# Addiction & the Humanities, Vol. 7(5) – Mission Accomplished? A look at the suggestions laid forth in the Global Commission of Drug Policy report.

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The United Nations Global Commission of Drug Policy (GCDP) released a scathing report on the War on Drugs this month. According to the GCDP, an independent group composed mainly of current and former politicians and businessmen, the War on Drugs "has failed, with devastating consequences for individuals and societies around the world" (Global Commission on Drug Policy, 2011, p. 2). In addition to this condemnation, the report also calls for governments to prioritize harm-reduction policies over criminalization and reduction in the supply of illicit drugs. Today's BASIS reviews research related to some of the suggestions included in the GCDP report.

**The Current State of the War on Drugs**

The term 'War on Drugs' can be traced back to 1971, when President Nixon declared war on drugs, citing drug abuse as "public enemy number 1". Two years later, President Nixon created the Drug Enforcement Administration and initiated an international crackdown on drug production and trafficking (NPR, 2007). Internationally, the UN Single Convention on Narcotic Drugs, signed during 1961, governs the production and trade of narcotics. While the Single Convention does not itself prohibit trafficking, it requires participating countries to pass ordinances controlling and criminalizing the production, trafficking and consumption of illicit drugs (United Nations, 1961).

*Supply-Reduction Strategies*

The US-led War on Drugs focuses on reducing the supply of illicit drugs with aggressive campaigns against growers and traffickers. Market forces dictate that reducing supply without reducing demand increases prices and therefore profits

for suppliers. This, in turn, encourages more players to enter the market. (Global Commission on Drug Policy, 2011). Furthermore, supply-reduction strategies cost a massive amount of money: a report suggests the US alone spent more than $35 billion on supply-reduction between 1981 and 2003, but only intercepted between 5-15% of drug imports (Vásquez, 2003).

Studies on supply reduction are rare, given the illicit nature of the trade and unpredictable supply levels. During 2001, Australia experienced a sudden and unexpected decrease in heroin supply. The majority of supply-reduction studies focus on this episode. According to one study, this reduction correlated with fewer heroin-related ambulance calls and increased enrollment in methadone-treatment clinics in the Australian Capital Territory (Smithson, McFadden, Mwesigye, & Casey, 2004). Interviews with law enforcement officers in nearby New South Wales, however, suggest a shift in demand from heroin to cocaine and other illicit drugs (Degenhardt, Conroy, Gilmour, & Collins, 2005).

These studies are not ideal and do not directly or fully evaluate supply-reduction strategies, but they do provide some insight on the practice. Profound supply reduction is associated with decreased usage of that substance, but might increase usage of other substances in the short term. It is unclear whether long-term small restrictions in supply have similar effects.

**Harm Reduction vs. criminalization**

A central philosophy of the War on Drugs is the idea that drug use is morally unacceptable, and any production, use, or possession should be treated as a criminal offense. The GCDP report, however, calls on governments to reject this idea and embrace the principles of harm-reduction instead. Harm-reduction stems from the idea that some drug use is inevitable, and the government should focus on minimizing the harm this use creates for individuals and society. Examples of harm-reduction policies include needle exchange programs, supervised injection facilities, safe-ride programs to prevent DUI, and more. Proponents of criminalization policies often cite ‘process’ measures, such as number of arrests or quantity of drugs seized, to argue the efficacy of their policies. The GCDP argue that these measures are irrelevant, as they do not measure the benefits of such policies on the welfare of the population; instead, the focus should be on ‘outcome’ measures, such as drug-related deaths prevented or diseases prevented. Harm-reduction policies should influence such outcome measures, as

well as some process measures.

*Illustration: Harm Reduction-Based Treatments*

Harm reduction treatments focus on reducing the harm drug use causes to users and the community, rather than reducing the use of drugs *per se*. The GCDP recommends encouraging this type of treatment, rather than punitive punishments, such as heavy fines, criminal sentences, and jail time. The GCDP highlights two types of harm-reduction treatments, in particular: Supervised Injection Facilities and Heroin Assisted Therapy.

Supervised Injection Facilities (SIF) are sites where users can use drugs previously purchased in a safe, supervised facility. The SIF provides clean needles and nursing staff to guard against overdose and adverse reactions. Many also offer counseling and treatment for users who wish to overcome their habits (Marshall, Milloy, Wood, Montaner, & Kerr, 2011). The first SIF in North America opened in Vancouver during 2003, and saw over 300,000 visits per year (Vancouver Costal Health). A retrospective study found that the rate of fatal overdose within a 500 meter (0.3 mile) radius of the SIF decreased 35% during the two years after the opening of the facility, compared to the same span before the facility opening. This decrease is much greater than the 9.3% reduction in citywide overdose fatalities during the same period (Marshall, et al., 2011). Andresen and Boyd (2010) estimate that the SIF facility prevents 35 new HIV cases and 3 deaths annually, translating to over C$6 million in societal benefit. However, a more recent study suggests the HIV reduction is more likely to be in the range of 4-8 cases annually, much lower than previously estimated (Pinkerton, 2011). The SIF has enjoyed strong support from law enforcement and residents of Vancouver, although the site faces a funding dispute, potentially challenging its future (Marshall, et al., 2011). Please refer to a previous BASIS op-ed for further details about SIFs.

Heroin-assisted treatment (HAT) involves providing heroin users with controlled doses of heroin in a supervised setting, in addition to additional doses of methadone. Programs intend HAT to reduce the continued illicit drug use seen by those in methadone treatment. Nevertheless, HAT remains controversial, and studies are rare. Blanken et al. (2010) found that the randomized control Dutch HAT trial resulted in 22-25% abstinence one year after treatment, compared to 4-12% for the methadone-only treatment. A similar randomized-control trial

among heroin users in the UK who failed conventional methadone treatment found 72% of patients on injectable heroin tested negative for street heroin more than half of the time, compared to 27% of participants treated with methadone alone (Strang et al., 2010).

**Decriminalization and Legalization**

In line with the concepts and philosophies of harm-reduction is decriminalization. Under decriminalization, possession and use of drugs remains illegal, but users are no longer subject to criminal penalties; administrative sanctions and/or fines replace jail time. Decriminalization often is controversial, with opponents often claiming that decriminalization represents a government endorsement of drug use, leading to unbridled drug use (DuPont & Voth, 1995).

Portugal might be the poster child of drug decriminalization – the government decriminalized possession and personal use of all drugs during 2001, although producing, dealing and trafficking remain criminal activities. The Portuguese government adopted decriminalization as part of a sweeping revamp of its drug policy, including reallocating funding towards treatment and adoption of several harm-reduction policies (Greenwald, 2009). Between 1999 and 2003, drug-related HIV cases in Portugal decreased 25% and drug-related fatalities decreased by 59%. Fears of rampant drug use also proved unfounded (Tavares, Graça, Martins, & Asensio, 2005). It is important to keep in mind that it is impossible to single out the effect of decriminalization alone, as it was implemented in conjunction with other policies.

| | Legalization goes one-step further than decriminalization: governments exert no punishments against users. So far, no countries have truly legalized drugs (Global Commission on Drug Policy, 2011). However, under Dutch law, sale and consumption of marijuana is illegal, but is not punishable even with sanctions – de facto legalization. Reinarman and colleagues (2004) compared user's self-reported marijuana usage in Amsterdam and San Francisco, where marijuana remains criminalized. Past year marijuana usage is very similar between the two cities: 62% in Amsterdam and 68% in San Francisco reporting any use. Twenty-nine percent of users in Amsterdam and 21% in San Francisco endorsed using marijuana once a week or more. Taken together, these data suggest that neither legalization nor decriminalization is associated with large increases in drug use prevalence. Money spent enforcing criminalization laws can be reallocated to treatment and other programs. |
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**Other Suggestions**

The GCDP report also lays out several other suggestions beyond the scope of this review. Among these are breaking the stigma and taboo associated with drug use and addiction, diverting first-time offenders from jail to treatment and alternative sentences, and increased coordination between governments and inter-governmental institutions, such as the UN to provide a unified global strategy against drugs. The full report is available on the GCDP website (http://www.globalcommissionondrugs.org/Report).

**Conclusion**

Many of the suggestions contained within the GCDP report show promise. Harm-reduction guided policies effectively target public health concerns. Whether countries follow Portugal's lead and adopt such procedures or remain stalwartly supportive of the War on Drugs remains to be seen.

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**References**

Andresen, M. A., & Boyd, N. (2010). A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy, 21*, 70-76. doi: 10.1016/j.drugpo.2009.03.004

Blanken, P., van den Brink, W., Hendriks, V. M., Huijsman, I. A., Klous, M. G., Rook, E. J., . . . van Ree, J. M. (2010). Heroin-assisted treatment in the Netherlands: History, findings and international context. *European Neuropsychopharmacology, 20*(S2), S105-S158. doi: 10.1016/S0924-977X(10)70001-8

Degenhardt, L., Conroy, E., Gilmour, S., & Collins, L. (2005). The effect of a reduction in heroin supply in Australia upon drug distribution and acquisitive crime. *British Journal of Criminology, 45*(1), 2-24. doi: 10.1093/bjc/azh096

DuPont, R. L., & Voth, E. A. (1995). Drug legalization, harm reduction and drug policy. *Annals of Internal Medicine, 123*(6), 461-465.

Global Commission on Drug Policy. (2011). *War on Drugs: Report of the Global Commission on Drug Policy.* Rio de Janeiro, AR: Global Commission on Drug Policy.

Greenwald, G. (2009). *Drug decriminialization in Portugal: Lessons for creating fair and successful drug policies*. Washington, DC: The Cato Institute.

Marshall, B. D., Milloy, M.-J., Wood, E., Montaner, J. S., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *Lancet, 377*(1429-1437). doi: 10.1016/S0140-6736(10)62353-7

NPR. (2007, Apr. 2). Timeline: America's War on Drugs Retrieved Jun. 22, 2011, from http://www.npr.org/templates/story/story.php?storyId=9252490

Pinkerton, S. D. (2011). How many HIV infections are prevented by Vancouver Canada's supervised injection facility? *International Journal of Drug Policy, 22*(3), 179-183. doi: 10.1016/j.drugpo.2011.03.003

Reinarman, C., Cohen, P. D., & Kaal, H. L. (2004). The limited relevance of drug policy: Cannabis in Amsteram and in San Francisco. *American Journal of Public Health, 94*, 836-842. doi: 10.2105/AJPH.94.5.836

Smithson, M., McFadden, M., Mwesigye, S.-E., & Casey, T. (2004). The impact of illicit drug supply reduction on health and social outcomes: The heroin shortage in the Australian Capital Territory. *Addiction, 99*(3), 340-348. doi: 10.1046/j.1360-0443.2003.00603.x

Strang, J., Metrebian, N., Lintzeris, N., Potts, L., Carnwath, T., Mayet, S., . . . Forzisi, L. (2010). Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): a randomised trial. *Lancet, 375*, 1885-1895. doi: 10.1016/S0140-6736(10)60349-2

Tavares, L. V., Graça, P. M., Martins, O., & Asensio, M. (2005). *External and Independent Evaluation of the "National Strategy for the Fight Against Drugs" and of the "National Action Plan for the Fight Against Drugs and Drug Addiction – Horizon 2004"*. Lisbon, PT: Portuguese National Institute of Public Administration.

United Nations. Single Convention on Narcotic Drugs (1961).

Vancouver Costal Health. User Statistics. *Supervised Injection Site* Retrieved Jun. 22, 2011, from http://supervisedinjection.vch.ca/research/supporting_research/

Vásquez, I. (2003). *56. The International War On Drugs.* Washington, DC: Cato Institute.