Chapter 2
Criminal justice
2.1 Drug law reform

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.

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. 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.

- 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.³

• 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.

Additional consequences of tough drug control include, to name a few,⁴ the issue of laws prohibiting the distribution of drug paraphernalia, deterring people who use drugs from using needle and syringe exchange programmes;⁵ 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;⁶ and the imposition of disproportionate penalties on drug offenders.⁷

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**⁸ 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**⁹ 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**¹⁰ 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. 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. 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 (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. 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’, 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**

The only explicit reference to illicit drug use appears in article 33 of the UN Convention on the Rights of the Child, but issues raised in drug law and drug policy are implicit throughout the human rights treaty architecture. 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 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 and the International Narcotics Drug Board (INCB). 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 and revised in 2010, 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.

**Figure 1. UN classification of substances and levels of harm**

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’, and the increasing use of pharmaceutical drugs.

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

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. 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**

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’.24
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. 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). 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**).

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**Box 3. The use of the death penalty for drug offences**

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.

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.
• **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-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. 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. 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.29

**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.\(^{30}\)

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.\(^{31}\)

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.\(^{32}\)

**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.

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**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.’\(^{33}\)

The last decade has seen the first detailed proposals emerge\(^{34}\) 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*, 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**

- **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.

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**


**Endnotes**


3. Recently, for example, the criminalisation of illicit drug use has pushed users to stop using known drugs, including psychotropic plants with mild effects, and they have turned instead to unknown and sometimes highly dangerous synthetic substances known as ‘legal highs’ (i.e. substances having psychoactive properties but not included in a country’s drugs legislation).

4. For more information about the consequences of the global drug control system, please refer to the Count the Costs website: [www.countthecosts.org](http://www.countthecosts.org)


11. Articles 36 and 38 of the 1961 Convention, articles 20 and 23 of the 1971 Convention, and article 3 of the 1988 Convention.

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.

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.


2.2 Effective drug law enforcement

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.¹

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.

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. 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**

‘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**

![Diagram of cocaine trafficking routes](image-url)
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

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**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**

**Figure 3. Annual prevalence of controlled drug use among grade 12 students in the USA, 1975 to 2002**
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).5

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.

**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, focusing on how their operations impact on society. This may lead to difficult decisions on priorities, focusing on the most harmful aspects of their operations rather than solely on seizures and arrests, and encouraging markets to be conducted away from public places 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 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.

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. 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.\textsuperscript{13} 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).\textsuperscript{14} 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%.\textsuperscript{15}
**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**


Endnotes


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


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

13 See, for example, Hughes, C.H. & Stevens, A. (2010), ‘What can we learn from the Portuguese decriminalization of illicit drugs?’, British Journal of Criminology, 50: 999–1022. However, this approach has not yet been effective in reducing the overall crime rates. This suggests that the latter will be more influenced by wider social factors (such as inequality, poverty or social marginalisation) than by the drug markets. Similar effects have been observed in China. See: Yin, W., Hao, Y., Sun, X., et al (2010), ‘Scaling up the national methadone maintenance treatment program in China: achievements and challenges’, The International Journal of Epidemiology, 39(2): 29–37


2.3 Reducing incarceration

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. Less significant rises have also taken place throughout Europe, Asia, Africa, Oceania and the Americas. 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

‘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, 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.

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. 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’.
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. 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, and a 2006 study in Germany found that 75% of prisoners who injected drugs continued to inject while in prison.

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 reformative 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.

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).
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.

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, in particular the UN Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules), 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’.

- **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 determine the relevance and proportionality of punishment.

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.\(^{16}\)

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**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.\(^ {17}\)

**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. Since the 1980s, the buying and selling of small quantities of cannabis has been permitted in licensed ‘coffee shops’ under strict regulations.

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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).
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. 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**

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.

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**


**Endnotes**


14 [http://www2.ohchr.org/english/law/tokyorules.htm](http://www2.ohchr.org/english/law/tokyorules.htm)


16 See, for example: Hughes, C.E. & Stevens, A. (2010), ‘What can we learn from the Portuguese decriminalisation of illicit drugs?’, *British Journal of Criminology*, **50**: 999–1022, [http://bjc.oxfordjournals.org/content/50/6/999.abstract](http://bjc.oxfordjournals.org/content/50/6/999.abstract)


20 The Development Centre for Scotland, Social Work in Youth and Criminal Justice, *Diversion*, [http://www.cjsw.ac.uk/content/diversion](http://www.cjsw.ac.uk/content/diversion)

2.4 Effective drug interventions in prisons

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.

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 underserviced 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. 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. 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.

The number of people in prison, and 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. Drugs have become established at the heart of prison life, and are often now ‘the central medium and currency in prison subcultures’.

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.
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. 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%.6

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.7

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.8 Another study demonstrated that the prevalence of tuberculosis in a prison in Victoria (Australia) had reached 10%, 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%.9

**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.11

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.12 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.13
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.\textsuperscript{14}

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 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’.\textsuperscript{15}

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’.\textsuperscript{16} 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’.\textsuperscript{17}

In December 2010, the UN General Assembly passed the UN Rules for the Treatment of Women Prisoners, usually known as the Bangkok Rules.\textsuperscript{18} 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’.\textsuperscript{19} 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)’.

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. UNODC itself declared that these programmes should be avoided in prisons.

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).

- **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.

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
• **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).

**Box 1. Needle and syringe programmes in German prisons**

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 …’.

• **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. 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.

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, have been effective at reducing drug dependence in prisons. 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. The principles behind prison-based treatment are similar to those of drug dependence treatment in the community.

- Efficient mechanisms need to be put in place to identify those in need of treatment 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. 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. 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.\(^{32}\) 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.\(^{33}\)

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.\(^{34}\)

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.\(^{35}\)

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


Endnotes


17 European Prison Rules, para.40.4 and 40.5 https://wcd.coe.int/ViewDoc.jsp?id=955747


