



International Drug Policy Consortium  
A global network promoting objective and open debate on drug policy

# Drug Policy Guide



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# Introduction

## What is the Guide?

The International Drug Policy Consortium (IDPC) *Drug Policy Guide* (the Guide) brings together global evidence and examples of best practice to provide guidance on the review, design and implementation of drug policies. The Guide is targeted at national government policy makers and civil society organisations involved in the development or review of local or national drug strategies.

This is the second edition of our Guide. Like the first edition in 2010, it was compiled through research and consultation with our global network of experts.

## Why was the Guide developed?

National policy makers engaged in the field of drug policy are working in an era of uncertainty. Simplistic 'war on drugs' strategies have failed in their key objectives of eradicating illicit drug markets and reducing the prevalence of drug use. At the same time, there is increasing evidence that the current drug control regime has caused severe negative consequences for development, public health and human rights. A growing number of governments are considering alternative policy options to address the harms associated with drug markets and use.

The Guide is designed to assist national policy makers in the process of developing effective, humane and appropriate drug policies and programmes for their country. Each chapter of the Guide introduces a specific type of policy challenge, analyses existing evidence and experiences of different countries, and presents advice and recommendations for developing effective policy responses. The Guide will be updated every two years to reflect changes in global evidence and experience.

The Guide is also a useful tool for civil society organisations to use in their advocacy work with policy makers.

## How can the Guide be used?

The information and advice in the Guide can be used to conduct reviews of national drug policies and programmes, and to develop more effective and humane drug policies. The chapters of the Guide are designed to function as stand-alone sets of analysis and advice, and may be referred to individually where policy makers and civil society organisations find only select chapters are applicable to their local needs.

Through its global network of members and individual experts, IDPC can provide policy makers with specialist advice and support to adapt our recommendations to local contexts. This can be done through the dissemination of written materials, presentations at conferences, meetings with key government officials, study tours, and capacity building and advocacy training for civil society organisations. For more information, please contact us at [contact@idpc.net](mailto:contact@idpc.net).

## Foreword

The global nature of the drugs phenomenon demands national, regional and multilateral approaches. It is a transnational problem and international co-operation is the key to an appropriate, effective and balanced response.

Although individual countries have adopted different approaches to this subject, some of which are outlined in this Guide, there is a clear consensus that drug policies must be based on facts rather than on ideology. Drug policies should take into account different cultures and norms around the world, and drug control measures should include respect for human rights and human dignity.

Drug-related health and social risks and drug-related crime are major public concerns. Despite the resources devoted to controlling drug markets and drug use, there has been an increase in the availability and use of drugs. The role of policy makers is to promote the most effective use of resources and contribute to achieving the central goals of drug policy – a high level of health protection, social cohesion and public security.

This should be done by advocating a balanced, integrated and multidisciplinary approach with regard to the world drug problem, in which actions towards reducing drug supply and demand for drugs are seen as mutually supportive and equally important.

The current economic austerity experienced by some countries may have implications for the levels of drug use in society and may impact service provision. It is known that marginalised and socially disadvantaged communities are the most vulnerable, and there are fears that the economic crisis may be accompanied by an increase in problematic forms of drug use, with a collateral increase in criminal activities.

I would like to stress the importance of reliable and comparable data to form the basis of a sound understanding of the situation and adoption of effective measures. In times of problematic economic situations, there is a need, more than ever, for reliable and robust drug-monitoring information that alerts us to new threats and emerging problems. This information also provides a background for defining reliable and clear policy priorities and for investing in areas of proven effectiveness.

I believe that countries can learn from each other, by sharing research and best practices, always taking into account that a specific policy that works in one country may not turn out well in another. The most important thing is to encourage countries to promote a health-oriented approach to drug dependence, based upon scientifically derived knowledge.

Civil society has a role to play in drug policies, as a platform to increase awareness regarding drug use and to promote dialogue and exchanges of best practices among the various actors.

However, as we all know, the development of effective drug policies and responses is not an easy task. Policy makers face several challenges, such as the emergence of new psychoactive substances and new patterns of use. We need proactive strategies that allow us to rapidly identify new threats and anticipate their potential implications.

The second edition of the IDPC *Drug policy guide* lays out clearly the key issues of concern for policy making in this complex area, presenting the global evidence for effective strategies that are balanced and grounded in health, human rights and development principles. It is an important tool to guide us as we respond collectively, and in a co-ordinated way, to this fast-moving phenomenon, and I encourage national policy makers to make good use of the advice and information contained within its pages. We must concentrate on the international search for best practices, as individual national efforts are likely to prove ineffective. The international community must, therefore, pursue its efforts to tackle all the aspects of the drug problem, based on scientific information and evidence.

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# Acknowledgements

The International Drug Policy Consortium (IDPC) is a global network of non-governmental organisations (NGOs) and professional networks that promotes 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 (for a full list of IDPC Members, visit: [www.idpc.net/members](http://www.idpc.net/members)). We produce occasional briefing papers, disseminate reports on drug-related matters, and offer expert consultancy services to policy makers 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.

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## Abbreviations

AIDS	Acquired immunodeficiency syndrome
DARE	Drug Abuse Resistance Education (programme)
DDC	Dedicated drug court
ECOSOC	Economic and Social Council (UN)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
GHB	Gammahydroxybutyrate
HAARP	HIV/AIDS Regional Programme
HAT	Heroin-assisted treatment
HIV	Human immunodeficiency virus
HRI	Harm Reduction International
IDPC	International Drug Policy Consortium
INCB	International Narcotics Drug Board
INPUD	International Network of People who Use Drugs
LSD	Lysergic acid diethylamide
MDG	Millennium Development Goal
NADA	National Anti-Drugs Agency (Malaysia)
NATO	North Atlantic Treaty Organization
NGO	Non-governmental organisation
NIDA	National Institute on Drug Abuse
NSP	Needle and syringe programme
OST	Opioid substitution therapy
STI	Sexually transmitted infection
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UPP	Unidades de Policia Pacificadora (Rio de Janeiro)
USA	United States of America
WHO	World Health Organization

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# **Chapter 1**

## **Core principles for developing effective drug policy**

# Core principles for developing effective drug policy

## Principles of an effective drug policy

To be fit for purpose in tackling the complex challenges posed by drug markets and drug use in the 21<sup>st</sup> century, drug policies and strategies need to:

- be based on an **objective assessment** of priorities and evidence
- be fully compliant with **international human rights standards**
- be focused on reducing the **harmful consequences** of drug use and markets
- seek to promote the **social inclusion** of marginalised groups
- build open and constructive relationships between governments and **civil society**

For the past 50 years, most national governments have faithfully followed the model of drug policy promoted by the United Nations (UN) drug control conventions – The 1961 UN Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Drugs and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Although the conventions' fundamental objective, as stated in the preamble of the 1961 and 1971 Conventions, is to protect the 'health and welfare of mankind', the model has been strongly based on the principle of deterrence. It has focused on law-enforcement operations to interrupt supply, and severe punishments to deter demand, as the primary strategies for disrupting and eventually eradicating the illicit drug market. These policies have usually been characterised by ideological debates and political sensitivities, viewing policy decisions through the lens of being 'tough' or 'soft' on drugs.

Policy makers have recently been forced to re-evaluate these strategies because:

- it has proved impossible to significantly and sustainably reduce the overall scale of illicit drug markets<sup>1</sup>
- the implementation of the current drug control system has led to significant negative consequences – for example, an increase in the profits and reach of organised crime<sup>2</sup>
- the growth of health and social problems among people who use drugs has forced a review of the effects of their criminalisation and marginalisation<sup>3</sup>
- some drug-related harms can be effectively tackled through policies that do not primarily aim to reduce the prevalence of drug use or the overall scale of the drug market<sup>4</sup>

- the UN has raised concerns about the breach of fundamental human rights and freedoms in the pursuit of drug control objectives.<sup>5</sup>

Governments need to conduct meaningful reviews of their national drug laws to maximise human security, health and development.

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.<sup>6</sup>

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. The Guide has drawn on this evidence and experience to offer accessible advice to policy makers and guide them to develop effective policies that are relevant to the problems and challenges in their country.

We propose five high-level policy principles for the design and implementation of national drug policies:

- 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 core principles.

## Endnotes

- 1 European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 19982007* (Luxembourg: European Communities), [http://ec.europa.eu/justice/anti-drugs/files/report-drug-markets-full\\_en.pdf](http://ec.europa.eu/justice/anti-drugs/files/report-drug-markets-full_en.pdf)
- 2 Global Commission on Drug Policy (2011), *War on drugs* (Rio de Janeiro: Global Commission on Drug Policy), [http://www.idpc.net/sites/default/files/library/Global\\_Commission\\_Report\\_English.pdf](http://www.idpc.net/sites/default/files/library/Global_Commission_Report_English.pdf); 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](http://www.ukdpc.org.uk/resources/Refocusing_Enforcement_Full.pdf)
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- 5 Grover, A. (August 2010), *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (United Nations General Assembly A/65/255), <http://idpc.net/sites/default/files/library/Right%20to%20highest%20standard%20of%20health.pdf>; UNODC (March 2010), *From coercion to cohesion: treating drug dependence through healthcare, not punishment* (Vienna: UNODC), <http://idpc.net/sites/default/files/library/Coercion%20FULL%20doc%20%282%29.pdf>; Nowak, M. (February 2010), *Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment* (United Nations General Assembly A/HRC/13/39/Add.5), [http://idpc.net/sites/default/files/library/A.HRC\\_13.39.Add\\_5\\_en.pdf](http://idpc.net/sites/default/files/library/A.HRC_13.39.Add_5_en.pdf); 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.unis.unvienna.org/unis/pressrels/2009/unisnar1048.html>.
- 6 Preamble of the 1961 UN Single Convention on Narcotic drugs: 'The Parties [are] concerned with the health and welfare of mankind', <http://www.unodc.org/unodc/en/treaties/single-convention.html>

# 1.1 A structured approach to strategy development and review

Governments should take a structured approach to developing comprehensive and integrated drug policy responses.

The complexity of the factors that affect the levels and patterns of drug production, supply and use means that governments should take a highly structured approach to developing comprehensive and integrated drug policy responses – drug laws and their enforcement are just one of many areas of government activity that can be used to tackle the drugs problem.

The process for good policy making at the national level should include the components listed below.

- **A statement of high-level objectives** – these will flow from an assessment of which consequences of drug markets and use are most harmful to society. Communities and civil society, in particular representatives of people who grow and use drugs, are a valuable source of expertise in assisting policy makers with determining the priority issues that need to be addressed in a national drug strategy. Depending on local contexts, priorities may focus on reducing organised crime and violence, tackling the impact of drug use on families and communities, or limiting the transmission of HIV and other health problems. Operational objectives, such as the number of drug seizures or arrests, do not provide accurate indicators of progress in reducing drug-related harms and are therefore not appropriate objectives to include in a national-level strategy.
- **A description of the activities that the government will pursue and support to meet these objectives** – there is growing evidence to guide policy makers in developing programmes that are most effective in achieving their objectives. For example, the availability of treatment programmes for drug dependence reduces street crime,<sup>1</sup> while harm reduction programmes reduce HIV and hepatitis C infections.<sup>2</sup> Although the range and extent of activities will be constrained by available resources, investing in effective measures will lead to greater savings by reducing the costs associated with crime, health and social problems.<sup>3</sup>
- **Clear identification of the role of departments or agencies responsible for these activities and coordination between them** – 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 authorities, community and faith groups, civil society organisations, and affected communities such as people who use and/or grow drugs.

- **The amount of resources made available by the government to support these activities** – national drug strategies differ significantly on the issue of resource attribution. Some countries (notably the United States of America [USA]) spend billions of dollars every year in implementing their national drug strategy, while others invest very little. Expenditure may be hidden in general health, education, justice or law-enforcement budgets, where its impact on achieving drug strategy objectives may not be explicitly evaluated. Policy makers need to understand the 'proactive' amount spent on funding drug policy measures (i.e. law-enforcement activities, prevention campaigns and programmes for harm reduction and treatment of drug dependence), and the consequent savings that could be made on 'reactive' expenditure (i.e. responding to drug-related crime, loss of economic activity or treatment of HIV and other blood-borne diseases).
- **An articulation of the scope and timescale of the strategy, and evaluation of progress** – learning from drug policy successes and failures requires that strong mechanisms be established to assess the impact of drug strategies. This involves setting clear goals and timescales, and committing to carrying out objective and structured reviews on a regular basis (e.g. every five years). Many countries created comprehensive national drug strategies in the 1990s, but did not review their strategy in a systematic and objective manner. This led to the continuation of ineffective policy measures and missed opportunities to introduce more effective approaches. Since no country has managed to fully resolve the problems associated with drug markets and use, policy makers should continuously search for better policy responses, by referring to evidence and experience, instead of being influenced by ideology and political interests.

## Endnotes

- 1 Gossop, M. (2005), *Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study (NTORS)* (London: National Treatment Agency for Substance Misuse), <http://www.addictionservicesguide.com/articles/NTORS.PDF>; Hughes, C.E. & Stevens, A. (2010), 'What can we learn from the Portuguese decriminalization of illicit drugs?', *The British Journal of Criminology*, **50**(6): 999–1022; Rajkumar, A.S. & French, M.T. (1997), 'Drug abuse, crime costs and the economic benefits of treatment', *Journal of Quantitative Criminology*, **13**(3): 291–323, <http://www.springerlink.com/content/bg6247650485q36v/>
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## 1.2 Ensuring compliance with fundamental rights and freedoms

According to the UN drug conventions, the primary concern of the drug control system is the 'health and welfare of mankind'.<sup>1</sup> Drug control bodies and national governments 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.<sup>2</sup>

Human rights stem from the dignity and worth of the individual.<sup>3</sup> They are universal, interdependent, interrelated, indivisible and inalienable,<sup>4</sup> which means that they cannot

Human rights law should be recognised as a core element of the national legal framework for drug policy.

be taken away from a person because they might be growing or using controlled drugs, or living with HIV. This was explicitly proclaimed in 2009 by the UN High Commissioner for Human Rights, Navanethem Pillay: 'individuals who use drugs do not forfeit their human rights'.<sup>5</sup>

Human rights are not only a statement of principle – states also have binding obligations under international law to respect, protect and fulfil them.<sup>6</sup> This means that governments should not interfere with the human rights of their citizens (including people who are using and/or growing drugs) nor allow third parties such as law-enforcement officers to do so. They should also adopt appropriate legislative, constitutional, budgetary and other measures to fully realise the human rights of all their citizens.

Governments and law-enforcement authorities have paid insufficient attention to fundamental rights and freedoms in the design and implementation of national drug policies. Despite concerns raised by several UN agencies – including the UN Special Rapporteur on the right to health, Anand Grover<sup>7</sup> – human rights abuses continue to proliferate under the auspices of drug policy (see [Table 1](#)).<sup>8</sup>

**Table 1. Violations of human rights in the name of drug control**

Human right	International human rights convention	Violations in the name of drug control
Right to life	<ul style="list-style-type: none"> <li>Article 4 of the Universal Declaration of Human Rights, 1948</li> <li>Article 6 of the International Covenant on Civil and Political Rights, 1966</li> </ul>	<ul style="list-style-type: none"> <li>Use of the death penalty for drug offences<sup>9</sup></li> <li>Extra-judicial killings by law-enforcement agencies<sup>10</sup></li> </ul>
Right to be free from torture, cruel and inhuman punishment	<ul style="list-style-type: none"> <li>Article 5 of the Universal Declaration of Human Rights, 1948</li> <li>Article 7 of the International Covenant on Civil and Political Rights, 1966</li> <li>Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975</li> <li>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984</li> </ul>	<ul style="list-style-type: none"> <li>Arbitrary detention of people who use drugs</li> <li>Abuses in compulsory centres for drug users<sup>11</sup></li> </ul>
Right to be free from slavery	<ul style="list-style-type: none"> <li>Article 4 of the Universal Declaration of Human Rights, 1948</li> <li>Article 8 of the International Covenant on Civil and Political Rights, 1966</li> </ul>	<ul style="list-style-type: none"> <li>Use of forced labour in the name of drug treatment<sup>12</sup></li> </ul>
Right to health	<ul style="list-style-type: none"> <li>Constitution of the World Health Organization (WHO), 1944</li> <li>Article 25 of the Universal Declaration of Human Rights, 1948</li> <li>Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966</li> </ul>	<ul style="list-style-type: none"> <li>Restricted access to essential medicines for pain relief<sup>13</sup></li> <li>Restricted access for drug or HIV prevention, treatment and care</li> </ul>
Social and economic rights	<ul style="list-style-type: none"> <li>Article 22 (and next) of the Universal Declaration of Human Rights, 1948</li> <li>Articles 6 and 7 (and next) of the International Covenant on Economic, Social and Cultural Rights, 1966</li> </ul>	<ul style="list-style-type: none"> <li>Implementation of forced crop-eradication campaigns, leaving many farmers with no means of subsistence<sup>14</sup></li> </ul>
Right to be free from discrimination	<ul style="list-style-type: none"> <li>Article 7 of the Universal Declaration of Human Rights, 1948</li> <li>Article 26 of the International Covenant on Civil and Political Rights, 1966</li> <li>International Convention on the Elimination of All Forms of Racial Discrimination, 1965</li> <li>Convention on the Elimination of All Forms of Discrimination Against Women, 1979</li> </ul>	<ul style="list-style-type: none"> <li>Discriminatory application of drug control laws, notably towards minority ethnic people,<sup>15</sup> indigenous people, young people and women</li> </ul>
Right to privacy	<ul style="list-style-type: none"> <li>Article 12 of the Universal Declaration on Human Rights</li> </ul>	<ul style="list-style-type: none"> <li>Practice of stopping and inspecting people, including school children, suspected of carrying drugs, use of sniffer dogs in schools</li> </ul>

Today, these human rights abuses are receiving greater attention from the public, and non-governmental organisations (NGOs) have become more active in scrutinising states' human rights performance.<sup>16</sup> 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), Yury Fedotov declared: 'UNODC works to improve the lives of people and communities worldwide ... Public health and human rights must therefore be central to that work'.<sup>17</sup> Both the former UN Special Rapporteur on torture, Professor Nowak, and the UN High Commissioner for Human Rights, Navanethem Pillay, have also called for a human rights-based approach to drug policy.<sup>18</sup>

A paradigm shift is needed, where human rights law is recognised as a core element of the national legal framework for drug policy.<sup>19</sup> This new legal framework should focus on:

- **public health**, in order to improve access to essential medicines and develop evidence-based harm reduction, prevention, treatment and care programmes
- **development**, in order to refocus on alternative development, poverty reduction, education, employment, social security, etc
- **human security**, in order to refocus law-enforcement efforts on those most responsible for drug-related harms, rather than low-level and non-dangerous dealers, people who use drugs, and vulnerable farming communities.

## Endnotes

- 1 Preamble of the 1961 UN Convention on Narcotic Drugs, <http://www.unodc.org/unodc/en/treaties/single-convention.html>
- 2 According to article 103 of the UN Charter, the obligations contained in the Charter prevail upon every international agreement, including the three drug conventions.
- 3 1948 Universal Declaration of Human Rights.
- 4 World Conference on Human Rights (1993), *Vienna Declaration and Programme of Action* (A/CONF.157/23), 12 July 1993, para.1
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## 1.3 Focusing on the harms associated with drug markets and use

National governments have focused much of their drug control effort on reducing the scale of drug markets through punitive means, believing that this would eventually reduce drug-related harms.<sup>1</sup> At the time of the drafting of the UN drug conventions, these health and social objectives were assumed to be best achieved through stopping the supply of drugs, and incarcerating dealers and users. Progress in drug policy has therefore largely been measured in terms of 'process measures' – the numbers of drug seizures, the numbers of traffickers and users arrested, and the severity of punishments.

However, these attempts have been largely unsuccessful. Despite all the political and financial investment in repressive policies over the last 50 years, drugs are more available, and more widely used, than they have ever been. Theoretically, reductions in the scale of drug markets could lead to a reduction in harms, but in practice the opposite has often occurred. For example, successful operations against a dealing network can increase violence as competing gangs fight over the vacant 'turf';<sup>2</sup> and an action against a particular drug can lead people who use drugs to switch to substances that may be more harmful.<sup>3</sup>

Experience has also shown that there is very little correlation between increases in the 'process' of implementing repressive drug control policies, and the achievement of outcomes that matter to individuals and communities – better health, increased security, and community well-being.

The concept of harm reduction should be applied to all aspects of drug policy.

In consumer markets, for example, the mass arrest of people who use drugs does not decrease use but does itself increase health and social problems. The success measures of the number of arrests, or of clampdowns on particular drugs or dealing networks, are therefore of little relevance to the achievement of the desired outcomes – reductions in drug-related crime, improvements in community safety, and reductions in drug-related health problems such as overdoses and HIV/AIDS.

Similarly, the eradication of crops in source countries does not stop the flow of drugs into consumer markets, but does lead to significant social and economic problems in the communities living in drug-growing areas. The process measures applied in the field of supply reduction – the size of areas of crops eradicated, and levels of drug production – are also poor indicators of achievement. As these eradication programmes have ebbed and flowed in their local impact, the overall market for the drugs produced remains largely unaffected, since the areas and methods of production move around in response to law-enforcement action. The desired outcomes should rather focus on reducing violence associated with the drug market, and improving the social and economic development of the vulnerable and marginalised communities living in these areas.

Simply pursuing the long-term objective of a 'drug-free society' is no longer a sustainable policy. The focus on the objective inherent in the international and most current national strategies – to significantly reduce the scale of markets and use – is similarly unachievable, and has led to the misdirection of attention and resources towards ineffective programmes, while the health and social programmes that have been proven to reduce drug-related harms are starved of resources and political support. On this basis, the objectives of drug policy need to be reframed.

The concept of harm reduction has traditionally been associated with the set of public health activities that reduce the health risks of drug use, while not necessarily reducing the overall level of use.<sup>4</sup> As harm reduction has been shown to be effective in improving health and social outcomes, the concept should equally be applied to all aspects of drug policy. Policy makers should be explicit in articulating the specific harms that they are aiming to reduce through their drug policies, design and provide resources for programmes that have a reasonable evidence base for reducing these harms, and evaluate these programmes to ensure that they deliver the desired outcomes.

It is necessary to move away from measures of scale, to indicators of actual harm, such as levels of violent crime and corruption associated with drug trafficking, social and economic development indicators for communities in drug-growing areas, and improvements in health and social-economic welfare in consumer markets.

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## 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 is evenly distributed geographically, across social classes and different races or cultures; in others, it is concentrated in particular areas or groups. A trend, however, seems to persist in all societies – drug dependence remains strongly concentrated among the most marginalised groups of society. This is unsurprising, as evidence shows that harsh living conditions and the associated trauma are major factors contributing to drug dependence.<sup>1</sup> Similarly, the cultivation of crops destined for the illicit drug market is concentrated in the poorest areas of the world.<sup>2</sup>

Much of the work of national social affairs departments is focused on improving the living conditions of marginalised groups and integrating them more strongly into the social and economic mainstream. Many aspects of national drug control policies have had the opposite effect:

- disapproval of drug use stigmatises individuals and sometimes entire communities, restricting their ability to engage in social and economic activity
- young people caught using or in possession of drugs are often excluded from education or employment, increasing the risk that their health, social and economic problems will worsen
- programmes that focus on arrests and harsh penal sanctions towards people who use or grow drugs have little deterrent effect, removing them instead from positive social influences and increasing their exposure to health risks and criminal groups
- law enforcement and other activities that push people who use drugs underground make it harder for health and social programmes to reach them.

Social marginalisation can be minimised by adopting policies that challenge the stigmatisation of vulnerable groups.

Social marginalisation can be minimised by reducing the reliance on widespread arrest and harsh punishments for people who grow or use drugs, and adopting policies and programmes that challenge the marginalisation and stigmatisation of vulnerable groups.

This idea has gained increasing support internationally. For example, the UN Secretary-General urged ‘... 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’.<sup>3</sup> This is a significant departure from historical approaches

to drug policy based on the principle of deterrence (the idea that harsh punishment will deter current and potential users from consuming drugs, leading to the disappearance of the illicit drug market). Deterrence is not a significant factor in the level of drug dependence among a particular group, but the price and availability of a drug, poverty, inequality and harsh living conditions definitely are.<sup>4</sup>

Many countries are now leaning towards **depenalisation** (reduced penalties for drug offences) or **decriminalisation** (the drug offence is no longer considered as a criminal one) (see [Box 4](#) in Section 2.1: Drug law reform), to avoid worsening the social exclusion of people who use drugs.<sup>5</sup> More generally, policies seeking to promote social inclusion can either be drug specific, or part of a wider health, social and economic programme.

### **Drug-specific policy**

- Drug laws and enforcement tactics should avoid measures that worsen the social marginalisation of people who grow or use drugs.
- Prevention and education programmes should be carefully designed to avoid processes that inhibit young people's healthy transition to adulthood, such as exclusion from school or denial of services.
- Treatment programmes for drug dependence should be focused on facilitating the re-integration of people dependent on drugs in their community.
- Representatives of the groups most affected by drug policies, especially people who use or grow drugs, have a right to be involved in the design and implementation of drug policies and programmes that affect them. This ensures that these are informed and do not lead to unintended negative consequences.<sup>6</sup>

### **Wider social and economic policy**

Overall levels of poverty and inequality have a greater long-term impact on the prevalence of drug use in any society than do specific national drug policies.<sup>7</sup> 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.<sup>8</sup> 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 they should seek to address wider challenges in social policy rather than deepen social exclusion through tough drug policies.

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## 1.5 Building open and constructive relationships with civil society

For the purposes of this Guide, the term 'civil society' encompasses the people and communities most affected by drug policy (and their representatives), such as people who use drugs, people living with HIV, growers of crops destined for the illicit drug market, indigenous people, young people and women, harm reduction service providers, and NGOs and academics working on drug policy.

The HIV/AIDS response recognised at an early stage that the participation of people and communities most affected by the virus was critical for an effective and sustainable response to the epidemic. In the field of drug policy, civil society organisations also play a major role in analysing the drug phenomenon and in delivering programmes and services. However, political sensitivities around the drugs issue have often led policy makers to view civil society as a problem to be avoided. Because of their knowledge and understanding of drug markets and drug-using communities, as well as their ability to reach out to the most marginalised groups of society, civil society organisations constitute an invaluable source of information and expertise for policy makers. This is particularly true for organisations representing people who grow or use drugs.

Recently, the UN drug control system has started to recognise the added perspective and value that civil society organisations have brought to the drug policy debate.<sup>1</sup> For example, a structured mechanism of NGO engagement was created at the Commission for Narcotic Drugs through the 'Beyond 2008' initiative. This two-year project 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.<sup>2</sup> The Global Fund's International Board also offers three seats with full voting powers to civil society organisations, while the Global Fund Country Coordinating Mechanisms organise partnerships between civil society actors and government bodies, to ensure that all relevant actors are included in the decision-making process.<sup>3</sup> The involvement of the International Network of People who Use Drugs (INPUD),<sup>4</sup> for example, has been instrumental in promoting humane and evidence-based drug policy in these various forums.

Respectful, strategic, constructive, transparent and accountable lines of communication should be created between governments and civil society.

The positive involvement of civil society groups in drug policy debates is highly beneficial for policy makers to:

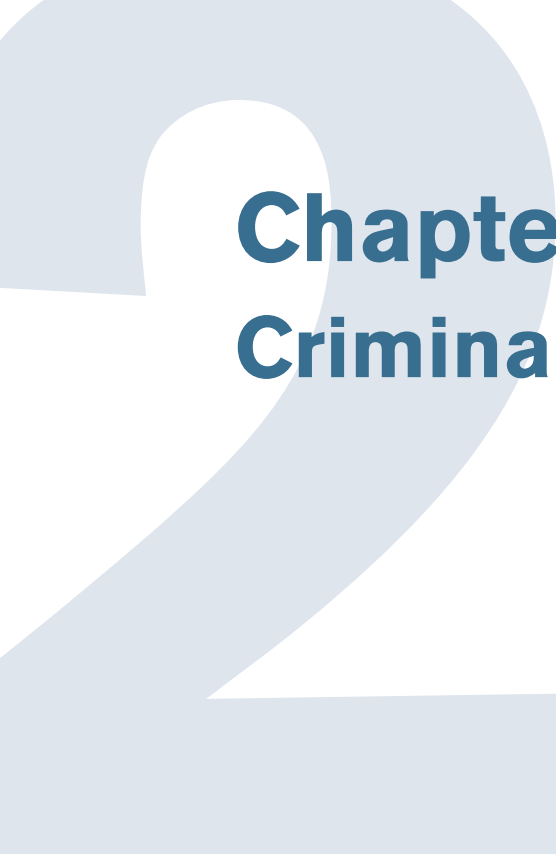
- set priorities and formulate better-informed policies based on practical advice and experience

- facilitate communication between policy makers and key civil society stakeholders, ensuring that people and communities are involved in planning interventions that will impact on them
- establish mutually beneficial partnerships with civil society organisations to undertake joint programming and/or act as programme implementers to reach out to the most vulnerable and marginalised groups
- create a vibrant network of civil society organisations that can continue to support effective policy and programme design, implementation, monitoring and evaluation.

Respectful, strategic, constructive, transparent and accountable lines of communication should therefore be created between governments and civil society representatives, in order to ensure meaningful and respectful exchanges of information and perspectives.

## Endnotes

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# **Chapter 2**

## **Criminal justice**

## 2.1 Drug law reform

### In this section

- The international legal framework
- Technical issues to consider within existing drugs law
- Options for drug law reform
- Depenalisation
- De facto decriminalisation
- Decriminalisation
- Legal regulation

**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 drug law reform important?

Since the creation of the international drug control system, the dominant strategy of reducing the scale of drug markets and use has been based on the principle of deterrence and focused on implementing tough laws prohibiting the production, distribution and use of controlled substances. It was believed that this strategy, which seeks to deter any involvement in the illicit drug market with the threat of punishment, would reduce, and eventually eliminate, the global drug market and its associated health and social harms.

Current drug control strategies have failed to reduce the scale of the illicit drug market and have led to serious negative consequences.

Many studies have now acknowledged the limited effect of the two main elements of this strategy – suppression of supply through controls on production and distribution, and suppression of demand through punishment and deterrence.<sup>1</sup> This policy has also led to a number of negative consequences. In 2008, the then Executive Director of UNODC provided a list of unintended negative consequences. These are summarised below.<sup>2</sup>

- A huge and lucrative **criminal black market** is created, exploited by powerful criminal organisations. Law-enforcement actions against these markets can create the conditions that favour the most violent and ruthless criminals.
- The issue of **policy displacement** refers to the fact that already limited resources used to tackle the drug market are mainly targeted at ineffective law-enforcement interventions, the consequence being that little is left for public health and socio-economic programmes.

- **Geographical displacement**, also referred to as the 'balloon effect', means that once an operation has been successful against one drug-producing region, drug production rises in another part of the country, region or the world. 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.
- **Substance displacement** means that when an intervention tackles a specific substance through reduction of supply or demand, drug dealers and people who use drugs turn to other, and sometimes more harmful, substances.<sup>3</sup>
- The criminalisation of people who use drugs increases their **marginalisation and stigmatisation**. Law-enforcement actions against people who use drugs, and social disapproval of their behaviour, is often counterproductive, hindering their access to social and healthcare services and their productivity in society. Criminalising people who use drugs also breaks up positive family and community ties and undermines access to jobs and education. Minority groups are particularly affected because they are often the primary targets of law-enforcement interventions.

Governments need to look for options for drug law reform that suit their own situations and legal structures.

Additional consequences of tough drug control include, to name a few,<sup>4</sup> the issue of laws prohibiting the distribution of drug paraphernalia, deterring people who use drugs from using needle and syringe exchange programmes;<sup>5</sup> laws that inhibit legitimate access to controlled medicines (such as cannabis, morphine, ecstasy, methadone and buprenorphine) for medical or research purposes, leaving millions of people unable to treat opioid dependence and moderate or severe pain;<sup>6</sup> and the imposition of disproportionate penalties on drug offenders.<sup>7</sup>

Given the limited impact, and negative consequences, of traditional legal frameworks on reducing the scale of the global drug market, national governments need to look at options for drug law reform that suit their own situations and legal structures. This chapter looks at the international framework within which any reform should operate, analyses key principles of drug laws, and describes different types of potential reform.

## The international legal framework

### 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.

- **The 1961 UN Single Convention on Narcotic Drugs**<sup>8</sup> details controlled substances within schedules, requiring that stringent controls be placed upon them because of their harmful characteristics, risks of dependence and/or limited therapeutic value. The primary objective of the convention is to control drugs by restricting their use to 'medical and scientific' purposes.

- **The 1971 UN Convention on Psychotropic Drugs**<sup>9</sup> introduced a broadly equivalent control regime for newly developed psychotropic drugs such as hallucinogens and tranquillisers, restricting their use to 'medical and scientific' purposes. The convention also encourages international co-operation to address drug trafficking (article 21).
- **The 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances**<sup>10</sup> was introduced to counter the increasingly powerful and sophisticated transnational organised criminal groups, and promotes international co-operation to address drug trafficking effectively. Signatory states are compelled to establish as criminal offences 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).

All three conventions allow signatory states to adopt measures for the treatment, education, aftercare, rehabilitation or social re-integration of those who have committed drug-related offences and are found to be drug dependent. These offenders may be encouraged to enter drug treatment, either as an alternative or in addition to criminal justice sanctions.<sup>11</sup> In terms of drug consumption, there is no specific requirement to criminalise this within any of the conventions and there is considerable flexibility for minor offences related to personal consumption.<sup>12</sup> A level of **depenalisation** and/or **decriminalisation** (see [Box 4](#), Section 2.1: Drug law reform) is therefore possible under the UN drug conventions for personal use offences such as possession or cultivation for personal use<sup>13</sup> (these two concepts are explained below).

While these conventions impose obligations on national governments, signatory states have much discretion and flexibility as to how domestic drug laws should be framed and implemented.<sup>14</sup> In implementing the UN drug conventions, governments should keep in mind first that the main concern of the conventions is to improve the 'health and welfare of mankind',<sup>15</sup> and second that they are also bound by their obligations under other international conventions, including those protecting human rights and fundamental freedoms.

### **The United Nations human rights system**

Human rights and fundamental freedoms apply in the context of drug policy, and people who use or grow drugs, like any other citizen, should benefit from these rights at all times (see [Chapter 1.2: Ensuring compliance with fundamental rights and freedoms](#)). Governments from around the world have signed a number of international treaties and declarations that protect different aspects of human rights, including the right to life, to health, to due process and to be free from discrimination, torture and slavery, to name a few.

However, as explained in [Section 1.2](#), a number of drug policies have led to serious human rights violations. It is crucial that, when designing drug laws, policy makers ensure that these are consistent with their international human rights obligations.

## Technical issues to consider within existing drug laws

### Drugs and their classification

Most national laws regroup controlled substances into schedules according to their perceived danger, with the schedules linked to a hierarchy of penalties that will help in judging the seriousness of the offence committed in relation to a substance.

The problem posed by drug schedules is the difficulty of maintaining a scientific approach to classifying drugs.

The international drug conventions provide guidance to national governments on how to classify controlled substances. However, the scheduling mechanism offered by the conventions was created 50 years ago – at a time when scientific evidence was scarce – and is at times confusing

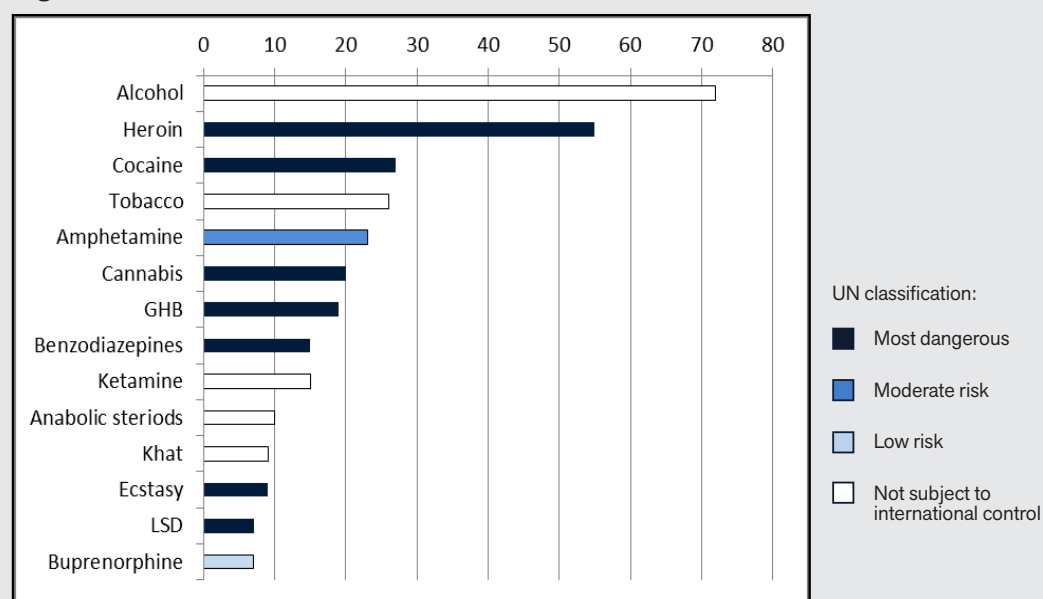
and inconsistent, as was highlighted by both WHO<sup>16</sup> and the International Narcotics Drug Board (INCB).<sup>17</sup> For example, cannabis, the coca leaf and morphine have been used for pain relief for hundreds of years. However, despite evidence that these substances cause little harm to the individual, they are included in Schedule I of the 1961 Convention – the strictest drug control regime applied, for example, to heroin.

Box 1 highlights discrepancies between levels of harm and control for various drugs. Although the study discussed has limitations because of the difficulty in measuring the harms associated with a specific substance, it clearly shows that the classification system promoted in the UN drug conventions is not evidence based.

#### Box 1. Discrepancies between levels of harm and control

In a report published in *The Lancet* in 2007<sup>18</sup> and revised in 2010,<sup>19</sup> a team of British scientists ranked licit and controlled drugs according to the actual and potential harms they could cause to society, and contrasted these findings with the classification of each substance within the United Kingdom (UK) Misuse of Drugs Act. The graph in Figure 1 uses the 2010 findings on related harm and contrasts them with the drug classification system established by the UN drug conventions.<sup>20</sup>

Figure 1. UN classification of substances and levels of harm



Governments need to ensure that penalties for drug offences are proportionate.

The main problem posed by drug schedules is therefore the difficulty of maintaining a scientific approach to classifying drugs. One issue is the continuous evolution of research on the harms linked with certain drugs. Another major issue leading to poor assessments of drug-related harm is the fact that harm is largely determined by dosage, the mode of administration, the frequency of use, poly-drug use, the type of drug-using environment, etc. As a result, classification is rarely based on solid evidence, but rather on ideological and cultural judgements. The mechanism of drug classification is further complicated by the rapid emergence of new synthetic substances, also called 'legal highs',<sup>21</sup> and the increasing use of pharmaceutical drugs.

The principle that different types of substances can attract different levels of control for drug-related offences can still be useful, provided that scheduling is not the only determinant in sentencing when the offence is within the realm of the criminal justice (see paragraph below on ensuring the proportionality of sentencing). Classification should therefore be accompanied by some level of judicial discretion that takes into account a range of other factors relating to the offence and the offender, in order to determine a proportionate sentence – for example, the nature of supply, previous criminal history, treatment needs, etc.

Based on this understanding, several elements need to be taken into account when reviewing national drug classifications:

- whether the current drug classification system should be maintained or replaced by an alternative process for judging the seriousness of offences (for example, aggravating or mitigating factors); if the current drug classification system is retained, is the current placement of substances evidence based, and is the classification system widely understood?
- which substances the legislation should cover (when considering UN obligations) and how they should be distributed across classes
- whether the quantity or street value of the drug substance should be taken into account when determining its class
- the process that should be used to scrutinise and incorporate new psychoactive substances; if a substance falls into disuse, or evidence emerges that its harms are greater or less than previously understood, what is the process for reviewing its place in the national classification system?
- the framework that is most suitable to reflect the link between controlled drugs and licit substances (alcohol, tobacco and pharmaceuticals).

Several studies have been conducted on the respective harms associated with the availability and use of different drugs.<sup>22</sup> This research can provide governments with guidance for appropriate classification.

## **Ensuring proportionality of sentencing for drug-related offences**

Traditional criminal 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 were insufficient to distinguish accurately between different actors in the drug market, or focus enforcement resources on those powerful and violent people who control illicit drug markets. This system has also led judges to impose disproportionate penalties for relatively minor drug offences, as was the case for example in Ecuador (see [Box 2](#)), or in other parts of the world where certain drug offences are punished with the death penalty (see [Box 3](#)).

### **Box 2. The Ecuadorian experience of proportionality of sentencing<sup>23</sup>**

Ecuadorian drug laws were drafted in the 1980s under intense international pressure and soon became some of the harshest in Latin America. The strict enforcement of these laws led to massive problems of prison overcrowding – in 2008, 17,000 individuals were being detained in a prison infrastructure that was built to hold up to 8,000 inmates. Out of these 17,000 prisoners, 34% were being held on drug charges. At the time, a mandatory minimum sentence of 10 years' imprisonment was imposed on all drug offenders without distinction – people using drugs, first-time offenders, low-level dealers and high-level traffickers. The overuse of preventive detention further worsened the prison situation.

In 2008, the government announced a national campaign that included, among other components, pardon for low-level traffickers. This shift in policy was justified as follows: '[The current law] establishes punishment that is disproportionate to the crime committed; in reality, the majority of sentenced persons are not large-scale traffickers or sellers but persons called "drug couriers", mostly women, the majority of whom have no control over narco-trafficking but are persons who rent their bodies ... as drug containers in exchange for ... money unrelated to the amount obtained by the scale of such substances'.<sup>24</sup>

In July 2008, the Ecuadorian Constitutional Assembly adopted a package of reforms and proposals that included pardon for low-level traffickers. By January 2009, 6,600 prisoners had been released by simplifying legal proceedings and granting pardon to those who had terminal diseases and to low-level traffickers; 1,600 of these were drug couriers.

### **Box 3. The use of the death penalty for drug offences<sup>25</sup>**

Thirty-two countries and territories worldwide retain the death penalty for drug offences. Although only a small number of states use the death penalty, hundreds of drug offenders are executed every year. Several countries, including Egypt, Iran, Kuwait, Lao People's Democratic Republic and Sudan, even prescribe the death penalty as a mandatory sentence for certain drug offences.

The use of the death penalty contravenes the principle of proportionality of sentencing protected under international law. The International Covenant on Civil and Political Rights in particular states that the death penalty may only be legally applied for the 'most serious crimes' (article 6.2). International human rights bodies have concluded that drug crimes do not meet this criterion. One of the arguments brought forward is the fact that those executed often come from economically vulnerable groups, exploited by trafficking gangs.

In the past decade, countries such as the Philippines, Uzbekistan and Kyrgyzstan, have abolished the death penalty altogether, while Tajikistan and Jordan removed capital punishment for drug offences.

It is possible for governments to ensure that penalties for drug offences are proportionate and that available resources are used effectively. To achieve these objectives, it is helpful to consider four broad groups and suggest ways in which they can most effectively be dealt with under the law.

- **People who use drugs 'recreationally' or occasionally** are individuals caught in possession of small amounts of drugs, where there is no evidence of drug dependence (such as repeated convictions for possession, other related offences or medical history) or criminal behaviour. Deterrence through harsh punishment is not effective in reducing the prevalence of drug use among these individuals.<sup>26</sup> Under revised drug laws, people who use drugs recreationally should be considered as a low priority and take up a minimum amount of resources (or none at all in a regulated market) from the criminal justice system. Policies can involve **depenalisation** (e.g. informal warnings), **de facto decriminalisation** (orders to the police to de-prioritise this group) or **decriminalisation** (e.g. the imposition of fines, informal sanctions such as donations to a charity, community work or other civil or administrative sanctions). These types of policies will be described in further detail below (see [Box 4](#)).
- **People dependent on drugs** are individuals arrested in possession of drugs for whom there is evidence that use is part of a wider pattern of behaviour that may cause harm to themselves and/or others. They are usually arrested for drug possession or for other offences, such as property crime, sex work or low-level dealing. Drug laws should include mechanisms to offer this group evidence-based treatment for drug dependence.

Diversion should be based on the principle of due process and involve mechanisms for appropriate screening by professional staff (see [Section 2.2: Effective drug law enforcement](#)). If people dependent on drugs are sent to prison, they should also be offered drug treatment services (see [Chapter 2.4: Effective drug interventions in prisons](#)).

- **'Social' or low-level dealers** are those at the bottom end of the retail drug market and most likely to be arrested and punished since their activities are more visible to law-

It is helpful to consider four broad groups:

- People who use drugs recreationally
- People dependent on drugs
- Social or low-level dealers
- Serious or organised traffickers

enforcement authorities. Some of these people are purely social suppliers, who deal for little or no profit. Others are 'drug couriers', who have been pressed into getting involved, through intimidation or desperation.<sup>27</sup> 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, low-level dealers are often under the power of those who truly control the drug market. Drug laws should re-focus on high-level drug traffickers rather than low-level offenders, and take into account the circumstances under which the drug

crime was committed, to ensure proportionate sentences. Finally, some low-level dealers may also be dependent on drugs, in which case they should fall under the category above.

- **Serious or organised traffickers** are the crime gangs that control the large-scale drug markets, often using high levels of violence. These are the individuals that cause the most harm to the 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.<sup>28</sup> These include possession of weapons, use of violence and indicators of involvement of organised crime, or of involving children. Dealing drugs in public places can be added to this list, but must be handled with care and sensitivity, since organised criminals with the real power and wealth will usually remain in the background, using small user-dealers (often vulnerable individuals) to work the streets for them. 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 (see [Section 4.2: Reducing drug market violence](#)).

## Options for drug law reform

Many governments have now realised that drug laws should primarily seek to contribute to the overall national objectives of reducing crime and promoting public health and socio-economic development. Various alternative strategies are at their disposal to design more humane and effective drug laws, which will focus resources on the most harmful aspects of the drug market, while encouraging the provision of support and health care for people who grow and/or use drugs. Four main policies are increasingly accepted as viable alternatives to the current drug control regime (see [Box 4](#)).

### Box 4. Definitions

**Depenalisation** – reduction of the severity of penalties associated with drug offences. Penalties remain within the framework of criminal law.

**De facto decriminalisation** – drug use or possession for personal use remains illicit under the law, but in practice, the person using that drug or in possession of it will not be arrested or prosecuted.

**Decriminalisation** – drug use and/or possession, production and cultivation for personal use are no longer dealt with through criminal sanctions, but drug trafficking offences remain a criminal offence. Under this legal regime, sanctions may be administrative or may be abolished completely.

**Legal regulation** – all drug-related offences are no longer controlled within the sphere of criminal law, but production, supply and use are strictly regulated through administrative laws, as is the case for tobacco or alcohol.

### Depenalisation

Depenalisation involves reducing the level of penalties associated with drug offences, but these penalties remain within the framework of criminal law and the offender will usually retain a criminal record. In the UK, for example, a person arrested for drug possession for personal use is given a warning, rather than a prison sentence (see [Box 5](#)).

### Box 5. The UK cannabis warning scheme

The 'cannabis warning scheme' was introduced in 2004 and allows the police to take an escalated approach to possession offences involving small amounts of cannabis. Those caught in possession for the first time can receive a 'cannabis warning', which does not result in their arrest or a criminal record and is dealt with on the street. If caught on a second occasion, the individual will receive a penalty notice for disorder (an £80 on-the-spot fine), which will not be put on a criminal record provided that the fine is paid within 21 days. A person caught on a third occasion will be arrested and will either be given

a caution or prosecuted. In case of aggravating circumstances (e.g. smoking in public), the scheme does not apply. The scheme is also discretionary and a police officer can therefore decide to arrest an individual without following the guidance. Evidence shows that since 2004, cannabis use has dropped significantly in the UK, especially among young people.<sup>29</sup>

### **De facto decriminalisation**

*De facto* decriminalisation refers to situations where activities such as large-scale possession, production and supply of a drug remain illicit, but people arrested for use, possession and/or cultivation for personal use will no longer be subject to arrest and prosecution in practice. This usually follows an order from the government not to enforce the law. One of the most striking examples of such an approach has been developed in the Netherlands concerning cannabis possession and use (see [Box 5](#) in Section 2.3: Reducing incarceration). The problem with *de facto* decriminalisation is that it is an informal order that can easily be reversed after a change in government.

### **Decriminalisation**

Decriminalisation entails the repeal of laws that define drug use or possession for personal use as a criminal offence, or transferring the process to administrative or health services. The obvious advantage of decriminalisation over *de facto* decriminalisation is that it is formalised in the law. Decriminalisation also presents a major advantage over depenalisation – the individual caught in possession of drugs will not have a criminal record, which is an important barrier to access to education, employment and social services.

In practice, decriminalisation can raise important issues for governments since they need to create mechanisms to distinguish between possession for personal use and possession with intent to supply to others. Some governments have established threshold quantities to provide guidance on whether the amount should be considered to be for personal or for commercial use, while other governments leave it to the discretion of judges or the police to assess the intent of possession. Although there is no 'silver bullet' response to this issue, evidence shows that threshold quantities should be *indicative only* and should be considered jointly with additional factors, including drug dependency, intention, culpability and harm.<sup>30</sup>

About 30 countries and states have moved towards decriminalisation of drug possession, including countries as different as Portugal (2001), Brazil (2006) and the Czech Republic (2010). Argentina is also currently revising its drug laws to decriminalise drug possession for personal use. In the USA, 14 states have now decriminalised cannabis possession for personal use.<sup>31</sup>

Having been developed and extensively evaluated for more than 10 years, the Portuguese decriminalisation model shows encouraging trends. Under the Portuguese law adopted in 2001, although drug possession for personal use is still legally prohibited, violations of the prohibition are exclusively administrative rather than criminal. The decriminalisation process is coupled with a comprehensive public health approach (see [box 6](#) in Section 2.3: Reducing

incarceration). Evidence demonstrates that the policy has led to a significant reduction in drug-related health problems (including HIV infections and drug-related deaths), improved attendance at programmes treating drug dependence, reduced prison and criminal justice overload, a decrease in drug-related crime, an increase in law-enforcement actions focused on large-scale drug trafficking with a consequent improvement in public safety, and no significant increase in the prevalence of drug use.<sup>32</sup>

### **A regulated drug market**

As the critiques of a blanket prohibitionist approach have gathered momentum, the parallel question around alternatives to prohibition has begun to enter mainstream policy debate (see [Box 6](#)). 'Legal regulation' differs from 'legalisation' – in both systems, drug production, supply and use is legal, but a regulatory model means that strict regulations are put in place to control these activities.

#### **Box 6. Abstract from the report of the Global Commission on Drug Policy**

'[We] encourage experimentation by governments with models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens. This recommendation applies especially to cannabis, but we also encourage other experiments in decriminalization and legal regulation that can accomplish these objectives and provide models for others'.<sup>33</sup>

The last decade has seen the first detailed proposals emerge<sup>34</sup> that offer different options for controls over products (dose, preparation, price, and packaging), vendors (licensing, vetting and training requirements, marketing and promotions), outlets (location, outlet density, appearance), who has access (age controls, licensed buyers, club membership schemes) and where and when drugs can be consumed.

The report *Blueprint for regulation*,<sup>35</sup> for example, explores options for regulating different drugs among different populations and suggests various regulatory models for discussion that may lead to the management of drug markets with less health and social harm (see [Box 7](#)). Lessons can be drawn from successes and failings with alcohol and tobacco regulation in various countries, as well as controls over medicinal drugs and other harmful products and activities that are regulated by governments.

#### **Box 7. Five basic models for regulating drug availability<sup>22</sup>**

- **Medical prescription model or supervised venues** – for drugs that can be used in a harmful way (injected drugs, including heroin, and more potent stimulants such as methamphetamine)
- **Specialist pharmacist retail model** – combined with named/licensed user access and rationing of volume of sales for moderate-risk drugs such as amphetamine, powder cocaine, and ecstasy

- **Licensed retailing** – Including tiers of regulation appropriate to product risk and local needs; this could be used for lower-risk drugs and preparations such as lower-strength stimulant-based drinks
- **Licensed premises for sale and consumption** – similar to licensed alcohol venues and Dutch cannabis 'coffee shops', these could potentially also be for smoking opium or drinking poppy tea
- **Unlicensed sales** – minimal regulation for the least-risky products, such as caffeine drinks and coca tea

The regulation of drug markets, using one of the available models, is no silver bullet. It is argued that in the short term it can only reduce the problems that stem from prohibition and the illicit trade it has created. It cannot tackle the underlying drivers of drug dependence such as poverty and inequality. However, by promoting a more pragmatic public health model and freeing up resources for evidence-based public health and social policy, it would create a more conducive environment for doing so. The costs of developing and implementing a new regulatory infrastructure would need to be considered, but would be likely to represent only a fraction of the ever-increasing resources currently directed into efforts to control supply and demand. There would also be potential for translating a proportion of existing criminal profits into legitimate tax revenue.

Different social environments will require different approaches in response to the specific challenges they face, but the range of regulatory options available to manage drug markets and use, through legitimate state and commercial institutions, are now a credible option for policy makers if the harms facing their societies cannot be addressed within the current drug control system. Moves towards legal regulation will also require that the substantial institutional and political obstacles presented by the international drug control system are overcome. Finally, they would need to be phased in cautiously over several years, with close evaluation and monitoring of the effects of the system.

## Recommendations

- 1) 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.
- 2) As part of this process, governments and international agencies should conduct human rights impact assessments of current drug laws and their implementation as part of this process.
- 3) When creating or revising drug laws, governments should clearly determine which aspects of the drug market are most harmful to society, and target their laws accordingly to reduce those harms.

- 4) New or revised drug laws should contain provisions that draw a clear distinction between the different actors operating in the market, with particular protection for people who use drugs. Such laws should also facilitate the adoption of appropriate responses for each of these categories. Alternatives to imprisonment, such as fines, or referral to treatment and care services, should be designed for low-level drug dealers and people dependent on drugs.
- 5) New or revised drug laws need to be clear on the range of substances covered. They should provide a structured and scientific approach to assess the seriousness with which different substances will be treated, and a simple process for adding, moving or removing particular substances.
- 6) New or revised drug laws need to be carefully drafted to support, instead of undermine, health and social programmes. They should authorise and encourage public-health and harm reduction interventions, such as needle and syringe programmes and opioid substitution therapy.

## Key resources

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- 12 Bewley-Taylor, D. & Jelsma, M. (2012) 'The UN Drug Control Conventions; Latitude and Limitations'
- 13 To understand the flexibility within the conventions, it is useful to divide drug offences into two categories. The first are those which relate to commercial activities include possession with intent to supply commercially. The second are those offences related to personal use, such as possession for personal use, cultivation, production as well as social supply. With respect to commercial or trafficking offences there is very little room to deviate from the requirement to criminalise, except for minor offences when the offender is deemed to be drug dependent (1988 Convention, Article 3, para 4). The conventions offer more flexibility for dealing with personal use offences outside of the criminal justice system.
- 14 The conventions are not treaties of direct applicability. While they impose obligations on states to apply international law, they can only be implemented at the national level when the signatory state has adopted domestic laws and regulations that translate the international obligations of the treaty at the national level. The autonomy of domestic law is stressed within all three conventions, and is further reflected in the declarations and reservations made by signatory states. In addition, the conventions specify that signatory states are required to implement the conventions' provisions in domestic legislation in accordance with their constitutional principles and the basic concepts of their national legal systems.
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## 2.2 Effective drug law enforcement

### In this section

- Limitations of current strategies
- New objectives and indicators for law enforcement
- Setting more effective objectives and indicators

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

### Why is an effective law-enforcement strategy important?

The UN drug control conventions and the majority of national drug control systems are based on the belief that the strong enforcement of laws prohibiting drug production, distribution and use will eventually eliminate the supply and demand of controlled drugs, and therefore eradicate the illicit market. Police forces, specialised drug-enforcement agencies and, in some countries, even the military, have therefore played prominent roles in developing and implementing drug policies. So far, law-enforcement strategies to reduce drug demand and supply have mainly consisted of:

- production controls, including eradication and violent measures against manufacturers and growers
- operations to disrupt drug smuggling operations
- investigation and incarceration of people suspected 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 controlled drugs.<sup>1</sup>

Law-enforcement tactics against producers and traffickers have been focused on physically restricting the supply of drugs to consumers, while actions against consumers have focused on deterring potential drug use through the threat of arrest.

Law enforcement strategies focusing on arrests and punishment against producers, traffickers and consumers have been unsuccessful in reducing the scale of illicit drug markets.

These strategies have been unsuccessful in reducing the overall scale of illicit drug markets, and many of the activities behind these strategies have had serious negative consequences (see [Section 1.3: Focusing on the harms associated with drug markets and use](#), for more details).

In 2011, the Global Commission on Drug Policy (see [Box 1](#)) produced an analysis report showing that the world market for controlled drugs had grown, despite the escalation of law-enforcement measures in the past five decades.<sup>2</sup> The focus of law-enforcement strategies needs to be reoriented in order to reduce drug-related harms to the health and social welfare of communities.

### **Box 1. Abstract from the Global Commission on Drug Policy report<sup>3</sup>**

'When the United Nations Single Convention on Narcotic Drugs came into being 50 years ago, and when President Nixon launched the US government's war on drugs 40 years ago, policy makers believed that harsh law enforcement action against those involved in drug production, distribution and use would lead to an ever-diminishing market in controlled drugs such as heroin, cocaine and cannabis, and the eventual achievement of a "drug free world". In practice, the global scale of illegal drug markets – largely controlled by organized crime – has grown dramatically over this period'.

## **Limitations of current strategies**

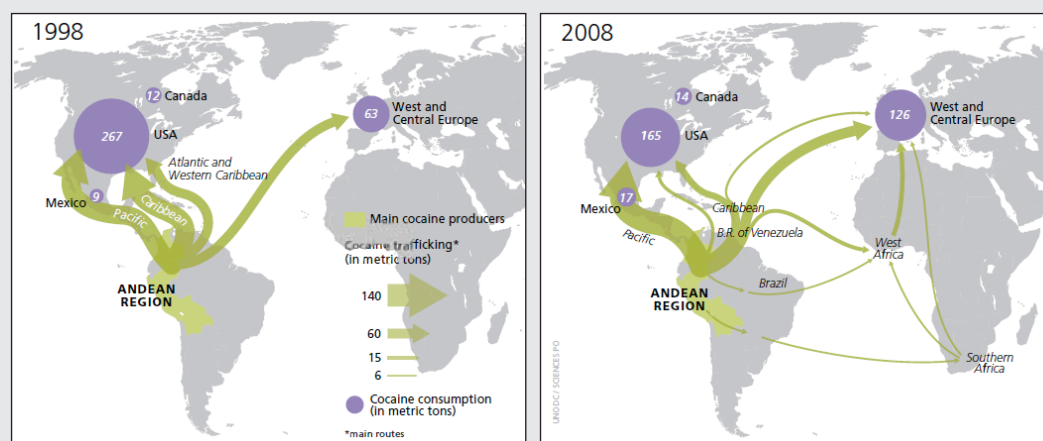
On a global scale, successive campaigns and commitments to eliminate or significantly reduce drug markets have failed to achieve their objectives, despite widespread political and financial support. Operational successes in particular countries, or against particular trafficking groups, have quickly been offset by the 'balloon effect' (see [Box 2](#)). The illicit 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.

### **Box 2. The 'balloon effect'**

**The 'balloon effect'**: an intervention succeeding in suppressing a drug-related activity merely pushes the same activity to another part of the drug market. Figure 1 below illustrates this phenomenon – law-enforcement activities aimed at the Caribbean region have only resulted in new trafficking routes being created for drugs produced in Latin America for consumption in Europe to be transported through West Africa. Similar trends appear for drug production and consumption – successful law-enforcement activities that eradicate drug production in a specific region lead to an increase in production in

another area (e.g. a reduction in opium poppy cultivation in Thailand led to an increase in cultivation in Afghanistan) and law-enforcement activities targeting people using a specific substance have resulted in users turning to other, sometimes more harmful, substances, such as 'legal highs'.

**Figure 1. Switching trafficking routes for cocaine, 1998–2008<sup>4</sup>**



These strategic dilemmas for policy makers do not mean that law-enforcement agencies should give up their attempts to control drug markets. Rather it means that policy makers have to adopt more effective law-enforcement strategies that minimise any 'unintended negative consequences' (see [Section 2.1: Drug law reform](#)).

## New objectives and indicators for law enforcement

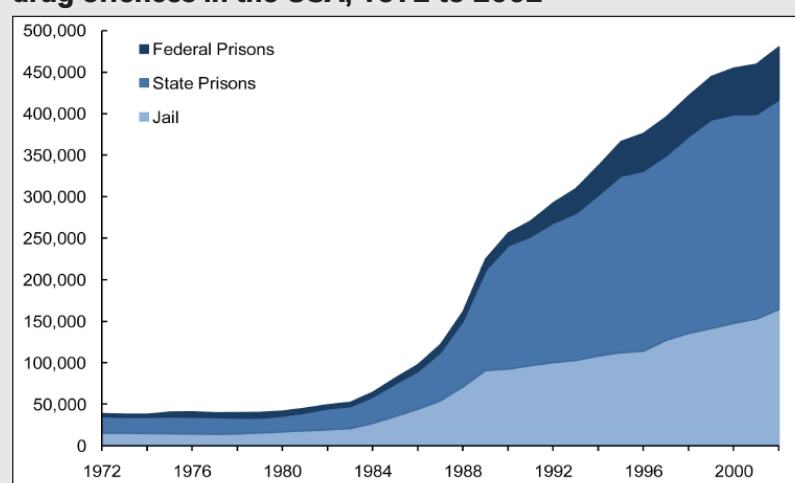
At the heart of reviewing existing drug strategies is the need to reconsider the objectives and priorities for law-enforcement action against drug markets and drug use. At a fundamental level, it is the duty of police and other law-enforcement agencies to protect the health and welfare of citizens. The assumption of many policy makers and law-enforcement managers has been that the best way to protect citizens from drug-related harm was to focus on eradicating illicit drug markets. As a result, the success of law-enforcement strategies has been measured in terms of steps towards the goal of eradication, such as the area of crops destroyed, amount of drugs or precursors seized, and number of arrests of people who use drugs or of low-level dealers.

Unfortunately, none of these indicators has been an accurate measurement to whether the overall scale of the drug problem is being reduced. Nor are they a relevant barometer of the health and welfare of mankind, as envisaged in the Preamble of the 1961 Convention. For example, successful operations to disrupt trafficking organisations have not led to sustained reductions in drug availability, and widespread crop eradication has not led to a reduction in the overall global drug production. Similarly, there is no correlation between the number of people who use drugs arrested in a given country and trends in the prevalence of drug use (see [Box 3](#)).<sup>5</sup>

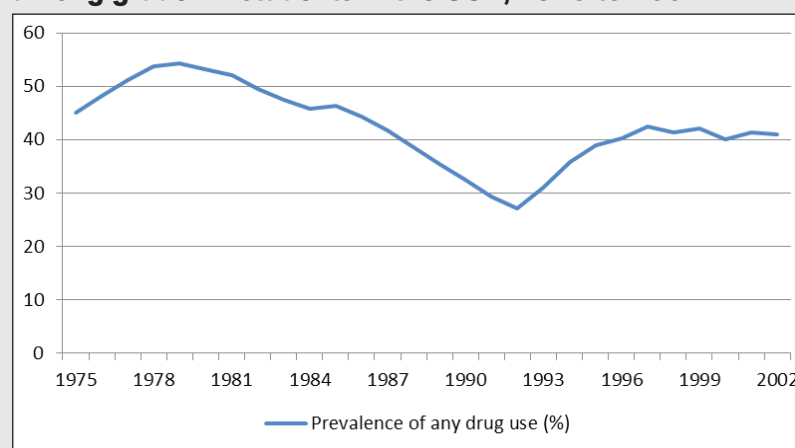
### Box 3. Comparison of the United States' high arrest rate and the prevalence of drug use

Figure 2 shows the estimated number of adults incarcerated for drug offences in the USA over a 30-year period. According to the graph, the numbers of incarcerated adults increased by 1,000% between 1972 and 2002. As can be seen in Figure 3, a snapshot of the prevalence of drug use among young American students shows that there is no correlation between the levels of incarceration for drug offences and the prevalence of drug use.

**Figure 2. Estimated number of adults incarcerated for drug offences in the USA, 1972 to 2002<sup>6</sup>**



**Figure 2. Annual prevalence of controlled drug use among grade 12 students in the USA, 1975 to 2002<sup>7</sup>**



### Setting more effective objectives and indicators

It is no longer possible to rely on the claim that strategies and tactics focusing on seizures, arrests and punishments will solve the drug problem. Instead, law-enforcement resources should be targeted at reducing drug-related crime and health and social harms, in order to better achieve the ultimate goal of securing the health and welfare of citizens. Law-enforcement strategic objectives should be more focused on the consequences – whether positive or negative – of the drug market, rather than its scale. To evaluate the progress of law-enforcement agencies in reaching these revised objectives, new indicators need to be developed:

- **indicators of drug markets that focus more on the outcomes of law-enforcement operations:**
  - have law-enforcement operations reduced the availability of a particular drug to young people (measured by the level of use or ease of access)?
  - 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 people who use drugs?
- **indicators measuring drug-related crime:**
  - 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 people dependent on drugs been reduced?
- **indicators measuring the law-enforcement contribution to health and social programmes:**
  - how many people dependent on drugs have law-enforcement agencies referred to drug-dependence treatment services?
  - how many people have achieved a sustained period of stability as a result of treatment?
  - has the number of overdose deaths been reduced?
  - has the prevalence of HIV and viral hepatitis among people who use drugs declined?
- **indicators evaluating the environment and patterns of drug use and dependence:**
  - 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 possible indicators for measuring law-enforcement's contribution to reducing the negative impacts of drug markets, and which can also be more realistically achieved. If law-enforcement strategies and activities are to be guided by a different set of objectives and indicators, it does not mean a reduction in the role of law enforcement in drug control efforts. Rather, enhancing the objectives and indicators for law-enforcement strategies will strengthen the capacity of law-enforcement agencies to develop more effective responses – particularly in the areas discussed below.

Law-enforcement resources should be targeted at reducing drug-related crime and health and social harms.

### **Tackling organised crime**

Law enforcement will never be able to fully eradicate the illicit drug market (long and costly operations to disrupt one group only lead to its replacement by another). Strategies and interventions should therefore focus on curtailing the operations of those criminal organisations and individuals whose actions are causing the most harm to society, whether it be through the corruption of officials and institutions, violence against and intimidation of law-abiding citizens, or the distortion or undermining of legitimate economic activities. Actions against organised crime groups need to be based on quality intelligence,<sup>8</sup> focusing on how their operations impact

Law enforcement efforts should focus on:

- Tackling organised crime
- Tackling the problems associated with retail markets
- Reducing availability to young people
- Reducing petty crime committed by people dependent on drugs
- Supporting health and social programmes.

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<sup>9</sup> or reliant on non-violent friendship networks (for more information, see [Section 4.2: Reducing drug market violence](#)). As this is a transnational issue, international co-operation will often be required.

### **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 markets 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 organisation leads to increased violence through battles over the vacated 'turf', or the rise to prominence of a more violent organisation. Similarly, a raid on private premises where drug trafficking is concentrated can result in 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 in order to minimise consequential harms (for more information, see [boxes 4 and 5](#) and [Section 4.2: Reducing drug market violence](#)).

#### **Box 4. The 'Boston Miracle'**

The 'Boston Miracle' is a good illustration of an approach tackling the problems associated with retail markets. 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 per 100,000 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 lethal incident in 1992, a coalition of faith groups was created and started to organise forums gathering offenders who were involved in gangs, police officers, church ministers and social service personnel. Gang offenders were given the choice of either accepting help with education and training or being 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% decrease in the monthly rate of murders among young people.<sup>10</sup>

### **Box 5. Law enforcement in High Point, North Carolina, USA**

Another illustration is provided by the city of High Point, North Carolina, where the police applied the Boston model. Over a long period of time, the police gathered data on young dealers in the local drug market, contacted their parents and other people likely to influence them, then approached the dealers with the information. The police made the dealers aware that they were at high risk of imprisonment if they continued their activities. This initiative resulted in fewer arrests after two years and a 25% decrease in violent and property crime. Today, the local market is no longer in operation.<sup>11</sup>

### **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 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.

Drug policy agencies may consider instituting the supply of drugs to children or involvement of minors in dealing as an aggravating factor in sentencing. This approach has been 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.

In a regulated market, availability to young people could be easily reduced by applying strict regulations on drugs, such as those that apply tobacco, alcohol or pharmaceutical drugs (see [Box 7](#) of Section 2.1: Drug law reform).

### **Reducing petty crime committed by people dependent on drugs**

The most common forms of drug-related crime are theft, fraud, commercial sex work and robbery offences committed by people dependent on drugs, to raise money to pay for drug purchases.<sup>12</sup> Many countries have found that people dependent on drugs account for a significant proportion of the overall rates of certain petty crimes. Those that have implemented initiatives to identify the most active offenders and refer them to evidence-based treatment programmes for drug dependence have found that it is a cost-effective mechanism for reducing individual crime rates.<sup>13</sup> As law-enforcement agencies come into regular contact with these offenders, these agencies 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 people dependent on drugs away from a lifestyle of petty offending and drug dependence (for more information, see [Section 2.3: Reducing incarceration](#)).<sup>14</sup> Law-enforcement agencies should therefore put greater emphasis on referring these people to services and treatment rather than on the more expensive process of prosecution and imprisonment.

## **Supporting health and social programmes**

Because of the current drug control regime, people who use drugs are often forced to live on the margins of society. Poverty and alienation are often contributing factors in the initiation to drug use and development of drug dependence (harsh living conditions and emotional trauma can increase vulnerability to drug dependence) and, in turn, drug dependence exacerbates these problems.

Some governments have adopted drug policies that tend to increase social exclusion. Arresting and punishing people who use drugs, or denying them access to employment and education, for example, can add to the marginalisation they already experience. In these circumstances, drug use can result in significant health risks, including overdose and blood-borne infections such as hepatitis or HIV. In many countries, the HIV epidemic is driven by the sharing of contaminated injection equipment, and public health authorities are engaged in a global response to scale-up HIV prevention services targeted at people who use drugs. Many of these measures, such as the distribution of sterile needles and syringes, work within the context of continuing drug use, and seek to keep people who use drugs stay alive and healthy, while encouraging them to consider treatment options. Many law-enforcement agencies have been reluctant to support these initiatives, as they mistakenly believe them to be condoning or perpetuating drug use.

The lack of clear support from law-enforcement agencies for social and health initiatives targeting people who use drugs is a serious policy barrier. Law-enforcement agencies can and should support the referral of people who use drugs to appropriate health and social services, in order to improve public health, specifically in efforts to reduce HIV transmission and overdose deaths. As police and court officials, in particular, come into regular contact with people who are vulnerable to HIV infections, they can play an important role in the provision of advice and information, facilitating access to harm reduction services as well as 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 (see [Box 6](#)).

### **Box 6. The ‘Four pillars policy’ in Switzerland**

In 1994 the Swiss government adopted a new drug strategy that integrated public security, health and social cohesion objectives. It comprised four pillars: prevention, treatment, harm reduction and law enforcement. The strategy was developed on the basis of consultations with members from the law-enforcement, public health and community sectors. The new policy involves prescribing opiates (notably heroin) to treat dependence on opiates. 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%. Third, levels of injection drug use-related HIV infections were reduced by 80% within 10 years. Finally, the frequency of crimes against property and hard-drug trafficking by users on the heroin prescription programmes dropped by 90%, and shoplifting by 85%.<sup>15</sup>

## Recommendations

- 1) Law-enforcement strategies should be reviewed and refocused, moving away from a singular focus on seizing drugs and arresting users towards working in partnership with relevant agencies to reduce health and social harms.
- 2) A new set of strategic objectives and success indicators for law enforcement should be adopted.
- 3) Actions against criminal organisations must be based on quality intelligence, and resources concentrated on the most harmful aspects of organised crime rather than on seizures or arrests of low-level dealers.
- 4) Law-enforcement strategies against retail markets must be based on good intelligence assessments of local market dynamics, and seek to shape these markets in order to minimise their consequential harms.
- 5) Policies and strategies 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.
- 6) Evidence-based and cost-effective mechanisms for referral of drug offenders to appropriate services, such as community-based drug dependence treatment services are needed. Law-enforcement agencies can identify and refer dependent drug users to these facilities.

## Key resources

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## 2.3 Reducing incarceration

### In this section

- Problems associated with high rates of incarceration
- Alternative strategies to incarceration
- Decriminalisation/depenalisation of drug possession for personal use
- Diversion mechanisms

**Reducing incarceration rates through decriminalisation, depenalisation, and mechanisms of diversion offers more effective and less costly ways to reduce drug-related crime, and promotes the health and social inclusion of low-level drug offenders.**

### Why is it important to reduce incarceration?

In an attempt to reduce illicit drug markets, many governments rely on the incarceration of drug offenders. The rationale for instituting incarceration as punishment for drug-related crimes is the belief that harsh penalties instituted by a strong criminal justice system will deter potential growers, users and dealers from becoming involved in the drug market. Incarceration therefore plays an important part in most national drug control systems, although the extent and nature of its use varies widely from one country to another.

In the past four decades, increasing numbers of people arrested for drug-related offences have been 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.<sup>1</sup> Less significant rises have also taken place throughout Europe, Asia, Africa, Oceania and the Americas.<sup>2</sup> The rising trend of incarceration is concerning, and its effectiveness for alleviating drug-related problems is highly questionable (see [Box 1](#)).

#### **Box 1. Abstract from the UNODC *Handbook of basic principles and promising practices on alternatives to imprisonment*<sup>3</sup>**

'Individual liberty is one of the most fundamental of human rights, recognized in international human rights instruments and national constitutions throughout the world. In order to take that right away, even temporarily, governments have a duty to justify the use of imprisonment as necessary to achieve an important societal objective for which there are no less restrictive means with which the objective can be achieved.'

The UN drug control system is ambivalent in its attitude towards 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 framework that still strongly encourages a punitive approach, particularly article 3 of the 1988 Convention,<sup>4</sup> which compels governments to adopt all the necessary measures to establish criminal sanctions for drug-related offences. At the same time, the UN drug conventions offer countries considerable flexibility by allowing social and health measures to be used in addition to, or instead of, criminal penalties for drug-dependent offenders and do not make a specific requirement for drug use to be criminalised. In practice, most governments have introduced tough drug laws and penalties to comply with the letter and 'spirit' of the UN drug conventions. Over the years, concerns have grown that the widespread incarceration of people who use drugs is too costly, is ineffective and exacerbates health and social problems, while failing to prevent and deter drug use.

The widespread incarceration of people who use drugs is costly, ineffective and exacerbates health and social problems, while failing to deter drug use.

## **Problems associated with high rates of incarceration**

Evidence shows that tough law-enforcement tactics that aim to achieve high incarceration rates for drug offenders have led to negative consequences, not only for drug offenders but also for the criminal justice system and wider society:

### **Financial costs**

According to Harvard economist Jeffrey Miron, the USA spent US\$15.2 billion to keep state and federal drug law offenders in prison in 2006.<sup>5</sup> In the early 1990s, it was estimated that the yearly cost of a prison place was more than the cost of tuition, room and board at Harvard University. High expenditure on incarceration is not limited to the USA. North of the border, Canada spent almost US\$3 billion on custodial services in 2005–2006. The enormous resources devoted to incarcerating drug offenders diverts resources away from vital socio-economic and health programmes such as housing, education and treatment for drug dependence that are crucial to alleviating drug-related problems and tackling the very social conditions that may lead some people to use drugs in the first place.

### **Excessive burden on 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 efficient functioning of a country's criminal justice system. Sentencing laws 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 legal system. 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 reducing drug use**

Some governments argue that punitive law-enforcement measures will reduce drug consumption by directly lowering demand. This assertion is based on the flawed assumption that if people who use drugs are incarcerated, they are not contributing to the illicit drug market, and heavy sentences will deter drug 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 (see [Box 2](#) for more details). WHO itself concluded that 'countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies'.<sup>6</sup>

#### **Box 2. Comparison of incarceration rates and the prevalence of drug use in Amsterdam and San Francisco**

A 2004 study comparing cannabis use in Amsterdam, the Netherlands, and San Francisco, USA, demonstrated that the perceived risk of punishment had no impact on levels of drug use. Despite significantly different law-enforcement regimes in the two cities – Amsterdam allowed drug use in coffee shops and San Francisco imposed imprisonment as a penalty for drug use – the research found remarkable similarities in patterns of drug use.<sup>7</sup> Research suggests that punishment generally has a limited impact on all types of drug use, especially for people dependent on drugs.

The argument linking high incarceration rates with the reduction of drug use also ignores the existence of active drug markets in many prisons worldwide. For example, a 2004 EMCDDA report estimated that the lifetime prevalence of drug use among prisoners varied from 22% to 86% in European prisons,<sup>8</sup> and a 2006 study in Germany found that 75% of prisoners who injected drugs continued to inject while in prison.<sup>9</sup>

Other governments have justified their incarceration policies by citing the positive effects of imprisonment on the rehabilitation of drug offenders. However, it is widely accepted that imprisonment in itself does not have a reformatory effect. While appropriate drug treatment for detainees dependent on drugs can have an impact on drug use and re-offending rates after release, drug treatment in prisons should always be considered as a last option, as evidence shows that better results can be achieved through treatment in the community (see [Box 3](#)).

#### **Box 3. Community-based treatment versus treatment in prisons in New York**

The Drug Treatment Alternative-to-Prison was developed in Brooklyn, New York in 1990. The programme provides 15 to 24 months of treatment for drug dependence, in a residential therapeutic community. It is open to people dependent on drugs who have repeatedly sold drugs, have not been convicted of a violent crime and are willing to engage in treatment and communal living, do not have a history of violence or severe mental health problem, and are facing a mandatory prison sentence. A five-year evaluation of the programme found that only 26% of offenders diverted into treatment were reconvicted, compared to 47% of comparable offenders who had been sent to prison.<sup>10</sup>

## Health consequences

Incarceration also entails significant collateral costs for health, particularly with regard to blood-borne infections such as HIV and hepatitis C. There are consistently higher levels of drug use, especially by injection, in prison populations than in the general population. As needle and syringe programmes (NSPs) remain limited or non-existent in the prisons in most countries, prisoners are usually forced to reuse contaminated equipment. 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 and other blood-borne diseases. Ultimately, this contributes to HIV epidemics in the communities to which prisoners living with HIV return after their release from prison (for more information, see [Section 2.4: Effective drug interventions in prisons](#)).<sup>11</sup>

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 problems with oral health and nutrition. Longer sentences have resulted in increasing numbers of older people in prisons, with the 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 during imprisonment.

High levels of incarceration lead to significant collateral costs for health.

While services to prevent and treat HIV and other infectious diseases are increasingly available in the community, prisoners typically lack access to basic health care, adequate nutrition and diagnosis and treatment of HIV and other infectious diseases.

## Alternative strategies to incarceration

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. Consideration of alternative strategies to incarceration that are effective for addressing drug dependence and related crimes, should be premised on two core principles, as discussed below.

- **Approaching drug use as a health problem, not a crime** – a change of focus is needed from considering drug use as a crime to approaching it as a health problem, and from punishing people dependent on drugs to promoting their access to evidence-based treatment for drug dependence. This approach means reducing incarceration and developing alternative mechanisms to deal with arrested users. Such an approach is supported by the UN drug conventions,<sup>12</sup> in particular the UN Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules),<sup>13</sup> and more recently by the INCB, which emphasised that the principle of proportionality should be applied to offences of personal possession, purchase, cultivation and use 'as complete alternatives to conviction and punishment'.<sup>14</sup>

- **Imposing proportional penalties for drug offences** – a fundamental shift in approach is needed for the punishment of drug offences. Laws and regulations prescribing sentences and penalties for drug offences should be reformed to reflect the seriousness of the crime and the likely impact of punishment on the overall illicit drug market. In any case, the death penalty should not be used for drug offences (see [Box 3](#) in Section 2.1: Drug law reform). Of particular importance is the need to distinguish between different types of drug offenders – ‘recreational’ or casual users, people dependent on drugs, ‘social’ or low-level dealers, and serious or organised traffickers (see [Section 2.1: Drug law reform](#)). Pre-trial detentions and mandatory minimum penalties should be avoided for low-level and non-violent drug offenders, in order to reduce prison overcrowding. Policy makers should seek to understand the extent and type of harms caused by different drug-related activities, in order to determine the relevance and proportionality of punishment.

Diversion mechanisms reduce the incarceration rate of low-level and non-dangerous drug offenders.

Diversion mechanisms can contribute to reducing the incarceration rate of low-level and non-dangerous drug offenders. Different mechanisms for diverting these individuals from imprisonment can be combined to reduce the pressure on countries' criminal justice systems, and achieve better health and social outcomes

### **Depenalising and decriminalising drug possession for personal use**

People caught in possession of drugs for personal use should be recognised as a special category, and should not be sent to prison solely for the possession or use of controlled drugs. Three main strategies have been adopted so far to remove incarceration as a response to the use or possession for personal use of controlled drugs:

- depenalisation (see [Box 4](#) for an example from Australia)
- *de facto* decriminalisation (see [Box 5](#) for an example from the Netherlands)
- decriminalisation (for detailed examples, see [Section 2.1: Drug law reform](#)).

These strategies have been effective in reducing the burden on the criminal justice and prison systems and improving access to social and healthcare services, while not leading to an increase in drug use.<sup>15</sup>

#### **Box 4. Depenalisation in Australia**

Several Australian states have adopted a balanced policy between law enforcement and treatment services for drug offenders. In those states, cannabis cultivation and possession are met with civil penalties such as fines or infringement notices rather than incarceration. Police officers have implemented this mild enforcement system with substantial success, while avoiding some of the negative outcomes of an overly prohibitionist model, such as loss of productivity and threats to civil liberties. Their approach has had a positive effect on incarceration levels, since only 11% of the prison population was incarcerated for drug offences in 2010.<sup>16</sup>

**Box 5. The Netherlands *de facto* decriminalisation model**

In the Netherlands, the Dutch authorities applied *de facto* decriminalisation to cannabis in the 1970s. Under this system, although cannabis possession and use remain illegal under the law, the Dutch Ministry of Justice chooses not to enforce the law. Possession of less than 5 grams of cannabis is no longer a target for law-enforcement interventions. During the 1980s, the buying and selling of small quantities of cannabis was eventually permitted in licensed 'coffee shops' under strict regulations.

Diversion is an effective mechanism for implementing depenalisation and decriminalisation. Several countries around the world have established systems of diversion, which vary in many ways, but can be categorised by the stage at which diversion occurs (these will be explained below):

- diversion at arrest
- diversion at prosecution
- diversion at sentencing

Another distinction between diversion systems can be made – in some countries, diversion applies to people caught in possession of controlled drugs, while in others diversion can apply to people arrested for offences motivated by drug dependence (e.g. theft, fraud or sex work).

**Diversion at arrest**

Diversion mechanisms at arrest are designed to avoid burdening the criminal justice system with low-level offenders, and to provide appropriate services to people dependent on drugs. Diversion at arrest relies on police managers and officers as the key personnel making decisions on whether to divert a person into treatment or criminal prosecution. Portugal provides a good example of diversion away from the criminal justice system (see [Box 6](#)).

**Box 6. The Portuguese Dissuasion Commissions<sup>17</sup>**

In July 2001, Portugal adopted a nationwide law that decriminalised the possession of all controlled drugs for personal use. Under this legal regime, drug trafficking is still prosecuted as a criminal offence, but drug possession for personal use is an administrative offence. The law also 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 a social worker, a legal adviser and a medical professional, and supported by a team of technical experts.

The commissions use targeted responses to dissuade new drug users and encourage people dependent on drugs 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 people dependent on drugs.

After adoption of this new system, the proportion of drug offenders sentenced to imprisonment dropped to 28% in 2005 from a peak of 44% 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.<sup>18</sup> These data suggest that the Portuguese reform has indeed taken some of the pressure off the criminal justice system.

### **Diversion at prosecution**

In this system of diversion, prosecutors are the key decision makers that determine whether the person arrested should appear before a court or be sent into treatment (see [Box 7](#)).

#### **Box 7. The Scottish diversion system<sup>19</sup>**

The Scottish national Diversion from Prosecution scheme rolled out in 2000–2001 applies to offenders of all ages. The approach is designed to prevent a person who has committed a relatively minor crime and does not represent a significant risk of harm to the public from being sent to the criminal justice system. In Scotland, Procurators Fiscal (equivalent to prosecutors) are responsible for identifying which of the accused reported to them by the police are suitable for diversion into social work interventions.

A young person on diversion will be involved in individual and/or group sessions, which cover a range of areas such as offending behaviour, alcohol and drug use, social skills, education, employment and training and problem solving. This diversion mechanism has shown particularly positive outcomes with respect to re-offending. The Youth Justice Diversion from Prosecution scheme in Dumfries and Galloway, for instance, has shown very encouraging results – between May and August 2010, 80 young people were diverted to a 6-week social work programme, and only five re-offended.

### **Diversion at sentencing**

Diversion at sentencing relies on judges as the key decision makers. There are two types of diversion at sentencing: diversion through the proceedings of a regular court, or through a specialised drug court. Some countries, such as the UK, process drug offenders through both (see [Box 8](#)).

#### **Box 8. Diversion at sentencing in the UK**

The UK has established both general and specialised courts for processing drug-related offences. Since the mid-1990s, a major campaign was developed to divert offenders dependent on drugs away from prison and into treatment.

Every court in the country has resources and procedures to assess whether the offence committed is related to drug dependence, and whether the offender would benefit from treatment (the UK rarely imprisons people for drug possession, so most

of these offenders are charged with related offences such as drug dealing, theft, fraud and sex work). If the court determines that a non-custodial penalty is appropriate, and a treatment place is available, then it may sentence the individual to a period of treatment instead of imprisonment. The advice to the court on appropriate treatment options is provided by probation officers.

In 2004, the UK experimented with specialised drug courts by establishing six pilot 'dedicated drug courts' (DDCs) to specifically deal with offenders dependent on drugs. These courts have the same basic powers as regular courts, that is, to assess drug treatment needs and alternatives to imprisonment. However, they have specialist staff and judges specifically focused on the drug problem of the offender, and they have a higher level of scrutiny of the offender's progress in treatment. For example, specialised courts require regular reporting on how the treatment is progressing, and the offender discusses treatment progress regularly with the judge. This regular reporting helps to develop a closer relationship between the offender and the sentencing judge, which can in itself improve the prospect of successful treatment outcomes. An evaluation of the DDC initiative found that the specialised courts were useful for helping to reduce drug use and offending. However the evaluation also concluded that the effectiveness of the DDCs also depended on access to **appropriate** treatment.<sup>20</sup>

## Recommendations

- 1) A change of approach is needed to start treating drug use as a health problem instead of a criminal offence. Treatment is a more effective policy response to people who are dependent on drugs but are not involved in serious or violent crime. Incarceration should be reserved as an option for responding to serious offenders.
- 2) Laws and regulations prescribing penalties for drug offences need to be reviewed, with the objective of drawing a clear distinction between the severity of the crime, different actors and their impact upon the illicit drug market:
  - the use of incarceration as punishment should be reserved for high-level and/or violent drug offenders
  - governments should consider introducing depenalisation or decriminalisation as alternative responses to people who use drugs and non-dangerous, low-level street dealers.
- 3) Diversion mechanisms at arrest and at sentence need to be developed to help ensure that cases of low-level drug offenders do not overload and incapacitate criminal justice systems, and that people dependent on drugs can access appropriate services, including evidence-based treatment of drug dependence.

- 4) Any criminal procedure that increases the pressure on prison capacities, such as mandatory minimum sentences and pre-trial detention procedures, should be reserved for the most serious criminal offenders.

## Key resources

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## 2.4 Effective drug interventions in prisons

### In this section

- Health risks in prison
- Responsibilities for prisoners' health: international obligations
- Managing health risks in prison
- Providing treatment for drug dependence in prisons
- Responsibility for prison health care

**Policy makers and prison authorities need to have a clear plan for making prisons as effective as possible in protecting the health and human rights of prisoners, including through the delivery of evidence-based treatment for drug dependence and harm reduction services to those who need them.**

Prison authorities must pursue strategies that minimise the health and social problems associated with prison-based drug markets and use.

### Why are effective interventions in prisons important?

Other sections of the Guide have argued that legal reforms should be pursued to minimise the numbers of non-violent drug offenders sent to prisons or other forms of custodial setting. In many countries, however, drug offenders, and particularly people who use drugs, make up a significant proportion of the prison population. In addition, attempts to

prevent controlled drugs from entering prisons have persistently failed, and they continue to circulate amongst prisoners, with all the attendant health risks this entails in overcrowded and under-served closed settings. This means that effective drug policies are needed **within** the prison environment.

There are a number of further reasons why an effective prisons policy is essential for drug policy makers.

- **Public health** – prisons constitute an extremely expensive system for incubating health problems, because, by their nature, such institutions are difficult places in which to stay healthy. This is particularly so in the case of the use of controlled drugs, where practices such as the sharing of injecting equipment can pass on blood-borne viruses. Although life inside prisons is concealed from public view, prisons are not in fact sealed off from society, and they form an important part of the interconnected sphere of public health. Consequently, they remain the responsibility of governments. Health

problems, infections and illness are not sealed away from the rest of the community, but pass across the prison walls as people enter and exit the institutional setting.

- **Economics** – responding to drug-related crime, overdoses and blood-borne infections both within prison and beyond the prison walls (amongst ex-prisoners, their families, etc) can be very expensive, in particular for illnesses such as HIV that are chronic and long-lasting conditions. This means that there is a powerful economic case to be made for measures that can effectively prevent these health problems in prisons.
- **Human rights obligations** – the right to the highest attainable state of physical and mental health is written into the goals of the UN and a number of international treaties (especially the International Covenant on Economic, Social and Cultural Rights). It is also a part of the Universal Declaration on Human Rights. These texts do not specifically mention prisoners, though many countries are signatories of other treaties that *do* explicitly extend this right to prisoners. The international treaties applying health-related human rights to prisoners are discussed below.

Prison authorities must comply with their international human rights obligations, and pursue strategies that minimise the health and social problems associated with prison-based drug markets and use.<sup>1</sup> The pursuit of health-based policies in prisons, will lead to improvements not only in the health of the drug-using population, but also in the health of the wider population. In addition, it will impact positively on public finances as well as health outcomes.

## Health risks in prisons

### People who use drugs who are detained in prisons and other custodial settings

The best estimate of the current world prison population is 10.1 million, a figure rising to 10.75 million if the 650,000 individuals detained in China's 'detention centres' are included.<sup>2</sup>

Because of the difficulties in obtaining data, and problems of comparability where data are available, it is not possible to provide an accurate global figure for the proportion of these detainees who use drugs. However, some indication of the size of the population can be given: in the European Union (EU), around 50% of prisoners have a history of drug use; in the USA, the figure is over 80%. People who inject drugs are vastly over-represented, often accounting for 50% of prison inmates, but only 1–3% of the broader community.<sup>3</sup>

The number of people in prison, and the number of people who use drugs among them, has been growing fast in the past few decades. In many countries, this has resulted from the widespread arrest and incarceration of people for minor drug offences – possession, consumption or small-scale dealing – while in others, the driving factors are drug-related offences such as theft, robbery and fraud committed to raise money to fund drug purchases.

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Drugs have become established at the heart of prison life, and are often now ‘the central medium and currency in prison subcultures’.<sup>4</sup>

The presence of such a large proportion of people who use drugs, and risks related to drug use, in an environment where the maintenance of health is already difficult represents a serious challenge for policy makers, but one that they can meet by applying the growing evidence base referenced in this section.

### **The prevalence of diseases among prisoners**

As a result of their lifestyles prior to imprisonment, the specific risk activities arising while detained, and poor healthcare services available in prison, drug-using prisoners are affected by high levels of general health problems, in particular infections such as HIV, hepatitis B and C, and tuberculosis. HIV and hepatitis C virus, in particular, can spread at an extraordinary rate in the prison setting, unless appropriate harm reduction measures are taken.

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HIV is a serious health threat for the 10 million plus 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.<sup>5</sup> In terms of HIV transmission through injecting drug use – the main concern in many countries – evidence shows that rates of injection are lower among prisoners than in the drug-using community outside of prisons. However, the rates of sharing needles, and the associated risks, have reached worrying levels: most countries report sharing rates in prisons of between 60% and 90%.<sup>6</sup>

The levels of hepatitis C virus are also high among prison inmates. WHO estimates that about 3% 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% in an Indian jail to 92% in northern Spain.<sup>7</sup>

Similarly, the prevalence of tuberculosis is often much higher in prisons than it is in the general population. A Thai study revealed that the prevalence of tuberculosis among prison inmates was eight times higher than in the general population.<sup>8</sup> Another study demonstrated that the prevalence of tuberculosis in a prison in Victoria (Australia) had reached 10%,<sup>9</sup> whereas a study in a prison in Bahia (Brazil) reported a prevalence of latent tuberculosis of 61.5%, with a prevalence of active tuberculosis of 2.5%.<sup>10</sup>

### **Risk behaviours**

Except perhaps in countries with high levels of heterosexually transmitted HIV, the major risk of HIV infections spreading in the prison environment stems from the sharing of injecting equipment. In prisons, large numbers of people are likely to share needles and syringes due to

the lack of availability of sterile equipment via harm reduction services such as NSPs, and due to fear of detection of drug use. Some users resort to needle sharing for the first time while in prison, while others begin to inject drugs in prison. Such risky behaviour is at least in part a product of the prison context itself – drugs are often used to escape the misery, brutality, lack of privacy, anxiety and chronic insecurity that frequently characterise life within these institutions. The factors associated with the prison setting combine with the life history and subcultural practices of people who inject drugs, to provide a greatly heightened environment for health-related risk.<sup>11</sup>

Rape and sexual violence are also vectors for the transmission of infection. Those prisoners at the base of the prison's informal hierarchy are most prone to being victims of such assaults. In countries where people who use drugs are especially stigmatised, they may be particularly vulnerable to these types of risks.

Prisoners who use drugs are highly vulnerable to accidental overdose, particularly in the period immediately after release. Indeed, as people dependent on drugs 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 from 124 times higher than in the general drug-using population for ex-prisoners aged 15 to 24 years through to 274 times higher for released prisoners aged 35 to 54 years.<sup>12</sup> Prisoners are also at risk of dying in prison, whether from suicide, loss of tolerance or contaminated drugs. In another study of Washington state prisons, ex-prisoners were found to be 129 times more likely to die from drug overdose in the first two weeks after release than their counterparts in the general population.<sup>13</sup>

## **Responsibilities for prisoners' health: international obligations**

The concept of **the right to the highest attainable standard of physical and mental health** derives from the Constitution of the WHO. In recent years, WHO has been at the forefront of attempts to establish as a practical reality the right to health of prisoners, who represent an especially marginalised population group.<sup>14</sup>

The right to health is also grounded in the UN Charter, the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights. Building on this universal right, the international community has gradually established **the principle of equivalence**, which argues that the right to health applies to prisoners as it applies to those living outside of prisons, and indeed to all human beings.

The first explicit reference to prisoners in international agreements came in the 1977 Minimum Standard Rules for the Treatment of Prisoners, which laid down

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a set of basic standards for the treatment of prisoners, including one relating to health. Agreed by the UN General Assembly, the resolution established a general principle of equivalence, stating that these basic standards should apply to all with no 'discrimination on grounds of race, colour, sex ... or other status'.<sup>15</sup>

Section 9 of the 1990 UN Basic Principles for the Treatment of Prisoners made this principle of equivalence explicit: 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation'.<sup>16</sup> This resolution was also adopted by the General Assembly.

The EU agreed a further set of standards in 2006, known as the European Prison Rules, which reiterates the principle of equivalence and adds that, 'All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose'.<sup>17</sup>

In December 2010, the UN General Assembly passed the UN Rules for the Treatment of Women Prisoners, usually known as the Bangkok Rules.<sup>18</sup> These rules acknowledge that earlier instruments such as the Minimum Standard Rules are not sufficiently sensitive to the specific needs of women prisoners. Prisons were designed principally around the needs of male detainees, and the Bangkok Rules provide additional safeguards for women prisoners.

These and other guidelines do not represent legal provisions as such – they are non-binding recommendations, and there are no mechanisms for enforcement. However, their force lies in the fact that they have been agreed to by signatory states, UN members etc, and represent moral principles that states have publicly agreed to abide by.

These guidelines establish the principle that prisoners are entitled to equivalent healthcare services to those available outside prison; this stipulation applies to prisoners who use or have used drugs. Again, WHO has shown leadership in driving forward the agenda for the provision of effective healthcare services to incarcerated people who use drugs. In the course of providing guidance to policy makers on the provision of essential pain-killing medications, WHO has covered the issue of providing treatment for drug dependence in the prison setting. It states unequivocally that, 'Prisons should have functioning treatment programmes for opioid dependence'.<sup>19</sup> These WHO guidelines on controlled substances have been endorsed by the INCB.

The INCB has likewise advised in its 2007 annual report that: 'Governments have a responsibility to ... provide adequate services for drug offenders (whether in treatment services or in prison)'.<sup>20</sup>

These standards of good practice relating to the treatment of incarcerated drug users are, therefore, firmly enshrined in international agreements that most states have signed up to.

## Managing health risks in prisons

Although numerous research studies have examined policies and interventions relating to drug use in general, relatively few have focused on treatment of drug dependence 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 people dependent on drugs.

Prison authorities have usually tried to tackle the power of drug dealers and limit the availability of controlled drugs through tough security measures or drug-testing programmes. These interventions have failed to achieve the intended goal of a drug-free prison, and have sometimes resulted in negative consequences. For example, drug testing in prisons can encourage people who use drugs to switch to drugs that are not being tested for, or are harder to detect and may be more harmful (e.g. prisoners can switch to heroin use from cannabis, as cannabis 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.<sup>21</sup> UNODC itself declared that these programmes should be avoided in prisons.<sup>22</sup>

A range of options are open to prison authorities, a combination of which is promoted as best practice by the WHO, UNODC and the Joint United Nations Programme on HIV and AIDS (UNAIDS).

A combination of options can address health risks in prison, which include:

- Education and information
- Vaccination programmes
- Access to measures for safer sex
- NSPs
- Prevention of overdose

- **Education and information** – many prisoners are unaware of the health 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 used educational videos or lectures to deliver the same messages, leading to higher levels of awareness. Used in combination with the provision of adequate healthcare and harm reduction services, education and information campaigns can be efficient in promoting safer behaviours.
- **Vaccination programmes** – effective vaccination exists to protect people against hepatitis A and B, and a period of imprisonment is an opportunity to encourage people to be vaccinated (many of them do not use preventive health services in the community). This consists of two injections, six months apart. Many prison administrations have targeted hepatitis A and B vaccination programmes at drug-using prisoners and report high levels of engagement and compliance.
- **Access to measures for safer sex** – many prison administrations have allowed the distribution of condoms to prisoners, offering them access to the same protection that is available outside of prisons. 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

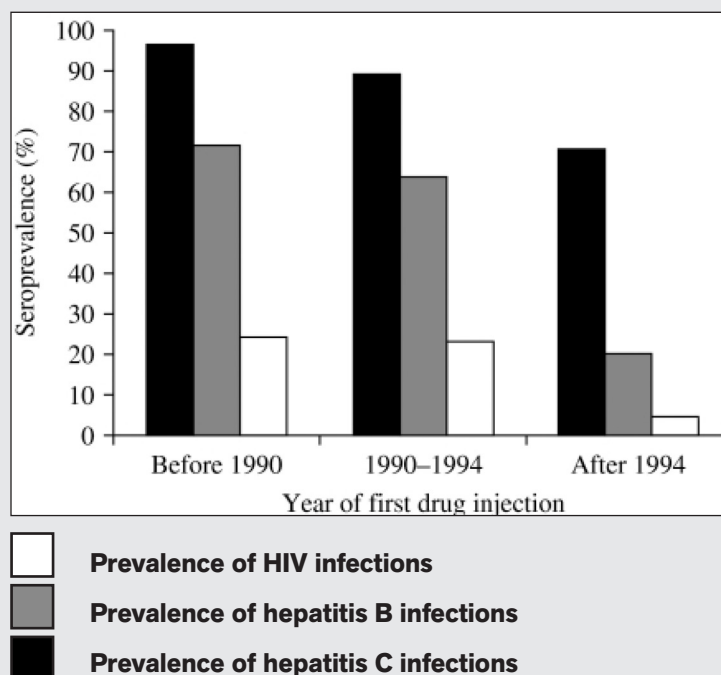
prison staff on sexually transmitted infections (STIs), consisting of voluntary counselling and testing for prisoners or measures to prevent rape, sexual violence and coercion.

- **Needle and syringe programmes** – programmes involving the distribution of sterile injecting equipment to people who inject drugs have been effective at preventing HIV infection. However, there has been great reluctance to introduce these public health programmes in prisons. Arguments against prison-based NSPs have 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 sterile needles and syringes would increase the prevalence of drug injecting in prisons. In 2009, 10 countries had introduced NSPs in prisons. The outcomes have been very positive in reducing the sharing of injecting equipment and none of the fears outlined above have materialised in practice (see [Box 1](#)).<sup>23</sup>

#### **Box 1. Needle and syringe programmes in German prisons<sup>24</sup>**

A NSP was started in 1998 in two prisons in Berlin, Germany. A study was conducted in these two prisons to investigate the feasibility and safety of the programme and to assess its effects on patterns of drug use and health risks. The study found that rates of sharing injecting equipment had fallen from 71% of prisoners who inject drugs to virtually none, following the introduction of a needle-exchange programme. The study also concluded that the programme had had positive effects in reducing HIV and hepatitis B infections (see Figure 1). Hepatitis C infections did reduce but for NSPs to be efficient in reducing such infections, the study concluded that they should be coupled with additional programmes.

**Figure 1. Prevalence of HIV, hepatitis B and hepatitis C infections among imprisoned people who inject drugs, according to year of first drug injection**



The Madrid Recommendation, made in October 2009 at an international conference of high-ranking prison health experts and attended by Spain's Ministry of Health, WHO and UNODC representatives, spoke of 'the overwhelming evidence that health protection measures, including harm reduction measures, are effective in prisons ...'.<sup>25</sup>

- **Preventing drug overdose** – programmes for overdose prevention, identification and management should involve information and awareness raising, and practical measures such as training in expired air resuscitation and the distribution of naloxone (a medication that temporarily blocks the effects of opiates). The continuity of opioid substitution therapy (OST) through detention, prison incarceration and post release is also effective in preventing overdose.

## Providing treatment for drug dependence in prisons

With a large number of people dependent on drugs held in custody, prisons can provide a useful location for delivering treatment for drug dependence, to break the cycle of dependence and crime. This requires that evidence-based treatment and rehabilitation programmes are made available within custodial settings.

There is evidence that a range of treatment interventions for drug dependence can be implemented effectively in prison settings. OST – in particular with methadone – is feasible in a wide range of prison settings for opioid-dependent people. Prison-based OST programmes appear to be effective in reducing the frequency of injecting drug use and the associated sharing of injecting equipment, provided that a sufficient dosage and treatment are provided for long periods of time (see [Box 2](#)). 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.<sup>26</sup> Moreover, OST has a positive effect on institutional behaviour by reducing drug-seeking behaviour, thereby improving prison safety. The challenges that had been experienced by prison administrations in managing some drug-dependent prisoners (e.g. security, violent behaviour) have been ameliorated by OST programmes.<sup>27</sup>

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, have been effective at reducing drug dependence in prisons.<sup>28</sup> Structured therapeutic programmes using therapeutic community, 12-step or cognitive-behavioural models, have been shown to move a proportion of prisoners away from drug dependence, with resulting reductions in crime and health problems.

Effective treatment for drug dependence in prisons should therefore incorporate a range of options for detainees dependent on drugs. It maximises opportunities for rehabilitation and prevents a return to dependence and crime after release.<sup>29</sup> The principles behind prison-based treatment are similar to those of drug dependence treatment in the community.

Evidence-based drug dependence treatment programmes should be made available in prisons.

- Efficient mechanisms need to be put in place to identify those in need of treatment opportunities. As long as the treatment programmes provided are voluntary, humane and of good quality, prisoners will be likely to participate. Screening procedures on reception, and the provision of specialist assessment, advice and referral services, can identify and motivate prisoners to accept treatment.
- Various models of treatment in prisons are effective in improving health and crime outcomes in many countries.<sup>30</sup> Prison authorities should aim to make available a range of detoxification, OST and psychosocial programmes in their prisons. These should be organised so that prisoners are able to move between services throughout their time in prison, according to their needs and when they choose to do so.
- Careful attention needs to be paid to the aftercare process, and continuity of treatment post release. Several studies have suggested that aftercare is needed to optimise the effects of in-prison treatment for drug dependence on reducing drug re-offending.<sup>31</sup> 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 treatment for drug dependence in prisons can be improved by linking treatment progress to prisoner incentives, such as consideration for early release.

## **Box 2. Opioid substitution therapy in Indonesian prisons**

Indonesia has a fast-growing HIV epidemic, driven largely by the sharing of injecting equipment in injecting drug use. The state's harsh response to drug use resulted in the incarceration of large numbers of people who inject drugs, with the result that prisons became a significant factor in escalating the epidemic. The Indonesian Network of People Who Use Drugs, and in 2008 UNAIDS, urged the country to begin treating people who use drugs as patients rather than criminals.<sup>32</sup> The Indonesian government has initiated positive responses to these calls.

The Kerobokan prison in Bali, Indonesia, began providing OST with methadone in August 2005. It was the first Indonesian prison to do so, and as of 2009, the programme had treated 322 patients.

The institution combines OST with a range of harm reduction measures, including needle and syringe exchange, bleach for cleaning injecting equipment, and condoms. It is likely that these measures have led to the Kerobokan programme being much more successful than, for example, that based in Banceuy Prison, Bandung, where harm reduction is less integrated in the prison programme, and only nine patients had been registered for OST between 2007 and 2009.<sup>33</sup>

## Responsibility for prison health care

There is a growing call for the ownership of health in prisons to be transferred away from ministries responsible for justice to those responsible for health. A number of countries and states, including Norway, France, England and Wales in the UK, and New South Wales in Australia have already taken this step, with broadly positive results.<sup>34</sup>

The reasons for this change centre upon questions such as whether healthcare staff who are employed by the prison are sufficiently independent, trusted by inmates and in touch with clinical and professional developments in the wider society – a set of logistical and ethical issues. Moreover, prisons lack effective monitoring and evaluation by the general public health system; this work is carried out instead by corrections or justice ministries with little expertise in health care. All of this tends to separate prison health from that in the rest of society.<sup>35</sup>

The responsibility for health in prisons should be transferred away from ministries responsible for justice to those responsible for health.

Effective public health demands precisely the kind of integration that is often lacking in these arrangements, and governments should therefore consider the potential benefits of bringing prison health under the auspices of their health ministries.

## Recommendations

- 1) An understanding of the level and nature of drug use and drug dependence among prisoners is needed to design appropriate policies.
- 2) A range of treatment and harm reduction services should be developed in custodial settings – if carefully designed and properly resourced, these services can have a highly positive impact on reducing the health and crime harms associated with drug-using offenders.
- 3) NSPs in prisons are needed to avoid the risks related to sharing injection 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.
- 4) Additional harm reduction programmes – such as information and education programmes, naloxone distribution, etc – for preventing blood-borne diseases and drug overdoses should also be provided.
- 5) Evidence-based treatment for drug dependence should be offered to all detainees dependent on drugs, with the appropriate mix of substitution, psychosocial and mutual aid approaches. These treatment programmes should be stringently evaluated.

- 6) Better links and continuity of care should be established between prisons and community-based services, in order that individuals can continue treatment when entering prison or on release.
- 7) Governments should consider bringing prison health under the control of health ministries rather than justice ministries.

## Key resources

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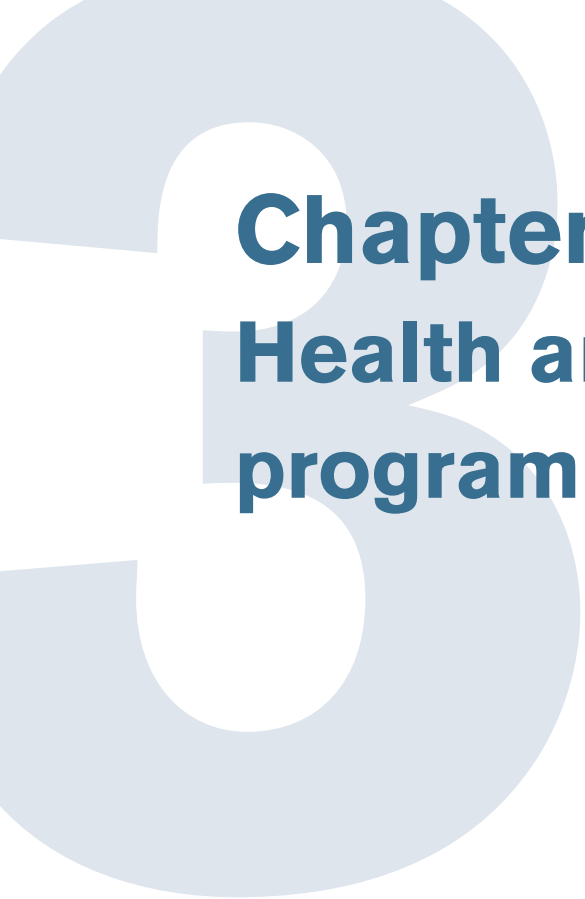
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# **Chapter 3**

## **Health and social programmes**

## 3.1 Prevention of drug use

### In this section

- The effectiveness of current prevention approaches
- Social marketing interventions
- School-based prevention interventions
- Community-based interventions
- Peer-based interventions

**Drug prevention programmes involving mass social marketing and school-based interventions focused on the deterrence paradigm are not efficient in reducing levels of drug use. More efficient drug-prevention initiatives include community-based interventions that seek to address the underlying socio-economic causes for drug use, and peer-based interventions.**

### Why is effective drug prevention important?

Drug use is a widespread global phenomenon. While drug use occurs among diverse subpopulations, young people consistently report higher than average levels of drug use compared with other subpopulations.<sup>1</sup> Data suggest that young people most often initiate cannabis use, and a minority of young people who use drugs also report using a variety of other illicit substances, including methamphetamine, cocaine, and heroin, among others.<sup>2</sup>

Drug use may lead to a number of preventable health consequences, including the transmission of blood-borne infections such as hepatitis B and C and HIV through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses.<sup>3</sup> Given the potential for the manifestation of such health harms, a key objective of international and national drug control strategies is focused on the prevention of drug use.<sup>4</sup>

Drug prevention is codified within the mandate of the UNODC.<sup>5</sup> However, despite a consistent allocation of substantial government resources towards drug-prevention interventions, available evidence indicates that the rates of drug use among young people remain at high levels, and are largely unaffected by the prevention approaches tried to far.<sup>6</sup> It is therefore necessary to move away from ineffective drug-prevention interventions, and focus on those interventions that have had more positive outcomes on levels of drug use and reducing harms.

## The effectiveness of current prevention approaches

As explained in detail in [Chapter 2](#) of the Guide, most national drug policies have traditionally been guided by the principle of deterrence – the belief that tough law enforcement and severe

It is necessary to move away from ineffective drug-prevention interventions, and focus on those that have more positive outcomes on levels of drug use.

sanctions against people who grow and use drugs will reduce drug production and use.<sup>7</sup> Programmes for drug prevention have been based on the same principle of deterrence, which assumes that people who use drugs will stop consuming drugs if they are told about the negative effects of use and the penalties they risk by using them.

As demonstrated throughout this Guide, there is no evidence that suggests that drug policies based on deterrence have resulted in a reduction in the initiation of drug use among young people, or in a reduction in the production of crops destined for the illicit

drug market.<sup>8</sup> A similar observation can be made in terms of drug prevention, although some prevention approaches have been shown to be more promising than others.

### Ineffective prevention approaches

Despite their popularity with politicians wishing to 'send a tough message' about the risks of drug use, mass social marketing interventions and school-based prevention programmes have been expensive and ineffective in reducing drug use among the population groups they sought to target, and may even have negative effects on the prevalence of drug use. Evidence suggests that such prevention approaches should be avoided.

### Social marketing interventions

One of the most popular approaches to preventing drug use among young people is the implementation of social marketing campaigns. These campaigns can take a variety of forms, although they most commonly feature the dissemination of anti-drug public service announcements via the television and radio. Recently, however, social marketing campaigns have expanded in scope to take advantage of new media. For example, internet-based videos and web pages devoted to conveying anti-drug messages have become an increasingly important and sophisticated aspect of prevention interventions.<sup>9</sup> The vast majority of social marketing interventions, including anti-drug public service announcements, are based on social cognitive theory and its derivations,<sup>10</sup> including the theory of reasoned action,<sup>11</sup> and the theory of planned behaviour,<sup>12</sup> all of which are based on a specific contiguous relationship between intention and behaviour.

Mass social marketing interventions and school-based prevention programmes are expensive and ineffective (and sometimes counter-productive) in reducing drug use.

The bulk of scientific research on drug prevention conducted to date has focused on social marketing and school-based approaches. With respect to social marketing, a recent systematic review of all scientific evaluations of anti-drug public service announcements found that these interventions had been largely ineffective, and may in fact encourage drug use (see [Box 1](#)).<sup>13</sup>

**Box 1. The National Institute on Drug Abuse's anti-drug social marketing campaign**

An evaluation commissioned by the United States' National Institute on Drug Abuse (NIDA) on a national anti-drug social marketing campaign that has cost US\$1.3 billion since 1998,<sup>14</sup> found that:

- this campaign had no effect on young people who had already started using cannabis
- higher exposure to the campaign may have significantly increased the rate of initiation of drug use among targeted young people
- the campaign may have weakened the perception of anti-cannabis norms among targeted young people
- while other favourable and unfavourable changes in drug-using behaviour were observed among targeted young people, there was no indication that the campaign itself was responsible for these changes.<sup>15</sup>

While the United States' Office of National Drug Control Policy disputed these findings, a United States Government Accountability Office audit declared the initial evaluation sound.<sup>16</sup>

***School-based prevention interventions***

School-based anti-drug interventions have been evaluated extensively, particularly in the USA, since at least the 1970s,<sup>17</sup> though their inclusion in the education system of the USA dates back as far as the 19<sup>th</sup> century, according to some researchers.<sup>18</sup> The most popular of such prevention interventions is no doubt the Drug Abuse Resistance Education programme, commonly known as DARE (see [Box 2](#)).

**Box 2. Drug Abuse Resistance Education and the ineffectiveness of school-based prevention**

Drug Abuse Resistance Education, also known as DARE, was introduced in 1983 and is the largest of the school-based programmes, now operating in over 75% of all American school districts, as well as in 43 countries internationally.<sup>19</sup> DARE and similar school-based interventions are based on the gateway theory of drug use, which claims that the use of drugs such as alcohol, tobacco or cannabis predicts the subsequent use of 'harder' drugs such as heroin, cocaine and amphetamines,<sup>20</sup> as well as on theories of self-efficacy, which promote the development of interpersonal and social skills that reduce the vulnerability of young people to peer influence for the initiation drug use.<sup>21</sup>

A number of evaluations investigating the effects of DARE have observed limited effects of the programme in the long term. One 5-year randomised controlled trial, which observed the drug habits of high school seniors exposed to DARE in the seventh grade as compared to a control group, found no significant differences between the DARE-exposed group and the non-exposed group in terms of the frequency, recency and prevalence of use of a variety of drugs after 5 years; the only statistically significant exception was the rate of hallucinogen use in the last 30 days among the DARE-exposed group, which was almost triple that of the non-exposed group.<sup>22</sup> Another 6-year DARE randomised controlled trial carried out across 36 elementary schools and 300 high schools found no statistically significant relationship between young people's drug use and exposure to the DARE programme when measured over the entirety of the 6-year study period.<sup>23</sup> Other studies have corroborated these results.<sup>24</sup>

Finally, multiple meta-analyses of DARE studies have concluded that the programme's positive effects are negligible or non-existent.<sup>25</sup> The fact that DARE is still so widely implemented despite clear evidence of its ineffectiveness is a good illustration that many policy makers are more interested in the symbolism of drug prevention campaigns, rather than their impact.

### **Promising prevention approaches**

Although the interventions presented below need to be further evaluated, they do show promising results in terms of drug prevention.

#### ***Community-based interventions***

Community-based prevention programmes often involve a number of stakeholders and multiple components, applied either in sequence or simultaneously. These programmes generally seek not only to change specific behaviours, but have broader goals oriented towards comprehensive community empowerment and change, focusing on strengthening the protective factors (e.g. strong and positive family bonds, success in school performance, good social skills, opportunities for employment, etc) that will reduce the problem of drug use among

Community- and peer-based interventions have shown promising results in terms of drug prevention.

communities, especially young people.<sup>26</sup> In this sense, they are technically not only drug-prevention programmes but wider social and community-development approaches. This broad set of goals is consistent with the large set of stakeholders needed to implement such a programme. While the makeup of those involved varies between communities, a number of young people and family organisations, media, community groups, schools, law enforcement, faith-based organisations

and government are all often involved as stakeholders in many of these programmes.<sup>46</sup> The creation of such coalitions enables the pursuit of community-empowerment goals that seek to create agency among community participants, in contrast to the notion of community members as passive recipients of public health prevention programmes.<sup>27</sup>

Community-based approaches have become increasingly popular to prevent drug use among young people. It should be recalled that, because the interventions are concerned primarily with building skills that can be used towards community empowerment, it is often difficult for evaluators to identify specific outcomes that can be analysed within the usual timeframes allotted for evaluation.<sup>28</sup> Indeed, community empowerment is a long-term outcome that can be difficult to evaluate.<sup>29</sup> Community-based prevention strategies also often include a complex set of components, which will interact to prevent drug use, adding to the complexity of evaluation of these interventions. However, these long-term programmes have shown encouraging results in addressing the risk factors that lead to drug use, and strengthening the protective factors that reduce the risks of use within a community.

One example of a community-based programme in the UK is discussed in [Box 3](#).

**Box 3. The Positive Futures programme in the UK<sup>30</sup>**

One example of a community-based intervention targeting broad socio-environmental factors is the Positive Futures programme, which was implemented in the UK by Sport England, The Youth Justice Board and the United Kingdom Anti-Drugs Co-ordination Unit in 2000. This programme utilised sport and other activities to engage with young people aged 10–19 years, identified as at risk of initiating drug use.

An evaluation of Positive Futures reported that young people enrolled in the programme reported improved social relations, higher educational performance, and higher levels of employment.<sup>31</sup> The Positive Futures programmes have been widely expanded and welcomed in many UK communities, and are popular with participants and politicians alike. However, despite broadly positive qualitative evaluations, no statistical analyses have been conducted about the programmes' outcomes, and little is therefore known regarding the mechanism of change, and the effect of the intervention was never quantified. For instance, no data on the effect of Positive Futures on patterns of drug use among young people have yet been reported.

***Peer-based interventions***

Peer-based prevention interventions seek to engage directly with affected community members in order to connect with marginalised individuals at risk of drug use.<sup>32</sup> While peer-based components have become increasingly integrated into social marketing preventive interventions through social networking, stand-alone peer-based preventive interventions are nevertheless present in a number of different settings. All peer-based preventive interventions involve engaging members of a specific group ('peers') to act as educators.<sup>33</sup> In principle, peers simply need to belong to the same group in order to act as, and be perceived as, peer educators. In practice, peer educators can be co-workers, schoolmates, team-mates, or people who use drugs within a drug-using network, among others. Peer-based approaches are often perceived to have an increased capacity to convey preventive messages to otherwise hard-to-reach groups. To date, little scientific research has been undertaken on peer-based drug prevention.

The small number of evaluations of peer-based interventions for drug prevention may partly be a result of the fact that, similar to community-based preventive interventions, peer-based interventions often have outcomes such as information delivery or increases in general self-confidence that do not necessarily constitute the primary objective of drug prevention. Further, evaluations of peer-based preventive interventions undertaken among people who use drugs have typically focused on interventions for the prevention of drug-related harm rather than preventing drug use itself. Despite the limited evidence base, research has indicated that peer-based interventions may be successful in reducing rates of drug use (see [Box 4](#)).

**Box 4. A peer-based intervention programme among young Thai amphetamine users<sup>34</sup>**

There has been a proliferation of amphetamine use in Thailand since the 1990s, particularly among young people. Simultaneously, risky sexual behaviours among this population group have increased. A randomised behaviour trial study was conducted to evaluate the effects of a peer network intervention and a life-skills intervention on methamphetamine and HIV risk behaviours among 18–25 year olds in Chiang Mai, Thailand. The study found that a peer-educator, network-oriented intervention was associated with reductions in methamphetamine use, increased condom use and reductions in incident STIs. The study concluded that small group interventions were an effective means of reducing methamphetamine use and sexual risk among Thai younger generations.

## Conclusions

Despite the availability of a variety of preventive interventions implemented so far, rates of drug use (i.e. cannabis, cocaine, heroin and amphetamines) have remained steady or increased in major markets across the world, and do not seem to have been influenced by the drug-prevention campaigns implemented by governments.<sup>16</sup> This may be the result of a primary focus on fear and deterrence for drug prevention, as is the case for most drug control policies focusing on harsh law enforcement and severe punishment mechanisms. This has led to a preference for prevention approaches that do not have a resonance with young people's lived experience, and that do not target the factors that mostly impact on individuals' decisions around drug use – fashion, peer pressure, emotional welfare and social and community equality and cohesion.

Evidence demonstrates that mass social marketing campaigns and school-based programmes seeking to sensitise the population and young people about the harms caused by drugs have been ineffective in reducing drug use or lowering the age of initiation to drug use. Some studies have even shown that such prevention programmes could, on the contrary, increase the prevalence of drug use among the target population group, by raising awareness or curiosity around particular drugs.

Studies analysing the effects of community-based interventions or peer-based prevention programmes have shown more optimistic results, although more research is needed to truly assess the impact of these interventions on the prevalence of drug use.

## Recommendations

A re-oriented drug-prevention paradigm should prioritise the following drug-related outcomes:

- 1) drug-prevention interventions should both identify the underlying social causes of drug use and work to address them through health and socio-economic programmes, in particular through community-based prevention intervention programmes
- 2) drug prevention interventions should prioritise education and information provision through peer-based programmes
- 3) governments should explore new drug-prevention programmes based on evidence.
- 4) implementation plans for drug-prevention interventions should systematically include scientific evaluation of process and outcomes, in order to measure the effectiveness of drug-prevention programmes.

## Key resources

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## 3.2 Harm reduction

### In this section

- Principles of harm reduction
- A wide range of interventions
- Supporting groups at higher risk of drug-related harm

**Harm reduction refers to public health interventions that seek to reduce the negative consequences of drug use and drug policies. Harm reduction has been rigorously evaluated and shown to be effective at reducing the transmission of blood-borne infections as well as morbidity and mortality related to drug use.**

### Why is harm reduction important?

A broad definition of harm reduction was presented in [Chapter 1](#). This chapter focuses primarily on harm reduction as a set of health interventions, while touching on related efforts to shape public policies in ways that promote the well-being of people who use drugs.

Drug use, particularly in the context of the current drug control regime, may lead to a number of preventable health consequences, including soft tissue infections and transmission of blood-borne infections such as hepatitis B and C and HIV, through use of non-sterile injection equipment, death from overdose, and exacerbation of existing psychiatric or physical illnesses. Harm reduction is equally concerned with the harms caused by public policies and attitudes directed at people who use drugs. In many countries, most harms result directly or indirectly from the criminalisation and mass incarceration of people who use drugs, but also include discrimination in medical settings and subsequent problems with access to health care, barriers to employment, housing or social benefits, or denial of child custody. As such, harm reduction is often conceived as both a public health and a human rights concept.

There are around 16 million people who inject drugs worldwide,<sup>1</sup> and it is estimated that 10% of all HIV infections occur through injection drug use, with 30% of new infections occurring outside sub-Saharan Africa.<sup>2</sup> In many countries in Eastern Europe, the Middle East, North Africa, Central, South and Southeast Asia, and Latin America, the largest share of HIV infections occurs among people who inject drugs.<sup>3</sup> Injection-related transmission has more recently become an important part of HIV epidemics in sub-Saharan Africa as well, where the prevalence of injection drug use now approaches the global average.<sup>4</sup>

Harm reduction is both a public health and a human rights concept.

The EMCDDA identified drug overdose as a major cause of mortality in EU countries.<sup>5</sup> An international study supported by the EMCDDA found that in seven European urban areas, between 10% and 23% of all deaths among those aged 15 to 49 years could be attributed to opioid use.<sup>6</sup> In the USA, overdose is the leading cause of injury-related mortality among people aged 35–54 years.<sup>7</sup> Studies have found that 89% of heroin users had witnessed at least one overdose in their lifetime in San Francisco (USA),<sup>8</sup> personal experience of overdose has ranged from 51% of heroin users in Australia,<sup>9</sup> to 66% in Yunnan province, China,<sup>10</sup> and 83.1% in North Vietnam.<sup>11</sup> In Russia, overdose caused 21% of all deaths among people living with HIV in 2007,<sup>12</sup> and the country reported a total of 9,354 overdose deaths the previous year, which is almost certainly an undercount.<sup>13</sup>

Non-opioid and non-injecting drug use can also be related to negative health outcomes. Many parts of the world have seen an increase in use of cocaine and amphetamine-type stimulants such as methamphetamine, and in the non-medical use of pharmaceutical medications.<sup>14,15</sup> Non-injection drug use has been found to be associated with an increased risk of sexual transmission of HIV in some contexts.<sup>16</sup> It has been speculated that sharing crack-smoking paraphernalia may increase the risks of hepatitis C transmission.<sup>17</sup> Stimulant drugs may cause hyperthermia, acute psychiatric disorders, and other harms, and inhaled drugs may cause lung infections and possibly leukoencephalopathy.<sup>18</sup> [Box 1](#) provides examples of effective harm reduction services for people who use non-injectable drugs.

### **Box 1. Harm reduction services for people who use non-injectable drugs**

Although sometimes less visible because of the emphasis on HIV within public financing around drugs and health, services supporting people who use non-injectable drugs are a crucial part of harm reduction. In response to the harms associated with non-injection drug use, organisations such as DanceSafe in North America have promoted education, pill testing, and other services to ensure that ‘party drug’ users are well informed about safer use and know what they are consuming.

Harm reduction groups in Canada and elsewhere have promoted kits for safer crack use that include education and smoking paraphernalia made out of materials that do not emit toxic chemicals when heated, and that have resulted in adoption of less risky drug-using behaviour among participants.<sup>19</sup> Similarly, in Latin America and the Caribbean, where powder cocaine and crack use predominate, harm reduction services for people who use non-injectable drugs, such as counselling, housing services, linkages to drug dependence treatment, etc, have existed alongside NSPs since the early 1990s. ‘Safer-inhalation facilities’, where people may smoke or sniff drugs in a medically supervised environment have also been established alongside safer injecting facilities in several countries.<sup>20</sup>

While sharing non-sterile injecting equipment has been a major source of HIV infections in North America and Western Europe, implementation of harm reduction services has increasingly controlled the epidemic. For example, in 2009 New York City, which had been supporting harm reduction services for nearly 20 years, reported that only 5% of new HIV cases

were transmitted through injecting drug use.<sup>21</sup> Similarly, Australia, the first country to have incorporated harm reduction into its national HIV strategy, has maintained an extremely small HIV epidemic among people who inject drugs, and as a result had net healthcare cost savings of more than US\$820 million<sup>22</sup> in the years 2000–2009 alone.<sup>23</sup> The UK, the Netherlands, France, Spain and other European countries have seen similar success in reducing HIV incidence among people who inject drugs through widespread availability of NSPs, OST and related services. On the contrary, countries like Russia and Thailand, which have refused to develop harm reduction interventions, have a high prevalence of HIV infections among people who inject drugs.<sup>24</sup>

Harm reduction programmes have always had a commitment to evidence-based practice. Core harm reduction services have been exhaustively evaluated and found to be effective at reducing the transmission of HIV and other blood-borne diseases, broadly improving health, and have been found not to be associated with increased drug use.<sup>25,26</sup> As a result, harm reduction has become the leading public health approach to drug use, and has been endorsed by numerous international health agencies, professional associations, including the UN system, the International Federation of Red Cross and Red Crescent Societies, the International AIDS Society, and the American Medical Association. At least 82 countries support harm reduction in policy and/or practice.<sup>27</sup>

Harm reduction is evidence-based and effective at reducing the transmission of blood-borne diseases, broadly improving health, and are not associated with increased drug use.

## Principles of harm reduction

This chapter uses the definition of harm reduction principles espoused by Harm Reduction International (HRI)<sup>28</sup> and describes how these principles are applied in practice.

According to HRI, 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’.<sup>29</sup>

At its roots, harm reduction recognises that despite the negative consequences associated with drug use, many people are unwilling or unable to stop using drugs; that most harms associated with drug use are preventable; and that drug use has positive aspects for many people, which must be considered in the frame of reducing drug-related harm. Harm reduction strives to respond to each individual’s unique experience of drug use, and at the community level to integrate with primary care and specialist medicine, drug treatment, housing services, the criminal justice system, and other relevant areas. At local,

Harm reduction is targeted at risks and harms, evidence based and cost effective, incremental, rooted in dignity, respectful of human rights, challenges policies that maximise harm, and values transparency, accountability and participation.

provincial and national levels, harm reduction is concerned with orienting government policy toward health promotion and away from criminal justice approaches to drug use.

**Harm reduction:**

- **is targeted at risks and harms** – harm reduction begins from the standpoint of identifying what specific risks and harms are occurring with an individual's or population's drug use, defining the causes of those risks and harms, and determining what can be done to reduce them. In Thailand, this could involve encouraging methamphetamine users to smoke methamphetamine rather than injecting it, in order to avoid the harms associated with injection. In Ukraine, for example, this has led harm reduction practitioners to identify unequal access to reproductive health care for women who use drugs and to develop innovative services in response.<sup>30</sup> In the USA, harm reduction programmes have used geographic mapping to determine 'hot spots' where people who inject drugs most frequently run out of new, sterile syringes, in order to better target NSP services<sup>31</sup>
- **is evidence based and cost effective** – harm reduction approaches are founded on public health science and practical knowledge, and employ methods that are most often low cost and high impact. New evidence on the efficacy of syringe-cleaning methods, for example, has led to renewed attention to how to support people who reuse syringes.<sup>32</sup> There is a growing body of literature on the cost effectiveness of harm reduction intervention – particularly regarding needle exchange and OST<sup>33</sup>
- **is incremental** – as HRI explains, 'Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative rather than coercive, and ... are designed to meet people's needs where they currently are in their lives'.<sup>34</sup> This principle plays out in countless ways in the day-to-day work of harm reduction service providers, from working with individuals to reduce immediate harms associated with chaotic crack cocaine use in Rio de Janeiro, to helping people who use drugs to find housing in New York
- **is rooted in dignity and compassion** – a harm reduction approach views people who use drugs as valued members of the community, as well as friends, family members and partners, and consequently rejects discrimination, stereotyping and stigmatisation. The COUNTERfit harm reduction project in Toronto used this principle to develop widely influential, drug-user-friendly workplace guidelines.<sup>35</sup> Early harm reduction programmes in Iran propagated a caring, open environment and made a strong case for harm reduction in Islamic terms, in order to reach out to an extremely marginalised population of people who inject drugs<sup>36</sup>
- **acknowledges the universality and interdependence of human rights** – the UN High Commissioner for Human Rights, Navanathem Pillay, declared that 'People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment' (see [Section 1.2: Ensuring compliance with fundamental rights and freedoms](#))<sup>37</sup>

- **challenges policies and practices that maximise harm** – the political environment in which drug use occurs plays an important part in creating the harms linked with drug use. Harm reduction thus seeks to reduce harm associated with **drug policy**, just as it seeks to reduce harms resulting from **drug use**. In much of Western and Central Europe, this insight has led governments to decriminalise drug use, which in some countries, such as Portugal, has resulted in substantial public health gains.<sup>38</sup> In other countries, the objective has been to remove policies that prevent people who inject drugs from accessing HIV treatment,<sup>39</sup> OST and other life-saving medical care
- **values transparency, accountability and participation** – harm reduction staff, donors, public officials, and other relevant people are ultimately accountable to people who use drugs. Harm reduction seeks to ensure such accountability by prioritising participation and leadership by people who use drugs in the design and implementation of policies and programmes that affect them. Examples of this principle include the central role of people who use drugs in conceiving and building the US harm reduction movement, requirements by harm reduction organisations that people who use drugs be represented on their boards of directors, the 2006 'Vancouver Declaration'<sup>40</sup> and founding of the International Network of People Who Use Drugs (INPUD).

### **Box 2. The Community Action on Harm Reduction project**

The Community Action on Harm Reduction (CAHR) project is an example of how harm reduction principles can be incorporated into a comprehensive programme. The CAHR project seeks to expand access to harm reduction services for people who inject drugs in Kenya, China, India, Indonesia and Malaysia. The project is unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local authorities, public health facilities, and academics, and , addressing the policy and structural barriers to programme sustainability.

The project places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce essential harm reduction interventions in Kenya, improve access to community-based support services in China, increase the quality of behavioural change programming in India and Malaysia, and expand quality harm reduction services to new communities within the injecting drug using population in Indonesia.

There is a strong policy agenda that is defined by the pragmatic objective of developing effective HIV and drug use services based on available evidence. Experiences of the project on the ground are captured to influence policy debates both at the national and international level. Finally, CAHR objectives include the full and meaningful participation of people who use drugs in policy and programme design and a strong commitment to protecting and promoting human rights.<sup>41</sup>

## A wide range of interventions

Harm reduction interventions mutually reinforce each other and maximise effectiveness in terms of health outcomes.

Harm reduction entails a holistic approach to dealing with the health of people who use drugs. WHO recommends a comprehensive package of harm reduction interventions<sup>42</sup> and recognises that such interventions mutually reinforce each other and maximise effectiveness in terms of health outcomes. Evidence also shows that harm reduction services lead to an increase in access to general healthcare interventions. The following, while not exhaustive, is an indication of evidence-based and cost-effective harm reduction interventions.

### Needle and syringe programmes (NSPs)

The most recognisable harm reduction intervention is the supply of sterile injecting equipment to reduce the spread of HIV and other blood-borne infections. Such programmes also prevent skin and soft tissue infections (such as abscesses and cellulitis) that may result from using non-sterile injection equipment. NSPs also serve as a bridge by which people may access a wide array of other health and social services, including primary health care, drug treatment, etc.

The success of NSPs depends on a wide range of factors. These include the involvement of people who use drugs in the design and implementation of the service; accessibility and breadth of coverage; adaptability of the service to moving local drug use patterns;<sup>43</sup> engagement with law-enforcement agencies not to interfere with the services;<sup>44</sup> and consultation with the wider community.<sup>45</sup>

While many early NSPs were developed primarily for heroin and cocaine injectors, today harm reduction addresses the complete spectrum of drug use. Similar in concept to NSPs, Canada and the USA, for example, pioneered the development of safer crack smoking materials to reduce the potential for burns, lung infections and possible transmission of hepatitis or other infections through blood–blood contact from sharing pipes.<sup>46</sup> Methamphetamine-oriented programmes like Crystal Clear in Vancouver, Canada have used peer-based programming to adapt the approach to both injecting and non-injecting use (see [Box 4](#)).

### Drug-consumption rooms

Some governments, such as Australia, Canada, Spain, Germany and Switzerland, have established drug-consumption rooms.<sup>47</sup> These are supervised facilities where people may bring their own drugs and inject (or in some places smoke) them without fear of arrest, and where overdoses or other health problems can be addressed by medical staff. They have been especially successful at reducing overdose mortality: deaths in the neighbourhood around Vancouver's Insite facility dropped by 35% in the year after it opened.<sup>48</sup>

### Treatment for drug dependence

Opioid substitution therapy (OST) using methadone or buprenorphine is currently the most widely used evidence-based method of treatment for opioid dependence. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) as a substitute for street heroin,

which is usually adulterated. OST programmes have been shown to reduce or eliminate injection drug use, reduce criminality, and improve a wide range of measures of health and social well-being.<sup>49</sup> OST plays a crucial role in supporting adherence to HIV,<sup>50</sup> hepatitis C and tuberculosis<sup>51</sup> treatment among opioid-dependent people, and is a potent tool for overdose prevention.<sup>52</sup> Although substitution therapies are not yet available for non-opioid drugs, alternate forms of treatment, such as cognitive-behavioural therapy and other psychosocial approaches, are supported by public health evidence. For more information, see [Section 3.3: Treatment for drug dependence](#).

### **Overdose prevention**

Overdose is experienced by a substantial portion of opioid users over their lifetime, and is a leading cause of death among people who inject drugs, and young people generally, in many countries. In the 1990s, programmes in the UK, the USA (see [Box 3](#)) and elsewhere began educating heroin users and their friends and families about overdose prevention and response, and distributing naloxone, a medication that quickly and safely blocks the effects of opioids, thereby reversing the respiratory depression that may lead to death. Such programmes have recently become more widespread, from Vietnam to Tajikistan and Puerto Rico to Slovakia, and there is growing evidence that they have contributed to significant reductions in mortality.<sup>53,54</sup> Drug-consumption sites and OST facilities are also important tools for overdose prevention (see above). Cocaine overdose, which is implicated in a large number of deaths in some countries,<sup>55</sup> poses a challenge in that there is no medication equivalent to naloxone that could be administered by lay people. Other policies that support overdose prevention include improving emergency medical services for overdose, 'good Samaritan' laws protecting people who respond to overdoses from potential liability, and increasing overdose surveillance and research.

#### **Box 3. The first overdose-prevention programmes in New York City**

After years of increasing overdose mortality and the deaths of many harm reduction participants, and inspired by colleagues in Chicago, San Francisco and New Mexico, three community-based harm reduction programmes launched New York City's first overdose-prevention programmes in 2004 that included naloxone distribution to people who use opioids. The three groups covered a geographically diverse section of the city, included one programme of harm reduction services for young people, and quickly moved from an initially small-scale, periodic service to one that expanded to street-based training and saturated communities with information and tools to prevent and reverse overdose. In mid-2006, following an evaluation of the first projects, the New York City government picked up the programme, contributing enough funding to support overdose programmes at all of the city's harm reduction organisations and to hire a full-time medical director for the programme. In the two years that followed, overdose mortality dropped by 27% citywide,<sup>56</sup> and unpublished data indicate that this trend has continued. Hundreds of similar projects have since proliferated around the world, based on the simple model pioneered in the USA and parts of Western Europe.

### **Prevention, testing and treatment of HIV and other sexually transmitted infections**

As with anyone else at risk of sexual transmission of HIV or other STIs, condoms and sexual health education and services should be made available to people who use drugs, and their sexual partners. STI testing and treatment is often linked to harm reduction services, in part because STIs – particularly those that cause genital lesions – may increase the risk of HIV transmission. Voluntary HIV counselling and testing is also a core harm reduction activity, and should be tied to efforts to connect newly diagnosed individuals to care and treatment services. Research has found that people with a history of injecting drug use have comparable success with HIV treatment to non-drug users.<sup>57</sup>

### **Prevention, testing and treatment of viral hepatitis**

Vaccines for hepatitis A and B are highly effective and should be made available to all people at risk of hepatitis infection, especially people who inject drugs. Globally, some 90% of new hepatitis C cases are related to injecting drug use, and while there is no hepatitis C vaccine available, hepatitis A and B immunisation may improve clinical outcomes for people with hepatitis C. There have recently been major advances in treatment for hepatitis C and it should be made available to any eligible person, regardless of their drug-use status.<sup>58</sup>

### **Prevention and treatment of tuberculosis**

People who have compromised immune systems, such as people living with HIV, are at high risk of active tuberculosis infection, particularly in closed environments such as prisons and in countries with endemic tuberculosis.<sup>59</sup> Tuberculosis is the leading killer of people living with HIV worldwide, including people living with HIV who use drugs, and notably in Eastern Europe and Central Asia, where multi-drug-resistant strains have proliferated. Harm reduction programmes like the Anti-AIDS Foundation in Tomsk, Russia, have responded by leading surveillance efforts, educating people who use drugs about tuberculosis prevention, and supporting people in tuberculosis treatment.

### **Mental health, social welfare, and other services**

While sometimes not considered to be core harm reduction strategies, a number of other services are often offered to people who use drugs. Psychiatric illness, for example, is more prevalent among people dependent on drugs than among the general population.<sup>60,61</sup> Major depression, post-traumatic stress disorder, and other illnesses may exacerbate drug-related risk behaviour, and drug use may complicate psychiatric care. Chronic stress related to social, economic and other circumstances may also impact drug use and psychiatric comorbidity (for more information, see [Section 3.1: Prevention of drug use](#)).<sup>62</sup> New York's Lower East Side Harm Reduction Centre has, for example, established a team of mental health professionals to support clients living with psychiatric illness, as well as housing services, legal support, and case management to co-ordinate health and social services.

### **Supporting groups at higher risk of drug-related harm**

Some groups, including women, young people and minorities, are at higher risk of drug-related harm because of discrimination, power relationships, and other factors. Harm reduction

programmes consequently have a responsibility to identify people in their communities who may face unique challenges in terms of drug use, and develop appropriate services.

Harm reduction should address the specific needs of groups at higher risk of drug-related harm.

### Young people

Although many young people use drugs,<sup>63</sup> most harm reduction services are designed for adults. Most obviously, young people often have shorter drug-use histories than adults, and may also have different risk behaviours and different social, economic and legal circumstances, and may be at risk of exploitation by adults. For all these reasons, youth-specific harm reduction programmes are needed (see [Box 4](#)), yet are absent in many countries. Many barriers also exist that prevent young people from accessing harm reduction services, including parental consent. These barriers should be removed. Successful youth-oriented harm reduction programmes, such as The Way Home in Odessa, Ukraine, and the Homeless Youth Alliance in San Francisco, USA, have given young people a leading voice in the design and administration of programmes, and grow out of a rights-based approach to health. Other interventions have targeted young people in nightlife settings, with interventions ranging from drug-information leaflets to drug-checking services, information sharing through websites, etc.<sup>64</sup>

#### Box 4. Harm reduction services for young people

Established in 2003, Vancouver, Canada's Crystal Clear harm reduction project began as a three-month, peer-based training course for street-involved young people concerned about their methamphetamine use. With support from the national and city health agencies, Crystal Clear expanded to become an ongoing programme that includes peer outreach, support and leadership development, harm reduction education and health services, and engagement with other civic and governmental organisations, to represent young people who use methamphetamine. The project has also produced a manual published by the Vancouver Coastal Health Authority, *Crystal Clear: a practical guide for working with peers and youth*.<sup>65</sup>

Similarly, Youth RISE, a membership-based international harm reduction network of young people, was established in 2006 to advocate for high-quality harm reduction services and policies for young people. Rooted in peer-based leadership and human rights, including application of the Convention on the Rights of the Child to harm reduction, among other work, Youth RISE piloted a series of workshops on harm reduction for young people in Romania, India, Mexico and Canada, subsequently producing a training manual with Espolea, a Mexico City-based youth AIDS, gender and drug policy organisation.<sup>66</sup>

### Women

Although women represent a minority of people who inject drugs in most countries, they often face specific social stigma and marginalisation due to their drug use, because of cultural perceptions. A range of factors increase women's risk of drug-related harm, including misogyny; unequal social and economic power relationships with men; discrimination, extortion, or sexual violence perpetrated by law-enforcement officers or others; discrimination by healthcare providers,

especially towards pregnant drug-using women; and a preponderance of harm reduction and treatment programmes that are primarily directed at men. Women who use drugs are often less likely than men to buy drugs themselves, know how to inject properly, or access harm reduction services. Pregnant and parenting women who inject drugs are particularly vulnerable.<sup>67</sup> Some harm reduction programmes have addressed these issues in numerous ways (see [Box 5](#) and [6](#)), including by creating women-only spaces and support groups, adapting outreach models to better suit women, and developing a range of sexual and reproductive health services specific to the needs of women who use drugs. Global networks have also been formed to advocate for the rights of women who use drugs, including the International Network of Women Who Use Drugs and the Women's Harm Reduction International Network.

#### **Box 5. Building services for women who use drugs in Ukraine and Russia**

In response to the particular issues facing women who use drugs, harm reduction organisations in Ukraine and Russia have made important progress in establishing model services in recent years. After discovering that some two-thirds of drug-using women in their city had no access to health services, the Tomsk Anti-AIDS Foundation in Western Siberia established a women-only space that has resulted in better linkages to medicine and uptake of harm reduction services by women, and a more than 100% increase in the number of women tested for HIV. Similarly, St Petersburg's Humanitarian Action Foundation operates an outreach bus exclusively targeting female sex workers, as well as one of Russia's few crisis centres for women with young children.<sup>68</sup>

Simple efforts to focus more attention on outreach to women can have a dramatic effect on access to services: by doing so, the organisation Virtus, in Dnipropetrovsk, Ukraine, saw a 50% increase in the number of women clients and an 80% increase in the number of women clients with children. The MAMA+ program in Kyiv, meanwhile, offers a more intensive service model for women living with HIV. MAMA+ has increased the proportion of clients who use drugs, and provides HIV and STI testing and treatment, counselling, family planning, gynaecological care, child care, and nutritional services, multidisciplinary support for pregnant women, home visits, and legal assistance.<sup>69</sup>

#### **Box 6. Reaching out to women who inject drugs in Manipur, India**

Although women only constitute a small proportion of people who inject drugs in Manipur, India, they are highly vulnerable to blood-borne infections, especially HIV. In partnership with the Social Awareness Service Organization (SASO), the International HIV/AIDS Alliance India developed a programme to meet their immediate needs, enhance access to harm reduction services for women who inject drugs and their partners.<sup>70</sup>

A drop-in centre was established as part of the project where women receive support such as NSP, free condoms, health check-ups (including basic healthcare, clinic-based detoxification, OST, counselling and referrals to other institutions for reproductive health and HIV care and support. The drop-in centre also offers recreational opportunities

including watching TV, reading newspapers and magazines, and a space for chatting with friends and staff. Women can also bathe and use make-up kits provided by the centre. Finally, the centre acts as a venue for meetings for self-help and support groups as well as for educational classes. As women who use drugs constitute a particularly marginalised group of society, the main objective of the centre is to reach out them and encourage them to access harm reduction and general healthcare services.<sup>71</sup>

### **Minority groups**

Some minority groups, including lesbian, gay, bisexual, transsexual, transgender and intersex and queer (LGBTTIQ) people, racial or ethnic minorities, immigrants, or refugees, may be at increased risk of drug-related harm due to discrimination, legal or economic pressures, and barriers to accessing services. Local harm reduction services should be explicitly designed so as to be accessible by minority groups, and should be undertaken as collaborative projects between policy makers and affected communities. They should also be accessible to minorities in their own language and be culturally sensitive.<sup>72</sup> Numerous positive examples exist (see [Box 7](#)), such as NSP services targeting Uzbek minority communities in Osh, Kyrgyzstan or Roma in Bucharest, Romania, and peer-based amphetamine-type stimulant harm reduction counselling at the San Francisco AIDS Foundation.

#### **Box 7. Protecting the health of minority groups in Australia and Romania**

From London to Chiang Mai to Zanzibar, racial and ethnic minorities often have relatively poor access to harm reduction services, and services that are less culturally appropriate when they do gain access.

In Australia, rates of drug use, HIV, viral hepatitis, and related health issues are significantly higher among Aboriginal (indigenous) communities than Australians of European descent.<sup>73</sup> While some drug services for Aboriginal Australians are longstanding, efforts to expand them are more recent, and have included engagement by the governmental National Council on Drugs and partnerships between key organisations such as the National Aboriginal Community Controlled Health Organisation and the Australian Injecting and Illicit Drug Users League.

In Romania, Roma are a significant minority group that is overrepresented in terms of poverty, poor health and drug use. From the time the first harm reduction programmes were founded in Bucharest in the late 1990s, such services have targeted Roma communities, employed Roma staff, and developed materials in the local Romani dialect. Roma communities deeply stigmatise drug use, which has created barriers to services. In response, in 2009 the first Roma-led harm reduction initiative was launched in Bucharest's Ferentari district by Sastipen, a Roma health services organisation. Among other tactics, Sastipen's basic preventive health services were made available to the entire community, as a means of increasing acceptance of the harm reduction programme.

## Recommendations

- 1) Based on public health, economic, and other evidence, a package of harm reduction services and policies should be adopted in all locations where injecting drug use is prevalent, in order to promote access to healthcare services and commodities and reduce unintended negative consequences of criminal, health and social policies.
- 2) Harm reduction should not be conceptualised as a standalone service but as an integrated approach that complements, and is complemented by, all levels of health, social and other services that people who use drugs come into contact with. Harm reduction should therefore be integrated whenever possible with drug treatment, primary and relevant specialist health care, social services and justice systems.
- 3) Harm reduction aims to empower people who use drugs to improve their health and manage, reduce, or eliminate the negative consequences of drug use. Programmes should therefore be evaluated in terms of harm reduction's core objective – to lead to any positive change. While abstinence is a potential outcome of harm reduction approaches, reducing 'success' to abstinence-only goals runs counter to scientific evidence about drug dependency and ignores the great value to individuals and society of countless incremental positive steps.
- 4) Harm reduction services should be as comprehensive as is feasible in a given setting, at minimum seeking to address the following either directly or through referral networks: prevention of HIV, hepatitis, STI and tuberculosis, and links to care and treatment; promotion of safer drug-use practices; overdose prevention and response; and basic mental health and social welfare needs.
- 5) Harm reduction programmes that target women, young people, and minorities who use drugs should be established, improved or scaled-up to ensure that such groups have equal access to appropriate services.
- 6) Harm reduction programmes and drug policies gain legitimacy when people who use drugs are meaningfully involved in their development, implementation and evaluation. Harm reduction and allied organisations, and government bodies should encourage the development of community-based organisations of people who use drugs, and should ensure that people who use drugs are represented at all levels of decision making and policy implementation and in ways that actively support participation.
- 7) It is critical that all these harm reduction interventions be extended to prison settings (for more information, see [Section 2.4: Effective drug interventions in prisons](#)).

## Key resources

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## 3.3 Treatment for drug dependence

### In this section

- Methods of treatments for drug dependence
- A cost-effective system
- An effective re-integration process

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

### Why is evidence-based treatment for drug dependence important?

On 24 June 2009, the then Executive Director of UNODC, Antonio Mario Costa, launched the 2009 *World drug report*, stating that 'people who take drugs need medical help, not criminal retribution'.<sup>1</sup>

Recent estimates suggest that 210 million people use controlled drugs.<sup>2</sup> The factors that lead experimental or occasional drug users to become drug dependent are complex. According to the UNODC/WHO definition, drug dependence is the result of a 'complex multi-factorial interaction between repeated exposure to drugs, and biological and environmental factors'.<sup>3</sup> In other words, social, cultural and psychological issues, combining with biological factors (possibly including a genetic component), are all involved in drug dependence. The WHO International Classification of Diseases, with a focus on symptoms, defines drug dependence 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.<sup>4</sup>

Only a small minority of people who use drugs develop dependent patterns of use for which treatment is required.

Only a minority of all people who use drugs – estimated by the UN at between 15 and 39 million globally<sup>5</sup> – will develop dependent patterns of use, for which a treatment intervention is required. It is vital, especially in times of economic austerity, that interventions should be directed where they are most needed and will be most effective. Treatment systems should therefore prioritise scarce resources on these dependent users. This requires the establishment of mechanisms to accurately identify the target

population, and to communicate to them the availability and goals of treatment. Both health and legal services have a role to play in improving access to evidence-based drug-treatment options for people dependent on drugs.

The impact of drug use on an individual depends on the complex interaction between the innate properties of the drug used, the attributes/attitudes of the user, and the environment in which they use.<sup>6</sup> Interventions need to consider each of these factors and how they interact. In all societies, the prevalence of drug dependence has been concentrated among marginalised groups, where rates of emotional trauma, poverty and social exclusion are highest.<sup>7</sup> Given the many factors that drive drug dependence, 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 ideally offer psychosocial services but also take into account the impact of the social and cultural setting in which they do so. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

A growing number of governments have now accepted that offering treatment to people dependent on drugs is a more effective strategy than imposing harsh punishments (for more information, see [Chapter 2: Drug law reform](#)). Studies in a range of social, economic and cultural settings have confirmed that a variety of drug-related health and social challenges – including family breakdown, economic inactivity, HIV and petty street crime – could be tackled in a cost-effective manner through the widespread provision of evidence-based treatment for drug dependence.<sup>8</sup>

However, in many countries, treatment systems for drug dependence are non-existent or under-developed or pursue models that are inconsistent with human rights standards or global evidence of effectiveness. Research, experience and international human rights instruments indicate that certain treatment practices should not be implemented. Some governments, for example, 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 (see [Box 1](#)).<sup>9</sup>

Offering treatment to people dependent on drugs is a more effective strategy than imposing harsh punishments.

### **Box 1. Compulsory centres for drug users in South East Asia**

In certain parts of the world, the use of compulsory centres for drug users is an accepted practice. South East Asia represents the main case in point, where countries including China, Vietnam, Cambodia, Malaysia, Thailand and Lao People's Democratic Republic have established such facilities.<sup>10</sup> These compulsory centres are generally run by the police or military rather than medical authorities, and inmates are assigned compulsorily, often without due legal process or judicial oversight, often for several years. They are denied scientific, evidence-based drug treatment, and are subjected to forced labour, which is either unpaid or paid well below minimum wage levels, as well as a number of punishments such as physical, psychological and sexual abuse, and solitary

confinement. General medical health care is often non-existent, and diseases such as HIV and tuberculosis are widespread among detainees.

These conditions violate scientific, medical and human rights norms. Compulsory centres are also very costly and ineffective – re-offending rates are very high (in Vietnam, for example, from 80% to 97%). Governments often recognise this fact, but some have responded by increasing the length and severity of the 'treatment'.<sup>11</sup>

Although certain governments in the region have recently introduced new drug laws that have modified the status of people who use drugs from 'criminals' to 'patients', such as China's 2008 Anti-Drug Law and Thailand's 2002 Narcotic Addict Rehabilitation Act, the humanitarian rhetoric of legal texts is unrepresentative of the reality of life in the compulsory centres, which impose cruel and dangerous punishments under the guise of treatment.<sup>12</sup>

WHO, UNODC and a number of international NGOs, including Human Rights Watch and Open Society Foundations, have condemned the use of compulsory centres for drug users.<sup>13</sup>

Treatment approaches must respect human rights and the fundamental principle of individual choice to enter a treatment programme or not, and whether to comply and continue with it. This not only fulfils human rights obligations but also ensures programme effectiveness.

Treatment approaches must respect human rights and the fundamental principle of individual choice to enter a treatment programme.

Evidence shows that long-term behaviour change only comes about when individuals decide to change of their own free will. Treatment systems therefore need to be organised so that they encourage individuals to accept treatment 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 covert or overt coercion (see [Box 2](#)). As such, there is considerable ethical debate as to whether users should be coerced into

treatment by the criminal justice system or other means.<sup>14</sup> 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.<sup>15</sup> In either case, treatment systems will be ineffective if they do not respect the principles of self-determination and motivation.

**Box 2. The 'Cure & Care' model in Malaysia<sup>16</sup>**

For decades, Malaysia's main policy concerning people who use or are dependent on drugs consisted of arresting them and sending them to compulsory centres for drug users. In July 2010, Malaysia's National Anti-Drugs Agency (NADA) initiated an important transformation of its drug rehabilitation centres across the country. The new policy implies first and foremost that such centres will only accept voluntary admissions unless individuals are referred through application of the Drug Dependents (Treatment and Rehabilitation) Act.

The 'Cure & Care' model acknowledges that there should be a variety of treatment approaches tailored to the individual needs of the person dependent on drugs. This implies that centres will strive to provide a range of prevention, counselling, treatment (including OST), rehabilitation and support services for people who use drugs in the country.

The establishment and expansion of Cure & Care centres indicates an important change in approaches, values and strategies. First, the fact that this change emanates from Ministry of Home Affairs and NADA is a landmark position in the region, where law enforcement and drug control agencies have initiated changes in their activities to accommodate the needs of people who use drugs. Second, the programmatic implications of this change indicate that health systems integration is a viable and effective strategy to scale-up comprehensive and mutually supportive interventions to address HIV prevention, treatment, care and support. The appreciation of the imperative for the client to be able to choose health interventions based on each individual's needs is an element that is rarely integrated or articulated in South East Asia. Cure & Care services are accessible without conditions of completion or universal achievements: i.e. all clients are able to set their own objectives, and their progress and success is measured against those.

Although it is too early to assess the effectiveness of the Cure & Care centres in terms of health outcomes, the shift of the Malaysian drug policy from compulsory treatment to voluntary treatment is a highly positive development in South East Asia.

**Key elements for an effective treatment system**

In most countries, the delivery of treatment for drug dependence started with the experimental implementation of a particular model, which was expanded or complemented with other models over time. Although a single intervention, or a series of separate interventions, can deliver individual successes, governments should be encouraged to create integrated national, regional and local treatment systems for a wider and more demonstrable impact, while making the most effective use of resources.

A treatment system will have a limited impact if the individuals it targets are unable to access the services. The first challenge is therefore to identify people dependent on drugs and encourage them to engage with social and healthcare services. In addition, it is likely that hidden populations of target individuals will exist, and therefore gateways must be available through which these individuals can approach services. 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 user to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role, provided they are themselves educated regarding drugs and drug consumption
- **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. The existence of drop-in centres with a flexible and informal approach is essential in providing a gateway for those caught up in the time-consuming business of dependence, who are often wary of more rigid institutions and unlikely to attend appointments in what may appear a remote future (such as next week or next month)
- **identification through the criminal justice system.** Through the illicit nature of their drug use, and the need to fund it, dependent drug users may 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,<sup>17</sup> arrest referral schemes in the UK (see [Section 2.2: Effective drug law enforcement](#)), and the social work 'panel' system in Portugal (see [Section 2.1: Drug law reform](#)).<sup>18</sup>

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 offer them the right form of treatment. This requires a geographical spread incorporating rural and urban settings, and services must be culturally relevant and approachable, sensitive to issues of gender and ethnicity, and so on.<sup>19</sup>

Different systems can be used to identify people dependent on drugs and offer them evidence-based treatment.

There should also be a mechanism within the treatment system that manages each individual's progress through treatment (this is often described as a care plan). This ultimate

goal should be made clear, and processes of monitoring and review, which must be ongoing, should measure performance against this target. It is important to recognise that dependence

is a complex phenomenon that may require more than one treatment episode to address it. This is especially the case where clients leave treatment and return to the same setting, and points to the necessity of an integrated approach that brings social support in the form of housing, education and employment together as a comprehensive package.

## **Methods of treatment for drug dependence**

The complexity of drug use is such that the response, setting or intensity of treatment will need to be tailored to each person dependent on drugs. It is therefore essential that a menu of services be made available to suit the differing characteristics, needs and circumstances of each person wishing to access treatment. In addition, the range of drugs available is itself increasing, and a model that is effective for one (e.g. opiates) will not be effective for another (e.g. crack cocaine, methamphetamines, etc). Some countries have established 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 treatment services for drug dependence that makes efficient use of available resources to maximise health and social gains.

### **Treatment methods**

Over the last 60 years a wide range of models and structures for treatment of drug dependence 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 incomplete and do not apply to each of the socially and culturally specific national settings in which treatment may be required. The development of systems for drug treatment 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 demonstrate that NGOs and civil society groups are important actors in the provision of treatment services to people dependent on drugs. Their work should be clearly supported and facilitated by government authorities.

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

A menu of services should be available to suit the differing characteristics, needs and circumstances of each person wishing to access treatment.

### **Detoxification**

Detoxification is defined by WHO as follows: '(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'.<sup>20</sup> Many people dependent on drugs manage withdrawal without assistance from detoxification services. Others may be assisted by family or friends, or other services.

### ***Opioid substitution therapy***

OST is used to treat dependence on opiates. There is a significant global evidence base in its favour as the most closely studied treatment response for drug dependence. Substitution therapy 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'.<sup>21</sup> The most common drug substitutes include methadone, buprenorphine and naltrexone. Other governments are now using heroin assisted treatment (HAT) to treat heroin treatment (see [Box 3](#)).

OST can reduce the risks of contracting or transmitting HIV and other blood-borne diseases, by reducing the incidence of injecting, and therefore the sharing of injection equipment; people dependent on drugs from 'black market' origins are switched to drugs of known purity and potency, which reduces the motivation and need of people who use drugs to commit crimes to support their drug habit, minimises the risks of overdoses and other medical complications, maintains contact with people who use drugs and helps them stabilise their lives and re-integrate in the wider community.<sup>22</sup>

#### **Box 3. Heroin-assisted treatment (HAT) – the example of the UK**

An estimated 5% of opiate users in substitution treatment do not respond well to methadone. They are often among the most marginalised of users and suffer severe health and psychosocial problems, and may have high associated costs in terms of engagement with the criminal justice and welfare systems.

In the UK, there was a history of prescribing injectable heroin to opiate-dependent individuals. However, in the 1960s and 1970s, this practice became politically very controversial, mainly because users collected take-away doses from pharmacies and there was very little supervision. It was probable that this prescribing fed an illicit market. The prescribing of heroin then ceased almost entirely. Nonetheless, there continued to be an unmet therapeutic need among a highly vulnerable section of the drug-dependent population.

In recent years, a new and politically more acceptable regime of heroin treatment was developed in Europe, especially in Switzerland.<sup>23</sup> The UK began scientific trials of this method, in which most clients received doses of injectable heroin in special clinical facilities, under controlled conditions, with close supervision and support from medical staff in a clean and secure setting.<sup>24</sup>

Many of these clients found it to be a life-changing experience, and there was significant improvement in their health and social well-being, alongside large reductions in drug use and criminal activity. The trials involved service users in peer support and research assistant capacities. HAT enabled a hard-to-reach and hard-to-treat population to access health care and support services, as well as meeting political objectives and the requirements of clinical safety.

### ***Psychosocial interventions***

Psychosocial interventions refer to any non-pharmaceutical intervention carried out in a therapeutic context at an individual, family or group level. A wide variety of psychosocial interventions can be used, including cognitive-behavioural therapy, motivational interviewing, group therapy and narrative therapy. Assistance and support can be offered to cover a range of issues such as relapse prevention, coping skills, management of emotional well-being, problem solving, skills training, assertion skills, and mutual aid (self-help; see below) approaches – all of which cover different life domains, such as housing, personal financial management, skills for employment, etc.<sup>25</sup>

Psychosocial interventions are exemplified by the therapeutic community approach. 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 the clients as key agents of change. These members interact in structured and unstructured ways to influence the attitudes, perceptions and behaviours associated with drug use. However, the therapeutic communities approach to drug dependence has been criticised for its high relapse rates.

### ***Mutual aid support groups***

As a complement to formal treatment or a stand-alone option, mutual aid support groups are perhaps the most widespread response to drug dependence. Participation in these groups, particularly when supporting others, can have successful outcomes.<sup>26</sup> Most research focuses on '12-step' models, such as those used by Narcotics Anonymous and Alcoholics Anonymous. However, other models should be encouraged that suit a variety of people. The aim is to provide mutual support structures that offer therapeutic benefits both for those offering and for those receiving support.

### ***Treatment setting***

As well as offering a range of evidence-based interventions, an effective treatment system will also deliver interventions in a range of environments. These can be broadly categorised as street (involving activities such as outreach and drop-in centres), community<sup>27</sup> (such as regular attendance at a clinic where clients receive prescribed medications, counselling, etc) or residential settings.<sup>28</sup> It is difficult to be prescriptive about which should receive the greatest 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.

Community settings tend to be most appropriate where there is strong social, family and community support for the person dependent on drugs. However, it can be better for the client to be treated away from his/her home area when these supports are absent, and they may be susceptible to pressure to return to drug dependence by dealers and associates. Such decisions must be made on an individual basis, by the client and therapist working in a therapeutic partnership. Moreover, the chain of care must be thoroughly integrated; in

practice, clients may move across all three of these settings in their treatment career, and need assistance to achieve re-integration into society. This requires that interventions be developed that help dependent drug users access other forms of care that may not address their drug use directly, such as housing, education and employment services.

### **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, they may wish 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. It must also be borne in mind that drug treatment, however well designed and delivered, cannot provide all the answers. Where structural, intergenerational unemployment exists alongside poverty, inequality and social exclusion (for example), a high prevalence of drug dependence in a community may be understood as an indicator of underlying issues that can only be dealt with by determined political, economic and social intervention.

### **A cost-effective system**

There is a clear public expenditure case for expanding investment in treatment of drug dependence, and small investments in treatment can lead to multiple savings in health, social and crime costs.<sup>29</sup> A 2010 study by the UK Home Office estimated that for every £1 spent on drug treatment, society benefits to the tune of £2.50.<sup>30</sup> In the USA, the benefit return for methadone maintenance treatment is estimated to be around four times the treatment cost.<sup>31</sup> Indeed, according to the US

National Institute on Drug Abuse, 'Research has demonstrated that methadone maintenance treatment is beneficial to society, cost effective and pays for itself in basic economic terms'.<sup>32</sup>

Investments in evidence-based treatment can lead to multiple savings in health, social and crime costs.

As governments have limited resources to invest in this area of health and social care, it is important that resources are carefully prioritised towards those who experience symptoms of drug dependence and wish to undergo treatment. Efficient

management of the treatment programme should enable clients to access treatment easily, move between the different aspects of the system as their circumstances change, and re-integrate into society. This is why the treatment system promoted in the Guide consists of a 'menu' of services of different models, settings and intensity. 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.<sup>33</sup>

## **An effective re-integration process**

Many people dependent on drugs are economically vulnerable and socially excluded, mainly because of the high stigma and discrimination resulting from the criminalisation of drug use. A crucial objective of treatment is to improve each individual's ability to function in society. This means raising levels of education, facilitating access to employment, and offering other social support. A key element of this process is the strengthening of social and community ties. Family and community support is important, and in many countries support groups for former users play a key role in maintaining their commitment to a non-dependent lifestyle. The appropriate engagement of current and former users in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services.

The goal of drug treatment should be, if possible, to assist a person dependent on drugs to achieve a high level of health and well-being and facilitate their participation in society. In this context, it is necessary to recognise that some people may find it impossible or undesirable to attain abstinence. However, this need not preclude the main objective of treatment, that of helping clients to live happily and productively. Many people are, in fact, able to successfully achieve this while remaining on OST. The processes of education regarding drug treatment must, therefore, extend beyond the individuals in treatment to reach their fellow members of the community, who may entertain prejudices regarding OST.

## **Recommendations**

- 1) The primary objective of treatment systems for drug dependence is to enable individuals to live fulfilling lifestyles.
- 2) All governments should make a long-term investment in treatment of drug dependence, in order to respond to drug dependence and reduce the associated health and social costs.
- 3) This investment in treatment of drug dependence should demonstrate a systemic approach rather than a series of isolated interventions: it should identify those most in need of treatment; offer a balanced menu of evidence-based treatment services for drug dependence; and develop smooth mechanisms for individuals to move between different elements as their circumstances change.
- 4) 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.

- 5) 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. Services can be made more effective and responsive if they include the meaningful involvement of clients in their design and delivery.

## Key resources

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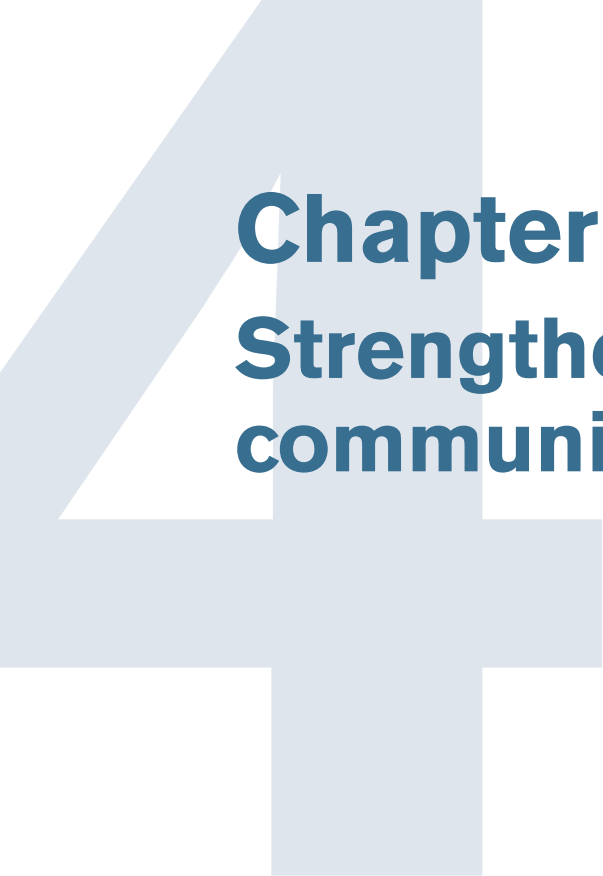
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# **Chapter 4**

## **Strengthening communities**

## 4.1 Controlled drugs and development

### In this section

- Understanding the nexus between illicit drugs and development
- Tackling illicit drugs through the millennium development goals
- A wider partnership for development

**There is clear evidence of the nexus between controlled drugs and development, but insufficient effort has been made to identify and implement approaches that address these issues in a cohesive manner. Bridging the current gap between controlled drugs and development programmes will mitigate the negative consequences associated with narrow drug control policies and support the realisation of broader development goals.**

### Why is it important to link controlled drugs and development?

The UN Millennium Development Goals (MDGs, see [Box 1](#)),<sup>1</sup> adopted by 189 world leaders at the UN Millennium Summit in 2000,<sup>2</sup> are the development 'blueprint' agreed to by all the world's countries and leading development institutions intended to drive this century's international development efforts. Although aiming to capture the key development areas where concerted efforts are essential, the eight MDGs and targets do not make a single reference to the issue of controlled drugs. Further, the UN agency responsible for controlled drugs, UNODC, is not included in the 27 UN agencies that are partners to the MDGs.

The absence of references to controlled drugs in the core development aspirations for the 21<sup>st</sup> century is indicative of a lack of attention to the link between drugs and development. This is particularly striking with regard to the first MDG, which addresses poverty, since drug problems are most often both a cause and consequence of poverty. Development constraints, in particular a lack of realistic economic alternatives, often foster drug cultivation, supply and consumption. In turn, drug use often results in a range of other development problems, including loss of productivity, poor health and negative impacts on community cohesion.<sup>3</sup>

There is a clear nexus between controlled drugs and development.

Despite clear evidence of the nexus between controlled drugs and development, little effort has been made by the development community to identify approaches that address these issues together in a cohesive manner. Yet the integration of drug components into programmes in the fields of rural development, poverty reduction, gender, HIV/AIDS, environmental protection

and good governance, can bring results that are more sustainable and more likely to produce a long-term positive and wider development impact than projects with a narrow focus on drugs.

#### **Box 1. The UN Millennium Development Goals**

- **MDG 1:** Eradicate extreme poverty and hunger
- **MDG 2:** Achieve universal primary education
- **MDG 3:** Promote gender equality and empower women
- **MDG 4:** Reduce child mortality rates
- **MDG 5:** Improve maternal health
- **MDG 6:** Combat HIV/AIDS, malaria, and other diseases
- **MDG 7:** Ensure environmental sustainability
- **MDG 8:** Develop a global partnership for development

### **Understanding the nexus between controlled drugs and development**

There are clear links between controlled drugs and development. For example, drug dependence can contribute to diminished health, leading to higher healthcare costs and decreased earning at the population level. This is most noticeable in the area of HIV/AIDS, where sharing contaminated needles increases the risk of HIV infection among people who inject drugs and fuels the broader spread of the epidemic. In addition, involvement in the illicit drug market absorbs people and resources that would otherwise be employed in licit economic activities, and the huge profits associated with the drug market foster organised crime and corruption, which in turn inhibit the development of good governance. Environmental degradation resulting from the cultivation and refinement of naturally derived drugs is also widely documented.<sup>4</sup>

Drug policy itself has a direct impact on development objectives. Many communities that grow opium or coca, for example, do so because of lack of realistic economic alternatives. Short-term crop-eradication campaigns have been extremely costly and have often destroyed

Drug policy has a direct impact on development objectives.

drug-producing communities' only form of economic survival, without providing alternatives to those affected. In addition, drug law enforcement results in significant numbers of people being incarcerated for minor possession charges, resulting in prison overcrowding, further depriving families and workforces of economic providers. Such policies also divert resources from

other priority areas, such as investments in public health and education.<sup>5</sup> This relates not only to the huge costs of finding and destroying drugs but also to the economic, human, health and social costs to societies across the world, resulting from the marginalisation, discrimination against, and repression of people who grow and use drugs.

Exerting pressure on drug control projects to deliver immediate, tangible 'drug-centred' results is socially and economically counter-productive, and bears evident short- and long-term negative consequences on broader development objectives. The idea of 'rapid success' can rarely be applied to drug control. In the same vein, development cannot happen overnight.

## **Tackling controlled drugs through the Millennium Development Goals**

To address the disconnect between drugs and development strategies, it may be useful to start by recognising that drug policies are linked to the MDGs.

### **Drug policy and the eradication of poverty**

*MDG 1 aims to reduce by half of the proportion of people living on less than a dollar a day.*

#### ***Addressing poverty in drug-producing areas***

Drug crops often represent a key element of smallholder families' survival strategy. Drug production is mainly concentrated in developing countries and undertaken by the poorest and most vulnerable groups. They often inhabit hostile environments, and are subject to inequitable land tenure and credit arrangements. They usually only receive a share of the final crop or may be forced to sell their share in advance at prices well below the harvest time rate. The farmers usually benefit very little in terms of revenue. In Afghanistan, for example, less than 20% of the US\$3 billion in opium profits goes to impoverished farmers, while more than 80% goes into the pockets of Afghan's opium traffickers and their political connections. Even heftier profits are generated outside of Afghanistan by international drug traffickers.<sup>6</sup> This reality is being played out in many other countries, including opium-producing countries such as Burma/Myanmar, or coca-producing countries such as Colombia or Peru.

Drug control responses in drug-producing areas have traditionally taken the form of standardised 'one-size-fits-all' opium/coca bans, crop eradication and the criminalisation of producers. Even where there have been attempts to promote alternative livelihoods, these have often been unrealistic in terms of the alternatives pursued (e.g. production of goods without market access or inadequate to the local geographical contexts), or too short term to enable communities to make the necessary adjustments. The effects of drug control measures in terms of sustainable reductions in poverty have been mainly negative: many communities that used to cultivate drugs now face food shortages, reduced access to health and education due to diminished incomes, growing indebtedness, displacement and/or forced migration.<sup>7</sup> The vacuum left by the sudden disappearance of their primary source of economic survival can sometimes force these communities to engage in survival alternatives involving sex work or increased participation in the drug trade.<sup>8</sup>

Repressive measures against consumers and producers demonstrably reduce neither the consumption nor the cultivation of crops destined for the illicit drug market in the long term. Yet, their impacts can push further the spiral of violence (see [Section 4.2: Reducing drug market violence](#)), poverty and migration, and raise prices on the illicit market, which in turn makes cultivation and trafficking attractive.

Some positive alternatives exist – in some Latin American and South East Asian drug-producing areas, promising approaches have recently been developed.<sup>9</sup> These programmes focus on long-term strategies that address the indirect causes of the drug problem, going beyond the immediate objectives of drug control (see [Section 4.3: Promoting alternative livelihoods](#)). A number of lessons have been learned from such approaches and are discussed below.

Long-term strategies should be developed to address the indirect causes of the drug problem, going beyond the immediate objectives of drug control.

- Programmes must go beyond the immediate objective of crop eradication and aim instead at breaking those cycles that hinder human development and instability. Crop eradication should happen only within the context of broader rural development and programmes for poverty reduction, to ameliorate drug-producing communities' living conditions and break their dependence on the drug economy.
- Programmes need to prioritise increasing food production, strengthening and diversifying income-generating opportunities and markets, and improving access to education and health services.
- Efforts should be undertaken to improve opportunities for participation by marginalised groups – such as ethnic minorities, indigenous people, women and young people – in the design and implementation of these programmes, to reduce their vulnerability to drug production, couriership and use.
- Areas where cultivation of crops destined for the drug market takes place are heterogeneous in terms of the nature and size of cultivation zones, and socio-cultural, ethnic, economic, legal and political structures. Policies must incorporate local culture and the knowledge and skills of local communities.
- Long-term efforts to improve institutional frameworks should be an overarching objective of any drugs and development programmes (e.g. promote dialogue between government agencies and marginalised groups, increase the efficiency and transparency of public institutions, and address human rights violations).
- In societies that experience socio-economic transition, development efforts should address social and economic inequality, particularly among young people.<sup>10</sup>

### ***Addressing poverty in drug-using communities***

Attempts to reduce consumption by imposing legal sanctions have failed to curb drug use. The deterrence principle has often exacerbated the social marginalisation of such groups. Overall, the recourse to criminal justice measures to respond to what are primarily health and

socio-economic issues has been inappropriate. There is ample room for addressing drug use, its causes and its consequences within social protection strategies. Social protection nets within development programmes need to be remodelled in order to reach vulnerable people who are, or may become, involved in the drug market.

Social protection nets should be developed to address the causes and consequences of drug use.

## Drug policy and gender issues

*MDG 3 calls for the promotion of gender equality and the empowerment of women.*

Over the last decade, gender issues have become a core area of development practitioners' discussions and have been given a prominent role within the MDGs. However, gender considerations have been largely absent from drug policies. The predominant discourse about women who use drugs is in the context of vulnerability to HIV and STIs.<sup>11</sup> Other factors have received little attention in the context of drug policy and overall development strategies, including women's social status and often low autonomy, social stigma, abuses from the police or courts and fear of punishment or loss of child custody, and the lack of women-centred health care and treatment services for harm reduction and drug dependence.<sup>12</sup>

Women are particularly affected by harmful drug policies and their needs should be addressed in long-term drug control strategies.

Programmes and policies have also taken little notice of the particular role played by women in drug cultivation and trafficking. Women are involved in most stages of opium poppy cultivation, and in areas of conflict are often required to fill the labour gap left by men involved in the conflict. Furthermore, women are often used as drug couriers for drug trafficking (see [Box 2](#)).

### **Box 2. Gender, poverty and drug couriership<sup>13</sup>**

From 2006 to 2009, the number of foreign women detained for drug-trafficking offences in Brazil rose by 253%. Similarly, in the last decade, the female UK prison population has doubled and is still rising. Official UK statistics show a 60% increase in the number of foreign national female prisoners who have committed drug offences, mainly drug trafficking. These are almost always first-time offenders from the poorest countries in the world, with the majority coming from Jamaica and Nigeria. These 'international drug traffickers' are in fact drug couriers. Despite the extreme dangers they face, the reason women become drug couriers is a relatively simple one – it is almost always due to situations of extreme poverty.

Incarcerating these women for lengthy sentences (in most cases between 6 and 8 years in the UK) has had little impact on the large global trafficking networks, which can rely on an endless, easily replaceable pool of desperate couriers. Rather, poverty-reduction approaches, income-generating programmes and women-empowerment strategies in the countries of origin would surely be more effective measures. This would prevent these women from falling prey to the exploitation of criminal groups, and deprive the large drug-trafficking organisations of this cheap and expendable manpower resource, upon whose desperation traffickers build their money and power.

A few programmes do incorporate strategies that place a genuine focus on the needs and particular characteristics of women affected by controlled drugs, with special attention to their cultural and social contexts. Where they exist,<sup>14</sup> such strategies:

- ensure that gender assessments are part of the situation analysis for all drugs and development projects, and that programmes are designed to ensure women and men's equitable participation and access to services
- identify and address legal, political, socio-economic and cultural barriers that keep women vulnerable to drug traffickers
- promote awareness and education campaigns to reduce stigma and empower communities to address women's drug-use problems
- promote gender-responsive drug programmes through advocacy and networking at the international, national and community levels and within multi-sector programmes; women's needs should be included in guidelines, targets and drug strategies (see [Box 3](#))
- link treatment programmes for drug dependence and facilities such as prenatal and obstetric/gynaecological services, child welfare/protection services, crisis services including women's shelters or sexual assault services and mental health services, to provide the array of support that women require
- ensure that women who use drugs can benefit from the protection of the law in full respect of their rights
- address linkages between drug use and sex work by, for example, reaching sex workers through harm reduction services or partnering with programmes targeted at sex workers, to provide harm reduction services.

### **Box 3. A practical checklist of concrete steps to assist gender integration throughout development programme cycles<sup>15</sup>**

The HIV/AIDS Asia Regional Programme (HAARP) supports gender-sensitive harm reduction programmes in South East Asia. The HAARP gender integration strategy, developed in 2008, includes a 'gender checklist'. The HAARP Technical Support Unit first used this checklist to guide a consultation process with country programmes to help them reflect on their progress, challenges and opportunities in relation to gender-responsive programming. The checklist includes various statements that describe different aspects of a good-quality gender-responsive programme. These components are listed under the following headings:

- partnerships and engagement
- capacity building
- programmes and services
- monitoring and evaluation.

Country programmes can use this checklist to assess their progress towards comprehensive, gender-sensitive programming for both men and women who inject drugs, as well as their partners and spouses.

## **Drug policy, HIV prevention, and public health**

*MDG 6 calls for the halting and reversing of the spread of HIV/AIDS and the achievement of universal access to treatment for HIV/AIDS.*

In many parts of the world, the HIV epidemic is driven by the sharing of contaminated equipment for injecting drug use. Efforts in most countries to develop and implement pragmatic health-driven and harm reduction responses to drug use have sometimes been limited or undermined by drug policies based primarily on punitive approaches.

The criminalisation of drug use and possession can hinder attempts by people who inject drugs to engage with available HIV prevention, treatment and care services. According to non-governmental sources reporting to UNAIDS, only 16% of countries have laws or regulations protecting people who use drugs from discrimination. It is further estimated that 40% of countries have laws that interfere with the ability of service providers to reach people who inject drugs.<sup>16</sup> In particular, restrictions on access to OST for people dependent on opioids constitute an important barrier to HIV prevention and other public health efforts.<sup>17</sup>

Evidence-based harm reduction strategies are effective in reducing HIV transmission among people who use drugs.

There are a number of evidence-based harm reduction services that can be offered to people who use drugs. These include, for example, OST and NSPs (for more information, see [Section 3.2: Harm reduction](#)).

## **Drug policy and the protection of the environment**

*MDG 7 seeks to integrate sustainable development into country policies and reverse the loss of environmental resources.*

There are numerous opportunities and ways to link environmental protection strategies with programmes to reduce supply within such a framework.

Crop eradication is a major cause of deforestation as farmers move cultivation to remote areas after their fields have been destroyed. In the Andean-Amazon region, this often involves burning down plots in national parks and the tropical forest, resulting in great damage to rich but fragile eco-systems.

A number of environmental and health consequences are also associated with crop eradication. In Colombia, the glyphosate sprayed over coca fields by US planes has caused gastrointestinal problems, fevers, headaches, nausea, colds and vomiting in people, and similar effects have been detected in animals. The spraying has sometimes forced whole villages to be abandoned.<sup>18</sup> Management of natural resources in drug-cultivating regions is often inappropriate and results in increasing clearance of forests and drug cultivation in conjunction with drug trafficking. To counter these problems, a number of measures have been locally considered and/or implemented (see [Box 4](#)),<sup>19</sup> including:

Drug policies should seek to protect the environment.

- development of new approaches for the cultivation and processing of agricultural products; these can include supporting small producers' associations in sectors such as fish farming, fruit growing and product enhancement (e.g. fruit juices) and in the marketing of these products
- promotion of agricultural and forestry measures, with particular emphasis on environmental compatibility, as well as off-farm measures
- transformation of indigenous populations' extensive knowledge on the cultivation of medicinal plants into income-generating opportunities for their communities
- support to small and medium-sized livestock farmers to promote economically sustainable, and socially self-reliant, livestock farming, by making production and marketing both more profitable and more ecologically sound.

#### **Box 4. Promoting legal sources of income in drug-cultivation zones in Peru<sup>20</sup>**

The Selva Central Region of Peru is prone to drug cultivation because it attracts migrants from the uplands and offers limited licit income-generating opportunities. Management of natural resources in the region is usually inappropriate. One result of this is increasing clearance of the tropical forest; another is the possible expansion of coca cultivation in conjunction with drug trafficking and all the negative effects on the ecology, economy and social infrastructure that that entails.

The 'Promoting the Production of Niche Products in Two Coca Cultivation Regions of Peru' project was launched in 1997 to support selected indigenous producer groups in diversifying and marketing their medicinal plants and non-timber forest products. The aim was not only to transform the indigenous population's extensive knowledge on medicinal plants into income-generating opportunities for their communities, but also to help counteract the marginalisation of these groups. Since they did not own any coca fields, they were usually not included in alternative development projects. Yet, these communities, which comprise around 5–10% of the population in the cultivation zones, were continuously subject to cultural and socio-economic pressures and the threat of displacement. Building on the indigenous groups' existing knowledge, it proved possible to both increase and assure the quality of products, and contacts were established with distributors to market the exportable products.

For the indigenous population, the cultivation and marketing of native medicinal plants is an economic option that is socially and ecologically compatible, is rooted in their traditional knowledge, and at the same time permits integration into modern markets. These types of projects aim to ensure that natural resources and traditional knowledge are valued and protected, while legal economic and social structures are strengthened and made more sustainable, in order to undermine the foundations of illicit activities.

## A wider partnership for development

At the 2010 UN Summit, world leaders reiterated that ‘all the Millennium Development Goals are interconnected and mutually reinforcing’<sup>21</sup> and underlined the need to pursue the MDGs through a holistic and comprehensive approach. Regrettably, they have so far failed to address the interconnection between drugs and development, which has inevitably severed any holistic and comprehensive approach to the pursuit of the MDGs, and hindered the achievement of lasting success in those areas.

Over the years, partners in co-operation have adopted differing positions and disjointed approaches to drugs and development. This is despite collective endorsement of the MDGs and other guiding principles, such as those articulated in the UN drug conventions and the 1998 United Nations General Assembly Special Session on Drugs, which include the principle of human development based on shared responsibility for drug consumption, trafficking and cultivation. The collective endorsement of the MDGs has had little impact on the practice of disjointed drugs and development approaches.

The USA, for example, has put huge efforts into eradicating drug crops as a means to reduce supply, whereas the EU prioritises the establishment of sustainable licit livelihood systems before crop eradication and operates on the basis that development co-operation should not be conditional on particular drug control targets.<sup>22</sup> Overall, very few international donors<sup>23</sup> have sought to reduce drug-related problems by promoting broader development processes. Even fewer have seen drug control as an instrument of human development or understood that supply reduction is more likely to result from long-term integrated development processes than from short-term inventions that bear severe consequences for the communities concerned.

Regardless of the approach, it is now clear that drugs and development projects implemented in isolation from one another have not been able to reduce the harms associated with the global drug market, nor have they enhanced socio-economic development. Conversely, some have created new vulnerabilities and/or exacerbated existing ones.

While the severity of the drug crisis has triggered some important calls for a critical review of current drug control strategies (see [Section 2.1: Drug law reform](#)),<sup>24</sup> it is also time to broaden the scope of the analysis and action and adopt more comprehensive policies. Policies and strategies must jointly address the causes of the problem (especially those directly resulting from narrow drug control policies) rather than simply its symptoms. Hence, drug use needs to be addressed in conjunction with issues of unemployment, social exclusion, discrimination and poor housing and health care, especially among marginalised communities; drug production and drug-couriering must be linked to rural development and poverty reduction; and drug trafficking must be tackled by targeting the real beneficiaries of drug profits and must thus be linked to strategies that tackle money laundering and organised crime.

It is time to broaden the scope of the analysis and adopt more comprehensive drug policies.

Alternative political strategies should also seriously consider options in relation to the depenalisation, decriminalisation or legal regulation of drug consumption and/or production (see [Section 2.1: Drug policy reform](#)).

## Recommendations

- 1) Considerations of short- and long-term impact on social and economic development, with particular attention to the MDGs' objectives and targets, should be the foundations upon which to build comprehensive development approaches to controlled drugs.
- 2) Drugs and development programmes must be bridged, and involve all relevant stakeholders in the design and implementation of integrated policies.
- 3) A common language and understanding of the overall objectives of drug policy and development must be agreed upon by all stakeholders working on drug policy and development, prior to the design of drugs and development programmes.
- 4) Integrated drugs and development programmes should promote positive change in the lives of people involved in drug production, couriering, trafficking and consumption, in order to provide them with viable alternatives to the illicit drug market. These programmes should address specific gender-related issues.
- 5) Drug policies should no longer aim to reduce the scale of the drug market but should aspire to reduce the harms associated with these markets through a development-oriented approach (see [Section 4.2: Reducing drug market violence](#)).
- 6) Alternative livelihoods should be promoted as the only viable option for reducing the production of crops used in the illicit drug market (see [Section 4.3: Promoting alternative livelihoods](#)).
- 7) Drug policies enshrined in development programmes should seek to promote the economic, social and cultural rights of indigenous people and use their knowledge, experience and participation to develop policies and programmes that affect them (see [Section 4.4: Protecting the rights of indigenous people](#)).

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## 4.2 Reducing drug market violence

### In this section

- Examples of drug-related violence
- The nature of drug markets
- Promoting a harm reduction focus for the supply side

**Drug policies and law-enforcement strategies should focus on reducing the violence associated with drug markets rather than their overall scale, and reduce levels of socio-economic inequality in the areas most affected by them.**

### Why is reducing drug market violence important?

Urban violence and organised crime are some of the most worrying aspects of the global drug market. As those involved in the illicit drug market cannot appeal to legal methods to avoid or 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 the violent drug trade (see [Box 1](#)).

#### **Box 1. Former UNODC Executive Director statement**

'The first unintended consequence is a huge criminal black market that now thrives in order to get prohibited substances from producers to consumers. Whether driven by a 'supply push' or a 'demand pull', the financial incentives to enter this market are enormous. There is no shortage of criminals competing to claw out a share of a market in which hundred fold increases in price from production to retail are not uncommon.'<sup>1</sup>

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,<sup>2</sup> before dropping slightly in 2011.<sup>3</sup> Similarly, Mexico is currently experiencing an explosion of violence related to the drug market – since December 2006, at least 47,000 people have died as a result of drug-related violence,<sup>4</sup> and Ciudad Juarez, on the border with the USA, is the most violent city in the world.<sup>5</sup> In contrast, other Latin American cities have experienced a reduction in murder rates compared to a decade ago. Bogotá (Colombia), which used to be the world's most violent city, has seen its murder rate decline to 21.5 per 100,000 inhabitants in 2011.<sup>6</sup> Similarly, many US cities that

experienced spikes in urban violence in the 1990s have seen more recent declines. Despite hosting some of the most lucrative drug markets, European cities are less affected by large-scale urban violence.

Evidence suggests that increases in violence are largely linked to the transit routes of controlled drugs and related drug consumption in areas where poverty is high and governance is weak. 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.<sup>7</sup> The same phenomenon is now occurring in West Africa, which has become a new transit area for drugs en route to Europe.

Shaping the illicit market to make it less harmful, promoting socio-economic development and strengthening justice institutions and community ties are more effective approaches in increasing citizen security and reducing the reach of organised criminals.

Thus far, governments have believed that implementing tough drug laws against drug traffickers and users would automatically reduce violence by removing drug markets. However, these measures have not succeeded in reducing the scale of the global drug market and related violence. The opposite has often happened in practice and the use of law enforcement by the police and sometimes the military has tended to exacerbate levels of violence. An approach focusing on shaping the illicit market to make it less harmful, coupled with socio-economic development and strengthening of justice institutions and community ties are more effective in increasing citizen security in the face of high levels of violence, and reducing the reach of powerful organised criminals.<sup>8</sup> Some experts have recently started to promote such an approach as the application of 'harm reduction for the supply side'.<sup>9</sup>

## 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.

### Drug production

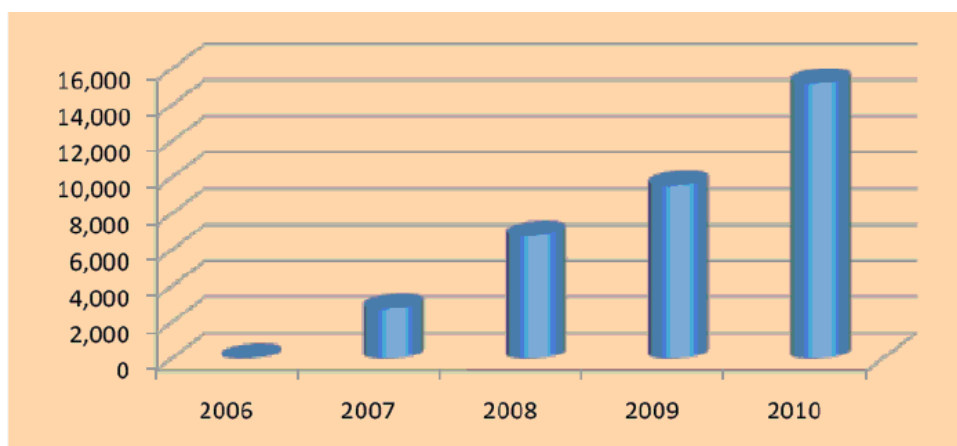
Violence may be employed to control the crops destined for the illicit drug market. This includes the use of violence by individuals and groups wanting to protect their crops from seizures or destruction by state authorities or criminal rivals. In Colombia, clashes often occur between farmers and factions of the Revolutionary Armed Forces of Colombia.<sup>10</sup> Violence is also commonly employed in Afghanistan. In 2001, the Taliban severely restricted the production of opium through threats of violence to farmers who grew opium poppy. North Atlantic Treaty Organization (NATO) soldiers are also engaged in ongoing deadly operations to control Afghan opium fields.<sup>11</sup> In the Andean region, less direct forms of violence include poisoning food crops and water supplies and displacement of farmers because of aerial herbicide fumigation campaigns.

Crops destined for the illicit market also tend to proliferate in areas affected by conflict. In Colombia, for example, coca and poppies 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. Violent incursions by the Colombian army add to the pressure on the local population and the abrogation of their human rights.<sup>12</sup>

### Drug trafficking

Significant levels of violence are associated with trafficking of drugs en route to Europe and North America, especially in Central America and the Caribbean. Mexico is particularly affected by drug-related violence because of intense conflicts among heavily armed trafficking gangs and between drug-trafficking organisations and state authorities, especially since the Calderón government intensified its war on the drugs cartels. 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 government responded with a major crackdown against drug cartels in 2006. The conflict unleashed an upsurge of violence in border cities (see [Figure 1](#)).

**Figure 1. Drug war killings in Mexico since the launch of President Calderón's offensive on drug cartels<sup>13</sup>**



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' (for a definition, see [Box 2](#) in Section 2.2: Effective drug law enforcement).<sup>14</sup>

### 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. However, this requires that the government or local authorities realise that there will always be some level of drug dealing and that the new focus should be on targeting those retail markets that cause most harms to society, while implicitly tolerating other forms of less harmful retail markets.

## 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, the Caribbean and West Africa, where drug markets have become entwined with competition between local businesses, bureaucracies and politicians are, for example, 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 so as 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 important 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 problems related to the drug market in economically vulnerable neighbourhoods
- **socio-economic conditions** – cities and neighbourhoods that are socio-economically vulnerable, 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. 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 [see [Box 2](#)], Mexico and Brazil) where drug control policies have led to high levels of urban violence.

### Box 2. Thailand's 2003 war on drugs

In February 2003, the Thai government launched a 'war on drugs', which resulted in the extrajudicial killing of approximately 2,800 people, the arbitrary arrest of several thousand more, and the use of extreme levels of violence by government officials.<sup>15</sup> In August 2007, the military-installed government of General Surayud Chalanont appointed a special committee to investigate the extrajudicial killings during the 2003 war on drugs. The committee's report, which has never been made public, found that of the 2,819 people killed between February and April 2003, more than 1,400 were not involved in the drug market, and that there was no apparent reason for killing them.<sup>16</sup>

- **the availability of firearms** – drug markets flooded with automatic and semi-automatic weapons 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.

## Promoting a harm reduction focus for the supply side

The challenge for policy makers is to design law-enforcement strategies that create incentives for drug dealers to avoid the worst aspects of violence, intimidation and corruption.

New policies have focused on tackling the underlying causes of drug-related violence through a combination of law-enforcement efforts and socio-economic programmes.

There has recently been a shift in focus from several local governments that have experimented with new policies seeking to shape the illicit drug market in order to reduce its associated harms and violence. These policies have primarily focused on tackling the underlying causes of drug-related violence and involvement in organised crime, through a combination of law-enforcement efforts and socio-economic programmes that seek to:

- promote good governance and the rule of law
- fight corruption within police forces and government institutions
- provide health and socio-economic services to communities that had so far been outside of the reach of the state; this includes the construction of healthcare facilities, the promotion of education with the provision of scholarships, the construction of libraries, parks and community centres, creation of life-skill programmes, etc
- strengthen community ties and the involvement of community representatives in the design and implementation of programmes seeking to reduce drug market violence
- involve local policy makers in the co-ordination and support of local strategies.

The new policy adopted in Rio de Janeiro, Brazil, has attracted much attention in Latin America and elsewhere (see [Box 3](#)). Another interesting case study, presented in [Box 4](#), is that of city of Santa Tecla, El Salvador. The final example in [Box 5](#) explains the principle of 'focused deterrence' law enforcement adopted in some US communities to reduce drug market violence.

### Box 3. Rio de Janeiro's 'Pacifying Police Units'<sup>17</sup>

Rio de Janeiro has a long history of violence associated with controlled drugs, organised crime and police repression. In Rio, the drug trade remains concentrated within economically and socially vulnerable communities living in the city's *favelas* (slums). Since the 1970s, Rio became an important transit point for cocaine exports to North America, Europe and South Africa. Newly established drug factions quickly settled in the *favelas*, where they became important figures in the socio-political life of the community, providing them with health and social services and opportunities for employment in the drugs trade – services that were not offered by the government itself. In the 1980s and 1990s, divisions within and between drug factions, the increasing availability of high-calibre weapons, and violent police interventions in the *favelas* led to increasing levels of violence. High numbers of deaths (in 2010, the murder rate in Rio reached 46 per 100,000 inhabitants), an overcrowding of Brazilian prisons with drug offenders, high levels of corruption, and an ever-expanding drug market led the local government in Rio to review its drug policy.

Launched in 2008 in the *favela* of Santa Marta, UPPs ('Unidades de Polícia Pacificadora', Pacifying Police Units) consist of a new public security policy that combines law enforcement with actions seeking to tackle the social, economic and cultural aspects of the drug market. A key element of this policy is that it should focus on those areas where the market is most harmful, while acknowledging that some level of trafficking will be tolerated elsewhere. The pacification process consists of four steps:

- **invasion:** this step aims to retake control of the territories under the influence of a drug cartel; it involves the intervention of the military
- **stabilisation:** while the military used to invade problematic *favelas* only to withdraw a few hours later, this new strategy now entails that the military remain in the pacified territory until the UPPs take over
- **occupation:** the UPPs start to operate in the *favelas* and seek to restore the rule of law through a system of community policing
- **post-occupation:** the UPPs develop a strong relationship of trust with the community and establish socio-economic programmes to boost education and employment opportunities.

Since 2008, 17 *favelas* have been retaken by the UPPs. Several concerns were raised about the policy. First, some have criticised a feeling of militarisation of the communities, with the military remaining in the *favelas* for an extended period of time, leading to tight police control, arbitrary search and seizures and harassment. Others have raised concerns about the capacity of the UPPs to tackle drug-related violence extensively. Indeed, out of the 1,000 *favelas* in the city, only 17 have been pacified so far. This may lead organised criminal groups to migrate to those neighbouring *favelas* that have not yet been pacified and resume their violent activities. Nevertheless, the UPPs have been well received by *favela* residents. A study in eight pacified *favelas* found that 83% of the residents considered that their security situation had improved as a result of the programme.<sup>18</sup>

**Box 4. The example of Santa Tecla, El Salvador<sup>19</sup>**

With a national homicide rate of 66 per 100,000 in 2010, El Salvador has one of the highest murder rates in the world. During the 1980s, El Salvador suffered a bloody civil war that led to massive internal migration from the countryside to the major cities. A devastating earthquake in 1986 left a further 100,000 people homeless. Today, El Salvador suffers from high levels of violence, predominantly in urban areas. In a 2010 survey, 24.2% of Salvadorans reported having been the victim of crime in their neighbourhoods.

Throughout the 1990s, El Salvador also experienced a rise in gang culture. The government principally used security forces and the criminal justice system to tackle the problem. This policy did little to reduce crime rates and resulted in driving these criminal organisations underground. It also led to thousands of arbitrary arrests and a greater gang presence in the country's prisons.

In the face of this problem, the municipality of Santa Tecla, a satellite city of San Salvador, developed a different approach, focusing on a social-oriented strategy, to combat drug-related violence. The municipality undertook long-term plans that prioritised social development, community-building capacity, and co-ordination among local government agencies. The municipal government analysed city infrastructure and connectivity, land use demographics, employment, access to basic services and other factors crucial to development. Other policies such as 'school scholarships' were devised, offering financial incentives to stay in school and projects to 'recuperate' public spaces. The municipal government also created a local Observatory for the Prevention of Crime, which gathered data on violent crimes, in order to fine-tune local decision making, based on standardised evidence and information.

A model of community policing focused on prevention was implemented, including joint patrols between the municipal police and the national police. Mechanisms were also implemented to co-ordinate violence-prevention activities amongst local, state and national actors; this also allowed local citizens to participate in the design of policies, an important factor in the more socially oriented response to violent crime. The policy evolved thanks to civic participation, and the objective shifted to 'strengthening peaceful community coexistence in the city through interagency co-operation and co-ordination and the promotion of responsible citizen participation in a way that is civic-minded and democratic'. This community-orientated style of policing, combined with long-term social projects, has been very popular with citizens who see it has achieved results. Indeed, since the initiation of the programme, although other security problems subsist today, Santa Tecla has seen a significant reduction in its homicide rate. In 2007, Santa Tecla was removed from the list of the 20 most dangerous municipalities.

### **Box 5. The US 'focused deterrence' law-enforcement strategy**

In the US context, 'focused deterrence' law-enforcement strategies have achieved notable successes in reducing violent crime in numerous localities, from Boston, Massachusetts (see [Box 4](#) in Section 2.2: Effective drug law enforcement), to High Point, North Carolina.

One of the central insights of 'focused deterrence' is that, at any given time, enforcement capacity is limited and clear priorities must therefore be set. Regardless of the country and circumstances, reducing crime understandably rises to the top of the priority list. By implication, other enforcement objectives take a back seat, at least temporarily. 'Focused deterrence' strategies arise from key insights about how law enforcement can shape criminal behaviour in ways that discourage violence – if the consequences of a certain type of criminal conduct (e.g. murder) are clearly communicated to the potential offenders, and the promised consequences are quickly brought to bear should such crimes be committed, there will be an important disincentive to engage in violence. That is, violence will be understood to be bad, rather than good, for business. Targeted enforcement has impressed upon drug dealers that flagrant violence makes them less competitive than their less violent rivals, and violent crime has fallen to a lower, more manageable equilibrium.

The successes achieved through variants of focused deterrence in US communities do not mean that illicit sales have been eliminated, but rather than the illicit drug market has shifted into modes of conduct that generate less mayhem in the streets.

Other cities that have suffered extremely high levels of drug market violence and have so far implemented policies primarily focused on law enforcement (sometimes involving the military), are also turning to this new approach. This includes, for example, Ciudad Juarez.

As these policies essentially involve long-term socio-economic development and community-strengthening strategies, time will be needed to truly assess their impact on drug-related violence. In addition, as each local drug market and its historical, political and cultural contexts are unique, it will often be difficult to apply one strategy in another context. However, important lessons have been learned from each of these policies, and available evidence shows promising results in areas where the policies have been implemented.

### **Recommendations**

- 1) Law-enforcement efforts need to focus more on reducing the violence associated with the illicit market rather than attempting to reduce drug availability itself.
- 2) Policy makers need to recognise that social, political and economic exclusion form the context in which crime and violence take root, and that programmes that aim to reduce

drug-related violence will require a long-term commitment based on socio-economic development, community strengthening, and citizen participation in policy-making processes.

- 3) Drug law-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 directly related to the drug market? Who is most likely to participate in and suffer from the drug market?
- 4) Where compromised by corruption, law-enforcement agencies and criminal justice systems need to be overhauled. Reforms are needed to generate an environment that is 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.
- 5) Government agencies should always stay within the frame of the rule of law when intervening in drug markets.
- 6) Efforts should be made to reduce the availability of firearms in cities affected by drug markets. This involves a 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.
- 7) At the local level, the policy makers should set up integrated inter-agency partnerships, including law-enforcement, educational, social and health sectors, as well as communities, in order to design and implement strategies aimed at reducing drug market violence.

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## 4.3 Promoting alternative livelihoods

### In this section

- Forced crop eradication – a counter-productive approach
- Promoting development in a drugs environment
- Promoting preventive alternative development

**The cultivation of crops destined for the illicit drug market is an essential part of shadow survival economies. Crop eradication in the absence of viable alternative licit livelihood options is a violation of human rights and a costly initiative that impacts negatively on marginalised and vulnerable farmers. An alternative livelihoods approach can more successfully reduce the cultivation of these crops.**

### Why is the promotion of alternative livelihoods important?

Reducing crops destined for the illicit drug market 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.<sup>1</sup> Cultivation of the opium poppy, the raw material for opium and heroin, has shifted over time. The Golden Triangle of Thailand, Lao People's Democratic Republic, and Burma/Myanmar once produced more than 70% of the world's opium, most of which was refined into heroin. Since 1998, dramatic decreases in opium cultivation have taken place in the Golden Triangle and it is now concentrated in what is known as the Golden Crescent, the poppy-growing areas in and around Afghanistan. Nevertheless, Myanmar remains the second largest opium poppy grower in the world after Afghanistan and still produces 23% of the global opium supply.<sup>2</sup>

Supply reduction efforts have typically been measured according to the areas of crops cultivated, the amounts of cocaine and opium produced, and the number of hectares eradicated. However, determining how much coca and poppy is cultivated today remains elusive. Differences in the US government and UNODC statistical estimates 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 approximately 200,000 hectares, although as a result of the 'balloon effect' (see [Box 1](#) in Section 2.2: Effective drug law enforcement), there have been significant shifts in the amount grown in each country. By contrast, UNODC reported a decrease in production.

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. UNODC reports a similar trend with regard to poppy cultivation and opium production. Between 1994 and 2010, global poppy cultivation decreased from 272,479 to 195,700 hectares (but had increased from 150,000 to 195,700 hectares between 2005 and 2010). However, between 1994 and 2007, potential opium production increased from 5,620 to 8,890 tonnes, subsequently dropping to 4,860 tonnes in 2010.<sup>3</sup> In Afghanistan, although poppy cultivation declined by 22% between 2007 and 2009, opium production decreased by only 10%. Similarly, the 7% increase in Afghan poppy cultivation between 2009 and 2010 resulted in a 52% increase in potential opium production.<sup>4</sup>

Efforts to reduce the cultivation of crops destined for the illicit drug market have mainly consisted of forced crop-eradication campaigns – the physical destruction of the crop on

the ground. Over time, crop-eradication campaigns have become associated with violence and conflict, and a number of health and socio-economic harms, in particular destruction of the only means of subsistence of farmers involved in the cultivation of these crops, therefore exacerbating their vulnerability to poverty, conflict and forced migration.

'Alternative livelihoods' programmes aim to reduce farmers' reliance on cultivation of crops destined for the illicit drug market by addressing the structural and institutional factors that shape their decisions to grow these crops.

The idea of 'alternative development' – i.e. rural development programmes in areas where drug-linked crops are grown – was developed in the late 1960s as an integrated approach to improving community livelihood options to address the underlying factors that drive farmers to grow opium poppy and coca. The concept subsequently evolved towards the

principle of 'alternative livelihoods', moving from isolated, project-specific interventions to broader, multi-sectorial development-oriented policies aimed at reducing farmers' reliance on the cultivation of opium poppy and coca, by addressing the structural and institutional factors that shape their decisions to grow these crops.<sup>5</sup>

In most recent cases, crop eradication and development of alternative livelihoods have been carried out simultaneously. However, a growing number of experts have demonstrated that forced eradication can result in more harm than good, especially if alternative livelihoods programmes have not been properly sequenced – for crop reductions to be maintained, alternative sources of income must be put in place before the farmers' primary source of income is eliminated. Additional reasons for rethinking crop-eradication policies will be explained below.

Farmers will only be able to reduce their dependence on income from coca and poppy crops if they are provided with alternative livelihoods through long-term multi-sectorial development programmes.

## **Forced crop eradication – a counter-productive approach**

Crop eradication consists of manual eradication, the use of aerial fumigation of chemical agents on coca fields, and biological methods. Crop-eradication campaigns are conducted without the consent of coca and opium poppy farmers, although they are sometimes encouraged to participate in the campaigns in return for compensation or development assistance.

Over the years, forced crop eradication has been associated with a number of negative consequences.

- It is a very expensive approach, which has not led to desired result of reducing the cultivation of crops destined for the illicit market. For example, manual fumigation requires approximately 20 days of work per hectare for coca and 3 days of work per hectare for opium poppy.<sup>6</sup> In the case of aerial fumigation, coca farmers tend to wash the chemical off their crops or immediately replant new crops to replace those that have been damaged.
- Small farmers involved in coca and poppy production usually do so for lack of viable economic alternatives. It is estimated that farmers earn only 1% of the overall global illicit drug income – most of the remaining revenue being earned by traffickers within developed countries.<sup>7</sup> As farmers involved in coca and poppy cultivation often tend to be marginalised and vulnerable, implementing forced eradication programmes before providing them with alternative sustainable livelihoods pushes them deeper into poverty.<sup>8</sup> The abrupt cut-off in income can impact negatively on the health and nutrition of those affected. Families may be forced to migrate to more remote areas and children may be taken out of school in order to supplement the household income, creating greater difficulties for escaping poverty in the future.
- In some parts of the world, such as Colombia, aerial fumigation campaigns have led to health problems among farmers, sometimes forcing them to migrate to other parts of the country. Aerial fumigation techniques can be devastating for the environment, including those lands used to grow licit food crops.
- Price incentives sometimes counter the impact of a 'successful' eradication campaign. 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.
- Eradication tends to move the cultivation of illicit 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 ecosystems.<sup>9</sup> This makes cultivation more difficult to detect and eliminate, and spreads the problems associated with these crops to new areas.
- Forced eradication increases opportunities for corruption and organised criminal networks. 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.

- More generally, 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 human rights abuses that often accompany eradication campaigns, alienate the local population and further undermine the legitimacy of the state. In turn, this can boost political support for the insurgents.
- Even when conducted hand-in-hand with alternative development programmes, eradication campaigns undermine co-operation with the local community, which 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 subsistence farmers off the cultivation of crops destined for the illicit drug market (see [Box 1](#)).

**Box 1. Forced crop eradication in Bolivia and its consequences on alternative development assistance**

Prior to the signature of an agreement between the Bolivian government and coca growers in 2004, forced eradication in Bolivia 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 subcontractors that carry out alternative development projects are viewed with suspicion and distrust by the local community.

- Finally, it is necessary to remember that not all cultivation is destined for the illicit market, and therefore not all coca and opium poppy should be eradicated.

First, indigenous people in the Andean region have consumed the coca leaf for centuries, and coca chewing is an integral part of religious and other ceremonies. Similarly, opium has long been used in Asia for medical, social and recreational 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. Opium is used in some traditional Asian societies to ward

off the symptoms of gastrointestinal illness, and in this context can be a life-saver in infants. Such cultures are often among those most acutely lacking essential medicines such as morphine. However, national and international drug control systems prohibit traditional uses of these plants, leading to violation of the social, economic and cultural rights of indigenous communities (see [Section 4.4: Protecting the rights of indigenous people](#)).<sup>10</sup>

Second, the licit cultivation of coca and opium poppy continues to take place in countries such as Australia, India, Turkey and France, for medical and culinary purposes, especially for the pharmaceutical production of morphine, codeine and thebaine (paramorphine). An increase in licit uses of these substances should be considered, in order to decrease the share of cultivation currently destined for the illicit market and respond to the needs of millions of people living in moderate or severe pain because of lack of essential medicines.

## Promoting development in a drugs environment

Programmes for alternative livelihoods, or programmes aimed at promoting 'development in a drugs environment' are intended to address the underlying structural conditions faced by coca and opium poppy farmers and provide them with legal and economic opportunities in order to reduce their dependence on the cash income these generate. This approach is also designed to improve the overall quality of life of farmers, including: improved access to health care, education (see [Box 3](#)) 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.<sup>11</sup>

### **Box 2. Abstract from *Inputs for the draft – International Guiding Principles on Alternative Development*<sup>12</sup>**

'Alternative development should be mainstreamed into a larger socio-cultural-economic development context with emphasis on the need to address poverty, inadequate enforcement of the rule of law in some areas, and other related social injustices reflecting also the United Nations Millennium Development Goals, and as part of sustainable strategies for the control of illicit crops'.

Alternative livelihoods programmes are no longer purely focused on reducing the production of crops destined for the illicit drug market, but are incorporated, or mainstreamed, into comprehensive strategies for rural development and economic growth. Specifically, they call for embedding strategies for reducing coca and poppy crops in local, regional and national development initiatives.

### The importance of sequencing

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,

It is only 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.

as long as alternative livelihood options are not sufficiently in place, farmers replant to secure income or move into new areas where it is easier to avoid detection. 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 and fertiliser, or to bridge family income gaps until harvest time, farmers need to be offered micro-credit schemes to enable them to switch from illicit to licit sources of income. At that point, crop reduction should be voluntary and

conducted in collaboration with the local community. It is therefore crucial that alternative livelihoods programmes are properly sequenced (see [Box 3](#)).

#### **Box 3. The Thai alternative livelihoods model<sup>13</sup>**

Beginning in 1969, the Thai government sought to integrate highland communities into national life and therefore 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 placed on providing social services such as healthcare services and schools, as well as infrastructure development such as roads, electricity and water supplies. Alternative livelihoods programmes were integrated into local, regional and national development plans. This led to steady improvement in farmers' quality of life, and increased opportunities for off-farm employment. The Thai approach evolved over time. Initially, international donors defined the strategy with little participation from the local communities or even the local government. The second phase fully involved the local 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 also points to the importance of proper sequencing. Efforts at crop reduction only started in 1984, after about 15 years of sustained economic development. While some forced eradication did take place initially, proper sequencing allowed farmers to reduce poppy production gradually, as other sources of income developed, avoiding the problem of re-planting that inevitably frustrates crop-eradication efforts. Although

the entire process took about 30 years, 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 methamphetamine use in the region since the 1990s.<sup>14</sup>

Some caution is advised about how far this model can be replicated elsewhere. First, in Thailand farmers grew poppy in fertile areas where other crops could easily be produced, which is not necessarily the case in other parts 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. Finally, global market dynamics were not much affected, since the relatively insignificant exports of Thai opium and heroin could easily be replaced from other sources. Although these particular factors may make it difficult to replicate this experience in other regions, this experience does provide useful guidelines for designing alternative livelihoods strategies elsewhere.

### **Promoting good governance and the rule of law**

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.<sup>15</sup>

Nation building and promoting good governance and the rule of law are also essential components of an alternative livelihoods approach.

### **Linking alternative livelihoods to the protection of the environment**

The lack of accessible natural resources can be one of the driving factors leading to the cultivation of crops destined for the illicit drug market. The use of natural resources must be recognised as a means for subsistence for communities that are dependent on them to meet their livelihood needs. A multi-sector approach towards alternative livelihoods requires the adoption of measures that create incentives for rural communities to refrain from engaging in other illicit activities that would harm natural resources. This should not simply consist of incentives to stop growing crops used in the illicit drug market, but should also include incentives for conservation of the environment, allowing communities to improve their livelihoods while caring for their environment. For example, reforestation programmes that allocate land as a mix of conservation forest, economic forest and sustenance forest can assist in balancing the community's survival with environmental protection (see, for example, [Box 4](#) in [Section 4.1: Controlled drugs and development](#)).<sup>16</sup>

### **Including coca and opium farmers as key partners in alternative livelihoods programmes**

Alternative livelihoods programmes require that coca or poppy farmers should no longer be considered as criminals but should instead be viewed as key stakeholders in the design and implementation of the development programmes that affect them.<sup>17</sup> The involvement of farmers is necessary, both because local farmers have a better knowledge and understanding of the local geographical conditions, and in order to protect the rights and cultural traditions of local communities (see [Section 4.4: Protecting the rights of indigenous communities](#)). This principle was included in the draft version of International Guiding Principles on Alternative Development recently drawn up by a group of experts and government officials during a workshop in Thailand.<sup>18</sup> Additional UN reports have also underscored the importance of community involvement in such efforts.

### **Moving from indicators of crops eradicated to broader indicators of human development**

So far, most crop-eradication and alternative development projects have primarily evaluated their success by reductions in the cultivation of drug-linked crops. However, in an evaluation report to the Commission on Narcotic Drugs in 2008, UNODC stated that, 'there is little proof that the eradications reduce illicit cultivation in the long term as the crops move somewhere else', adding that, 'alternative development must be evaluated through indicators of development and not technically as a function of illicit production statistics'.<sup>19</sup> While reductions in cultivation are not an adequate measure of progress or impact in drug control strategies, there is a direct relationship between improved social and economic conditions of an area and the sustained reduction of illicit cultivation (see [Box 4](#)).

#### **Box 4. The promotion of alternative livelihoods in Lao People's Democratic Republic**

The Alternative livelihoods project in Lao People's Democratic Republic targets village communities that are dependent on opium poppy cultivation because of high levels of poverty. The project resulted in the expansion of road networks, improved farming technologies, the generation of alternative sources of income, and social leadership and empowerment of villagers to help them respond to changing socio-economic conditions and benefit from emerging improvements in government services and economic opportunities.<sup>20</sup> Significant improvements in economic opportunities and the provision of social services to these communities, along with greater security, improved infrastructure and increased access to markets have correlated with reductions of opium poppy production from 26,000 hectares in 1998 to 2,000 hectares in 2009.<sup>21</sup>

Experience has demonstrated that successful alternative livelihoods programmes have a limited effect on the global illicit drug market, as production tends to shift elsewhere to meet global demand, but they have, nevertheless, proved to be successful at the local and national level. Expectations about what alternative development programmes can achieve concerning reducing illicit supply to the global drug market should be modest and realistic, as the effectiveness of any strategy for supply reduction depends on the market dynamics

of supply and demand. This demonstrates the need to adopt a balanced approach towards the global drug problem, tackling both supply and demand at the same time, with evidence-based policies and programmes. A successful policy also needs to include the recognition that poverty is a multidimensional problem that requires a multidimensional approach. It further needs to acknowledge the important role of sustainable resource use and management and the provision of social services, and address issues of conflict, crises, lack of good governance, violence, the rule of law and security – all elements that characterise most areas where opium poppy and coca are cultivated.

## **Promoting preventive alternative development**

Some countries, in particular Ecuador, have promoted the concept of 'preventive alternative development' in areas where cultivation of crops destined for the illicit drug market could start, or in areas that offer a pool of available workers for harvest. Although such programmes have so far failed to attract sufficient international donor interest, especially in current times of budget restrictions, this concept should be kept in mind and experimented by governments whenever possible.<sup>22</sup>

## **Recommendations**

- 1) 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, involving 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.
- 2) 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, and representatives of coca and opium poppy farmers, should be involved in the decision-making process.
- 3) Proper sequencing is essential. Alternative livelihoods and improved quality of life must be achieved before crop reductions.<sup>23</sup> An alternative livelihoods approach should also incorporate the concept of 'preventive alternative development'<sup>24</sup> in areas that could be conducive to producing crops for the illicit market.
- 4) Development assistance should not be conditional on meeting prior targets for crop reduction. 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 under way and bearing fruit, governments can work with local communities to encourage reduction, and in some cases elimination, of crops destined for the illicit market.

- 5) Local communities must be involved in the design, implementation, monitoring and evaluation of development efforts. This includes community leadership, and the involvement of local organisations such as producer groups and the farmers themselves. Government officials can play a key role in mobilising, co-ordinating and supporting community participation.
- 6) Results should not be measured in terms of hectares of crops eradicated. Rather, alternative livelihoods programmes should be evaluated using human development and socio-economic indicators – indicators that measure the well-being of society.<sup>25</sup>

## Key resources

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## 4.4 Protecting the rights of indigenous people

### In this section

- International law and the rights of indigenous people
- National levels of controls for traditional plants

**Many aspects of drug policy, including the blanket prohibition of the traditional cultivation and use of certain plants, violate indigenous peoples' rights that are enshrined in United Nations conventions.**

### Why is protection of the rights of indigenous people important?

For generations, people worldwide have used psychoactive plants such as coca, cannabis, opium poppy, kratom, khat, peyote and ayahuasca for traditional, cultural and religious purposes. In Latin America, for example, 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 been bound to faith and mysticism in Hindu and Islamic traditions for centuries, and are enshrined in countless cultural practices. Other plants, such as khat in Eastern Africa and kratom in South East Asia, have also been used for traditional and social purposes for centuries. Some of these substances have also been employed medicinally, especially for the treatment of rheumatism, migraine, malaria, cholera and other gastrointestinal complaints, and to facilitate surgery.<sup>1</sup> They can also provide food grain, oil seed or fibre for manufacturing products.

The UN drug conventions have classified some of these plants (i.e. cannabis, the coca leaf and opium) as harmful and subject to controls that limit their production, distribution, trade and use to medical and scientific purposes. The premise behind this policy was that it was considered difficult to achieve effective reduction of the production of controlled drugs to amounts required for medical and scientific purposes as long as large-scale local consumption of raw materials for these drugs continued in the main producing countries. This led to pressure on producing countries to end traditional uses of the plants used as raw materials for controlled drugs. Opium, cannabis and the coca leaf were therefore placed under the same strict levels of control as extracted and concentrated alkaloids such as morphine and cocaine (Schedule I of the 1961 Convention).<sup>2</sup>

The value of traditional use of controlled plants was recognised in the 1988 Convention, which provides that drug policies should 'respect fundamental human rights' and 'take due account of traditional licit uses, where there is historical evidence of such use' (article 14, para.2).

The value of traditional use of controlled plants is recognised in the 1988 Convention.

However, the 1988 Convention (articles 14.1 and 25) also states that its provisions should not derogate from any obligations under the previous drug control treaties, including the 1961 obligation to abolish any traditional uses of coca, opium and cannabis (article 49).<sup>3</sup> In legal terms, therefore, the significance of the 1988 recognition of 'traditional licit uses' is questionable and, in practice, most governments have disregarded this provision and have placed strict control mechanisms on cannabis, the coca leaf and opium, but also on traditional psychoactive plants that have not been classified by the UN, such as khat and kratom.

## **International law and the rights of indigenous people**

The 1989 Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries<sup>4</sup> defines indigenous people as those who, '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'.

In addition to the universal human rights recognised in international conventions (see [Section 1.2: Ensuring compliance with fundamental rights and freedoms](#)), 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 and 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 a large number of governments, now endorse these achievements.

The 2007 Universal Declaration on the Rights of Indigenous Peoples<sup>5</sup> notably recognises indigenous peoples' right to:

- self-determination and autonomy
- maintain, protect and develop cultural manifestations of the past, present and future (article 11)
- maintain their traditional medicines and healing practices (article 24)
- maintain, control, protect and develop their cultural heritage, traditional knowledge and manifestations of their science, technology and culture (article 31).

The declaration is not binding under international law, but represents an important advance in the recognition of indigenous rights and provides governments with a comprehensive code of good practice.

## National levels of control for traditional plants

National governments have applied varying levels of control for traditional plants. These controls have been associated with a number of consequences for the rights of indigenous people.

### Full prohibition of traditional plants' cultivation and use

Some governments have sought to prohibit the cultivation, trafficking, distribution and use of traditional plants, both for plants that have been scheduled at the international level, and also for other mild plant stimulants. These policies have often focused on crop eradication on the supply side and/or on the criminalisation of people who use these plants on the demand side.

For instance, although the UN drug conventions do not compel signatory states to control kratom production, trafficking, distribution and use, Australia, Malaysia, Burma/Myanmar and Thailand (see [Box 1](#)) have decided to ban kratom, despite little evidence that the use of this plant impacts negatively on the health of users. Kratom can also have beneficial medicinal properties for the digestive system and in reducing pain from opioid withdrawal symptoms.<sup>6</sup>

#### **Box 1. Kratom prohibition in Thailand**

Kratom has been used for medicinal and traditional purposes in Thailand for centuries, in particular in the southern part of the country. The plant was scheduled in 1943 under the Kratom Act, and was then included in the Thai Narcotics Act in 1979. Over the past 10 years, the application of kratom laws and policies has become increasingly rigid, leading to widespread arrests of kratom users and eradication campaigns to destroy kratom trees. This policy has had a limited effect on levels of kratom use and has led to a number of negative consequences for the right of communities to use kratom as an integral part of southern Thai culture.<sup>7</sup>

In the Andean region, while Bolivia and Peru have protected a domestic legal coca market, crop-eradication campaigns have caused widespread damage to the health, habitat and traditions of coca-growing indigenous communities. In countries where violent clashes take place between armed groups fighting for control of the drug trade, or where conflicts have erupted between coca farmers and law-enforcement agencies, forced eradication has militarised coca-producing areas, placing the local rural population (and especially indigenous communities) in the middle of the battlefield.

Plan Colombia, for instance, a counterinsurgency and counter-narcotics strategy that launched a massive crop-eradication campaign initiated in 1999, has not only had disastrous consequences on the lives and economy of indigenous people and farmers, 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, but has led instead to a serious humanitarian crisis, leading to the displacement of 3.6 to 5.2 million people<sup>8</sup> and resulting in increased levels of poverty and insecurity.

Forced eradication can militarise crop-producing areas, placing the local rural population in the middle of the battlefield.

In instances when alternative development programmes were implemented, these did not always incorporate local knowledge, know-how and cultural traditions, leading to further alienation of the indigenous populations. It is necessary that these programmes are developed in collaboration with local populations after a careful assessment of the local cultivation possibilities and market access, and with full respect for the

rights and traditions of indigenous people (for more information, see [Section 4.3: Promoting alternative livelihoods](#)).

On the consumption side, the coca leaf has been used for thousands of years in the Andean region for traditional and religious purposes. The international prohibition introduced by the 1961 Convention demonstrates a clear misunderstanding of indigenous customs and traditions. Andean and Amazonian coca consumers often feel ignored, insulted and humiliated by the international community and the UN call to abolish what they consider to be a healthy ancestral tradition. Allegations that chewing coca was a form of drug addiction causing malnutrition in indigenous people and that it was a degenerative moral agent helped justify its classification as a controlled substance. Since then, scientific research has convincingly proved otherwise, including a 1995 WHO study that concluded that the 'use of coca leaves appears to have no negative health effects and has positive therapeutic, sacred and social functions for indigenous Andean populations'.<sup>9</sup> [Box 4](#) illustrates how the Bolivian government has remedied the issue raised by the international ban on coca leaf chewing.

### **Special legal and constitutional provisions to protect the rights of indigenous people**

Some governments have developed provisions within their national legal system to allow for the traditional use of certain psychoactive plants under special circumstances. This is the case, for example, in Canada, with Section 56 exemption of the Canadian Controlled Drugs and Substances Act (see [Box 2](#)), and in the USA for peyote use among indigenous communities (see [Box 3](#)).

#### **Box 2. The case of Santo Daime in Canada<sup>10</sup>**

Section 56 of the Canadian Controlled Drugs and Substances Act provides that: 'The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of the Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest'.<sup>11</sup>

In practice, this exemption is rarely exercised. It has usually been granted for medical and scientific purposes, for instance to some physicians to prescribe methadone as part of OST, to conduct specific research trials for a supervised injection site in Vancouver, and for heroin prescription in Vancouver and Montreal. In 2001, for the first time, Section 56

was used with the aim of protecting the right to use a controlled substance for traditional and cultural purposes (i.e. using the 'public interest' provision).

In 1996, Jessica Williams Rochester returned to Canada after a visit to Brazil and established Ceu do Montreal, based on the Santo Daime religion. From the time of its founding until 2000, Ceu do Montreal leaders imported Daime sacrament (i.e. ayahuasca<sup>12</sup>) into Canada with Brazilian agricultural export documents and practised their religion according to church doctrines. In 2000, the Canadian customs intercepted a shipment of Daime and sent it for chemical analysis. Ceu do Montreal was informed that possession of Daime constituted an offence under the Canadian criminal code, but was advised to apply for a legal exemption for their Daime sacrament under Section 56 of the Canadian Controlled Drugs and Substances Act, which it did in 2001. In this particular case, the government concluded that 'in principle', the case could benefit from an exemption under Section 56, pending receipt of documentation from the government of Brazil allowing legal export of Daime.<sup>13</sup>

Although this policy is limited in scope, as an exemption only applies to a particular group of individuals for a specific substance, this example remains useful as it provides for a possibility to protect the right to use a plant for cultural and traditional purposes.

### **Box 3. Peyote use among indigenous communities in the USA**

Peyote is a small, spineless cactus containing psychoactive alkaloids. In the USA, the religious use of peyote is allowed for members of the Native American Church, a pan-tribal religion derived from the practices of native Americans who inhabited what is now southern Texas and northern Mexico.

This exception is inscribed in Title 21, Section 1307.31 of the US Code of Federal Regulations, which states that: 'The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the Native American Church'.

These provisions effectively enable Native Americans to perpetuate their religious traditions and rituals by using peyote without fear of prosecution.

Bolivia is no doubt the country that has gone furthest in this domain, by recognising the traditional use of the coca leaf as a cultural heritage within its constitution,<sup>14</sup> and therefore ensuring that the rights of Bolivian indigenous communities to chew the coca leaf be protected. While Peru, Colombia and Argentina also have domestic legal exemptions for coca leaf consumption,<sup>15</sup> Bolivia is the first country to acknowledge that such exemptions and practices represent breaches of drug control treaty obligations. In doing so, Bolivia decided to denounce the 1961 Convention to re-accede to it with a reservation on the coca leaf to ensure that its national laws and practices are in line with its international obligations (see [Box 4](#)).

#### **Box 4. Bolivia, coca leaf chewing and the protection of indigenous culture**

Coca has been sacred to the indigenous peoples of the Andean region for thousands of years. In Bolivia, the Quechua and Aymara peoples make up the majority of the rural population, and use of the coca leaf is widespread among them. The practice is associated with social and cultural solidarity, economic activity and work, medicinal factors (such as adding nutrients to the diet and providing protection against altitude sickness), and spirituality, restoring the balance between natural and spiritual realms. As in Britain, where people might invite friends around for a cup of tea, or for a coffee in the USA, Bolivia's indigenous people will say, 'Come around for a chew' (*aculli*).<sup>16</sup> This gives some indication of how thoroughly embedded traditional practices of coca consumption are in Bolivia.

The first Western attempts at prohibiting coca came with colonisation in the 16<sup>th</sup> century, when the Catholic church became aware of the plant's role in native religious ritual. An informal accommodation with coca was achieved, however, which lasted until the 20<sup>th</sup> century and its disastrous 'war on drugs'. Following the Second World War, the UN led a drive for 'modernisation', which identified the practice of coca chewing with the primitive and outmoded. The 1950 report of the UN Economic and Social Council (ECOSOC) Coca Leaf Inquiry Commission, led by a US representative, supported the assumption that the use of coca was harmful, and resulted in the scheduling of the coca leaf along with cocaine and heroin in the 1961 Convention and its provision that coca chewing had to be abolished within 25 years.<sup>17</sup> Though the 1950 report has often been criticised for being biased, scientifically flawed, culturally insensitive and even racist, it remains the prime UN reference document on the coca issue.

These historical factors are becoming increasingly understood as the main shapers of the present international drug control regime and were accused of 'drug control imperialism' by the Global Commission on Drug Policy.<sup>18</sup> The fact that the UN drug control regime still fails to recognise the rights of Andean indigenous communities to chew the coca leaf today stands symbol to the embarrassing inability of the regime to stay in touch and in line with developments in the UN system, and more broadly with international human rights.

As a result, in June 2011, Bolivia withdrew from the 1961 Single Convention, announcing its intention to re-accede with a reservation allowing coca leaf chewing in the country.<sup>19</sup> Some of the reasons for Bolivia's move, in addition to those already stated above, are that:

- coca is regarded by the Constitution of the Plurinational State of Bolivia as a cultural patrimony. The international drug control treaties make repeated allowance for the fundamental constitutional principles of member states to be respected
- coca is central to the cultural life & sense of identity of the indigenous peoples of Bolivia
- coca is at the core of the forms of sociability developed within their culture
- coca has important medicinal and therapeutic uses

- coca has highly significant spiritual associations and functions
- coca is at the heart of a subsistence economy, and many attempts to substitute alternative crops have failed in the Andean region.

Bolivia's withdrawal from the 1961 Convention, submitted in June 2011, came into effect on 1 January 2012. A few days before that, on 29 December 2011, in a letter to the UN Secretary-General, Bolivia presented the reservation it requires to reconcile its various national and international legal obligations before becoming a full treaty member again. Bolivia expresses that it reserves the right to allow traditional coca leaf chewing in its territory, but also the consumption and use of the coca leaf in its natural state in general, as well as the cultivation, trade and possession of the coca leaf to the extent necessary for these licit purposes. At the same time, the reservation clarifies that Bolivia will continue to take all necessary measures to control the cultivation of coca in order to prevent the illicit production of cocaine. In the letter, Bolivia also made clear that its effective re-accession to the 1961 Convention was subject to the authorisation of this reservation. The treaty procedure establishes that all members have one year to express any objections and that the reservation will be accepted unless one-third or more of the states object to it during that period. In this case, 'the 12-month period for objections will expire on 10 January 2013'.<sup>20</sup>

### **Legal regulation of traditional plants**

As explained before, some mild plant stimulants have not been included in the UN classification system, leaving governments responsible for deciding on their status. This is the case, for example, for kratom and khat. As observed earlier, kratom was prohibited under national laws in several Asian countries, while the national legal status of khat varies considerably from country to country.

Khat has been used for hundreds, if not thousands, of years, in the highlands of Eastern Africa and Southern Arabia. Traditionally, khat has been chewed communally, after work or on social occasions, in public spaces or dedicated rooms in private houses. Global khat markets have been driven by demand from diaspora populations settling in Europe, particularly from Somalia. So far, there has been little cross-over from migrants to the mainstream European population. A number of studies have demonstrated that the potential for dependence associated with khat, and the physical and mental health risks of khat use, remain very low.<sup>21</sup> Evidence suggests that prohibiting khat use has led to a number of negative consequences, including expanding the isolation and vulnerability of immigrant populations, and impacting negatively on livelihoods and economic development in producer countries.<sup>22</sup> In countries where khat is legally regulated, none of these unintended consequences have occurred (see [Box 5](#)). Khat use remains concentrated among Eastern African migrant communities who consume khat safely in commercial establishments, and communal centres where social and community bonds remain strong. This enables consumers to control the quality of the khat they use and to perpetuate cultural and social traditions among their community.

### **Box 5. Khat regulation in the UK**

In the UK, khat chewing remains legal. There has been substantial research on the social harms associated with khat. In 2005 the Advisory Commission for the Misuse of Drugs advised against regulating khat under the Misuse of Drugs Act 1971, concluding instead that educational and awareness campaigns should be implemented.<sup>23</sup>

Khat retails in the UK at £3 to £6 per bundle.<sup>24</sup> VAT is now imposed on khat imports, raising £2.9 million in 2010 when around 3,002 tonnes of khat entered the UK, a large increase since the late 1990s.<sup>25</sup> The fresh product is mainly imported from Kenya and Ethiopia for the consumption of mainly East African and Yemini communities in the UK.

In the UK, khat is mainly consumed in commercial establishments, which act as local communal centres where food and drinks are served. These establishments are subject to local health and safety laws, ensuring that there is no nuisance for local residents.<sup>26</sup> Studies of khat use in the UK imply that it is of cultural importance among diaspora communities, enabling them to maintain their identity. Immigrant communities often gather to chew khat and discuss politics in their country of origin, as well as giving advice on problems they experience and on job opportunities.<sup>27</sup>

There is little evidence to connect khat chewing, crime and public disorder in the UK. In fact, khat is seen as preventing people from offending, as it strengthens social bonds and relaxes users.<sup>28</sup> Some members of diaspora communities have, however, raised some concerns associated with khat chewing, such as income diversion, family breakdown and unemployment. It should be noted that these social harms would be highly exacerbated if khat were to be controlled as an illicit drug.

## **Recommendations**

- 1) International obligations, particularly those arising from human rights legal instruments that are at the heart of international law, need to be fully respected at the national level.
- 2) Governments should address the discrepancies between the UN drug conventions and international human rights agreements, to ensure that the rights of indigenous peoples are upheld.
- 3) The historical, cultural and traditional character and potential benefits of plants controlled at the national and international level should be recognised. At the national level, new laws and regulations are needed to provide for the controlled cultivation of these plants for traditional use.
- 4) The participation of indigenous communities should be promoted in the design and implementation of policies and regulations that affect them.

## Key resources

Bewley-Taylor, D. & Jelsma, M. (2011), *TNI Series on legislative reform of drug policies Nr. 12 – Fifty years of the 1961 Single Convention on Narcotic Drugs: a reinterpretation* (Amsterdam: Transnational Institute), <http://www.idpc.net/sites/default/files/library/fifty-years-of-1961-single-convention.pdf>

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## Endnotes

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## Glossary

<b>Abstinence</b>	State of refraining from using drugs.
<b>Cocaine</b>	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 may produce dependence. Cocaine can be ingested orally, nasally and 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 can be 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'.
<b>Coca leaves</b>	The leaves of the coca bush <i>Erythroxylon coca</i> , are traditionally 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.
<b>Controlled drug</b>	Psychoactive substance, the production, sale or use of which is prohibited. Although the term 'illicit drug' was used in the previous version of the IDPC Drug Policy Guide, we decided to use 'controlled drug' as a more correct term in this new version of the Guide. Indeed, it is not the drug itself 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.
<b>Decriminalisation</b>	The repeal of laws or regulations that define a behaviour, product or condition as criminal. The behaviour, product or condition remains illegal but are considered as a civil or administrative offence.
<b>Demand reduction</b>	A general term used to describe policies or programmes directed at reducing the consumer demand for psychoactive drugs. It is applied primarily to controlled 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.
<b>Depenalisation</b>	Reduction of the severity of penalties associated with drug offences. The penalties remain within the realm of criminal law.
<b>Detoxification</b>	The process by which an individual is withdrawn from the effects of a psychoactive substance. As a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimised. Many people dependent on drugs manage withdrawal without assistance from detoxification services, while others can be assisted by family, friends or other services.
<b>Drug control</b>	The regulation, by a system of laws and agencies, of the production, distribution, sale and use of specific controlled drugs locally, nationally or internationally. It is equivalent to drug policy.

<b>Drug dependence</b>	Drug dependence refers to a strong desire to consume drugs, the difficulty in controlling substance use, the continued use of the substance despite physical, mental and social problems associated with that use, increased tolerance over time, and sometimes withdrawal symptoms if the substance is abruptly unavailable. Drug dependence is not a failure of will or of strength of character, but a chronic, relapsing medical condition with a physiological and genetic basis.
<b>Drug policy</b>	In the context of psychoactive drugs, the aggregate of policies designed to affect the supply and/or the demand for controlled 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.
<b>Drug testing</b>	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 testing is not an effective method to deter drug use and has led to a number of negative consequences, such as users moving to more harmful substances to avoid detection.
<b>Drug use</b>	Self-administration of a psychoactive substance.
<b>Heroin</b>	Heroin is the popular name, (originally a brand name devised by the German pharmaceutical company Bayer), for diacetylmorphine, a semi-synthetic opioid that is used in medicine as an analgesic, and that produces feelings of relaxation and euphoria in non-therapeutic consumption. On the illicit market, it generally comes in two forms: white heroin, which is soluble in water and is usually injected, and 'brown sugar' brown heroin, the base form of the drug, which is often smoked.
<b>Heroin-assisted treatment (HAT)</b>	Heroin-assisted treatment is a therapeutic option that has been added to the range of OST in a growing number of countries in the past two decades, as its evidence base has grown more extensive and secure. It involves the provision of diamorphine to patients, usually those who have not gained benefit from more traditional OST employing methadone, etc. Diamorphine doses are given under clinical supervision in a safe and clean medical setting, and the medication elements are combined with intensive psychosocial support mechanisms. HAT is currently provided with positive outcomes in Switzerland, Germany, the UK, Denmark, Spain, Canada and the Netherlands.
<b>Injecting drug use</b>	Injectations may be intramuscular (into a muscle), subcutaneous (under the skin), intravenous (into a vein), etc.
<b>Legal high</b>	A substance with psychoactive properties (capable of altering mood and/or perception), whose production, distribution, possession and consumption is not subject to drug-related legislation in a given jurisdiction or set of jurisdictions.

<b>Legal regulation</b>	The production, distribution and consumption of drugs are no longer considered as illicit, but are subject to a regulated system (e.g. the regulatory system applied for tobacco, alcohol or medicines).
<b>Needle sharing</b>	The use of syringes or other injecting instruments by more than one person, 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 OST and NSPs are designed to reduce needle sharing.
<b>Opioid</b>	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 relaxation, tranquillity and well-being (euphoria). The opium alkaloids and their synthetic analogues also cause stupor, coma and respiratory depression in high doses. Repeated exposure to opioids can produce a state of dependence, whereby distressing physiological and psychological symptoms are experienced upon withdrawal; this is the characteristic state of withdrawal sickness or abstinence syndrome with which these alkaloids are associated.
<b>Opioid substitution therapy</b>	<p>Opioid substitution therapy (OST) involves using long-acting drugs and is currently the most effective treatment option available for opioid dependence. Methadone and buprenorphine are the two most commonly used OST medications.</p> <p>Within one or two weeks of beginning OST, most users experience reduced craving, and over a period of time decrease or stop opioid use. OST introduces stability and removes the user from the 'black market'. The risk of contracting blood-borne diseases (e.g. HIV and hepatitis B and C) and other harms associated with injecting are reduced. Overall, the goal of OST is to improve the health, social and economic outcomes for the individual users, their families and the community.</p> <p>The use of OST is supported by the UN as an essential element in the management of opioid dependence and the prevention of HIV infection among people who use drugs, and OST medications are listed in the WHO list of 'Essential medicines'. The INCB declared that OST 'does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice'.</p>
<b>Overdose</b>	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 controlled drugs. Overdose may produce transient or lasting effects, or death. The lethal dose of a particular drug varies with the individual and with circumstances.
<b>Proportionality principle</b>	In essence, the legal principle of proportionality refers to a fit between the harm caused by a given infraction and the legal or judicial response toward it: that is, it raises the question of the appropriateness of punishment, as in the popular belief that 'the punishment should fit the crime'. In order to achieve a proportionate sanction in drugs offences, a number of practical issues should be examined: the background of the offender (issues of poverty, coercion, cultural norms) and the degree of their involvement in an offence (are they a 'courier', or dependent on drugs? Or are they, on the contrary, an international trafficker garnering vast profits?).

<b>Psychoactive plant</b>	A term that refers to plants containing mild stimulants, often having been used in indigenous cultural settings, such as coca, khat, ephedra and kratom. The term is used to point to the distinction between mild, naturally occurring stimulants such as coca, used traditionally across the Andean region, and powerful alkaloid extracts and pharmaceutically produced substances (cocaine, crack, amphetamine, methamphetamine), the uses of which have much greater associated harms.
<b>Recidivism</b>	The term refers to the tendency to repeat an offence and/or to keep on returning to prison. There is a growing awareness that recidivism is often a result of the focus of law enforcement (i.e. on socially and economically disadvantaged areas where previously convicted people live) and/or of drug dependence (which can compel an individual to break drug laws).
<b>Rehabilitation</b>	The process by which an individual dependent on drugs achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification, 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 also include long-term OST.
<b>Relapse</b>	A return to drug use after a period of abstinence, often accompanied by reinstatement of dependence symptoms. Some writers distinguish between relapse and lapse, with the latter denoting an isolated occasion of drug use.
<b>Supply reduction</b>	Policies or programmes aiming to reduce and eventually eliminate the production and distribution of drugs. Historically, the international drug control system has been focused on supply-side strategies based on crop eradication, interdiction by law enforcement, etc. Evidence demonstrates that these strategies have been unsuccessful in curbing the global drug market. Some countries have now turned to an approach based on alternative livelihoods.
<b>UN drug conventions</b>	International treaties concerned with the control of production and distribution of psychoactive drugs. The first treaty dealing with 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 a controlled 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. Cravings are prominent and continue 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 NGOs and professional networks that promotes 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. 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.

The IDPC Drug Policy Guide is designed to assist national policy makers in the process of developing effective, humane and appropriate drug policies and programmes for their country. Each chapter of the Guide introduces a specific type of policy challenge, analyses existing evidence and experiences of different countries, and presents advice and recommendations for developing effective policy responses.

*'The second edition of the IDPC Drug Policy Guide lays out clearly the key issues of concern for policy making in this complex area, presenting the global evidence for effective strategies that are balanced and grounded in health, human rights and development principles. It is an important tool to guide us as we respond concertedly and collectively to this fast-moving phenomenon, and I encourage national policy makers to make good use of the advice and information contained within its pages'.*

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