

Media information resource pack on the UN review of global drug policy

This pack has been compiled by the International Drug Policy Consortium (IDPC), a global network of national and international NGOs that specialise in issues related to illegal and legal drug use. This pack provides information and easily accessible background resources on the key issues relating to the UN review of global drug policy. The articles in this pack have been written by experts in the field of drug policy to highlight the failings of the current global system of drug control and draw attention the upcoming UN review, the outcome of which will shape international drug control for the next 10 years.

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The International Drug Policy Consortium

The International Drug Policy Consortium (IDPC) is a global network of 32 national and international NGOs that specialise in issues related to illegal and legal drug use. IDPC promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. Based on the findings of its members' research and written work, IDPC engages with officials and politicians in national governments and international agencies - through correspondence, face-to-face meetings and involvement in conferences and seminars - to promote effective policies, thereby making the most up-to-date research and practice knowledge available to decision makers.

The Consortium will play a key role at this important juncture in the development of global drug policy, when the UN and its member states gather in Vienna to devise a roadmap for the strategic direction of the international community's efforts in the coming years. Our task will be to co-ordinate the work of our membership and network and help to bring its collective energies to bear in an accurately and timely way. Our hope is that civil society, working in partnership with the many progressive governments who will be present, will be able to steer drug policy in a new direction, which is both more humane and more effective.

www.idpc.info

The UN review of global drug policy

The year 2009 marks 100 years of global drug prohibition. The worldwide ban on the cultivation, distribution and use of a wide range of psychoactive substances has been enthusiastically supported by most governments since the signing of the Shanghai Convention in 1909(i). The UN conventions that represent the current legal framework for this system of prohibition have been signed and ratified by almost all UN member states.

On March 11 and 12, political leaders will gather in Vienna for the latest review of progress in the global 'war on drugs'(ii). The UN 'high level' meeting will reflect on the objectives and commitments made by the UN General Assembly Special Session (UNGASS) on Drugs in New York in 1998(iii) and agree on a framework for the next phase of global drug policy.

The key objective agreed at the 1998 meeting, the slogan of which was 'A Drug Free World – We Can Do It', was the complete eradication of the illegal market for psychoactive substances, such as cannabis, heroin and cocaine, primarily through enforcement action against growers, traffickers and users.

It is clear that these objectives are no nearer being met now than they were 10, 20, or even 100 years ago - illegal drug markets are now larger and more diverse than they have ever been. Every area of the globe is affected and no government has been conspicuously successful in responding.

While this reality has been recognised by all those who will attend the Vienna meeting, there are significant political differences about how to react to it. For the first time, the global consensus on drug policy can no longer be taken for granted.

The main schism has existed between the USA and Western Europe. America has, historically, been the cheerleader for strident 'zero-tolerance' policies, pressing for a strengthening of the harsh enforcement and punishment-led approaches of the "Drug-War". Within those European countries which argue for an acceptance that some level of drug is inevitable and that policies should focus on minimising the negative social and health consequences, hopes have risen that a new Obama presidency will modify its stance. Certainly Obama's own public statements have given some cause for optimism (iv).

Thus, while differences of perspective have led to bruising diplomatic exchanges in the run up to Vienna, observers are eagerly awaiting signs that the new US administration will take a more multilateral approach to the issue.

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End notes

i) The International Opium Commission in Shanghai in 1909 gave rise to the first instrument of international law to deal with psychoactive substances (the Hague Opium Convention of 1912).

ii) From March 2008 the international community began a process evaluating the action plan set out at the UN General Assembly Special Session (UNGASS) on Drugs in 1998 (see note 3). A year long 'period of global reflection' has been leading towards a High Level Meeting (HLM) at the Commission on Narcotic Drugs (CND), the central UN policy-making body on drugs, in Vienna. The HLM will take place, in Vienna, on 11 and 12 March 2009. Senior ministers representing the member countries of the Commission on Narcotic Drugs (CND) will attend and agree upon a Political Declaration that will map the direction of drug policy over the next ten years.

iii) For more information on the 1998 *UN General Assembly Special Session on The World Drug Problem*, see: <http://www.un.org/ga/20special/>

iv) Early signs from the Obama administration has given US advocates cause for hope. See "Obama's Choice: Sane U.N. Drug Policy or the Same Old Failed War-on-Drugs Routine?" by Allan Clear, the Executive Director of the Harm Reduction Coalition at this link:
http://www.alternet.org/drugreporter/122853/obama%27s_choice%3A_sane_u.n._drug_policy_or_the_same_old_failed_war-on-drugs_routine/?page=2

Background information

International Drug Policy Consortium. (2008). *The United Nation's review of global policy on illegal drugs: an advocacy guide for civil society*. London, UK: Author. Retrieved from http://www.idpc.info/php-bin/documents/IDPC_AdvocacyGuide_June08_EN.pdf

UNGASS. (1998). *Political Declaration from the 1998 UN General Assembly Special Session on The World Drug Problem*. (A/S-20/4, chapter V, section A) Vienna, Austria: Author. Retrieved from <http://www.un.org/ga/20special/poldecla.htm>

Death penalty for drug offences: a violation of international human rights law

Rick Lines, Deputy Director of the International Harm Reduction Association, examines whether the use of the death penalty for drug-related offences is legitimate under international human rights law.

There are 59 countries around the world that continue to use capital punishment. Approximately half of these nations have legislation that allows for the use of the death penalty for drug-related offences (i).

Over the past 20 years there has been a remarkable international trend towards the abolition of capital punishment, a trend that culminated with UN General Assembly resolutions in 2007 and 2008 calling for a worldwide moratorium on executions (ii).

Despite this trend, the number of countries expanding the use of the death penalty to include drug offences has *increased* during the same period. And the definition of capital narcotics crimes is not limited to trafficking offences. In some countries it includes possession.

Although the number of people put to death annually for drug convictions is difficult to calculate, it is clear that a significant number of executions for drug offences take place each year.

In April 2005 the Malaysian Internal Security Ministry reported that 229 people had been executed for drug trafficking over the previous 30 years (iii). In 2004 in Saudi Arabia, Amnesty International reported that 26 of the 50 executions during the previous year were for drug-related offences (iv).

In 2003, the government of Vietnam stated in a submission to the UN Human Rights Committee that "over the last years, the death penalty has been mostly given to persons engaged in drug trafficking".(v) Media reports suggest most of the estimated 100 people executed by firing squad in Vietnam each year were found guilty of drug-related offences (vi). In Singapore, more than 400 people have been executed since 1991, the majority for drug offences (vii). It has been reported that from 1994-1999, three quarters of all executions were drug-related (viii).

In recent years, China has used the UN's annual International Day Against Drug Abuse and Illicit Drug Trafficking, on 26 June, to conduct public executions of drug offenders. In 2007, Indonesia marked the UN day by executing two Nigerian drug offenders by firing squad. The following month, Iran carried out a mass execution of drug offenders when it hanged 20 people in one day in July in a prison north of Tehran.

The application of the death penalty for drug offences continues to be used despite the authoritative findings of various UN human rights bodies and monitors that such executions take place in violation of international human rights law.

Although capital punishment is not prohibited under international law, article 6(2) of the *International Covenant on Civil and Political Rights* states that the penalty of death may only be lawfully applied to the 'most serious crimes'. While many retentionist governments argue that drug offences fall under this umbrella, this is not the assessment of international human rights monitors and treaty bodies.

Both the UN Human Rights Committee (the body responsible for monitoring and interpreting the terms of the *Covenant*) and the UN Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions have authoritatively stated that drug offences do not constitute 'most serious crimes' and that executions for such offences are in violation of international human rights law. In a letter written to delegates to the 2008 session of the Commission on Narcotic Drugs, both the UN Special Rapporteur on Torture and Special Rapporteur on the Right to Health stated that 'the weight of opinion indicates clearly that drug offences do not meet the threshold of "most serious crimes" for which the death penalty may be lawfully applied' (ix).

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About the author

Rick Lines is Deputy Director of the International Harm Reduction Association (www.ihra.net) in London, where he leads their Harm Reduction & Human Rights Programme (www.ihrablog.net). He is a leading international authority on human rights and drug policy, and is the author of *The Death Penalty for Drug Offences: A Violation of International Human Rights Law* (IHRA, 2007), the leading international legal analysis of capital punishment for drugs (available at <http://www.ihra.net/Assets/489/1/DeathPenaltyforDrugOffences.pdf>).

End notes

i) In 2001, the United Nations Commission on Crime Prevention and Criminal Justice identified the Bahrain, Bangladesh, Brunei Darussalam, China, Cuba, Democratic Republic of Congo, Egypt, Guyana, India, Indonesia, Iran, Iraq, Jordan, Kuwait, Libya, Malaysia, Myanmar, Oman, Pakistan, Philippines, Qatar, South Korea, Saudi Arabia, Singapore, Sri Lanka, Sudan, Syrian Arab Republic, Taiwan, Tajikistan, Thailand, United Arab Emirates, the United States (federal law) Uzbekistan and Viet Nam as those countries with capital punishment for drug crimes. Commission on Crime Prevention and Criminal Justice 'Capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty' (29 March 2001) E/CN.15/2001/10 para 90. Since this report was published, the Philippines has abolished the death penalty, and Amnesty International has judged Brunei Darussalam, Myanmar and Sri Lanka to be abolitionist in practice. However, the above list does not include Yemen, which has capital punishment for drug offences 'ANGD: Record of Success' *Yemen Times* (29 June – 2 July 2006) issue 959 vol 14.

ii) Two UN General Assembly resolutions calling for a worldwide moratorium on the death penalty have been passed, one in 2007 and the other in 2008. The 2008 resolution was adopted by 106 votes in favour, compared with 104 votes in favour in 2007. Votes against totalled 46, compared with 54 in 2007. Abstentions increased to 34,

five more than in 2007. The results of the resolution simply confirm the continued progression towards abolition of capital punishment worldwide. According to Amnesty International, 137 of the 192 United Nations Member States may be considered abolitionist, either in law or in practice. Approximately 2-3 States abolish the death penalty each year, a trend that exists for more than twenty years. If this continues, the death penalty will disappear in twenty-two years, that is, by 2030.

iii) *Malaysiakini* (2005), '229 Executed or Drug Trafficking in Past 30 Years', 13 April: www.malaysiakini.com/news/35303

iv) See Amnesty International *Amnesty International Report 2004* (Report) (2004) AI Index POL 10/004/2004, p 301.

v) UN Human Rights Committee 'Comments by the Government of Viet Nam on the concluding observations of the Human Rights Committee' (21 July 2003) UN Doc CCPR/CO/75/VNM/Add.2 para 1.

vi) 'Vietnam law commission wants death penalty for fewer crimes' *Thanh Nien News* (3 November 2006).

vii) Amnesty International *Singapore – The death penalty: A hidden toll of executions* (Report) (15 January 2004) AI Index ASA 36/001/2004.

viii) The figures come from a written reply dated 12 January 2001 from the Minister for Home Affairs (Ninth Parliament of Singapore, Second Session). Cited in Commission on Crime Prevention and Criminal Justice (n 6) para 69.

ix) Letter is available online at <http://www.ihra.net/Assets/1384/1/SpecialRapporteursLettertoCND012009.pdf>

Background information

Alston, P. (2007). *Report of the UN Special Rapporteur on extrajudicial, summary or arbitrary executions*. New York: United Nations. Retrieved from <http://daccessdds.un.org/doc/UNDOC/GEN/G07/105/00/PDF/G0710500.pdf?OpenElement>

Amnesty International. (2007). *Death Sentences for drug crimes rise in the Asia Pacific*. (AI Index No: ASA 01/002/2007). Hong Kong: Anti-death Penalty Asia Network (ADPAN). Retrieved from <http://www.amnesty.org/en/library/asset/ASA01/002/2007/en/dom-ASA010022007en.pdf>

Lines, R. (2007). *The Death Penalty for Drug Offences: A Violation of International Human Rights Law*. London, UK: International Harm Reduction Association. Retrieved from <http://www.ihra.net/Assets/489/1/DeathPenaltyforDrugOffences.pdf>

Failed policies: the impact of misguided drug policies on the spread of HIV/AIDS

As HIV continues to spread through injecting drug use, many countries let ideology trump proven HIV prevention measures. Daniel Wolfe, Director of the Open Society Institute's International Harm Reduction Development Program investigates.

Despite clear evidence that the provision of sterile injection equipment and prescription of medications such as buprenorphine and methadone (i) can reduce HIV risk and rates of HIV infection, epidemics among injecting drug users in many regions, including Eastern Europe, Central Asia, and other parts of Asia, continue unchecked.

Drug control policies that contradict public health approaches, such as the arrest of those carrying injecting equipment, mass incarceration and government registries of all those with a history of drug use are among the causes for this failure in HIV prevention.

There has been an explosive spread, through contaminated needles, of HIV (ii). An estimated three million people who inject drugs are HIV positive. Excluding Africa, nearly one in three new HIV infections worldwide is caused by contaminated injecting equipment. Injecting drug users (IDUs) account for the largest share of cumulative HIV infections in Russia, China, Ukraine, Indonesia, Malaysia, Vietnam, all the Central Asian Republics, Baltic states, as well as parts of Latin America.

The spread of the HIV infection through contaminated injecting equipment can be much more rapid than infection caused by sexual transmission. In cities in China, Russia, India, and Thailand, among others, studies have documented levels of HIV infection among IDUs increasing from one per cent to more than 40 per cent in a single year.

Multiple studies have found that the provision of sterile injection equipment reduces needle sharing without encouraging drug use (iii). Prescription of legal medications such as methadone and buprenorphine decrease the incidence of injection among drug users as well as reducing their participation in criminal activity. Positive benefits of these interventions include better relationships with family, the take up of productive employment and adherence to HIV treatment.

Where harm reduction initiatives are long established, such as Australia, New Zealand and much of Western Europe, HIV prevalence among people who inject drugs remains low.

Yet despite evidence of the effectiveness of these approaches, which have been endorsed by the World Health Organization, UNAIDS and UNODC (iv), drug users in many countries have no access to these life saving measures.

According to the UN Secretary-General in 2008, only 34 per cent of countries with a concentrated or low HIV epidemic have implemented programs to reduce risk among

injecting drug users (v). A 2008 report that surveyed 10 countries with injection-driven HIV epidemics found that 98 per cent of those in need, estimated at more than 3.7m people, had no access to methadone and buprenorphine (vi).

Drug control approaches pose a major obstacle to effective HIV prevention. Although the International Narcotics Control Board has clearly stated that provision of sterile injecting equipment and prescription of methadone and buprenorphine are in line with international drug control conventions, police harassment of those seeking sterile injecting equipment and overly strict controls on legal opiates continue to hamper HIV prevention.

Harm reduction groups in China and India report that police harass outreach workers at needle exchange sites and arrest drug users attempting to access clean syringes. In the US many drug users are unwilling to carry safe injection or bleach kits due to fear of arrest, a situation which makes them more likely to share needles.

Although the Malaysian government endorsed the use of methadone in 2005, patients undergoing treatment at community clinics have their names added to government registries and often face arrest during police raids on clinics. Similarly, in Indonesia, organizations report that police are ill informed about methadone treatment's legality and arrest people at clinics.

Users often face overly restrictive policies on the prescription of the essential medicines methadone and buprenorphine. While in Russia, which has the fastest-growing HIV epidemic in the world - with more than 80 per cent of infections related to drug injecting - people dependent on opiates have zero access to methadone and buprenorphine, because it is illegal.

In order to curb the HIV epidemic, countries must not only institute and expand proven prevention and treatment approaches, including needle exchange and treatment with methadone and buprenorphine, but they must also ensure that people who use drugs are able to access these programs. This will mean training police on the legality of such approaches, and working with drug users themselves to ensure that programs are tailored to their needs. Until that happens, people who use drugs will miss out on vital health programs, and HIV will continue unchecked.

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About the author

Daniel Wolfe is the Director of the International Harm Reduction Development (IHRD) program at the Open Society Institute (<http://www.soros.org/>). Mr. Wolfe has been a community scholar at Columbia University's Center for History and Ethics of Public Health, the recipient of the Revson Fellowship awarded to individuals who have made a substantial contribution to the city of New York, and the director of communications at Gay Men's Health Crisis (GMHC), the largest and oldest AIDS NGO in the U.S. He is the author of several books, book chapters and articles in publications including AIDS, New York Times Book Review, the International Herald Tribune, the Lancet, International Journal of Drug Policy, the Nation, and the Village Voice.

End notes

(i) These are treatment options for people who are dependent on opiates and are referred to as opiate substitution therapy (OST). They can be taken in tablet or liquid form and are usually prescribed in conjunction with a support programme to help the individual manage their opiate dependence. It has been established that opiate substitution therapy reduces the incidence of injecting behaviour and the associated risks. See this link for studies on the effectiveness of OST:
http://international.drugabuse.gov/collaboration/guide_methadone/partb_question3.htm
!

(ii) Studies that document the explosive increase in HIV transmission among injecting drug users include:

Burack, J.H., and D. Bangsberg 1998. "[Epidemiology and transmission of HIV among injection drug users](#)." In *The AIDS Knowledge Base*. Ed. P.T. Cohen, M.A. Sande, and P.A. Volberding. USA: Lippincott, Williams & Wilkins, 1998.

<http://hivinsite.ucsf.edu/InSite?page=kb-07-04-01>

RHODES Tim ; LOWNDES Catherine ; JUDD Ali et al. (2002) Explosive spread and high prevalence of HIV infection among injecting drug users in Togliatti City, Russia. *AIDS*. Vol. 16, n°13, pp. F25-F31 (31 ref.).

(iii) Studies providing evidence that needle and syringe programmes reduce HIV risk behaviors without encouraging drug use include:

Watters JK, Estilo MJ et al (1994). "Syringe and needle exchange as HIV/AIDS prevention for injection drug users." *Journal of the American Medical Association* 271:115–120.

(iv) UNAIDS, UNODC and WHO have all endorsed harm reduction measures. There are various documents from each of these bodies that endorse individual harm reduction interventions, the following document outlines a "comprehensive package of prevention, treatment, and care of HIV in injecting drug users," which includes harm reduction measures:

WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2009) Available at <http://www.who.int/hiv/pub/idu/OMSTargetSettingGuide.pdf>.

See also the following journal article where the package is articulated:

Donoghoe, M., Verster, A., Pervilhac, C., Williams, P. (2008) "Setting targets for universal access to HIV prevention, treatment and care for injecting drug users (IDUs): Toward consensus and improved guidance." *International Journal of Drug Policy* 19S; S5-S14.

(v) In 2008, the Secretary-General of the UN stated that only about 34% of countries with a concentrated or low HIV epidemic have implemented programs to reduce risk among injecting drug users. See:

Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals. Report of the Secretary-General (2008) available at

<http://www.ua2010.org/en/UNGASS/UNGASS-2008/Secretary-General-s-Report-released>

(vi) A 2008 report by Fiellin, Green and Heimer found that in 10 countries with injection-driven HIV epidemics, 98% of those in need had no access to opiate substitution therapies:

David A. Fiellin, Traci C. Green, and Robert Heimer (2008) *Combating the Twin Epidemics of HIV and Drug Addiction: Opportunities for Progress and Gaps in Scale*. Washington, D.C.: Center for Strategic and International Studies.

Background information

Barrett, D., et al. (2008). *Recalibrating the regime: The need for a human rights-based approach to international drug policy*. (Report 13). UK: The Beckley Foundation. Retrieved from http://www.internationaldrugpolicy.net/reports/BFDPP_RP_13_Recal_Regime_EN.pdf

Cook, C. and Kanaef, N. (2008). *Global State of Harm Reduction*. London, UK: International Harm Reduction Association. Retrieved from <http://www.ihra.net/Assets/1396/1/GSHRFullReport1.pdf>

Open Society Institute. (2009). *At what cost? HIV and human rights consequences of the global war on drugs*. New York: Author. Retrieved from www.soros.org/health/drugwar

Open Society Institute. (2009). *Fact Sheet: Abuses in the Name of Drug Treatment*. New York: Author. Retrieved from www.soros.org/health/drugwar

Wolfe, D. and Malinowska-Sempruch, K. (2009). *Illicit Drug Policies and the Global HIV Epidemic*. New York: Open Society Institute. Retrieved from http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/cnd_20040316/Illicit%20Drug%20Policy%20for%20web%20FINAL.pdf

The failure of punishment as a tool of drug policy

It costs the taxpayer millions, ensures an ever-expanding prison population and contributes to public health harms. But does punishing drug users actually work? Mike Trace, chair of the International Drug Policy Consortium and former deputy UK drugs tsar thinks not.

One of the basic assumptions of the international drug control system is that demand for illegal drugs is reduced by the threat of penal sanctions against potential users. This in turn lowers the amount of users and therefore the potential for profits for traffickers.

For many years, UN bodies, national governments and local authorities have put their faith in the principle of deterrence, by enacting tough laws against drug possession and use, sending tough messages on the unacceptability of drug use and investing huge amounts in the arrest and punishment of users.

In practice, the enthusiasm with which countries have pursued this line has varied widely around the world, and over time. The USA has led the way in articulating and implementing the belief in deterrence through punishment. Around 1.8 million (i) Americans are arrested each year for drug possession offences, this is 13 percent of the total number of all arrests. Approximately a quarter of the current total of over 2 million prisoners in the USA are there for drug offences. Russia, Thailand, the UK and Japan also have relatively high arrest or imprisonment rates for drug offences.

Conversely, countries such as the Netherlands, Spain, Portugal and Australia have consciously moved away from harsh laws and penalties, responding to drug possession and use primarily through civil procedures. Many other countries, particularly in the developing world, rarely use the harsh penalties that exist in their legislation, with vigorous rhetoric hiding very low arrest rates (ii).

Strong drug law enforcement and the use of imprisonment as a deterrent has led to serious abuses and harms around the world.

Arrests and punishments in many countries are concentrated amongst poor or minority groups. In the USA, although African-Americans and whites use and sell drugs at similar rates, African-Americans are more likely to be imprisoned for drugs offenses. In 2005, of the 253,300 incarcerated in state prison for drug offenses, 44.8% were black and 28.5% were white (iii)

Prison terms can be longer for drug use than for crimes involving serious violence, while crackdowns on drug users have led to multiple human rights abuses. In Thailand in 2003, thousands of extra judicial killings resulted from a government-driven anti-drug campaign (iv).

The concentration of large numbers of drug users in prisons around the world, where HIV prevention measures such as sterile injection equipment are frequently unavailable,

can lead to greater health and social problems. HIV epidemics in several countries, including Russia, Canada, Brazil, Iran and Thailand have been traced back to unsanitary conditions in jail. In Russia in 2002, 4% of the prison population was registered as HIV positive, some 36,000 prisoners, representing 20% of the total of known cases in the whole of the country (v), Syringes are shared between large numbers of users, re-sharpened and passed from wing to wing within the prison (vi). Studies report up to 86% of imprisoned drug users had shared injecting equipment in the past month (vii).

In terms of police, prosecution and prison budgets, the policy of deterrence results in a heavy burden for the taxpayer. Several US states spent nearly twice as much on corrections (\$42.89 billion) as they did on public assistance (\$24.69 billion) (viii).

Moreover, the threat of prison has been an almost complete failure in terms of its main objective – to reduce demand and thus supply. Successive research studies (Stern 1998, Reinerman et al, 2004, King & Mauer, 2005, Reuter & Stevens 2007) (ix) find little correlation between the severity and extent of drug law enforcement, and trends in demand for illegal drugs. Some of the toughest countries, the prime example being the United States, have some of the highest rates of drug use, while some of the most lenient, such as the Netherlands, have low rates. Analysts have been unable to draw a link between clampdowns on drug users and significant and sustained reductions in demand.

At the 10-year review of current global drug strategy in March 2008, Antonio Maria Costa, the executive director of the UN Office on Drugs and Crime, acknowledged that enforcement-centred drug policies like those on which the international community has relied for much of the last century have produced a range of “unintended consequences”. The routine resort to imprisonment for non-violent drug users illustrates these graphically. Aside from the research evidence that tells us that incarceration falls far short of meeting its intended objectives, the marginalized populations condemned to cycles of crime and incarceration, poverty and ill-health are a dramatic symbol of the failure of a policy. As they meet in Vienna this year to map the policies of the future, our leaders should have the courage to face the reality of this failure, and to change direction.

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About the author

Mike Trace has a wide range of experience in the field of drug treatment and policy, from direct work with problematic drug users, to senior positions in national government and international agencies. He is the former deputy UK drugs tsar and has chaired the European Union drugs agency, the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). He worked for a short time at the United Nations Office on Drugs and Crime in Vienna before returning to the UK to work in the non-governmental sector. He is currently the Chief Executive of RAPT, one of the biggest providers of drug treatment services in the UK prison system. Mike continues to engage in policy issues as Chair of the International Drug Policy Consortium, a global network of NGOs with an interest in the promotion of evidence-based drug policy.

End notes

i) <http://www.fbi.gov/ucr/cius2007/arrests/index.html>

ii) For further discussion see Dave Bewley-Taylor, Mike Trace & Alex Stevens (2005) *Incarceration of Drug Offenders: Costs and Impacts*, Briefing Paper 7, Beckley Foundation Drug Policy Programme.

iii) Sabol, William J., PhD, and West, Heather C., Bureau of Justice Statistics, Prisoners in 2007 (Washington, DC: US Department of Justice, December 2008), NCJ224280, p. 21, Appendix Table 10.

iv) Thailand's 'War on Drugs' in 2003 has become notorious for the extrajudicial killings and abuses that it entailed. According to an unpublished report commissioned by the Thai government and seen by Human Rights Watch, 2,819 people were killed between February and April of that year. Moreover, 1,400 of the victims had no links to the drugs trade; little investigation followed these events, and no prosecutions.

For more information see:

<http://www.hrw.org/en/reports/2004/07/07/not-enough-graves-0>

and:

<http://www.hrw.org/en/news/2004/07/07/thailand-drug-war-darkens-aids-success>

v) Jurgens, R., Ball, A. & Verster, A. "Interventions to reduce HIV transmissions related to injecting drug use in prison." *Lancet Infectious Diseases* 2009 Vol. 9 pp.57-66

vi) Scott Rutter, Kate Dolan, Alex Wodak, Wayne Hall, Lisa Maher & David Dixon. "Is Syringe Exchange Feasible in a Prison Setting? An exploratory study of the issues." [http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_27/\\$file/TR.025.pdf](http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_27/$file/TR.025.pdf)

vii) *UNDP HIV/AIDS in Eastern Europe and the CIS: Reversing the Epidemic- Facts & Policy Options* (2004)

viii) National Association of State Budget Officers (NASBO), 2005 State Expenditure Report (Washington, DC: NASBO, Fall 2006), p. 35, Table 18, and p. 58, Table 32.

ix) There are many research studies that demonstrate the lack of fit between the toughness of a country's or a city's drug laws and the prevalence of its drug use. These are some examples:

King, R. S., & Mauer, M., (2005) *The War on Marijuana: The Transformation of the War on Drugs in the 1990s*. Washington DC, The Sentencing Project.

Reinarman, C., Cohen, P.D.A., & Kaal, H.L. (2004). "The Limited Relevance of Drug Policy: Cannabis in Amsterdam and San Francisco." *American Journal of Public Health*, 94.

Reuter, P. & Stevens, A. (2007) *An Analysis of UK Drug Policy*, UKDPC, London.

Stern, V., (1998). *A Sin Against the Future: Imprisonment in the World*, London, Penguin Books.

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Bewley-Taylor, D., et al. (2005). *Incarceration of drug offenders: costs and impacts* (Briefing Paper 7, June 2005). Oxford: The Beckley Foundation. Retrieved from http://www.beckleyfoundation.org/pdf/paper_07.pdf

King, R. (2008). *Disparity By Geography: The War on Drugs in America's Cities*. Washington, DC: The Sentencing Project. Retrieved from http://www.sentencingproject.org/Admin%5CDocuments%5Cpublications%5Cdp_drugar_restreport.pdf

An obstacle to controlled medicines

Diederik Lohman, Senior Researcher of Human Rights Watch's Health and Human Rights Division, explores how the implementation of the international drug conventions has left millions of people, many with terminal illnesses, with untreated chronic pain or untreated drug dependence.

UN drug conventions recognize the importance of controlled substances for medical and scientific purposes. Indeed, the 1961 Single Convention on Narcotic Drugs states that "narcotic drugs are indispensable for the relief of pain and suffering" and must be made available for that purpose (i).

Yet, almost 50 years after the convention was adopted, the availability of controlled medications for the relief of pain and suffering remains very poor in many parts of the world. Dozens of countries in Africa, Asia and elsewhere use almost no morphine, the mainstay drug for the treatment of chronic pain. The failure to offer that treatment leaves tens of millions of people, including cancer patients and people living with HIV/AIDS, to suffer from severe pain without treatment.

In September 2008, the mother of a cancer patient in Colombia was driven to such desperation by her inability to obtain morphine for her daughter that she placed a classified ad in a local paper stating: "Cancer is killing us. Pain is killing me because for several days I have been unable to find injectable morphine in any place. Please Mr. Secretary of Health, do not make us suffer any more."

In many countries, people with opioid dependence due to illicit drug use cannot get methadone substitution treatment because it is either banned or not readily available, despite its proven effectiveness. In 2007 a 25-year old female heroin user in Russia, where substitution treatment is outlawed, expressed her deep anguish about the inadequate drug treatment services in her country. She told Human Rights Watch, "I'm not going back there [the drug treatment clinic]. There's no point, they don't cure you. I would go to the detoxification clinic if they actually helped [me] there. I'm sick and tired of injecting. But I can't [withdraw] at home. I would like to live to 30 at least..."(ii).

Many countries see prevention of the misuse of controlled substances, rather than their availability for legitimate purposes, as the primary objective of the UN drug conventions, even though the World Health Organization and International Narcotics Control Board have repeatedly reminded them of their obligation to ensure availability of controlled substances for medical use.

As a result, this obligation has been widely neglected or marginalised. Indeed, in preparing for the UN review of the last ten years of drug policy in Vienna, not a single meeting was dedicated to improving access to controlled medications. The issue is only addressed in the margins of the draft political declaration prepared for adoption in March.

"The UN has recognized the importance of narcotic pain medicines and pledged to work with countries to make them widely available" said Lohman. "The UN review in March is an opportunity to work toward that goal and spare millions of people needless suffering from chronic, debilitating pain or other health conditions."

A clear and ambitious plan of action is needed to improve availability of controlled medications. Access to controlled substances should be elevated to the same level of priority as prevention of drug abuse.

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Media Notes

About the author

Diederik Lohman is a senior researcher with the Health and Human Rights Division of Human Rights Watch (www.hrw.org). He has conducted extensive research and advocacy on various health issues, including drug dependence treatment in Russia, HIV testing policies in Lesotho, and palliative care and pain treatment services in India, and access to controlled medicines globally.

End notes

i) The Single Convention codified all previously existing multilateral treaties on drug control. It established the modern-day international system for the prevention of abuse of controlled substances and mechanisms for ensuring their availability for medical and scientific purposes.

ii) Human Rights Watch, *Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-Based Drug Dependence Treatment*, November 7, 2007. Available at: <http://www.hrw.org/en/reports/2007/11/07/rehabilitation-required>

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Human rights abuses in the name of drug treatment

Thousands of people around the world are forced or coerced into various forms of treatment for drug use every year. Human Rights Watch advocate, Rebecca Schleifer, takes a look at this harsh treatment.

In some countries people identified as or suspected to be drug users can be detained in locked facilities and consigned to 'treatment' for months, or even years at a time without trial or any semblance of due process.

Compulsory treatment facilities are often run by military or public security bureaus and staffed by people untrained in medical care or drug dependence treatment. The treatment provided often consists of forced labour, psychological and moral re-education, military exercises and in some cases, being chained, caged, or caned. Poor conditions of detention pose additional risks to the health and lives of detainees. Former detainees frequently report physical and sexual assault at the hands of guards.

In many countries, people who seek treatment voluntarily are subjected to similar abuses. And regardless of whether residential treatment is voluntary or forced, evidence-based medical care to manage drug dependence, as well as HIV prevention and treatment, is frequently limited or unavailable altogether.

International human rights law protects the right of every person, including those who use illicit drugs, to the highest attainable standard of health and freedom from torture and other forms of ill treatment. These and other rights are frequently violated in the name of treatment of drug dependence.

Since 2003, thousands of people in Thailand have been coerced into 'drug treatment' centres run by security forces, without a clinical assessment that they are indeed drug dependent. Many are subjected to 'rehabilitation' provided by security personnel, with military drills a mainstay of the so-called treatment. Thailand's coerced treatment and rehabilitation policy has had long-term consequences on the health and human rights of drug users, as many continue to avoid drug treatment or any government-sponsored health services out of fear of arrest or police action.

In China, as many as 350,000 people are interned in mandatory drug detoxification and 're-education through labour' centers throughout the country, where they can be detained without trial or due process for up to three years on suspicion of drug use. Detainees are required to work without pay to produce goods such as trinkets for the tourist trade. Treatment in these centres consists of little more than repetition of slogans like "drug use is bad, I am bad" and military-style drills. Methadone is not provided. As a doctor at one drug detention centre stated: "The purpose of the detox centre is really just disciplinary, it's not to give people medical care."

In India, treatment can involve drug users being physically isolated, chained, denied meals and forced to work. Some are caged, beaten and in some cases given dangerous medication.

Drug users in some facilities in Russia have been subjected to 'flogging therapy', handcuffed to beds during detoxification and denied medication to alleviate painful withdrawal symptoms. Those who enter treatment voluntarily are consigned to locked wards, in some cases with fatal consequences. In 2006, 46 young women died in a fire in a Moscow substance abuse hospital, where staff had abandoned residents to struggle against locked windows and doors. Government officials acknowledge that opioid dependence is a serious problem, but methadone and buprenorphine, the most effective treatments, are banned.

In Vietnam, drug users who test positive in periodic compulsory urine tests are forced into rehabilitation through labour centres. Even those who enter voluntarily, expecting stays of six months, are often kept longer against their will, including two years of 'rehabilitation' and two to three years of 'post-rehabilitation'.

Police in Cambodia conduct sweeps of street drug users and force them en masse into so-called treatment centres. Though many detainees suffer from tuberculosis, hepatitis C or HIV, medical treatment is unavailable. One former detainee described the physical abuse he experienced: "I saw three staff beat a guy unconscious, they then dragged him away to another room. They also beat me once but they put a blanket over my head so I couldn't see or defend myself."

UN agencies have provided little guidance to countries to address human rights abuses carried out in the name of 'drug treatment.' UN drug control agencies have paid little attention to whether drug treatment is conducted consistent with human rights protections. UN human rights bodies have likewise paid scant attention to human rights abuses in the name of drug policy.

In March 2009, the Commission on Narcotic Drugs will meet in Vienna to adopt a framework to guide the next decade of global drug control efforts. This meeting presents a critical opportunity to reassess the human rights impact of its drug policies, and for member states to agree to specific commitments to ensure that drug dependence treatment and rehabilitation services are in full compliance with international human rights norms. But ensuring human rights-based drug policy is not the sole responsibility of UN drug control agencies.

Torture and ill-treatment occur as a consequence of drug control efforts throughout the world. The Commission on Narcotic Drugs and the Human Rights Council must make sure that human rights are not sacrificed in the name of zero tolerance anti-narcotics policies and unproven and ineffective approaches to 'drug treatment.'

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Media Notes

About the author

Rebecca Schleifer is the advocate for the Health and Human Rights Division at Human Rights Watch. She has authored numerous reports and advocacy documents on HIV and AIDS in Africa, Asia, Central and Eastern Europe, and North America, focusing on the human rights of people living with and at highest risk of HIV and AIDS. Her research and advocacy have covered the role of criminal law in addressing (or impeding) the response to HIV/AIDS; government restrictions on harm reduction services to injection drug users and on HIV/AIDS information and services to youth, people who use drugs, and sex workers; access to HIV prevention and other post-rape services to survivors of sexual violence; and abuses against people living with and at high risk of HIV/AIDS in the United States, Bangladesh, South Africa, Jamaica, Ukraine, India, and Thailand. Rebecca has a JD and an MPH from the University of California, Berkeley, and an AB from Harvard-Radcliffe College.

Background information

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<http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.44AEV.pdf>

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Human Rights Watch has documented human rights abuses in the name of drug dependence treatment in China, Thailand, and Russia and has called on Governments around the world to adopt and expand needle and syringe exchange programs and effective drug dependency treatment as part of their efforts to address HIV among people who use drugs:

- Human Rights Watch (December 2008), “An Unbreakable Cycle: Drug Dependency Treatment, Mandatory Confinement, and HIV/AIDS in China’s Guangxi Province.”
- Human Rights Watch (November 2007), “Rehabilitation Required: Russia’s Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment.”
- Human Rights Watch (November 2007) “[Deadly Denial](#) Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand.”

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Aerial fumigation: the collateral damage

Sanho Tree, Fellow at the Institute for Policy Studies in Washington DC, looks at the impact of forced crop eradication on the Colombian environment and its people.

The over-reliance on forced illicit crop eradication (i) through measures such as aerial fumigation has failed to reduce the amount of coca being grown in Colombia. Even worse, it has caused tremendous damage, both to the country's diverse and precious environment and to the health of many Colombian people.

The substance used in aerial fumigation is a super-concentrated version of Roundup, a brand of weed killer, the active ingredient of which is a chemical called glyphosate (ii). Against manufacturers' instructions, Roundup is mixed with other chemicals (iii) to make the product more effective at the eradication of coca plants. The resulting mixture kills anything green, but is particularly devastating to crops such as corn and yucca. Coca bushes tend to be hearty and resilient plants, so they can resist some of the fumigation if farmers take countermeasures such as dispersing their planting patterns or trimming the fumigated plants back to the stump so that they can resprout faster than new seedlings.

Aerial fumigation takes place across Colombia's conflict zones, meaning spray plane pilots frequently fly at higher than recommended altitudes in order to avoid trees, as well as hostile ground fire from FARC guerrillas. Crosswinds sweep the chemical cloud away from the intended target, causing damage to the jungle, food crops, aquaculture ponds, livestock and humans (iv). Local NGOs have linked fumigation exposure to skin rashes, vomiting, diarrhoea and infant deaths.

Of course, aerial fumigation is not the only consequence of the cocaine trade to impact on the environment in Colombia. The production of cocaine itself is very damaging. When peasant farmers process coca leaves into coca paste, they dump waste chemicals such as gasoline and sulphuric acid into the ecosystem, causing significant damage.

But aerial fumigation only compounds this problem. Fumigation does not deter re-cultivation - many farmers have few viable economic alternatives in rural regions, historically abandoned by central government. When a coca plantation has been damaged by spraying, farmers often will venture deeper into the jungle to replant coca, cutting down more rainforest and introducing their waste products to new areas of this delicate ecosystem. Of course, the spray planes follow.

As with so many drug war measures, it is the unintended consequences that are the most alarming. Forced eradication is usually carried out before alternative livelihood programmes are in place. The devastation it wreaks leads many farmers to join the nearly four million internally displaced in Colombia - or worse, to join the ranks of the guerrillas or narco-traffickers.

The folly of policy makers (as evidenced by Plan Colombia) (v) has been to expect coca farmers to grow legal alternative crops without substantial agricultural and infrastructure assistance. The regions in which they live are often remote and undeveloped. A kilo of coca paste is easy to transport and sell. It is much harder to grow hundreds of kilos of fruits and vegetables that must be transported on vehicles farmers do not have, over roads that do not exist, to sell in domestic and international markets to which they do not have access. In addition, they have to compete against cheaper imports from international agribusiness - often subsidized by US taxpayers - against which they do not stand a chance.

Those who implement Washington's policies define success by relatively meaningless targets, such as the number of hectares eradicated or kilos interdicted. They fail to take into consideration whether the coca growers have basic food security or realistic economic alternatives – measures that might give eradication 'successes' some sustainability. Thus, measuring success by 'hitting the numbers' is as misleading as 'body count' was to the Vietnam war. Coca farmers – like peasant farmers anywhere else in the world – will do whatever it takes to feed their families, including replanting coca.

Forced eradication puts the cart before the horse: once these farmers have basic food security, they can *then* diversify their local economy with different crops and livelihoods. Unfortunately, too many elected officials in the US place a greater emphasis on eradication than on alternative development because they want to look tough, rather than be effective, at election time.

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Media Notes

About the author

Sanho Tree is a Fellow of the Institute for Policy Studies (IPS), Washington DC (<http://www.ips-dc.org/>). He directs the Drug Policy Project at the IPS and has made more than ten visits to Colombia over the last decade to monitor US counternarcotics policies.

End notes

i) Crop eradication is the destruction of illicit crops through either manual or chemical means. Manual or mechanical means are most common, except in Colombia, which employs aeroplanes to spray herbicides. Occasionally crop eradication is done voluntarily in exchange for aid, but it is more often forced eradication.

ii) Roundup is the brand name of a type of systemic herbicide manufactured by Monsanto (www.monsanto.com). Its active ingredient is glyphosate.

iii) Chemicals that are added to Roundup include a proprietary Colombian additive called Cosmoflux 411. It acts as a surfactant (or soap) to make the product stick to coca leaves more effectively. Monsanto specifically warns against adding surfactants to their product. A study published by the Universidad de Antioquia (Colombia) entitled *Assessment of toxic effects and lethal concentration of surfactant Cosmoflux 411F on*

juveniles of cachamar blanca (Piaractus brachypomus), demonstrated how dangerous, even lethal, this substance is for fishes and other aquatic species. To see the paper, visit:

http://www.scielo.org.co/scielo.php?pid=S0120-06902007000400003&script=sci_abstract&tlng=en

iv) The health and environmental impacts of fumigation have been well documented: "The adverse effects on human health and the environment due to exposure to the spray chemicals may be considerably more severe than has been officially acknowledged."

Chemical Reactions: A WOLA Report on the Failure of Anti-Drug Fumigation in Colombia, Washington Office on Latin America (WOLA), 2008

http://www.wola.org/index.php?option=com_content&task=viewp&id=669&Itemid=2

"A number of studies have found that Roundup is far more toxic than glyphosate alone. This is often due to the presence of an "inert" ingredient called polyethoxylated tallowamine, or POEA. POEA is added to help the herbicide penetrate into the plant leaves. The herbicide mixture used in Colombia contains POEA."

New Science on Roundup: Threats to Human Health and Wildlife, Latin America Working Group, 2005

http://www.lawg.org/countries/colombia/Roundup_Fact_Sheet.htm

v) Plan Colombia was first proposed in 1998 by Colombian president Pastrana as an integrated and balanced development and counternarcotics plan. The Clinton Administration militarized the program and began fumigations in 2001.

Background information

Latin America Working Group. (2002). *Blunt Instrument: The United State's punitive fumigation program in Colombia*. Washington, DC: Latin America Working Group. Retrieved from

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<http://www.lawg.org/storage/lawg/documents/going2extremesfinal.pdf>

Transnational Institute. (2007). *Crop spraying: a déjà vu debate: From the Andean strategy to the Afghan strategy* (Drug Policy Briefing No 25, December 2007).

Amsterdam, Netherlands: Author. Retrieved from

http://www.tni.org/detail_page.phtml?&act_id=17711

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http://www.wola.org/index.php?option=com_content&task=viewp&id=669&Itemid=2

Glossary

blood borne viruses (BBV)	<p>BBVs are viruses that some people carry in their blood and which may cause severe disease in certain people and few or no symptoms in others. The virus can spread to another person, whether the carrier of the virus is ill or not.</p> <p>The main BBVs of concern are: hepatitis B virus (HBV), hepatitis C virus and hepatitis D virus, which all cause hepatitis, a disease of the liver; and human immunodeficiency virus (HIV) which causes acquired immune deficiency syndrome (AIDS), affecting the immune system of the body.</p>
buprenorphine	<p>Brand name Subutex, this is a medication used in opiate substitution therapy for people who are dependent on heroin or other illicit opioids. Buprenorphine is a semi-synthetic opioid with partial agonist and antagonist actions. This means it eases withdrawal symptoms and helps to reduce cravings for heroin and other street opioids, but, in proper doses, gives the user no euphoric effect.</p>
CND	<p>Commission on Narcotic Drugs. This was established in 1946 as the central policy-making body of the United Nations in drug-related matters. www.unodc.org/unodc/en/commissions/CND/index.html</p>
contaminated needles	<p>Injecting drug users sometimes share injecting equipment. This puts them at risk of contracting blood borne viruses (BBVs) such as HIV and Hepatitis B or C. Even a tiny amount of blood left on a needle from an infected person can be enough to cause spread to others. Using other used injecting items such as syringes, etc, is sometimes a cause of infection.</p>
controlled drugs	<p>A drug or chemical whose manufacture, possession and use are regulated. This may include illegal drugs and prescription medications.</p>
crop eradication	<p>The destruction of illicit crops through either manual or chemical means. Manual or mechanical means is most common, except in Colombia where aeroplanes are employed to spray herbicides. Occasionally, farmers undertake crop eradication voluntarily in exchange for aid, but it is more often forced eradication.</p>
demand reduction	<p>Demand reduction refers to efforts aimed at reducing public desire for illegal and illicit drugs. This drug policy is in contrast to the reduction of drug supply, but the two policies are often implemented together.</p>

drug dependence	Dependency describes a compulsion to continue taking a drug in order to feel good or to avoid feeling bad. When this is done to avoid physical discomfort or withdrawal, it is known as physical dependence; when it has a psychological aspect (the need for stimulation or pleasure, or to escape reality) then it is known as psychological dependence.
drug detoxification	Detoxification or detox describes the way in which a drug such as heroin is eliminated from a drug user's body, often with the help of a doctor and/ or specialist drug worker. This is often a gradual process and may take a number of days or weeks.
drug prohibition	<p>The prohibition (forbidding) of drug use through legislation or religious law is a common means of attempting to control drug use. Prohibition of drugs has existed at various levels of government or other authority, from the Middle Ages to the present.</p> <p>While most drugs are legal to possess, many countries regulate the manufacture, distribution, marketing and sale of some drugs, for instance through a prescription system. Only certain drugs are banned with a "blanket prohibition" against all use.</p> <p>Many governments do not criminalise the possession of a limited quantity of certain drugs for personal use, while still prohibiting their sale or manufacture, or possession in large quantities. Some laws set a specific volume of a particular drug, above which is considered ipso jure to be evidence of trafficking or sale of the drug.</p>
drug rehabilitation (rehab)	An umbrella term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and so-called street drugs such as cocaine, heroin or amphetamines. The general intent is to enable the user to cease substance misuse.
drug use / misuse / abuse	<p>Drug use is an easy term to understand. Drug misuse and drug abuse are more difficult to pin down as they are highly subjective. In most circles, misuse means using in a socially unacceptable way. However, for many people, misuse is defined as using drugs in a way that results in experience of social, psychological, physical or legal problems related to intoxication and / or regular consumption.</p> <p>Many regard the term abuse as too judgemental, as it suggests impropriety regardless of how the drug is being used. As abuse and misuse can be morally loaded terms, many people prefer to talk of drug-taking or of harmful or problematic use instead, where appropriate.</p>
harm reduction	<p>Refers to policies and projects that aim to reduce the health, social and economic harms associated with the use of psychoactive substances. Needle exchange programmes, for example, are a key harm reduction intervention.</p> <p>Harm reduction is an evidence-based and cost-effective approach. Harm reduction recognises that society is unlikely to ever be drug-, drink- or</p>

	nicotine-free. Harm reduction does not exclude abstinence as a goal for individuals who are dependent but, rather, provides people with more pragmatic choices such as limiting their intake or using drugs more safely.
injecting drug user (IDU)	Someone who uses drugs by injecting them, intravenously (directly into their bloodstream), intramuscularly, or subcutaneously (under the skin).
methadone	This is a medication used in opiate substitution therapy for people who are dependent on heroin or other illicit opioids. Methadone is a long-acting synthetic opioid. This means it eases withdrawal symptoms and reduces cravings for heroin or street opioids, but, in appropriate doses, gives no euphoric effect.
narcotic	Commonly used to mean any illicit drug, especially in the US. However, the term technically refers to chemicals that induce stupor, coma or insensibility to pain, such as opiates or opioids.
needle exchange programmes	A key harm reduction intervention that was borne out of the rise in blood borne viruses such as HIV and hepatitis B/C. Injecting drug users hand in used needles and syringes in return for sterile injecting equipment.
opiate substitution therapy (OST)	<p>A key harm reduction intervention. OST refers to the medical procedure of treating people dependent on illegal opiates such as heroin, by prescribing a longer acting opioid, usually methadone or buprenorphine, that is taken under medical supervision.</p> <p>The driving principle behind OST is that someone dependent on opiates will be able to regain a normal life while being treated with a substance that stops him/her from experiencing withdrawal symptoms and cravings, but does not provide strong euphoria. It also reduces the risk of transmitting blood borne viruses through contaminated needles or other injecting equipment.</p>
opiates	Drugs derived from the opium poppy. Includes morphine, codeine and heroin.
opioids	This term includes both opiates and their synthetic analogues, such as methadone and buprenorphine.
paraphernalia	Equipment used for drug taking e.g. silver foil, spoon, syringe, needle.
problem drug use	Tends to refer to drug use that could be either dependent or recreational. In other words, it is not necessarily the frequency of drug use that is the primary problem, but the effects that the drug-taking have on the user's life (they may, for example, experience social, financial, psychological, physical or legal problems as a result of their drug use).
psychedelic	This term was coined in 1956 by LSD researcher Humphrey Osmond and literally means 'soul manifesting' - an activation of consciousness. Although virtually synonymous with hallucinogenic, psychedelic implies that the drug or experience acts as a catalyst to further feelings and

	thoughts and is not merely hallucinatory.
psychoactive / psychotropic	Perhaps the most all-encompassing ways of describing mood-altering drugs in general, although they are more often used to describe LSD and similar hallucinogenic drugs.
recreational drug use	The use of drugs for pleasure or leisure.
residential rehabilitation, residential services	Residential treatment programmes are usually used by heavily dependent users who experience ongoing social and psychological problems as a result of their drug use. Usually residents must be drug free on admission, which usually entails that the entrant has undergone detoxification before entry. Programmes most commonly last for between three and six months (although some last up to a year).
supply reduction	Supply reduction means using various strategies to disrupt the production and supply of illicit drugs, for example, crop eradication or interrupting the trafficking of drugs. Supply reduction has been used for decades but the evidence is that it is extremely expensive and not cost-effective.
tolerance	Refers to the way the body gets used to the repeated presence of as drug, meaning that higher or more frequent doses are needed to maintain the same effect.
UNAIDS	UNAIDS is the Joint United Nations Programme on HIV/AIDS. This is a joint venture of the United Nations, bringing together the efforts and resources of ten UN agencies to help prevent new HIV infections, care for people living with HIV, and mitigate the impact of the HIV/AIDS epidemic. http://www.unaids.org/en/
UNGASS	United Nations General Assembly Special Session Established in 1945, the UN General Assembly occupies a central position as the chief deliberative, policy-making and representative organ of the United Nations. It also plays a significant role in the process of standard-setting and the codification of international law. The Assembly meets in regular session intensively from September to December each year but reconvenes for Special Sessions when necessary. In 1998 there was an UNGASS on Illicit Drugs. That meeting concluded by adopting a political declaration where actions for the next decade were outlined. As part of a UN review of the success of these measures, another UNGASS is being held on drug policy in New York in 2009.
UNODC	United Nations Office on Drugs And Crime This UN agency was established in 1997 to assist the UN in better

	<p>addressing a coordinated, comprehensive response to the interrelated issues of illicit trafficking in and misuse of drugs, crime prevention and criminal justice, international terrorism, and corruption. It was originally named the Office for Drug Control and Crime Prevention but was renamed as the UNODC in 2002.</p> <p>http://en.wikipedia.org/wiki/United_Nations_Office_on_Drugs_and_Crime - cite note-UN STSGB20046 page1-1 www.unodc.org/</p>
WHO	<p>World Health Organisation. This is the directing and coordinating authority for health within the United Nations system.</p> <p>http://www.who.int/en/</p>
withdrawal	<p>The body's reaction to the sudden absence of a drug to which it has adapted. A range of physical and psychological symptoms may manifest themselves during the period of withdrawal. The effects can be stopped either by taking more of the drug, by managed detoxification or by 'cold turkey' - which may last up to a week.</p>

Background to UN Drug Control Treaties

The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 protocol)
<p>The Single Convention replaces previous international drug controls enacted in the 20th century. Its objective is to restrict the use of narcotic drugs to medical and scientific purposes, and it is focused on plant-based drugs (opiates, cannabis and cocaine).</p> <p>There are two strands to this objective: to suppress illicit drugs and to ensure supplies for medical and scientific use.</p>
The 1971 Convention on Psychotropic Drugs
<p>The Psychotropics Convention is concerned with manufactured drugs such as amphetamines, barbiturates, hallucinogens and minor tranquillisers. It aims to restrict use of these substances to medical and scientific purposes, to suppress illicit production, supply and use while facilitating supplies for medical and research objectives.</p>
The 1988 Convention against the Illicit Trafficking in Narcotic Drugs and Psychotropic Substances
<p>The Trafficking Convention was brought into being to combat the dynamic and flexible trafficking networks that had grown up over the 1970s and 80s.</p> <p>Its objective is to harmonise drug laws and enforcement measures around the world; it obliges signatories to enact specific legislation to criminalise all supply-related activities, and includes measures for judicial co-operation, extradition, seizure of assets, cross-border actions against money-laundering and so on. It also establishes a control regime for precursor chemical used to produce illegal drugs.</p>

List of IDPC member organisations

Organisation	Country	Website
Alcohol and other Drugs Council of Australia, The (ADCA)	Australia	www.adca.org.au
AKZEPT	Germany	www.akzept.org
Andean Information Network (AIN)	Bolivia	www.ain-bolivia.org
Andreas Papandreou Foundation	Greece	www.agp.gr
Asian Harm Reduction Network (AHRN)	Thailand	www.ahrn.net
Association Nationale des Intervenants (ANITEA)	France	www.anitea.fr
Australian National Council on Drugs (ADCA)	Australia	www.ancd.org.au
Beckley Foundation Drug Policy Programme, The (BFDPP)	UK	www.internationaldrugpolicy.net
Canadian Foundation for Drug Policy (CFDP)	Canada	www.cfdp.ca
Caribbean Drug & Alcohol Research Institute (CDARI)	Saint Lucia	www.cdari.org
Connections	UK	www.connectionsproject.eu
Correlation European Network	Netherlands	www.correlation-net.org

Drug Policy Action Group (DPAG)	Ireland	www.drugpolicy.ie
Drug Policy Alliance (DPA)	USA	www.drugpolicy.org
DrugScope	UK	www.drugscope.org.uk
Eurasian Harm Reduction Network (EHRN)	Lithuania	www.harm-reduction.org
ERIT (The Federation of European Professionals Working in the Field of Drug Abuse)	Belgium	www.erit.org
Forum Droghe	Italy	www.fuoriluogo.it
Groupement Romand D'Études des Addictions (GREA)	Portugal	www.grea.ch
Hungarian Civil Liberties Union (HCLU)	Hungary	www.drugreporter.net
Indian Lawyers Collective	India	www.lawyerscollective.org
Intercambios	Argentina	www.intercambios.org.ar
International Harm Reduction Association (IHRA)	Australia, UK	www.ihra.net
International Harm Reduction Development Program (IHRD)	USA	www.soros.org/initiatives/health/focus/ihrd
New Zealand Drug Foundation (NZDF)	New Zealand	www.nzdf.org.nz
Release	UK	www.release.org.uk

South Eastern European Adriatic Addiction Treatment Network (SEEAN)	Slovenia	www.seea.net
Society for the Promotion of Youth & Masses (SPYM)	India	www.spym.org
Transnational Institute Drugs & Democracy Programme (TNI)	International	www.tni.org
Viva Rio	Brazil	www.vivario.org.br
Washington Office on Latin America (WOLA)	USA	www.wola.org