

An alternative to the war on drugs

Stephen Rolles argues that we need to end the criminalisation of drugs and set up regulatory models that will control drug markets and reduce the harms caused by current policy

Consensus is growing within the drugs field and beyond that the prohibition on production, supply, and use of certain drugs has not only failed to deliver its intended goals but has been counter-productive. Evidence is mounting that this policy has not only exacerbated many public health problems, such as adulterated drugs¹ and the spread of HIV and hepatitis B and C infection among injecting drug users, and has created a much larger set of secondary harms

“Non-medical drug markets can remain in the hands of unregulated criminal profiteers or they can be controlled and regulated by appropriate government authorities”

associated with the criminal market. These now include vast networks of organised crime, endemic violence related to the drug market,² corruption of law enforcement and governments, militarised crop eradication programmes (environmental damage, food insecurity, and human displacement), and funding for terrorism and insurgency.^{3,4}

These conclusions have been reached by a succession of committees and reports including, in the United Kingdom alone, the Police Foundation,⁵ the Home Affairs Select Committee,⁶ the prime minister’s Strategy Unit,⁷ the Royal Society of Arts,⁸ and the UK Drug Policy Consortium.⁹ The United Nations Office of Drugs and Crime has also acknowledged the many “unintended negative consequences” of drug enforcement,¹⁰ increasingly shifting its public rhetoric away from its former aspirational goals of a “drug free world,” towards “containment” of the problem at current levels.

Problems of prohibition

Despite this emerging consensus on the nature of the problem, the debate about how policy can evolve to respond to it remains driven more by populist politics and tabloid headlines than by rational analysis or public health principles.

The criminalisation of drugs has, historically, been presented as an emergency response to an imminent threat rather than an evidence based health or social policy intervention.¹¹ Prohibitionist rhetoric frames drugs as menacing not just to health but also to our children, national security, and the moral fabric of society itself. The prohibition model is positioned as a response to such threats,^{12,13} and is often misappropriated into populist political narra-

tives such as “crackdowns” on crime, immigration, and, more recently, the war on terror.

This conceptualisation has resulted in the punitive enforcement of drug policy becoming largely immune from meaningful scrutiny.¹⁴ A curiously self justifying logic now prevails in which the harms of prohibition—such as drug related organised crime and deaths from contaminated heroin—are conflated with the harms of drug use. These policy related harms then bolster the apparent menace of drugs and justify the continuation, or intensification, of prohibition. This has helped create a high level policy environment that routinely ignores or actively suppresses critical scientific engagement and is uniquely divorced from most public health and social policy norms, such as evaluation of interventions using established indicators of health and wellbeing.

Despite this hostile ideological environment, two distinct policy trends have emerged in recent decades: harm reduction¹⁵ and decriminalisation of personal possession and use. Although both are nominally permitted within existing international legal frameworks, they pose serious practical and intellectual challenges to the overarching status quo. Both have been

driven by pragmatic necessity: harm reduction emerging in the mid-1980s in response to the epidemic of HIV among injecting drug users, and decriminalisation in response to resource pressures on overburdened criminal justice systems (and, to a lesser extent, concerns over the rights of users). Both policies have proved their effectiveness. Harm reduction is now used in policy or practice in 93 countries,¹⁶ and several countries in mainland Europe,^{17,18} and central and Latin America have decriminalised all drugs, with others, including states in Australia and the United States, decriminalising cannabis.¹⁹

Decriminalisation has shown that less punitive approaches do not necessarily lead to increased use. In Portugal, for example, use among school age young people has fallen since all drugs were decriminalised in 2001.²⁰ More broadly, an extensive World Health Organization study concluded: “Globally, drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones.”²¹

Similarly US states that have decriminalised cannabis do not have higher levels of use than those without. More importantly, the Netherlands, where cannabis is available from licensed premises, does not have significantly different levels of use from its prohibitionist neighbours.¹⁹

New approach

Although these emerging policy trends are important, they can be seen primarily as symptomatic responses to mitigate the harms created by the prohibitionist policy environment. Neither directly tackles the public health or wider social harms created or exacerbated by the illegal production and supply of drugs.



Drug use in Russia: see the video at bmj.com/video

The logic of both, however, ultimately leads us to confront the inevitable choice: non-medical drug markets can remain in the hands of unregulated criminal profiteers or they can be controlled and regulated by appropriate government authorities. There is no third option under which drugs do not exist. The choice needs to be based on an evaluation of which option will deliver the best outcomes in terms of minimising the harms, both domestic and international, associated with drug production, supply, and use. This does not preclude reducing demand as a legitimate long term policy goal, rather it accepts that policy must also deal with the reality of current high levels of demand.

A historical stumbling block in this debate has been that the eloquent and detailed critiques of the drug war have not been matched by a vision for its replacement. Unless a credible public health led model of drug market regulation is proposed, myths and misrepresentations will inevitably fill the void. So what would such a model look like?

Transform's blueprint for regulation²² attempts to answer this question by offering different options for controls over products (dose, preparation, price, and packaging), vendors (licensing, vetting and training requirements, marketing and promotions), outlets (location, outlet density, appearance), who has access (age controls, licensed buyers, club membership schemes), and where and when drugs can be consumed. It then explores options for different drugs in different populations and suggests the regulatory models that may deliver the best outcomes (box). Lessons are drawn from successes and failings with alcohol and tobacco regulation in the UK and beyond, as well as controls over medicinal drugs and other risky products and activities that are regulated by government.

Such a risk guided regulatory approach is the norm for almost all other arenas of public policy, and in this respect it is prohibition, not regulation, that can be viewed as the anomalous and radical policy option.

Moves towards legal regulation of drug markets depend on negotiating the substantial institutional and political obstacles presented by the international drug control system (the UN drug conventions). They would also need to be phased in cautiously over several years, with close evaluation and monitoring of effects and any unintended negative consequences.

Rather than a universal model, a flexible range of regulatory tools would be available with the more restrictive controls used for more risky products and less restrictive controls for lower risk products. Such differential application of regulatory controls could additionally help create a risk-availability gradient. This holds the potential to not only reduce harms associated with illicit supply and current patterns of consumption but, in the longer term, to progressively encourage use of safer products, behaviours, and environments. Understanding of such processes is emerging from "route transition" interventions aimed at encouraging injecting users to move to lower risk non-injecting modes of administration by, for example, providing foil for smoking.²³ This process is the opposite of what has happened under prohibition, where a profit driven dynamic has tended to tilt the market towards ever more potent (but profitable) drugs and drug preparations, as well as encouraging riskier behaviours in high risk environments.

The oversight and enforcement of new regulations would largely fall within the remit of existing public health, regulatory, and enforcement agencies. Activities that take place outside the regulatory framework would naturally remain prohibited and subject to civil or criminal sanctions.

Regulation is no silver bullet. In the short term it can only seek to reduce the problems that stem from prohibition and the illicit trade it has created. It cannot tackle the underlying drivers of

problematic drug use such as inequality and social deprivation. But by promoting a more pragmatic public health model and freeing up resources for evidence based social policy and public health based interventions it would create a more conducive environment for doing so. The costs of developing and implementing a new regulatory infrastructure would represent only a fraction of the ever increasing resources currently directed into efforts to

control supply. There would also be potential for translating a proportion of existing criminal profits into legitimate tax revenue.

Different social environments will require different approaches in response to the specific challenges they face. Transform's blueprint does not seek to provide all the answers but to move the debate beyond whether we should end the war on drugs to what the world could look like after the war on drugs. It is a debate that the medical and

public health sectors have failed to engage with for far too long.

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See **EDITORIAL**, p 107; **FEATURE**, p 124; **ANALYSIS**, p 129; **RESEARCH**, p 135

Why Russia must legalise methadone

Despite its effectiveness in HIV prevention, some countries remain resistant to opioid substitution treatment. **Tim Rhodes and colleagues** explain the potential benefits of a change in policy

The health harms of injecting drug use include HIV, hepatitis C, bacterial infections, overdose, and substantial excess mortality. An estimated 16 million people inject drugs worldwide, 3 million of whom live in eastern Europe.¹ Around 1.5 million people are infected with HIV in eastern Europe, with most infected through injecting drug use.² The largest European epidemics are those in the Russian Federation and Ukraine, where over a third of injecting drug users are thought to be HIV positive.^{1,2} One contributing factor is policy resistance to harm reduction.

Harm reduction

Harm reduction encompasses interventions and policies that seek primarily to reduce the harms of drug use without necessarily requiring abstinence from drug use. The Council of the European Union, World Health Organization, and United Nations Joint Programme on HIV/AIDS recommend a comprehensive package of harm reduction services for people who inject drugs, including programmes providing easy access to clean needles and syringes, opioid substitution treatment, and antiretroviral drugs for HIV.³ Access to opioid substitutes and syringe distribution programmes can reduce risky injecting practices and incidence of HIV.^{4,6} Opioid substitution also reduces deaths from overdose, drug related mortality, and offending. Access to antiretroviral HIV treatment improves mortality and morbidity among injecting drug users.⁷

A critical factor determining the effect of interventions is their coverage among target populations.⁸ Intervention coverage varies widely globally but is especially low in eastern Europe, where only around 10% of injecting drug users have access to syringe exchange programmes and, at best, 1% have access to opioid substitutes.⁹ The UN made providing “near universal access” to harm reduction services for those who need them by 2010 a global priority.³ However, the availability and accessibility of interventions depends on environmental and policy factors, and sufficient coverage is unlikely without policy, legal, or social change.^{10,11}

Moreover, harm reduction interventions are more effective when they are combined.¹⁰ For example, a cohort study in Amsterdam showed that “full participation” in combined syringe exchange and opioid substitution programmes reduced incidence of HIV by two thirds, whereas



Russia's HIV epidemic is driven by drug injecting, but the country resists interventions that would help

participation in syringe exchange alone was not associated with a reduction in HIV incidence.¹² Initiation and adherence to antiretroviral HIV treatment also improves when access to opioid substitutes is good.¹³ The enhanced effects of combining opioid substitution with syringe distribution and antiretroviral HIV treatment are particularly relevant for countries with large HIV outbreaks.

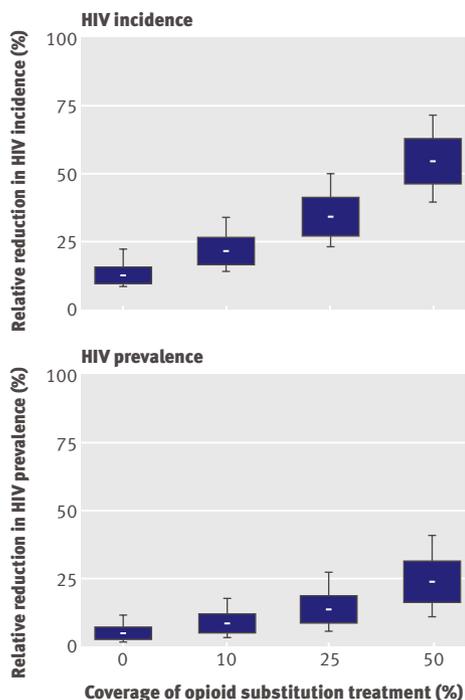
Policy resistance

Although harm reduction is central to European Union policies, some countries are resistant to this approach. The United States, for instance, has long acted as a force of resistance to harm reduction on the global stage and nationally. It has emphasised a “war on drugs” policy, which, until recently, promoted federal or state restrictions on the funding and evaluation of syringe distribution programmes.¹⁴ In Russia, there is also strong resistance to harm reduction. The use of methadone and buprenorphine in treating opioid dependence is legally prohibited, syringe distribution programmes lack adequate coverage and political support, and the primary emphasis on law enforcement and the criminalisation of

drug use create an environment that can exacerbate HIV risk and other harms.

The record of a recent meeting of the Security Council of the Russian Federation, attended by the president (Dmitry Medvedev), prime minister (Vladimir Putin), minister of health (Tatyana Golikova), director of the Serbsky National Research Centre for Social and Forensic Psychiatry (Tatyana Dmitrieva), and director of the Federal Drug Control Service (Viktor Ivanov), captures Russia's policy resistance to harm reduction.¹⁵ Tatyana Dmitrieva, speaking in her role as the deputy chair of the International Narcotic Control Board, said: “Russia is against the introduction of harm reduction policy. This is a really very difficult topic because we are facing very powerful pressure which undoubtedly has political implications . . . We are not for harm reduction, we are for supply reduction.”

At the same meeting, the minister of health said Russia is “categorically against” providing “substitution treatment for drug addicts” and that “the distribution of sterile needles and syringes stimulates social tolerance of drug addicts and violates the Criminal Code of the Russian Federation. Unfortunately, purchasing sterile needles and



Effect of different coverage of opioid substitution treatment on HIV incidence and prevalence after five years assuming coverage of needle and syringe exchange programmes stays at 10%. Bounds for each scenario show the range of effect estimates for different HIV epidemics modelled (whiskers are 10% and 90% percentiles, box limits are 25% and 75% percentiles, and lines are median estimates)

syringes is not a problem in the Russian Federation. Today, the price for sterile syringes is much lower than the price for the cheapest narcotic drugs available.”

Russia prohibits the use of methadone and buprenorphine (or other opiates) to treat opioid dependence, despite international pressure and good evidence supporting opioid substitution treatment.^{4,5} WHO defines it as an “essential medicine,” and substitutes are prescribed to over 650 000 people in Europe. Treatments for opioid users in Russia are instead modelled on alcohol detoxification, oriented to alleviating short term symptoms of withdrawal, and have high relapse rates.^{16,17} With heroin more accessible than substitution treatment, opportunities for preventing HIV infection are reduced.

Russia has only about 75 needle and syringe programmes for its two million injecting drug users.¹ Such programmes do not “violate” the national criminal code, as the health minister suggested, but one reason for their poor coverage remains a fear that distribution of syringes may be interpreted as promoting drug use under article 230 of the Criminal Code (1996). In 2003, an amendment to this article exempted the provision of health equipment, subject to the agreement of regional representatives of the Ministry of Health and Federal Drug Control Service. Formal instruc-

tions on this agreement have yet to be instituted, even though studies do not show that syringe distribution programmes encourage drug use or “social tolerance” of it.^{5,10} If it was not for the availability of cheap needles and syringes from pharmacies, HIV rates could be worse.

In the absence of national funding for HIV prevention for injecting drug users, the Global Fund has continued its support of 22 pilot programmes. Evaluation of these has estimated that they averted 37 000 HIV cases,¹⁸ with surveys in 2006 and 2008 finding that injecting drug users who participated in the programmes halved their risk of HIV infection compared with those who did not participate.¹⁹

Roots of resistance

Aside from Russia, only three countries in the European and central Asian region do not provide opioid substitution treatment: Tajikistan, Turkmenistan, and Uzbekistan.^{9,20} Uzbekistan discontinued its programme for about 150 users last year. Tajikistan plans to pilot opioid substitution treatment, partly to prevent jeopardising international health funding.²⁰ Other programmes in central Asia operate as fragile pilots with little evidence of meaningful expansion. One of the largest is in Kyrgyzstan, providing treatment to about 950 people. The programme was threatened with closure in 2009, and like many others in the region relies heavily on international funding.

Resistance to introducing or scaling-up opioid substitution treatment in former Soviet countries partly stems from concerns about the adverse economic effects of changes to existing drug treatment systems alongside concerns that current systems would be unable to prevent substitute medicines (such as methadone or buprenorphine) entering the illicit market or safely monitor their use.^{17,20} More fundamentally, resistance to substitution treatments is grounded in the history, teaching, and mentality of “narcology,” a subdivision of Soviet criminal psychiatry with close links to state law enforcement. Narcology conceives of treatment from addiction in terms of abstinence^{17,21} and is closely linked with the Serbsky Central Research Institute of Social and Forensic Psychiatry, once infamous for using psychiatric medicines for state ordered “treatment” of Soviet dissidents. Narcologists have opposed the use of methadone in opioid treatment as a “vicious practice,” as one step

removed from “legalising” drug use, as a failing intervention of the West, and, most importantly, as a failure to deal with the criminality of drug users.^{17,22}

Resistance to opioid substitution thus has a cultural historical context. Nevertheless, change is needed since drug policies that emphasise repressiveness through law enforcement are linked with higher health risks.¹⁴ In Russia, administrative and criminal codes relating to drug use and possession combine with aggressive police surveillance, resulting in the mass imprisonment of drug users and a prison system linked to outbreaks of HIV infection.²³ Intense police surveillance can make drug users reluctant to seek help or carry sterile needles and syringes for fear of arrest, fine, or detention, and studies show that drug users who have contact with the police, from arrest through to assault, may be more likely to share syringes.^{11,24,25}

Benefits of change

What effect might legalisation of opioid substitution treatment have in Russia? We carried out simulations using a dynamic model of HIV transmission in injecting drug users for different types of HIV epidemic in Russia. We estimated the effect of current syringe distribution programmes, optimistically assuming that they reduce the average syringe sharing frequency of all reached participants by 75%.⁶ Studies suggest that opioid substitution treatment can reduce risk of HIV infection by 60–84%, and we used this range in our simulations.⁴ A full description of the model is available on bmj.com.

The figure shows that the current coverage of syringe distribution programmes in Russia (10%) is unlikely to reduce HIV incidence

among injecting drug users by more than 15% over five years. Conversely, increasing the coverage of opioid substitution treatment from 0% to 10%, 25%, or 50% could decrease incidence by 21% (90% confidence interval 14% to 34%), 34% (23% to 51%), or 55% (40% to 71%), respectively. Most of the uncertainty in the projections is due to uncertainty about the effect of opioid substitution and



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the baseline HIV prevalence of the different epidemics modelled. For example, at a prevalence of 15% (which best fits many Russian cities including Moscow), 25% coverage of opioid substitution could decrease HIV incidence by 44–53%

over five years. However, if HIV prevalence is 40% or 60% (similar to that in Russian cities such as Irkutsk or Ekaterinburg), the resulting decrease in HIV incidence is reduced to 33-43% or 24-38%, respectively.

Changing HIV prevalence takes longer (figure, bottom). Nevertheless, increasing opioid substitution to 25% or 50% could reduce prevalence by 14% (6% to 28%) or 24% (12% to 41%) after five years. Again, the effect depends on baseline HIV prevalence, with 25% coverage reducing prevalence by 25-31%, 16-21%, and 10-17% for baseline prevalences of 15%, 40%, and 60% respectively (see bmj.com).

Conclusion

Opioid substitution is a critical component of HIV prevention and treatment.^{3,4,10,12,13} Our projections suggest that Russia could substantially reduce the incidence of HIV infection if it permitted the use of opioid substitution treatment. The benefits could be even greater than we estimate as the model does not include changes in offending, or antiretroviral HIV treatment. The prohibition, by federal law or otherwise, of opioid substitution treatment limits rights of access to evidence-based health care, as championed by the UN and other international agencies.³ The roots of resistance to harm reduction in Russia are complex, and show why efforts to bring about structural changes in national laws and policies should be at the forefront of global efforts to scale-up HIV prevention.

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See **EDITORIAL**, p 107; **FEATURE**, p 124; **ANALYSIS**, p 127; **RESEARCH**, p 135

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Decriminalisation in Latin America

Last August the Supreme Court of Argentina unanimously ruled that the drug law criminalising possession of illicit drugs for personal use was unconstitutional. Martin Acuna, a Buenos Aires judge who is active in harm reduction activities, said that too much money was being spent on policing, prosecuting, and incarcerating persons for these crimes; the judges pushed for a change.

Chile decriminalised possession of small amounts of drugs for personal use in 2005, following the lead of Paraguay (1988) and Uruguay (1998). Brazil changed its policy in 2006. Mr Acuna said that the changes throughout much of Latin America represent a paradigm shift in drug policy toward greater emphasis on access to health care and respect for the drug user's dignity and basic human rights.

Ten years ago about a third of HIV infections in Argentina and Chile were attributed to injecting drug use, but that has declined to below 20%. Acuna said that the pattern of drug use has changed over time, with a decrease in injecting drugs and an increase in snorting or smoking various forms of cocaine. The HIV epidemic in most Latin American countries is concentrated largely within men who have sex with men and secondarily sex workers. The portion of infections attributed to injecting drug use often is in the low single digits.

The problems and policies in Mexico and Colombia, and their neighbours who have similar but lesser problems, are largely tied to the huge demand for illicit drugs within the United States. The leaders of these countries have called upon the US to decriminalise and regulate that demand, but there seems to be little political will within the US to do so.

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