

# **DRUG POLICIES: A REFLECTION OF UNDERSTANDING AND A FRAMEWORK FOR ACTION**

- **Findings From A United Nations Drug Policy & HIV Vulnerability  
Research Study In Asia**

**Adapted from Paper presented at a Meeting of the Global Research Network in  
Melbourne, 11-12 October 2001**

**Adrian Reynolds, M.B.B.S., B.Sc. (Hons.), M.P.H.**

## **1. INTRODUCTION**

This paper will draw upon the findings of a drug policy and HIV vulnerability research project commissioned by the *UNAIDS-APICT Task Force on Drug Use and HIV Vulnerability in the Asia-Pacific Region* in 1998, in examining the manner in which drug policies are constructed in seven Asian countries and the potential impact of these policy development processes and their technical merits, on public health. In particular, this study was designed to facilitate an examination of whether national drug control and public health laws and policies might be serving to facilitate or impede implementation of interventions designed to reduce the risk of HIV transmission among drug users.

### **1.1 Why Drug Policy is Important**

Drug policy lies at the heart of the challenge facing governments wishing to address drug problems in more effective ways and in particular, wishing to prevent, limit or reverse drug-fuelled HIV epidemics. Drug policies reflect the way governments and their decision-makers understand and view the determinants and the consequences of drug use and the manner in which they believe drug-related problems are best addressed. More generally, policies reflect the importance accorded a particular issue among decision makers and provide a framework for what is possible. Policies also determine the manner in which governments and their organizational instruments can and do respond to particular problems and how governments seek to achieve their aspirations and goals.

## 1.2 UN Drug Policy & HIV Vulnerability Study in Asia

In 1998, an officer of UNAIDS-APICT\* recognized the critical impact of drug policy on the efforts of governments to better address drug problems as they relate to HIV vulnerability. Subsequently, the *UNAIDS-APICT Task force on Drug use and HIV Vulnerability in the Asia Pacific Region* commissioned a study to examine drug policies in the Asia Pacific Region, and in particular, the linkage between drug policy and HIV vulnerability. This study provided for a systematic review of drug policy in seven countries in Asia, representing approximately half of the world's population. Two consultants were selected to undertake this research – Edna Oppenheimer from London, U.K. and Adrian Reynolds (the writer) from Brisbane, Australia. The countries visited were China, Viet Nam, Thailand, Malaysia, Myanmar, India and Nepal. The Task Force selected these countries in substantial part because drug use was recognized as a major determinant of HIV in five out of the seven of them, and loomed ever larger in the other two.♥

During this research project, the researchers met with and interviewed senior government officers in all immediately relevant sectors (Health, Public Health, Narcotics Control, Police, Prisons, Education, Finance, Home Affairs, Economic planning, Justice, Social Justice, Social Welfare and so on), as well as with representatives from key NGOs, International NGOs and UN agencies and with drug users and drug user support groups during field visits. The study was implemented over a three-month period. The researchers examined relevant legislation and government and scientific papers and reports. A sum total of 426 questions were drafted in preparation for the research, across relevant sectors and these were honed down to 19 major areas of inquiry.

---

\* Christian Kroll, UNAIDS-APICT

♥ The final report is available on the UNAIDS website at: <http://www.unaids.org/publications/documents/health/access/Drug.pdf>

1. Information, education and communication activity
2. Acceptance of outreach, peer education and user self-organization approaches and current activity
3. Treatment and prevention interventions
4. Drug substitution treatments – policy and practice
5. Legal situation regarding needles and syringes
6. Managing people with dual drug problems and HIV/ AIDS – policies & practices
7. Drug laws more broadly
8. Criminal justice system and HIV prevention policy and practice in prisons, police lock-ups and detention centres
9. Organizational framework to support & facilitate implementation of health protection policies
10. Consensus building and consulting the general and IDU communities
11. Socio-economic factors influencing drug use
12. Acceptability of the concept and jargon of ‘harm reduction’
13. The policy decision-making process
14. General drug Use and HIV situation data
15. Drug prevention, treatment and control policy development & planning
16. HIV/AIDS prevention, treatment, policy development and planning
17. Drug policy and intervention research
18. Future drug policy options that could be considered

A wide range of issues was examined, including the manner in which drug policy is actually constructed by governments and how it is translated into practice. This policy research included an examination of drug-specific and HIV prevention-related legislation.

Examples of themes explored included the following:

- Is drug use an offence in itself?
- Is the possession of needles and syringes unlawful?
- Do police officers often arrest people for possession of needles and syringes?
- Is treatment abstinence-oriented only?
- Is methadone provided for detoxification?
- Is substitution therapy available?
- Are needle and syringe exchange programmes available?
- Are IDU peer-led approaches available?
- Are policy-makers currently opposed to substitution therapy?
- Are policy-makers currently willing to consider substitution therapy?
- Are policy-makers currently opposed to needle and syringe exchange programmes?
- Are policy-makers currently willing to consider needle and syringe exchange programmes?
- Are policy-makers currently opposed to peer education programmes?
- Is drug use addressed in last HIV/AIDS national plan?
- Is HIV/AIDS addressed in last national drug plan?

The findings were analyzed and reported in terms of constraining factors and facilitators, levers and opportunities for addressing drug use and HIV vulnerability. The survey was completed in May 1999 and the report was distributed to governments and concerned agencies for their review and comments, prior to publication.<sup>1</sup>

<sup>1</sup> Oppenheimer, E & Reynolds, A. “*Drug Use and HIV Vulnerability: Policy Research Study in Asia*”, UNAIDS and United Nations Office for Drug Control and Crime Prevention (2000).

## 2. MAJOR RESEARCH FINDINGS

The results of this study provided some grounds for guarded optimism in certain areas of policy endeavor, for example, some governments would, under certain circumstances, be willing to review their policies concerning interventions to reduce the risk of HIV transmission among people who inject drugs. Particularly important would be regional support for policy reform that is supportive of harm reduction policies and interventions. However, in many other areas, the findings were disturbing. The following are some of the more salient findings of this policy research study:

1. **No coherent framework for problem analysis:** Fundamentally important was an observation that in all seven countries, senior government officers could provide no information to suggest the existence of a coherent framework for analyzing drug use and its determinants, the range of public health problems associated with drug use, the impacts of current policies and interventions and a formal process for achieving remedial policy reforms.
2. **Complex administrative arrangements to deal with drug & HIV Problems:** There are often complex administrative arrangements and a paucity or complete absence of communication, researching, planning and co-ordination between drug control and public health sectors that are serving to seriously impede evidence-informed policy development.
3. **No dialogue between drug control & HIV/AIDS control agencies:** the research revealed in all countries, there was inadequate or no dialogue between drug control and HIV/AIDS control agencies, nor between HIV and drug service professionals
4. **Mechanisms for drug policy development are unclear:** Indeed, this research revealed that it is largely unclear how drug policies are constructed in these countries. In a number of cases, senior policy decision makers from a range of ministries and departments, conceded that they were often unclear themselves about the manner in which policy was actually formulated in their country and the reasons.
5. **No theoretical modelling of policy:** There was no evidence of any theoretical modelling of policy that would allow specific assumptions and hypotheses to be precisely described and tested out.

6. **No processes for routinely examining local and international evidence:** Some senior government decision-makers admitted they did not adopt any systematic process for examining local and international evidence and developing policy with this evidence in mind.
7. **No commitment to searching for evidence generally speaking:** During this study little was found to indicate policy makers routinely search for evidence of any nature, seek expert advice, or take this advice where it is proffered, and understand the principles of evidence-based decision-making.
8. **No commitment to searching for evidence of the determinants of drug use:** Furthermore, little or no evidence was found of a commitment to searching for evidence of the determinants of drug use and related harms and what works best in preventing or mitigating these harms in different settings. Policy decision-makers appear to make a number of untested and clearly contestable assumptions about the nature of the problems and their solutions. These findings were particularly salient to the researchers' task of seeking an understanding of how senior decision-makers formulate drug policy and the reasons for adopting one approach in preference to an alternative set of options.
9. **No questioning of absence of evidential basis or research methodology:** There was no questioning of the absence of evidential basis or research methodology underpinning policy and practice, in any of the countries.
10. **Decision-makers do not appear cognizant of research:** Decision-makers do not appear cognizant of the experiences and research undertaken in their own country and internationally, regarding 'what works' in preventing or reducing HIV transmission among people who inject drugs. They are often not interested to know about evidence and may assert that replicated international research findings are 'not relevant' to their country or culture.
11. **Evidence not to be trusted:** Many senior decision-makers in government hold to the view that evidence not to be trusted unless the research undertaken in own country. However, there was no such insistence on evidence to support a current focus on repression, boot camp treatments and drug education for a 'drug free' nation.
12. **No culture of learning from lessons:** There was little evidence of a policy of continuing review of the impacts and outcomes associated with policy decisions in

any of the study countries or a culture of learning from lessons when it comes to drug problems and no culture of evaluation of current policy and practice. Nor was there evidence or a lessons learned approach. This is considered neither necessary nor important. One notable exception was in Manipur state in north-eastern India, where a policy reversal was adopted in 1997 when it became clear to government that the emphasis on repressive measures was serving to worsen the situation and render prevention effort completely ineffective.

13. **Drug policy dominated by personal opinion & personal belief:** The drug policy study suggested that drug policy is dominated by personal opinion and personal belief. It also revealed that religious belief; socio-cultural traditions and personal moral values play an important role. This stands in tension with the principles of evidence-based processes as demonstrated by evidence-based medicine for example, and the increasing demands of well-informed communities. Evidence is now the guiding beacon for clinical medicine in the most parts of the world. This is not routinely the case when it comes to drug policy and intervention.
14. **Adherence to traditional values is strong:** Adherence to traditional values is strong, rendering debate on HIV/AIDS prevention and sexual behaviour sensitive and difficult.
15. **The ‘tradition’, ‘culture’ & ‘religion’ cards are often dealt:** The ‘tradition’, ‘culture’ & ‘religion’ cards are often dealt as a basis for excluding the possibility of arguably more adaptive policy reforms.
16. **Drug problems treated primarily as a moral issue:** Drug problems in study countries are treated primarily as a moral issue rather than a public health and social policy issue. This continues to seriously hinder efforts to contain the HIV/AIDS epidemic (while acknowledging that the philosophy and practices of harm reduction might in themselves be seen to represent an alternative form of moral endeavour).
17. **Senior policy decision makers reject potential utility of harm reduction policies:** On a number of occasions in discussions, senior policy decision makers said they rejected the potential utility of harm reduction policies and interventions in their own country, on the basis an incorrect claim that there was no evidence to support their implementation in a developing a country context, such as their own. Senior officers in government would also often play the “cultural card” in arguing against the possibility that any such change could be contemplated in their country.

*“We cannot accept it because there is no evidence that it can work in our country and in our cultural setting. It is not possible.”*

18. **Decision makers don’t require evidence in support of current drug policies:** At the same time, these same decision makers did not appear to require, yet alone demand evidence to support the effectiveness of current drug policies and practices in their own country, in the face of demonstrably poor public health and social outcomes associated with current policies.
19. **Countries investing heavily in non-evidence supported approaches:** Study countries are naively investing all or substantial drug control resources in drug and life skills education, lengthy and expensive residential treatment of an involuntary, punitive and non-evidence based nature and repressive law enforcement interventions, as lead or sole strategies.
20. **Redoubling of efforts seen as the solution:** Decision-makers cling to the hope that if only current interventions can be delivered with more commitment and enhanced resources, these approaches will surely succeed.
21. **Harm reduction sends the wrong message:** Health protection/ harm reduction strategies often condemned in study countries as morally incorrect because they “send the wrong message to young people” about drug use.
22. **Some governments willing to consider harm reduction:** Notwithstanding, some governments would, under certain circumstances, be willing to review their policies concerning interventions to reduce the risk of HIV transmission among people who inject drugs.
23. **Scattered selection of harm reduction interventions:** There is a scattered and incoherent selection of harm reduction interventions in the study countries, with no country adopting the full suite of interventions that are supported by evidence.
24. **Less than optimum implementation:** When harm reduction approaches are adopted in study countries (e.g. methadone maintenance) they are often implemented in less than optimum ways and without adequate attention to the lessons learned in their own and many other countries. This is despite a capacity to do so.
25. **Methadone is demonised politically:** Buprenorphine maintenance treatment is offered in one study country instead of methadone because methadone carries a stigma

and is politically unacceptable. This makes little sense since methadone is equally effective overall and is much less expensive for clinically equivalent doses. The country concerned has a very large population living in absolute poverty and needs to use its limited resources in the most cost-effective manner possible. Methadone or even slow release oral morphine would make much more sense in this context.

26. **Health protection measures are not delivered to scale:** The measures that are adopted in an attempt to prevent the spread of HIV among drug users are often localised, short-term, under-funded and insufficient in scope.
27. **Absence of supportive policy and funding frameworks hinders sustainability:** An absence of supportive policy and funding frameworks hinders sustainability. Expensive, resource-demanding interventions are instead adopted to no demonstrated public benefit, save perhaps the satisfaction of 'traditional values'.
28. **Substantial legal and political barriers:** There are substantial legal and political barriers in study countries, which are serving to impede implementation of the most effective preventive interventions available for limiting the spread of HIV infection among people who inject drugs.
29. **Unquestioning application of the UN drug treaties:** The study revealed that senior decision-makers often unquestioningly and unthinkingly orient themselves towards the international drug treaties, as well as associated guidelines and institutions, without probing the merits of their application or seeking evidence in relation to their benefits and costs.
30. **Governments misinterpret meaning & intent of the United Nations drug treaties:** The drug policy study revealed that governments often appear to misinterpret the meaning and intent of the United Nations drug treaties for their own purposes of emphasizing repressive measures over alternative policy approaches.
31. **Senior decision makers confused about UN position on harm reduction:** A number of senior decision-makers in government expressed their confusion about what it is the UN recommended in relation to harm reduction policy. While UNDCP and INCB say one thing, WHO and UNAIDS appear to be saying something quite different in this regard.
32. **Process of policy decision-making is often superficial:** An examination of the process of policy decision-making suggested that it is often superficial and based on a highly questionable analysis of the set of problems.

33. **Widespread denial, complacency, or indifference to public health threats:** There was evidence of widespread denial, complacency, or indifference regarding the public health threats posed by injecting drug use.
34. **Serious paucity of knowledge & understanding of basic scientific methodology:** There was a serious absence, or paucity of knowledge and understanding of basic scientific methodology and scientific evidence on what works, among key decision makers.
35. **Poor understanding of human behavior and it's determinants more generally:** There was also evidence suggesting a poor understanding of human behavior and its determinants more generally, for example, the widely held assumption that education and punishment provide meaningful pathways to the prevention of a wide range of problematic human behaviours.
36. **Emphasis on traditional narrow policy responses – a recipe for poor outcomes:** In all countries examined, there is an emphasis in policy, in resource allocation and in focus, on drug education in schools for a drug free country, repression through law enforcement and interdiction, and in most of the study countries, involuntary military-style boot camp treatment programs.
37. **Drug problems not generally accorded high funding priority:** With the exception of law enforcement, drug problems are not generally accorded high funding priority in the study countries.
38. **Misallocation of funds:** One of the study countries currently invests the equivalent of nearly one-third (29.7%) of its entire health budget in these three low yield and often-counterproductive approaches and government is currently considering further substantial investment in these interventions. This country has serious and substantial alcohol and tobacco problems, but as the following table shows, it allocates no serious funds to these problems. This country also has a very serious and expanding HIV epidemic, particularly amongst injecting drug users. Seventy seven per cent of all known cases of HIUV infection were drug injectors while estimates of HIV seroprevalence among IDU varied from 10-27%. In the face of these serious public health threats, this country allocates disproportionate funding to interventions that are not supported by empirical evidence or by a rigorous in-country evaluation of outcomes. Economists would label this a 'misallocation' of funds. Notwithstanding these substantial investments, the problem of HIV among injecting drug users continues to

grow more serious. Rather than contemplating a shift in policy and funding allocations to respond more effectively to the situation with health protection policies and interventions, government is now seriously considering increases in expenditure in these same interventions, with greatly extended periods of coerced “treatment” (from 2 years to 13 years) and harsher penalties.

	<b>Program Area</b>	<b>Annual Budget</b>	<b>% Health Budget</b>
1.	<i>Tobacco control</i>	USD 400,000	0.011%
2.	<i>Alcohol control</i>	USD 27,000	0.0027%
3.	<i>HIV/AIDS</i>	USD 11.4 MILLION	1.13%
4.	<i>Drug control</i>	USD 297 MILLION	29.7%
5.	<i>Health budget</i>	USD1,000	100%

### 3. DISCUSSION

The following issues are relevant to a consideration of the relationship between drug policy and HIV vulnerability.

#### 3.1 Seeking a More Erudite Understanding of the Determinants of Drug Use

Drug use is often analyzed in terms of traditional public health model - the environment, the individual and the drug, but of course there are other models of analysis and understanding. The evidence and analysis that I present in this paper points to the fact that the pathway to prevention and the pathway out of drug dependence and other drug problems is not a simple one, so simple solutions to the problem are unlikely. In seeking to address problems of any description, it is axiomatic that one needs first to identify and distinguish those factors that have a simple association with the problem and those that may have a causal relationship. to be effective. It is now clear from the research and analysis of authors such as Spooner, Hall & Lynskey (2001)<sup>2</sup>; Keating (1999)<sup>3</sup>; Spooner, Mattick &

<sup>2</sup> Spooner C., Hall W. & Lynskey M. (2001). *The structural Determinants of Youth Drug Use*, Report prepared by the National Drug and Alcohol Research Centre, UNSW for the Australian National Council on Drugs, 2001.

<sup>3</sup> Keating, D. (1999). Developmental health as the wealth of nations. In *Developmental Health and the Wealth of Nations: Social, biological, and educational dynamics* D. Keating and C. Hertzman (eds). New York: Guildford Press, pp. 337-347.

Howard (1996)<sup>4</sup>; Jessor (1998)<sup>5</sup>; Homel et al (1999)<sup>6</sup> and many others that the determinants of drug use are multi-faceted, complex and interactive, and are not influenced only by the activities of health, police, prison or education departments.

Drug use and abuse is not an isolated form of behaviour, a point made repeatedly by a number of authors (Keating & Hertzman, 1999<sup>4</sup>; Jessor, 1998<sup>6</sup>; Rutter, et al, 1998<sup>7</sup>); Problematic drug use usually co-occurs with other types of problem behaviour (Spooner and Hall, 2001)<sup>8</sup>. Rather, drug use sits alongside a raft of other 'problem behaviours' that may have common origins in early childhood development (particularly in the first 6 years of life), family and broader socio-cultural modeling, and the physical, economic and political environments.

This past decade has seen a rapid increase in neurobiological research in the early childhood field. It is now understood that during critical periods in the first few years of life, particular parts of the brain require positive stimulation to develop properly and negative experiences in those early years can have long-lasting effects that are difficult to overcome later. Virtually every aspect of human development, from the brain's evolving neural circuitry to the child's capacity for empathy, is affected by the environments and experiences that are encountered in a cumulative fashion, beginning well before birth and extending until a child is about six (National Research Council and Institute of Medicine, 2000)<sup>9</sup>. This research shows that what happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being but because it sets either a sturdy or a fragile stage for what follows.

This Canadian research found that while the highest risk is in the poorest groups, the largest number of children with problems is spread broadly across the middle classes. Socio-economic status was found to be a key determinant of childhood developmental outcome. The gradient was found to be related to the qualities of the environments that stimulate, support and nurture children, to how work-life conflict is played out, to parenting style, childcare, the resources for remedial work, the security of neighbourhoods, how marriage breakdown is resolved.

---

<sup>4</sup> Spooner, C., R. Mattick and J. Howard (1996). *The Nature and Treatment of Adolescent Substance Abuse* (NDARC Monograph no. 26). Sydney: University of New South Wales, National Drug and Alcohol Research Centre.

<sup>5</sup> Jessor, R. (ed.) (1998). *New Perspectives on Adolescent Risk Behaviour*. Cambridge: Cambridge University Press. National Crime Prevention (1999).

<sup>6</sup> Homel R. et al, *Pathways to Prevention: Developmental and early intervention approaches to crime in Australia* Canberra: Attorney-General's Department.

<sup>7</sup> Rutter, M., Giller, H. & Hagell, A. (1998) *Antisocial behavior by young people* (New York, Cambridge University Press).

<sup>8</sup> Spooner, C & Hall, W. Paper for *Current Opinion in Psychiatry*: Submitted 18 Dec. 01

These findings are consistent with a large body of research demonstrating the complexity and wide array of determinants of health and social well-being (e.g. Marmot et al (1991)<sup>10</sup>; Kennedy et al (1996)<sup>11</sup>; Kawachi et al 1996<sup>12</sup>, UK Department of Health, White Paper, 1998<sup>13</sup>). It follows that if the determinants are multifaceted, complex, and arise substantially outside of those public sector areas where governments commonly invest most heavily, then surely the solutions must also come from new and more sophisticated investments in other sectors and areas of community endeavour that shape human behavior, in this case, drug use behaviors that place people at significant health and social risk.

Spooner & Hall (2001)<sup>10</sup> comment as follows:

*“The co-occurrence of many problem behaviours demands an end to the separate funding of interventions directed at subsets of these behaviours: such as crime prevention, suicide prevention, mental health promotion, and drug prevention programs. A continued dispersion of effort and resources is inefficient; more collaborative efforts are needed.”*

These are the areas that now deserve our closer attention. The international experience, empirical evidence and analysis that is now available to governments suggests they must now reduce their emphasis on individual focused interventions and think more broadly in terms of the macro environment and how this might influence pathways to a range of problem behaviours, including those of crime and unsanctioned, hazardous and harmful drug use. Drug policy is pivotal in this context as it reflects the depth and richness of problem analysis and ‘solution’ selection. One can infer from the literature (e.g. Keating & Hertzman<sup>5</sup>, 1999; Homel et al, 1999<sup>9</sup>; Spooner et al, 2001<sup>4</sup>) that governments are currently failing to strategically address a long list of structural issues that potentially impact on drug use and other problem behaviours. To be fair, many of these issues are very difficult to address, particularly in the context of government structures, funding arrangements and operational processes that are invariably arranged in silos. Governments can’t promise nirvana but clearly, to continue along a present pathway that resembles those chosen by the seven study countries is untenable. The findings of this research, when considered alongside

---

<sup>9</sup> National Research Council and Institute of Medicine; Committee on Integrating the Science of Early Childhood Development; J.P. Shonkoff & D.A. Phillips eds. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*, National Academy Press, Washington, DC.

<sup>10</sup> Marmot, M.G., Davey-Smith, G., Stansfield, S., Patel, C., North, F., Head, J., White, I., Brunner, B. and Fenney, A. 1991, ‘Health Inequalities Among British Civil Servants: The Whitehall II Study’ in *The Lancet*, Volume 337, pp 1387-1393.

<sup>11</sup> Kennedy, B., Kawachi, I., and Prothrow-Smith, D. 1996, ‘Income Distribution and Mortality: cross sectional ecological study of the Robin Hood index in the United States’ *British Medical Journal*, Volume 312, pp 1004-1007.

<sup>12</sup> Kawachi, I., Colditz G.A. et al, (1996). *A prospective study of social networks in relation to total mortality and cardio-vascular disease in men in the U.S.* *Journal of Epidemiology and Community Health*. 50: 245-51.

<sup>13</sup> UK Department of Health, “*Our Healthier Nation - A Contract for Health*”, 1998.

the relevant body of international research, suggest that Governments must now reflect carefully upon the evidence in support of current policies and approaches and if persuaded by this new analysis, must make a start in pursuing new policy directions. There are substantial opportunity costs associated with current funding allocations. Governments like those involved in the drug policy research study can certainly do much more than they are at present to improve outcomes, but they must first convince themselves this is the case and demonstrate a commitment to outcomes based funding in preference to more superficial problem analysis and populist politics.

### **3.2 The Enlightenment and A Valuing of Scientific Methodology**

As a result of this and other studies, one is prompted to ask why is it that so many countries continue to reject scientific methods and empirical evidence as a basis for drug policy decision-making and intervention? Why do they fail to adopt more rigorous processes in formulating, monitoring and evaluating the impacts and outcomes associated with selected policies and approaches? Why is it that personal values and beliefs continue to prevail when local and international evidence in a range of forms, repeatedly suggests yields associated with current approaches are poor and new thinking is required? The explanation may have its origins, at least in part, in the historical period of the Renaissance. This period saw the dawning of a new age of *'The Enlightenment'* when the principles scientific methodology began to usurp religious dogma as a guiding light for human decision-making. Of course, not all countries and cultures embraced this set of intellectual and social reforms, and even today, religious beliefs dominate decision-making in many parts of the world. Of course, even in countries that did embrace the Enlightenment and along with it, a valuing of scientific methodology, there remain significant gaps and inconsistencies and oftentimes, difficulties disconnecting from dogma and non-scientific problem analysis. The drug policy research supports the thesis that nowhere does this disjunction loom larger, is it more obvious, is it more serious, and is it of more concern, than in the drug policy area.

It is to be recognised that it isn't always easy to base decisions on evidence - in some matters there is little quality (especially level I or II) evidence available. Evidence is in any case invariably the subject of expert, political and moral contest. However, to ignore evidence where it exists and to fail to look for evidence where it does not exist, is a recipe for stagnation and invites poor outcomes.

### 3.3 Inequality & Poverty as Determinants of Drug Use

The *UNDP Human Development Report (2000)*<sup>14</sup> describes how in a world of globalization, some countries are benefiting substantially in terms of economic growth and poverty reduction while others are fairing poorly. Economic, social and health inequities have declined in some countries while they have increased in many others. There are clear winners and losers.

Marmot (2001)<sup>12</sup> observes that poverty and inequality overlap but are not the same. Spooner and Hall (2001)<sup>10</sup> make the case that both need to be addressed by public policy if drug use and abuse are to be reduced. Economic and social inequalities, poverty, social tension and violent crime tend to go hand in hand. Drug use is invariably more problematic in such social contests. Spooner and Hall (2001)<sup>10</sup> question whether government policies that have stimulated economic growth and increased wealth in many countries over the past decades, have also increased happiness. They argue to the contrary and point to the increases in prevalence of psychosocial disorders among young people, such as, crime, depression, drug abuse and suicidal behaviour.

In the context of an increasingly deregulated and globalized economic environment, it would seem facile to suggest that hazardous, harmful and unsanctioned drug use can be eliminated or even reduced within the foreseeable future. While the *Special Session of the General Assembly on Drugs* in 1998<sup>15</sup> signaled lofty but scientifically implausible aspirations to the contrary, it is well established that globally, the face of drug use is constantly changing and that overall, the situation is worsening in terms of amounts used and the numbers of people involved (e.g. Commission on Narcotic Drugs, 2001)<sup>16</sup>. Crime and other problem behaviours are also on the increase<sup>17</sup>.

### 3.4 Drug Use is an Adaptive Option for Many - Not a Demon

While conventional wisdom might suggest otherwise, for many people who use illicit or unsanctioned drugs, the use of drugs is in the eyes the most adaptive personal and social option available to them. For many, life offers little in the way of economic, social

---

<sup>14</sup> *UNDP Human Development Report, New York, (2000).*

<sup>15</sup> United Nations Drug Control Programme, *A Drug Free World – We can do it*, General Assembly Special Session on the World Drug Problem, Fact Sheet Kit, New York, 8-10 June 1998.

<sup>16</sup> Economic and Social Council, Commission on Narcotic Drugs, Forty-fourth session, Vienna, 20-29 March 2001. Drug demand reduction: world situation with regard to drug abuse, in particular among children and youth.

and personal opportunity and much angst, boredom, loneliness and suffering while drug use offers relief or escape from these negative emotional and social states and some enjoyment, even if it is short-lived. Not to mention drug dependence and mental health co-morbidity, which is highly over-represented in prevalence among people with alcohol and other drug problems, as important determinants of continuing drug use in the face of great risk or harm<sup>18</sup>

### 3.5 The Punishment Paradigm

The finding that the determinants of drug use are complex and multiple applies to crime and its determinants more generally. The criminology literature is now paying increasing attention to these concepts (e.g. Homel et al, 1999, Aos et al 2001). There is a growing realization in some scientific quarters that the punishment paradigm is not an effective basis for addressing drug problems in a sustainable manner at the population level and that governments need to move towards more expansive and constructive social policy reforms if they are to prevent, reduce, reverse or mitigate problem behaviors such as those related to drug use. Once again, this suggests governments need to move away from a preoccupation with education as prevention and punishment as deterrence, because there is limited evidence to support these approaches and a great deal of evidence pointing to the potential for induced harm (e.g. Hawthorn et al, 1995<sup>19</sup>; Ritchie, 1999<sup>20</sup>; White & Pitts, 1998<sup>21</sup>; Falco, 1996<sup>22</sup>; Rydell et al, 1997<sup>23</sup>; Aos et al, 2001<sup>24</sup>; Wardlaw, 1986<sup>25</sup>; Wardlaw 1992<sup>26</sup>). Indeed, the punishment paradigm is incompatible with more constructive social policy reforms that could afford governments some chance of protecting and promoting public health.

Munro and Milford (2001)<sup>27</sup> argue that drug use in youth is often incidental to a young person's life, a result of curiosity, an experimental phase that passes quickly. They

---

<sup>17</sup> United Nations Office for Drug Control & Crime Prevention, *World Drug Report 2000*, Oxford University Press, 2000.

<sup>18</sup> Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., & Goodwin, F.K. (1990) *Co-morbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) study*. *Journal of the American Medical Association*, 264, 2511-2518.

<sup>19</sup> Hawthorne, G. Garrard J. & Dunt D. *Does life education's drug education programme have a public health benefit?* *Addiction* (1995), Research reports 90, 205-215.

<sup>20</sup> Ritchie, J. *New Study on Drug Education Program*, AOL News, The Associated Press, 3 August 1999.

<sup>21</sup> White D, Pitts M. Educating young people about drugs: a systematic review. *Addiction* 1998;93: 1475-87.

<sup>22</sup> Falco, M. *"US Drug Policy: Addicted to Failure"*. *Foreign Policy*, No. 102, Spring 1996, pp. 120-133, Carnegie Endowment for International Peace

<sup>23</sup> Rydell CP, Caulkins JP, Everingham SS. Enforcement or treatment? Modeling the relative efficacy of alternatives for controlling cocaine. RAND: Santa Monica, CA, USA, 1997.

<sup>24</sup> Aos et al, 2001, Washington State Institute for Public Policy, *The comparative Costs & Benefits of Programs to Reduce Crime*. Document No. 01-05-1201.

<sup>25</sup> Wardlaw, G. *The Realities of Drug Enforcement*, *The Journal of Drug Issues*, 16(2), 171-182, 1986.

<sup>26</sup> Wardlaw, G. in National Campaign Against Drug Abuse: *Overview of National Drug Control Policies: Comparative Analysis of Illicit Drug Strategy*, Monograph Series No. 18, AGPS, Canberra, 1992.

<sup>27</sup> Munro & Midford, Zero tolerance and drug education in Australian schools. *Drug and Alcohol Review* (2001) 20, 105-109.

make the additional point that only a minority of novice users graduate to problematic use and they are likely to be adolescents already troubled. They point out that one of the problems of adopting zero tolerance is the strong possibility that drug use and drug problems will be driven underground, and young people who require assistance will not receive it. They view zero tolerance as an overzealous response that makes no allowance for the natural history of drug use, offers vulnerable young people no help, and may intensify rather than reduce drug problems.

In a criminological literature review, Homel et al (1999)<sup>8</sup> observe: “The roots of criminal offending are complex and cumulative, and embedded in social as well as personal histories”. Particularly salient is the thesis that more effective crime prevention should be based around “developmental approaches that emphasize intervening early in pathways that lead to antisocial or offending behaviour”.

The evidence that prohibition policy has greater effects in physical complications & patterns of use than in levels of use (e.g. Wardlaw 1986)<sup>27</sup> has profound implications for public policy, legislation and community policing activity. It would appear that this evidence has not yet impacted on public policy and community policing activity internationally, in any meaningful manner. Wardlaw (1992)<sup>28</sup>, former Director of the Australian Institute of Criminology, observed: “the most one can reasonably expect of supply-reduction strategies is a holding function—containing the problem at present levels until more-effective demand-reduction strategies are developed, or preventing the situation from getting worse”. However, these considerations have to be balanced against the risks of harm associated with an over investment in ‘supply reduction strategies and the associated opportunity costs, which were found to be substantial in all of the study countries. None of the countries involved in the drug policy study demonstrated an awareness of, or attention to these matters, but to be fair, this is generally the case internationally.

The punishment paradigm dominates policy in the seven countries studied and the Hidden Epidemic Revisited (2002)<sup>28</sup> suggests this is the case in many other developing countries. This does not reflect evidence based thinking. Rather, it reflects undisciplined thinking, and unproductive problem analysis and solution generation. It ought to be of concern to governments that the punishment paradigm is serving to preclude or negate more constructive and potentially more effective approaches to drug use, crime and other problem behaviors.

Given its domination of global thinking and action, the UN Task Force on Drug Use and HIV Vulnerability in the Asia-Pacific Region has on several occasions recommended the punishment paradigm be the subject of international (UN-initiated) research and review, with a view to informing future UN technical support and drug policy guidance. Unfortunately, this idea was not embraced by senior officers of UNDCP and UNAIDS.

### **3.6 Involuntary Treatment of a Punitive Nature – a Faulty Concept & Failed Strategy**

Many governments continue to fund involuntary boot camp type treatments, which are really prisons by a different name. In a study to examine the comparative costs and benefits of programs to reduce crime, Aos et al (2001)<sup>26</sup> found that relative to comparison groups, juvenile offenders in these programs had higher, not lower, subsequent recidivism rates. The average effect size was a positive 0.10; meaning recidivism rates were, on average, about 10 percent higher for boot camp participants compared to juvenile offenders who went through regular juvenile institutional facilities. One might ponder the likely difference if boot camp programs were compared to strategies other than incarceration. Aos et al (2001)<sup>26</sup> point out that boot camp programs were intended to: serve as a cost-effective alternative to institutionalization; promote discipline through physical conditioning and teamwork; instill moral values and a work ethic; promote literacy and increase academic achievement; reduce drug and alcohol abuse; encourage participants to become productive law-abiding citizens; and ensure that offenders are held accountable for their actions. In their review of the ten existing evaluations of juvenile boot camps in the United States, Aos et al (2001) estimate these boot camps are cheaper up front but lead to increased costs to taxpayers and crime victims associated with the higher recidivism rates.

One has to wonder at the rationale for this. While boot camps may be intuitively appealing to some and a political vote winner in many countries, they carry with them substantial opportunity costs. And the strategy allows governments to tick off on the problem politically in claiming they are doing something to address the problem in an effective manner when they are not. At the same time, governments abrogate their responsibility to continuously monitor their policies and actions and to search for evidence of effectiveness and induced harm.

---

<sup>28</sup> Reid, G & Costigan G, A situation assessment of Drug Use in Asia in the Context of HIV/AIDS. The Centre for Harm Reduction, The Burnet Institute, Australia, January 2002.

What is more, in some of the study countries, incarceration is known to be associated with a substantial increase in risk for exposure to HIV and a range of other transmissible diseases. In one study country in particular, HIV sero-prevalence rates are reported to be as high as 95% in some of its involuntary ‘treatment’ centers. It is known that high-risk drug use is a serious problem in these centers and it would appear that treatment approaches of this nature bring with them a triple punishment – a double punishment to the individual whose liberty is taken and who enters ‘treatment’ free of disease and leaves with HIV/AIDS and other diseases and a further punishment to the community to which the individual returns, whereby the disease acquired while in treatment is transmitted to many others. This represents a public health and human rights crisis of the highest proportions. It is simply not possible to defend public policies that allow and promote public sector responses to drug problems of this nature. In attempting to address drug problems on the basis of demonstrably incorrect assumptions about the determinants to a set of health endangering and unsanctioned social behaviours and their remedy, policy decision-makers are wittingly or unwittingly actively fueling HIV epidemics in their country.

It would appear that the seven study countries provide but a window to broader international approaches to drug policy decision-making and intervention. The punishment and seclusion paradigms continue to dominate drug policy and political decision-making in the seven study countries as they do in many other countries of the world. Assumptions of punishment as deterrence continue to go unquestioned and unchallenged by governments and the UN remains a passive observer in all of this. And the real impacts associated with these approaches are readily observable for all who care to look. Drug-related HIV epidemics are being fuelled by simplicity in thinking, analysis and response. Many governments appear to believe they can educate, imprison, involuntarily treat and punish their way out of drug problems and HIV epidemics when clearly, they cannot.

### **3.7 Problems Associated With Disease Model Treatment Models**

This study did not provide for a systematic review of treatment policies and practices in the seven countries engaged in this research, however, it did afford the researchers some opportunity to view the treatment approaches adopted in the study countries. It was difficult to discern the use of any specific theoretical framework for treatment, save the common and simple assumption that punishment, seclusion, discipline, work therapy and recreational

therapy provide a pathway to abstinence. There were variations around the themes of a therapeutic community and boot camp styled programs. The drug policy research revealed no evidence to suggest the disease model has made serious inroads into the treatment methods and culture in any of the study countries. However, it is relevant to note that 12-step programs are appearing in some neighboring Asian countries not included in this drug policy study. Some study respondents expressed the view that AA/ NA type programs would not sit well in Asian culture. Others said the same about cognitive-behavioural treatment (CBT) approaches, however, CBT is has been introduced in some Asian countries. It remains to be seen whether CBT will be embraced more widely. Since treatment is pivotal to any strategy to address drug problems as they relate to HIV vulnerability specifically and other problems more generally, this issue is one of considerable importance.

While social learning theory and cognitive-behavioural therapies are assuming greater prominence in drug treatment programs across the globe, many countries continue to base their treatment approaches around 12-step, disease model approaches. Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) are based on the constructs of the disease model. AA and NA are not treatments in the sense that they address the cognitive, behavioural and environmental determinants of drug use in any systematic, theoretical and empirically supported manner. Rather, they provide a mechanism for personal support, one that can be very valuable for many people seeking a pathway to abstinence from alcohol and other drug use. However, the tenets of the disease model are incompatible with many aspects of social learning theory and cognitive-behavioural therapies. Disease model programs are by their very nature unattractive to many people with alcohol and other drug problems, have limited population reach and are often associated with poor compliance and poor retention rates. They are often very expensive when operated by private sector agencies in western countries. These agencies sometimes operate cottage, farm or other forms of for-profit industry and are sometimes economically opportunistic in exploiting clients for 'cheap labour'. They may also see alcohol and drug rehabilitation programs as an opportunity for proselytisation of the religious beliefs a particular religious faith and pay too little or no attention to the provision of evidence-based interventions. The repetitive and negative cathartic nature of the model ('I am an addict, I am an addict, I am an addict – I will always be an addict...') is also unattractive to many. These programs may in many cases be associated with counter productive outcomes, perhaps in substantial part because they can dis-empower people. They may be associated with a self fulfilling prophesy for

people who relapse, with potentially harmful impacts on their self-efficacy and outcome expectancies.

Social learning theory and cognitive-behavioural therapies when implemented in tandem with appropriate environmental interventions, rest on firmer scientific grounds and would appear to offer more (e.g. Miller & Hester, 1986a,b; Holder et al, 1999; Hester & Miller, 1995; NIDA, 1999, Heather & Tebbutt, 1989<sup>29, 30, 31, 32, 33, 34</sup>). To the degree that UN agencies, INGOs and other bilateral and multilateral agencies are involved in providing technical support and policy guidance to governments, it would be helpful if they would advocate for and facilitate the adoption of contemporary, evidence based treatment approaches. Too little is occurring in this regard at present, given the existence of the international drug conventions and the serious responsibilities these confer on the UN in relation to their ongoing monitoring, evaluation and adjustments on the basis of their measured benefits, costs and harms.

### **3.8 Does Law of Diminishing Returns Apply to Drug Repression**

As history has taught us repeatedly, more of the same does not necessarily mean better outcomes. Sometimes, the law of diminishing returns applies. While one often hears in international forums, the notion that ‘if only we can invest more heavily in a policy or punishment and if only we can apply these approaches more forcefully and reliably, we will surely win the day. We will prevent drug use’ or, we will achieve a ‘drug-free society’. One might argue this is analogous to the arguments that are forcefully made for scaling up needle and syringe programs or immunization programs targeting vaccine preventable diseases. When it comes to vaccine preventable diseases, we certainly know that governments must deliver interventions to scale and in a sustainable way if they are to exert a discernable and worthwhile public health impact. Well is it the same? I would argue it is not. I would argue that one (harm reduction) is both scientifically plausible and proven while the other (the punishment paradigm) is neither plausible nor proven. One provides perceived benefits

---

<sup>29</sup> Miller, W. R., & Hester, R. K. (1986a). The effectiveness of alcoholism research: What research reveals. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 121-174). New York: Plenum.

<sup>30</sup> Miller W. R., & Hester, R. K. (1986b). Matching problem drinkers with optimal treatments. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 175-204). New York@ Plenum.

<sup>31</sup> Holder, H., Longabaugh, R., Miller, W R. & Rubonis, A. V. (1991). The cost -effectiveness of treatment for alcoholism: A first approximation. *Journal of Studies on Alcohol*, 52, 517-540.

<sup>32</sup> Hester, R. & Miller W., *Handbook of Alcoholism Treatment Approaches, Effective Alternatives*, 2<sup>nd</sup> Ed., Allyn & Bacom, 1995.

<sup>33</sup> National Institute on Drug Abuse, National Institutes of Health, *Principles of drug addiction treatment, a research based guide*. NIH Publication 99-4180, October 1999.

to the target audience while the other does not. One addresses the fundamental structural determinants of behaviours that place people at risk while the other does not. One embraces people where they are at and provides constructive social policy reform while the other is often socially and culturally divisive, with a potential for enormous collateral damage to users, to their families and to their communities. As many writers have observed, repressive policy approaches are also often associated with significant and serious breaches of the *Universal Declaration on Human Rights* and are often a reflection of selective morality.

---

<sup>34</sup> Heather, N & Tebbut, J. The effectiveness of treatment for drug and alcohol problems: an overview. Monograph Series No. 11, Commonwealth of Australia, 1989.

### 3.9 The Education Paradigm

The idea that education provides a pathway to prevention and that a focus on the youth of today is an investment in the future, is for many, intuitively appealing. Unfortunately, the evidence in support of drug education as a sole or lead strategy for drug prevention is not at all compelling. What is more, a focus on youth in the absence of attention to adults who construct the world in which children grow and learn, would appear folly to say the least.

Wetherburn (2002)<sup>35</sup>, director of the NSW Bureau of Crime Statistics and Research puts the case that economic and social stress do not produce crime by motivating individuals to offend. Rather, they produce it by disrupting the parenting process. Weatherburn adds that stressed parents are less likely to form a strong emotional bond with children, are more likely to neglect, reject or abuse them and more likely to engage in disciplinary practices that are harsh, erratic and inconsistent.

Milford (2000)<sup>36</sup> observes: “Presenting students with arguments as to why they should resist drinking will be very difficult in a society that provides all kinds of reinforcements for alcohol use”.

Caulkins et al <sup>37</sup>(1999) comment as follows:

*While treatment may be more cost-effective, there is a clear cost dividend from such a comprehensive education approach in that estimated savings of US \$2.40 in social costs associated with cocaine use accrue for every education programme dollar spent. There would also be parallel savings of US \$0.75 and US \$0.80 in social cost, respectively, associated with tobacco and alcohol use and additional savings from reduced use of other illicit drugs apart from cocaine. This research demonstrates clearly that there would be substantial cost benefit to the community from comprehensive, effective drug education programmes.*

On the other hand, in their review of the effectiveness of drug education, Midford 2000<sup>38</sup> cites the findings of White and Pitts (1998):

*White & Pitts, in their meta-analysis of drug education programme evaluations, found that 10 of 18 methodologically sound school-based programmes had a statistically significant impact on drug use. The effect size of these programmes was, however, very small. At 1-year follow-up these programmes delayed onset or prevented drug use in 3.7% of the participating students. Effect size also*

---

<sup>35</sup> Wetherburn, D. in Bagnal, D, The Bulletin, January 9, 2002.

<sup>36</sup> Midford, R. Does drug education work? *Drug and Alcohol Review* (2000) 19, 441-446.

<sup>37</sup> Caulkins JP, Rydell CP, Everingham SS, Chiesa J, Bushway S. *An ounce of prevention, a pound of uncertainty*. Santa Monica, CA: Rand, 1999.)

*declined with time. Similarly sound programmes were effective, with only 1.8% of the participating students at 2-year follow-up.*

In other words, these studies suggest drug education is cost effective but the size of the population level changes in drug use behaviour are very modest and decline rapidly over a relatively short period of time. In public health, small benefits from multiple interventions are often very useful in aggregate. So we cannot dismiss education completely, notwithstanding the small effect sizes associated with this strategy. The review by Spooner, Hall & Lynskey (2001) and others of similar theme, add to the complexity of the analysis of drug education programs but are generally unfavourable. Ballard et al (1994)<sup>38</sup> conclude that it is unrealistic to believe drug education in schools can succeed in preventing initiation to drug use in the absence of other supportive environments.

### **3.10 The Individual Responsibility Paradigm**

A great deal of drug use and HIV-prevention effort is aimed at the level of individual behavioural choice, and pays little attention to the broader environmental or systemic determinants of behaviour. This is an issue of immense importance for prevention planning - with respect to HIV in particular and with respect to other drug-related harms more generally.

Such individualistic understandings of the motivations for licit and illicit drug use tend to ignore or at the very least play down the whole array of broader socio-cultural phenomena that underpin and motivate drug use, including the cultural and symbolic meanings of such drugs, the use of drugs as commodities to define self, and the economics and politics of production, marketing and very substantial profits that are to be made from the sale of alcohol and other drugs (Petersen & Lupton, 1997)<sup>39</sup>. The addictive properties of drugs are also often down played or ignored and anyone who has ever tried to give up tobacco smoking will attest to the substantial challenge, personal angst and personal distress that this may cause. The perceived or real benefits associated with drug use are also often afforded insufficient attention.

Individual's do not live in a social, cultural, commercial, economic, political or public policy vacuum and unless they possess extraordinary insights and independence of

---

<sup>38</sup> Ballard, R., Gillespie, A. and Irwin, R. *Principles For Drug Education in Schools*, University of Canberra, Faculty of Education, 1994.

<sup>39</sup> Petersen, A.R. and Lupton, D. *The New Public Health: health and self in the age of risk*, Allen & Unwin, 1996.

thought and action, their drug use behaviours will, like other social behaviours, inevitably be heavily influenced by these structural/ environmental factors and the lifestyle that they have embraced in the context of their lived experiences and their own socio-cultural, physical and economic environments. That physical and socio-cultural environments, norms, personal experiences and political processes may often impede if not run in a counter direction and shape such behavioural choices, is invariably ignored.

Having made the observation that individuals cannot be held to account for their behaviour at every level, there is an opposing tension that must be considered. That is, that to shield or deny the individual any say or potential role in influencing their own destiny, including their health destiny, may be to unwittingly, unintentionally or unhelpfully foreclose on or reduce to a minimum their life advancement possibilities and capacities. It may be to shield them from active encouragement and motivation to take some steps that are feasible in the context of their life circumstances and that may improve their health and well-being. The logical conclusion towards which one is inevitably drawn in identifying the structural determinants of health as those that have either have primacy over or that cannot be separated from individual behavioural choice is the scenario that almost every person might be said, in effect, to be a blameless victim of their circumstances (Peterson & Lupton, 1997)<sup>41</sup>. Clearly, a middle ground needs to be found between the extremes of full responsibility and no responsibility for drug-related harm. It follows from the above discussion that a rigid application of any attribution of responsibility without taking into account the range of personal capacities, deficits and socio-economic and political opportunities of an individual stands to repeat the policy errors of history.

### **3.11 Early Development & Effective Parenting**

There is a substantial body of literature (e.g. Keating & Hertzman, 1999) supporting the notion that effective parenting is a crucial issue for promoting healthy early development (e.g. the evidence pertaining to ‘biological imprinting’). Keating and Hertzman point to the evidence related to behavioural modeling at ‘critical transition points’ and the importance of finding ways to enhance resilience in environments conducive to initiation to drug use and other problem behaviours (e.g. crime).

### **3.12 Shifting the Focus of Attention from Children to Adults**

Accordingly, there is a need to shift the focus of attention from children to adults who model and nurture (or fail to model) socially aware, socially responsible and healthy behaviours and to commercial, policy and political decision-makers. There is a need to address adult behaviours as a basis for (re-)shaping the drug use behaviours of young people. There is a large body of evidence indicating a pathway from early tobacco and use in young people to illicit drug use. Tobacco use appears in adolescence to be a stronger predictor of illicit drug use than alcohol use in most studies although some studies show alcohol as a more likely to precede than follow tobacco smoking.<sup>40</sup> This suggests more attention needs to be paid to regulating commercially irresponsible practices (e.g. sporting stars and media personalities promoting the use of alcohol). There is a need for a conceptually more expansive model of preventive intervention which broadens the focus from individual children and their families to the functioning of local community institutions, and aspects of social organization that affect the development of children.

### **3.13 The Challenge of Responding to Scale**

There are a number of serious and complex problems facing governments in this regard. Firstly, in many countries of the world, drug policies are stand in tension with the existing body of international experience and empirical evidence on ‘what works best’ in preventing or mitigating drug-related harm. Where evidence-supported interventions are implemented, it is often on a small-scale basis and insufficient to make a public health difference. While it is true that small-scale local action can sometimes lead to broader policy reforms and the delivery of interventions to scale, evidence-supported interventions are far more likely to be delivered in a generalized and sustainable manner if they are supported in policy, legislation where relevant, and government program funding. This is critical if such programs and approaches are to have a measurable public health benefit.

Labonte (1994)<sup>41</sup> comments on the issue of acting locally:

---

<sup>40</sup> Surgeon General’s report (USDIAHS, 1988) – summarizes the key literature.

<sup>41</sup> Labonte, R, *Econology Health And Sustainable Development*, in Chu, C & Simpson, R, Eds., *Ecological Public Health: from vision to practice*, Griffith University, 1994.

*Unless local actions are integrated with advocacy and political action strategies directed towards higher-level government policies, our drive for decentralized decision-making and community development may unwittingly "privatize", by rendering local, what are much larger issues. We risk mystifying the actual exercise of political power, just as green products mystify the sustainable limits of consumption. Local actions and green products are starting points only, and represent the community-organizing rule "to begin where the people are." But where people are is not necessarily where they should be. The environmental motto to "Think Globally, Act Locally" may well need amending to "Start Locally, Act Globally."*

It is interesting in this regard to examine the ideas of Labonte in the context of the development of needle and syringe exchange programs in Australia. In late 1986, Dr. Alex Wodak and Dr. Kate Dolan, opened the first needle and syringe program in Sydney, following mounting concerns about the potentially devastating impact of unsafe drug injecting practices on public health. They did so without support in law or public policy. The NSW Police were naturally very quick to examine this case, presumably with a view to identifying a basis for laying charges. Fortunately for the people of New South Wales, when the public health rationale for these actions was explained, common sense prevailed and no charges were laid (Wodak, 2000<sup>42</sup>). The foresight and courageous actions of two people were in this case responsible for the initiation of needle and syringe exchange programs in New South Wales, at a time when such programs were embraced neither in policy nor in law. Within a short few months, needle and syringe programs were accepted in policy and later supported by legislation, in this Australian State. Other States and Territories soon followed suit and needle and syringe exchange programs began to open all over the country. This series of events would, I believe, be fairly unusual internationally. That is to say, such a rapid and widespread change in policy of this nature arising from an informal local intervention, initiated by just two people who were unsupported by anything other than knowledge, wisdom and a determination to do what they firmly believed to be right from a public health perspective.

Of course, in many societies it is very difficult to achieve policy reforms of any type, yet alone those of a sensitive and contentious nature. So depending on the social, cultural and political circumstances, it may or may not be possible for such local action to stimulate broader policy reform.

---

<sup>42</sup> Alex Wodak, personal communication, October, 2001

### **3.14 UN Drug Treaties Confer Great Responsibility on the UN**

The existence of the three drug treaties and their ancillary instruments assigns the United Nations a pivotal role in drug policy and intervention. The very existence of these treaties commits the UN to a role in monitoring, guiding and supporting their implementation in policy, in legislation and in practice. So it is really very important in the international context for the United Nations to adopt a proactive role in educating, clarifying, advocating for and supporting evidence-guided approaches at every single opportunity. Unfortunately, this is not the case at present.

Also problematic is the fact that the drug treaties are serving to perpetuate thinking for prevention and intervention within the narrow confines of ‘supply reduction’ and ‘demand reduction’ which is as noted above, now untenable in the context of an expanded understanding of the determinants of drug use and drug-related harm. There is an urgent need to review the treaties in light of this more recent and erudite understanding of drug use and its determinants and harms, particularly in view of the strong relationship between injecting drug use and HIV vulnerability.

Progress is hampered by limitations in the UN’s own technical capacity and its current focus on the purchase of external expertise is not serving it well enough. Nor are the current processes of consultancy management.<sup>^</sup> It is necessary to appreciate the paucity of finances and other resources and the political and diplomatic constraints, which the U.N. must work within. In many ways the U.N. has been handed a poison chalice. But it can do more and it can do it better.

### **3.15 The Need for a Unified & Integrated UN Response to Drug Problems**

Particularly worrisome was a drug policy study finding that the drug treaties are serving to emphasize a narrow understanding of the determinants of drug use, drug-related harm, and their ‘remedies’. It is of great concern that different U.N. agencies are currently sending different and conflicting messages to governments requesting technical support in the area of drug policy and intervention. While WHO has over the years made calls to governments to adopt harm reduction policies and interventions, UNDCP has found it politically unacceptable to embrace the jargon of harm reduction, preferring instead to use

---

<sup>^</sup> This analysis is based in substantial part of the author’s personal experiences working as a Technical Adviser, Short Term Consultant, Short Term Professional and Acting Regional Adviser, with six agencies of the UN system.

obtuse and confusing language. During the drug policy research study, senior decision-makers in government often asked: “What is the UN’s position on harm reduction or not? UNDCP and INCB say one thing while WHO and UNAIDS say something quite different!”

The situation may be changing now that UNDCP has become a co-sponsor of UNAIDS but it remains unclear to the world just how far UNDCP will shift in supporting and promoting evidence-based harm reduction approaches.

Within the U.N. one can observe a number of individuals who appear to be doing their own thing. During the study, one senior UN official argued that this is acceptable because it is consistent with the principle of complementarity across the U.N. system, as called for by the Secretary-General in 1997. Arguably, what is needed instead is a strategic and tactical approach to drug problems, one that is integrated and coordinated across the U.N. system, rather than a complementarity or harmonization of activity on which basis anything and everything can be defended.

The System Wide Action Plan, UNDAF and UNDG are examples of UN processes that have been designed to facilitate a unified approach to a range of UN endeavours, including those related to drug policy and intervention. One would have to say that to date, these approaches have not worked at all well in terms of addressing the global drug problem.

### **3.16 UN Agencies are Short on Technical Capacity in the Drug Problems Area**

Few U.N. agencies that currently provide technical support to governments in relation to drug policy and intervention have a critical mass of in-house expertise, particular at senior policy decision-making levels. It is pleasing to learn that the Substance Abuse Department of WHO in Geneva is now expanding. However, there is no longer a Regional Advisor in Alcohol and Drugs at the Western Pacific Regional Office of WHO, and no expertise in many other UN offices across the globe. Yet many of these officers involve themselves in matters pertaining to drug policy and intervention. Where there are alcohol and drug programs, they are invariably staffed by a small handful of people who can do very little with the small human and financial resources available to them. In a world where drug-related harm including HIV infection is so substantial and ever increasing, this would seem unwise and unacceptable. Many of those who know the literature on drug use and HIV vulnerability and who view harm reduction as a pragmatic and effective approach

express concern that the International Narcotics Control Board (INCB) has a narrow and incompletely informed command of contemporary knowledge and skill, whereas those who hold to the view that punishment provides a constructive pathway forward are more likely to endorse the hardliner public pronouncements of this UN body. Once again, more recent analysis of the evidence related to the determinants of drug use and drug problems demonstrates the chasm in thinking and analysis between the traditional supply reduction/demand reduction paradigm and more contemporary and expanded thinking. These are critical matters since the interpretations and pronouncements of INCB and UNDCP have substantial potential to influence drug policies across the globe.

Without a critical mass of expertise at both operational and senior management levels, the U.N. affords itself little or no opportunity to impact meaningfully on drug use and HIV vulnerability at national, regional and international levels. There is an urgent need for capacity building in the internal technical and management capacity of UN agencies engaging in technical support activity as it relates to drug use and HIV vulnerability, particularly within UNAIDS and its co-sponsoring agencies. There is also a need for a unity in approach by agencies of the United Nations system when providing technical support and policy guidance to governments. In one sense, it would be preferable if the UN would play no role if it cannot meet acceptable standards of technical capacity, however, the existence of the three drug treaties renders such non-engagement infeasible.

### **3.17 Policy Remedies Lie Beyond the Roles & Influences of the UN System**

It needs to be said that the problem extends beyond a need for organizational reform with the UN system. It is of great concern to observe that many countries requesting technical support from the United Nations in the area of drug policy and intervention repeatedly ignore the advice that is provided. Numerous technical support missions fail to impact on government policy and intervention. There are many reasons why that might be so. For a start, many governments do not have the technical, structural or financial capacity to respond to recommendations for reform. There may be little understanding and little commitment to the principles of evidence-based decision-making. There may be poorly developed mechanisms and capacity for ‘good governance’, although to be fair, the idea that some high-income, developed countries are the harbingers of good governance is itself open to contest. There may be little commitment to reform, notwithstanding rhetoric to the

contrary. This suggests the methodology of providing technical support requires a substantial rethink.

The UN routinely sends single consultants with expertise in a particular area, on mission to countries to undertake a rapid situational assessment and make recommendations to governments on methods for addressing a particular problem. When it comes to drug problems, the use of single consultants in this manner lies in tension with the highly complex and multifaceted nature of drug use and its determinants. Recommendations may not be understood or may be viewed as impracticable or culturally unacceptable. Many missions of this nature lead no-where and nothing changes in the country concerned.

What may often be required is a team of people with a wide range of complementary expertise to assess and provide pragmatic, evidence-supported advice on aspects that lie outside as well as within the traditional areas of government attention. There is a need for better preparation and expanded models of engagement by governments, by the U.N. agencies concerned and by consultants, before, during and following technical support missions. Current technical support approaches offer governments little opportunity to comprehensively analyze drug problems in their country and their determinants and too few options for dealing with these problems in the context of their real life circumstances.

### **3.18 The UN needs to do Much More & Do it Much Better**

The U.N. is presently doing far too little in working with governments to challenge and promote rigorous review of these assumptions and unhelpful policy responses, many of which appear to be substantially influenced by a rigid and often incorrect interpretation of the UN drug treaties.

The responses of UN agencies in working with governments should reflect contemporary knowledge and understanding of the determinants of hazardous, harmful and unsanctioned drug use and should reflect evidence supported or plausible responses that offer most hope in advancing the cause of preventing or mitigating drug-related harms. At a minimum, all agencies of the United Nations System should work in a way that is at all times consistent with the *Position Paper of the UN System on Preventing the Transmission of HIV among Drug Abusers*<sup>43</sup>. If the UN fails to meet this challenge, it is likely that governments will continue to adopt policy decision-making processes that are devoid of

scientific rigour and failed drug policies and interventions. In this context, drug-fuelled HIV and other blood-borne viral epidemics will continue to expand uncontrollably. Surely, this is not an acceptable option to any government?

### **3.19 Evidence vs. Rhetoric as a Basis for Preventing HIV Epidemics**

There is now sufficient international empirical evidence available to guide rational decision-making in relation to effective health protection oriented drug policies and interventions. For governments placing priority on a goal of preventing, containing or reversing drug-related HIV epidemics in their country, the key policy decision is essentially this. They can either continue with dogma and rhetoric, for example, the rhetoric of a “drug free world”, “just say no” and “zero tolerance” and in so doing, actively fuel drug-related HIV epidemics. Or they can think and speak the language of health protection and harm reduction and support these philosophies in policy and practice with evidence-based interventions. The choice is that simple.

### **3.20 Challenging Traditional Ideas about a Balanced Drug Strategy**

The idea that a balanced drug policy should consist of a mix of supply reduction, demand reduction and in some cases, harm reduction is often stated in government drug strategies and in some UN documents. The notion that such a mix can provide for effective responses to drug problems, is simply too limiting in scope. Once again, this ignores the key determinants of drug use that lie outside of the influence of health, education, police and prison departments.

While there is a need to strengthen links among the traditional public sectors involved in drug control activity (health, education, police, justice), there is a greater need to broaden the base for policy intervention and action that extends well beyond these conceptual and program boundaries. The phraseology and thinking that underpins a framework of demand & supply reduction oversimplifies and neglects the broader structural determinants of drug use. As such, this terminology ceases to have utility as a basis for policy and planning. Language is important because it signals the writer or speaker’s framework of knowledge and understanding of an issue and his/ her conceptual boundaries

---

<sup>43</sup> ACC Subcommittee on Drug Control, *Preventing the Transmission of HIV among Drug Users, A position paper of the United Nations*

for intervention. If governments and the UN continue to use the jargon of demand and supply reduction as a basis for policy and planning, they will continue to think and operate in a relative vacuum, disconnected or ignorant of the more important and primordial areas of concern where new thinking and action is required.

Accordingly, it would be helpful if governments and relevant UN agencies would now abandon this simplistic notion in the context of their public policy and planning endeavours and in their public pronouncements. Notwithstanding, policy reforms in these areas remain critical to preventing, containing and reversing HIV epidemics, because many governments currently invest heavily in these areas in ways that provide for very limited or negative returns. Drug-fuelled HIV and viral hepatitis epidemics are but one manifestation of such policy-driven harm.

#### **4. CONCLUSIONS**

Drug policy stands as a key reflection of how governments understand drug problems and HIV vulnerability. They provide a framework for what is possible and what is done to address these problems. The drug policy study in seven Asian countries commissioned by the *United Nations Task Force on Drug Use and HIV Vulnerability in the Asia-Pacific Region* provides many keen insights into the manner in which drug policy is constructed by governments and indicates a paucity of attention to the principles of scientific methodology and to evidence as a guiding light to policy decision-making. There are reasons to believe the findings of this study are representative of what happens more generally in many other countries of the world currently facing serious drug problems. Governments and relevant agencies of the United Nations system need to work together to gain a better understanding of the issues raised in this drug policy research and search for new pathways to prevention and intervention.

**Dr. Adrian Reynolds**  
**Alcohol, Tobacco & Other Drug Services**  
**G/FI, Quarters 1, Gold Coast Hospital,**  
**Queen Street, Southport**  
**Queensland, Australia (4215)**  
**Tel: ++ 61 7 5571 8777 (W)**  
**Fax: ++ 61 7 5571 8505 (W)**  
**Email: [adrianreynolds@ozemail.com.au](mailto:adrianreynolds@ozemail.com.au)**

## 5. References

1. Oppenheimer, E & Reynolds, A. “*Drug Use and HIV Vulnerability: Policy Research Study in Asia*”, UNAIDS and United Nations Office for Drug Control and Crime Prevention (2000). The final report is available on the UNAIDS website at: <http://www.unaids.org/publications/documents/health/access/Drug.pdf>
2. Spooner C., Hall W. & Lynskey M. (2001). *The structural Determinants of Youth Drug Use*, Report prepared by the National Drug and Alcohol Research Centre, UNSW for the Australian National Council on Drugs, 2001.
3. Keating, D. (1999). Developmental health as the wealth of nations. In *Developmental Health and the Wealth of Nations: Social, biological, and educational dynamics* D. Keating and C. Hertzman (eds). New York: Guilford Press, pp. 337-347.
4. Spooner, C., R. Mattick and J. Howard (1996). *The Nature and Treatment of Adolescent Substance Abuse* (NDARC Monograph no. 26). Sydney: University of New South Wales, National Drug and Alcohol Research Centre.
5. Jessor, R. (ed.) (1998). *New Perspectives on Adolescent Risk Behaviour*. Cambridge: Cambridge University Press. National Crime Prevention (1999).
6. Homel R. et al, Pathways to Prevention: Developmental and early intervention approaches to crime in Australia Canberra: Attorney-General's Department
7. Rutter, M., Giller, H. & Hagell, A. (1998) *Antisocial behavior by young people* (New York, Cambridge University Press).
8. Spooner, C & Hall, W. Paper for *Current Opinion in Psychiatry*: Submitted Dec. 2001.
9. National Research Council and Institute of Medicine; Committee on Integrating the Science of Early Childhood Development; J.P. Shonkoff & D.A. Phillips eds (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*, National Academy Press, Washington, DC.
10. Marmot, M.G., Davey-Smith, G., Stansfield, S., Patel, C., North, F., Head, J., White, , Brunner, B. and Fenney, A. 1991, ‘Health Inequalities Among British Civil Servants: The Whitehall II Study’ in *The Lancet*, Volume 337, pp 1387-1393.
11. Kennedy, B., Kawachi, I., and Prothrow-Smith, D. 1996, ‘Income Distribution and Mortality: cross sectional ecological study of the Robin Hood index in the United States’ *British Medical Journal*, Volume 312, pp 1004-1007.
12. Kawachi, I., Colditz G.A. et al, (1996). *A prospective study of social networks in relation to total mortality and cardio-vascular disease in men in the U.S.* *Journal of Epidemiology and Community Health*. 50: 245-51.
13. UNDP Human Development Report, New York, (2000).
14. UK Department of Health, “*Our Healthier Nation -A Contract for Health*”, 1998.
15. United Nations Drug Control Programme, *A Drug Free World – We can do it*, General Assembly Special Session on the World Drug Problem, Fact Sheet Kit, New York, 8-10 June 1998.
16. Economic and Social Council, Commission on Narcotic Drugs, Forty-fourth session, Vienna, 20-29 March 2001. Drug demand reduction: world situation with regard to drug abuse, in particular among children and youth.
17. United Nations Office for Drug Control & Crime Prevention, *World Drug Report 2000*, Oxford University Press, 2000.
18. Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L., & Goodwin, F.K. (1990) *Co-morbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiological Catchment Area (ECA) study*. *Journal of the American Medical Association*, 264, 2511-2518.
19. Hawthorne, G. Garrard J. & Dunt D. *Does life education's drug education programme have a public health benefit?* *Addiction* (1995), Research reports 90, 205-215.
20. Ritchie, J. *New Study on Drug Education Program*, AOL News, The Associated Press, 3 August 1999.

21. White D, Pitts M. Educating young people about drugs: a systematic review. *Addiction* 1998;93: 1475-87.
22. Falco. M. "US Drug Policy: Addicted to Failure". *Foreign Policy*, No. 102, Spring 1996, pp. 120-133, Carnegie Endowment for International Peace
23. Rydell CP, Caulkins JP, Everingham SS. Enforcement or treatment? Modeling the relative efficacy of alternatives for controlling cocaine. RAND: Santa Monica, CA, USA, 1997.
24. Aos et al, 2001, Washington State Institute for Public Policy, *The comparative Costs & Benefits of Programs to Reduce Crime*.
25. Wardlaw, G. *The Realities of Drug Enforcement*, *The Journal of Drug Issues*, 16(2), 171-182, 1986.
26. Wardlaw, G. in National Campaign Against Drug Abuse: *Overview of National Drug Control Policies: Comparative Analysis of Illicit Drug Strategy*, Monograph Series No. 18, AGPS, Canberra, 1992.
27. Munro & Midford, Zero tolerance and drug education in Australian schools. *Drug and Alcohol Review* (2001) 20, 105-109.
28. Reid, G & Costigan G, *A situation assessment of Drug Use in Asia in the Context of HIV/AIDS*. The Centre for Harm Reduction./The Burnet Institute, Australia, January 2002.
29. Miller, W. R., & Hester, R. K. (1986a). The effectiveness of alcoholism research: What research reveals. In W.R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 121-174). New York: Plenum.
30. Miller W. R., & Hester, R. K. (1986b). Matching problem drinkers with optimal treatments. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change* (pp. 175-204). New York@ Plenum.
31. Holder, H., Longabaugh, R., Miller, W R. & Rubonis, A. V. (1991). The cost-effectiveness of treatment for alcoholism: A first approximation. *Journal of Studies on Alcohol*, 52, 517-540.
32. Hester, R. & Miller W., *Handbook of Alcoholism Treatment Approaches, Effective Alternatives*, 2<sup>nd</sup> Ed., Allyn & Bacom, 1995.
33. National Institute on Drug Abuse, National Institutes of Health, *Principles of drug addiction treatment, a research based guide*. NIH Publication 99-4180, October 1999.
34. Heather, N & Tebbut, J. *The effectiveness of treatment for drug and alcohol problems: an overview*. Monograph Series No. 11, Commonwealth of Australia, 1989.
35. Wetherburn, D. in Bagnal, D, *The Bulletin*, January 9, 2002.
36. Midford, R. Does drug education work? *Drug and Alcohol Review* (2000) 19, 441-446.
37. Caulkins JP, Rydell CP, Everingham SS, Chiesa J, Bushway S. *An ounce of prevention, a pound of uncertainty*. Santa Monica, CA: Rand, 1999.)
38. Ballard, R., Gillespie, A. and Irwin, R. *Principles For Drug Education in Schools*, University of Canberra, Faculty of Education, 1994.
39. Petersen, A.R. and Lupton, D. *The New Public Health: health and self in the age of risk*, Allen & Unwin, 1996.
40. Surgeon General's report (USDIAHS, 1988).
41. Labonte, R, *Econology Health And Sustainable Development*, in Chu, C & Simpson, R, Eds., *Ecological Public Health: from vision to practice*, Griffith University, 1994.
42. Alex Wodak, personal communication, October, 2001.
43. ACC Subcommittee on Drug Control. *Preventing the Transmission of HIV among Drug Users, A position paper of the United Nations System*. Annex to the Report of 8<sup>th</sup> Session of ACC Subcommittee on Drug Control, 28-29 September 2000.