, P.D., & Kaal, H.L. (2004). 'The limited relevance of drug policy: cannabis in Amsterdam and San Francisco'. *American Journal of Public Health* **94**(5):836-842, http://www.ncbi.nlm.nih.gov/pubmed/15117709

75 European Monitoring Centre for Drugs and Drug Addiction, (2003). *Annual Report 2003. State of the Drugs Problem in the European Union and Norway* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction), http://www.emcdda.europa.eu/publications/annual-report/2003

76 Stark, K., Herrmann, U., Ehrhardt, S., & Bienzle, U. (2006). 'A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin', Germany *Epidemiology and Infection* **134**(4):814-819, http://journals.cambridge.org/action/displayAbstract;jsessionid=16924D20C547071C9D74A6CDC1FC504A.tomcat1?fromPage=online&aid=449884

77 National Center on Addiction and Substance Abuse (2003), *Crossing the bridge: An evaluation of the drug treatment alternative-to-prison (DTAP) Program.* ACASA White Paper. (New York: National Center on Addiction and Substance Abuse, Colombia University), http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/1a/ce/67.pdf

'mass' levels, the criminal justice system started to weaken systematic processes of informal social control within these African-American communities.[78]

Health consequences Incarceration also entails significant collateral costs on health, particularly with regard to blood-borne infections such as HIV and hepatitis C. Prisoners have higher levels of drug use, especially by injection, than the general population. Risk of exposure to this practice is greatly increased on incarceration, and with it, the risk of being infected by HIV or other blood-borne diseases. A 2009 review of evidence on HIV in prisons demonstrates that the high prevalence of HIV and drug dependence among prisoners, combined with the sharing of injecting drug equipment, make prisons a high-risk environment for the transmission of HIV. Ultimately, this contributes to HIV epidemics in the communities to which infected prisoners return after their release from prison (see Section 2.4 on drug policies in prison). [79]

Mass incarceration also impacts on a wide range of other health conditions, including undiagnosed mental health problems, chronic conditions such as diabetes and hypertension and poor oral health. Longer sentences have resulted in increasing numbers of older people in prisons, with their associated disease profile of Alzheimer's disease, respiratory and heart conditions and so on. Overcrowding and lack of resources mean that prisoners' health problems are often aggravated rather than alleviated during imprisonment.

Alternative strategies to incarceration

Several countries are now turning to depenalisation or the decriminalisation of drug use.

Given the significant costs of incarceration and its limited deterrent effect, it is hard to justify a drug policy approach that prioritises widespread arrest and harsh penalties on grounds of effectiveness. A change of focus is needed from drug use as a crime to drug use as a health problem, and from punishment to treatment for dependent drug users. This approach means reducing incarceration and developing alternative mechanisms to deal with arrested drug users.

Reviewing criminal laws A fundamental shift in focus is needed for the punishment of drug offences. National drug laws should be reformed so that priority is given to the seriousness of the crime and the impact of the sanction on the overall illegal drug market. In addition, pre-trial detentions and mandatory minimum penalties should be avoided for low-level drug offenders who are no danger to society, so as to reduce prison overcrowding. Detailed recommendations are provided for policymakers in Section 2.1 on drug law reform.

78 Western, B. & Wildeman, C. (2009), 'The Black family and mass incarceration', *Annals of the American Academy of Political and Social Science, Sage Online,* http://ann.sagepub.com/cgi/reprint/621/1/221.

79 Jürgens, R., Ball, A. & Verster, A. (2009), 'Interventions to reduce HIV transmission related to injecting drug use in prisons'. *The Lancet Infectious Diseases* **9**(1):57-66.

Depenalisation and decriminalisation In the past decade, countries such as Portugal, Mexico, Argentina and the Czech Republic have turned to the decriminalisation of drug use as a new strategy to combat drug-related crime and the negative consequences of a prison crisis. Decriminalisation usually applies to offences related to drug consumption, and involves imposing civil sanctions (for example, administrative ones) or abolishing all sanctions, rather than processing minor drug offences through the criminal justice system. So far these strategies seem to have been effective in reducing criminal justice system and prison overload, and have not led to an increase in drug use (see section 2.1 on drug law reform for more information on decriminalisation and examples of best practice).

Other countries have turned to depenalisation, a process by which the level of penalties associated with drug offences is reduced, so that imprisonment is used more sparingly. This is notably the case for the UK when dealing with those caught in possession of cannabis (see Section 2.1 on drug law reform for additional details).

Diverting drug offenders at arrest Diversion mechanisms at arrest are designed to minimise the use of traditional criminal justice pathways and avoid burdening the criminal justice system with cases of low-level offences. Different alternative systems have been developed to prevent overcrowding of criminal justice systems, but also to provide appropriate services to dependent drug users.

The 2001 Portuguese law on decriminalisation (see Section 2.1 on drug law reform) introduced a system of referral to Commissions for the Dissuasion of Drug Addiction (Comissões para a Dissuasão da Toxicodependência). When a person in possession of drugs is arrested, the police refer them directly to these regional panels consisting of three people, among them social workers, legal advisors and medical professionals, and supported by a team of technical experts. The Commissions use targeted responses to dissuade new drug users and encourage dependent drug users to enter treatment. To that end, they can impose sanctions such as community service, fines, suspension of professional licences and bans on attending designated places, and recommend treatment or education programmes for drug dependent people. Since the adoption of this new system, the proportion of drug offenders sentenced to imprisonment dropped to 28 per cent in 2005 from a peak of 44 per cent in 1999. This decline has contributed to a reduction in prison overcrowding, which fell from a rate of 119 to 101.5 prisoners per 100 prison places between 2001 and 2005.[80] This data suggests that Portuguese reforms have indeed taken some of the pressure off the criminal justice system.

Diversion at arrest aims to minimise the use of traditional criminal justice resources and provide treatment and health services to drug users.

80 Aebi, M.F. & Delgrande, M. (2009), *Council of Europe annual penal statistics, Space I, Survey 2007*. (Council of Europe), http://www.coe.int/t/e/legal_affairs/legal_co-operation/prisons_and_alternatives/statistics_space_i/PC-CP_2009_%2001Rapport%20SPACE%20I_2007_090505_final_rev%20.pdf

The UK's arrest referral scheme, while not an alternative to incarceration, is based on a system whereby those arrested for drug offences, or for offences motivated by problematic drug use (such as theft), are referred to a drug treatment provider. This policy is premised on the idea that treatment will reduce or bring to an end illicit drug use and hence drug-related offending. Arrest referrals take place in police cells or court premises. Evidence so far suggests that these schemes can be effective in reducing drug use and drug-related crimes, although their long-term impact on incarceration rates still needs to be assessed.

Diverting drug offenders at sentence Prison overcrowding due to systematic incarceration for drug offences can be reduced through court diversion initiatives. Some governments have developed these alternative mechanisms to incarceration so that non-violent drug offenders who do not represent a danger to society are referred to treatment services or have other penalties imposed on them.

Non-violent drug offenders who do not represent a danger to society are referred to treatment services and/or have other penalties imposed on them as an alternative to imprisonment.

The Australian government has adopted a balanced policy between law enforcement and treatment services for drug offenders. It responds to cannabis cultivation and possession with civil penalties such as fines or infringement notice systems rather than incarceration. In most Australian states, police officers have implemented this mild enforcement system with substantial success, while avoiding some of the negative outcome of an overly prohibitionist model, such as loss of productivity and threats to civil liberties. Their approach seems to have had some effect on incarceration levels, since only 10 per cent of the prison population was indicted for illicit drug offences in 2005.[81]

The USA has developed a drug court system whereby judges oversee the treatment of arrested dependent drug users in community-based or residential settings as an alternative to imprisonment. The idea behind drug courts is that providing drug treatment to some defendants will lead to better outcomes for them and their communities. Unlike typical criminal proceedings, drug courts are intended to be collaborative, with judges, prosecutors, social workers and defence attorneys working together to decide what would be the best solution for the defendant and the community. Drug courts can operate either by diverting offenders into treatment before sentencing, or by sentencing offenders to prison terms and suspending these sentences provided they comply with treatment demands.

Some 55,000 people are currently in drug court programmes across the USA. Evidence shows that drug court systems, and especially diversion to drug treatment, have reduced recidivism and proved to be more cost-effective than incarceration (see Section 3.2 on

81 Australia Bureau of Statistics (2006), *Prisoners in Australia*, www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/0D2231601F85888BCA2570D8001B8DDB/$File/45170_2005.pdf

drug dependence treatment). For example, the average annual cost of incarceration in the USA is estimated to be $23,000 per inmate, while the average annual cost of drug court participation is about $4,300 per person.[82]

All of these initiatives can contribute to reducing the incarceration rate for low-level drug offenders. Different mechanisms for diverting these individuals from custody can combine to reduce the pressure on countries' criminal justice systems, and achieve better health and social outcomes.

Recommendations

- Laws and penalties for drug offences need to be reviewed, with the objective of drawing a clear distinction between the different actors and their role in the illicit drug market. Law enforcement interventions and incarceration penalties should be focused on high-level or violent drug offenders, and governments should consider the introduction of depenalisation or decriminalisation regimes for low-level and non-violent offenders.

- Diversion mechanisms at arrest need to be introduced and designed so that cases of low-level drug offenders do not overload and incapacitate criminal justice systems.

- Incarceration penalties should be reduced or removed altogether for low-level drug offenders, who should be diverted instead to more appropriate forms of intervention. These can include administrative penalties for recreational users, or treatment services for drug dependent people. Any criminal procedure that increases the pressure on prison capacity, such as mandatory minimum sentences and pre-trial detention procedures, should only be used for the most serious offenders.

- More generally, a change of focus is needed from treating drug use as a crime to dealing with it as a health problem, and from punishment to treatment for dependent drug users who are not involved in serious or violent crime.

82 King, R.S. & Pasquarella, J. (2009), *Drug courts, a review of the evidence.* (The Sentencing Project: Research and Advocacy for Reform), http://www.sentencingproject.org/doc/dp_drugcourts.pdf

Key resources

Bewley-Taylor, D., Hallam, C. & Allen, R. (2009), *Beckley Report 16 – The incarceration of drug offenders, an overview.* (The Beckley Foundation Drug Policy Programme), http://www.idpc.net/sites/default/files/library/Beckley_Report_16_2_FINAL_EN.pdf

Canadian HIV/AIDS Legal Network (2006), *Legislating on health and human rights: model law on drug use and HIV/AIDS. Module 1: Criminal law issues*, http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1052

Crossen-White, H. & Galvin, K. (2002), 'A follow-up study of drug misusers who received an intervention from a local arrest referral scheme'. *Health Policy* 61(2):153-171, http://www.journals.elsevierhealth.com/periodicals/heap/article/PIIS016885100200009X/abstract

Edmunds, M., May, T., Hearnden, I. & Hough, M. (1998), *Arrest referral – Emerging lessons from research*. (Criminal Policy Research Unit, South Bank University), Report prepared for the Home Office, http://www.kcl.ac.uk/depsta/law/research/icpr/publications/Arrest%20Referral,%20emerging%20lessons%20from%20research.pdf

Greenwald, G. (2009), *Drug decriminalisation in Portugal – Lessons for creating fair and successful drug policies*. (Washington D.C.: CATO Institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

Jürgens, R., Ball, A. & Verster, A. (2009), 'Interventions to reduce HIV transmission related to injecting drug use in prisons', *The Lancet Infectious Diseases* **9**(1):57–66, http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(08)70305-0/abstract

2.4 Effective policy for prisons

IN THIS SECTION

Key message

Despite all supply-reduction efforts, drug use and distribution remains a significant problem in prisons. Prison authorities need to have a clear plan for preventing infections and overdoses, and delivering treatment to prisoners with drug problems.

Why is it important?

Other sections of this guide argue that law reforms should be pursued to minimise the number of non-violent drug offenders being sent to prisons or other forms of custodial institutions. This argument arises from the assessment that widespread imprisonment of casual or dependent drug users has a limited deterrent impact on levels of use and creates extreme burdens on public finances, while the concentration of these groups in custody leads to increased health and social risks.

Nevertheless, in many countries, drug users make up a significant proportion of the prison population[83] due to the following factors:

- drug laws and enforcement strategies that include the widespread use of imprisonment for drug offences
- delays in the court process, leading to long periods of pre-trial detention
- the involvement of dependent users in prostitution, low-level drug dealing and property crime to raise funds to buy drugs
- the availability of drugs in prisons means that some people are initiated into drug use while incarcerated.

83 About 50% of prisoners in the European Union have had a history of drug use throughout their lives, and over 80% in the USA. IDUs are vastly over-represented, often accounting for half of all prison inmates, but only 1 to 3% of the broader community. See: Dolan, K., Khoei, E.M., Brentari, C. & Stevens, A. (2007), *Beckley Report 12 – Prisons and drugs: a global review of incarceration, drug use and drug services* (The Beckley Foundation), http://www.beckleyfoundation.org/pdf/Beckley_RPT12_Prisons_Drugs_EN.pdf

The IDPC recognises that one of the main duties of prison authorities is to make sure that security is maintained. However, none of these security measures has been effective so far in preventing drug availability in prisons, and the attendant health risks of drug use. This section aims to provide a comprehensive overview of evidence-based policies and programmes that promote the health of detainees in prisons and their social reintegration after release. Under international law, prison authorities have a legal duty to meet the health needs of those detained in their custody.[84] This should be guided by the principle of 'equivalence of care'; that is, those detained by the state have the right to the same medical treatment and care as the rest of the general public.

Health risks in prison

As a result of their lifestyles prior to imprisonment, and specific risk activities, drug-using prisoners present high levels of general health problems, in particular infections such as HIV, hepatitis and tuberculosis (TB). In some cases, the prevalence of these diseases among prisoners represents a serious challenge to prison authorities.

HIV is a serious health threat for the 10 million people in prison worldwide. In most countries, levels of HIV infection among prison populations are much higher than those outside of prisons. However, the prevalence of HIV infection in different prisons within and across countries varies considerably. In some cases, the prevalence of HIV infection in prisons is up to 100 times higher than in the community.[85] In terms of HIV transmission through injecting drug use – the main concern in many countries – evidence shows that rates of injection are lower amongst prisoners than in the drug-using community outside of prisons. However, the rates of sharing needles, and the risks associated with it, have reached worrying levels: most countries report sharing rates of between 60 and 90 per cent in prisons.[86]

HIV rates in prisons are up to 100 times higher than in the community.

The rates of sharing needles in prison have reached 60 to 90 per cent of injecting drug users.

The levels of hepatitis C virus are also high among prison inmates. The World Health Organization estimates that about 3 per cent of the world's population has been infected with hepatitis C, whereas the prevalence of infection in prisons has been reported to range from 4.8 per cent in an Indian jail to 92 per cent in northern Spain.[87]

84 Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR),

85 In Russia by late 2002, the number of people living with HIV/AIDS in prisons accounted for about 20% of known cases of HIV in the country. In Indonesia, HIV prevalence rates in prison varied from 4 to 22% in 2001, in Brazil, prevalence rates range from 3.2 to 20%. In South Africa, HIV prevalence in prisons reportedly reached 41.4% in 2002, and in Western Europe, particularly high rates were reported from southern countries, such as in Spain where 14% of prisoners are reportedly living with HIV/AIDS. For more information, see: United Nations Office on Drugs and Crime, World Health organization & Joint United Nations Programme on HIV/AIDS (2008), *HIV and AIDS in places of detention - A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings* (New York: United Nations), http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

86 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for Action Technical Papers – Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies* (Geneva: WHO), http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20NSP.pdf

87 United Nations Office on Drugs and Crime, World Health organization & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention - A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings* (New York: United Nations), http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

The prevalence of hepatitis C virus in prisons ranges from 4.8 per cent in an Indian jail to 92 per cent in northern Spain.

Similarly, the prevalence of TB is often much higher in prisons than it is in the general population. A Thai study revealed that the prevalence of TB among prison inmates was eight times higher than in the general population.[88] Another study demonstrated that TB prevalence in a prison in Victoria (Australia) had reached 10 per cent,[89] whereas a study in a prison in Bahia (Brazil) reported a prevalence of latent TB at 61.5 per cent, with a prevalence of active TB at 2.5 per cent.[90]

The prevalence of TB is much higher in prisons than in the general population.

Prison authorities therefore have to deal with some of the most extreme aspects of drug-related health issues: risk factors for infection are heightened in prison settings, and released prisoners often form a 'bridge' for infections to spread among the general population.

The risk of widespread infection within prisons is heightened due to a number of factors:

- The close proximity of large numbers of people in often unsanitary conditions, and with little access to protective measures, creates the conditions for air-borne infections such as TB and blood-borne viruses such as HIV and hepatitis to thrive.
- The prevalence of high-risk behaviours such as unprotected sexual contact, drug injection and tattooing is particularly high.
- The lack of access to prevention and harm reduction measures means that these activities are more likely to be unsafe.

These challenges are daunting enough where full public health and care services are available. But in most prisons, where the skills, resources and equipment available for general healthcare services are often inadequate, responding to these public health challenges is particularly difficult. However, international human rights law states that prisoners retain their right to the highest attainable standard of health provided for by the 1945 World Health Organization Constitution and the 1966 International Covenant on Economic, Social and Cultural Rights. Therefore all states do have the legal obligation to design and implement evidence-based programmes in detention facilities that preserve the health of drug users and reduce drug-related harms.

88 Sretrirutchai, S., Silapapojakul, K., Palittapongarnpim, P., Phongdara, A. & Vuddhakul, V. (2002), 'Tuberculosis in Thai prisons: magnitude, transmission and drug susceptibility'. *The International Journal of Tuberculosis and Lung Disease* **6**(3): 208–214, http://www.ingentaconnect.com/content/iuatld/ijtld/2002/00000006/00000003/art00005

89 MacIntyre, C.R., Carnie, J. & Randall, M. (1999), 'Risks of transmission of tuberculosis among inmates of an Australian prison'. *Epidemiology and Infection* **123**(3):445–450, http://www.jstor.org/pss/4617493

90 Moreira Lemos, A.C., Dias, Matos E. & Nunes Bittencourt, C. (2009), 'Prevalence of active and latent TB among inmates in a prison hospital in Bahia, Brazil'. *Jornal Brasileiro de Pneumologia* **35**(1): 63–68, http://www.ncbi.nlm.nih.gov/pubmed/19219332

Managing health risks

Although numerous studies have examined policies and interventions on drug use in general, few have focused on drug treatment and harm reduction services in prison. In many countries, limited resources are dedicated to prisons, and security is often prioritised over the health needs of dependent drug users. Prison authorities have usually tried to tackle the power of drug dealers and limit illicit drug availability through tough security measures or drug-testing programmes. These interventions have failed to achieve their intended goal, and have sometimes resulted in negative consequences. For example, drug testing in prisons encourages dependent drug users to switch to drugs that are not being tested for, or are harder to detect and may be more harmful (prisoners can switch to heroin use from cannabis, which can be detected in the body for a longer period of time). Several studies have also revealed that drug-testing programmes were far from being cost-effective.[91] The UNODC has declared that these programmes should be avoided in prisons.[92]

Drug testing should be avoided in prisons.

Prison authorities must rise to the challenge of complying with their international human rights obligations.[93] By pursuing health-based policies in prisons, as well as the community, countries will not only see improvements in the health of the drug-using population, but also in the health of the wider population. This will impact positively not only on health outcomes but also on public finances. Several options are open to prison authorities, all of which are promoted as best practice by the WHO, UNODC and the Joint United Nations Programme on HIV and AIDS (UNAIDS).

Prison authorities must rise to the challenge of complying with their international human rights obligations.

Education and information Many prisoners are unaware of the infection risks they are taking. Simple information on these risks and the steps they can take to protect themselves and others should be widely distributed around prisons. Some prison administrations have also implemented educational videos or lectures to deliver the same messages, leading to higher levels of awareness.

Vaccination programmes Effective vaccinations exist to protect against hepatitis B, and a period of imprisonment is an opportunity to encourage people (many of whom do

91 Dean, J. (2005), 'The future of mandatory drug testing in Scottish prisons: a review of policy'. *International Journal of Prisoner Health* **1**(2-4):163–170, http://www.informaworld.com/smpp/content~content=a743931394&db=all

92 United Nations Office on Drugs and Crime, World Health Organisation & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention – A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings* (New York: United Nations), http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

93 Jürgens, R, Ball, A & Verster, A (2009), 'Interventions to Reduce HIV Transmission Related to Injecting Drug Use in Prisons'. *The Lancet Infectious Diseases* **9**(1):57–66, http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(08)70305-0/abstract

not use preventive health services in the community) to have the vaccination. This consists of two injections, six months apart. Many prison administrations have targeted hepatitis vaccination programmes at drug-using prisoners, who are a specific risk group, and report high levels of engagement and compliance.

Access to safer sex measures Many prison administrations have allowed the distribution of condoms to prisoners, offering them access to the same protection that is available outside. Early fears that the availability of condoms would lead to their use for drug smuggling have proved groundless. Further measures have also included providing information, education and communication programmes for prisoners and prison staff on sexually transmitted diseases, consisting of voluntary counselling and testing for prisoners or measures to prevent rape, sexual violence and coercion.

Needle and syringe programmes Programmes involving the distribution of clean injecting equipment to those who inject drugs have been effective at preventing HIV infection. However, there has been great reluctance to introduce these public health programmes in prison settings. Arguments against prison-based needle exchange has included fears that prisoners would use needles as weapons against staff or other prisoners; that discarded needles would present an infection risk; and that the availability of clean needles would increase the prevalence of drug injecting in prisons.

In 2009, ten countries had introduced needle and syringe programmes (NSPs) in prisons. The outcomes have been very positive. Most studies found that the sharing of injecting equipment had been dramatically reduced, while none of the fears outlined above had materialised in practice.[94] For example, a study in two Berlin prisons found that rates of sharing injecting equipment had fallen from 71 per cent of imprisoned injectors to virtually none following the introduction of a needle exchange programme.[95]

Preventing drug overdose Drug-using prisoners are a very high risk group for accidental overdose, particularly in the period immediately after release. Indeed, as drug dependent people reduce their use while in prison, they lose their tolerance to drugs. This means that their body can no longer cope with the doses they were taking before prison, and if they resume similar doses when released they face a high risk of overdose and death. A 1997 study in a French prison revealed that overdose death rates were found to be from 124 times higher than in the general drug-using population for ex-prisoners aged 15 to 24 through to 274 times higher for released prisoners aged 35 to 54.[96] Prisoners are also at risk of dying in prison, whether from suicide, loss of tolerance or contaminated drugs. Overdose prevention programmes therefore need to be particularly targeted at prisoners,

94 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for Action Technical Papers – Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies* (Geneva: WHO), http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20NSP.pdf

95 Stark, K., Herrmann, U., Ehrhardt, S., & Bienzle, U. (2006), 'A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin'. *Germany Epidemiology and Infection* **134**(4):814–819, http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=449884

96 Verger, P., Rotily, M. & Prudhomme, J. (2003), 'High mortality rates among inmates during the year following their discharge from a French prison'. *Journal of Forensic Sciences* **48**(3): 614–616, http://www.ncbi.nlm.nih.gov/pubmed/12762532

and should involve information and awareness-raising, and practical measures such as the distribution of naltrexone (a medication that temporarily blocks the effects of opiates).

Drug treatment and rehabilitation With a large number of dependent drug users held in custody, prisons can sometimes provide a useful location for delivering drug dependence treatment to break the cycle of dependence and crime. The experience of imprisonment can represent for some dependent drug users an interruption to their chaotic street life that gives them the opportunity to consider the impact that drugs has on them.

There is evidence that a range of drug dependence treatment interventions can be implemented effectively in prison settings. Opiate substitution therapy – in particular with methadone – is feasible in a wide range of prison settings for opioid dependent people. Prison-based opioid substitution therapy (OST) programmes appear to be effective in reducing the frequency of injecting drug use and the associated sharing of injecting equipment *if* a sufficient dosage and treatment are provided for longer periods of time. The risk of transmission of HIV and other blood-borne viruses among prisoners is also likely to decrease. OST has further benefits for participating prisoners, the prison system and the community. Evidence shows that re-incarceration is less likely to occur among prisoners who receive adequate OST. Moreover, OST has been shown to have a positive effect on institutional behaviour by reducing drug-seeking behaviour, thereby improving prison safety. While prison administrations have often raised concerns initially about security, violent behaviour and diversion of methadone, these problems have been addressed successfully by OST programmes.[97]

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, have been relatively effective at reducing drug dependence in prisons.[98]

Effective drug dependence treatment in prisons therefore maximises opportunities for rehabilitation and prevents a return to dependence and crime after release.[99] The principles behind prison-based treatment are similar to those of drug dependence treatment in the community:

- Efficient mechanisms need to be put in place to identify those in need of treatment. So long as the treatment programmes provided are humane and effective, prisoners will be likely to participate voluntarily. Screening procedures on reception, and the provision of specialist assessment, advice and referral services, can identify and motivate prisoners to accept help.

97 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for Action Technical Papers – Interventions to address HIV in prisons: Drug dependence treatments* (Geneva: WHO), http://whqlibdoc.who.int/publications/2007/9789241595803_eng.pdf

98 European Monitoring Centre for Drugs and Drug Addiction (2003), *Annual report 2003: the state of the drugs problem in the European Union and Norway*, http://ar2003.emcdda.europa.eu/en/page061-en.html ; Moreno Jimenez, M.P. (2000), 'Psychosocial interventions with drug addicts in prison. Description and results of a programme'. *Psychology in Spain* **4**(1):64–74, http://www.psychologyinspain.com/content/full/2000/6.htm

99 Dolan, K., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A.D. (2005), 'Four-year follow-up of imprisoned male heroin users and methadone treatment: mortality, re-incarceration and hepatitis C infection'. *Addiction* 100(6):820–828, http://www.ncbi.nlm.nih.gov/pubmed/15918812

- Various models of treatment in prisons have shown to be effective in improving health and crime outcomes in many countries.[100] Prison authorities should aim to make available a combination of detoxification, substitution treatment and psychosocial programmes in their prisons. These should be organised so that prisoners are able to move between services throughout their time in prison and when they choose to do so.

- Careful attention needs to be paid to the aftercare process, making sure that any progress made inside the prison is maintained after release. Several studies have suggested that aftercare was needed to optimise the effects of in-prison drug treatment on reducing drug re-offending.[101] This means that specific mechanisms are needed to link treatment in prison to that in the community.

If carefully designed and organised, compliance and success rates of drug dependence treatment in prisons can be improved by linking treatment progress to prisoner incentives, such as consideration for early release.

100 Mayet, S. Farrell, M. & Mani, S.G. (2010) *Opioid agonist maintenance for opioid dependent patients in prison* (Cochrane Database of Systematic Reviews, Issue 1), http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD008221/frame.html

101 Bullock, T. (2003), 'Key findings from the literature on the effectiveness of drug treatment in prison'. In Ramsay, M. (ed.) *Prisoners' Drug Use and Treatment: Seven Research Studies. Home Office Research Study 267* (London: Home Office).

Recommendations

- An understanding of the level and nature of drug use and drug dependence among prisoners is needed to design appropriate policies.

- Needle and syringe exchange programmes in prisons are needed to avoid the risks related to sharing injecting equipment. The introduction of NSPs should be carefully prepared, including providing information and training for prison staff. The mode of delivery of needles and syringes (for example, by hand or dispensing machine) should be chosen in accordance with the environment of the prison and the needs of its population.

- Additional harm reduction programmes for preventing blood-borne diseases and other drug-related harms should be provided alongside NSPs (education on drug risk behaviours, overdose and unsafe sex, provision of condoms, etc.).

- All prisoners should be assessed for drug dependence and risks of withdrawal, and offered appropriate treatment if indicated. Substitution treatment should be offered to all opioid dependent prisoners as an option if they choose to attend the programme. Dosing levels must be adequate and treatment should not be time limited. Substitution treatment programmes in prison should be stringently evaluated.

- Other forms of drug treatment should be provided to drug dependent prisoners, including psychosocial therapy or mutual aid groups.

- Better links and continuity of care should be established between prisons and community-based services in order to continue treatment when entering prison or on release.

Key resources

Holloway, K., Bennett, T. & Farrington, D. (2005) *The effectiveness of criminal justice and treatment programmes in reducing drug-related crime:A systematic review* (UK: Home Office Online Report 26/05)

Jürgens, R., Ball, A. & Verster, A. (2009) 'Interventions to Reduce HIV Transmission Related to Injecting Drug Use in Prisons'. *The Lancet Infectious Diseases* 9(1):57–66, http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(08)70305-0/abstract

Lines, R. (2007), 'HIV infection and human rights in prison' *In* WHO, *Health in prisons:A WHO guide to the essentials in prison health* (Geneva: Switzerland), http://www.euro.who.int/document/e90174.pdf

Lines, R., Jurgens, R., Betteridge, G., Stover, H., Laticevschi, D. & Nelles, J. (2006), *Prison needle exchange: a review of international evidence and experience* (Montreal: Canadian HIV/AIDS Legal Network, 2nd Ed.), http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1173

Mayet, S. Farrell, M. & Mani, S.G. (2010) *Opioid agonist maintenance for opioid dependent patients in prison* (Cochrane Database of Sustematic Reviews, Issue 1), http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD008221/frame.html

Mitchell, O., Wilson, D.B. & MacKenzie, D.L. (2006) *The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behaviour*. Campbell Systematic Reviews 2006: 11, www.campbellcollaboration.org/lib/download/98/

Perry, A., *et al.* (2009), *Interventions for drug-using offenders in the courts, secure establishments and the community* (*Cochrane Database of Systematic Reviews* 2006, Issue 3), http://www.cochrane.org/reviews/en/ab005193.html

Stöver, H. & Nelles, J. (2003), '10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies'. *International Journal of Drug Policy* **14**:437–444, http://linkinghub.elsevier.com/retrieve/pii/S095539590300152X

UN Office on Drugs and Crime, World Health Organisation & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention - A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings* (New York: United Nations), http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf

World Health Organization (2009), *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings* (Geneva: WHO WPRO), http://www.who.int/hiv/topics/idu/prisons/clinical_guidelines_close_setting_wpro.pdf

World Health organization (2007), *Health in prisons.A WHO guide to the essentials in prison health* (Copenhagen: WHO Europe), http://www.euro.who.int/document/e90174.pdf.

World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Effectiveness of interventions to address HIV in prisons* (Geneva: WHO), http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf.

World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme for HIV/AIDS (2007), *Evidence for Action Technical Papers – Interventions to address HIV in prisons: Drug dependence treatments* (Geneva: WHO), http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf

World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for Action Technical Papers – Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies* (Geneva: WHO), http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20NSP.pdf

Chapter 3

Health and Social Programmes

3.1 Drug prevention

IN THIS SECTION

- Why is it important?
- Problems with current drug prevention strategies
- A more comprehensive approach to drug prevention
- Recommendations
- Key resources

Key message

Effective drug prevention interventions need to be designed as an integrated response at individual, community and environmental levels. They should focus to a greater extent on social and environmental factors, such as poverty and social exclusion, that facilitate drug problems.

Why is it important?

Drug prevention aims to increase awareness of drug-related risks and to change personal, social and environmental factors through actions promoting health and well-being. This is in order to delay or avoid the onset of drug use and its progression towards drug dependence.

Problematic drug use is rooted in complex social, emotional, psychological and environmental factors. These can be categorised into 'risk' and 'protective' factors. Protective factors are associated with a reduced potential for drug use. These can refer to a high socio-economic status in society, high educational aspirations and employment prospects, good family cohesion and negative views on drug use among family members, peers and in the community. Risk factors make drug use more likely. They include high drug availability, low socio-economic status in society, experience of trauma or abuse, drug dependence among peers or family members, or little formal support in the family or at the community level. Drug prevention programmes are usually designed to enhance protective factors and reduce risk factors.

Problems with current drug prevention strategies

In the past, policy-makers have tended to design mass prevention interventions consisting of drug education and testing in schools, media campaigns against drug use, and life skills programmes. The logic behind these interventions was to make sure that young people would be exposed to information about the risks of drug use, and therefore be less likely to start using drugs or escalate their use.

Many scholars have reviewed and assessed the impact of these prevention programmes on the prevalence of drug use and dependence. A small number of studies have concluded that specific programmes have been useful in reducing the prevalence of drug use in a given community. This was notably the case for Project STAR, a US-based programme that consisted of a drug prevention community intervention for schools, parents, community organisations, the media and health policy-makers. Several follow-up studies conducted after one and three years of implementation showed that the intervention had achieved measurable impacts on the prevalence of drug use among the targeted population.[102]

However, none of these studies has conclusively demonstrated that these interventions could be universally implemented to bring down the overall level of drug use across society. Many reports have clearly stated that national programmes of drug prevention had, at best, a limited impact on preventing drug use.[103] Most 'successful' prevention interventions are area or community specific and have not been assessed in a timeframe of more than a few years, which raises doubts about their real effectiveness. As such, they can scarcely be regarded as a universal and long-term solution to prevent drug dependence.

Further doubts about prevention programmes have been raised with the reviews of some other major investments in this area. A ten-year follow-up study of the US project DARE – a widespread and well-funded universal drug education programme – found no particular evidence that the project had successfully impacted on drug use.[104] Another striking example is that of the US youth anti-drug media campaign launched in 1998. Several evaluations of the programme found little evidence that the intervention had direct effects on young people's use of drugs.[105]

102 Pentz, M.A., et al. (1989), 'A multi-community trial for primary prevention of adolescent drug abuse: effects on drug use prevalence'. *Journal of the American Medical Association* **261**(22):3259–3266, http://jama.ama-assn.org/cgi/content/abstract/261/22/3259; Johnson, C.A., *et al.* (1990), 'Relative effectiveness of comprehensive community programming for drug abuse prevention with high-risk and low-risk adolescents'. *Journal of Consulting and Clinical Psychology* **58**(4):447–456.

103 Plant, E. & Plant, M. (1999), 'Primary prevention for young children: a comment on the UK government's 10 year drug strategy'. *International Journal of Drug Policy* **10**(5):385–401, http://www.ijdp.org/article/S0955-3959(99)00019-5/abstract; Cuijpers , P. (2002), 'Effective ingredients of school-based drug prevention programs – A systematic review'. *Addictive Behaviours* **27**(6):1009–1023, http://www.ncbi.nlm.nih.gov/pubmed/12369469

104 Lynam, D.R., *et al.* (1999), 'Project DARE: No Effects at 10-Year Follow-Up'. *Journal of Consulting and Clinical Psychology* **67**(4):590–593

105 Hornik R., et al. (2002), *Evaluation of the National Youth Anti-Drug Media Campaign: Fifth semi-annual report of findings, executive summary* (Rockville, MD: Westat), http://www.drugabuse.gov/about/organization/despr/westat/Westat2003/TOCExecSum.PDF

Moreover, some prevention activities can have harmful effects on young people.[106] This has been the case for drug testing programmes in schools. In 2007 the Australian National Centre for Education and Training on Addiction undertook a comprehensive and critical examination of drug testing in schools.[107] This study and a number of other reports have largely criticised this practice. They found that drug testing:

Some prevention activities, such as drug testing, can have harmful effects on young people.

- programmes are reported to be ineffective in deterring drug use among young people[108]
- is expensive and takes away scarce resources from other, more effective programmes that would keep young people away from drugs[109]
- drives students away from school and extracurricular activities like athletics that have proven effective in helping them stay away from drugs[110]
- undermines trust between students and their teachers and parents
- sometimes results in false positives; for example, evidence shows that over-the-counter decongestants may produce a positive result for amphetamine; codeine can produce a positive result for heroin; and food products with poppy seeds can produce a positive result for opiates. Indiscriminate testing can therefore easily lead to the punishment of innocent people
- does not effectively identify students who have serious problems with drugs, and therefore cannot refer them to appropriate services for treatment and care
- may lead to unintended consequences, as when students use drugs that are more dangerous but less detectable by a drug test (binge drinking; drugs that exit the body quickly, such as methamphetamines, ecstasy or inhalants)[111]

106 Kern, J., Gunja, F., Cox, A., Rosenbaum, M., Appel, J. & Verma, A. (2006), *Making sense of student drug testing – Why educators are saying no* (ACLU, Drug Policy Alliance), http://www.aclu.org/files/images/asset_upload_file598_23514.pdf.

107 Roche, A.M., Pidd, K., Bywood, P., Duraisingam, V., Steenson, T., Freeman, T. & Nicholas, R. (2007), *Drug testing in schools – Evidence, impacts and alternatives* (Australian National Council on Drugs: Camberra), http://drugaids.socialnet.org.hk/Documents/australia_drug_testing_in_schools%20(1).pdf.

108 Yamaguchi, R., Johnston, L.D. & O'Malley, P.M. (2003), 'Relationship between student illicit drug use and school drug-testing policies'. *Journal of School Health* **73**(4):159–164, http://www.monitoringthefuture.org/pubs/text/ryldjpom03.pdf; Brief of Amici Curiae American Academy of Pediatrics, et al. (2002), *Board of Education of Independent School District No.92 of Pottawatomie County, et al.V. Lindsay Earls, et al.*, No. 01-332.

109 DuPont, R.L., Campbell, T.G. & Mazza, J.J. (2002), *Report of a preliminary study: elements of a successful school-based student drug testing program* (Rockville, MD: United States Department of Education) ; Kammerer, C. (2000), 'Drug testing and anabolic steroids', in *Anabolic steroids in sport and exercise*, 2nd Edition, Ed. Charles, E. Yesalis (Champaign, IL: Human Kinetics).

110 Glancy, M., Willits, F.K. & Farrell, P. (1986), 'Adolescent activities and adult success and happiness: twenty-four years later'. *Sociology and social research* **70**(3):242–250.

111 American Civil Liberties Union (1999), *Drug testing: a bad investment* (New York: ACLU), http://aclu.org/FilesPDFs/drugtesting.pdf

It is clear that the current approach to drug prevention has been largely ineffective in its primary aim of reducing overall rates of use. It is therefore necessary to revise current national strategies and devise drug prevention programmes that can truly have an impact on drug use in a cost-effective manner.

A more comprehensive approach to prevention

The preliminary stage of an effective drug prevention strategy should be to clarify objectives. If policy-makers want people to make better-informed decisions about drug use, then drug education in schools and local or national media campaigns focusing on drug education might be efficient[112] if they are culturally sensitive and adapted to the groups they are trying to reach. However, if governments are seeking to reduce the prevalence of drug use in society, these interventions have proved to have little impact. Prevention strategies therefore need to set more realistic objectives: better informed and more resistant young people, rather than population-wide reductions in overall rates of use. Resources should be specifically directed at those who need them, rather than at young citizens in general.[113]

Effective drug prevention depends on an integrated response at individual, community and environmental levels.

At the international level, WHO considers that effective disease and drug prevention depends on an integrated response at individual, community and environmental levels.[114] Interventions therefore need to be targeted at multiple levels of society. At the individual level, prevention interventions will only be effective if they provide people both with the knowledge and the means to change their behaviour. Interventions should increase their awareness of drug use and encourage beliefs and intentions supportive of risk reduction, while providing practical means for behaviour change such as personal skills or treatment for drug dependent people. However, it is misleading to assume that by targeting individuals alone, prevention interventions will necessarily create the social conditions necessary for behavioural change. Individual and community actions operate within the constraints of a wider social, economic and political environment. For example, it is widely agreed that health inequalities in general are strongly related to socio-economic determinants and that marginalisation has a negative impact on the well-being of individuals and communities.

112 This is not always the case. For example, the US youth anti-drugs education media campaign had little impact on the prevalence of drug use among young people in the USA. See: United States Government Accountability Office (2006), *ONDCP Media Campaign,* http://www.gao.gov/new.items/d06818.pdf

113 Several studies demonstrate that, in certain Western countries, preventative education is usually effective on youth until their late teens. Afterwards, the mere fact that such substances are highly prohibited makes their use all the more attractive to young people.

114 World Health Organization & Social Change and Mental Health (1998), *The rapid assessment and response guide on injecting drug use (IDU-RAR)* (Eds. G.V. Stimson, C. Fitch and T. Rhodes), http://www.who.int/substance_abuse/publications/en/IDURARguideEnglish.pdf

Drug use and drug problems are clearly related to a number of wider socio-economic factors.

In practice, problems related to illicit drugs have rarely been considered as a socio-economic development issue. Instead they have been treated as a technical challenge, and segmented into policies focusing on demand, supply and harm reduction. Although theoretically problematic drug use can affect everyone in society, evidence shows that it is clearly related to certain wider socio-economic factors. These include low educational levels; early school leaving and drop-out; unemployment; low salaries and difficult jobs; low income and debt; insecurity of accommodation and homelessness; mortality and drug-related diseases; poor access to care and treatment; and social stigma.[115] Other studies have demonstrated that problematic drug use and dependence are less prevalent among socially inclusive communities, where the discrepancies between rich and poor are reportedly low. In the Netherlands and Sweden, government policies have long focused on social inclusion and socio-economic welfare. Despite very different drug policy strategies, the prevalence of drug use in these two countries is comparable and rather low. This clearly shows that the prevalence of drug use can be influenced by factors other than a drug policy strategy, such as community inclusion and socio-economic well-being in general.

This approach widens the focus from drug use and health problems to issues of vulnerability, poverty, underdevelopment and human rights.

Governments need to prioritise identifying the poorest communities that are most at risk of developing a drug use problem, and adopt a comprehensive approach that combines individual, community and environmental development.[116] Understanding what makes impoverished communities susceptible to problematic drug use will help policy-makers minimise the risks by implementing targeted socio-economic development projects. This approach widens the focus from drug use and health problems to issues of vulnerability, poverty, underdevelopment and human rights.[117] It suggests a broader vision for drug prevention interventions than that offered by traditional prevention programmes.
It is necessary to move away from drug prevention strategies that focus solely on (often exaggerated) drugs information. Instead, programmes should encompass broader socio-economic factors, promoting social empowerment and inclusion, and human rights. Successful strategies must adopt both upstream (tackling the underlying causes of inequality) and downstream approaches (introduce measures to reduce inequality). Upstream approaches address the macro socio-economic environment, such as human development and the reduction of social inequalities. They include improving access to

115 European Monitoring Centre for Drugs and Drug Addiction (2003), *The state of the drugs problem in the European Union and Norway*, http://ar2003.emcdda.europa.eu/en/home-en.html

116 Marmot, M.G. (1998), 'Improvement of social environment to improve health'. *The Lancet* **351**(9095):57–60, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(97)08084-7/fulltext?version=printerFriendly

117 Rhodes, T. (2002), 'The "risk environment": a framework for understanding and reducing drug-related harm'. *International Journal of Drug Policy* **13**(2):85–94, http://linkinghub.elsevier.com/retrieve/pii/S0955395902000075.

education, healthy working conditions, reducing unemployment, and social and community inclusion policies. Downstream measures make sure that health policies address vulnerable and disadvantaged social groups.

Recommendations

- Before starting to design a prevention strategy, clear objectives must be set about what is to be achieved.

- Prevention strategies that may have unintended negative consequences on the target population should be avoided. This includes measures that may increase the social exclusion of vulnerable people, such as drug testing or the use of sniffer dogs in schools.[118]

- Traditional drug prevention policies need to be included into a broader strategy based on the socio-economic and health development of citizens, with a particular focus on the communities at higher risk. To that aim, governments should identify the needs of the most vulnerable communities before designing appropriate drug prevention strategies.

- It is necessary to involve key players, including dependent drug users and their families, in the effective design and implementation of prevention strategies. Affected communities should continually participate in the process to make sure that the measures undertaken are properly targeted and will not have unintended negative consequences.

- Data needs to be gathered to regularly assess the impacts of national socio-economic development programmes on the prevalence of drug use in communities. This will make sure that best practice is clearly evaluated and evidenced for future interventions.

118 For a list of articles on drug testing and the use of sniffer dogs in schools, see: http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Info/rlsnifferdogs.pdf

Key resources

American Civil Liberties Union (1999), *Drug testing: a bad investment* (New York: ACLU), http://aclu.org/FilesPDFs/drugtesting.pdf

Cuijpers , P. (2002), 'Effective ingredients of school-based drug prevention programs – A systematic review'. *Addictive Behaviours* **27**(6):1009–1023, http://www.ncbi.nlm.nih.gov/pubmed/12369469

European Monitoring Centre for Drugs and Drug Addiction (2003), *The state of the drugs problem in the European Union and Norway,* http://ar2003.emcdda.europa.eu/en/home-en.html

Ezard, N. (2001), 'Public health, human rights and the harm reduction paradigm: From risk reduction to vulnerability reduction', *International Journal of Drug Policy* **12**(3):207-219

Marmot, M.G. (1998), 'Improvement of social environment to improve health'. *The Lancet* **351**(9095):57–60, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(97)08084-7/fulltext?version=printerFriendly

Plant, E. & Plant, M. (1999), 'Primary prevention for young children: a comment on the UK government's 10 year drug strategy'. *International Journal of Drug Policy* **10**(5):385–401, http://www.ijdp.org/article/S0955-3959(99)00019-5/abstract

Rhodes, T. (2002), 'The "risk environment": a framework for understanding and reducing drug-related harm'. *International Journal of Drug Policy* **13**(2):85–94, http://linkinghub.elsevier.com/retrieve/pii/S0955395902000075

World Health Organisation, Social Change and Mental Health (1998), *The rapid assessment and response guide on injecting drug use* (Eds. G.V. Stimson, C. Fitch and T. Rhodes), http://www.who.int/substance_abuse/publications/en/IDURARguideEnglish.pdf

3.2 Drug dependence treatment

IN THIS SECTION

- Why is it important?
- Key elements for an effective treatment system
- Methods of drug treatment
- A cost-effective system
- A reintegration process
- Recommendations
- Key resources

Key message

Drug dependence should no longer be considered as a crime but as a health issue. Drug dependence treatment has proved effective in tackling drug dependence, reducing drug-related harms and minimising social and crime costs.

'People who take drugs need medical help, not criminal retribution'.
Antonio Costa,
UNODC Executive Director

Why is it important?

On 24 June 2009, UNODC Executive Director Antonio Mario Costa launched the 2009 World Drug Report, stating that "people who take drugs need medical help, not criminal retribution".[119]

Recent estimates suggest that 205 million people use illicit drugs.[120] The factors that lead experimental or occasional drug users to become drug dependent are complex. Only a minority of all drug users – an estimated 25 million globally[121] – will develop 'problem' or 'dependent' patterns of use, for which a treatment intervention is necessary. Treatment systems should therefore prioritise scarce resources on these

Of the 205 million people who use drugs, only 1 in 10 are considered to be drug dependent.

119 United Nations Office on Drugs and Crime (2009), *World Drug Report*, http://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

120 United Nations Office on Drugs and Crime (2009), *Joint UNODC-WHO programme on drug dependence treatment and care* (IN PRESS)

121 United Nations Office n Drugs and Crime (2009), *Joint UNODC-WHO programme on drug dependence treatment and care* (IN PRESS)

dependent users. Dependent drug use is defined by the European Union as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines'.[122] Dependent drug use is defined within the World Health Organization international classification of diseases as a strong desire or sense of compulsion to take drugs, difficulties in controlling drug use, a physiological withdrawal state, tolerance, progressive neglect of alternative pleasures or interests, and persisting with drug use despite clear evidence of overtly harmful consequences.[123]

Governments should work towards a treatment system that encompasses closely integrated and mutually reinforcing models.

The impact of drug use on an individual depends on the complex interaction between the innate properties of the drug used, the emotional state of the drug user, and their personal and social circumstances. In all societies the prevalence of problematic drug use has been concentrated among marginalised groups, where rates of emotional trauma, poverty and social exclusion are highest. This is hardly surprising as the compulsive use of drugs is cited by many studies as a way of coping with harsh living conditions or emotional problems.[124] Given the many factors that drive drug dependence, it follows that no single approach to treatment is likely to produce positive outcomes across society. Therefore governments should work towards a treatment system that encompasses a range of models that are closely integrated and mutually reinforcing. The impact of the legal and physical environment means that effective drug treatment interventions will need to take into account not only why individuals use drugs but also the social and cultural setting in which they do so and their impact. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

A number of governments have now accepted that offering treatment and rehabilitation to problematic drug users is a more effective strategy than imposing harsh punishments. Studies in a range of social, economic and cultural settings have confirmed that a wide range of drug-related health and social problems – including family breakdown, economic inactivity, HIV and petty street crime – could be tackled in a cost-effective manner through the widespread provision of drug dependence treatment.[125]

122 European Monitoring Centre for Drugs and Drug Addiction online glossary: http://www.emcdda.europa.eu/publications/glossary#p

123 World Health Organization (2007), *International Statistical Classification of Diseases and Related Health Problems – 10th revision*, http://apps.who.int/classifications/apps/icd/icd10online

124 Botvin, G., Schinke, J. & Steven, P. (1997), *The etiology and prevention of drug abuse among minority youth,* (New York: Haworth Press) ; Beauvais, F. & LaBoueff, S. (1985), 'Drug and alcohol abuse intervention in American Indian communities'. *Substance Use & Misuse* **20**(1):139–171, http://informahealthcare.com/doi/abs/10.3109/10826088509074831; Davis, R.B. (1994), 'Drug and alcohol use in the Former Soviet Union: Selected factors and future considerations'. *Substance Use & Misuse* 29(3):303–323, http://informahealthcare.com/doi/abs/10.3109/10826089409047383.

125 Reuter, P. & Pollack, H. (2006) 'How much can treatment reduce national drug problems?' *Addiction* **101**(3):341–347, http://www.ingentaconnect.com/content/bsc/add/2006/00000101/00000003/art00007; Irawati, I. *et al.* (2006), 'Indonesia sets up prison methadone maintenance treatment'. *Addiction* **101**(10):1525 – 1526, http://www.essentialdrugs.org/edrug/archive/200609/msg00050.php ; MacCoun, R.J. & Reuter, P. (2001), *Drug War Heresies* (New York: Cambridge University Press) ; National Treatment Agency for Substance Misuse (2009), *The Story of Drug Treatment* (London: NTA), http://www.nta.nhs.uk/publications/documents/story_of_drug_treatment_december_2009.pdf; Godfrey, C., Stewart, D. & Gossop, M. (2004), 'The economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)'. *Addiction* **99**(6):697–707, http://cat.inist.fr/?aModele=afficheN&cpsidt=15796344.

Certain treatment practices – electro-convulsive therapy, forced detoxification, regimes based on physical or psychological punishment or denial of liberty – should be prohibited.

Nevertheless, in many countries drug dependence treatment systems are non-existent, under-developed or pursue models that are inconsistent with human rights standards or global evidence of effectiveness. Research, experience and standards of fundamental rights and freedoms indicate that certain treatment practices should not be implemented. These include electro-convulsive therapy, forced detoxification and regimes based on physical or psychological punishment, or denial of liberty. Many governments have introduced treatment regimes that rely on coercion, either to force individuals to accept treatment or to force their compliance once in the programme. Many of these compulsory treatment regimes also include ill-treatment, denial of medical care and treatment, or forced labour.[126]

It is important that treatment approaches respect human rights and the principle that it is always the individual's choice whether to enter a treatment programme, and whether to comply and continue with it. This will not only comply with human rights obligations but also ensure programme effectiveness. All studies show that long-term behaviour change only comes about where individuals decide to change of their own free will. Treatment systems therefore need to be organised so that they encourage individuals to accept treatment (for example, through criminal justice processes) and lay down rules and expectations for programme compliance (for example, scheduled and regular attendance in a drug treatment programme), but do not cross the line into overt coercion. There is considerable ethical debate as to whether users should be coerced into treatment by the criminal justice system or other means. Advocates of coercion schemes point to the successes of criminal justice referral schemes that retain an element of coercion (for example, where drug treatment is considered as an alternative to a prison sentence). Opponents point to the right of human beings to choose their own treatment.[127] In either case, treatment systems will be ineffective if they do not respect the principles of self-determination and motivation.

Key elements for effective treatment system

The delivery of drug dependence treatment in most countries has started with the experimental implementation of a particular model, and over time this has expanded and/or other models have been added. Although a single or a series of separate interventions can deliver individual successes, governments should think more in terms of creating national,

126 World Health Organisation Western Pacific Region (2009), *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles* (Manila: WHO), http://www.wpro.who.int/NR/rdonlyres/4AF54559-9A3F-4168-A61F-3617412017AB/0/FINALforWeb_Mar17_Compulsory_Treatment.pdf ; Richard Pearshouse (2009), *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*, (Canadian HIV/AIDS Legal Network), http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=917; 'Harm Reduction 2009: IHRA's 20th International Conference' in Bangkok (21 April 2009): Session on '*Compulsory drug dependence treatment centres: Costs, rights and evidence (supported by the UNODC and the International Harm Reduction Development Program of the Open Society Institute)*', http://www.ihra.net/Bangkok2009#Presentations&Videos–Tuesday21stApril

127 The human right to informed consent to medical procedures and the ethical requirement to secure informed consent are well established. The right to freedom from medical intervention without informed consent derives from the right to security of the person – that is, to have control over what happens to one's body. See Article 9 of the International Covenant on Civil and Political Rights and the interpretation of 'bodily security' as a foundation principle of informed consent at Canadian HIV/AIDS Legal Network HIV Testing, *Info Sheet 5 – Consent*, www.aidslaw.ca/testing. The right also derives from the right to full information about health and health procedures, which arises from General Comment No.14 para. 34.

regional or local treatment systems for a wider and more demonstrable impact, and in order to make the most effective use of resources.

A treatment system will have limited impact if the individuals it targets are unable to access the services. The first challenge is therefore to identify those who are dependent, or experiencing or causing problems related to their drug use, and encourage them to accept help and intervention. There are a number of potential routes through which this can happen:

- **Self-referral** by the individual.

- **Identification through general health and social service structures** Existing health and social care services will often be in an excellent position to recognise symptoms of dependent drug use and encourage the drug user to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role.

- **Identification through specialist drug advice centres or street outreach services** These services can offer food, temporary housing, harm reduction services, and the encouragement and motivation to engage with drug treatment – at which point direct access to a more structured treatment can be facilitated.

- **Identification through the criminal justice system** Through the illegal nature of their drug use, and the need to fund it, dependent drug users often come into contact with the criminal justice system. There have been a number of successful models of intervention that use this criminal justice system contact to identify and motivate dependent users to accept treatment; for example drug courts in the USA,[128] arrest referral schemes in the UK (see Section 2.2 on effective drug law enforcement),[129] and the social work 'panel' system in Portugal (see Section 2.1 on drug law reform).[130] This form of identification is sometimes criticised as a form of coercion into treatment (see above).

Different systems will place different priorities on these routes of identification. However, an efficient system should make sure that all these potential sources of referral can rapidly assess the individual's circumstances and move them into the right form of treatment.

There should also be a mechanism within the treatment system that manages each individual's progress through treatment (this is often described as 'case management'), with the aim of successfully reintegrating them into society.

128 Drug Court Clearinghouse and Technical Assistance Project, Drug Courts Program Office, Office of Justice Programs & US Department of Justice (1998): *Looking at a decade of drug courts* (Washington D.C.: US Department of Justice), http://www.ncjrs.gov/html/bja/decade98.htm

129 NHS website: *Drug intervention programme research*, http://www.nta.nhs.uk/areas/criminal_justice/drug_interventions_programme.aspx

130 Greenwald, G. (2009), *CATO Report: Drug decriminalization in Portugal – Lessons for creating fair and successful drug policies* (Washington D.C.: CATO Institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

Methods of drug treatment

The complexity of drug use is such that no one response, setting or intensity of treatment will be appropriate for all dependent drug users. Some countries have developed extensive treatment systems over many decades, while others are just starting to develop experience and understanding of this policy area. However, all countries have some way to go to achieve a sufficiently integrated range of drug dependence treatment services that makes efficient use of available resources to maximise health and social gains.

No one response, setting or intensity of treatment will be appropriate for all dependent drug users.

Responses can be based on substitution treatment, detoxification, psychosocial therapies and mutual aid support groups.

Treatment methods Over the last 60 years a wide range of models and structures for drug dependence treatment have been implemented, tested and evaluated. These can be categorised broadly by method, setting and intensity. Although a number of national and international publications have produced guidelines for drug treatment, these are not exhaustive or universally appropriate. The development of drug treatment systems should combine researching international evidence together with knowledge of what will work most effectively based on each country's history of drug treatment, socio-legal situation, culture, resources and workforce.

Experience and evidence demonstrates that NGOs and civil society groups are important actors in the provision of treatment services to drug dependent people. Their work should be clearly supported and facilitated by government authorities.

Treatment responses can be based on substitution treatment, detoxification, psychosocial therapies, and/or mutual aid support groups.

- **Detoxification** Detoxification is defined by WHO as: (1) the process by which an individual is withdrawn from the effects of a psychoactive substance; (2) as a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimised. The facility in which this takes place may be variously termed a detoxification centre, detox centre or sobering-up station.' Where detoxification involves a prescribing element, the medication given is usually a drug that either mimics or blocks the effect of the drug normally taken by the patient. The dose is calculated so that the patient is neither intoxicated nor does he enter withdrawal, and the dose gradually tapered until the patient is drug free. Normally this is supervised by competent personnel, though the term "self-detoxification" can sometimes be used to denote unassisted recovery from a bout of intoxication or withdrawal symptoms.[131]

131 World Health Organization lexicon of alcohol and drug terms, http://www.who.int/substance_abuse/terminology/who_lexicon/en/

- **Substitution therapy** Substitution therapies for opiates have a significant global evidence base in their favour as the most closely studied of drug dependence treatment responses. They can be defined as: 'The prescription of a substitute drug for which cross-dependence and cross-tolerance exist. A less hazardous form of the drug normally taken by the patient is used to minimise the effects of withdrawal or move the patient from a particular means of administration. The evidence base however suggests that for the most successful outcomes these therapies are delivered in tandem with psychosocial interventions.'[132]

  The success of substitution treatment rests on removing the dependent drug user from a chaotic street lifestyle that involves raising money (usually through crime), buying drugs from dealers, becoming intoxicated and then repeating the process. If they receive a safe dose from medical personnel, this can remove the most risky and anti-social behaviour, and stabilise their lifestyle.

- **Psychosocial interventions** Psychosocial interventions are non-pharmacological interventions (sometimes referred to as 'talking therapies') that aim to impact on the internal drivers for drug use in the individual. They can be brief interventions delivered during one-to-one sessions between a therapist and patient, such as relapse prevention, brief motivational interventions and mapping techniques (where the therapist works with the drug user to identify and counter the situations that lead to their drug use). They can also include more formal interventions, such as motivational interviewing and other motivational enhancement techniques; contingency management (where clients are offered incentives in response to desired behaviour); behavioural couples therapy for patients who have an established relationship and a drug-free partner; family therapy; and mutual aid (self-help) approaches.[133, 134]

- **Mutual aid support groups** As a complement to formal treatment or a standalone option, mutual aid support groups are perhaps the most widespread response to drug dependence. Evidence suggests that participation in these groups, particularly when supporting others, is highly successful.[135] Most research focuses on '12-step' models, such as those used by Narcotics Anonymous and Alcoholics Anonymous. However, other models should also be encouraged that suit a variety of people. The aim is to provide mutual support structures that offer therapeutic benefits for both those offering and receiving support.

132 World Health Organization lexicon of alcohol and drug terms, http://www.who.int/substance_abuse/terminology/who_lexicon/en/

133 National Institute for Health and Clinical Excellence (2007), *Clinical Guideline 51: Psychosocial interventions for substance misuse* (London: NICE), http://guidance.nice.org.uk/CG51/NiceGuidance/pdf/English

134 Department of Health (England) and the devolved administrations (2007), *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. (London: Department of Health in England, the Scottish Government, Welsh Assembly Government and Northern Ireland Executive), http://www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf

135 McIntire, D. (2000), 'How Well Does A.A. Work? An Analysis of Published A.A. Surveys (1968-1996) and Related Analyses/Comments'. *Alcoholism Treatment Quarterly* **18**(4):1–18, http://www.informaworld.com/smpp/content~content=a903283034&db=all ; Toumbourou, J.W., Hamilton, M., U'Ren, A., Stevens-Jones, P., & Storey, G. (2002), 'Narcotics Anonymous participation and changes in substance use and social support'. *Journal of Substance Abuse Treatment* **23**(1):61–66, http://www.journals.elsevierhealth.com/periodicals/sat/article/PIIS074054720200243X/abstract

Treatment setting As well as offering a range of interventions, an effective treatment system will also deliver them in a range of environments. These can be broadly categorised as street, community[136] or residential settings.[137] It is difficult to be prescriptive about which should receive the greater emphasis, as this will vary according to the particular needs of the local drug-using population; the tolerance of communities and the legal system towards visible treatment centres; and the availability of a competent workforce and funding. Whatever the setting, it is important that interventions help dependent drug users access other forms of treatment and care that may or not address their drug use directly, such as housing, education and employment services.

Community settings tend to be most appropriate where there is strong social, family and community support for the dependent drug user. However, it can be better for them to be treated away from their home area when these supports are absent, and they will be susceptible to pressure to return to drug dependence by dealers and associates.

Treatment intensity The intensity of drug treatment refers to the amount, nature and type of intervention delivered over a specified time. The intensity depends on the therapeutic needs of the individual rather than a defined amount based on resource, moral, philosophical or other foundations. In general, research indicates that the more entrenched and severe the level of dependence, the more intensive and long-term the treatment intervention should be. This does create a dilemma for governments, as with limited resources available it is tempting to try to treat the maximum number of people for the minimum cost. This can often lead to low-intensity interventions being offered to severely dependent people. Many countries have been disappointed with the high relapse rates from their treatment programmes. However, this is most likely to be the result of an inappropriate intensity or methodology in the interventions rather than any factor related to the individual.

A cost-effective system

While there is a clear public expenditure case for expanding investment in drug dependence treatment – small investments in treatment can lead to multiple savings in health, social and crime costs[138] – all governments will have limited resources to invest in this area of health and social care. Therefore it is important that resources be carefully prioritised towards those whose behaviour is of most concern. It is also important that the process of getting them into the treatment system, moving them between different aspects of the system as their circumstances change, and reintegrating them

136 Generally, therapeutic communities are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Therapeutic communities differ from other treatment approaches because they use members of the community as treatment staff and those in recovery as key agents of change. These members interact in structured and unstructured ways to influence the attitudes, perceptions and behaviours associated with drug use. Several reports on the effectiveness of therapeutic communities demonstrate that individuals who successfully completed treatment had lower levels of drug use, criminal behaviour and unemployment than they had before treatment. See for example: National Institute on Drug Abuse (2002), *Research report series – Therapeutic communities*, http://www.drugabuse.gov/PDF/RRTherapeutic.pdf

137 National Treatment Agency for Substance Misuse (2006) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*, http://www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf

138 Godfrey, C., Stewart, D. & Gossop, M. (2004), 'Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)'. *Addiction* **99**(6):697–707

into society is managed efficiently. This is why the treatment system promoted in this document consists of a 'menu' of services of different models, settings and intensity. Individuals should be guided through this menu according to their changing needs and circumstances. Many countries have also invested in specific case management systems, where health, social care or criminal justice workers assess the treatment needs of the individual, encourage and motivate them to change, and place them in the most appropriate treatment facility. Where these case management systems are well designed, they have the potential to increase the efficiency and effectiveness of treatment by making sure that the right people are getting the right treatment at the right time.[139]

A reintegration process

Most drug dependent people come from poor and deprived backgrounds. Indeed, emotional, economic and social problems are a key driver of drug dependence. Therefore a crucial objective of treatment, in addition to tackling physical and emotional issues, is to improve each individual's ability to function in society. This means raising their level of education, providing them with access to employment, and finding them living accommodation away from the pressures and temptations to return to drug use. A key element of this process is the development of social and community relationships that mitigate against drug use and offer positive alternatives. Family and community support is important, and in many countries support groups for ex-drug users (such as Narcotics Anonymous) play a key role in maintaining their commitment to a non-dependent lifestyle.

139 Weinstein, S.P., Gottheil, E., Sterling, R.C. & Demaria, P.A. (1993): 'Long-term methadone maintenance treatment: some clinical examples'. *Journal of Substance Abuse Treatment* **10**(3):277–281, http://cat.inist.fr/?aModele=afficheN&cpsidt=4751181

Recommendations

- The primary objective of drug dependence treatment systems is to enable individuals to live positive and constructive lifestyles, no longer being a burden on their families, their community or nation.

- All governments should make a long-term investment in drug dependence treatment in order to respond to drug dependence and reduce associated health and social costs.

- This drug dependence treatment investment should demonstrate a systemic approach rather than a series of isolated interventions: identify those most in need of treatment; offer a balanced menu of services incorporating different models, settings and levels of intensity; and develop smooth mechanisms for individuals to move between different elements as their circumstances change.

- Treatment approaches that breach human rights standards should not be implemented. Not only are these unethical, they are also highly unlikely to achieve the desired aims and are certainly not cost effective.

- It is necessary to constantly review and evaluate national treatment systems to make sure that they are operating effectively and in accordance with global evidence.

Key resources

National Institute on Drug Abuse, National Institutes of Health and US Department of Health and Human Services (2009), *Principles of drug addiction treatment, a research-based guide* (NIDA, 2nd Edition), http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf

United Nations Office on Drugs and Crime & World Health Organization (2008), *Principles of drug dependence treatment*, http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf

World Health Organization (2001), *Management of substance dependence review series – Systematic review of treatment for amphetamine-related disorders* (Geneva: WHO), http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.5.pdf.

World Health Organization (2009), *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence* (Geneva: WHO), http://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf

World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2004), *WHO/UNODC/UNAIDS Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

3.3 Harm reduction

IN THIS SECTION

- Why is it important?
- Harm reduction principles
- A wide range of interventions
- Targeting vulnerable groups
- Recommendations
- Key resources

Key message

A wide range of harm reduction interventions can be developed that are proven to be effective in reducing drug-related health problems and the social marginalisation associated with drug use.

Why is it important?

A broad definition of harm reduction, which applies to all chapters of this guide, was presented in Chapter 1. This chapter specifically focuses on harm reduction as a set of health interventions.

Drug dependence can lead to a number of harmful health consequences, including overdose deaths through acute poisoning, and the transmission of blood-borne infections such as hepatitis B and C and HIV through sharing contaminated drug injection equipment, abscesses, or wound infections.

There are around 16 million injecting drug users worldwide,[140] and it is estimated that up to 10 per cent of all HIV infections occur through injecting drugs.[141] In some countries in the Middle East, North Africa, Central, South and Southeast Asia, and Latin America, the largest share of HIV infections occurs among injecting drug users (IDUs).[142]

Injecting drug use is a factor in at least 10 per cent of all new HIV infections.

Drug overdose is a major cause of early death in European Union countries.

140 Mathers, D.M, *et al.* (2008), 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review', *The Lancet* **372**(9651):1733–1745

141 Aceijas, C., Stimson, G.V., Hickman, M. & Rhodes, T. (2004) 'Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users'. *AIDS* **18**(17):2295–2303, http://www.ncbi.nlm.nih.gov/pubmed/15577542

142 Aceijas, C., Stimson, G.V., Hickman, M. & Rhodes, T. (2004) 'Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users'. *AIDS* **18**(17):2295–2303, http://www.ncbi.nlm.nih.gov/pubmed/15577542

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identified drug overdose as a major cause of mortality in European Union countries.[143] An international study supported by the EMCDDA found that in seven European urban areas, between 10 and 23 per cent of all deaths among those aged 15 to 49 could be attributed to opioid use. Drug-related deaths are, along with traffic accidents, one of the main causes of death among young people.[144] In a 2008 report, the Eurasian Harm Reduction Network suggested that drug overdose prevalence among injecting drug users was between 15 and 33 per cent in Central and Eastern Europe and in Central Asia in 2006 and 2007.[145] Additional studies have shown that 48 per cent of heroin injectors reported at least one non-fatal overdose in their lifetime in San Francisco (USA), while in Sidney (Australia) and London (UK) the proportion reached respectively 68 per cent and 38 per cent.[146]

Efforts to reduce these and other consequences have become known as harm reduction policies and services. Unfortunately, harm reduction has become a controversial concept because it challenges the validity of an approach that unequivocally condemns and stigmatises drug users. However, in terms of effective HIV prevention, the evidence is clear. The UK, Australia and the Netherlands that adopted harm reduction principles and rapidly implemented needle and syringe programmes and opioid substitution therapy in the mid-1980s have experienced noticeably lower rates of the virus. Other countries, including Spain and France, who were slower to adopt these approaches, eventually managed to reduce the high prevalence of infection among injecting drug users. However, other countries, for example the Russian Federation and some governments in Southeast Asia, that have resisted such action, continue to record consistently a high prevalence of HIV among the population.

Many parts of the world have seen an increase in poly-drug use in recent years,[147] and substances such as crack cocaine and methamphetamine are also implicated in patterns of harmful and destructive drug usage. Consequently it is important to recognise that harm reduction principles and practices also apply to non-injecting drug users. There is growing evidence of transmission of HIV and hepatitis C via crack pipes.[148] Harm reduction techniques have been developed to minimise these risks, as well as those of

143 Presentation available for download at: http://www.emcdda.europa.eu/attachements.cfm/att_13402_EN_11%20JV%20Epidemiological%20Situation%20D-R%20Deaths.pdf

144 Bargagli, A.M., et al. (2005), 'Drug-related mortality and its impact on adult mortality in eight European countries'. *European Journal of Public Health* **16**(2):198–202, http://eurpub.oxfordjournals.org/cgi/content/abstract/16/2/198

145 Coffin, P. (2008), *Overdose: a major cause of preventable death in Central and Eastern Europe in Central Asia - Recommendations and overview of the situation in Latvia, Kyrgyzstan, Romania, Russia and Tajikistan* (Vilnius: Eurasian Harm Reduction Network), http://www.harm-reduction.org/library/1344-overdose-a-major-cause-of-preventable-death-in-central-and-eastern-europe-in-central-asia-recommendations-and-overview-of-the-situation-in-latvia-kyrgyzstan-romania-russia-and-tajikistan.html

146 Seal, K.J., Kral, A.H., Gee, L., Moore, L.D., Bluthenthal, R.N,. Lorvick, J., Edlin, B.R. (2001), 'Predicators and preventions of nonfatal overdose among street-recruited injection heroin users in the San Francisco Bay Area, 1998-1999'. *American Journal of Public Health* **91**(11):1842–1846, http://ajph.aphapublications.org/cgi/content/full/91/11/1842?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&titleabstract=predictors+prevention+overdose&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT ; Darke, S., Ross, J. & Hall, W. (1996), 'Overdose among heroin users in Sydney, Australia, I. Prevalence and correlates of non-fatal overdose'. *Addiction* **91**(3):405–411, http://www.ncbi.nlm.nih.gov/pubmed/8867202 ; Powis, B., Strang, J., Griffiths, P., Taylor, C., Williamson, S., Fountain, J. & Gossop, M. (1999), 'Self-reported overdose among injection drug users in London: extent and nature of the problem'. *Addiction* **94**(4): 471-478, http://www.ingentaconnect.com/content/bsc/add/1999/00000094/00000004/art00002.

147 European Monitoring Centre for Drugs and Drug Addiction (2009), *Annual Report 2009*, http://www.emcdda.europa.eu/publications/annual-report/2009

148 Leonard, L., DeRubeis, E., Pelude, L., Medd, E., Birkett, N., Seto, J.: "I inject less as I have easier access to pipes": injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed'. *International Journal of Drug Policy* **19**(3):255–264, http://www.ncbi.nlm.nih.gov/pubmed/18502378

people using methylamphetamine, smoking heroin and so on.[149] These interventions are an important part of the wide range of harm reduction measures that may be required in a country's illegal drug-using environment.

Harm reduction has grown to become the leading public health approach to drug problems in many parts of the world. This chapter uses the International Harm Reduction Association (IHRA) definition of harm reduction principles, and describes how these principles can be applied to the public health challenges of drug-related infections and overdoses. While a broader conception of harm reduction appears in Chapter 1, we are concerned here specifically with harm reduction as a health intervention to tackle the consequences of problematic drug use and the social marginalisation that accompanies it.

According to the IHRA, harm reduction refers to 'policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits drug users, their families and the community'.[150]

Harm reduction is based on the recognition that many people worldwide continue to use illegal drugs despite the strongest efforts to prevent drug supply and demand. Harm reduction accepts that many dependent drug users are unable or unwilling to stop using drugs. Therefore they need to be provided with options that help to minimise the risks from continuing to use drugs, and of harming themselves and others.

Focusing government policies on the reduction of drug-related harms within a specific socio-legal setting, rather than prioritising a rigid zero tolerance for drug *use,* is a pragmatic approach to public health protection. Harm reduction services can be delivered through a variety of sources, including the national healthcare system, rehabilitation centres, local NGOs and civil society organisations. Law enforcement agencies can contribute by identifying and referring dependent drug users to appropriate services (for additional details on the role of law enforcement agencies in harm reduction, see Section 2.2 on effective drug law enforcement).

Harm reduction has grown to become the leading public health approach to drug problems in many parts of the world.

What harm reduction policies offer is a change of focus away from penalising drug users to concentrating on preventing the related harms caused to them, their families and communities. It is important to move away from the polarised debate that pits harm reduction advocates against those who believe that abstinence is the only goal, and focus instead on the most effective ways to integrate

149 Razak, M.H., *et al.* (2003), 'HIV prevalence and risks among injection and noninjection drug users in northern Thailand: need for comprehensive HIV prevention programs'. *Journal of Acquired Immune Deficiency Syndrome* **33**(2):259–66, http://www.ncbi.nlm.nih.gov/pubmed/12794564

150 International Harm Reduction Association: *What is harm reduction? A position statement from the International Harm Reduction Association,* http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf

different services. Effective harm reduction measures need to be fully integrated in national systems for drug dependence treatment, since they are important mechanisms for stabilising the health and lifestyles of dependent users.

Harm reduction principles

- **Evidence and cost-effectiveness** Harm reduction bases its actions on the strongest evidence available. Most interventions are inexpensive, easy to implement and have a high impact on the health of individuals and communities.

- **A hierarchy of goals** Harm reduction services are designed to meet people's needs. Small gains for many people have more benefit for a community than heroic gains achieved for a select few. In addition, people are much more likely to take multiple small steps rather than one or two important ones. The objective of harm reduction in a specific context can often be arranged as a hierarchy, with the more feasible options at one end (which include measures to keep people healthy) and less feasible but desirable options at the other. Abstinence can be considered a difficult but desirable option for harm reduction in this hierarchy. Similarly, it is also important to recognise that many people can achieve healthy and productive lives while receiving OST, and can make valuable contributions to their societies. Keeping dependent drug users alive and preventing irreparable damage is regarded as the most urgent priority. Naturally, not all responses will be universal. For example, countries with a low prevalence of HIV among drug users will not need to focus harm reduction efforts on the prevention of HIV transmission and treatment. Instead they will focus on increasing HIV knowledge and education programmes to make sure that incidence remains low, and preventing other drug-related harms. All governments will have to adapt their strategy to their national situation.

- **Universality of human rights** Human rights apply to everyone. Drug users do not forfeit their human rights, and must be able to enjoy the right to the highest attainable standard of health, as well as to social services, employment, education, freedom from arbitrary detention and so on. Harm reduction opposes the deliberate harms inflicted on drug users and growers in the name of drug control and prevention, and promotes responses to drugs that respect and protect fundamental human rights.

- **Non-discrimination** In many countries drug use is still considered a 'social evil'. Stigma is a key barrier to the delivery of healthcare and harm reduction services to dependent drug users, and more particularly to socially marginalised groups. Healthcare workers are reluctant to provide services to dependent drug users, who they consider as criminals. In turn, the stigma associated with drug use pushes dependent drug users away from healthcare and harm reduction facilities for fear of being arrested or rejected by their families, friends or communities. Decreasing the

stigma associated with illicit drugs plays a crucial role in improving attitudes towards dependent drug users and those living with HIV, and to provide them with non-judgemental services. In addition, dependent drug users need to know that it is not only necessary but also safe for them to access harm reduction services.

- **Participation** One of the core principles of harm reduction is the empowerment of drug users; that is, services that are centred on and driven by them. Too often, drug users are excluded from the design and implementation of decisions that affect them. It is necessary that former and current drug users have a real voice in the creation and implementation of policies and programmes designed to serve them.

A wide range of interventions

The following list, while not exhaustive, is an indication of evidence-based and cost-effective interventions to tackle drug-related harms:

1) **Developing needle and syringe programmes** Perhaps the most recognisable harm reduction intervention offered to injecting drug users is the supply of sterile injecting equipment in order to reduce the spread of HIV and other blood-borne infections. NSPs also aim to prevent skin and soft tissue infections (such as abscesses and cellulites) that usually result from using and sharing injection equipment in unhygienic conditions. These conditions may be prevented by a combination of clean injecting equipment and advice on injecting technique, hygiene and so on. While primarily attracting injecting drug users through the exchange of clean-for-used equipment, NSPs can be useful settings for:

   a) advice on safer injecting practices
   b) advice on how to avoid an overdose
   c) information on safe disposal of injecting equipment
   d) access to blood-borne virus testing, vaccination and treatment services
   e) help to stop injecting drugs, including access to drug treatment (for example, OST) and encouragement to switch to non-injecting methods of drug taking
   f) other health and welfare services (including condom provision).[151]

   The success of these schemes depends on a wide range of factors. These include breadth of coverage; accessibility; the carefully targeted distribution of equipment relevant to patterns of local drug use, be it opiates, amphetamines, or anabolic steroid use;[152] close integration with local government or other authorities responsible for waste disposal;[153] agreements with local law

151 National Institute for Health and Clinical Excellence (2009), *Needle and syringe programmes: providing people who inject drugs with injecting equipment: NICE public Health Guidance 18* (London: NICE), http://www.nice.org.uk/nicemedia/pdf/PH18Guidance.pdf

152 National Institute for Health and Clinical Excellence (2009), *Needle and syringe programmes: providing people who inject drugs with injecting equipment: NICE public Health Guidance 18* (London: NICE), http://www.nice.org.uk/nicemedia/pdf/PH18Guidance.pdf

153 Department for Environment, Food and Rural Affairs (1995), *Tackling Drug Related Litter* (London: HMSO), http://www.defra.gov.uk/environment/quality/local/litter/documents/drugrelatedlitter.pdf

enforcement agencies not to interfere with legitimate use of the exchange;[154] and negotiation and consultation with the wider community.[155] We should also bear in mind that increased prevalence of HIV and hepatitis is associated with crack and methamphetamine use, whether the mode of transmission is by injection, the sharing of pipes or other equipment, or through risky sexual behaviour that can be provoked by stimulant drugs.

2) **Providing safe injection spaces** Some governments, such as Australia, Canada, Spain, Germany and Switzerland, have recently started to establish drug consumption rooms to provide injecting drug users with harm reduction services and prevent deaths by overdose.[156] Drug consumption rooms are supervised and well-equipped facilities where drug users can inject or otherwise consume their drugs without fear of arrest, and where overdoses or other health problems can be dealt with by medically trained staff. These facilities have been controversial, as they involve an explicit tolerance towards possession and use of drugs. Therefore they have been closely scrutinised and researched, with all studies so far indicating that they are effective in reducing overdose incidents and levels of disorder associated with street drug use.

3) **Reducing risks of overdose** Risks of overdose need to be seriously considered when designing harm reduction responses. A gradated response is required, depending on local and national circumstances. Policies should include providing education programmes and materials for dependent drug users and their carers, detailing how to avoid an overdose and actions to take in the event of one; agreements between ambulance and police services, and 'good Samaritan laws'[157] to protect people who report overdoses, so as not to deter them from asking for help for fear of legal consequences; and wide provision of naltrexone to dependent drug users and their families in order to give time to seek medical assistance.

4) **Treating drug dependence** OST is currently the most widely used evidence-based method of treatment for drug dependence. It involves prescribing methadone or buprenorphine; medications to help opiate users minimise or eliminate their use of illicit opiates. Some countries, notably Switzerland, prescribe legal heroin (diamorphine) as a substitute for street heroin. These programmes can reduce the incidence of drug-related harm by moving injecting drug users away from harmful behaviours, such as sharing injecting equipment that increases risks of HIV transmission, and reliance on street drugs. OST has

154 Beaumont, W.J., de Jongh-Wieth, F.E., Slijngard, W.E., Van der Boor, A., Van Kleef, R. & de Wildt, G.R. (6 June 1993), 'Needle exchange for HIV-control in The Hague, Netherlands: an outreach service with IVDU's as intermediaries', *International Conference on AIDS*. **9**: 115 (Abstract n. WS-D12-4), http://gateway.nlm.nih.gov/Meeting-Abstracts/ma?f=102202693.html

155 Downing, M., et al. (2006). 'What's community got to do with it? Implementation models of syringe exchange programs'. *AIDS Education and Prevention* **17**(1):68–78, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1510902/

156 Dagmar, H. (2004), *European report on drug consumption rooms* (EMCDDA), http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf

157 This refers to laws allowing compassionate people with no thoughts of reward to help individuals in need.

been shown to improve adherence to antiretroviral treatment, to be correlated with virological success in antiretroviral treatment patients, and to reduce mortality, including overdose-related mortality.[158] Drug treatment is also an efficient and long-term solution to reducing drug dependence and drug-related crime. Evidence also demonstrates the relative effectiveness of other forms of treatment, such as heroin or amphetamine substitute prescribing[159] and psychosocial therapy, to treat drug dependence. For more information, see Section 3.2 on drug dependence treatment.

5) **Preventing and treating HIV and other sexually transmitted infections** Condoms and sexual health education and services should be made available to problematic drug users, their sexual partners and the overall community. Injecting drug users should be encouraged to use HIV testing and counselling services, not only because they might be at high risk of contracting HIV, but also because, if they are HIV positive, they can receive and respond positively to treatment. These services should work with dependent drug users to assess their likelihood of having been infected; consider the impact of a positive test result; and facilitate their access to relevant treatment and care. This has implications for the long-term health of the individual drug user, but also for the non-drug-using population who are at risk of infection through sexual or other routes of transmission.[160]

6) **Preventing and treating hepatitis B and C** Vaccines for hepatitis B are highly effective and need to be made available to all current and former drug users. There is no vaccine currently available for hepatitis C, which is highly infectious and affects significant numbers of drug users. However, there is treatment for hepatitis C, which should be made available to all drug users.

7) **Preventing and treating tuberculosis** Problematic drug users are particularly at risk of TB in environments where the disease proliferates, such as homeless shelters, prisons, pre-trial detention centres and compulsory drug treatment centres.[161] The widely used TB treatment Rifampin interacts with methadone, accelerating the drug's clearance by the liver. Consequently, those on TB treatment will require an increased dose of methadone to treat their drug dependence otherwise the TB treatment will send them into withdrawal. A harm reduction policy should therefore target TB prevention and treatment programmes at dependent drug users.

158 Roux, P., *et al.* (2009), 'Retention in opioid substitution treatment: a major predictor of long-term virological success for HIV-infected injection drug users receiving antiretroviral treatment'. *Clinical Infectious Diseases* **49**(9):1433–1440, http://www.journals.uchicago.edu/toc/cid/2009/49/9

159 Frick, U., Relm, J., Kovacic, S., Ammam, J. & Uchtenhagen, A (2006), 'A prospective cohort study on orally administered heroin substitution for severely addicted opioid users'. *Addiction* **101**(11):1631–1639, http://www.ncbi.nlm.nih.gov/pubmed/17034443 ; Rosenberg, H., Melville, J. & McLean, P.C. (2001), 'Acceptability and availability of pharmacological interventions for substance misuse by British NHS treatment services'. *Addiction* **97**(1):59–65, http://cat.inist.fr/?aModele=afficheN&cpsidt=13495551

160 World Health Organization, Department of HIV/AIDS, Department of Child and Adolescent Health and Development (2003), *Rapid assessment and response technical guide TG-RAR*, http://www.who.int/docstore/hiv/Core/Index.html

161 Centers for Disease Control and Prevention (1992), *Prevention and control of tuberculosis among homeless persons recommendations of the Advisory Council for the Elimination of Tuberculosis* 41(RR-5); 001 (MMWR), http://www.cdc.gov/mmwr/preview/mmwrhtml/00019922.htm

Targeting vulnerable groups

Some social groups, such as women, young people and minorities, are particularly vulnerable to drug use and its associated harms. Evidence shows that their particular needs should be taken into account in harm reduction programmes that are specifically targeted at them.

Young people Although many young dependent drug users are at risk of drug-related harms – especially in Central and Eastern Europe, Asia and North America – most harm reduction services are only designed to deal with adult drug users. Drug policies should include specific interventions for young people and respect their human rights obligations under the UN Convention on the Rights of the Child. The Convention provides for:

> Some social groups are particularly vulnerable to drug use and its associated harms.

- **Non-discrimination** This includes removing age-related barriers, such as those requiring parental consent or denying confidentiality to minors;[162] removing age restrictions for accessing harm reduction services; and providing sexual and reproductive health services to young people.

- **The best interests of the child** Those most vulnerable and in need of support, such as young dependent drug users and street children, need to be particularly targeted by harm reduction interventions.

- **The right to health** Drug and health education, youth-friendly services and access to healthcare are all essential components to ensure the highest attainable standard of health for young dependent drug users. This includes the possibility of drug treatment as an alternative to detention or forced rehabilitation.

- **Participation** Countries need to involve young people who are most affected, such as young dependent drug users and those living with HIV, in meaningful engagement with drug policy and programme development.

Women Women who inject drugs are highly vulnerable to drug-related harms. A range of factors push women into behaviours that increase their risk of HIV. These factors include punitive policies, discrimination by police and healthcare providers, and a preponderance of harm reduction and treatment programmes that are particularly directed at men. Pregnant injecting drug users are particularly vulnerable to these

162 Statement by Youth Rise: http://www.ihrablog.net/2009/03/youthrise-statement-at-demand-reduction.html

abuses.[163] It is therefore crucial to make sure that all women drug users have access to harm reduction and other health services.

Minority groups Some minority groups, such as indigenous people, Roma, immigrants, refugees, ethnic or racial groups, are particularly affected by social stigma and drug-related harms. Harm reduction policies and programmes should be designed to make sure that they are accessible to a country's minorities. These interventions should be designed as collaborative projects between policy-makers and affected communities. They should be accessible to minorities in their own language, be culturally sensitive, and potentially incorporate traditional practices if desired by the patient.[164]

163 Pinkham, S. & Malinowska-Sempruch, K. (2007), *Women, harm reduction, and HIV* (New York: International Harm Reduction Development Program of the Open Society Institute), http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/women_20070920/women_20070920.pdf

164 Blume, A.W. & Lovato, L.V. (2010), 'Empowering the disempowered: Harm reduction with racial/ethnic minority clients'. *Journal of Clinical Psychology* **66**:1–12

Recommendations

- In order to respond to the spread of blood-borne diseases, accidental overdose and other harms, policy-makers should no longer focus their drug policies on the supply and availability of drugs but primarily on drug-related harms.

- Harm reduction cannot be conceptualised as a standalone service but as an approach to be used whenever drug users come into contact with generic services in health, education, and criminal justice settings.

- Harm reduction policies are part of a hierarchy of goals that aims to empower drug dependent users to improve their health and manage the negative consequences of drug use. Harm reduction services should be comprehensive and integrated in order to allow dependent drug users to access every service they need.

- Responses to drugs should be guided by the specific needs of those most at risk and the social, legal, and economic framework in each country. Partnerships between government authorities and NGOs, including groups representing drug users, are necessary to ensure success.

- Harm reduction programmes need to be specifically targeted at vulnerable groups, such as women, young people and minorities who use drugs, to make sure that they have access to services adapted to their particular needs.

- When embedding harm reduction as part of a national and/or local drug policy, it is necessary to consider the role and function of existing services that are in contact with those at risk of harm, or have the potential to be so; the direct and indirect factors that specifically impact on the local drug-using population; available evidence, and what needs to be gathered in order to convince local communities and opinion-formers of the need to adopt such an approach.

- It is critical that all these harm reduction interventions be extended to prison settings (see section 2.4 on better policies in prison for additional details).

Key resources

Aceijas, C., Stimson, G.V., Hickman, M. & Rhodes, T. (2004) 'Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users'. *AIDS* **18**(17):2295–2303, http://www.ncbi.nlm.nih.gov/pubmed/15577542

Ball, A., Rana, S. & Dehne, K.L. (1998), 'HIV Prevention among Injecting Drug Users: Responses in Developing and Transitional Countries'. *Public Health Reports* 113(1):170–181, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1307739/

International Harm Reduction Association, *What is harm reduction? A position statement from the International Harm Reduction Association,* http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf

Joint United Nations Programme on HIV/AIDS website, *Minimum requirements for effective HIV prevention programming – Know your epidemic and your current response,* http://hivpreventiontoolkit.unaids.org/Knowledge_Epidemic.aspx

National Institute for Health and Clinical Excellence (2007), *Drug Misuse: Psychosocial Interventions, National Clinical Practice Guideline Number 51* (London: British Psychological Society), http://www.nice.org.uk/nicemedia/pdf/CG051NICEguideline2.pdf

Savary, J.F., Hallam, C. & Bewley-Taylor, D. (2009), *Beckley Briefing Paper 18 – The Swiss four pillars policy: An Evolution From Local Experimentation to Federal Law* (The Beckley Foundation), http://www.beckleyfoundation.org/pdf/BriefingPaper_18.pdf

World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2009), *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva: WHO), http://www.who.int/hiv/idu/TechnicalGuideTargetSettingApril08.pdf

World Health Organization, Department of HIV/AIDS, Department of Child and Adolescent Health and Development (2003), Rapid assessment and response technical guide TG-RAR, http://www.who.int/docstore/hiv/Core/Index.html

Chapter 4

Strengthening Communities

4.1 Reducing drug market violence

IN THIS SECTION

- Why is it important?
- Examples of drug-related violence
- The nature of drug markets
- Efforts resulting in an increase in violence
- Successful efforts
- Recommendations
- Key resources

Key message

Law enforcement strategies need to be based on a clear understanding of the structure and dynamics of illegal drug markets. They must focus on reducing the violence associated with drug markets rather than their overall scale, and lessen levels of socio-economic inequality in the areas most affected by them.

Why is it important?

Urban violence is one of the most worrying aspects of the global drug market. Violence is not the only strategy available to those involved with drug markets; other strategies include negotiation, avoidance and tolerance. However, since those in the illicit drug market cannot appeal to legal methods to avoid and settle their disputes, they often engage in violence to protect their reputation, revenues, territory and profits. The extraordinarily high profit margins available to drug traffickers and dealers also provide them with great incentives to take the risks that come with violent behaviour.

Recently, many regions have experienced increased levels of drug market violence. The Caribbean has become the region most affected by lethal violence; murder rates in Jamaica reached 58 per 100,000 inhabitants in 2008.[165] Similarly, Mexico is currently experiencing an explosion of drug market-related violence; in 2008, 6,290 people died due to drug-related violence.[166] In contrast, other Latin American cities have experienced a reduction in murder rates compared to a decade ago. Bogota (Colombia), which used to be the world's most violent city, has

Many regions have experienced increased levels of drug market violence.

165 Braga, A.A., Pierce, G.L., McDevitt, J., Bond, B.J. & Cronon, S. (2008), 'The strategic prevention of gun violence among gang-involved offenders'. *Justice Quarterly* **25**(1):132–162, http://www.informaworld.com/smpp/content~content=a791582506~db=all~jumptype=rss

166 'Mexico Prez hoped to quell drug violence by 2012', *New York Times*, 27 February 2009.

seen its murder rate decline to 21 per 100,000 inhabitants. Similarly, many US cities that experienced spikes in urban violence in the 1990s have seen more recent declines. European cities, despite hosting some of the most lucrative drug markets, are less affected by large-scale urban violence.

Evidence suggests that increases in violence are largely linked to the transit routes of illicit drugs and related drug consumption. Puerto Rico had a very low murder rate until it became a trans-shipment point for drugs en route to the USA. Traffickers paid the local middlemen with drugs, which led to a surge in drug use and violent crime in the 1990s.[167] The same phenomenon is now occurring in West Africa, which has become a new transit area for drugs en route to Europe.

Examples of drug-related violence

There are various stages in the journey of drugs from their cultivation to their consumption, and each is associated with different forms of violence.

Production Violence is usually employed to control the crops used to produce illicit drugs. This includes the use of violence by individuals and groups wanting to protect their crops from seizures or destruction by state authorities or criminal rivals. This practice is commonplace in Colombia, where clashes often occur between farmers and factions of the Revolutionary Armed Forces of Colombia (FARC).[168] Direct forms of violence are also employed in Afghanistan. In 2001 the Taliban severely restricted the production of opium through threats of violence to farmers who grew opium poppy. NATO soldiers are also engaged in ongoing deadly operations to control Afghan opium fields.[169] In other parts of the world, such as Colombia and Brazil, less direct forms of violence include the poisoning of land and displacement of farmers because of aerial fumigation campaigns. These techniques can be devastating for the environment, and polluted lands often cannot be re-used for cultivation.

Crops destined for the illicit market also tend to proliferate in areas affected by conflict. In Colombia coca and poppy are cultivated in areas where both left-wing guerrillas and right-wing paramilitaries fight for territorial control or control of the various stages of the illicit drug industry. They wage war against each other and the local population, which results in massive human rights violations. The violent incursions of the Colombian army add to the stresses on the local population and the abrogation of their human rights.

167 Youngers, C.A. & Rosin, E. (2004), *Drugs and democracy in Latin America: the impact of US policy* (Reinner).

168 Vargas, R. (2005), 'Drugs and Armed Conflict in Colombia'. In Jelsma, M., Kramer, T. & Vervest P. (Eds.), *Trouble in the Triangle: Opium and Conflict in Burma* (Silkworm Books).

169 Farrell, G. & Thorne, J. (2005), 'Where have all the flowers gone? Evaluation of the Taliban crackdown against opium poppy cultivation in Afghanistan'. *International journal of Drug Policy* **16**(2):81–91, http://www-staff.lboro.ac.uk/~ssgf/PDFs/AfghanTalibanOpium.pdf

Trafficking Significant levels of violence are associated with drug trafficking en route to Europe and the USA, especially in Central America and the Caribbean. Mexico is particularly affected by drug-related violence because of intense conflict between heavily armed trafficking gangs and with state authorities, especially since the Calderon government launched its war on drugs. In 2003, following the imprisonment of several leaders of the Gulf cartel, the Sinaloa cartel aggressively attempted to seize control of their lucrative smuggling routes. The conflict unleashed an upsurge of violence in border cities, while official responses were largely undermined by high levels of corruption in the Mexican law enforcement mechanism.

Recently, tough law enforcement in the Caribbean has forced drug traffickers to find alternative trade routes. Drugs trafficked into Europe are now shipped via West Africa, which is currently experiencing an increase in drug use and drug-related violence. This is a result of the so-called 'balloon effect', explained in Section 2.2 on effective drug law enforcement.

Retail markets High levels of violence and intimidation are associated with street-level dealing. However, retail markets are not necessarily and continually violent, and co-operative relations are sometimes developed between street drug dealers. The level of violence in drug retail markets tends to depend on the nature and structure of the markets themselves and the context in which they develop.

The nature of drug markets

Several factors influence the levels of violence associated with drug markets:

- **The degree to which the wholesale drug trade has infiltrated the institutional structure of a city** Cities in Latin America and the Caribbean, where drug markets have become entwined with competition between local businesses, bureaucracies and politicians, are highly vulnerable to violence.

- **The type of retail drug market** Open-air, street-based drug markets tend to be violent, as dealers compete for cash, customers, territory and reputation. By contrast, delivery-style markets are associated with lower levels of violence, as dealers consciously avoid violence in order not to attract the attention of rivals and the police. Even though the overall prevalence of drug use in the two types of drug markets is usually comparable, hidden markets avoid some of the negative effects of open street dealing, with its implications for community safety, neighbourhood reputations and motivations for young men to aspire to criminal lifestyles. Delivery-style markets are also more mobile, with dealers often switching delivery points to avoid the police and rival dealers. This means that the reduction in violence is accompanied by a reduction in the spatial concentration of drug market-related problems in poor neighbourhoods.

- **Socio-economic conditions** Cities and neighbourhoods that are socio-economically at risk, suffering from lack of employment opportunities or urban segregation, are most vulnerable to drug markets and violence. Deprivation also causes low community cohesion, reducing the potential for informal social control of drug use and violence.

- **State violence** When law enforcement agencies increase the intensity of their operations against drug markets, rates of urban violence can soar, as experienced in Thailand in 2003 (see below)[170] and is happening in Mexico and Brazil.

- **The availability of firearms** Drug markets flooded with automatic and semi-automatic weapons, as in Mexico, are naturally more lethally violent than other markets. Once guns are introduced into a drug market, it is exceptionally difficult to eliminate them. This provides an incentive both to prevent the development of violent drug markets and to limit the availability of firearms among the general population.

Efforts resulting in an increase in violence

In some cases the state can become one of the main sources of drug market violence. Even if we leave aside those countries that still use the death penalty for drug offences, there are others (including at various times Thailand, Mexico and Brazil) where drug control policies have led to high levels of urban violence.

In some cases the state can become one of the main sources of drug market violence.

In the 1980s Brazil was an important drug route in Latin America. There was an exponential growth in cocaine use in the large cities, especially in the slums of Rio de Janeiro, together with an intense expansion of the cocaine trade and the arrival of the first arms used in the drug market.

Young people living in Rio *favelas* saw the leisure activities offered by drug traffickers as a rare opportunity for the entertainment they were lacking. The traffickers established close relations with local children and young people, first asking for ordinary small favours (get food, water, coffee) in exchange for money. Then they recruited them with compelling arguments – weapons, power, women, drugs and some measure of change – symbolically transforming their authoritarianism into an alternative to state neglect.

In the 1990s heavy-calibre weapons could be found throughout Rio de Janeiro. Processes of 'de-territorialisation' began. Outsider groups, without links with local communities, invaded and took control of enemy territories and their drug businesses, instigating an arms race between these groups and between them and the police. In

170 Cohen, J. (2004), 'Not enough graves: the war on drugs, HIV/AIDS, and violations of human rights', *Human Rights Watch* **16**(8): 1–58, http://www.hrw.org/en/node/12005/section/2

1998 the police were encouraged by a productivity bonus – the 'Western Bonus' – to execute traffickers. By the late 1990s Rio had hundreds of slums under the territorial control of armed youth working in the drugs business.

Between 2001 and 2008, confrontations between drug traffickers and the police resulted in the (official) killings of 7,542 civilians and 200 police officers in Rio de Janeiro.

When the crack epidemic started in the 2000s, Rio experienced the arrival of young, fearless, heavily armed, de-territorialised and disorganised drug retailers.[171] The intensification of their confrontation with the police, and the police use of armoured vehicles, prompted traffickers to buy weapons with increasing destructive power. This rapidly escalated an arms race between traffickers and the police, and with it higher levels of violence. Between 2001 and 2008, confrontations between drug traffickers and the police resulted in the (official) killings of 7,542 civilians and 220 police officers.[172] Currently, Rio de Janeiro is the Brazilian state with the highest death rate (46 per 100,000 inhabitants) from firearms.

Well-intentioned policies and law enforcement strategies that aim to control drug markets and their associated violence can have an opposite effect. The challenge for policy-makers is to design law enforcement strategies that reverse this trend and create an incentive for drug dealers to avoid the worst aspects of violence, intimidation and corruption.

Successful efforts

The three following examples highlight how law enforcement efforts can successfully shape the illegal drug market in order to reduce its associated violence.

In New York City (USA), drug sales used to be centred on fixed distribution points, such as houses or flats in deprived neighbourhoods. The dominant policing model consisted of filling prisons with low-level dealers, and little attention was given to the gangs' ability to keep selling drugs. These interventions gave way to intelligence-led operations, involving lengthy surveillance, which enabled the police to arrest entire supply chains at once. When the main players in the drug market realised the dangers of being connected to the street level, and that operating from fixed locations exposed them to sustained surveillance, the market became more fluid. Wholesale drug suppliers therefore started to outsource retail distribution to freelance drug dealers. These dealers could not afford to pay for enforcers, and so they had to secure access to lucrative selling locations relying on their reputation for violence. This led to waves of violence in the city. Following these attacks, the gentrification of many drug-selling

171 It is believed that the PCC (First Command of the Capital, a drug dealing faction from São Paulo) is imposing the crack trade to the Red Command (this faction, from Rio de Janeiro) as a precondition to the supply of cocaine. The police of both states are categorical in stating that the crack that is marketed in Rio de Janeiro comes from Sao Paulo. See: Kawaguti, L. (18/10/2009), 'Facção impõem droga a traficantes do Rio', *Jornal São Paulo Agora*, http://www.agora.uol.com.br/saopaulo/ult10103u639581.shtml.

172 Rodrigues, R. I. & Rivero, P. (2009), *Segregação territorial e violência no Município do Rio de Janeiro* (Rio de Janeiro: IPEA), http://www.ipea.gov.br: there is a coincidence between areas of concentration of homes belonging to victims of violence, and the places where criminality and police repressive actions are concentrated.

The most successful example of reduction in urban violence is that of the 'Boston miracle'.

areas, combined with intensive policing, pressured the market again to take a new shape. The wider availability of pagers and mobile phones enabled the drug market to move indoors to a model of ordered deliveries. This involves an individual or partnership providing the capital to buy the drugs wholesale. The drugs are then distributed through a small team of couriers, directed by dispatchers. Under this model, labour relations are less aggressive than in other drug market models, and violence is avoided, since the delivery teams are only able to operate in the absence of police attention.[173]

In London (UK) the crack market has recently started to follow the New York pattern of becoming more closed, with less crack dealing from fixed locations, and dealers preferring to sell only to people whom they already know. The capacity of treatment agencies has expanded rapidly, and the criminal justice system has been used to encourage dependent crack users to enter treatment. The police also started to close premises used as crack houses. Various community initiatives were developed, combining community development with youth work and drug treatment. Between 2002 and 2007, the number of murders in London fell by 10 per cent and the number of recorded firearms offences fell by 14 per cent.[174]

The most successful example of reduction in urban violence is that of the 'Boston Miracle' (see Section 2.2 on effective drug law enforcement). The 'gang forums', involving police officers, gang offenders, church ministers and social workers, as well as interventions to prevent weapons trafficking, had a significant impact on youth murder rates. Although the drug market was not significantly reduced in scale, the associated violence was brought under control.[175]

173 Stevens, A. & Bewley-Taylor, D., contributions from Dreyfus, P. (2009), *Report 15 – Drug markets and urban violence: Can tackling one reduce the other?* (Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_15.pdf

174 Povey, D., Coleman, K., Kaiza, P., Hoare, J. &Jansson, K. (2007), *Homicides, forearm offences and intimate violence 2006/07. 3rd edition (Supplementary Volume 2 to Crome in England and Wales 2006/07)* (London: Home Office).

175 Braga A.A. (2008), 'Pulling levers focused deterrence strategies and the prevention of gun humocide', *Journal of Criminal Justice*, Vol.36, No.4, pp.332-343; Braga A.A., Kennedy D.M., Waring E.J. & Piehl A.M. (2001), 'Problem-oriented policing, deterrence, and youth violence: An evaluation of Boston's Operation Ceasefire', *Journal of Research in Crime and Delinquency*, Vol.38, No.3, pp.195-225; McGarrell E.F., Chermak S, Wilson J.A. & Corsaro N. (2006), 'Reducing homicide through a "level-pulling" strategy', *Justice Quarterly*, Vol.23, No.2, pp.385-413.

Recommendations

- Law enforcement efforts need to focus more on reducing the violence associated with the illicit market rather than attempting to win a battle with drug dealers.

- Drug enforcement strategies must be based on a clear understanding of the structure and dynamics of specific illicit drug markets. Which drugs are more popular? What form does the market take? Is violence in the locality directly related to the drug market? Who is most likely to participate in and suffer from the drug market?

- Where compromised by corruption, law enforcement agencies and criminal justice systems need to be overhauled. Reforms are needed to generate an environment suitable for implementing policies aimed at reducing drug-related urban violence. These should include higher salaries, and better oversight and control mechanisms to root out corruption and prosecute those who engage in it.

- Law enforcement agencies should always stay within the frame of the rule of law when intervening in drug markets.

- Efforts should be made to reduce the availability of firearms in cities affected by drug markets. This involves tighter regulation of the registration of firearms, campaigns to encourage the handing in of illegally held weapons (such as firearms amnesties), and other measures that make it harder for organised criminal groups to acquire weapons.

- It is necessary to reduce the levels of socio-economic disadvantage and inequality in cities, especially those most affected by drug markets.

Key resources

Braga, A.A., Kennedy, D.M., Waring, E.J. & Piehl, A.M. (2001), 'Problem-oriented policing, deterrence, and youth violence: An evaluation of Boston's Operation Ceasefire'. *Journal of Research in Crime and Delinquency* **38**(3):195–225, http://www.hks.harvard.edu/criminaljustice/publications/bgp_evaluation.pdf

Braga, A.A., Pierce, G.L., McDevitt, J., Bond, B.J. & Cronon, S. (2008), 'The strategic prevention of gun violence among gang-involved offenders'. *Justice Quarterly* **25**(1):132–162, http://www.informaworld.com/smpp/content~content=a791582506~db=all~jumptype=rss

Stevens, A., Bewley-Taylor, D., with contributions from Dreyfus P (2009), *Beckley Report 15 – Drug markets and urban violence: Can tackling one reduce the other?* (Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_15.pdf

United Nations Office on Drugs and Crime (2009), *World Drug Report,* www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf

Wilson, L. & Stevens, A. (2008), *Beckley Report 14 – Understanding drug markets and how to influence them*, (Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_14.pdf

4.2 Promoting alternative livelihoods [176]

IN THIS SECTION:

- Why is it important?
- A counter-productive approach
- Promoting development in a drugs environment
- The example of Thailand
- Recommendations
- Key resources

Key message

Crop eradication is a costly initiative that impacts particularly negatively on poor and marginalised farmers. Evidence shows that an alternative livelihoods approach, which entails a comprehensive development strategy designed to improve the overall quality of life of peasant producers, can successfully reduce the cultivation of crops destined for the illicit drug market.

Why is it important?

Reducing and eventually eliminating crops used in the production of illicit drugs is a central component of supply-side drug control policies. The South American countries of Colombia, Peru and Bolivia are the primary source of coca, the raw material for cocaine. By contrast, the geographical base for cultivating poppy, the raw material for opium and heroin, has shifted. The Golden Triangle of Thailand, Laos, and Burma once produced more than 70 per cent of the world's opium supply, most of which was refined into heroin. Today, according to the UNODC, those countries produce only about 5 per cent of the world total. Poppy cultivation and opium production are now concentrated in what is known as the Golden Crescent, the poppy-growing areas in and around Afghanistan.

Determining how much coca and poppy is cultivated today remains elusive. Differences in the US government and UNODC statistics provide ample evidence of the degree of uncertainty in the measurements. According to the US government, coca cultivation has remained relatively constant over the last two decades in the Andean region at

176 This section of the guide is based in part on the following report: Youngers, C.A. & Walsh, J.M. (2009), *Development First: A More Humane and Promising Approach to Reducing Cultivation of Crops for Illicit Markets* (the Washington Office on Latin America), http://www.wola.org/media/Drug%20Policy/WOLA%20Development%20First%20--%20FINAL%20TEXT.pdf

approximately 200,000 hectares (although as a result of the 'balloon effect' (see Section 2,2 on effective drug law enforcement), there have been significant shifts in the amount grown in each country). By contrast, the UNODC reports a decrease. However, the development of higher-yield crops that can be planted at greater density levels mainly explains this reduction, which means that more cocaine can be produced from smaller plots of coca.

Not all cultivation is destined for the illicit drug market. Indigenous people have consumed these plants for centuries.

The UNODC reports a similar trend with regard to poppy cultivation and opium production. Between 1994 and 2007, worldwide poppy cultivation decreased slightly, from 272,479 to 235,700 hectares. However, over that same period, potential opium production increased from 5,620 to 8,890 tons. For the second year in a row, from 2008 to 2009, poppy cultivation in Afghanistan declined significantly. However, the 22 per cent decline resulted in only a 10 per cent decrease in opium production, as farmers extracted more opium per bulb.

Alternative sources of income must be put in place before the growers' primary source of cash income is eliminated.

Efforts to reduce cultivation include forced crop eradication and economic development to provide alternative sources of income to farmers dependent on coca and poppy cultivation. In most cases these strategies are carried out simultaneously. However, a growing number of experts and officials believe that forced eradication does more harm than good, and that for crop reductions to be maintained, alternative sources of income must be put in place before the farmers' primary source of cash income is eliminated. This approach was successfully implemented in Thailand. In Latin America, the Bolivian government is also allowing limited coca production while a variety of economic development programmes are implemented.

Not all cultivation is destined for the illicit market. Andean peoples have consumed the coca leaf for centuries, and coca chewing is an integral part of religious and other ceremonies. Opium has long been used in Asia for the same purposes. Chewing or drinking coca tea has beneficial attributes, such as helping to alleviate the symptoms of high altitudes, cold and hunger. Coca consumption is spreading to new geographic areas and among the middle classes. However, the current drug control system prohibits traditional uses of plants that are also destined for the production of illicit drugs (see Section 4.3 on protecting the rights of indigenous people).

Two reasons for rethinking crop eradication policies stand out. First, many experts believe that targeting coca and poppy plants is the least cost-effective approach,[177] as the retail price of crops is such a trivial share of the retail price of drugs on the world market. Second, poor and marginalised farmers bear the brunt of the negative impact of the present policy.[178] Small farmers involved in coca and poppy production do so for lack of viable economic alternatives. Only when they are provided with alternative livelihoods will they be able to reduce their dependence on income from coca and poppy crops.

Targeting the eradication of coca and poppy plants is not cost effective.

Poor and marginalised farmers bear the brunt of the negative impact of the present policy.

A counter-productive approach

Forced eradication can stimulate production and feed the cycles of poverty, violence and forced migration (within and outside Andean countries) seen in drug-producing regions. Indeed, an apparently 'successful' eradication can create perverse incentives to further stimulate production, compromising long-term sustainability with short-term gains. Price incentives counter the impact of eradication. If successful in the short-term, eradication drives up farm-gate prices, making it more lucrative for farmers to continue cultivation and encouraging newcomers to the market.

In some parts of the world such as Colombia and Brazil, aerial fumigation campaigns have led to the poisoning and/or displacement of farmers. These techniques can be devastating for the environment because polluted lands become unfit for cultivation. Eradication also tends to disperse crops to new and more inaccessible areas. In the Andean countries, forced manual and aerial eradication programmes spread coca and poppy production to new regions, including national parks, resulting in even greater damage to fragile local eco-systems.[179] This makes cultivation more difficult to detect and eliminate, and spreads the problems associated with these crops to new areas.

Forced eradication also increases opportunities for corruption and bolsters criminal networks. In addition, it enhances the revenue base of irregular forces that take advantage of, or depend on, the income generated by the illicit drug trade. In Afghanistan, crop eradication efforts and strict implementation of opium bans have contributed to an increase in poppy production in provinces with high levels of conflict and a significant Taliban presence. This has bolstered rather than depleted their funding base. It also stimulates corruption and undermines the rule of law, as government forces in these areas tend to profit from the illicit trade.

177 Moore, M. (2008), "Struggling for Solutions As Opium Trade Blossoms," *The Washington Post*, 21 March 2008, http://www.washingtonpost.com/wp-dyn/content/article/2008/03/20/AR2008032003456.html

178 Youngers, C.A. & Walsh, J.M. (2009), *Development First: A More Humane and Promising Approach to Reducing Cultivation of Crops for Illicit Markets* (the Washington Office on Latin America), http://www.wola.org/media/Drug%20Policy/WOLA%20Development%20First%20--%20FINAL%20TEXT.pdf

179 Democracy and Global Transformation Project & Transnational Institute (2007), *Hablan los Diablos: Amazonía, Coca y Narcotráfico en el Perú* (Lima, Peru).

In short, forced eradication fuels conflict. Security forces carrying out crop eradication or combating insurgents are often the only state presence in these areas, where public services and infrastructure are non-existent or woefully inadequate. These conditions, together with the violence and the human rights abuses that often accompany eradication, alienate the local population and further undermine the legitimacy of the state. In turn, this can boost political support for the insurgents.

Forced eradication also undermines the co-operation with the local community that is needed to carry out effective development programmes. It causes distrust between donors, state agencies and recipient communities, and undermines the very development efforts needed to wean poor farmers off illicit crop production. Forced eradication in Bolivia, prior to a 2004 agreement between the government and coca growers, led to protests, violent confrontations and attacks on alternative development installations. This occurred in part because alternative development assistance was conditioned on the eradication of all coca, which left families with no income. In 2008 Chapare coca growers announced that they would not sign any further agreements with the US Agency for International Development for alternative development projects. In all three coca-producing Andean countries, the US sub-contractors that carry out alternative development projects are viewed with suspicion and distrust by the local community.

As farmers involved in coca and poppy cultivation tend to be marginalised and vulnerable, implementing forced eradication programmes before providing alternative sustainable livelihoods pushes them deeper into poverty. The abrupt cut-off in income can impact negatively on the health and nutrition of those affected. Families may be forced to migrate and children may be taken out of school in order to supplement the household income, creating greater difficulties for escaping poverty in the future.

Promoting development in a drugs environment

Alternative livelihoods programmes are intended to provide legal and economic opportunities to farmers cultivating coca and poppy crops in order to reduce their dependence on the cash income these generate. The concept evolved over time from a simple focus on crop substitution to an alternative development approach, carried out in most countries with a combination of rural development and law enforcement efforts. An alternative livelihoods approach – a more comprehensive development strategy now promoted by some international donors – is designed to improve the overall quality of life of peasant producers. This includes improved access to healthcare, education and housing; the development of infrastructure and other public services; and income generation, such as the industrialisation of agricultural produce and off-farm employment opportunities.[180]

180 Mansfield D. (2006), *Development in a Drugs Environment: A Strategic Approach to 'Alternative Development'*, Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ).

This approach calls for the incorporation, or mainstreaming, of alternative development programmes into comprehensive rural development and economic growth strategies. Specifically, it calls for embedding coca and poppy crop reduction strategies in local, regional and national development initiatives. It will only be possible to successfully reduce or eliminate the cultivation of crops destined for the illicit market once the overall quality of life and income of the local population has been improved. In areas where poppy farmers receive advances from traffickers to buy poppy seeds, farmers need to be offered the same advantages to enable them switch from illegal to legal crops. At that point, crop reduction should be voluntary, in collaboration with the local community. This approach means seeing coca or poppy growers not as criminals but as partners in promoting development. [181]

Nation-building and promoting good governance and the rule of law are also essential components of an alternative livelihoods approach. These are particularly necessary to foster the legitimacy and credibility of the government in areas where state presence is often limited to security and/or eradication forces. A growing body of academic literature now points to the absence of violent conflict as a pre-condition for sustainable development and drug control efforts.

An alternative livelihoods approach is a comprehensive development strategy designed to improve the overall quality of life of peasant producers. The approach means seeing growers not as criminals but as partners in promoting development.

Despite increasing acceptance of an alternative livelihoods approach, this has rarely been implemented in practice. Thailand is considered to have most successfully implemented this model. The country succeeded in virtually eliminating opium poppy cultivation as a result of comprehensive and participatory economic development and nation-building efforts sustained over 30-year period.

The example of Thailand[182]

Beginning in 1969, the Thai government sought to integrate highland communities into national life and later developed and carried out sustained economic development activities over a 30-year period. Over time, it became clear that agricultural alternatives alone were insufficient. As a result, increasing emphasis was put on providing social services such as health clinics and schools, as well as infrastructure development such as roads, electricity and water supplies. Alternative development programmes were integrated into local, regional and national development plans. This led to steady improvement in farmers' quality

181 EU Presidency Paper (2008), *Key points identified by EU experts to be included in the conclusion of the open-ended intergovernmental expert working group on international cooperation on the eradication of illicit drug and on alternative development,* Presented to the open-ended intergovernmental working group on international cooperation on the eradication of illicit drug crops and on alternative development (2-4 July 2008).

182 Youngers, C.A. & Walsh, J.M. (2009), *Development First: A More Humane and Promising Approach to Reducing Cultivation of Crops for Illicit Markets* (the Washington Office on Latin America), http://www.wola.org/media/Drug%20Policy/WOLA%20Development%20First%20--%20FINAL%20TEXT.pdf ; Renard, R.D. (2001), *Opium Reduction in Thailand 1970 – 2000, A Thirty Year Journey* (United Nationals International Drug Control Program, Regional Center for East Asia and the Pacific).

of life, and increased opportunities for off-farm employment. For example, according to the United Nations Development Programme, the development of flowers as an alternative to poppy cultivation ultimately resulted in a fifty-fold increase in profits for local producers.

The Thai approach evolved over time. Initially, international donors defined the strategy with little participation from the local communities or even the Thai government. The second phase fully involved the Thai government (with the King's public backing, which was politically significant). Eventually, a focus on local community participation emerged.

The Thai experience underscores the importance of local institution-building and community involvement in the design, implementation, monitoring and evaluation of development efforts. Community-based organisations, such as women's and youth groups and rice banks, were important in ensuring a successful outcome. Local know-how became the basis for problem-solving, and local leadership was fully integrated into project implementation.

The Thai experience underscores the importance of local institution-building; of community buy-in and involvement in the design, implementation, monitoring and evaluation of development efforts; and of proper sequencing.

The Thai experience also points to the importance of proper sequencing. Only in 1984, after about 15 years of sustained economic development, did crop reduction efforts get underway. While some forced eradication did take place initially, proper sequencing allowed peasants to reduce poppy production gradually as other sources of income developed, avoiding the problem of re-planting that inevitably frustrates crop eradication efforts. The entire process took about 30 years. Yet, the results of the Thai strategy have proved sustainable, as only very small pockets of poppy cultivation now persist. However, on the negative side, there has been an increase in methylamphetamine use in the region since the 1990s.[183]

Some caution is advised about how far the Thai model can be replicated elsewhere. First, in Thailand farmers grew poppy in fertile areas where other crops could easily be produced. This benefited the development effort, but these circumstances are not always available in other regions of the world. Second, steady economic growth in the 1980s and 1990s allowed for government investments in infrastructure and other programmes. Third, there was a strong relationship between local demand and production. Much of the opium produced was consumed locally, so demand reduction programmes could work in tandem with alternative livelihoods efforts, meaning that both demand and production declined together. Although these particular factors may make it difficult to replicate the Thai experience in other regions, nevertheless the example provides useful guidelines for thinking about and designing alternative livelihoods strategies in other parts of the world.

183 Advisory Council on the Misuse of Drugs (2005), *Methylamphetamine review* (UK), http://drugs.homeoffice.gov.uk/publication-search/acmd/ACMD-meth-report-November-20052835.pdf?view=Binary

Recommendations

- Decades of experience in promoting alternative development show that reducing the cultivation of coca and poppy crops is a long-term problem that needs a long-term solution. Ultimately, success depends on the achievement of broader nation-building and development goals. Government strategies need to be based on promoting economic growth and providing basic services; democratic institution-building and the rule of law; respect for human rights; and improved security in the impoverished rural areas where coca and poppy cultivation flourishes.

- Crop reduction efforts should be mainstreamed into development efforts. The potential impact of development policies and programmes on the cultivation of coca and poppy crops should be taken into account, and steps taken to maximise positive impacts and minimise negative ones. A range of ministries and agencies, as well as civil society groups, should be involved to promote development in a drugs environment.

- Proper sequencing is essential. Alternative, sustainable livelihoods and improved quality of life must be achieved before eradication.[184] A 2008 UNODC Secretariat document recommends that member states 'ensure that eradication is not undertaken until small-farmer households have adopted viable and sustainable livelihoods and that interventions are properly sequenced'. An alternative livelihoods approach also incorporates the concept of 'preventive alternative development'[185] in areas that could be conducive to producing crops for the illicit market.

- Economic assistance should not be conditioned on meeting prior crop reduction targets. It is clear that forced eradication or demanding the elimination of crops before providing economic assistance may be successful in the short term. However, over the medium to long term, farmers replant to secure income or move into new areas where it is easier to avoid detection. With proper sequencing, farmers are more likely to collaborate with efforts to reduce the cultivation of coca and poppy. Once economic development efforts are well underway and bearing fruit, governments can work with local communities to encourage reduction, and in some cases elimination, of crops destined for the illicit market.

184 United Nations Office on Drugs and Crime (2005), *Alternative development: A global thematic evaluation* (Vienna: UNODC), http://www.unodc.org/pdf/Alternative_Development_Evaluation_Dec-05.pdf; World Bank (2005), *Afghanistan: State building, sustaining growth and reducing poverty*, *http://siteresources.worldbank.org/INTAFGHANISTAN/Resources/0821360957_Afghanistan–State_Building.pdf*; United Nations Office on Drugs and Crime Secretariat's Report (2008), *Results attained by member states in achieving the goals and targets set at the twentieth special session of the General Assembly, the limitations and problem encountered and the way forward; international cooperation on the eradication of illicit drug crops and on alternative development*, Presented to the open-ended intergovernmental working group on international cooperation on the eradication of illicit drug crops and on alternative development (2-4 July 2008).

185 Preventive alternative development refers to a strategy based on socio-economic development and environmental conservation as a means to prevent the displacement of illicit crops to other areas and reduce the increase of illicit drug production: Commission on Narcotic Drugs (8 December 2005 and 13-17 March 2006), *Report of the forty-ninth session* (ECOSOC, Official Records, 2006, Supplement No.8), http://daccess-dds-ny.un.org/doc/UNDOC/GEN/V06/526/23/PDF/V0652623.pdf?OpenElement

- Local communities must be intimately involved in the design, implementation, monitoring and evaluation of development efforts. This includes community leadership, local organisations such as producer groups and the farmers themselves. Meaningful community participation is the cornerstone of any effective development programme. A 2002 international conference on alternative development, hosted by the German government, concluded that a participatory approach means more than consultation, it requires serious dialogue in which communities are given substantial leeway for negotiation.[186] Subsequent UN reports have also underscored the importance of community involvement in such efforts.

- Results should not be measured in terms of hectares of crops eradicated. Rather, programmes should be evaluated using human development and socio-economic indicators – indicators that measure the well-being of society.[187]

186 Documentation on the Feldafing Conference is available at: http://www.gtz.de/de/dokumente/en-alternative-development.pdf

187 The UNODC refers to 'a mix of impact indicators [that] include measuring improvements in education, health, employment, the environment, gender-related issues, institution-building, and governmental capacity', in the following document: 'UNODC's Executive Director's Report on the *action plan on international cooperation on the eradication of illicit drug crops and on alternative development*', presented at the 51st session of the Commission on Narcotic Drugs in March 2008, E/CN.7/2008/2/Add.2, 17 December 2007, p. 20.

Key resources

Kramer, T., Jelsma, M. & Blickman, T. (2009), *Withdrawal Symptoms in the Golden Triangle: A Drugs Market in Disarray* (The Transnational Institute), http://www.tni.org/report/withdrawal-symptoms-golden-triangle-4

Mansfield, D. (2006), *Development in a Drugs Environment: A Strategic Approach to 'Alternative Development'*, Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ).

Renard, R.D. (2001), *Opium Reduction in Thailand 1970 – 2000, A Thirty Year Journey* (United Nationals International Drug Control Program, Regional Center for East Asia and the Pacific).

United Nations Office on Drugs and Crime (2005), *Thematic Evaluation of UNODC's Alternative Development Initiatives* (the Independent Evaluation Unit),
http://www.unodc.org/documents/evaluation/2005-alternativedevelopment.pdf

Youngers, C.A. & Walsh, J.M. (2009), *Development First: A More Humane and Promising Approach to Reducing Cultivation of Crops for Illicit Markets* (the Washington Office on Latin America),
http://www.wola.org/media/Drug%20Policy/WOLA%20Development%20First%20--%20FINAL%20TEXT.pdf

4.3 Protecting the rights of indigenous people

IN THIS SECTION

Key message

Many aspects of current drug policy, including the blanket prohibition of the traditional use of certain plants or crop eradication campaigns, violate indigenous peoples' rights that are enshrined in United Nations agreements.

Why is it important?

For generations, many people worldwide have used plants for traditional and cultural purposes that have been banned by the UN drug conventions. In Latin America the coca leaf has long had a wide application in social, religious and medical areas for indigenous people, and is now used by the general population. Similarly, in India cannabis and opium have for centuries been bound to faith and mysticism in Hindu and Islamic traditions. These substances have also been employed medicinally for thousands of years, especially for the treatment of rheumatism, migraine, malaria, cholera and to facilitate surgery. The plants also provide food grain, oil seed and fibre for manufacturing products in India. However, the UN drug conventions classify these plants as harmful and subject to global control of production, distribution and use. The 1988 UN drug convention recognises that plants internationally deemed harmful do have some traditional purposes, and provides that measures aiming at crop eradication and demand should 'take due account of traditional licit use, where there is historic evidence of such use' (article 14, para. 2). However, in practice, governments who have focused on forced eradication and the punishment of all drug users tend to disregard this article.

The 1989 Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries[188] stipulates that peoples are 'regarded as indigenous on account of their descent from the populations which inhabited the country at the time of conquest, colonisation, or the establishment of present state boundaries and who, irrespective of their legal status, retain some, or all, of their own social, economic, cultural and political institutions'.

188 The Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries was adopted in 1989 by the International Labour Organisation, http://www.un-documents.net/c169.htm

In addition to universal human rights recognised in international conventions, indigenous people enjoy certain specific rights that protect their identity and defend their right to maintain their own culture, traditions, habitat, language and access to ancestral lands.

UN bodies such as the United Nations Economic and Social Council or the Human Rights Council, have made significant progress in promoting, protecting and consolidating indigenous peoples' rights and freedoms. Several declarations and conventions, signed and ratified by most governments, now endorse these achievements The 2007 Universal Declaration on the Rights of Indigenous Peoples recognises indigenous peoples' right to self-determination and autonomy; the right to maintain, protect and develop cultural manifestations of the past, present and future (article 11); the right to maintain their traditional medicines and healing practices (article 24); and the right to maintain control, protect and develop their cultural heritage, traditional knowledge and manifestations of their science, technology and culture (article 31).[189] The declaration is not binding under international law, but represents an important advance in the recognition of indigenous rights. It also provides governments with a comprehensive code of good practice that hopefully will become fully recognised by every state in the future.

Forced eradication

The supply-control drug policies aimed at eliminating the raw material destined for illicit drugs disproportionately impacts on vulnerable groups and marginalised communities, such as ethnic minorities, peasants, rural populations, rural immigrants and indigenous groups.

Crop eradication violates indigenous peoples' rights as it causes environmental degradation and health problems, and can represent a direct assault on their culture and traditions.

Illicit crop eradication campaigns often violate these populations' human rights because they cause environmental degradation and health problems, and affect their culture and traditions. The 1988 UN convention clearly states in article 14 para. 2 that 'government measures on drug policy should respect fundamental human rights and take due account of traditional licit uses, where there is historical evidence of such use'.

In Peru and Bolivia the coca leaf is still an important part of the customs and traditions of a significant proportion of the population. In Peru the coca leaf is not only used by indigenous peoples but also by the middle classes, who consume it in tea or add it to food as a supplement. However, the Peruvian government focuses its drug policy on militarised interdiction programmes and forced eradication, which have resulted in increased levels of corruption, social and economic disarray in coca growing areas and, in many cases, human rights abuses of indigenous people and peasants.

189 The Declaration was signed by most UN countries. Some rather influential states, however, such as the USA, Canada, Australia, New Zealand or Brazil, have refused to support the document.

In most countries the military or police carry out forced eradication manually or by aerial spraying. In Bolivia anti-narcotics policies championed by the USA have long focused on coca eradication. Recently, the Bolivian government changed its strategy and officially recognised the traditional use of the coca leaf as a cultural heritage in the 2008 constitution.[190] Despite this constitutional improvement, 'Law 1008' (1988) still governs drug policy and has led to significant human rights abuses. Under this law, many individuals, especially poor indigenous people, have suffered from arbitrary arrests and long periods of detention pending their judgements. The law has also worsened prison overcrowding throughout the country. However, the New Criminal Procedures Code (1999) sought to redress this situation, and has significantly improved the average time spent in pre-trial detention and prison sentencing for drug offences.

In countries where violent clashes take place between armed groups fighting for control of the drug trade or with law enforcement agencies, forced eradication has militarised the producing areas, placing the local peasant population (including indigenous communities) in the middle of the battlefield. Plan Colombia, a counterinsurgency and counter-narcotics strategy that launched a massive crop eradication campaign, has not only had disastrous consequences on the lives and economy of indigenous people and peasants, but has also put them in the crossfire between government forces, insurgent groups, and paramilitary gangs fighting to control the territory. The plan did not lead to an overall reduction in cocaine production in Colombia. Instead, it has created a serious humanitarian crisis, leading to the displacement of large numbers of people and resulting in increased levels of poverty. The presence of armed groups restricts the movement of people and food. This situation leaves alienated and impoverished local communities vulnerable to recruitment by armed groups. These groups do not recognise indigenous laws and authorities. Indigenous people and peasants are therefore sucked into the conflict and become easy targets of the shootings.

Considering the negative impacts of forced eradication on the cultural, social, economic, health, security and environmental rights of indigenous people and local communities, these programmes should be avoided. Crop eradication programmes need to occur in agreement with local communities, and provide them with alternative means of subsistence.

190 Article 384:'*El Estado protege a la coca originaria y ancestral como patrimonio cultural, recurso natural renovable de la biodiversidad de Bolivia, y como factor de cohesión social; en su estado natural no es estupefaciente. La revalorización, producción, comercialización e industrializacióon se regirá mediante la ley*' (The State protects coca in its original and ancestral form as a cultural patrimony, a renewable biodiversity resource in Bolivia, and a social cohesion factor; in its natural state, it is not considered as a psychoactive substance. Its revalorisation, production, commercialisation and industrialisation will be governed by the law.)

Alternative development

In some instances, even where eradication actions are accompanied by government alternative development initiatives, these programmes do not incorporate different paradigms and models of development, or the views of indigenous peoples and their agricultural uses of the territory. This contradicts the right of indigenous peoples to determine how to administrate their own territories, as stipulated in the 2007 declaration. In some cases, alternative development programmes try to grow crops that are not adapted to the local environment. This often leads poor peasants to replant illicit crops as a means of subsistence.

Alternative development is not a 'silver bullet'. These measures must be properly sequenced and be introduced before any crop reduction plan, so that farmers are never deprived of their means of subsistence. Programmes need to be developed in collaboration with local populations after an assessment of the local cultivation possibilities and market access, and with respect for the rights and traditions of indigenous peoples. Additional information on alternative development can be found in Section 4.2 on promoting alternative livelihoods.

Stigmatising traditional plants

There is ample evidence of the traditional use of coca leaves among many indigenous communities in the Andes–Amazon region. Indigenous peoples have long claimed their right to cultivate and consume coca leaves and produce other natural derivatives to perpetuate their cultural and religious traditions. They also vindicate the use of coca to generate revenue through the commercialisation of natural products.

The international community has largely ignored the traditional attributes of the coca leaf. The 1961 convention classified it as a controlled substance, and includes two articles within 25 years prohibiting coca leaf chewing.[191]

Continued prohibition contravenes other international conventions. Article 14 of the 1988 convention includes the concept of 'traditional use'. However, this article has not been respected, and the difference between coca and cocaine consumption is often misunderstood. Considering how difficult it is to extract alkaloid, the mere presence of cocaine in the coca leaf should not justify the current level of international control. A clear difference needs to be made between the control regime for leaf consumption and for refined alkaloid. The coca leaf should be differentiated from cocaine and removed from the drug control classification system.

There is ample evidence of the traditional use of coca leaves among many indigenous communities.

191 Articles 26 and 49 para.2(e) of the 1961 Single Convention on Narcotic Drugs. See Metaal, P., Jelsma, M., Argandona, M., Soberon, R., Henman, A. & Echeverria, X. (2006), *Beckley Foundation Drugs & Conflict Debate Paper 13 - Coca yes, cocaine, no? Legal options for the coca leaf* (Beckley Foundation), http://www.tni.org//archives/reports/drugs/debate13.pdf

This prohibition also demonstrates a misunderstanding of indigenous customs and traditions. Andean and Amazonian coca consumers often feel ignored, insulted and humiliated by the international community and the UN's call to abolish what they consider to be a healthy ancestral tradition. Allegations that chewing coca caused malnutrition in indigenous people and was a degenerative moral agent helped justify its classification as a controlled substance. Yet a Harvard study demonstrated in 1975 that coca was not only a source of nutrients but was also chewed after meals as a digestive component.[192]

Ill-founded justifications for the current prohibition regime focus on environmental degradation supposedly generated by illicit crop cultivation, and its connection to drug trafficking. National authorities have failed to recognise that it is the criminalisation of cultivation and the consequential human occupation of the Amazon basin that have caused much of the environmental degradation. Forced eradication itself has led growers to move crop cultivation to remote areas of rainforest, such as the national parks of Colombia and Bolivia, resulting in deforestation and environmental destruction.

192 Duke, J.A., Aulik, D. & Plowman, T. (1975), 'Nutritional value of coca'. *Botanic Museum Leaflets Harvard University* **24**(6):113-118.

Recommendations

- International obligations, particularly those arising from human rights legal instruments that are at the heart of international law, need to be respected at all times. Governments should address the discrepancies between the UN drug conventions and international human rights agreements, including the rights of indigenous peoples.

- The historical, cultural and traditional character of certain plants destined for the illicit drug market, as well as their potential benefits, should be recognised. At the national level, new laws and regulations are needed to provide for the controlled cultivation of plants for these purposes.

- It is necessary to provide for the full participation of all stakeholders in the development of policy on supply reduction. Governments can no longer focus on the criminalisation of farmers and on the forced eradication of illicit crops. They should focus instead on development assistance with the collaboration of affected cultural communities to design projects that are achievable in practice and respectful of their economic, social and cultural rights.

- Supply reduction measures need to be sequenced appropriately. Only once alternative livelihoods are in place can policy-makers start to work with local community organisations to reduce, and possibly eliminate, crops destined for the illicit drug market.

- A new approach is needed to evaluate the impact of alternative livelihood programmes that no longer focuses on the number of hectares of crops eradicated but on human development indicators.

Key resources

Beckley Foundation Drug Policy Programme, International Harm Reduction Association, Human Rights Watch & The Canadian HIV/AIDS Legal Network (2008), *Report 13 - Recalibrating the regime:The need for a human rights-based approach to international drug policy,* http://www.idpc.net/php-bin/documents/BFDPP_RP_13_Recal_Regime_EN.pdf

Declaration on the Rights of Persons Belonging to National or Ethnic, Religious or Linguistic Minorities (1992), http://www.ohchr.org/Documents/Publications/GuideMinoritiesDeclarationen.pdf

ILO Indigenous and Tribal Peoples Convention No. 169 (1989), http://www.ilo.org/ilolex/cgi-lex/convde.pl?C169

Foro Mundial de Productores de Cultivos Declarados Ilicitos (2009), *Political Declaration,* http://idpc.net/sites/default/files/library/Political_Declaration_FMPCDI.EN.pdf

Henman, A. & Metaal, P. (2009), *Drugs and Conflict Debate Paper No.17 - Coca Myths* (Translational Institute), http://www.tni.org/reports/drugs/cocamyths.pdf

International Drug Policy Consortium (2008), *IDPC Advocacy Note – The UN Drug Policy Review, International Cooperation on the Eradication of Illicit Crops and on Alternative Development,* http://idpc.net/sites/default/files/library/IDPC_Advo_CEADWG_June08_EN.pdf

Jelsma, M. (2008), *The Current State of Drug Policy Debate:Trends in the Last Decade in the European Union and United Nations* (Transnational Institute), http://www.tni.org/archives/jelsma/currentstate-e.pdf

Metaal, P., Jelsma, M., Argandona, M., Soberon, R., Henman, A. & Echeverria, X. (2006), *Drugs and Conflict Debate Paper No.13 - Coca yes, cocaine, no? Legal Options for the coca leaf* (Transnational Institute), http://www.tni.org/reports/drugs/debate13.pdf

Quimbayo Ruiz, G.A. (2008), *Drug Policy Briefing No.28 - Crops for Illicit Use and Ecocide* (Transnational Institute), http://idpc.net/sites/default/files/library/TNI_Crops_EN.pdf

Universal Declaration of Human Rights (1948), http://www.un.org/en/documents/udhr/

United Nations Declaration on the Rights of Indigenous Peoples (2007), http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

Glossary

Abstinence	Refraining from drug use, whether as a matter of principle or for other reasons.
Adverse drug reaction	In the context of substance use, the term includes unpleasant psychological or physical reactions to drug taking.
Cocaine	An alkaloid obtained from coca leaves or synthesised from ecgonine or its derivatives. Cocaine was commonly used as a local anaesthetic in dentistry ophthalmology and ear, nose and throat surgery because its strong vasoconstrictor action helps to reduce local bleeding. Cocaine is a powerful central nervous system stimulant used non-medically to produce euphoria or wakefulness. Repeated use produces dependence. Cocaine may be ingested orally, often with alcohol, and combined opioid and cocaine users are likely to inject it intravenously. 'Freebasing' refers to increasing the potency of cocaine by extracting pure cocaine and inhaling the heated vapours through a cigarette or water pipe. An aqueous solution of the cocaine salt is mixed with an alkali, and the free base is then extracted into an organic solvent such as ether or hexane. The procedure is dangerous because the mixture is explosive and highly flammable. A simpler procedure, which avoids use of organic solvents, consists of heating the cocaine soda. This yields 'crack'.
Coca leaves	The leaves of the coca bush *Erythroxylon coca,* traditionally are chewed or sucked in Andean cultures with a pinch of alkaline ashes as a stimulant and appetite suppressant and to increase endurance at high altitudes. Cocaine is extracted from coca leaves.
Decriminalisation	The repeal of laws or regulations that define a behaviour, product or condition as criminal. It is sometimes also applied to a reduction in the seriousness of a crime or of the penalties the crime attracts; as when possession of marijuana is downgraded from a crime that warrants arrest and a jail term to an infraction to be punished with a warning or fine. Thus decriminalisation is often distinguished from legalisation, which involves the complete repeal of any definition as a crime, often coupled with a governmental effort to control or influence the market for the affected behaviour or product.
Demand reduction	A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to illicit drugs, particularly with reference to educational, treatment and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs.
Depenalisation	Involves the reduction of the level of penalties associated with drug offences so that imprisonment can be used more sparingly.

Detoxification	(1) The process by which an individual is withdrawn from the effects of a psychoactive substance. (2) As a clinical procedure, the withdrawal process carried out in a safe and effective manner, such that withdrawal symptoms are minimised. The facility in which this takes place may be variously termed a detoxification centre, detox centre or sobering-up station. Typically, the individual is clinically intoxicated or already in withdrawal at the outset of detoxification. Detoxification may or may not involve the administration of medication. When it does, the medication given is usually a drug that shows cross-tolerance and cross-dependence to the substance(s) taken by the patient. The dose is calculated to relieve the withdrawal syndrome without inducing intoxication, and is gradually tapered off as the patient recovers. Detoxification as a clinical procedure implies that the individual is supervised until recovery from intoxication or from the physical withdrawal syndrome is complete. The term 'self-detoxification' is sometimes used to denote unassisted recovery from a bout of intoxication or withdrawal symptoms.
Drug control	The regulation by a system of laws and agencies of the production, distribution, sale and use of specific illicit drugs locally, nationally or internationally. Equivalent to drug policy.
Drug dependence	As applied to drugs, 'dependence' implies a need for repeated doses of the drug to feel good or to avoid feeling bad. In DSM-IIIR, dependence is defined as a 'cluster of cognitive, behavioural and physiologic symptoms that indicate a person has impaired control of psychoactive substance use and continues use of the substance despite adverse consequences'. In 1964 a WHO Expert Committee introduced 'dependence' to replace addiction and habituation. The term can be used generally with reference to the whole range of psychoactive drugs, or with specific reference to a particular drug or class of drugs. Dependence refers to both physical and psychological elements. Psychological or psychic dependence refers to the experience of impaired control over drinking or drug use, while physiological or physical dependence refers to tolerance and withdrawal symptoms. In biologically oriented discussion, dependence is often used to refer only to physical dependence. Dependence or physical dependence is also used in the psychopharmacological context in a still narrower sense, referring solely to the development of withdrawal symptoms on cessation of drug use.
Drug policy	In the context of psychoactive drugs, the aggregate of policies designed to affect the supply and/or the demand for illicit drugs, locally or nationally, including education, treatment, control and other programmes and policies. In this context, 'drug policy' often does not include pharmaceutical policy (except with regard to diversion to non-medical use) or tobacco or alcohol policy.

Drug-related problem	Any of the range of adverse accompaniments of drug use, particularly illicit drug use. 'Related' does not necessarily imply causality. The term was coined by analogy with alcohol-related problems but is less used, since it is drug use itself, rather than the consequences, that tends to be defined as the problem. It can be used to refer to problems at an individual or societal level. In international drug control, drug-related problems are taken into account in setting a level of control for a controlled substance through a WHO assessment of the drug's dependence potential and abuse liability.
Drug testing	The analysis of body fluids (such as blood, urine or saliva), hair or other tissue for the presence of one or more psychoactive substances. Drug testing is employed to monitor abstinence from psychoactive substances in individuals pursuing drug rehabilitation programmes, to monitor surreptitious drug use among patients on maintenance therapy, and where employment is conditional on abstinence from such substances.
Drug use	Self-administration of a psychoactive substance.
Heroin/Opioid	The generic term applied to alkaloids from the opium poppy, their synthetic analogues, and compounds synthesised in the body that interact with the same specific receptors in the brain, and have the capacity to relieve pain, and produce a sense of well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses. Opioids can also produce analgesia, mood changes, respiratory depression, drowsiness, psychomotor retardation, slurred speech, impaired concentration or memory, and impaired judgement. Over time, morphine and its analogues induce tolerance and neuro-adaptive changes that are responsible for rebound hyper-excitability when the drug is withdrawn. There are numerous physical sequelae of opioid use, principally as a result of the usual intravenous method of administration, which include Hepatitis B and C, HIV infection, septicaemia, endocarditis, pneumonia, lung abscess, etc. Psychological and social impairment, often reflecting the illicit nature of non-medical use of these drugs, is prominent.
Illicit drugs	Psychoactive substance, the production, sale or use of which is prohibited. Strictly speaking, it is not the drug that is illicit, but its production, sale or use in particular circumstances in a given jurisdiction. 'Illicit drug market', a more exact term, refers to the production, distribution, and sale of any drug outside legally sanctioned channels.
Injecting drug use	Injections may be intramuscular, subcutaneous, intravenous (IV), etc.
Intravenous drug use	Included within injecting drug use.
Needle-sharing	The use of syringes or other injecting instruments by more than one person, particularly as a method of administration of drugs. This confers the risk of transmission of viruses (such as HIV and hepatitis B) and bacteria. Many interventions such as methadone maintenance and needle/syringe exchanges are designed partly or wholly to eliminate needle-sharing.

Opioid substitution therapy	Opioid substitution therapy (OST) refers to the medically supervised delivery of medications, usually long-acting opioids (e.g. methadone, buprenorphine), that prevent the patient from going into withdrawal as a result of opiate dependence. For example, it allows a heroin dependent drug user to extricate themselves from the cycle of drug dependence: the daily buying, consuming and obtaining of funds for drugs. Once outside this complex of crime, health problems, stress and so on, the OST patient can begin to focus on an alternative way of life.
Overdose	The use of any drug in such an amount that acute adverse physical or mental effects are produced. Deliberate overdose is a common means of suicide and attempted suicide. In absolute numbers, overdoses of licit drugs are usually more common than those of illicit drugs. Overdose may produce transient or lasting effects, or death. The lethal dose of a particular drug varies with the individual and with circumstances.
Problematic drug use	Problematic drug use refers to an individual whose drug use is 'out of control' and a source of high risk for them and the community. It often involves the dependent use of injected heroin, cocaine or methamphetamine, but the concept focuses more on the behaviour than the drug. Thus Cannabis use can also be problematic. The core elements are compulsive use, lack of insight as to risk, social marginalisation, health problems, criminal involvement, and the entire complex of chaotic behaviours associated with substance use that is out of control.
Rehabilitation	The process by which an individual with a substance use disorder achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification and medical and psychiatric treatment). It encompasses a variety of approaches, including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual-help group, residence in a therapeutic community or halfway house, vocational training, and work experience. It can include long-term OST or 'maintenance therapy'. There is an expectation of social reintegration into the wider community.
Relapse	A return to drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse ('slip'), with the latter denoting an isolated occasion of drug use.
Relapse prevention	A set of therapeutic procedures employed to help individuals avoid or cope with lapses or relapses to drug use. The procedures may be used with treatment, and in conjunction with other therapeutic approaches. Patients are taught coping strategies that can be used to avoid situations considered dangerous precipitants of relapse, and they are shown, through mental rehearsal and other techniques, how to minimise drug use once a slip has occurred.

Screening test	An evaluative instrument or procedure, either biological or psychological, whose main purpose is to discover, within a given population, as many individuals as possible who currently have a condition or disorder or who are at risk of developing one at same point in the future. Screening tests are often not diagnostic in the strict sense of the term, although a positive screening test will typically be followed by one or more definitive tests to confirm or reject the diagnosis suggested by the test. A test with high *sensitivity* is able to identify the majority of genuine cases of the condition under consideration. *Specificity*, on the other hand, refers to a test's ability to exclude false cases; that is, the greater its specificity, the less likely the test is to give positive results for individuals who do not, in fact, have the disease in question. The term 'screening instrument' is also in widespread use, typically referring to a questionnaire or brief interview schedule.
Substance use disorders	A group of conditions related to drug use. ICD-I0, section FI0-F19, 'Mental and behavioural disorders due to psychoactive substance use', contains a wide variety of disorders of different severity and clinical form, all having in common the use of one or more psychoactive substances that may or may not have been medically prescribed.
Supply reduction	Refers to policies or programmes aiming to interdict the production and distribution of drugs, particularly law enforcement strategies for reducing the supply of illicit drugs.
United Nations drug conventions	International treaties concerned with the control of production and distribution of psychoactive drugs. The first treaty dealing with currently controlled substances was the Hague Convention of 1912: its provisions and those of succeeding agreements were consolidated in the 1961 Single Convention on Narcotic Drugs (amended by a 1972 protocol). To this have been added the 1971 Convention on Psychotropic Substances and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
Withdrawal syndrome	A group of symptoms of variable clustering and degree of severity that occur on cessation or reduction of use of an illicit drug that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. A withdrawal syndrome is one of the indicators of a dependence syndrome. The onset and course of the withdrawal syndrome are time-limited and are related to the type of substance and dose being taken immediately before cessation or reduction of use. Opioid withdrawal is accompanied by running nose, excessive tear formation, aching muscles, chills, gooseflesh and, after 24 to 48 hours, muscle and abdominal cramps. Drug-seeking behaviour is prominent and continues after the physical symptoms have abated. Stimulant withdrawal ('crash') is less well defined than withdrawal syndromes from central nervous system depressant substances; depression is prominent and is accompanied by malaise, inertia and instability.

The International Drug Policy Consortium (IDPC) is a global network of non-governmental organisations and professional networks that specialises in issues related to the production and use of controlled drugs. We aim to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and support evidence-based policies that are effective in reducing drug-related harms. We produce occasional briefing papers, disseminate the reports of our member organisations about particular drug-related matters, and offer expert consultancy services to policy-makers and officials worldwide. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates.

This drug policy guide was compiled in 2009 through research and consultation with our network of experts. It aims to provide our regional and national partners with a resource that they can use to conduct reviews of the national drug policies and programmes in their areas, and engage with policy-makers to work towards policy and programme improvements. The guide will be updated annually to reflect changes in global evidence and experience.

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