

Modernising Drug Law Enforcement Report 1

Police support for harm reduction policies and practices towards people who inject drugs

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Key Points:

- Many police services have long played an important role in the protection and promotion of various aspects of public health – the primary role of police officers is to protect *life* and property.
- On their appointment police officers swear or affirm to uphold the laws of their countries including those which directly or indirectly speak to the protection of public health, fundamental human rights and the promotion of health related programmes and interventions.
- Police services from around the world have engaged with a range of harm reduction interventions incorporated within the WHO, UNODC, UNAIDS 'comprehensive package for the prevention, treatment and care of HIV among [people who inject drugs (PWID)]', including needle and syringe programmes and opioid substitution therapy (OST).
- Some police services also engage in good practice relative to the operation of drug consumption rooms, drug overdose prevention and drug referral schemes.
- Evidence shows that harm reduction interventions are cost effective, produce positive public health outcomes, and in some cases lead to reductions in drug related criminal activity.
- In some countries police services remain antagonistic towards harm reduction interventions and often operate contrary to national laws and rights-based treaties.
- Chief police officers need to ramp up, and in many cases initiate, engagement with a full range of harm reduction interventions relating to people who inject drugs and work to change related laws where necessary.
- Embedding harm reduction principles within police service training curricula can bring about positive and beneficial change in policing attitudes towards people who inject drugs.
- The proper exercise of police discretion will also help to achieve positive and beneficial change and engender support for harm reduction programmes.
- Police service performance indicators should, where possible, support the broader agenda of public health.

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Introduction

Many police services¹ have long played an important role in the protection and promotion of various aspects of public health.² This is quite proper since the primary role of police officers is to protect *life* and property. Furthermore, police officers on their appointment swear or affirm to uphold the laws of their countries including those which directly or indirectly speak to the protection of public health and the promotion of related programmes and interventions.³ Within this context, in recent years the role of police services in preventing the spread of blood-borne infections amongst PWIDs has been the subject of considerable research.⁴ Much of this, however, has focused on negative examples – documenting draconian policing practices, including the arbitrary use of stop and search/frisk laws and powers of arrest, police violence towards PWIDs and sex workers and the fabrication of evidence, that inhibit or undermine public health objectives.⁵ Given that policing tactics of this kind violate domestic and international rights-based legislation by which police services are bound, subvert public health policies and practices and in some cases are associated with higher HIV prevalence rates, attention on these issues is both understandable and desirable.⁶ Yet, such an approach has tended to overshadow the beneficial contributions made by police services at points where law enforcement, PWIDs and public health interests intersect.

This briefing paper aims to shift the focus of the debate on policing and HIV-related outcomes and explore these more positive relationships and, where appropriate, the related benefits to be derived by police services engaging directly with PWIDs. As we shall see, over the last twenty-five years or so an increasing number of police services from countries around the world have devised and implemented policies and practices that have specifically supported increasingly widespread harm reduction policies and practices aiming to prevent, halt and reverse HIV and hepatitis B and C (HBV and HCV) epidemics amongst PWIDs and their sexual partners.⁷

While there remains no universally accepted definition of the term harm reduction, it is used here to describe laws, policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of injecting drug use without necessarily reducing the number of PWIDs or their levels of drug consumption.⁸ The paper expressly looks at police support for the core interventions that make up what the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC) and the Secretariat of the Joint United Nations Programme on HIV and AIDS (UNAIDS) refer to as the 'comprehensive package'.⁹ It also examines three other important interventions; drug consumption rooms, drug overdose prevention programmes and drug referral schemes in which police channel people dependent on drugs into treatment and support services. As well as describing positive examples of policies and practices, the paper also highlights recent examples where police services have thwarted public health ambitions in these areas. The paper concludes that whilst many police services have made determined efforts to support harm reduction programmes, and in so doing have helped to improve public health outcomes and in some instances reduced levels of drug related crime, much more needs to be done. In some countries, notably the Russian Federation, HIV prevention efforts are repeatedly foiled by ill-informed law enforcement policies and practices. On the basis of the conclusions drawn, a number of recommendations are made.

The comprehensive package

While aspects of the topic remain the focus of much, and often heated, debate within a range of policy circles,¹⁰ there is now good scientific evidence for the effectiveness of widely implemented harm reduction practices, policies and programmes targeting PWIDs and their sexual partners.¹¹ At the global policy level, evidence-based guidance on this topic found expression in 2009 in the *WHO, UNODC and*

*UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.*¹²

This key document, which should be seen as a 'major advance with regard to a joint UN response' on the issue area,¹³ includes within it what the contributing agencies refer to as the 'comprehensive package for the prevention, treatment and care of HIV among IDUs'. The package includes the following nine interventions:

1. Needle and syringe programmes (NSPs) – working primarily to prevent the spread of HIV/AIDS and other blood-borne viruses, this intervention provides PWIDs with free and accessible sterile needles and syringes and thus reduces the need for sharing and re-use
2. Opioid substitution therapy (OST) – using drugs such as buprenorphine, methadone, and slow-release oral morphine – and other kinds of drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes for PWIDs and their sexual partners
7. Targeted information, education and communication for PWIDs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis.

These interventions are included because 'they have the greatest impact on HIV prevention and treatment'. And, according to UNODC, they should be provided in the context of a continuum of services that includes outreach, other evidence-informed drug dependence treatment, overdose prevention and management, free-of-charge social and legal services, and other services depending on specific needs.¹⁴ As the *Technical Guide* demonstrates, there is a wealth of scientific

evidence supporting the efficacy of the nine interventions in preventing the spread of HIV with numerous evidence-informed technical papers and reviews endorsed by the WHO, UNODC and the other nine cosponsors of UNAIDS.¹⁵ Further, in fiscal terms it has been shown that prevention of HIV, HBV and HCV is less expensive than treating these diseases. For example, the Commission on AIDS in Asia concluded in 2008 that the comprehensive package of HIV-related harm reduction interventions costs approximately \$39 for every disability-adjusted life saved, considerably less than antiretroviral treatment, which costs around \$2,000 per life year saved.¹⁶ Comprehensive reviews of NSPs have demonstrated their effectiveness in terms of both preventing and reducing HIV infections and their cost-effectiveness.¹⁷ For instance, research from Australia in 2009 revealed that NSPs directly averted an estimated 32,050 new HIV infections and 96,667 new HCV infections within the country between 2000 and 2009. For every Australian dollar invested in NSPs, more than four were returned in health care savings.¹⁸

Police support for the comprehensive package

As the following section demonstrates, informed by an increasingly robust evidence base regarding health-related benefits and those relating to crime levels and financial savings, many police services from around the world have engaged with the interventions incorporated within the comprehensive package.

Needle and syringe programmes

Despite the legal uncertainties surrounding the provision of sterile syringes and other injecting paraphernalia (e.g. sterile water ampoules, acidifiers and medi-swabs)¹⁹ to PWIDs, police services in a number of countries have utilised their powers of discretion to find ways to support NSPs.²⁰

For example, in England and Wales although the carrying of sterile hypodermic syringes with needles by PWIDs in a public place appears to fall within the terms of the offence created under section 139 of the Criminal Justice Act 1988²¹ the Metropolitan Police Service (MPS), London, issued a Police Order in June 1988 stating that it was service policy that PWIDs should not be arrested under the provisions of this section. Going a step further, in June 1990, the MPS instructed its officers to stop submitting syringes containing residual amounts of controlled drugs to the MPS Forensic Science Laboratory for examination to support investigations relating to unlawful possession offences.²² Although this advice was primarily issued because of the perceived risks to police officers and laboratory staff of contracting HIV or HBV²³ through needle-stick injuries,²⁴ the policy obviously favoured PWIDs since the Crown Prosecution Service is reluctant to prosecute unlawful possession cases in the absence of forensic evidence.²⁵

Despite some opposition at senior levels,²⁶ British police services have also supported NSPs more directly. In the late 1980s, when most NSPs were strictly operating a 'one-for-one exchange' policy²⁷ the MPS in the London boroughs of Lambeth, Lewisham and Southwark, agreed to provide stamped receipts to PWIDs (who had had their used syringes confiscated following arrest) which they could hand to NSP staff to explain their failure to return their used syringes. However, perhaps an even clearer demonstration of their commitment to NSPs is to be found in the fact that some British police services now allow their officers to supply sterile injecting equipment to PWIDs on their release from police stations. Avon and Somerset Constabulary and Staffordshire Police, England, ran pilot NSPs in the early 2000s.²⁸ A 2006 review of NSPs in Scotland identified six schemes operating from police stations.²⁹ More recently, Kent Police (England) and the KCA Harm Reduction Team, a civil society organisation (CSO) have refined and broadened this idea (see Box 1).

Comparable practices have taken place in other parts of the world. In terms of providing arrestees with sterile syringes in exchange for ones used, the Municipal Police in Amsterdam was operating a similar policy in the early 1990s.³¹ Police services in Australia were also quick to lend their support to NSPs. In 1988 an instruction from the Commissioner of New South Wales Police stated that: 'Without restricting their day to day duties and obligations, police should be mindful not to carry out unwarranted patrols in the vicinity of NSPs that might discourage injecting drug users from attending'.³² Other police services in Australia introduced similar instructions around the same time. Notwithstanding entrenched resistance from politicians, journalists, the medical profession and many of his colleagues, the former Head of the Main Department, Sverdlovsk Oblast Police, Russia, issued an order in 2001 along the lines of the Australian instructions.³³ In addition, the order also directed officers to ensure that they provided adequate protection to NSP staff since there was a fear they could be attacked by members of the public.³⁴ Up until December 2011, senior police officers from the Russian cities of Chelyabinsk, Irkutsk and Voronezh supported UNODC funded fixed-site and mobile NSPs operating in and around these cities.³⁵

The Royal Malaysian Police Force (RMPF) policy support for NSPs is evident in the related 2006 Guidelines for Police prepared by the Ministry of Health in cooperation with the RMPF³⁶ and in March 2007, the Commissioner of the New York City Police, USA, issued detailed operations order relating to NSPs. The order advises officers that the 'circumstances wherein ANY person who is found in possession of a hypodermic instrument or needle may be arrested are severely limited'.³⁷ In addition, the order also advises officers that 'the mere presence of an unknown substance in a hypodermic instrument or needle by itself is NOT a sufficient basis to arrest a person'.³⁸

It is, however, unsafe to assume that the written instructions or guidelines are always faithfully

Box 1. Kent Police and KCA Harm Reduction Team

PROTOCOL FOR THE REPLACEMENT OF INJECTING EQUIPMENT IN POLICE STATION CUSTODY SUITES

THIS POLICY WILL ONLY APPLY
TO DETAINED PERSONS AGED SEVENTEEN OR OVER

Kent police agree to adhere to the following procedures

When a detainee arrives in custody with either a used or unused needle(s) either loose or in a pack, then the police will dispose of them in the SHARPS container provided and kept solely for this purpose

Officers are reminded of the need at all times to handle needles with care and to take precautions to avoid needle stick injuries. Disposable gloves should always be worn when handling items contaminated with blood.

N.B. ANY OFFICER THAT FEELS THEY REQUIRE FURTHER TRAINING IN THE SAFE HANDLING OF INJECTING EQUIPMENT SHOULD CONTACT THE INSPECTOR IN CHARGE OF CUSTODY OR THE DRUG LIAISON OFFICER TO DISCUSS APPROPRIATE TRAINING.

- The detainee will be informed that their used needles will be disposed of to safeguard others from needle stick injuries and to safeguard their own health by preventing them from re-using that needle.
- The detainee will be informed that they will be provided with a needle replacement pack and this will be added to the detainee's property on arrest. These packs will be provided by KCA Harm Reduction Team and will contain 20 1ml single use syringes, 10 sterile swabs for pre-injection, a sharps container, cigarette filters and a condom. They will also be provided with information about safe injecting, safe disposal of used sharps and where to obtain help and advice on drug related matters.
- When a replacement needle pack is provided to a detained person this should be duly recorded on the Custody Record.
- Any needle packs that appear to have been interfered with or are actually open should be brought to the immediate attention of KCA and SHOULD NOT IN ANY CIRCUMSTANCES be handed to the detained persons.
- In all circumstances where a replacement needle pack be provided to a detained person they should be actively encouraged to speak with the Custody Nurse and a note made that this has been done on the Custody Record.
- AT NO TIMES SHOULD A NEEDLE REPLACEMENT PACK BE PROVIDED TO A DETAINEE WHO IS NOT IN POSSESSION OF NEEDLES OR SYRINGES AT THE TIME THAT THEY ARE BROUGHT IN TO CUSTODY.
- NO NEEDLE REPLACEMENT PACKS ARE TO BE GIVEN TO DETAINEES UNTIL THEY ARE RELEASED FROM THE POLICE STATION.

PACKS WILL NOT BE GIVEN DIRECTLY TO DETAINED PERSONS THAT ARE AWAITING REMAND HEARING PROCEEDINGS OR TRANSFER TO ANOTHER POLICE STATION³⁰

translated into practice and there is a steady flow of reports documenting instances of policing tactics which intentionally or unintentionally, disrupt the day-to-day work of NSPs and their outreach workers. For example, there is some evidence to suggest that police crackdowns on street heroin markets deter PWIDs from visiting local NSPs.³⁹ In some countries patrolling officers make a point of hanging around NSPs or pharmacies in the hope of arresting PWIDs for offences under drug paraphernalia or drug consumption/possession laws.⁴⁰

Furthermore, the policy climate and law enforcement practice in some countries is openly antagonistic to NSPs. In Russia, police support for NSPs, which was always the exception, rather than the rule, has been drastically curtailed since the creation of the Federal Drug Control Service (FDCS) in 2003. To judge by its public pronouncements, the FDCS appears determined to ensure that NSPs in Russia continue to operate in a climate of legal uncertainty, which is intended to discourage federal, oblast or city funding – the FDCS is fully aware that, in the absence of funding from international donors, NSPs will not be sustainable.⁴¹ Moreover, contrary to the spirit of an amendment to the 1996 Criminal Code which creates a legal footing for the provision of 'tools and equipment' for the 'purposes of preventing HIV infection' the FDCS has, on a number of occasions, threatened to prosecute NSP staff under Article 230 of the Criminal Code.⁴² This Article creates an offence of 'inclining to consumption of narcotic drugs or psychoactive substances'. The threats have even been extended to CSOs asking permission to set up NSPs (see Box 2).

Elsewhere, police services have been actively engaged in altering the law to improve the interface between policing and NSPs. In Britain, for instance, the MPS was instrumental in bringing about legislative changes regarding the supply of drug injecting paraphernalia'.⁴⁴ Acutely aware that the legal prohibition on the supply of these and other articles obstructed the work of NSPs, officers lobbied the Home Office for years for the necessary amendments to be made to section 9A of the Misuse of Drugs Act 1971⁴⁵ which would allow doctors, pharmacists and persons employed or engaged in the lawful provision of drug treatment services to provide PWIDs with a range of drug injecting articles. This objective was finally achieved following the introduction of the Misuse of Drugs (Amendment) (No. 2) Regulations 2003.⁴⁶

Opioid substitution treatment in police stations

The two main drugs used in OST, namely methadone and buprenorphine are on the WHO Model Lists of Essential Medicines and are known to be efficacious, safe (when used as prescribed and under a physician's care) and cost-effective for the treatment of opiate withdrawal and dependence. Methadone is by far the most widely prescribed drug in the treatment of opiate dependence and Methadone Maintenance Treatment (MMT) has been in operation in different parts of the world for over forty years. Accordingly, the drug is extraordinarily well studied and has been shown to be very successful in terms of reducing the spread of HIV, HBV, HCV, opioid overdose deaths,

Box 2: *Help Now*, the FDCS and NSPs in Kaliningrad

In the summer of 2008, *Help Now*, a CSO in the Kaliningrad Region, Russia, notified the local FDCS department that it intended to start a NSP in September of that year. The notification was made in line with the requirements indicated in the Note to Article 230 of the 1996 Criminal Code of the Russian Federation. In its reply, the FDCS threatened to initiate a prosecution under the said Article if it started the NSP. The CSO dropped the idea. To date, there are no NSPs operating in Kaliningrad, but the number of HIV infections linked to injecting drug use continues to rise.⁴³

the illicit consumption of opiates, drug supplying and, more holistically, unemployment.⁴⁷ The benefit return for MMT is estimated to be around four times the treatment cost.⁴⁸ Evidence also shows the prescription of methadone to be highly effective in reducing levels of acquisitive crime (e.g. theft, burglary and fraud) and the illicit consumption of opiates.⁴⁹

Interestingly, although current police support for MMT is very much linked to its crime reduction benefits⁵⁰ (see Box 3), the MPS was supporting the idea of methadone as a viable form of drug treatment long before much of the research confirming these benefits had been conducted.

Indeed, it appears that the MPS had protocols in place in the mid-1920s that allowed police surgeons to prescribe morphine to people dependent on opiates whilst in police custody.⁵¹ In London, it is certainly the case that the practice of Forensic Medical Examiners (formally known as 'police surgeons') prescribing dihydrocodeine and methadone (in oral and injectable forms) to detainees held in police stations so as not to disrupt their treatment regimens or help them stave off withdrawal dates appears to date back to the 1970s. Methadone has also been prescribed to detainees held in police stations in Amsterdam since the 1970s.⁵²

Box 3: Methadone treatment, drug use and crime

There is a solid body of research showing the positive impact of MMT on levels of drug related crime. Within the UK this was well demonstrated by the National Treatment Outcome Research Study (NTORS). This was a large-scale, multi-site prospective study of treatment outcome conducted with a cohort of more than 1,000 people who entered drug treatment services in England during 1995. In keeping with other similar studies, the cohort reported committing huge numbers of crimes prior to treatment. NTORS researchers estimated the costs to victims and the criminal justice system totalled £12 million for the NTORS cohort in the year before starting treatment. After one year in treatment, the proportion of methadone clients committing acquisitive offences had almost halved. In terms of the number of crimes committed, shoplifting and burglary were reduced by 70 per cent, robbery by 45 per cent and fraud by 80 per cent. Reductions in acquisitive crime were associated with reductions in frequency of heroin use.⁵³

Similar results can be seen in a 2000 UK Home Office report. This described the characteristics of 221 people dependent on opiates participating in a typical community-based MMT in inner-city London and the impact of treatment on their drug dependence and criminal behaviour. Most subjects (85 per cent) had been committing crimes to help fund their drug use. The most common offences were theft or shoplifting, fraud or deception, and 'drug dealing'. A total of 54 per cent had suffered from mental illness at some time in their lives, and 30 per cent had attempted suicide. Following treatment, heroin use decreased by 56 per cent, from 25 days per month on average before treatment to 11 days per month after treatment. Theft decreased by 52 per cent, from 44 days in the six-month period before treatment to 21 days after treatment. Drug-dealing decreased by 64 per cent, from 56 days to 20 days. Average illegal earnings from the previous six months of criminal activity decreased by 73 per cent, from £10,984 in the period before treatment to £2,930 after treatment. Treatment was most effective for those who had the highest levels of drug use and who were the most criminally active before treatment. Those who were in treatment the longest showed the greatest reduction in daily expenditure on drugs. Economic modelling suggests that, when a person dependent on opiates receives methadone treatment for a full 6 months, the cost of this treatment (£960) compares favourably with the estimated reduction in illegal earnings over this period (between £2,142 and £7,878).⁵⁴

Buprenorphine and methadone are provided to arrestees in police stations in Australia. In accordance with Victoria Police instructions, although arrestees cannot begin a buprenorphine or methadone programme whilst in police detention, they can be prescribed these drugs if they are already registered with a programme.⁵⁵ Victoria Police cover the cost of providing these drugs in the circumstances described.⁵⁶ Within Europe, a 2007 study of eight countries in the European Union found that methadone was available to detainees in German police stations.⁵⁷ The same study found that detainees in Bulgaria who are able to verify their participation in a community methadone programme could have their methadone brought to the police station by their families.⁵⁸ Buprenorphine and slow-release oral morphine are also available to detainees in Austria.⁵⁹ In some parts of Britain, it is possible for PWIDs to access methadone or buprenorphine treatment programmes within 24 hours of their arrest following a referral from a police station.⁶⁰ In South East Asia, plans are currently in hand that will enable Vietnamese police officers in Hanoi, to refer PWIDs to a local community-based methadone programme as an alternative to sending them to one of the so-called 'compulsory drug treatment centres'. Senior police officers in the Kolkata police service, in India, have been supporting harm reduction programmes for around a decade⁶¹ and did much to help facilitate the administration of sub-lingual buprenorphine to arrestees in police stations.⁶²

It is a matter of no small concern to UNODC, WHO, the UNAIDS Secretariat, international donor organisations and CSOs, however, that in some countries the debate as to whether OST programmes should be introduced is dominated by police services rather than health authorities. Whilst they have every right to voice their concerns on OST and are under a legal and professional obligation to make known their views on matters such as the diversion of methadone and buprenorphine to illicit markets, the theft and forgery of prescriptions, and safe custody of stocks, the debate should primarily be informed

by public health considerations and therefore public health agencies and clinicians should assume the leading role. In turn, their opinions should be informed by scientific research and be free from arbitrary interference. This last point is worth stressing because in some countries, police services have threatened to use drug incitement/inclining/propaganda laws to stifle debates on OST, even when in the form of master classes and workshops.⁶³ Threats of this kind are an affront to the long-established practices governing scientific discourse and public debate on issues relevant to the health and well-being of populations. Indeed, in some cases, threats of this nature will amount to a flagrant breach of international and national legislation which guarantee freedom of speech and expression. In recent years, police officers in parts of Ukraine have sought to impede the work of OST programmes by raiding clinics, interrogating, fingerprinting and photographing patients, confiscating medical records and medications, and detaining medical personnel.⁶⁴ This has happened despite the fact that OST programmes have enjoyed the support of government officials and are underpinned by legislation.

HIV testing and counselling, antiretroviral therapy, prevention and treatment of sexually transmitted infections, and vaccination, diagnosis and treatment of viral hepatitis, and prevention, diagnosis and treatment of tuberculosis

In a number of countries, the above interventions are available to arrestees within the framework of Drug Referral Schemes (DRS), an issue to which we will return. In those countries where police services are also responsible for running prisons and pre-trial detention centres (e.g. Vietnam), some of the interventions are available to inmates although the quality and coverage of these services varies greatly from country to country and is often woefully inadequate. Since harm reduction programmes in prison settings is outside the scope of this paper we will not explore the issue further.

Condom programmes for PWIDs and their sexual partners

In many countries it is a longstanding practice of police services when dealing with sex workers⁶⁵ arrested for offences such as loitering or soliciting in public places for the purposes of sex work, to include in their evidence the fact that the sex worker has condoms in her/his possession. A recent Human Rights Watch report found that this practice still continues in four major cities in the USA (New York, Washington, D.C., Los Angeles and San Francisco).⁶⁶ In a number of countries this practice extends to the actual confiscation of the condoms. A 2012 United Nations Development Programme report found that the practice of confiscating condoms or harassment of sex workers possessing them was current in 11 Asian and Pacific countries.⁶⁷ Further, recent research in St. Petersburg, Russia, concluded that police officers seize condoms as evidence of sex work.⁶⁸ However, some police services have discontinued these practices recognising that it may discourage sex workers from carrying condoms and therefore increase their risk of contracting or transmitting HIV, hepatitis A or B or other diseases such as gonorrhoea and syphilis. The MPS discontinued

this practice as long ago as 1993.⁶⁹ According to one report, China's Ministry of Public Security (the country's principal police authority) has issued similar instructions to police officers.⁷⁰ However, it appears that this instruction is not always followed.⁷¹ In Kyrgyzstan, as part of a broader change in legislation and attitudes, training programmes have gradually altered the attitudes of police officers to sex workers. (See Box 4).

As described above (see Box 1), some police services in Britain also provide condoms to detainees on their release from police stations.

Targeted information, education and communication for PWIDs and their sexual partners

This is done largely through DRSs. In addition, police stations in a number of countries have HIV prevention etc. leaflets, booklets, posters etc. on display in public areas. In some countries, leaflets and booklets on safer injecting practices and OST are available to arrestees.⁷³

Box 4 – Police Training in Kyrgyzstan

In 2005 a rapid assessment by the Central Asian Centre on Drug Policy revealed that 40 per cent of those sent to prison for drug offences were people dependent on drugs. A change in the law in 2005 introduced possession thresholds to differentiate between drug dealers and people who use drugs (PWUD). In policing the new environment, there has been close cooperation between police services and NGOs, medical doctors and social workers. This has included a 48-hour course in the police academy to explain to police officers how to deal with PWUD, how to cooperate with NGOs and engage with harm reduction interventions that prevent drug injecting-related HIV infection. As Aleksandr Zelichenko, a practicing police officer explains 'At first, this change was difficult to accept among police officers. The process took ten years, beginning in 1998, during which the Ministry of Internal Affairs did a lot of advocacy to educate law enforcement agencies... about the change'. Among other training programmes, peer training by PWUD and sex workers is provided to high-level police officers. According to Zelichenko, 'The police can now refer drug users to harm reduction services and treatment centres'.⁷²

Police service engagement with other key interventions

Although not included in the comprehensive package, there are a number of other interventions that have also been shown to be effective in terms of achieving positive health outcomes for PWUD (e.g. reduction of drug overdose deaths), but also crime reduction and significant cost-savings to the public purse. The relationship between these three outcomes and police services are discussed below.

Drug consumption rooms

For the purposes of this paper, the term 'drug consumption room' (DCR) is used to describe any room specifically set up for the hygienic consumption of pre-obtained controlled drugs under professional supervision.⁷⁴ This definition distinguishes DCRs from so-called 'crack houses', 'shooting galleries' and other premises given over to the illicit and unhygienic consumption of drugs bought at the same location.⁷⁵

Not surprisingly, the idea of providing PWIDs and others who use a variety of controlled substances with a place to use their illegally obtained drugs is highly contentious and one which has triggered convoluted and heated legal and moral debates.

For example, at the multilateral level the International Narcotics Control Board (INCB), the 'independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions'⁷⁶ rejects the legality of DCRs. It takes this position on the grounds that such facilities are contrary to the fundamental provisions of the UN drug control treaties, which oblige State parties to ensure that controlled drugs are used only for medical and scientific purposes.⁷⁷ However, some prominent lawyers take a different view,⁷⁸ including some from within the United Nations itself. In 2002, the Legal Affairs section of the United Nations International Drug Control Programme produced an internal document

detailing multiple arguments that justified a range of harm reduction interventions, including DCRs. In 2004, Roberts, Klein and Trace noted that the UNODC had no official position on DCRs⁷⁹ and at the time of writing this remains the case. Despite such a situation, evidence for the efficacy of the intervention is growing. Research findings of DCRs indicate a number of health benefits, including a statistically significant relationship in four German cities between the establishment of DCRs and a reduction in drug-related deaths.⁸⁰ Indeed, a 2010 review noted that none of the overdoses recorded at DCRs have resulted in death (the only known death at a DCR involved anaphylactic shock).⁸¹ Research concerning the impact on crime and public nuisance is more equivocal, although there is some evidence that the operation of DCRs leads to a decrease in crime.⁸²

Driven by the growing evidence base concerning their benefits to public health, as of 2010 there were over 90 DCRs operating in countries around the world, including Australia, Canada, Denmark, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland and their numbers are likely to increase.⁸³ There is a recent media report that France is intending to pilot DCRs in 2013.⁸⁴

Police support or at the very least, tolerance, is needed to ensure that clients will not be harassed or arrested when entering or exiting, or just being in the immediate vicinity, of a DCR. Despite the ongoing debate over their legality vis-à-vis the UN drug conventions, many Australian, Canadian, Dutch, German, Spanish and Swiss police support DCRs (See Box 5). A 2008 study of the Vancouver DCR, for example, found that nearly 17 per cent of its clients reported being referred to the facility by police.⁸⁵

Preventing drug overdose deaths

Opioid overdose is a burgeoning public health crisis, accounting for many thousands of deaths annually around the world.⁸⁸ In recent years, a number of police services, working with public

Box 5 – Swiss police services and the four pillars policy

In November 2008, the Swiss electorate voted in favour of a new federal approach to drug issues. This was the four pillars policy (prevention of drug use, therapy for drug dependence, harm reduction - including in some instances DCRs - and law enforcement/policing); an approach that had been practiced in many Swiss cities since the end of the 1980s and spread across the country in the following years. As is suggested by the integration of policing as one of the pillars, police services had been closely involved with and were supportive of the development of the approach both at the canton and federal level.

Although police services in some parts of the country initially resisted the four pillars approach, they came to recognise that public order issues would still feature prominently in drug policy. As Rhis-Middel and Hämmig noted in 2005, it seemed that many police leaders saw that the goals of the new public health measures included public order improvements such as reduction in crime, reduction in the number of drug users, and reduction in accidents related to drug use.⁸⁶ Moreover, as Joanne Csete points out, the police were motivated in their support of the approach 'by the fact that policing-centred methods had failed to deliver results'. As such police (and judicial system) officials were included in the high level discussion as 'equal partners with public health and medical specialists as the new drug policy was developed'.⁸⁷

health departments, have developed policies and practices which are aimed at preventing drug overdose deaths. As police officers are often called to the scene of an overdose, some police services have introduced policies which allow their officers to administer naloxone to overdose victims. Naloxone, a prescription drug, carries no potential for dependence and is inexpensive. The drug is used as the standard treatment for opiate overdose, and is administered in hospital emergency rooms and by paramedics. The State of New Mexico, USA, for example has allowed its police and highway patrol officers to carry and administer intranasal naloxone since 2004. The Quincy Police Department, Massachusetts, USA, introduced a similar training programme in 2010 and since then its officers have reversed at least 80 overdoses.⁸⁹

To help reduce drug overdose deaths, particularly those which occur in police stations, a number of police services have developed guidance which emphasises the need to treat suspected drug swallowing as a medical emergency that requires urgent hospitalisation. When confronted by police officers, suspects sometimes attempt to destroy evidence by orally ingesting drugs in

their possession. Given the inherent dangers of drug swallowing, particularly cocaine,⁹⁰ and the myriad of legal questions arising from the use of force by officers in an effort to prevent the imminent destruction of evidence, some chief police officers are advising that where arrestees are suspected of having swallowed drugs they are to be treated as having taken a potential overdose and an ambulance is to be called immediately to take them to hospital. Although not always followed, this has been the policy of the MPS since August 1988.⁹¹

Drawing on technological advances, some police services such as Hertfordshire Constabulary, England, have installed cell occupant and occupancy monitoring systems (COMS) in police cells and other places of temporary detention. Monitoring systems of this kind utilise sensor equipment capable of detecting breathing trouble such as experienced by a detainee choking on their vomit or by a sleep apnoea. COMS is intended to supplement, rather than replace the statutory or administrative cell visiting/monitoring requirements police officers make as part of their duty of care to arrestees/detainees.

Drug referral schemes

Drug Referral Schemes are partnerships between the police and local drug services that use the point of arrest within police stations as an opportunity for independent drug workers to offer arrestees help and refer them to appropriate treatment services primarily as a means for reducing their drug-related offending. In addition, they also provide a route to HIV testing and counselling services, antiretroviral therapy (ART), prevention and treatment of sexually transmitted infections (STIs), and vaccination, diagnosis and treatment of viral hepatitis, and prevention, diagnosis and treatment of tuberculosis (TB).

DRS allow specially trained drug workers (known as drug/arrest referral workers) to contact arrestees whilst they are held in police stations and sufficient time is granted to the drug worker to interview the arrestee and complete a 'needs assessment' form which will form the basis of a treatment and care plan. In Britain, some drug workers are provided with their own office in police stations and are on call between 7.00 am and 11.00 pm.

Pioneered in Britain by the City of Birmingham Police and the local drug dependency clinic in the late 1960s⁹² and the USA in the early 1970s,⁹³ DRS are now operating in a number of countries, including Australia, Ireland and parts of Russia and have been shown to be effective in identifying arrestees at high-risk of HIV and HCV, offering them drug treatment, and reducing their levels of drug-related offending.

In Russia they have helped arrestees to contact HIV/AIDS, TB and STI prevention, treatment and care services. The pilot DRS in Voronezh which was set up in 2006, found that the majority of those referred did not know their HIV status and were not in contact with prevention, treatment or care services at the time of their arrest.⁹⁴ In 2011, DRS were known to be running in nine Russian cities.⁹⁵ Whilst the Russian police should be congratulated on their support for DRSs and their willingness to expand them, the schemes offer little in the way

of referral to effective drug treatment due to the ongoing ban on the prescribing of buprenorphine, dihydrocodeine, methadone and slow-release oral morphine, so the schemes will only produce modest results in terms of bringing about significant reductions in acquisitive crime.⁹⁶

Currently, the UNODC Country Office in Vietnam is working with the Ministry of Public Security's Anti-narcotics Department (C47) to set up a pilot DRS in Hanoi. As part of this initiative, the former head of C47 and colleagues from his department and Hanoi city police travelled to London in December 2010 to see first-hand how the referral process operates from Charing Cross police station. Unlike Russia, Vietnam has methadone programmes and many senior police officers are avid supporters of the initiative, so UNODC anticipates that it will be possible for the police to refer arrestees to community-based methadone programmes as an alternative to the compulsory drug treatment centres. As mentioned above, the Vietnamese police service also has responsibility for running prisons and a number of senior police officers have recently called for the introduction of pilot MMT programmes in prisons. Vietnamese police officers working in prisons are also keen to promote harm reduction approaches and officers, medical staff and inmates, have all recently benefited from UNODC and WHO organised training sessions, which are underpinned by harm reduction principles.

Following their formal introduction in the mid-1990s, DRS in Britain have developed into the well-resourced Drug Interventions Programme (DIP) which engages and directs arrestees who test positive for opiates or cocaine on arrest to drug treatment services. The research findings from DIP support the notion of using arrest as one route for getting opiate and cocaine users into treatment.⁹⁷ The research also shows that rates of entry into treatment for DIP referrals were higher than for previous DRS and that the levels of retention in treatment for DIP entrants equalled those of non-criminal justice route entrants to treatment.⁹⁸

The DIP research also provides evidence about the role of coercive approaches to improve engagement in drug treatment services. Comparing levels pre- and post-DIP contact, the research shows offending levels in the first six months following DIP were lower than in the six months before DIP. The overall volume of offending by a cohort of 7,727 individuals was 26 per cent lower following DIP identification.⁹⁹

Conclusions and recommendations

On the basis of the available research and the examples provided in this paper, three major conclusions can be drawn and a number of recommendations for future action made.

First, despite many unfortunate examples of unacceptable policing practices and law enforcement policies, it is also clear that many police services around the world have taken concrete steps over the last twenty-five years to support a range of harm reduction programmes for PWIDs and their sexual partners.

Second, some police chiefs and their advisors have risked their careers and standing on the back of their support for harm reduction and components of the comprehensive package. Ideally, in order to facilitate change, police responses to public health threats such as injecting drug use and opioid overdose deaths should be underpinned by a change in the laws, codes of practice and in-house rules to which they are subject. However, in the majority of cases this has not happened and many chief officers have been forced to develop policies and practices against a backdrop of legal uncertainty, competing pressures and interests, and criticism from politicians, the communities they serve and their colleagues – in many respects, it boils down to the fact that one person's marginalised group is another person's criminal network. Given these difficulties, many police chiefs deserve great credit for their accomplishments.

Third, whilst welcoming the marked shifts in policy and practices made by some police services, much more needs to be done. And many more police services need to adopt policies and practices which are now commonplace in countries like Australia, Britain and the Netherlands. Failure to do so is likely to result in more HIV, HBV and HCV infections, more needless drug overdose deaths, higher acquisitive crime rates, and even greater demands on the public purse.

In light of these issues and aware of a variety of socio-cultural environments within which police services and the interventions discussed here operate, a number of specific recommendations can be made:

- *Needle syringe programmes* – Without further delay, police services using their powers of discretion, should devise and implement policies and practices which allow NSPs to operate freely without fear of unwarranted interference by patrolling officers.
- *Opioid substitution therapy* – Chief police officers should use their influence and standing to advocate the introduction of OST. In countries where programmes are up-and-running, chief officers must develop protocols that allow arrestees who are OST patients, to receive supplies of the drug they are prescribed whilst held in police detention. In light of the concerns over the actions of some police services, chief law enforcement officers are reminded of their statutory obligations to uphold the fundamental human rights.
- *Antiretroviral therapy* – Acknowledging their legal obligations and professional duty to protect life, chief police officers, as a matter of urgency, need to develop and implement specific policies which ensure that arrestees living with HIV have ready access to free-of-charge antiretroviral drugs whilst held in police detention.

- *Condom programmes for PWIDs and their sexual partners* – Police services should immediately stop using the possession of condoms as evidence to question, detain or arrest persons suspected of sex work, or to support the prosecution of sex work and homosexual acts between consenting adults.¹⁰⁰ Chief police officers should, where possible, issue a directive to their officers emphasising the importance of condoms for HIV prevention and sexual and reproductive health.
- *Targeted information for all PWUD* – Police services should develop and implement protocols and guidelines which cover the release of information to mass media outlets pertaining to dangerous batches of illicit drugs. In addition, chief officers should also ensure that there is an adequate supply of literature on health issues relating to PWID on display in the public areas of police stations and that these publications are made available to arrestees in custody areas of police stations.
- *Drug consumption rooms* – Given the evidence base of the efficacy of drug consumption rooms, police officials should collaborate with DCR staff to support their work and ensure that those PWID with whom they come in contact know about the existence and functions of the DCR.
- *Preventing drug overdose deaths* – Chief officers, should, as a matter of urgency,

develop and implement policies and training programmes which will enable their police officers to administer naloxone to an overdose victim (in much the same way as to how police are trained to use a defibrillator for victims of heart attacks).

- *Drug referral schemes* – As a priority, chief officers should explore the feasibility of developing and implementing DRS with a view to increasing the number of people who use opiates and stimulant drugs such as cocaine and methamphetamine, accessing relevant prevention, treatment and care services.

To help bring about compliance with these recommendations, chief officers should ensure that their officers are regularly trained regarding related service protocols, orders, instructions and so on and held accountable for any transgressions. Within this context, measures should be taken to ensure that the principles of harm reduction are embedded in police service training curricula. Moreover, police chiefs should regularly review their policies, strategies, tactics and performance indicators and key performance targets to ensure they support the broader agenda of public health imperatives and are underpinned by rights-based international treaties. Indeed, it must not be forgotten that while engagement with the harm reduction approach often produces tangible benefits in terms of crime reduction and associated costs, ultimately police services are also bound by a fundamental duty to protect public health.

Modernising Drug Law Enforcement

A project by IDPC, with the participation of the International Security Research Department at Chatham House and the International Institute for Strategic Studies

Drug law enforcement has traditionally focused on reducing the size of the illicit drug market by seeking to eradicate drug production, distribution and retail supply, or at least on the stifling of these activities to an extent that potential consumers are unable to get access to particular drugs.

These strategies have failed to reduce the supply of, or demand for, drugs in consumer markets. Given this reality, and a wider policy context where some governments are moving away from a 'war on drugs' approach, drug law enforcement strategies need to be adjusted to fit the new challenge – to manage drug markets in a way that minimises harms on communities. A recognition that law enforcement powers can be used to beneficially shape, rather than entirely eradicate, drug markets is being increasingly discussed.

The objective of this project, led by IDPC, with the participation of the International Security Research Department at Chatham House and the International Institute for Strategic Studies, is to collate and refine theoretical material and examples of new approaches to drug law enforcement, as well as to promote debate amongst law enforcement leaders on the implications for future strategies.¹⁰¹ For more information, see: <http://idpc.net/policy-advocacy/special-projects/modernising-drug-law-enforcement>.

Endnotes

- 1 For the purposes of this paper the term 'police services' is used to describe those statutory bodies empowered to enforce national laws within the confines of their country, a state, territory, or possession (or political subdivision) of their country, or within the borders of a host nation. The term also includes other law enforcement agencies entrusted with 'policing powers' (e.g. inspection, entry, search, arrest, detention and other investigative powers) such as the Drug Enforcement Administration (DEA) in the USA, the Federal Drug Control Service (FDCS) in Russia, and the Serious and Organised Crime Agency (SOCA) in Britain. In some countries, Vietnam for example, police officers are also responsible for running prisons and other places of detention
- 2 For example, in late 19th century Britain, police officers were empowered to help enforce laws relating to the sale of adulterated food and drugs; see section 13 of the Sale of Food and Drugs Act 1874, 38 & 39 Vict. Ch. 63

Lobanov, A.V. and Kuznetsov, O.V. (2011), *Activities of law enforcement agencies in ensuring the epidemiological security of the Russian State*. In Nazarov, V.U. and Chenishev, B.V., *National Security: state and legal aspects* Eds. (Saratov Law Institute, Ministry of Interior, Saratov, Russian Federation)

The role of American police services in enforcing anti-liquor laws in accordance with the Volstead Act 1919 is well documented as are the overwhelmingly negative consequences of alcohol prohibition. See, for example: Behr, E. (1997), *Prohibition – The 13 years that changed America* (London: BBC Books)
More recently, police services in Indonesia, Taiwan, Vietnam and other countries were called upon to help enforce isolation and quarantine laws in the wake of the outbreak of severe acute respiratory syndrome (SARS) in South East Asia
- 3 For example, attempts by Russian officials and police officers to censor or stifle debates, discussion, workshops and training courses on the merits of methadone maintenance therapy and needle and syringe programmes, would appear to violate Article 29 paragraphs 4 and 5 of the 1993 Russian Constitution which state: 'All shall have the right to freely seek, receive, transmit, produce, and disseminate information by any legal means' and 'The freedom of mass information shall be guaranteed. Censorship shall be prohibited'. Likewise, attempts by Russian police officers to suppress information on safer injection techniques on the grounds that such information and associated counselling amount to 'pernicious propaganda' or as inciting to the illicit consumption of controlled drugs run contrary to Article 10 of the Constitution on the freedom of expression. See: *Open Door and Dublin Well Women v Ireland* (1992) 15 EHRR 244. For a comprehensive discussion on these points, see: Butler, W.E. (2005), *Narcotics & HIV/AIDS in Russia – Harm reduction policies under Russian law* (London: Wiley, Simmonds & Hill Publishing), pp. 29-30

Similarly, forced labour and other abuses in Vietnamese drug detention centres appear to violate Article 71 of the 1992 Constitution of the Socialist Republic of Vietnam which states: 'All forms of coercion, humiliation and violation of a citizen's honour and dignity are strictly prohibited'. Additionally, all forms of forced labour are prohibited under Article 5 of the Vietnam Labour Code, 23 June 1994. For a detailed discussion on this point, see: Human Rights Watch (2011), *The Rehab Archipelago – Forced Labor and Other Abuses in Drug Detention Centers in Southern Vietnam* (New York), <http://www.hrw.org/reports/2011/09/07/rehab-archipelago-0>

- 4 Law Enforcement and Harm Reduction at the Nossal Institute (LEHRN) Partnership (2010), 'Sleeping with the enemy? Engaging with law enforcement in prevention of HIV among and from injecting drug users in Asia', *HIV Matters*, **2**(1): 14-16, http://www.leahn.org/wp-content/uploads/2010/03/HIV_Matters_24-August_2010_Article7_Nick.pdf

Joint United Nations Programme for HIV and AIDS (2009), *Regional consultation on role of police and law enforcement in AIDS response in Asia and the Pacific*, Meeting Proceeding [sic] and Recommendations, 3-5 February 2009, Bangkok, Thailand, http://www.leahn.org/wp-content/uploads/2010/03/Report_Police-Workshop_August-3_reviewedfinal.pdf

Midford, R., Acres, J., Lenton, S., Loxley, W. & Boots, K. (2002), 'Cops, drugs and the community: establishing consultative harm reduction structures in two Western Australian locations', *International Journal of Drug Policy*, **13**: 181-188, <http://www.sciencedirect.com/science/article/pii/S0955395902000312>
- 5 Rhodes, T., Platt, L., Sarang, A., Vlasov, A., Mikhailova, L. & Monaghan, G. (2006), 'Street policing, injecting drug use and harm reduction in a Russian city: a qualitative study of police perspectives', *Journal of Urban Health*, **83**: 911-925, <http://www.ncbi.nlm.nih.gov/pubmed/16855880>

Rhodes, T., Simic, M., Baros, S., Zikic, B. & Platt, L. (2008), 'Police violence and sexual risk among female and transvestite sex workers in Serbia: Qualitative Study', *British Medical Journal*, **337**: a 811, <http://www.bmj.com/content/337/bmj.a811>

Sarang, A., Rhodes, T., Sheon, N. & Page, K. (2010), 'Policing drug users in Russia: Risk, fear, and structural violence', *Substance Use and Misuse*, **45**: 813-864, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946846/>

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- 6 Friedman, S., et al (2006), 'Relationship of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan area', *AIDS*, **20**(1): 93-99, <http://www.ncbi.nlm.nih.gov/pubmed/16327324>

Davis, C.S., Burris, S., Kraut-Becher, J. & Metzger, D. (February 2005), 'Effects of an intensive street-level police intervention on syringe exchange program use in Philadelphia, PA', *American Journal of Public Health*, **95**(2): 233-236, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449157/>
- 7 See, for example: Spooner, C., McPherson, M. & Hall, W. (2004), *The role of police in preventing and minimizing illicit drug use and its harms*. Monograph Series No. 2 (Australia: National Drug Law Enforcement Research Fund), http://www.ndlerf.gov.au/pub/prevent_illicit_drug.pdf; Hellawell, K. (1995), 'The role of law enforcement in minimizing the harm resulting from illicit drugs', *Drug and Alcohol Review*, **14**(3): 317-22, <http://onlinelibrary.wiley.com/doi/10.1080/09595239500185411/abstract>; Zaal, L. (1992), 'Police policy in Amsterdam'. In O'Hare, P., Newcombe, R., Mathews, A., Buning, E. C. & Druker, E., (Eds) *The reduction of drug related harm* (London: Routledge), p.93
- 8 This definition builds on the work of Lenton, S. & Single, E. (1998), 'The definition of harm reduction', *Drug Alcohol Review*, **17**(2): 213-219, <http://onlinelibrary.wiley.com/doi/10.1080/09595239800187011/abstract>; Riley, D., et al (1999), 'Harm reduction: Concepts and practice. A policy discussion paper', *Substance Use & Misuse*, **34**(1): 9-22, <http://www.ncbi.nlm.nih.gov/pubmed/10052387>; International Harm Reduction Association (2009), *What is harm reduction? A position statement from the International Harm Reduction Association* (London), <http://www.ihra.net/what-is-harm-reduction>
- 9 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Program on HIV and AIDS (2009), *WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf
- 10 Ball, A.L., (2007), 'HIV, injecting drug use and harm reduction: a public health response', *Addiction*, **102**(5): 684-90, <http://www.ncbi.nlm.nih.gov/pubmed/17506148>
- 11 Kimber, J., Palmateer, N., Hutchinson, S., Hickman, M. Goldberg, D. & Rhodes, T. (2010), 'Harm reduction among injecting drug users – Evidence of effectiveness. In Rhodes, T. and Hedrich, D., *Harm reduction: evidence, impacts and challenges* (Eds.), EMCDDA Monographs 10 (European Monitoring Centre for Drugs and Drug Addiction), pp. 115-163
- 12 World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Program on HIV and AIDS (2009), *WHO, UNODC and UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, https://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf
- 13 Donoghoe, M.C., Verster, A., Pervilhac, C., Williams, P. (2008), 'Setting targets for universal access to HIV prevention, treatment and care for injecting drug users (IDUs): towards consensus and improved guidance', *The International Journal of Drug Policy*, **19**(Suppl 1:S5-14), <http://www.ncbi.nlm.nih.gov/pubmed/18243681>
- 14 Executive Director of the United Nations Office on Drugs and Crime (21 December 2009), *Responding to the prevalence of HIV/AIDS and other blood-borne diseases Report of the Executive Director*, E/CN.7/2010/11
- 15 The UNAIDS cosponsors are UNODC, WHO, UNDP, UNICEF, UNHCR, WDF, World Bank, ILO, UNESCO, UNFPA and UN Women
- 16 Commission on AIDS in Asia (2008), *Redefining AIDS in Asia: Crafting an effective response*, (New Delhi: Oxford University Press), http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf
- 17 Pates, R., Heimer, R. & Morris, D. (2012), 'Injecting'. In Pates, R. and Riley, D. *Harm reduction in substance use and high-risk behavior – International Policy and Practice* (Eds.) (West Sussex, England: Blackwell Publishing Ltd), pp. 135-154
- 18 Australian Government, Department of Health and Aging, (2009), *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia* (Canberra, ACT: Department of Health and Aging), <http://www.health.gov.au/internet/main/publishing.nsf/content/needle-return-2>
- 19 Butler, W.E. (2005), *Narcotics & HIV/AIDS in Russia – Harm reduction policies under Russian law* (London: Wiley, Simmonds & Hill Publishing)

Monaghan, G. (2012), 'Harm reduction and the role of police services in harm reduction'. In Pates, R. and Riley, D., *Substance use and high-risk behavior – International Policy and Practice* (Eds.), (West Sussex, England: Blackwell Publishing Ltd.), pp. 59-76

Derricot, J. (2012), 'Making tools for harm reduction: the story of exchange supplies' in In Pates, R. and Riley, D., *Substance use and high-risk behavior – International Policy and Practice* (Eds.), (West Sussex, England: Blackwell Publishing Ltd.), pp.289-297

Police services must also understand that NSPs do not contravene article 13 of the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (which aims to prevent trade in and the diversion of materials and equipment for illicit production or manufacture of drugs). See p.291, para. 13.5 of: *Commentary on the 1988 United Nations Convention Against*

- Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, United Nations, 1998. This view is also supported by leading experts on the UN drug conventions, notably, Professors William E Butler (see: Butler, W.E. (2005), *Narcotics & HIV/AIDS in Russia – Harm reduction policies under Russian law* (London: Wiley, Simmonds & Hill Publishing); Wiley, Simmonds & Hill Law Publishing, London) and Neil Boister (see: Boister, N. (2001), *Penal aspects of the UN drug conventions* (Kluwer Law International))
- 20 Monaghan, G. (2012), 'Harm reduction and the role of police services in harm reduction'. In Pates, R. and Riley, D., *Substance use and high-risk behavior – International Policy and Practice* (Eds.), (West Sussex, England: Blackwell Publishing Ltd.), pp. 59-76
- 21 The full text of Section 139 of the Criminal Justice Act 1988, as amended, and entitled 'Offence of having an article with a blade or is sharply pointed in a public place', reads as follows:
- (1) Subject to subsections (4) and (5) below, any person who has an article to which this section applies with him in a public place shall be guilty of an offence.
 - (2) Subject to subsection (3) below, this section applies to any article which has a blade or is sharply pointed except a folding pocketknife.
 - (3) This section applies to a folding pocketknife if the cutting edge of its blade exceeds 3 inches.
 - (4) It shall be a defense for a person charged with an offence under this section to prove that he had good reason or lawful authority for having the article with him in a public place.
 - (5) Without prejudice to the generality of subsection (4) above, it shall be a defense for a person charged with an offence under this section to prove that he had the article with him—
 - (a) for use at work;
 - (b) for religious reasons; or
 - (c) as part of any national costume.
 - (6) A person guilty of an offence under subsection (1) above shall be liable—
 - (a) on summary conviction, to imprisonment for a term not exceeding six months, or a fine not exceeding the statutory maximum, or both;
 - (b) on conviction on indictment, to imprisonment for a term not exceeding four years, or a fine, or both.]
 - (7) In this section "public place" includes any place to which at the material time the public have or are permitted access, whether on payment or otherwise.
 - (8) This section shall not have effect in relation to anything done before it comes into force.
- See: letter dated from 23 November 1988, Ref: FRM/88 71/9/2: *Section 139 of Criminal Justice Act 1988: Hypodermic Syringes* signed by F.J. Warne, F8 Division, Home Office, London, to Chief Officers of Police, England and Wales
- 22 MPS Police Orders (5 June 1990), *Syringes and needles submitted to the Forensic Science Laboratory*, Item 16, pp.404-405
- 23 Since HCV was only properly identified in 1989, it took some time for policy makers to specifically acknowledge the disease. Consequently, the MPS Police Order, 5th June 1990, makes no reference to HCV
- 24 In the period 1983-1986, a total of 105 needle-stick injuries involving MPS officers were recorded by the Department of Virology, St. Thomas's Hospital in London. See: Welch, J., et al (October 1988), 'Risk to Metropolitan police officers from exposure to hepatitis B', *British Medical Journal*, **297**: 835-836, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1834629/>
- 25 However, people have been prosecuted and convicted in English courts for offences of unlawfully possessing and supply controlled drug in the absence of evidence from a forensic science laboratory. See: *Bird v. Adams* [1972] Crim. L.R. 179 and *R v. Chatwood* [1980] 1 All E.R. 467. For an extended discussion on this point, see: Fortson, R. (2011), *Misuse of drugs and drug trafficking offences* (UK: 6th Edition, Sweet & Maxwell).
- 26 For example, over a decade after NSPs were set up, the former Chief Constable of Scotland's Central and Grampian police services, Dr. Ian Oliver, expressed strong reservations as to their efficacy and suggested NSPs might encourage increased use of heroin and cocaine and that the increase in HVC was linked to their introduction. See: Oliver, I. (1 October 1999), 'Needle exchange programmes: Is there a point?', *International Police Review*: 6-7
- 27 This means that a sterile hypodermic syringe would only be issued to a PWUD in exchange for a used one. The policy was intended to discourage NSP clients from discarding used syringes in public places and encourage their regular contact with NSP staff. Over time, the policy became more lenient as increased access to syringes ('syringes as objects of "prevention" rather than "risk"') became the main focus of the NSPs and as relationships were formed between providers and clients.
- 28 Police Review (20 July 2001), 'Needle syringe scheme approved for use', *Police Review*
- 29 Griesbach, D. et al (2006), *Needle exchange provision in Scotland: A report of the national needle exchange survey* (Edinburgh: Scottish Executive), p.18
- 30 Kent Police, *Protocol for the replacement of injecting equipment in police station custody suites*, http://www.ukhra.org/practice_development/needle_exchange_custody_protocol.html
- 31 Zaal, L. (1992), 'Police policy in Amsterdam'. In O'Hare, P., Newcombe, R., Mathews, A., Buning, E. C. & Druker, E., (Eds) *The reduction of drug related harm* (London: Routledge), p.93
- 32 Hansen, F. (2007), *Are police interfering with Harm reduction? The role of police in harm reduction*. <http://www2.cdc.gov.tw/public/Attachment/81321254371.pdf>
- 33 Order No. 1564, dated 2 December 1999, of the Sverdlovsk Oblast Department of the Interior: 'On maintaining law and order in the neighbourhood of the needle exchanges for injecting drug users'
- 34 Order No. 1564, dated 2 December 1999, of the Sverdlovsk Oblast Department of the Interior: 'On maintaining law and order in the neighbourhood of the needle exchanges for injecting drug users'
- 35 UNODC received its funding from the Dutch Ministry of Health and Sports
- 36 *The National Needle and Syringe Exchange Programme Guidelines for Police* (2006), Malaysia
- 37 New York City Police Operations Order (23 March 2007), *Syringe Exchange Program (SEP)* Number 19, para. 2
- 38 New York City Police Operations Order (23 March 2007), *Syringe Exchange Program (SEP)* Number 19, para. 2
- 39 Aitken, C., Moore, D., Higgs, P., Kelsall, J. & Kerger, M. (2002), 'The impact of a police crackdown on a street drug scene: evidence from the street', *International Journal of Drug Policy*, **13**(3): 189-198, <http://www.journals.elsevierhealth.com/periodicals/drupol/article/PIIS0955395902000750/abstract>
- 40 Rhodes, T., Mikhailova, L., Sarang, A., Lowndes, C.M., Rylkov, A., Khutorskoy, M. & Renton, A. (2003), 'Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment', *Social Science & Medicine*, **57**: 39-54, <http://www.ncbi.nlm.nih.gov/pubmed/12753815>

- 41 Bewley-Taylor, D. R. (2012), *International drug control: Consensus fractured* (Cambridge University Press), p. 60
- 42 The text of the Note to Article 230 of the 1996 Criminal Code reads as follows: 'The operation of the present Article shall not extend to instances of propaganda of the application for the purposes of the prevention of HIV infection and other dangerous infectious diseases of respective tools and equipment to be used for the consumption of narcotic means and psychotropic substances, if these acts were effectuated by agreement with agencies if executive power in the domain of public health and agencies for control over turnover of narcotic means and psychotropic substances'. The note was added by Federal Law 162, of 8 December 2003 (Translation by Professor W.E. Butler)
- 43 Minutes of the 3rd Meeting of the NDPHS [Northern Dimension Partnership in Public Health and Social Well-being] Expert Group in HIV/AIDS and Associated Infection⁶ 6-7 October 2011, Kaliningrad Region. According to the Minutes, in 2011, HIV infections increased by 9% compared to the number recorded in 2010
- 44 Monaghan, G. (1997), 'Drugs and the pharmacist'. In *Drugs and the community, national drugs conference, 1997, Final report* (Association of Chief Police Officers, England, Wales and Northern Ireland), pp. 50-51

Monaghan, G. (August 2000), *Kits, bits, balloons and spoons: Drug paraphernalia law in Britain*, Briefing Paper submitted to the United Kingdom Anti-Drugs Coordinating Unit (MPS Drugs Directorate)
- 45 Section 9A (1) of the Misuse of Drugs Act 1971 creates the offence of prohibiting the supply or offer to supply any article which may be used or adapted to be used (whether by itself or in combination with another article or articles) in the administration by any person of a controlled drug to himself or another, believing that the article (or article as adapted) is to be used in circumstances where the administration is unlawful, is guilty of an offence. Subsection (2) states that it not an offence under subsection (1) to supply or offer to supply a hypodermic syringe, or any part of one. NB: Section 9A is often erroneously shown as 'section 9a' in academic texts, articles and websites discussing drug paraphernalia laws in Britain. Section 9 (a) of the Misuse of Drugs Act 1971 prohibits the smoking of opium. In English law the insertion of a capital letter following the number of a particular section, indicates that the original Act has been amended. Thus, a new section inserted between section 9 and section 10 will be numbered 'section 9A'. Section 9A was inserted into the original Act by section 34 (1) of the Drug Trafficking Offences Act 1986
- 46 Regulation 6, of the Misuse of Drugs Regulations 2001 as amended, allows for the supply of ascorbic acid, swabs, utensils for the preparation of a controlled drug, citric acid, filters, and ampoules of water for injection but only if supplied or offered for supply in accordance with the Medicines Act 1968 or any instrument which is in force thereunder
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- 101 Dave Bewley Taylor is the editor of the Modernising Drug Law Enforcement project publication series

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