Chapter 2: Health policies and programmes
The Preambles of the 1961 and the 1971 UN drug conventions establish, as the primary objective of the treaties, the need to protect the health and welfare of mankind. The right to health is also protected in a number of international human rights instruments. Protecting health should therefore be at the centre of any national drug policy. The UN drug control treaties also impose a dual obligation on member states: that of prohibiting the production, sale and use of internationally controlled substances for recreational purposes on the one hand, while ensuring their access for medical and scientific purposes on the other. In practice however, the focus has been placed on reducing the scale of the illicit drug market through prohibition-led drug policy, with far less attention paid to the need to ensure the availability of controlled substances for medical and scientific purposes.

Scheduling is at the heart of any drug control policy. It is the mechanism through which policy makers place controlled substances in diverse schedules according to their level of harm and potential for medical and scientific usages. However, scheduling has posed many political, technical and ideological issues. Chapter 2.1 will review available practices and evidence on scheduling – with a specific focus on cannabis, khat, ketamine and new psychoactive substances – in an attempt to provide guidance on how best to overcome the main challenges of scheduling.

The scheduling of controlled substances has a significant impact on whether a substance will be made available for medical and scientific purposes – one of the two core objectives of the UN drug control system. However, as Chapter 2.2 highlights, 5.5 billion people currently live in countries with limited or no access to controlled medicines. The chapter provides a set of practical recommendations on how to remove the legislative, technical and ideological barriers that are currently hindering access to controlled medicines for medical usage.

Chapter 2 then turns to the health policies and programmes targeting people who use drugs. Drug use may lead to a number of preventable health consequences, including the transmission of infections such as hepatitis B and C and HIV, overdose deaths, and an exacerbation of existing psychiatric or physical illnesses. It is therefore essential that a comprehensive health approach is developed to address drug use and dependence.

Chapter 2.3 offers guidelines on how to develop effective and evidence-based drug prevention programmes, focusing on identifying objectives, methods and settings, on the basis of the international quality standards on drug prevention that have so far been developed.

Chapter 2.4 reviews international evidence on harm reduction and provides a list of principles and interventions that should be developed to address the health, social and economic harms associated with drug use.

Finally, Chapter 2.5 turns to drug dependence treatment, offering guidance on how to develop and implement a comprehensive menu of effective, voluntary and evidence-based drug dependence treatment programmes – with detailed recommendations on treatment referrals, methods, settings and associated social support services.
Introduction

Although a complex technical issue, scheduling is at the heart of drug control. Both international law as embodied in the UN drug control conventions and national legislation systems include hierarchical classifications based on the degree of risk and the level of medical usefulness associated with controlled substances.

These hierarchies are often known as schedules, and their objective is to assign appropriate levels of control to a given set of substances. They are intended to apply the tightest control measures to those substances considered the most dangerous. Similarly, substances believed to carry the lowest levels of risk are assigned to the least restrictive schedule. The medical utility of drugs is also factored into the decision to assign a substance to the appropriate schedule in drug laws and policies. Whether these classifications are appropriate in practice is, however, a matter of considerable dispute – often the scheduling is based on unexamined cultural beliefs or historical accidents instead of scientific evidence.  

The mandate for scientifically reviewing substances proposed for international control lies with the World Health Organisation (WHO), while at the national level many countries have set up specialised agencies to advise their governments on the appropriate schedules for substances. It is of great importance that the principle of scientific review is maintained, which should be independent of governments, and that its assessment of scheduling and classifying substances

Key recommendations

• International drug control bodies and national-level policy makers should attain the proper degree of balance between restriction of harm and the medical usefulness of a substance when making a scheduling decision

• The UN drug control regime should urgently review its scheduling processes to ensure that these reflect the latest evidence and the needs of the contemporary drug response. An expert group should be assigned this task, and the resulting advice should be passed on to governments to assist them in re-designing their national scheduling processes

• The role of scientific reviews – conducted by the WHO’s ECDD – should be strengthened and protected as part of international scheduling processes at the UN level, including mandatory periodic reviews of currently controlled substances (including cannabis) to reflect any emerging evidence and make the necessary adjustments to the policy response

• Where they do not already exist, policy makers should establish national advisory committees composed of scientific and social scientific experts to recommend appropriate classifications for substances proposed for control

• Policy makers should be bound by the recommendations of their advisory committees. If governments reject the advice of their expert committees, the grounds for doing so should be systemically and transparently articulated, and must be based upon evidence

• The unique problems presented by NPS should be embraced as an opportunity for better scheduling approaches based on evidence. For example, the approach originally adopted by New Zealand should be re-established and its results monitored and studied to examine the potential of replicating it elsewhere.
substances proposed for control is carried out on a scientific basis. However, governments are often unwilling to take the advice of their own advisory bodies, fearing public reactions to scientific recommendations on drug control or holding ideological positions on substances that run counter to scientific advice.

Scheduling has recently become a more complex issue due to the emergence of large numbers of new psychoactive substances (NPS). These substances have generated a sense of panic among many governments. The proliferation of these new substances – and the dynamic ways in which they are produced and brought to market through the internet and social networking – have led to the conclusion that the customary processes of scheduling involving detailed scientific reviews are too slow and unwieldy to meet the control requirements of this novel situation.

**Legislative/policy issues involved**

**Evidence-based hierarchies of harm**

Attempts should be made to base scheduling on both hierarchies of harm, and a balance between those harms and medical usage. Figure 1 below represents an alternative pattern of scheduling derived from the work of Professor David Nutt in the UK. It compares an ‘independent expert assessment of harm’ with the current classification within the international drug control system administered by the UN. It is notable that the two lists vary widely; cannabis, for example, is included in the most dangerous drugs (and with no medical value) within the UN system, while Nutt’s system places it in the low risk category. A similar dissonance applies to LSD and ecstasy.

In general, the UN system classifies many more substances as ‘most dangerous’, which is arguably a result of cultural and historical factors at work during the early and mid-20th century, during which period colonial judgements and values, as well as xenophobia and racism, tended to prevail.

In 2007, the Nutt classification placed ketamine very close to the most dangerous drugs in its scale, whereas, for the moment, the substance is not scheduled in the UN system. Proposals to schedule it are being debated, as will be discussed below – but even if these efforts are successful, ketamine will be classified as a low-risk substance because of its high medical value. This demonstrates the difficulty of assigning scientific schedules to psychoactive substances through an objective and evidence-based assessment of both harms and medical benefits. The best practice at the moment involves recommendations made by expert committees of scientists to advise governments based on available evidence, and for governments to base policy decisions on these recommendations.

**Assessing the medical usage of substances**

The campaign against the non-medical consumption of controlled substances, which was waged...
through much of the 20th century, has resulted in a bias against the supply of controlled substances for medical purposes, demonstrating once more the imbalance within the international system and in many countries’ domestic policy contexts.

At the 58th Session of the Commission on Narcotic Drugs (CND) in March 2015, it was proposed that ketamine be controlled under schedule IV of the 1971 UN Convention on Psychotropic Substances. This move was motivated by the expansion in the recreational use of ketamine, particularly in China and South East Asia, and increases in associated harms such as ketamine bladder syndrome, and patterns of dependence that had not previously been seen among populations using the substance for recreational purposes. A campaign by medical and clinical professionals, drug policy NGOs and some governments was initiated to resist the proposal to schedule ketamine, because the substance is a vital anaesthetic in both human and animal medicine, particularly in rural districts of low and middle income countries. The restriction on ketamine stemming from international control would probably not adversely affect wealthy countries, but developing states would lack the economic, administrative and technical resources necessary to meet the requirements of international drug control – even if the substance were included in the least restrictive schedule IV of the 1971 Convention. For these developing countries, it would be much cheaper and simpler to effectively ban the substance altogether. Valium and Phenobarbital represent equivalent cases, and are extremely difficult to obtain in rural Asia and Africa, despite being classified under schedule IV of the 1971 Convention.
At the 2015 CND, the proposal to schedule ketamine was deferred owing to the controversy over its effect on the availability of this important anaesthetic. However, the proposal is likely to return at the next CND session. The WHO, which has the mandate to recommend on scheduling within the international regime, has critically reviewed the substance four times and found that it does not need to come under international control. Furthermore, the WHO has stated that the scheduling of ketamine would constitute a ‘public health crisis’. The WHO position recognised that there are far more effective ways than scheduling to address the harms associated with ketamine use while avoiding restrictions in access for this vital anaesthetic substance.

The controversy of the scheduling status of ketamine, which is on the WHO’s Model List Of Essential Medicines, goes beyond the particular substance. If the UN drug control system is to meet its rhetorical claims to be a more health- and human rights-focused regime, it needs to demonstrate its new orientation by shifting the balance toward medical applications in the field of scheduling, as well as listening to the advice of its expert committee. Individual countries should take similar steps to assign proper importance to the medical and therapeutic capacities of substances proposed for scheduling.

Implementation issues involved

Conflicts between expert groups assembled to provide guidance on the classification of substances on the one hand and those making the political decisions on the other have arisen both at national levels and in the international, UN-administered system. The following case studies, on cannabis, khat...
and new psychoactive substances (NPS), illustrate these frictions. A similar case on the coca leaf is discussed in Chapter 4.3.

### Scheduling controversies around cannabis

This has been particularly the case for discussions around the scheduling of cannabis. For example, the UK’s Misuse of Drugs Act 1971 established the Advisory Council for the Misuse of Drugs (ACMD) – an independent expert scientific group which advises the government on scheduling matters. In 2007, when cannabis had been re-scheduled as a ‘Class C’ drug (the least harmful category) under the 2001 Misuse of Drugs Regulation, the government requested the ACMD to review this classification based on reports of severe mental health effects from high-strength ‘skunk’ preparations of the substance. The government wished to return cannabis to its earlier ‘Class B’ classification, but after extensive review the ACMD recommended that the drug remain in ‘Class C’. Nevertheless, in 2008, cannabis was re-scheduled as a ‘Class B’ substance.

Then, in February 2009, the UK government once more rejected an ACMD recommendation, this time that ecstasy be downgraded from ‘Class A’ to ‘Class B’. The government’s justification for this decision at the time was: ‘It is our view that the system should be based on evidence, but it should also be based on the considered view of those responsible for policy making, and should take into consideration the impact that changes in classification are likely to have on the use of, and harms caused by drugs and the impact that has on the criminal justice system. That is why it will remain the case that our advisers will advise us, and we will decide.’

The UK government is legally entitled to reject the ACMD recommendations, as the statutory framework only requires conscientious consultation by the government with the ACMD on classification decisions, not that its recommendations be followed. However, relations between the government and the ACMD, and parts of the scientific community more generally, became further strained following the sacking of the ACMD Chair, Professor David Nutt, over his views on the relative safety of ecstasy and cannabis compared to alcohol and tobacco. The Home Secretary wrote to the Professor explaining that, ‘it is important that the government’s messages on drugs are clear and as an advisor you do nothing to undermine public understanding of them.’

A total of six members of the ACMD resigned over the sacking and the issues it raised. Later in 2010, the UK government once again discarded the ACMD recommendations when it announced its ban on mephedrone.

### Scheduling controversies around khat

Khat – a plant with leaves that are chewed for their mild stimulant properties – is not subject to international control at present. The Advisory Committee on the Traffic in Opium and Other Dangerous Drugs of the League of Nations first discussed khat in 1933, and the substance has appeared on the international agenda repeatedly since then. Several studies, including by the UN Narcotics Laboratory, subsequently identified a number of phenylalkylamine alkaloids as the major psychoactive compounds in the khat plant: cathinone and cathine (norpseudoephedrine), and to a lesser degree norephedrine. Cathinone is unstable and undergoes decomposition rapidly after harvesting and during drying of
Box 2 The European Union’s approach to NPS

In Europe, the first formal action to respond to the growing problem of NPS was the creation, in 2005, of the EU ‘Early Warning System’ and structures that went with it. Through this, EU member states could register new substances of concern. Their risks were then assessed by the EU institutions (principally the European Monitoring Centre on Drugs and Drug Addiction, EMCDDA), and a decision made on whether or not to recommend the substance for control measures. In practice, this process was only fully used in a small number of substances.22 Furthermore, in most cases it took a long time and considerable resources to produce a recommendation. This naturally led to concerns about how the process could respond to the growing number of substances coming onto the market. As a result, the European Commission (EC or Commission) initiated a process to evaluate the existing early warning mechanism. At the beginning of 2010, amidst the emergence of mephedrone and the reports of deaths associated with its use – particularly in the UK and Ireland – the Commission started the preparatory work.

In July 2011, the EC published its assessment,23 concluding that there were three major shortcomings when it came to submitting NPS to Europe-wide control measures. First, the existing system was unable to tackle the large increase in the number of NPS on the market because it addresses substances one by one, through a lengthy process. Second, it was seen to be overly reactive since substances brought under control measures were quickly replaced with new ones with similar effects, often through small modifications of their chemical composition. And third, it lacked a range of effective options for control measures that would allow for rapid and targeted action. Driven by these conclusions, and coinciding with discussions of the issue in the Informal Council on Justice and Home Affairs, the Commission engaged in a consultation process to propose to EU member states a mechanism to replace a system that was deemed ‘no longer fit for purpose’.24

The Commission’s proposal aims to speed up the ‘Union’s ability to fight’25 NPS by providing for:

- **A quicker procedure:** It currently takes a minimum of two years to ban a substance in the EU. Under the new structure, the EU will be able to act within 10 months. In some cases, the procedure would be shorter since it will also be possible to withdraw a substance immediately from the market for a year. This measure is intended to ensure that the substance is no longer available to customers while a full risk assessment is being conducted. The current system does not allow temporary measures, with proposals to restrict substances having to wait for a full risk assessment.

- **A more proportionate system:** It is intended that the new system will allow for a graduated approach where substances posing a moderate risk will be subject to consumer market restrictions and substances posing high risk to full market restrictions. Only the most harmful substances posing severe risks to consumers’ health will be submitted to criminal law provisions. This is a significant departure from the current system since it only provides for binary options – taking no action at EU level or imposing full market restrictions and criminal sanctions. This lack of options means that at present, the Union does not take action in relation to some harmful substances.26 It is hoped that the new system will allow the EU to tackle more cases and deal with them more proportionately, by tailoring its response to risks involved and taking into account legitimate commercial and industrial uses.27

The proposal now needs to be adopted by the European Parliament and by EU member states in the EU Council in order to become law. This may not be a straightforward process since it is becoming clear that, as is often the case within the EU, there is no universal agreement on the issue.28 Beyond this, it remains likely that EU institutions and national governments will continue to lag behind drug designers and the changing nature of the NPS market.29 Moreover, introducing the concept of proportionality and the option of regulating – rather than prohibiting – NPS within the new system raises interesting questions about the relative harm of organic substances, such as cannabis, that are currently under the strictest controls within the UN-based international scheduling framework.
On the other side of the planet, New Zealand was faced with a flood of NPS that lay beyond the scope of existing drug control legislation.\(^{30}\) New Zealand passed what appeared to be the ground-breaking Psychoactive Substances Bill in July 2013.\(^{31}\) The resultant Act set up a legal framework for the testing, manufacture, sale and regulation of previously uncontrolled psychoactive products, placing the responsibility on manufacturers to prove a product poses a ‘low risk’ before it can be sold. To this end, it established a Psychoactive Substances Regulatory Authority within the Ministry of Health, responsible for ensuring that products met appropriate safety standards before they could be distributed in New Zealand.

Underpinned by a belief in pragmatism, evidence and the protection of health, the Act acknowledged the demand for psychoactive substances and consequently focused on attempting to ensure that this was met in a low-risk manner. Unlike earlier legislation, it provided alternatives to a criminal justice approach and sought to protect the health of the user ‘without undue emphasis on illegality and punishment’.\(^{32}\) As such, offences within the Act predominantly focused upon illegal manufacture and/or supply. It also contained an inbuilt five-year review mechanism to allow for aspects of the legislation to be revisited if it was felt that they were not operating as intended. Furthermore, while the legislation removed the onus of proof regarding the level of risk away from the government and placed it with manufacturers, authorities retained oversight by being able to quickly remove a product from the market. It was the intention that the legislative framework would also incentivise manufacturers to make low-risk products rather than constantly seeking to circumvent the law by producing chemical variants of unknown harm potential. Approved products would only be available in certain outlets, would come with health warnings and be subject to restricted advertising at the point of sale only.

Under the Act, 41 of the lowest-risk substances were assigned temporary approval; however, in April 2014, the government suspended these approvals. According to Health Minister Peter Dunne, this sudden reversal in policy was prompted by increased reports of harmful side-effects of the substances in question. The terms of the Act were subsequently amended, bringing to an end the interim or provisional product approvals that had enabled certain substances to be sold prior to full testing. All interim licences to retail NPS have been revoked, and it is now illegal to supply and possess the products.

The reversal in New Zealand’s policy was driven by fears of an underground economy and mass drug use and an attempt to prevent harm through the application of controls. Ironically, the Act probably represented the best available method of regulating the market, and its amendment – which is effectively an abandonment of its principles – means that in reality the state has little, if any, control over the market, which has, after a promising start, reverted into the hands of criminals.

Box 3  New Zealand’s Psychoactive Substances Act

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Cathinone and cathine are alkaloids with similar effects on the central nervous system to those of amphetamine, though less potent. In the early 1980s, all amphetamine-type stimulants (ATS) have been placed as a group under international control. Cathinone and cathine were, based on a 1985 recommendation of the WHO Expert Committee on Drug Dependence (ECDD), added to the list of controlled substances of the 1971 UN Convention on Psychotropic Substances, respectively to Schedules I and III.\(^ {33}\) Norephedrine was subsequently included in the list of precursors controlled under the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, as it was often used in the illicit manufacture of amphetamines.

The WHO ECDD concluded in 2006 on the basis of a critical review of khat that scheduling of the plant itself was not required: ‘The Committee reviewed the data on khat and determined that the potential for abuse and dependence is low. The level of abuse and threat to public health is not significant enough to warrant international control. Therefore, the Committee did not recommend the scheduling of the plant material. This is the main reason why fresh khat leaves are preferred by chewers. Dried leaves, which contain much lower levels of cathinone, are more often used to make tea, known as Abyssinian or Arabian tea.

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of khat. The Committee recognized that social and some health problems result from the excessive use of khat and suggested that national educational campaigns should be adopted to discourage use that may lead to these adverse consequences.34

Scheduling controversies around new psychoactive substances

By December 2014, the United Nations Office on Drugs and Crime (UNODC) had received notice of 541 different NPS, compared to just 126 in 2009. This proliferating class of drugs has resulted in panic among many national governments, and put immense strain on the traditional methods of review and classification that take place prior to scheduling. NPS can be developed extremely rapidly, and are often marketed via the internet and social networks. Once one substance is scheduled, chemical variations of it can often be produced and marketed which are not covered under the scheduling decision, and therefore circumvent the law. It is problematic – and often impossible – for governments and law enforcement agencies to keep up. A number of new approaches have therefore been attempted, in particular at EU level (see Box 2) and in New Zealand (see Box 3).

Key resources


Cannabis at a Colorado dispensary
Ensuring access to controlled substances for medical and scientific purposes

Key recommendations

- National drug control regulations should be reviewed using WHO’s 2011 guidance to ensure that they do not needlessly interfere with the availability and accessibility of controlled medicines, especially opioid analgesics.
- The adequacy of annual estimates for medical and scientific needs of controlled substances should be reviewed in accordance with the INCB and WHO’s Guide on estimating requirements for substances under international control, and estimates should be adjusted as needed.
- Adequate training for current healthcare workers should be provided on the use of controlled medicines, and incorporated into undergraduate and graduate curricula for all relevant healthcare workers.
- National health strategies should be reviewed, including for cancer, non-communicable diseases and HIV, to ensure that they adequately address the need for palliative care.
- More scientific research should be encouraged, conducted and funded on the medical value of cannabis and psychedelics.

Introduction

Some substances controlled under the international drug control treaties are routinely used in healthcare in diverse fields of medicine, such as anaesthesia, drug dependence, maternal health, mental health, neurology, pain management and palliative care. For example, the World Health Organisation (WHO) has included 12 medicines that contain internationally controlled substances in its Model List of Essential Medicines: buprenorphine, codeine, di-azepam, ephedrine, ergometrine, hydromorphone, lorazepam, midazolam, methadone, morphine, oxycodone and phenobarbital. These represent the ‘minimum medicine needs for a basic healthcare system’ and ‘the most efficacious, safe and cost-effective medicines’. A number of countries also apply similar national controls to other essential medicines outside of those proscribed by international law – such as ketamine (see Chapter 2.1 for more details).

Although ensuring the adequate availability of controlled substances for medical and scientific purposes is one of the fundamental aims of the UN drug conventions, the UN system and UN member states have so far failed at fulfilling this objective. The WHO estimates that 5.5 billion people live in countries with low or non-existent access to controlled medicines, and that tens of millions of people in these countries experience moderate to severe pain without access to treatment every year, including 5.5 million people with terminal cancer and a million people with late-stage HIV/AIDS.

The international drug control regime also interferes with scientific research into potential medical uses of controlled substances. An increasing body of evidence suggests that substances such as cannabis and cannabinoids, heroin, ketamine, ketobemidone, LSD and MDMA, have medical uses in the treatment of a variety of conditions, including pain, multiple sclerosis, drug dependence, glaucoma, depression, post-traumatic stress disorder, and Parkinson’s disease. Yet, the fact that these substances are listed in schedules that recognise no medical or scientific use in the drug control treaties creates significant regulatory and financial obstacles to further research and the development of new medications.

Legislative/policy issues involved

The 1961 Single Convention on Narcotic Drugs and the 1971 UN Convention on Psychotropic Substances articulate a dual obligation for states with respect...
countries must ensure their availability for medical and scientific use, and prevent their use and diversion for other uses (i.e. recreational and non-medical use). The Single Convention formulates four basic requirements for national regulations of opioid analgesics, which are in the strictest schedule for substances with medical uses:

- Individuals dispensing the medication must be licensed, either by virtue of their professional license or through a special licensing procedure
- Only authorised institutions or people may handle and transfer these medications
- The medications can only be dispensed to a patient upon a medical prescription
- Records on the movement of these medications are kept for no less than two years.

The 1971 Convention contains similar provisions for psychotropic substances. However, both the 1961 and the 1971 conventions explicitly open the door for countries to adopt measures of control stricter or more severe than those provided by the drug control treaties, including a special prescription form for controlled medications, if they deem it necessary.

In contrast, specific operative paragraphs requiring states parties to ensure access to controlled medicines are conspicuously absent.

Many countries have adopted regulations around controlled substances that go far beyond the requirements of the 1961 Convention or the 1971 Convention. Often, these regulations directly interfere with medical practice and make controlled medicines inaccessible for patients. Common barriers in national legislation include:

- requirements for special prescription forms
- limitations on the number of days a prescription can cover
- limitations on which healthcare workers can prescribe controlled substances
- requirements for additional licenses for hospitals, pharmacists and healthcare workers
- additional record keeping or reporting requirements
- limitations on the daily doses that can be prescribed.

Furthermore, the laws on controlled substances of some countries impose harsh criminal punishments for healthcare workers, sometimes even for unintentional errors in handling them.

The WHO, the International Narcotics Control Board (INCB), the Commission on Narcotic Drugs (CND), the United Nations Office on Drugs and Crime (UNODC), and the World Health Assembly (WHA) have repeatedly called on UN member states to review their regulations on controlled substances to ensure they do not needlessly interfere with medical use. The WHO has also published guidance for countries on reviewing their national policies on controlled substances.

Implementation issues involved

Regulatory barriers are not the sole reason why the availability of controlled medicines, especially opioid analgesics, is so limited in much of the world. Few governments have put in place effective supply and distribution systems for these medications; they have no relevant health policies or guidelines for practitioners; they do not ensure that healthcare workers get instructions on the use of controlled medicines as part of their training; and they do not make sufficient efforts to ensure that they are affordable. Myths about controlled medicines among both healthcare workers and the public, as
Box 1 Mexico reviews its prescribing and dispensing system for opioid analgesics

On 15 June 2015, Mexico introduced a new system for prescribing and dispensing opioid analgesics in response to concerns that the old system was so cumbersome that it deprived people with advanced illnesses of access to essential pain medicines. The new system allows physicians to download special prescriptions from a secure website with bar codes required for prescribing opioid pain relievers. It also introduces electronic record keeping for pharmacies.

Before June 2015, physicians had to travel in person to state capitals to obtain the bar-code stickers that Mexican law requires for prescriptions of opioid analgesics. This highly time-consuming requirement discouraged many physicians from prescribing these medicines. Moreover, pharmacies had to record all transactions involving these medicines in multiple log books, posing a significant bureaucratic burden. A 2014 Human Rights Watch report found that Mexico’s regulations were so burdensome that the vast majority of doctors, especially those living outside state capitals, simply did not prescribe these medications and that very few pharmacies kept them in stock.

Apart from simplifying the prescription of opioid analgesics, the electronic system also improved government oversight of their use. Previously, pharmacies were unable to scan the bar-code stickers on prescriptions for opioid analgesics to authenticate them because they were not linked to a central system. Thus, the requirement for bar codes, which was intended to allow close monitoring of prescribing and dispensing opioid analgesics, did not actually help prevent their misuse, but did create a major barrier to legitimate medical use.

Under the new system, pharmacies will be able to authenticate prescription forms using the bar code, and scripts will be automatically cancelled once they have been scanned. The new system for prescribing opioid analgesics is one of a series of measures by the Mexican government to improve access to palliative and end-of-life care. Pain treatment is an important component of this kind of healthcare.

In December 2014, the Ministry of Health issued guidelines to its healthcare system to put into effect provisions on end-of-life care as outlined in Mexico’s 2009 health law and created a department to advance palliative care. In January 2015, the government adopted an inter-agency agreement on palliative care, which made it mandatory and instructed medical schools to include it in their curricula.
Box 2  *Kenya’s improved access to opioid analgesics*

Kenya has made significant progress in improving access to opioid analgesics in the last five years, with morphine consumption jumping more than three-fold over that period. In 2010, access to opioid analgesics was very limited and available in just a few Kenyan hospitals. According to a 2010 Human Rights Watch report, Kenya recognised oral morphine as an essential medicine but its central pharmaceutical supplier – the Kenya Medical Supplies Agency, which procures essential medicines for public hospitals – did not purchase or stock oral morphine. Hospitals therefore had to negotiate individually with pharmaceutical companies to obtain the medication. Moreover, the government levied an import tax on morphine powder pushing up the price. As Kenya’s drug law prescribed heavy prison sentences for illicit possession of morphine and provided no detailed guidelines on lawful possession for healthcare workers and patients, many healthcare providers viewed morphine as a dangerous substance rather than as an essential medicine for pain.

Since 2010, Kenya has taken significant steps toward improving access to opioid analgesics. It has integrated palliative care into the public health system, developed clinical guidelines, and introduced multiple training curricula that include the use of opioid analgesics. In 2013, the Kenya Medical Supplies Agency began to procure morphine centrally for public hospitals, and the government removed the tax on morphine powder. As a result, 43 public hospitals offered palliative care by late 2014, and all had a steady supply of morphine.

well as often unfounded fears of diversion for illicit purposes, are key factors blocking improved access to controlled medicines.

In the case of pain management and palliative care, these factors combine to create a vicious cycle of under-treatment in many countries. Because pain treatment and palliative care are not policy priorities, healthcare workers do not receive the necessary training to assess the medicines necessary to treat moderate to severe pain. This leads to widespread under-treatment and to low demand for opioid analgesics. Similarly, the complex procurement and prescription regulations, as well as the threat of harsh punishment mentioned above, discourage pharmacies and hospitals from stocking these medicines, and healthcare workers from prescribing them, again resulting in low demand. This, in turn, reinforces the low priority given to pain management and palliative care. This low prioritisation is not a function of low prevalence of pain, but of the invisibility of its sufferers.

To break out of this vicious cycle, governments and the international community should:

- take a multipronged approach that focuses on eliminating regulatory barriers and criminal sanctions for legitimate medical uses of controlled medicines
- develop health policies, such as national strategies on cancer or on non-communicable diseases, that identify palliative care as an objective, and integrate such services into the healthcare system
- overcome gaps in training on the use of controlled medicines for healthcare workers
- take action to ensure an adequate supply and distribution system.

**Key resources**

## Key recommendations

- Drug prevention programmes should be based on available evidence of effectiveness and cost-effectiveness, and be in line with international minimum quality standards.
- Drug prevention should be considered as an integral part of – and never as a substitute for – a comprehensive health-centred approach towards drug use and dependence, alongside harm reduction, drug dependence treatment, care and support.
- The objectives of drug prevention should be realistic and based on an honest assessment of local realities and available resources.
- Drug prevention should focus on minimising the risk factors and strengthening the protective factors in the lives of targeted individuals and/or groups.
- Drug prevention must take care to avoid increasing the social stigma and marginalisation of people who use drugs.
- Drug prevention programmes should be subjected to short- and long-term scientific evaluations of processes and outcomes to measure the effectiveness and impact of the interventions, and should include mechanisms to adapt the programmes to new patterns of use and realities on the ground.

## Introduction

Drug prevention can be defined as any activity, campaign, programme or policy aimed at preventing, delaying or reducing drug use and/or its negative consequences – either in the general population or within targeted sub-populations.

A myriad of interventions have so far been developed in the field of drug prevention. In many countries, such interventions have been guided by the principle of deterrence – the belief that people will not use drugs if they are told about the negative effects of use and the harsh penalties they risk by using them. However, despite a consistent allocation of substantial government resources towards these interventions, available evidence indicates that the rates of drug use among young people remain high, and are largely unaffected by the prevention approaches tried so far.

The failure of these interventions (often taking the form of mass media campaigns) can be explained by the fact that they do not have a resonance with young people’s lived experiences, might increase normative beliefs (i.e. that drug use is normal and widespread), and that they do not target the factors that mostly impact on people’s decisions around drug use – fashion and perception of social norms, peer pressure or peer selection, emotional well-being, social and community equality, etc.

Investing in evidence-based drug prevention not only reduces the individual, family and community harms associated with illicit drug use, but it can also greatly reduce costs to society. A growing body of evidence over the last 20 years demonstrates that well-designed and targeted prevention efforts can lead to significant savings.

The key challenge for policy makers is therefore to develop and implement drug prevention programmes that are based on the available evidence of effectiveness and cost-effectiveness, that respond to local needs and contexts, and that are relevant and meaningful to the population(s) being targeted.

## Legislative/policy issues involved

### Setting realistic objectives for prevention interventions

The first challenge for policy makers is to establish clear objectives for what prevention interventions are seeking to achieve. A common misconception is that effective drug prevention need only consist of informing – generally warning – young people about the dangers associated with drug use. Prevention is
then often equated with scare tactics enshrined in mass media campaigns. However, there is currently no evidence to suggest that this approach has had an impact on drug use behaviours. On the contrary, some costly mass media programmes, in particular a well-evaluated cannabis mass media campaign in the USA, had no impact on levels of use, and was counterproductive for certain subgroups by giving the impression that cannabis use was more normal and widespread than it actually was.61

As stated above, one of the primary objectives of drug prevention is often to help people avoid or delay the initiation of drug use – or, if they have already started using drugs, to prevent their drug use from becoming problematic. However, in reality the challenge of prevention is much broader – it should aim to contribute to the positive engagement of children, young people and adults with their families, schools, workplaces and communities, and to build important life skills and capacities that will help individuals respond to multiple influences in their lives, such as social norms, interaction with peers, living conditions and their own personality traits.62

Available evidence collected over the past 20 years in the field of prevention offers a more complete understanding about:

• What makes people more vulnerable to experiencing problems with drug use – the so-called ‘risk factors’. These include personality traits, mental health problems, family neglect and abuse, poor attachment to school and the community, social norms and environments that reinforce drug use, and growing up in marginalised and deprived communities

• What makes people less vulnerable to experiencing problems with drug use – the so-called ‘protective factors’. These can include greater psychological and emotional well-being, greater personal and social competence, a stronger attachment to caring families, accessible economic opportunities, and schools and communities that are well resourced and organised.63

Some of the factors that make people vulnerable (or, in contrast, more resistant) to initiating drug use or experiencing problematic use differ according to age – with risk and protective factors evolving through infancy, childhood and early adolescence (e.g. family ties, peer pressure, etc.). At later stages of the age continuum, schools, workplaces, entertainment venues and the media may all contribute to make individuals more or likely to use drugs and engage in risky behaviours. Most importantly, there is a dynamic interaction of vulnerability factors at the personal (biological and psychological) and environmental (family, society, school, etc.) levels.

A significant reduction in the overall level of drug use in society is unlikely to be achieved through a prevention intervention alone. However, evidence shows that some prevention interventions have achieved positive results in delaying the onset of drug use and strengthening individuals’ ability to avoid drug problems.

Choosing the right prevention method

There are four broad categories of prevention interventions,64 some of which have proven more suitable than others in certain situations or for a specific group of people:
1. **Universal prevention – i.e. intervening with populations.** This is the broadest approach to prevention, targeting the general public without any prior screening for their risk of drug use. These interventions therefore assume that all members of the population are at equal risk of initiating use. Universal prevention interventions should target skills development and interaction with peers and social life, and can be implemented in schools, communities or workplaces. Available evidence shows that mass media campaigns are costly, and have not been effective at reducing levels of use, while often accentuating the already high levels of stigma experienced by people who use drugs. Nevertheless, some well-designed and well-funded universal prevention programmes targeting school children and using an interactive, skills-building approach have had some impact on levels of drug use (see Box 1).

2. **Selective prevention – i.e. intervening with (vulnerable) groups.** These interventions target specific sub-populations whose risk of starting using drugs or experiencing drug dependence is significantly higher than average. Often, this higher vulnerability to drug use stems from social exclusion (e.g. young offenders, school drop-outs, marginalised ethnic minorities, etc.) or from certain social contexts (youth in party settings). Selective prevention interventions therefore usually target the social risk factors (such as living conditions and social environment) that make this specific group more vulnerable to drug use. Available evidence shows that selective prevention interventions using multi-component, peer-led and interactive programmes focusing on teaching social and coping skills have showed a slight positive effect in delaying drug use initiation, as well as improving cognitive capabilities and self-worth (see Box 2).

3. **Indicated prevention – i.e. intervening with (vulnerable) individuals.** These programmes target high-risk individuals who are identified as being at greater risk of experiencing problems with drug use. Criteria for such risks might be mental illness, social failure, antisocial behaviour, hyperactivity and impulsivity. The aim of indicated prevention is not necessarily to prevent initiation of drug use, but rather to prevent the development of dependence. In this regard, prevention interventions are most effective when they seek to address those issues other than drug use by focusing on the social context and behavioural development of the targeted individual.

### Box 1 Universal prevention at school: The Unplugged programme

Unplugged is a school-based drug prevention programme which was developed Europe-wide and has been subject to a number of evaluations. The objective of the programme was to reduce the prevalence of use of illicit substances, alcohol and tobacco among youth, delay initiation and stop transition towards problematic use. The programme is based on a comprehensive social influence and interactive approach that includes training and the strengthening of social and coping skills. It consists of 12 one-hour long sessions delivered weekly by school teachers. The teachers were provided with a detailed handbook to guide them in the organisation of the sessions, including practical suggestions for communication, listening skills and promoting dialogue with the pupils. Teacher training was a crucial component of Unplugged to ensure a high-quality implementation of the programme.

The programme was evaluated between 2004 and 2007 in Austria, Belgium, Germany, Greece, Italy, Spain and Sweden, involving 143 schools and 7,079 pupils. The evaluation showed that Unplugged had reduced cannabis use – an effect which was prolonged over an 18-months follow-up period. Following the evaluation, Unplugged was reviewed and a second phase of the project included a revised teacher handbook, as well as redesigned cards to be used in the interactive sessions with the pupils.

4. **Environmental prevention – i.e. intervening with societies and systems.** These interventions and strategies are aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use. This perspective takes into account the fact that individuals do not become involved with drugs solely on the basis of personal characteristics, but rather that they are also influenced by a complex set of factors in their environment, what is expected or accepted in the communities in which they live, national legal contexts and the price, quality and availabil-
Searching family treasure was launched in 2004 in Portugal to reduce the family risk factors and increase family protective factors related to illicit drug use. The programme targeted vulnerable families with children aged 6 to 12 years old, and aimed to prevent drug use, but also delinquency, violence and mental health problems. It was composed of parent sessions, child sessions and family sessions. The objectives of the programme included:

- Decreasing parental use of harsh or inadequate discipline
- Improving parent/child relationships with better parenting skills
- Increasing parental supervision and monitoring
- Increasing family communication quality, strengths and resilience
- Decreasing children’s hyperactivity or inattention, emotional symptoms and peer problems
- Increasing children’s social behaviour.

The programme was organised around a family treasure hunt through which families learned and discovered their strengths and trained in parenting skills and children’s life skills – using attractive materials and activities including skills trainings, group discussions, role-play, comic books, games, storytelling, etc.

About 192 professionals were trained since 2004 and about 15 training programmes were implemented in Portugal, as well as one in Spain. An evaluation of the programme by the participants themselves showed that 57% of the children benefited/benefited greatly from the programme, and most parents reported implementing the skills gained in the programme back home. The families considered that the programme had improved their relationship with their children, increased their abidance to family rules, and reduced inattention problems. All parents reported being satisfied (37.5%), or very satisfied (65.5%), with the programme. In terms of impacts on substance use, while 91% of the participants consumed alcohol four or more times a week before the programme, upon its completion 62.5% of the parents reported total abstinence, 25% used alcohol once a month and only 12.5% consumed alcohol more than twice a month. Meanwhile, the perception of risks associated with illicit drug use largely increased among the children involved in the programme, and parents reported low levels of use for all substances among their children.

Enshrining prevention in broader health policies

Drug prevention is just one of the fundamental components of a health-centred drug policy, alongside harm reduction (see Chapter 2.4) and drug dependence treatment (see Chapter 2.5). In this respect, an effective drug prevention system should be:

- Embedded in – and never be a substitute for – a comprehensive and health-centred system of drug control focused on providing treatment and care for people who use drugs, and on preventing the health and social consequences of drug use (e.g. HIV/AIDS, hepatitis C, overdoses, marginalisation, etc.)
- Based on an understanding that not all drug use is problematic
- Based on the understanding of drug dependence as a complex health condition with a mix of biological, psychological and social causes
- Based on evidence of effectiveness and cost-effectiveness
- Mandated and supported at the national level by appropriate regulations and public health strategies: including national standards, training for practitioners, and requirements for schools, workplaces and health and social agencies to implement relevant prevention interventions.
Implementation issues involved

A series of minimum quality standards have been developed in the field of drug prevention, which can be useful to consider when designing and implementing a drug prevention programme (see Box 3).  

Among these quality standards, policy makers should consider several specific issues which are exposed below.  

Conducting a needs assessment of drug use and community needs

This is the first step to undergo for an effective prevention intervention, in order to gain a thorough understanding of the needs, local contexts and target populations or groups, and assessing how best to address them. This entails assessing drug use patterns among the general population and specific groups, using quantitative and qualitative data and studies. This data should be used to prioritise evidence-based programmes and carefully adapt prevention interventions when necessary to respond to new patterns of use and new socio-economic and cultural contexts. Risk and protective factors should be carefully studied, as well as other relevant issues, such as social marginalisation and inequalities. According to the EMCDDA, ‘A good understanding of the target population and its realities is a prerequisite for effective, cost-effective and ethical drug prevention’.

Box 3  The European drug prevention quality standards

The EMCDDA proposes a number of stages and components to ensure that drug prevention programmes are effective and of good quality.

These are exposed below:

1. Cross-cutting considerations:
   - Sustainability and funding
   - Communication and stakeholder involvement
   - Staff development
   - Ethical programme

2. Needs assessment:
   - Knowing drug-related policy and legislation
   - Assessing drug use and community needs
   - Describing the need and justifying the intervention
   - Understanding the target population

3. Resource assessment:
   - Assessing the target population and community resources
   - Assessing internal capacities

4. Programme formulation:
   - Define the target population
   - Use a theoretical model
   - Define aims, goals and objectives
   - Define the setting
   - Refer to evidence of effectiveness
   - Determine the timeline

5. Intervention design:
   - Design should respond to quality and effectiveness
   - Option of selecting an existing intervention
   - Tailor the intervention to the target population
   - Plan final evaluations

6. Management and mobilisation of resources:
   - Plan the programme
   - Plan financial requirements
   - Set up the team
   - Recruit and retain participants
   - Prepare the programme materials
   - Provide a project description

7. Delivery and monitoring:
   - Option of conducting a pilot intervention
   - Implementing the intervention
   - Monitoring the implementation
   - Adjusting the implementation

8. Final evaluations:
   - Option of conducting an outcome evaluation
   - Option of conducting a process evaluation

9. Dissemination and improvement:
   - Deciding whether the programme should be sustained
   - Disseminating information about the programme
   - Producing a final report
Some examples of quality standards:

- The main needs of the population are described, and if possible, quantified
- The organisation is aware of existing and recent drug prevention programmes
- The programme complements other health promotion or drug prevention programmes locally, regionally, and/or nationally
- The target population’s culture and perspectives on drug use are included in the needs assessment.

**Conducting a resource assessment**

Depending on their design and scale, prevention programmes can be very cheap or extremely expensive. It is therefore important to conduct an assessment to gain a better understanding of what can realistically be achieved within available resources (including staff and financial resources), and what the type and scope of the programme should be. In resource-poor settings, it is important to avoid rushing into eye-catching campaigns that show immediate action, but have little short- or long-term impact (such as mass media campaigns). In addition, the success or failure of a prevention programme largely depends on whether the target group and other relevant stakeholders are willing and able to take part in, or support, the programme and its implementation.

Some examples of quality standards:

- Sources of opposition to, and support of, the programme are considered
- The ability of the target population to participate in, or support, the programme is assessed
- Internal resources and capacities (i.e. human resources, organisational, technological, financial resources) are assessed.

**Evaluating the effectiveness and cost-effectiveness of prevention interventions**

Any drug prevention programme should include a scientific monitoring and outcome evaluation component to assess whether the prevention interventions being evaluated have achieved the desired outcome, and are evidence-based. In some cases, governments may choose to test the intervention first with a pilot project, which can help identify the practical issues and weaknesses of the project’s implementation. Once sufficient evidence is available around the impacts of the project, it can then be implemented on a broader scale after, if necessary, having been adapted to respond to any issues arising out of the pilot phase. While being carried out, the programme should be regularly monitored to help identify any need for modification. Outcomes and results should be carefully analysed on a regular basis to ensure that the programme is of high quality. The implementation of the programme should remain flexible to ensure that it can be adjusted in
line with the findings of the monitoring process. If such modifications are made, they should be well documented and evaluated to help understand their impact on the programme.

Some examples of quality standards:

- The intervention is implemented with high quality and an orientation towards participants
- The implementation of the intervention is adequately documented and adjusted if necessary
- Outcome and process data are collected frequently and reviewed frequently and systematically
- The conclusions of the evaluation indicate if and what elements of the programme need to be modified to complete the programme successfully
- Adjustments to the programme are well-justified and reasons for adjustments are documented.

Key resources

Key recommendations

- Harm reduction approaches and principles should be integrated across all areas of drug policy, and all services that work with people who use drugs – including across the health, social and security sectors.
- The UN-endorsed package of harm reduction interventions should be expanded to address harms other than HIV, and delivered to scale and in a way that is acceptable and accessible for people who use drugs.
- Governments and international donors should ensure sufficient funding to deliver the optimal harm reduction response. Funds should be diverted from punitive drug law enforcement practices and into harm reduction, where the returns on investments will be greater.
- Legal impediments to harm reduction and other health services (including an over-reliance on incarceration and repressive drug policies) should be removed. Law enforcement practices undermining harm reduction services should be addressed and rectified.
- Harm reduction should be delivered in a way that empowers communities and people who use drugs, and also meaningfully engages them in programme design, delivery and evaluation.
- Harm reduction programmes should ensure that they are gender-sensitive and accessible and relevant for young people who use drugs. This may require the creation of specialist services or programmes for women, young people and other specific groups.
- Harm reduction services must be made available in prisons and other closed settings, as well as in the community.

Introduction

Harm reduction has emerged as an evidence-based, highly effective and cost-effective response to drugs around the world in the last 30 years. This approach currently sits alongside other pillars of drug policy – such as demand reduction and supply reduction – and is distinct from these in that the primary focus is on reducing harms, even if this does not result in a reduction in the prevalence of drug use or the scale of the illicit drug market. Harm reduction is a pragmatic response to drug use that accepts that while abstinence may be a worthy goal, it may not be appropriate or desirable for some individuals.

Harm reduction has been best defined by Harm Reduction International as ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.’ In some contexts, this approach is referred to as ‘harm minimisation’ or ‘risk reduction.’

Harm reduction applies to all types of substances and drug use. Historically, it has been overwhelmingly associated with interventions aimed to reduce the health harms associated with the injection of opioids. This has resulted in a lack of attention for harm reduction interventions targeting other types of drugs and use – in particular stimulant use. As patterns of drug use and routes of administration are changing rapidly, there is an urgent need to redress this situation.

Harm reduction can most usefully be conceived as a set of principles rather than a list of interventions (see Box 1). It is both a public health and human rights concept, but also one that focuses on public safety and security: the harms to be targeted may include overdose, infections, over-incarceration, police violence, stigmatisation, marginalisation or harassment, to name just a few – while harm reduction should also seek to empower and engage people who use drugs in the formation, delivery and evaluation of policies and programmes.
The concept of harm reduction has been highly politicised in drug policy debates, with a large number of countries strongly in favour, some countries strongly against, and others preferring to refer to individual interventions rather than a harm reduction approach per se. Yet harm reduction is now widely endorsed and recommended by the UN General Assembly, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC), the Human Rights Council, the Global Fund, and many others. It is also endorsed in national policy documents in 91 countries, and such high-level endorsement (often through national HIV/AIDS policies) can be important for ensuring the funding and scale-up of these services.

Globally, the coverage of harm reduction services for people who inject drugs remains woefully inadequate: for example, just two needles are distributed per person who injects drugs per month, and only 8% of people who inject opioids had access to opioid substitution therapy (OST). In many settings, this is a consequence of a lack of political will to scale-up and endorse harm reduction programmes, and a global funding crisis for this approach. As highlighted above, people who use stimulants have even more limited access to harm reduction services that respond to their specific needs.

In some settings, the coverage of harm reduction is actively undermined by laws or law enforcement practice. For example, the delivery of needle and syringe programmes (which provide sterile injecting equipment to people who use drugs to prevent blood-borne virus transmission through the re-use of unsterile items) face severe barriers in countries where the possession of needles and syringes is deemed as evidence of drug use, or outlawed in its own right. Similarly, OST using methadone, buprenorphine or other medicines is prohibited in some countries. The WHO has therefore clearly stated that ‘Countries should work toward developing policies and laws that decriminalize the use of clean needles and syringes (and that permit NSPs) and that legalize OST for people who are opioid-dependent.’

Similar legislative reforms may also be required for other harm reduction interventions – including drug consumption rooms/safer injecting facilities, and pill or drug checking services. A wide range of UN agencies have now called for the decriminalisation of drug use in order to support harm reduction responses (see Chapter 3.1).

In many countries, harm reduction workers (especially peer and outreach workers) are also targeted by law enforcement for ‘promoting’ or ‘facilitating’ drug use, thereby undermining their ability to provide vital services to people who use drugs and those at risk of acquiring infections.

Legislative/policy issues involved

Available data and statistics clearly demonstrate the need for services and interventions which aim to protect the health and well-being of people who use drugs, prevent infections and prolong life, as well as policies to remove barriers to accessing health or justice.

Box 1 The principles of harm reduction

- Harm reduction is targeted at risks and harms
- Harm reduction is evidence-based and cost effective
- Harm reduction is incremental, acknowledging the significance of any positive change that individuals make in their lives
- Harm reduction is rooted in dignity and compassion, and consequently rejects discrimination, stereotyping and stigmatisation
- Harm reduction acknowledges the universality and interdependence of human rights
- Harm reduction challenges policies and practices that maximise harm – including criminalisation
- Harm reduction values transparency, accountability and participation.
Box 2 The Community Action on Harm Reduction (CAHR) Project

The CAHR project is an example of how harm reduction principles can be incorporated into a comprehensive programme. Funded by the Dutch Ministry of Internal Affairs (BUZA), via the International HIV/AIDS Alliance, the five-year project sought to expand access to harm reduction services for people who inject drugs in China, India, Indonesia, Kenya and Malaysia. The project was unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local stakeholders, and supporting international and national advocacy efforts to address the policy and structural barriers to programme sustainability.

By mid-2014, the project had reached 65,000 people who inject drugs and 240,000 further beneficiaries (such as sexual partners and family members). More than 13,000 people across the five countries have received voluntary HIV testing and counselling, 40,000 have benefited from psycho-social support, legal support, housing and/or income generation services, and 47,000 have been reached by sexual rights and health services. Furthermore, 90% of people who inject drugs reported the use of sterile injecting equipment the last time they injected.\(^9\)

The CAHR project also places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce or improve essential harm reduction interventions. In Kenya, for example, the project was instrumental in starting needle and syringe programmes (NSPs) and OST – despite major challenges from police crackdowns and some religious and community leaders.

CAHR also has a strong policy agenda that is defined by the pragmatic objective of developing effective HIV and drug use services based on available evidence. Experiences of the project on the ground are captured to influence policy debates both at the national and international level. Finally, CAHR objectives include the full and meaningful participation of people who use drugs in policy and programme design and a strong commitment to protecting and promoting human rights – for example, the project enabled the establishment of the Kenyan Network of People who Use Drugs.\(^9\)

It has been widely acknowledged that this list of interventions is not exhaustive. We therefore propose a number of additional evidence-based interventions (interventions 10 to 21 below) – although even this list is not comprehensive as harm reduction is forced to evolve to respond to new patterns of use and harms.

This list is predominantly focused on people who inject drugs and on HIV. However, in an effort to respond to the urgent need to elaborate better harm reduction responses for non-opioid and non-injecting drug use (for instance cocaine and ATS use,\(^9\) as well as the non-medical use of some pharmaceutical medications), we propose a set of harm reduction interventions specifically targeted at stimulant use (interventions 19 to 21).

1. **Needle and syringe programmes:** The supply of sterile injecting equipment (including needles and syringes, but also filters, spoons, cleaning swabs and sterile water) to reduce the spread of infections.\(^9\) Clients are also encouraged to return
their used equipment to allow for their safe disposal, and should be provided with information and education on safer injecting techniques. NSPs have a very strong evidence base in terms of reducing HIV transmission, risk behaviours such as syringe sharing, and helping to signpost individuals into drug treatment where required.97

2. **OST and other drug dependence treatment:**

WHO Essential Medicines such as methadone or buprenorphine can be used to substitute street opioids such as heroin – either in the long term (referred to as ‘maintenance’ therapy) or the shorter term. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) for this purpose, particularly to patients who have not responded to the other medicines available. This heavily-researched intervention has been proven to reduce injecting, reduce criminality, support adherence to HIV, hepatitis C and tuberculosis99 treatment, and improve overall health and well-being.100 For more information, see Chapter 2.5.

3. **HIV testing and counselling:**

This is targeted specifically at people who use drugs – but always on a voluntary and confidential basis, and ideally tied to efforts to connect newly diagnosed individuals to accessible care and treatment services.

4. **Antiretroviral therapy:**

People who use drugs should have the same access to HIV treatment, following the same recommendations as for all adults.101 In practice, they are often discriminated against or perceived as likely to fail on treatment – yet when treatment is provided in a supportive environment, people who use drugs have similar outcomes to everyone else.102-103

5. **Prevention and treatment of sexually transmitted infections:**

For people who use drugs and their sexual partners, particularly because such infections – especially those that cause genital lesions – may increase the risk of HIV transmission.

6. **Condom distribution:**

Targeted at people who use drugs and their sexual partners.

7. **Targeted information, education and communication:**

Including safer injecting advice (also known as ‘behaviour change communication’). It is important to provide credible information on the effects and harms associated with different substances, as well as objective information about different routes of drug administration. Information, education and communication should be up-to-date and adapt to changing patterns of drug use and purchase – for example, the trend in some countries towards online drug sales provides opportunities for the provision of harm reduction advice through online forums and customer reviews.

8. **Vaccination, diagnosis and treatment of viral hepatitis:**

The vaccine for hepatitis B is highly effective and should be made available to all people at risk, including people who use drugs, prisoners and harm reduction workers. There have been major advances in treatment for hepatitis C, which is a curable disease regardless of a person’s drug use.104

9. **Prevention, diagnosis and treatment of tuberculosis:**

People who use drugs are at heightened risk of tuberculosis (and multi-drug-resistant tuberculosis) for a range of reasons – from frequent incarceration to the
compromised immune systems associated with HIV infections.

10. Basic health services, including overdose prevention and management:106 Overdose is a common experience for many people who use drugs, and a leading cause of death among people who inject drugs. Harm reduction programmes include the provision of naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Box 3). Services may also focus on resuscitation techniques, and advice on how to prevent overdose in the first place. Additionally, medical amnesties and ‘good Samaritan’ laws in many countries help to protect people who respond to overdoses from potential liability, increasing the likelihood of life-saving interventions.

11. Services for people who are drug dependent or using drugs in prison or detention: The whole suite of harm reduction services should be made available in prisons and other closed settings, just as in the community. Yet only eight countries have NSPs in prison (compared to 90 countries with community programmes), and only 43 countries provide OST in prison settings (compared to 80 countries with community programmes). For more information, please refer to Chapter 3.6.

12. Advocacy: This is identified by UNAIDS as one of the ‘critical enablers’ for an effective HIV response, and covers a wide range of interventions promoting and protecting the health and human rights of people who use drugs, and other affected populations. A key part of this is advocacy for drug policy reform and for harm reduction services.107 Efforts to reduce the stigma associated with drug use are also crucial to remove key barriers faced by people who use drugs (see Box 4).

13. Psychosocial support: In order to meet the needs of people who use drugs, services should also be able to provide – or help clients to access – mental health, social and financial services where they are required. Psychiatric disorders such as depression, stress and post-traumatic stress disorder are more prevalent among drug using populations.108 New York’s Lower East Side Harm Re-
Box 4 Support Don’t Punish: A global show of force for harm reduction and policy reform

The ‘Support. Don’t Punish’ campaign\textsuperscript{109} is a global advocacy initiative calling for greater investments in the harm reduction response, and for the reform of ineffective drug policies. First conceived as part of the CAHR project (see Box 2), the campaign comprises independent branding, an interactive website featuring open-access resources, social media presence,\textsuperscript{110} an Interactive Photo Project where more than 7,000 supporters around the world have taken part,\textsuperscript{111} and a ‘Global Day of Action’. For the latter, advocacy efforts are focused on 26 June – the United Nations Day Against Drug Abuse and Illicit Trafficking – with the aim of reclaiming the media, the public narrative and the political discourse on this high-profile day. On 26 June 2015, activists in 160 cities around the world organised a wide variety of local actions – all using the ‘Support. Don’t Punish’ branding and messaging to raise awareness of the campaign issues, in particular allocating more funding for harm reduction, scaling up services, and removing political and legislative barriers to ensure better access.\textsuperscript{112}

14. Access to justice/legal services: As an almost universally criminalised population, people who use drugs often find themselves in confrontation with the criminal justice system. They may also be subject to human rights abuses, police abuse, mistrial and harassment. It is important, therefore, that they have access to legal support. For example, Release is a UK charity focused on drug laws and human rights, which provides a free helpline for people who use drugs to access confidential expert legal advice and support.\textsuperscript{114}

15. Children and youth programmes: Although many young people use drugs, most services are designed for adults and may not even be legally allowed to provide services to people under the age of 18 with services such as NSPs. Many other barriers exist that prevent young people from accessing harm reduction services, including parental consent in some countries. Yet many successful youth-oriented harm reduction programmes exist. For example, Vancouver’s Crystal Clear harm reduction project provides peer outreach, support and leadership development, harm reduction education and health services, to support young people who use methamphetamine.\textsuperscript{115}

16. Livelihood development/economic strengthening: This includes education, training and financial support for people to access employment, and micro-financing programmes to support people in generating legitimate incomes.

17. Drug consumption rooms/safer injecting facilities:\textsuperscript{116} These supervised facilities allow people to bring their pre-purchased drugs to be injected, smoked and/or snorted in a sterile, safe environment. The presence of medically trained staff ensures that overdoses and oth-
er health problems can be addressed quickly and effectively. As of 2015, there were 86 drug consumption rooms across seven European countries, plus additional services in Sydney, Australia and Vancouver, Canada. Despite many years of operation, and millions of injections overseen, there has never been a fatal overdose in these supervised facilities. The effects extend beyond the facilities themselves: deaths in the neighbourhood around Insite, Vancouver’s injection facility, dropped by 35% in the year after it opened. In Switzerland, drug consumption rooms have also drastically reduced levels of disturbance in the surrounding public areas.

18. Gender-sensitive services: Women who use drugs often face greater stigma, discrimination and risks than men, and their needs may differ significantly. For example, gender-sensitive harm reduction services are those which provide, or make alternative arrangements for childcare, the prevention of mother-to-child HIV transmission, family counselling and support, programmes to reduce gender-based violence, sex work services, female condoms, and women-only spaces and/or times.

19. Drug checking: In response to the harms associated with stimulant use and the emergence of a diverse array of NPS, drug checking has

Box 5 The Braços Abertos Programme in Sao Paulo

The ‘Braços Abertos’ (Open Arms) programme aims to address the significant health, social and security problems in Cracôlandia, a large open crack scene in Sao Paulo, Brazil. Launched in 2013, it is targeted at homeless people who use crack in the area. It provides housing in hotels contracted by the government, and offers access to healthcare, employment, clothing and one meal a day – without requiring abstinence from crack use. It is an example of a ‘Housing First’ approach – the objective being to support people with their drug problems by providing stable housing, hence enabling people to reduce a variety of harms associated with life on the street.

The ‘Braços Abertos’ programme required coordination across several municipal departments (health, culture, education, social welfare, environment, labour and human rights), as well as close partnerships with civil society groups. It seeks to strengthen social networks and encourage the participation and support of society. Since its creation, the programme has empowered participants to return to their families, gain formal employment or adhere to health treatments – and the Brazilian government has announced plans to scale up the approach in 21 cities.
emerged to help people know what they are consuming, and avoid using unknown and potentially dangerous adulterants. This service also assists emergency medical staff and public health agencies in identifying trends in illicit drug markets to better tailor their harm reduction and treatment response. Organisations such as DanceSafe in North America provide drug checking services directly at electronic music events, with the cooperation of local public health departments.122

20. Distribution of smoking paraphernalia: Crack use continues to be associated with various health problems, including blisters, sores, cuts on the lips and gums, as well as HIV and hepatitis C infections. Harm reduction groups in Canada have recently promoted the distribution of sterile crack smoking paraphernalia which include glass pipes (which are heat-resistant and shatterproof), mouthpieces, filters, alcohol swabs, screens and push sticks.123

21. Social support services: Other relevant harm reduction services include housing, shelter and employment services (see Box 5).

Key resources

Drug dependence treatment

Key recommendations

- The primary objective of treatment systems for drug dependence should be to enable individuals to enhance autonomy and live fulfilling lifestyles.
- Although abstinence may be a worthy goal, it may not be achievable or appropriate for some individuals, who should be given the right to remain under substitution therapy should they wish to do so, and as long as they deem it to be necessary.
- Policy makers should make a long-term investment in treatment, in order to adequately respond to drug dependence and reduce its associated health and social costs.
- Investments in drug dependence treatment should demonstrate a systemic approach rather than a w of isolated interventions: it should identify those most in need of treatment; offer a balanced menu of evidence-based services; and develop smooth mechanisms for individuals to move between different elements as their circumstances change.
- Approaches that breach human rights standards (such as the compulsory detention of people who use drugs) should not be implemented. Not only are these unethical, they are also highly unlikely to achieve the desired aims and are not cost-effective.
- More research should be conducted on the treatment of stimulant dependence.
- It is necessary to constantly review and evaluate national treatment systems to make sure that they are operating effectively and in accordance to global evidence. Services can be made more effective and responsive if they include the meaningful involvement of clients in their design and delivery.

Introduction

There is an increasing trend to view drug dependence in health terms rather than as a criminal and/or moral problem. Recent estimates suggest that in 2013, approximately 246 million adults used controlled drugs for non-medical purposes (range 162 to 329 million). Of this total, just one in ten (approximately 27 million adults), were estimated to be dependent on drugs.

Evidence-based drug dependence treatment has proved effective in managing drug dependence, reducing drug-related harms and minimising social and crime costs. Available data demonstrate that opioid substitution therapy (OST) improves retention in treatment and reduces illicit opioid use, thereby reducing the incidence of injecting, and consequently exposure to blood-borne viruses such as HIV and hepatitis C. However, only one in six people dependent on drugs has access to evidence-based drug treatment. In view of this situation, access to OST should be scaled up to address the unmet need that currently exists worldwide.

The range of drugs available is itself increasing, and a model effective for one (for example opioids) may not be effective for another (for example crack, methamphetamines, etc.). There is therefore an urgent need to give more prominence and attention to substitution treatment options for other substances, in particular stimulants. Indeed, pilot studies on the treatment of methamphetamine dependence using dexamphetamine, as well as on the use of cannabis to reduce crack dependence, have shown promising results.

There is a clear economic case for expanding investments in drug dependence treatment, as investments can lead to large-scale savings in health, social and crime costs. A 2010 study by the UK Home Office estimated that for every £1 (US$1.40) spent on drug dependence treatment, society benefits to the tune of £2.50 (US$3.60). Research in the USA has estimated that the benefit return for methadone maintenance treatment is around four times...
Drug dependence, no single approach to treatment is likely to produce positive outcomes across society. Therefore, policy makers should work towards a treatment system that encompasses a range of models that are closely integrated and mutually reinforcing – and that takes into account the choice and preferences of the person accessing treatment. The impact of the legal and physical environment means that effective treatment interventions should offer both medications and psychosocial services, while taking into account the impact of the social and cultural setting in which they do so. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

Legislative/policy issues involved

International obligations

The obligation on UN member states to provide drug treatment to their citizens is embedded in the international drug control conventions. Under Article 38 of the 1961 Single Convention on Narcotic Drugs, and article 20 of the 1971 Convention on Psychotropic Substances, signatory states are required to take practical measures for ‘the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved’.

Moreover, the right to treatment is included in the more general obligations relating to the right to the enjoyment of the highest attainable standard of physical and mental health (‘the right to health’). The right to health was first articulated in the Constitution of the World Health Organisation in 1946, and mentioned in the Universal Declaration of Human Rights two years later. These are foundational documents in the UN system, and the inclusion within them of the right to health demonstrates the importance with which the concept is endowed in international law. The preambles to the UN drug control conventions reinforce these principles; the first words of the 1961 Convention and the 1971 Convention express member states’ concern ‘with the health and welfare of mankind’. And, as the former High Commissioner for Human Rights stated: ‘Individuals who use drugs do not forfeit their human rights.’

Ensuring access to essential medicines for OST

Both methadone and buprenorphine are included in the WHO Model List of Essential Medicines. According to human rights treaties within which the right to health is protected, such as the International Covenant
An estimated 5% of opioid users in substitution treatment do not respond well to treatment with methadone. They are often among the most marginalised of people who use drugs and may experience a range of severe health and psychosocial problems. This may result in high costs in terms of welfare and engagement with the criminal justice system.

In the UK, there is a history of prescribing injectable heroin to people dependent on opioids. However, in the 1960s and 1970s, this practice became politically controversial, mainly because people collected take-away doses from pharmacies, with very little supervision. It is probable that this prescribing fed an illicit market. By the mid- to late-1970s, the prescribing of heroin ceased almost entirely. Nonetheless, there continued to be an unmet therapeutic need among a highly vulnerable section of people dependent on drugs, who did not progress with methadone and tended to purchase and use illicit supplies of heroin in addition to, or instead of, their methadone doses.

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

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

A recent systematic review and meta-analysis of randomised controlled trials with HAT has been carried out by some of the researchers involved in these trials. Those reviewed were carried out in Canada, Germany, the Netherlands, Spain, Switzerland and the UK. The research concluded that ‘heroin-prescribing, as a part of highly regulated regimen, is a feasible and effective treatment for a particularly difficult-to-treat group of heroin-dependent patients’.

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Box 1 Heroin-assisted treatment (HAT) - the UK example

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on Economic, Social and Cultural Rights, the medicines that signatory states are obliged to make available must be ‘scientifically and medically appropriate’.

In countries such as the Netherlands, the UK and Switzerland, governments have developed successful treatment programmes providing a large range of options, including substitution with methadone and buprenorphine, but also with morphine and heroin (see Box 1). It is essential that drug laws and policies be reviewed to ensure adequate access to these substances for OST.

In some countries, however, people who use drugs have lost their fundamental right to health. In Russia, Turkmenistan and Uzbekistan, for instance, the use of methadone is prohibited by law. This is despite the fact that the United Nations Office on Drugs and Crime (UNODC) estimates that 2.29% of the adult population of Russia are injecting drugs. A third of the global total of people who inject drugs living with HIV reside in Russia. The proportion of Russian AIDS cases linked to injecting drug use is estimated at 65%, while around 35% of people who inject drugs are living with HIV. The country is subject to epidemic levels of both injecting drug use and HIV, yet the availability of the treatment with the most extensive evidence base, OST, is blocked by the Russian government. In other countries where methadone is available, buprenorphine remains illegal, as is the case in Mauritius – leaving limited treatment options for people dependent on opioids.

Ending compulsory detention

In many countries, treatment systems for drug dependence are non-existent or under-developed, or pursue models inconsistent with human rights standards and global evidence of effectiveness. Research, experience and international human rights instruments indicate that certain treatment practices should not be implemented. Some governments, for example, have introduced treatment regimes that rely on coercion, ill-treatment, denial of medical care, or forced labour.

In China and South East Asia, including in Vietnam, Cambodia, Malaysia, Thailand and Lao People’s Democratic Republic, the use of compulsory centres...
for drug users (CCDUs) as a mode of rehabilitation is a widely accepted and common practice. The use of compulsory detention is also found in Latin America and Central Asia.

CCDUs are generally run by the police or military rather than health authorities, and people caught using drugs are forced to stay in such facilities, frequently without due legal process or judicial oversight, sometimes for several years. They are denied scientific, evidence-based drug treatment, and can be subjected to forced labour, which is either unpaid or paid well below minimum wage levels, as well as a range of punishment such as physical, psychological and sexual abuse, and solitary confinement. General medical healthcare is often non-existent, and diseases such as HIV and tuberculosis are widespread among detainees.

CCDUs are also very costly and ineffective. Relapse rates are very high (in Vietnam, for example, from 80% to 97%) and detainees face challenges with social reintegration largely due to the stigmatisation associated with being detained for using drugs. Although certain governments in the region have recently introduced new drug laws that have modified the status of people who use drugs from ‘criminals’ to ‘patients’, such as China’s 2008 Anti-Drug Law and Thailand’s 2002 Narcotic Addict Rehabilitation Act, the humanitarian rhetoric of these legal texts is unrepresentative of the reality of life in the compulsory centres, which impose cruel and dangerous punishments under the guise of treatment. These conditions violate scientific and medical standards, as well as international human rights law.

In 2012, a joint statement supported by 12 UN agencies called for the closure of compulsory detention centres on the grounds that they violate human rights and threaten the health of detainees. The UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have since run a series of consultations on compulsory centres. The third consultation took place in September 2015, and was attended by drug control, health and finance officials from Cambodia, China, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand and Vietnam. These countries agreed to sign up to a ‘roadmap’ toward evidence-based support services for people who use drugs.

Nonetheless, there is a clear need to accelerate national-level transitions to voluntary, community-based drug dependence treatment and support services, which require corresponding reforms to drug laws and policies in order to remove incarceration and other punitive responses for people who use drugs. Although the process may be a slow one, the UN and civil society stakeholders have worked hard to develop guidance and recommendations on the way forward, and elements of community-based treatment have already been established in Cambodia, China, Indonesia, Malaysia, Thailand and Vietnam.
wishing to access treatment. Moreover, treatment programmes should be thoroughly integrated with prevention and harm reduction services, and have effective linkage(s) with criminal justice, public health and social welfare services.

**Entering a treatment programme**

There are a number of potential routes through which a person can approach treatment services without falling into the trap of coercive treatment models or compulsory detention:

- **Self-referral** – Sufficient information should be available for people to be aware of the range of treatment services available
- **Identification through general health and social service structures** – Existing healthcare and social services will often be in an excellent position to recognise symptoms of drug dependence and encourage the person to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role, provided they have sufficient training on drugs and drug dependence
- **Identification through specialist drug advice centres or street outreach services** – These services can offer food, temporary housing, low-threshold harm reduction services, and mechanisms to refer people to drug treatment programmes on a voluntary basis
- **Identification through the criminal justice system** – Through the illicit nature of their drug use, and the need to fund it, people dependent on drugs may come into contact with the criminal justice system. A range of referral schemes can be established to offer people dependent on drugs who have committed low-level offences opportunities to attend a treatment programme (see Chapter 3.4 for more information).

**Implementation issues involved**

The complexity of drug dependence is such that the response, setting and intensity of treatment need to be tailored to each person. It is therefore essential that a comprehensive menu of services is made available to suit the differing characteristics, needs, preferences and circumstances of each person.

**Treatment methods**

Multiple methods of evidence-based treatment should be available, ranging from substitution therapy to psychosocial support and abstinence-oriented approaches, so that those seeking treatment may select the most appropriate form for themselves. When the treatment method chosen is substitution therapy, it is essential that medical staff providing the treatment be adequately trained, and that the dosage of the substitution drug is adequate for the needs of the client.

As the range of substances being used is expanding – and the demand for treatment for stimulant dependence is increasing – governments and
scientists are now playing catch-up to develop effective systems of treatment for methamphetamines (see Box 3), crack (see Box 4), and new psychoactive substances (NPS). Some countries have established extensive treatment systems over many decades, while others are just starting to develop experience and understanding of this policy area. However, all countries have some way to go to achieve a sufficiently integrated range of treatment services for drug dependence that makes effective use of available resources to maximise health and social gains.

Treatment success and recovery should not be understood only as abstinence from drug use. Recovery encompasses any positive step or change that leads to the improvement of the person’s health, well-being and overall quality of life. This is particularly true for people under substitution therapy, but also for people who have learned to control their drug use in order to minimise the health and social harms associated with it (for example, see Box 4). Recovery is therefore incremental, and it is up to each individual to decide what their goal towards recovery will be within their treatment programme.

**Treatment setting**

As well as offering a variety of evidence-based interventions, an effective treatment system should also deliver interventions in a range of environments. Treatment can be community-based (such as regular attendance at a clinic where clients receive prescribed medications, psychosocial support and counselling, etc.), residential, or delivered in other health services such as drop-in centres or harm reduction facilities. It is difficult to be prescriptive about which should receive the greatest emphasis, as this will vary according to the particular needs of the person, available resources, and the availability of trained medical professionals – for maximum coverage, a combination of all of these settings constitutes the best option. Community settings tend to be less costly in resource-constrained environment, and may be more appropriate where there is strong social, family and community support for the person dependent on drugs. However, it can sometimes be better for the client to be treated away from their home area when these supports are absent. Such decisions should be made on an individual basis, by the client and therapist working in partnership, as part of a care plan. The chain of care should be thoroughly integrated – as clients may wish to move across all three of these settings during their treatment programme, according to their needs.

**Box 3 Treatment for amphetamine-type stimulants**

Methamphetamine and other ATS are the second most widely used drugs globally, after cannabis. These stimulants can be associated with considerable levels of health harms, including psychological problems and medical complications, many of which can be severe in the case of heavily dependent use. Current treatment for ATS use is predominantly behavioural, with cognitive behavioural therapy amongst the most frequently given treatments.

Substitution therapies are not widely available to people who use ATS, as the evidence base remains nascent. Many prescribed psychostimulant substances have been proposed and utilised, including modafinil and dexamphetamine. In addition, dopamine agonists, anticonvulsants, antidepressants and antipsychotics have been used in trials of treatments for amphetamine. In Melbourne, Australia, dexamphetamine was prescribed in a supervised setting to a group of long-term ATS injectors. They reported that dexamphetamine reduced their drug cravings, and alleviated the symptoms of withdrawal. Approximately half became abstinent, according to self-report (although no urine analysis was carried out to confirm the abstinent status).

However, it is highly unlikely that a single substitute will be found suitable for treatment of the diverse range of ATS on the market. With ATS now a global commodity with prolific individual and social harms, it is important for researchers, pharmaceutical manufacturers and governments to cooperate in the urgent identification of new substitution treatments for ATS and other substances, such as cocaine.

**Effective aftercare support**

Many people dependent on drugs are economically vulnerable and socially excluded, mainly because of the high stigma and discrimination resulting from the criminalisation of drug use (see Chapter 3.1). A crucial objective of treatment is to improve people’s engagement in society. This means raising levels of education, facilitating access to employment and housing, and offering other social support. A key element of this process is the strengthening of so-
The engagement of people who use drugs – current and former – in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services. The goal of drug treatment should be, if possible, to assist a person dependent on drugs to achieve a high level of health and well-being. In this context, it is necessary to recognise that some people may find it impossible or undesirable to attain abstinence. However, this needs not preclude the main objective of treatment, that of helping clients to live happily and productively. Indeed, many people who are dependent on opioids are perfectly able to successfully achieve this while remaining on OST.

Key resources


Box 4 Evidence for crack dependence treatment: The case for medical cannabis

In Brazil, the use of crack is associated with a number of health and social harms, including marginalisation, violence, increased vulnerability to HIV, or involvement in petty crime and sex work. The lack of adequate harm reduction and treatment measures offered by the government has led people using crack to develop their own strategies for minimising these harms, in particular cravings and psychosis. Such measures have included combining crack use with cannabis.161

A 2015 qualitative study using interviews among 27 Brazilian people combining cannabis and crack consumption showed that this technique reduced craving for crack, improved people’s sleep and appetite, and ‘protected’ them from the violence often associated with crack culture in the country – therefore improving their overall quality of life.162 A 1999 study among 25 young men dependent on crack in Brazil showed similar results – 68% of those involved in the study stopped using crack and reported that cannabis use had reduced craving symptoms.163

The local government in Bogota, Colombia introduced a similar initiative in 2013 in an effort to assess whether cannabis use could alleviate the harms associated with crack use.229 Uruguay is also considering the use of medicinal cannabis for people dependent on cocaine and pasta base.165

Social and community ties. The engagement of people who use drugs – current and former – in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services.

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Chapter 2 – endnotes


5. Figure taken from: West Africa Commission on Drugs (2014), Not just in transit: An independent report of the West Africa Commission on Drugs, http://idpc.net/publications/2014/06/njit.html


25. Ibid


27. Ibid

28. Ibid

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54. Ibid


56. Communication with Dr. Zipporah Ali, Executive Director of the Kenya Hospice and Palliative Care Association, September 2015.


63. See: http://www.emcdda.europa.eu/topics/prevention


67. More information about Unplugged, as well as the tools, activities and various projects, can be found on the EU-Dap website: www.eudap.net


72. Ibid


80. Ibid


82. Ibid

83. Ibid


85. See, for example: http://booksofauthorities.info/


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103. International Drug Policy Consortium & Eurasian Harm Reduction Interventions 10 to 16 were elaborated as part of a broader pack - New York City Department of Health and Mental Hygiene (2010), [link]


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113. For more information, visit the Support. Don’t Punish campaign [website: http://supportdontpunish.org/]

114. For example: [link]

115. For more information, visit: [link]

116. See the Release website at: [link]

117. Vancouver Coastal Health (2006), Crystal Clear: A practical guide for working with peers and youth, [link]

118. For more information, visit: [link]


120. See: Croisier, J. (2 December 2014), ‘Brácos Abertos in Sao Paulo, what can we learn from the Housing First model?’, IDPC Blog, [link]


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123. See, for instance: National Post (30 December 2011), Vancouver health body begins free crack pipe program for addicts, [link]

124. See: Croisier, J. (2 December 2014), ‘Brácos Abertos in Sao Paulo, what can we learn from the Housing First model?’, IDPC Blog, [link]

125. For more information, see: [link]


128. Ibid, as observed by the UNODC, many people dependent on drugs ‘who would be motivated to treatment but do not find accessible well equipped treatment facilities in their neighbourhood are de facto condemned to remain in a condition of dependence and to perpetuate their dependence in social exclusion’ See: United Nations Office on Drugs and Crime (2009), Reducing the adverse health and social consequences of drug abuse: A comprehensive approach, [link]

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132. National Treatment Agency for Substance Misuse (2010), A long-term study of the outcomes of drug users leaving treatment, [link]


135. The texts of the 3 UN drug control treaties are available here: [link]

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143. Ibid


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165. BBC Mundo (25 March 2013), Bogotá quiere de aliada a la marihuana, http://www.bbc.com/mundo/noticias/2013/03/130322_colombia_marihuana_combate_adicciones_bogota_aw.shtml#reports