



Commentary

Seeing through the public health smoke-screen in drug policy

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ARTICLE INFO

Article history:

Received 24 November 2016

Received in revised form 20 February 2017

Accepted 24 February 2017

Available online xxx

Keywords:

Drug policy

Public health

Drug dependence treatment

Human rights

ABSTRACT

In deliberations on drug policy in United Nations fora, a consensus has emerged that drug use and drug dependence should be treated primarily as public health concerns rather than as crimes. But what some member states mean by “public health approach” merits scrutiny. Some governments that espouse treating people who use drugs as “patients, not criminals” still subject them to prison-like detention in the name of drug-dependence treatment or otherwise do not take measures to provide scientifically sound treatment and humane social support to those who need them. Even drug treatment courts, which the U.S. and other countries hold up as examples of a public health approach to drug dependence, can serve rather to tighten the hold of the criminal justice sector on concerns that should be addressed in the health sector. The political popularity of demonisation of drugs and visibly repressive approaches is an obvious challenge to leadership for truly health-oriented drug control. This commentary offers some thoughts for judging whether a public health approach is worthy of the name and cautions drug policy reformers not to rely on facile commitments to health approaches that are largely rhetorical or that mask policies and activities not in keeping with good public health practise.

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Introduction

The statements by member states at the UN General Assembly Special Session (UNGASS) on the world drug problem in 2016 show that countries are significantly divided on a number of topics central to drug policy reform. For example, many member states expressed their disappointment that the term “harm reduction” still does not figure in the Political Declaration of the UNGASS, while others asserted their clear opposition to mentioning the term. Similarly, there were starkly diverse views on the subject of the use of the death penalty for drug-related offenses, with numerous countries expressing passionate opposition and others defending the use of this measure.

By contrast, one element on which there appeared to be remarkable consensus, at least on a rhetorical level, is the need for a “balanced” approach to drug policy that includes a strong focus on public health, an idea repeatedly noted in the UNGASS outcome document (UN General Assembly, 2016a). Member states – from Norway to Guatemala, Nigeria to India and many in between – in the official record of the UNGASS asserted their commitment to

health-centred drug policy (UN General Assembly, 2016b), including treating drug use as a health rather than policing problem. Some, such as Thailand, explicitly endorsed the idea that “drug users should receive treatment and rehabilitation, not incarceration” (UN General Assembly, 2016b, Pt.4).

In distinct ways, Thailand and the US exemplify the inherent challenge of these statements. In 2013, it was estimated that about 60% of people receiving – or meant to be receiving – treatment for drug dependence in Thailand were doing so in detention centres where international observers concluded that that “treatment” consisted more of forced labour and humiliation than of anything that could be called scientifically sound care (Hayashi, Small et al., 2013). In addition, Thailand, like many other countries that profess to treat drug use as a health rather than a criminal law problem, also has a poor record on comprehensive HIV prevention, including harm reduction measures, for people who use drugs (Hayashi, Ti et al., 2013). In the United States, where drug policy-makers have for some time publicly espoused treating drug use as the health issue, court-supervised treatment of drug dependence as an alternative to incarceration through specialised drug courts is the linchpin of this approach (Botticelli, 2015). However, as discussed below, basing this ostensible health intervention in the criminal

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justice system calls into question a commitment to the fundamentals of a public health approach.

People interested in the reform of drug policy towards more “balanced” approaches in the post-UNGASS period face many challenges; a salient and enduring one is working out how to assess commitments and actions meant to reflect “public health approaches” to drug control. The objective of this commentary is to suggest that the near universal espousal of public health approaches to drug policy merits careful consideration of the effectiveness and credibility of efforts to put health at the centre of drug policy.

Public health approach to drug policy: UN and expert views

For purposes of this discussion, we take public health to mean preventing disease, prolonging life and improving the health and well-being of entire populations, for which the state has an inherent responsibility (WHO, 1998). The UN Commission on Narcotic Drugs (CND) has long recognised a role for public health in drug control. Member states report drug control progress according to the three-part framework comprising supply reduction, demand reduction – which includes treatment for drug dependence and prevention of drug use – and the combating of money laundering (UN Commission on Narcotic Drugs, 2014). Based on this framework, the UN Office on Drugs and Crime (UNODC) and its predecessor, the UN International Drug Control Programme (UNIDCP), encouraged national governments to establish inter-ministerial drug control authorities that include the health sector, especially because of its role in demand reduction (UNIDCP, 2002). The 2016 UNGASS outcome document reiterates that “successfully addressing and countering the world drug problem requires close cooperation and coordination among domestic authorities at all levels, particularly in the health, education, justice and law enforcement sectors, taking into account their respective areas of competence under national legislation” (UN General Assembly, 2016a).

CND resolutions have highlighted a specific role of the health sector in establishing services and practices that can constitute an alternative to managing minor drug offenses in the criminal justice system. A 2015 resolution, for example, “invites” member states to establish “measures aimed at reducing demand for drugs and promoting public health, in particular for those convicted of drug-related offences of a minor nature, by offering alternative measures to conviction or punishment . . .” (UN Commission on Narcotic Drugs, 2015). This idea is echoed in the 2016 UNGASS outcome document and, as noted above, was articulated by numerous countries in their UNGASS statements.

The report of the Johns Hopkins–Lancet Commission on Public Health and International Drug Policy, also issued in 2016, was the effort of a 26-member panel of international experts to define key elements of a public health approach to drug control (Csete et al., 2016). This panel concluded that a public health approach would feature, among other things:

- minimising incarceration linked to minor, non-violent drug infractions in favour of offering voluntary health and social services – not just drug dependence treatment – as needed;
- a state commitment to comprehensive, scaled-up, affordable, accessible HIV, HCV and tuberculosis prevention and treatment for people who use drugs, including harm reduction measures and including services for persons in state custody that are equivalent to those in the community; and
- quality standards and a quality-control oversight and monitoring system to ensure that drug dependence treatment is humane and scientifically sound.

Public health approaches in practice

National governments have brought their own definitions – explicit and implicit – to health approaches to drug control. The Thai and U.S. cases are variations on the theme of committing to treat people who use drugs as “patients, not criminals”. A first concern about reducing the choice to “patient vs. criminal” is the premise that the main alternative to criminal sanctions must be treatment for drug dependence. This idea reinforces the erroneous assumption that all people who use drugs or commit a drug-related infraction are drug-dependent or somehow would benefit from treatment—usually defined as inpatient, abstinence-based treatment—of drug dependence. But UNODC’s 2016 world report estimates that of 247 million people who used drugs in 2014, some 29 million—only 11.7%—have “drug use disorders,” which include dependence (UNODC, 2016). That the majority of users require no treatment for dependence is true for multiple substances, including “hard” drugs such as cocaine, methamphetamine, or heroin.

A second concern is the fact that, while a commitment to appropriate health services for people who use drugs may be laudable, in numerous countries the available treatment or rehabilitation services are not based on health evidence or approaches validated by health experts. Treatment likely to be offered as an alternative to prison is often of poor quality, with little or no oversight or quality control by health authorities, and in the worst cases is abusive and torturous. Thailand is one of a number of countries – along with Malaysia, Vietnam, Cambodia, China, Indonesia and the Philippines, among others (Amon, Pearshouse, Cohen, & Schleifer, 2014) – that operate what the United Nations calls compulsory drug treatment and rehabilitation centres (International Labour Organisation et al., 2012). As noted by the twelve UN entities that together denounced these institutions in 2012 (International Labour Organisation et al., 2012), these centres are in many cases essentially camps that confine people without due process or informed consent and offer virtually nothing in the way of scientifically sound drug dependence treatment but rather compel “patients” to engage in hard labour and humiliating exercises emphasizing the shame of being a drug user (Amon, Pearshouse, Cohen, & Schleifer, 2013; International Labour Organisation et al., 2012). They are run by the military in many cases, and not by military health personnel. In Thailand it was found that, upon release from detention, people who had been through this compulsory “treatment” were reluctant to seek health care in the community, at least partly because of the shame they carried related to their drug use (Kerr et al., 2014).

How does the United States’ version of “patient, not criminal” compare? As noted above, drug treatment courts (or drug courts) are for the US the centrepiece of an ostensibly compassionate, health-oriented approach. US officials have repeatedly presented drug courts at CND as a humane alternative to incarceration (see, e.g., Botticelli, 2015; UN Commission on Narcotic Drugs, 2016). Drug courts are a departure from an adversarial approach to adjudication of crimes in that the judge, prosecutor and defence attorney are meant to work together as a “support team” for the accused, all of them in principle working closely with health professionals who provide treatment. In addition to supporting drug courts domestically, the US through the Organization of American States (OAS) has promoted drug courts in Latin America, including in Argentina, Bahamas, Barbados, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Jamaica, Mexico, Panama, Peru, and Trinidad and Tobago (OAS, 2016).

The idea of drug courts is appealing in theory, particularly for countries seeking more health-oriented policies (or approaches that at least appear to be more health-oriented). But as the US

model of drug courts has evolved, their status as a health approach has been called into question. One concern, particularly at a time when the US is facing a crisis of opioid overdose mortality, is that many drug courts exclude medication-assisted therapy (MAT) with methadone or buprenorphine, prescribed to relieve cravings for and injection of opioids, as an option for court-supervised treatment. A 2013 survey of US drug courts found that virtually all of them had opioid-dependent participants, but only 25% allowed methadone maintenance therapy and 40% allowed buprenorphine maintenance (Matusow et al., 2013). Reasons for disallowing MAT included lack of local providers and simply “the court does not permit it” (Matusow et al., 2013). Some courts require MAT patients to withdraw from methadone or buprenorphine in arbitrary time periods that have nothing to do with what is clinically indicated. In New York City, where drug courts have a long history, the handbook given to new or potential participants in Manhattan and Brooklyn informs them that methadone patients will have their doses halved for the first four months and then will be required to “detox from methadone” for the remainder of their time in the court (Manhattan Treatment Court, 2005). This directive is despite substantial evidence that these medications reduce injection and HIV risk, improve adherence to HIV treatment and other medical regimens, increase family function and social satisfaction, and reduce risk of overdose.

Drug court prejudice against these medicines highlights a key weakness of these courts as a “health” intervention—that judges and drug court coordinators, most of whom are not trained as health professionals, are making clinical decisions better made by medically trained people or are vetoing the advice of health professionals. Responding to this situation, the US government’s Substance Abuse and Mental Health Service Administration (SAMHSA) informed drug courts that courts requiring patients to end MAT would no longer receive SAMHSA grants (US Department of Health and Human Services, 2015). At the same time, SAMHSA encouraged the courts to use up to 20% of their grants to fund MAT. Given the political popularity of the courts and the support that many courts receive from non-federal sources, it is not clear how effective this measure will be. Initial reports suggest that some drug courts are recommending exclusive use of another medication—injections with the long-acting opioid blocker naltrexone—as a way of complying with the SAMSHA requirement that they offer medication assisted treatment, while continuing to deny access to methadone and buprenorphine since these carry an intoxicating effect.

Preference for the opioid blocker naltrexone by drug courts and other criminal justice programs—including jails, prisons, and re-entry programs—reflects the intrusion of drug control into medical decisions. A recent survey of these criminal justice actors found that the majority said that they preferred injectable naltrexone based on the clinical evidence, despite the fact that there have been no head-to-head trials of naltrexone with buprenorphine or methadone, and that comparisons of oral naltrexone to these medications have found the former inferior (Festinger, Dugosh, Gastfriend, & Sierka, 2016).

A larger health question surrounding drug courts, at least under the US model, is whether they actually divert people from prison, incarceration being a direct and dire threat to the health of people who use drugs (Csete et al., 2016). In the US, drug courts were designed specifically to address the mass incarceration crisis by providing large numbers of non-violent drug “offenders” with an alternative to prison (Franco, 2010). But they do not seem to have made a dent in the prison population, partly because the courts, though numerous in the US, serve relatively small numbers of persons (Franco, 2010). In addition, at least in some jurisdictions, drug court participants may be incarcerated if they “fail” their court-supervised treatment program. One analysis of 19 US

jurisdictions found, for example, that persons in drug court programs did not spend less time in state custody overall than controls outside the drug court system, partly because prison sentences were their punishment for relapse or other treatment “failure” (Seigny, Fuleihan, & Ferdik, 2013). In the US, drug courts generally require that participants plead guilty to whatever charge is brought against them (Franco, 2010). If they “fail” in drug court, they may be returned to the regular court system, where their previous guilty plea removes the possibility of arguing for the more lenient sentence they might have received had they not chosen court-supervised treatment.

For these and other reasons, advocates have criticised US drug courts as “widening the net” of the criminal justice system on minor drug offenses rather than providing a true health-centred approach (Drug Policy Alliance, 2014). In 2016, the US government announced that it planned for the first time to allocate approximately equal funding to demand reduction and supply reduction efforts in the federal budget (Botticelli, 2016). Drug court funding is counted as demand reduction and “treatment”, but the experience of these courts calls into question whether it belongs in that category.

Thailand and the US are far from alone in espousing health approaches to drug control that seem in some ways to undermine health. For example, citing a range of cases from around the world, the United Nations Special Rapporteur on Torture in 2013 condemned “drug treatment” practises in “re-education through labour” centres or camps . . . commonly run by military or paramilitary, police or security forces, or private companies” that feature state-sanctioned beating, whipping, electrical shocks and many forms of “intentional humiliation” (Méndez, 2013). In an open letter on the occasion of the 2016 UNGASS, this Special Rapporteur and four of his peers (with mandates on the right to health, children’s rights, arbitrary detention, and extrajudicial killing) emphasised the importance of international quality standards for treatment of drug dependence and criticised the UNGASS outcome document for failing “to acknowledge that informed consent is a legal requirement to safeguard against torture and other forms of inhuman or degrading treatment” in managing drug dependence and rehabilitation (Adjovi, Heyns, Méndez, Puras, & Mezmur, 2016). Proposing treatment for drug dependence as an alternative to incarceration for non-violent drug offenses is farcical or worse if treatment services abuse people’s rights with impunity.

In many countries, even evidence-based drug dependence interventions are blurred with drug control measures, with the emphasis on regulation and control giving the lie to claims that countries are using a “health” approach. Across Eastern Europe and Asia, for example, enrolment in government addiction treatment programs is accompanied by mandatory registration as a drug user, with names on the registry shared by regulation or practise with police (Wolfe, Carrieri, & Shepard, 2010). Take-home doses of methadone treatment, a standard practise across Europe, are unavailable or too tightly regulated, burdening patients with the requirement of daily visits. In Mauritius, methadone dispensing facilities have been moved to the grounds of police stations (Republic of Mauritius, 2015)—a powerful deterrent to opioid-dependent individuals who have had negative experiences with police. In Ukraine, regulations require storage of methadone in a steel safe in a steel-lined room with a direct line to a police station (Government of Ukraine, 2009).

Change faces stumbling blocks

In Thailand, the US and many other countries, it is clear that many forces mitigate against true public health approaches to drug policy. An important one is the political appeal of abstinence-based

approaches and – the other side of the coin – rejection of harm reduction as a central pillar of drug policy. Thailand, for example, continues to espouse a “drug-free society” as the principal goal of drug policy (Windle, 2016). In addition to the detention of thousands in the compulsory treatment centres discussed above, over 60% of people in Thai prisons are there for drug-related offenses (PSI Thailand Foundation, 2015), and needle-sharing and other unsafe injection are estimated to be rampant in prison (Windle, 2016). While Thailand is praised for its work on HIV in the general population (UNAIDS, 2016), a very small percentage of HIV-positive people who use drugs receives antiretroviral therapy, and access to clean injection equipment and OST remains limited (Mathers et al., 2010; PSI Thailand Foundation, 2015). As Windle (2016) notes, while espousing a “compassionate” approach to people who use drugs, the compulsory treatment centres, calls for the death of drug dealers, and other repressive measures are popular with both the public and the media and will not yield easily to reasoned debates on harm reduction.

In the US in the Obama years, official drug policy statements imbued with “public health approach” commitments seemed to eschew the old “just say no” language of abstinence promotion, but still focused on prevention of all drug use among young people in addition to espousing expansion of treatment of drug dependence (US Office of National Drug Control Policy, 2014). Investment in harm reduction services, including OST, remains woefully inadequate in spite of the commitment to health approaches. As noted by the US Congress’ own auditing branch in 2016, methadone and buprenorphine used for treatment of opioid addiction are subject to much stricter controls than when they are used for pain management, and these stricter regulations discourage potential OST practitioners (US Government Accountability Office, 2016). People in need of OST in many parts of the US, particularly outside of larger cities, face long waiting lists if indeed there are any providers at all to serve them (US Government Accountability Office, 2016). And in spite of numerous studies, some federally funded, on the effectiveness of syringe programmes for HIV prevention and even as HIV and HCV are resurgent with opioid injection, “unfounded fears, stigmas, prejudices, and ignorance” still prevent the expansion of provision of clean injection equipment in the US (Kalichman, 2017).

Again, the US and Thailand are not alone. Even countries that have at times embraced harm reduction as a central element of drug policy run into changing political winds. In the UK, for example, a history of pioneering leadership in harm reduction services gave way around 2010 to the politics of a “recovery” agenda that established a “drug-free life” as a central drug policy goal, complete with a recrafting of methadone maintenance therapy as a barrier to sobriety rather than essential care (McKeganey, 2014). Drug policy reform advocates have charged that forcing people off long-term OST has contributed to a spike in drug-related deaths in the UK since the policy changed (Release, 2014).

Conclusion

The Johns Hopkins–*Lancet* Commission recommended that countries consider decriminalisation of minor drug offenses as a means of facilitating access to health services, citing the experiences of Portugal and the Czech Republic (Csete et al., 2016). But the same political factors that make harm reduction a challenging topic for policy-makers and the public may make decriminalisation a political impossibility. Nonetheless, even if a change in drug law is not on the immediate political horizon, a commitment to public health approaches to drug use and drug policy should open discussions about how appropriate, respectful and evidence-based health services and social support can be

scaled up for people who use drugs – in the community as well as in custodial settings – and monitored for their impact on individuals and communities.

In a report prepared on the occasion of the UNGASS, the Joint UN Programme on HIV/AIDS (UNAIDS) emphasized that health-oriented drug policy must inherently be human rights-based policy. Drug policy that aspires to “ensure the health, well-being and security” of all concerned cannot succeed without being respectful of the rights of people who use drugs and their communities and ensuring their equal access to services delivered respectfully and with measures of accountability built in (UNAIDS, 2015). Current standards for treatment of drug dependence drafted by WHO and UNODC also emphasise that human rights norms must shape treatment, recognising that it has too frequently been a source of cruel and degrading interventions (WHO and UNODC, 2016). Human rights approaches require political leadership of the kind that is willing to take the political heat in eschewing easy promotion of repression in favour of less politically popular approaches more beneficial to health.

Reformers looking towards a new era of humane and evidence-informed drug policy must know how to look beyond rhetorical commitments to public health to implementation of effective programs. “Public health approaches” that cling to incarceration for minor drug offenses, perpetuate myths about harm reduction, subject people to “treatment” that is little different from torture, and give judges and security personnel the authority to make medical decisions are not health-centred at all.

Conflict of interest

The authors have no relevant interests to declare. This commentary did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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