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Georgia HIV Prevention Project

Mapping the Future: Options for Drug
Policy in Georgia

May 19, 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by RTI International.

Georgia HIV Prevention Project

Mapping the Future: Options for Drug Policy in Georgia

Contract GHS-I-04-07-00005-00

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List of Acronyms

| | |
|---------|--|
| CND | Commission on Narcotic Drugs |
| EU | European Union |
| EMCDDA | European Monitoring Centre for Drugs and Drug Addiction |
| GEL | Georgian Lari (currency) |
| HAT | heroin-assisted treatment |
| IDACIRC | Infectious Diseases, AIDS and Clinical Immunology Research Center |
| IDU | injecting drug user |
| INCB | International Narcotics Control Board |
| INL | United States Department of State Bureau for International Narcotics and Law Enforcement Affairs |
| MoLHSA | Ministry of Labour, Health and Social Affairs |
| NGO | non-governmental organization |
| SCAD | South Caucasus Anti-Drug Programme |
| SMART | Specific, Measurable, Achievable, Relevant, and Time-limited |
| UN | United Nations |
| UNODC | United Nations Office on Drugs and Crime |
| USAID | U.S. Agency for International Development |
| WHO | World Health Organization |

Acknowledgements

This report was produced by Eric Carlin at the conclusion of a consultancy for the USAID-funded Georgia HIV Prevention Project (GHPP). The overall goal of GHPP is to support HIV prevention efforts among high-risk groups in order to avert the spread of HIV to the general population. The specific purpose of this consultancy was to engage stakeholders in national policy dialogue to help promote a supportive legal environment for effective efforts in reducing drug misuse and HIV transmission. This report draws upon existing reports and research from Georgia and other countries as well as information from a series of interviews and discussions that took place in Georgia February 7–20, 2011 with key stakeholders, including politicians, civil servants, drug professionals, and NGO representatives.

The author wishes to thank the numerous individuals who took time out of their busy schedules to share their knowledge, views, expertise and experience regarding drug prevention, treatment and control efforts in Georgia.

The author gives special thanks to the staff of GHPP for their assistance during this consultancy.

1. Introduction

National and international drug policy should be based at the “intersection of health, security, development and justice” (UNODC, 2010c, p. 4).

This report summarises findings, conclusions, and recommendations from a consultancy review undertaken in February 2011 on behalf of the Georgia HIV Prevention Project (GHPP), which is funded by the U.S. Agency for International Development (USAID). The overall goal of GHPP is to support HIV prevention among high-risk groups in order to avert the spread of HIV to the general population.

The purpose of the consultancy has been to suggest a process for the review of Georgia’s drug policy and identify appropriate objectives to be set as part of this. In doing so, the intention has been to position Georgia within the context of international drug policy and to draw on experiences from other countries that might be useful. Although principles are transferrable, each country must develop its own policy, based on its particular situation and its own cultural, social, and political norms. Evaluation of national drug strategies is difficult and has not been undertaken in a comprehensive way in many countries. Outcomes may relate to the drug strategy that operates in a country, but causality is impossible to measure without a control group against which to compare outcomes. Drawing on experiences in other countries, national and international literature, and following a series of meetings with key stakeholders in Georgia between February 6 and 20, 2011, this report suggests a way forward and indicates possible outcomes from currently proposed legislative changes. However, Georgia needs to undertake a rigorous economic and social modelling exercise in order to plan its next steps in drug policy reform.

It was originally envisaged that there would be four deliverables for this consultancy:

- a report with an overview of the current Georgian anti-drug legislation and two alternative packages,
- a policy brief on international experience in drug-related policy initiatives relevant to Georgia,
- a report on drug-related policy needs in Georgia, and
- a roadmap for implementation of the desired drug policy change.

As the activity progressed, the focus changed, and it was agreed that one report would be produced, which would include the following:

- commentary on the current proposed new legislation,
- a review of the Georgian Anti-Drug Strategy, and
- a suggested roadmap.

2. Georgia and drugs

2.1 Background

Georgia is situated between the Black Sea and Caspian Sea, on the border of Europe and Asia. In 1991, the collapse of the Soviet Union gave the country its independence, but the democratic transition has been a painful process with many social and political tensions: economic crises, civil war, and constant attempts from Russia to gain back political control over Georgia or force it to relinquish its territories. Since 1997, the population of Georgia has been decreasing due to emigration, and in 2006 it was estimated to be 4.4 million. Among other social problems since reclaiming its independence, the country has witnessed a dramatic increase of illicit drug use and related problems (Otiashvili, Sarosi, & Somogyi, 2008).

Traditionally, Georgia has not been considered to be a drug-producing country; the majority of narcotic drugs that have plant precursors (except marijuana) are produced in neighboring or distant countries. Marijuana is the most widely used illegal drug. The most frequently injected drug is heroin, but since 2004, buprenorphine, which is commercially known as Subutex, has also become popular for injection. Since 2008, the popularity of Subutex seems to have decreased, with a growth in the domestic production of (pseudo) ephedrine-based drugs, which go by names such as Vint and Jeff. The number of “problem” (i.e., by Georgian definition, “injecting”) drug users has been estimated to be around 35,000 persons, but there is a very low reporting rate of drug seizures by law enforcement bodies and a high prevalence of drug-related infectious diseases in drug users. There is no reliable data on drug-related mortality (Javakhishvili & Sturua, 2009). The number of drug users who use more than one type of drug has been estimated to be between 40,000 to 80,000 (United States Department of State Bureau for International Narcotics and Law Enforcement Affairs [INL], 2011, p. 3). Similar numbers—between 39,152 (using demographic indicator) and 41,062 (using prevalence rate coefficient)—were estimated for injecting drug users (IDUs) in the country under the South Caucasus Anti-Drug Programme (SCAD) funded by the European Union (EU) and implemented by the United Nations Development Programme (Sirbiladze et al. 2009, p. 10).

2.2 HIV/AIDS and Hepatitis B and C¹

By March 2011, a total of 2,752 HIV/AIDS cases had been registered by the Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC) in Tbilisi. This included 2,029 men and 723 women. The majority of patients are between the ages of 29 and 40; 1,450 patients have already developed AIDS, of whom 592 have died. As the following three figures show, the majority of people (57%) are understood to have

¹ Unless specifically referenced otherwise, data sources for this section, including diagrams, were retrieved from IDACIRC, March 8, 2011.

acquired HIV infection via injecting drug use; most cases of HIV are in the Georgian capital city, Tbilisi; and recent years have seen significant increases in the numbers of new HIV infections. HIV prevalence among IDUs varies in different regions of the country: for example, estimates of 2.5% prevalence in Tbilisi and 4.5%, the highest in the country, in Batumi (Government of Georgia, 2010). In 2009, it was estimated that there were 163 prisoners among the people living with HIV (Javakhishvili & Sturua, 2009, p. 9).

Figure 1. Distribution of HIV cases by routes of transmission

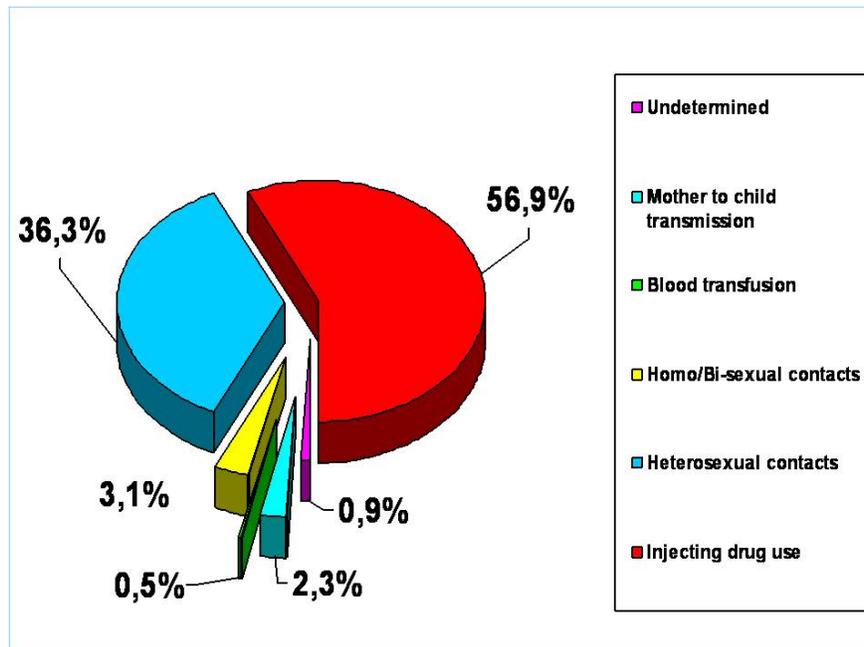


Figure 2. Distribution of HIV/AIDS cases by regions of Georgia

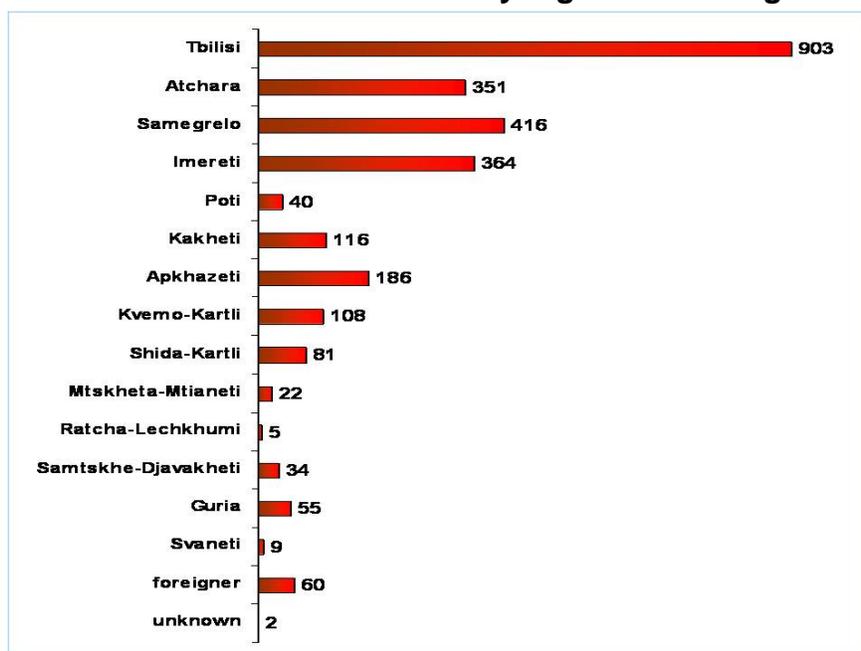
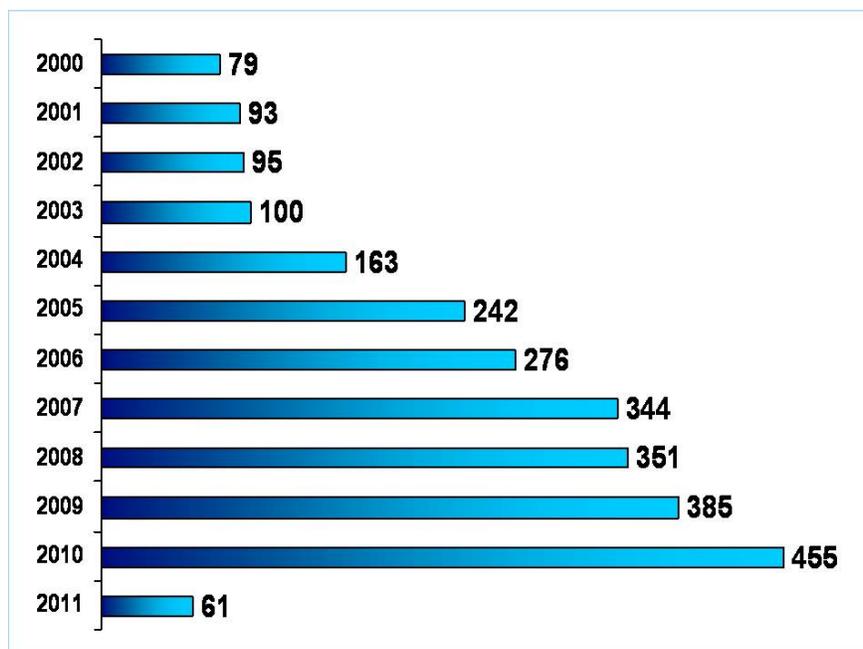


Figure 3. HIV cases registered in Georgia annually



Rates of Hepatitis C among injecting drug users are significantly higher than HIV rates. The statistics, although a few years old, indicate that in 2006 and 2007 the prevalence of Hepatitis C in the three largest cities in Georgia—Kutaisi, Tbilisi, and Batumi—ranged from 58.8% to 76.4%, respectively. The prevalence of Hepatitis B was much lower, however, from 3% to 7 % (Sirbiladze, 2007).

2.3 Drug treatment services

Georgian national drug policy is largely focused on supply reduction, a priority that is reflected in national policy documents and funding. In addition to significant underfunding of treatment services in Georgia, it has been argued that the treatment services that are provided are not in line with what would be regarded as best practice elsewhere. For example, a 2009 report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) stated that

- treatment is mainly limited to a detoxification course, with no support for medical and psychological rehabilitation;
- social rehabilitation programs do not exist;
- where methadone substitution treatment does exist, it is not supported with medical and psychological rehabilitation;
- there are no modern guidelines for addiction treatment; and
- health providers' qualifications, including those of nurses, psychologists, and social workers, do not meet international standards (Javakhishvili & Sturua, 2009, p. 51).

Georgia has six drug treatment clinics with a total of 60 beds and the capacity to detoxify more than 1,000 patients per year. The main treatment services provided are 2-week detoxification services and, increasingly, methadone substitution treatment. Primary prevention services have limited coverage, and there are virtually no rehabilitation or aftercare services. The majority of patients accessing treatment are opioid users, most of whom use heroin as their main drug. As of 2009, there were nine methadone substitution centers throughout the country, serving 1,705 clients (a twelvefold increase since 2006). However, it was estimated that coverage with substitution or detoxification services in the country remained low, barely reaching 4% of those in need (Government of Georgia, 2010, p. 8). HIV testing and counseling is provided by the AIDS Center in Tbilisi, in regional centers in Batumi and Zugdidi, and in approximately 60 other laboratories. Counseling and testing are voluntary, free of charge, and strictly confidential. HIV counseling and testing is increasingly being offered to by non-governmental organizations (NGOs) through various donor-funded programs (including USAID and the Global Fund to fight AIDS, Tuberculosis and Malaria). From late 2008, the government began to co-fund substitution treatment whereby the Ministry of Labour, Health and Social Affairs (MoLHSA) pays for the purchase of pharmaceutical methadone and patients pay for services such as the work performed by doctors, nurses, and other clinic staff (Javakhishvili & Sturua, 2009). There is no current waiting list for methadone substitution treatment; in fact, the services are not utilized to their full extent, possibly due to fear of legal sanctions for drug use. It has also been argued that over-restrictive drug legislation has affected the appropriate use of narcotics in medicine. Georgian levels for prescribed morphine consumption are well below European and world averages. By this argument, medications are dispensed that may be “unrealistic, totally unpractical, and

outdated,” and doctors may be afraid of being put in prison if they prescribe morphine (Eurasian Harm Reduction Network, 2009, p. 13).

In contrast to the demography in many countries, more than 90% of those registered on substitution therapy programs in Georgia have been enrolled in higher and university education. However, high numbers of people engaged in treatment are unemployed (Javakhishvili & Sturua, 2009, p. 9).

2.4 Arguments for balanced approach with a focus on effectiveness

In recent years, the Georgian Parliament and the government have shown themselves to be very willing to improve the response to dealing with the risks of illicit drug use within the country and they have committed substantial time to considering the issues involved. However, it has been argued that the political commitment to reducing harms and various risks due to drug use could be better focused on developing a balanced approach with specific attention to effectiveness for which EU standards and approaches can provide guidelines. The absence of a coordinated and balanced action in the field of drug policy represents one of the basic shortcomings of the efforts made to tackle drug problems in Georgia. However, there have been various substantial efforts in recent years to fill gaps and create a flexible framework for national drug policy. For example, in a February 13, 2007 resolution, the Georgian Parliament acknowledged the necessity of a “complex, balanced and consistent” drug policy with various priorities ranging from demand and supply reduction to harm reduction (Resolution of the Parliament #4334, 2007, cited in Otiashvili, Sarosi, & Somogyi, 2008, p. 6). The document emphasizes that in order to find feasible public policy responses to drug-related harms, it is necessary to foster effective cooperation within society, recruit qualified human resources, expand international cooperation, and improve an appropriate legal basis. The 2008 UN General Assembly Special Session (UNGASS) on HIV/AIDS Country Report highlights the steady increase in the prevalence of drug use within Georgia and points to injecting drug use as a major force for HIV transmission in the country (United Nations, 2009). An effective Georgian Anti-Drug Strategy, which would include measures to combat the spread of HIV, would need to include the reallocation of financial resources—much of which are now spent on costly interventions such as forced drug testing (Otiashvili, Sarosi, & Somogyi, 2008, p. 5)—to evidence-based and cost-effective law enforcement and public health strategies.

3. National and international drug policy and Georgian drug policy

3.1 Current discussions in Georgia

Georgia is currently engaged in an important and timely policy discussion about the future direction of its national drug policy, including how this policy fits with

international agreements and developments. As part of this discussion, a number of amendments to existing drug legislation have been proposed. Legislators in Georgia must consider whether the current package of proposed legislative measures contributes to achieving the coherent and consistent approach that they themselves would wish to have and which the United Nations, EU institutions, and other partners would expect to see. Among the strategic questions that they will need to consider over the coming months are what, besides legislative reform, needs to happen and what other policies need to be developed and implemented to restrict the supply and reduce the demand for drugs. In trying to learn from what has happened elsewhere, it is recognized that there have been very few systematic evaluations of drug policies in any country. Moreover, it is contentious and misleading to attribute direct causal relationships between national drug policy and individual behaviors. Drug-using behaviors are influenced by a wide range of social, economic, and cultural factors. Simplistic claims that what happened in one place because of a particular set of decisions will be replicated in another context are misleading (Reinarman, Cohen, & Kaal, 2004). In addition to introducing progressive legislative changes, Georgia needs to develop and implement a holistic and balanced Anti-Drug Strategy.

3.2 The United Nations

The United Nations Office on Drugs and Crime (UNODC) defines drug dependence as “a health disorder (a disease) that arises from the exposure to drugs in persons with these pre-existing psycho-biological vulnerabilities” (UNODC, 2010b, p. 6). This perspective suggests that punishment is not the appropriate response to persons who are dependent on drugs, arguing that “imprisonment can be counterproductive to recovery in vulnerable individuals who have already been ‘punished’ by the adverse experiences of their childhood and adolescence, and who may already be neurologically and psychologically vulnerable” (UNODC, 2010b, p. 6) The International Narcotics Control Board (INCB) has also stressed the importance of a balanced approach in policymaking, stating that “due respect for universal human rights, human duties and the rule of law is important for effective implementation of the international drug control conventions” (Costa, 2010, p. 4). A summary of the provisions of the United Nations Conventions on Drugs is included as Annex A.

A 2009 UNGASS AIDS report on Georgia emphasized the need for the country to review its legal arrangements so as to scale up HIV prevention efforts:

“According to the law on Narcotic Drugs and Psychotropic Substances, not only the sell (sic) and possession, but also consumption of narcotic drugs is punishable. In addition, according to the State Law on Prisoners, the possession of a syringe by a prisoner is prohibited. These restrictive provisions of the state laws create serious barriers to implementation of harm reduction services not only in correctional settings, but also in the whole country” (United Nations 2009, p. 14).

The report went on to welcome the package of amendments to the drug law and relevant articles of the Criminal Code that were developed and submitted to the Georgian Parliament in 2007. However, the report expressed disappointment at the slow process of adopting new, less restrictive legislation and stated that although “the extent to which the amendment can change restrictive regulations is quite limited, its adoption will be a positive development and incremental step towards lessening barriers to HIV prevention” (United Nations, 2009, p. 15).

In its draft program for promoting Justice and Security in Georgia, 2011–2013, UNODC stated its concern that Georgian drug legislation needed to be reviewed and committed itself to helping ensure that appropriate legislation can be put in place (UNODC, 2010a). UNODC also offered to provide assistance to develop a national Anti-Drug Strategy. In fact, there is a national Anti-Drug Strategy already in existence in Georgia (Ministry of Labour, Health and Social Affairs of Georgia, 2006). Given this, the priority should be to develop a roadmap for drug policy reform, including reviewing and updating legislation and developing a national Action Plan.

3.3 The European Union

The EU Drugs Strategy 2005–2012 states that the EU upholds the founding values of the Union, “respect for human dignity, liberty, democracy, equality, solidarity, the rule of law and human rights. It aims to protect and improve the well-being of society and of the individual, to protect public health, to offer a high level of security for the general public and to take a balanced, integrated approach to the drugs problem” (Council of the European Union 2004, p. 2). It goes on to assert that in reviewing and redrafting national legislation, policymakers need to take into account the political and health perspectives, research needs and evidence, and everyday practice in the field, and to operational cooperation against drug trafficking and bring them together in coherent and consistent propositions. The Strategy includes as a priority the intention to assist European Neighbourhood Countries, including Georgia, “to be more effective in both drugs demand and drugs supply reduction...by mainstreaming drugs issues into the general common foreign and security policy dialogue and development cooperation” (Council of the European Union, 2004, p. 18). Among a list of other priorities, in 2006 the EU-Georgia Action Plan (European Commission, 2006) committed the EU and Georgia to work together to reinforce national legislation and develop a national Anti-Drug Strategy covering drug supply and demand, including prevention programs and programs for treatment of drug addicts, and to develop the capacity of relevant law enforcement authorities. The Action Plan also commits the two parties to work together to reform and improve the health sector, improving access and affordability for the whole population, increasing primary health, prevention and health promotion services, information gathering and staff training.

3.4 Other countries' experiences: Sweden, Switzerland, and Portugal

More detailed case studies are included in Annex B.

3.4.1 Sweden

Sweden is often cited as an example of a country with a very “conservative” drug policy; however, its policy focuses not only on legal sanctions to control drugs but also on substantial investment in the provision of health and social support for people with drug problems. A relatively small, wealthy country, Sweden enjoyed for more than 70 years, up to the 1980s, a broad Social-Democratic popular consensus about the role of the state, including the belief that to have a fair society it was necessary to invest in a strong welfare system and to have high tax levels to support this. Sweden has always been a country with a low prevalence of drug use. At the very north of Europe, Sweden is not on any major trafficking routes. It has a strong temperance (anti-alcohol) tradition dating back to the nineteenth century, and temperance movement MPs still sit in the national Parliament. Traditionally, Swedes have been very health conscious. Income inequality, which has been cited as a risk factor in leading to the emergence of problematic drug use within communities (Wilkinson & Pickett, 2007), has always been very low. The increased prevalence of drug use, particularly the sharp increase in problematic drug use,² and the doubling of drug-related deaths in the 1990s caused the Swedish public and politicians considerable concern. The main drug-related problems were related to injection of amphetamines and heroin (Hallam, 2010).

Sweden briefly experimented with a “liberal” drug policy, but for almost 40 years a more conservative approach has been followed. There has consistently been a broad popular consensus in support of Sweden’s national drug policy, which includes a vision of a drug-free society with the establishment of severe criminal justice sanctions against drug use. However, at the same time, Sweden has consistently invested heavily in drug treatment services. It spends around 0.5% of its gross domestic product (GDP) on its drug policy, making it the EU’s second highest such expenditure after the Netherlands (0.66%) (UNODC, 2007, pp. 21, 35). Harm reduction does not factor into Swedish service provision or in public discourse, other than as an external dogma to be resisted. There has been some access to methadone substitution treatment since 1966, but it is not widely used and has restrictive entry protocols. The history of needle exchange programs is also limited. Needle exchanges were first made nationally available in 1988 but were then banned in 1989. They were permitted again beginning in 2006, but there are still only two programs in the entire country.

Sweden claims success for its policy in a number of areas:

² “Problem” or “problematic” drug use is defined by the EMCDDA as “injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines.” This definition specifically includes regular or long-term use of prescribed opioids such as methadone, but does not include their rare or irregular use, nor the use of ecstasy or cannabis.

- There are fewer reported drug users in Sweden now than there were in the 1960s. The lower prevalence includes young people. For example, in 2006 the prevalence of lifetime drug use at ages 15–16 was 22% across Europe, but in Sweden it was 8%.
- There are low rates of HIV/AIDS among IDUs in Sweden (UNODC, 2007).

However, although overall drug use prevalence is low in Sweden, problem drug use is only slightly below the EU average. This means that a far higher proportion of Sweden’s drug users fall into the “problem” category than in other countries (Hallam, 2010).

3.4.2 Switzerland and Portugal

Switzerland and Portugal are two countries that have been cited as developing innovative drug policies over the past few decades in response to the challenges they faced. The main areas of concern in both countries in the late 1980s and early 1990s included growing numbers of people infected with HIV through injecting drug use as a result of heroin being the most commonly injected drug. There was also a growing consensus in both countries that existing policy, which focused on criminal justice sanctions for drug use, had failed. Incrementally over time, with field testing, monitoring, and modeling of likely outcomes from particular courses of action, each country developed policies focused on public health and each has reported successful outcomes.

In Switzerland, the following outcomes have been reported:

- Between 1991 and 2004, the drug-related death toll in Switzerland fell by more than 50%.
- The number of drug users in treatment rose substantially.
- Levels of HIV infection acquired through injecting drug use were divided by 8 within 10 years (Savary, Hallam, & Bewley-Taylor, 2009).
- Over time, the public has become less worried about drugs as a serious social problem. For example, in surveys in 1988, 1995, and 2002 the number of people describing drugs as one of the five most serious social problems reduced from 64% to 34% and then to 12% (Csete, 2010).

In Portugal, since the decriminalization of drug use and the establishment of enhanced social and health support services, the following outcomes have been reported:

- Overall, the policy has had no adverse effects on the country’s drug usage rates, which, in numerous categories, are among the lowest in the EU. There has been a small increase in overall reported illicit drug use among all adults, but this is in line with European trends. However, although there has been an increase in the use of cannabis, there has been a decrease in heroin use, which is far more harmful.
- Illicit drug use among problematic drug users has decreased, as have opiate-related deaths.

- Illicit drug use among 15- to 19-year-olds has also decreased. This is particularly significant because experimentation at this age has been cited as an important determinant in predicting future lifelong use.
- There have been reported reductions in injecting drug use and, related to this, a significant decrease in newly reported HIV/AIDS cases, drug-related mortality, and infectious diseases.
- Along with a substantial increase in the uptake of drug treatment, there has been a reduced burden of drug offenders on the criminal justice system. The proportion of drug-related offenders in the Portuguese prison population dropped from 44% in 1999 to 21% in 2008.
- At the same time, there have been huge increases in the amount of drugs seized by authorities. This may indicate that by not having to police individuals' drug use, authorities are better able to focus on supply reduction.
- Despite decriminalization and reductions in the retail prices of drugs since 2001, there has not been a mass expansion of the drug market, as was feared by opponents of the drug policy reform. It is difficult, however, to draw clear conclusions about the overall impact of the policy change on crime (Hughes & Stevens, 2010, p. 1010).

3.4.3 What can be learned from the Swedish, Swiss, and Portuguese experiences?

Despite resisting international pressure to provide harm reduction services, Sweden has been able to claim success in keeping a low prevalence of drug use and of HIV/AIDS among IDUs. However, the fact that Portugal, despite its very different drug policy, has very similar prevalence rates leads one to question the causal relationship between policy and individual drug use. It is also very concerning that the ratio of problem to non-problem drug users in Sweden is so high.

The Swiss and Portuguese approaches made excellent use of research and scientific evidence to develop drug policy. In both countries, change took place over a long period of time. It was important to build and maintain consensus and confidence between policymakers and the general public as well as to develop an infrastructure and collaboration between criminal justice and health systems, which could support progressive legislative change. Neither country represents a panacea for all drug problems. However, these policies are popular in each country and provide examples of a reorientation of drug policy toward a public health focus and experience of provision of more integrated and effective responses to drug use.

The following is true of all three countries:

- Policy is based on ethical and political positions as well as on scientific evidence and legislation.
- Drug misuse continues to be regarded as a public health and social problem requiring a range of complex responses at individual and societal levels.

- Policies have become firmly established with public support, and there has been substantial investment in drug prevention and treatment services.

4. Currently proposed Georgian legislative amendments

This section covers amendments to Georgian legislation that have been proposed in 2011 by a Parliamentary working group. Each amendment is discussed individually in Section 4.3. Referencing relevant experience elsewhere, issues are suggested that should be considered by policymakers.

4.1 Purpose and context

The proposed Georgian legislative amendments should be cautiously welcomed as a step in the right direction, although not without substantial qualification and assertion of the need for further review and reform of the legislative framework and the drug strategy. The proposed amendments include harmonizing Georgian drug legislation with UN Conventions and EU guidance and agreements, as well as establishing fair and appropriate laws for the people of Georgia. The moves to align the categories of regulated drugs with the UN Conventions achieve this objective. However, in addition to fair and proportionate legislation, states have to invest in appropriate prevention and treatment services to protect their populations and to ensure that people who suffer from drug dependence—a long-term, chronic health condition—are supported to recover. It is clear that Georgia currently falls short of these goals and that to achieve them some financial reorganization will be required. Investment in a rigorous costing and economic modeling exercise is needed to understand the financial and other costs associated with the current system, which is focused on law enforcement and incarceration, and to project financial and social costs based on the likely scenarios that may arise in relation to the proposed legislative changes. In addition to direct costs, the assessment needs to consider the significant collateral costs of incarceration with regard to public health issues and the risk of exposure to bloodborne infections like HIV, Hepatitis B and C, and Tuberculosis. In practice, many European countries have learned that reducing the cost of arresting and punishing drug users enables resources to be focused on maximizing the other factors that protect against drug abuse, such as prevention and treatment.

It makes sense that Georgian drug legislation should fully harmonize with relevant UN international agreements, which include

- the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol,
- the 1971 Convention on Psychotropic Substances, and
- the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

However, the drug control conventions must also be implemented in such a manner as to be congruent with the health and human rights commitments inscribed in the UN Charter (1948), which take priority. Drug use and its treatment are also referred back to the Universal Declaration of Human Rights (1948), which enshrines health as a basic human right. In addition, the UN International Guidelines on HIV and Human Rights emphasize that criminal law should not be an impediment to reducing the risk of HIV transmission among IDUs or to the provision of HIV-related care and treatment for IDUs. In particular, member states are urged to consider the repeal of laws criminalizing the possession, distribution, and dispensing of needles and syringes in favor of the authorization or legalization and promotion of needle and syringe exchange programs.

The Constitution of the World Health Organization (WHO) is also relevant. It proclaims “the enjoyment of the highest attainable standard of health” to be one of the fundamental pillars of human rights, regardless of ethnicity, religious affiliation, political creed, or socioeconomic status. The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law.

Georgia is also a signatory to the UN Convention on the Rights of the Child, which includes (Article 24) the right to “the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health” (United Nations, 1990). As the only core UN human rights treaty to refer specifically to drug use, this Convention has a strong focus on protection rather than punishment.

It is important to consider the intentions of the international agreements and to judge whether sanctions proposed within the new legislation would be likely to improve support for the recovery and rehabilitation of the drug user or to reinforce the social exclusion that he or she is likely to experience. The latter will be likely to have significant social and economic costs.

4.2 Outstanding problems requiring additional attention

There are some outstanding problems that will not be resolved by the proposed legislative changes. These include the following:

- Under the proposed new legislation, all illicit drugs continue to be treated equally, whereas in most EU countries, the legal systems take into account the type and “harmfulness” of the drug in question and whether the offense relates to involvement in the drug market or to personal use or possession for personal use (EMCDDA, 2010b).
- The legislative proposals relate only to drug use. Although EU countries’ legislative practices establish useful personal use quantities, many differentiate between low-level supply, such as someone sharing a cannabis joint with a friend, and organized criminal trafficking and supply (EMCDDA, 2010b).

- In all countries that claimed reductions in drug-related problems, the legislation has been cited as only a possible contributory factor. Of equal, if not greater, importance has been the establishment of a public health-focused strategy, including significant investment in prevention and treatment services and diversionary approaches.
- Many countries afford judges significant flexibility in determining appropriate courses of action in relation to drug offenses. This can enable judges to consider all presenting factors and to act so as to protect vulnerable people and to reduce rather than reinforce social exclusion.
- The Georgian policy of coerced drug testing, introduced in 2006, has significantly increased government income, but the policy has failed to reduce the availability of illicit drugs within Georgia. The consequences of a positive test result include the imposition of severe fines and may even lead to the confiscation of assets. A comparison of data from 2006, 2007, and 2008 revealed a very sharp increase in the number of drug-related criminal proceedings in Georgia: 3,542 were reported in 2006 (1,926 of which were classified as major crimes by the police), 8,493 were reported in 2007 (1,970 of which were classified as major crimes), and 8,699 were reported in 2008 (2,013 of which were classified as major crimes). The disproportionately large increase in minor crimes compared to almost no increase in what are classified as major crimes suggests that this increase may have resulted from intensified police activity related to the 2006 legislation (Javakhishvili & Sturua, 2009, p. 9).
- In 2007, the Prosecutor General’s Office in Georgia initiated the drafting of the “Law on Tackling Drug Crime.” This law inhibits individuals’ ability to reintegrate into society after being convicted of a range of drug offenses by depriving them of the following rights for 3 to 15 years:
 - the right to drive a vehicle;
 - the right to practice a medical profession;
 - the right to practice a legal profession;
 - the right to work in pedagogical and educational institutions;
 - the right to work in national and local governments and public (government-funded) government agencies;
 - the right to be elected to Parliament;
 - the right to manufacture, purchase, store, and carry weapons (Javakhishvili & Sturua, 2009, p. 15).

These actions are severely punitive and reinforce the long-term (up to 15 years) social exclusion of and stigma against drug users (with the possible exception of that concerning weapons). Instead, there needs to be a fundamental shift toward and investment in a national Anti-Drug Strategy focused on public health, rather than relying on harsh criminal sanctions.

4.3 Specific comments on different components of the proposed new legislation

Proposed amendment: Articles 3 and 4 of the Law of Georgia on Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Care are to be aligned with the 1961, 1971, and 1988 UN Conventions. The same law is also to be amended based on the assessed social and medical risks associated with different drugs.

Consideration should also be given to reviewing the sanctions system and to diversifying penalties based on the same criteria. For example, many other countries, such as the United Kingdom, have judged that the social and medical harms associated with the use of heroin are substantially more serious than those associated with the use of cannabis. Accordingly, penalties associated with cannabis use are less severe than those associated with heroin.

Proposed amendment: Article 4 of the Law of Georgia on Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Care is amended so that small, large, and especially large amounts of narcotic drugs, psychotropic substances, and direct precursors withdrawn from illicit ownership or traffic are defined in a new way.

Commentary: By setting amounts that are deemed to denote personal use, it should become easier to separate drug users from the dealers and traffickers, and thus to apply different and proportionate penalties in line with UN guidance (Costa, 2010, p. 7). The new laws would rationalize the amounts, allowing law enforcement officials greater ability to focus limited resources on actual drug dealers and offering treatment to users caught with small amounts of dangerous drugs (INL, 2011, p. 257).

There is, however, no international consistency with regards to what amounts indicate that drugs are for personal use. At least seven EU countries (Belgium, Germany, Greece, Italy, Netherlands, Portugal, and Finland) have redefined limits for non-prosecution of individuals caught with drugs that appear to be for personal use (Blickman & Jelsma, 2009). In 2000, Portugal, in decriminalizing consumption and possession of all drugs, adopted the norm of “the quantity required for an average individual consumption during a period of 10 days.” Indications are given for what constitutes an average daily dose, for example, 2.5 grams for cannabis or 0.2 grams for cocaine. So long as there is no additional evidence implicating the drug user in more serious offenses, drug possession is dealt with as an administrative violation, as opposed to being prosecuted as a criminal offense (Blickman & Jelsma, 2009). According to the EMCDDA, the real emphasis in the EU “seems to be on the intent rather than the amount possessed... The great majority chooses to mention some sort of ‘small’ quantity in the law or guidelines, but leaves it to prosecutorial or judicial discretion, with knowledge of all of the surrounding circumstances, to determine the true intention behind the offense. No country definitively uses the quantity to determine who is a user or a trafficker” (Blickman & Jelsma, 2009, p. 8).

Existing Georgian law might inhibit effective provision of needle exchange services, an important and evidence-based component of a national HIV prevention strategy. Service providers may have been reluctant to accept returned needles for fear of facing prosecution because of small quantities of drugs being returned in the used needles. This amendment should remove such barriers to effective provision of needle exchange (as opposed to distribution) services, thus contributing to enhanced community safety because contaminated needles could now be collected and destroyed safely without any fear of legal reprisals.

In summary, possible outcomes from this amendment include

- a fairer system of penalties, allowing the opportunity to differentiate between personal drug use and supply;
- improved needle exchange service provision, supporting HIV prevention efforts for individuals;
- improved community safety through the removal of risk of prosecution for service providers who can improve their services, establishing targets for needle return rates and improving primary health care service provision; and
- possibly greater numbers of people using HIV prevention and harm reduction services, the costs of which should be offset in the longer term by reduced numbers of HIV-infected individuals.

Proposed amendment: Article 273 of the Criminal Code of Georgia: Illegal production, purchase, storage of narcotic drugs, their analogues or precursors for personal use and/or illegal use without doctor’s prescription: This is removed from the criminal code and becomes an administrative offense.

Commentary: Removing responsibility for personal use from the criminal code and setting it within the administrative code is consistent with UN Conventions and guidance:

“Serious offences, such as trafficking in illicit drugs, must be dealt with more severely and extensively than offences such as possession of drugs for personal use. In this respect, it is clear that the use of non-custodial measures and treatment programs for offences involving possession for personal use of drugs offer a more proportionate response and the more effective administration of justice” (Costa, 2010, p. 7).

The official commentary to the 1988 UN Convention states: “It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence.” The commentary suggests establishing a strategy regarding the range of offenses relating to personal use, similar to that practiced by many countries, in which such offenses are distinguished from those of a more serious nature by a threshold, for example, in terms of weight. To date, this has not been possible in Georgia, but it now would be under the current set of legislative proposals.

However, it is worth noting that different countries, while embracing the concept of separating less serious from more serious offenses, have established national

arrangements specific to their own setting. Some countries have opted to decriminalize personal drug use, shifting to administrative rather than criminal sanctions, as is now proposed in Georgia. Other countries have instead opted for a policy of depenalization, whereby they cease to apply criminal or administrative sanctions, although the laws still exist to prohibit activities. Legalization has not been adopted by any country and would be a clear breach of UN Conventions. For example, in Portugal possession of a small quantity of drugs for personal use has been completely decriminalized, whereas in other countries the approach has been not to decriminalize but simply to treat the offense as a low priority for law enforcement. In the Netherlands, Germany, and the Czech Republic, possession for personal use remains unlawful, but guidelines are established for police, public prosecutors, and courts to avoid imposing any punishment, including fines, if the amount is considered to be insignificant or for personal consumption. Very few EU countries (Sweden, Latvia, Cyprus) exercise the option to impose prison sentences for possession of small amounts (Blickman & Jelsma, 2009).

Antonio Costa, former UNODC Executive Director, has argued eloquently against the criminalizing and incarceration of people with drug problems (Costa, 2010). According to Costa, incarceration in prison and confinement in compulsory drug treatment centers often worsens the already problematic lives of drug users and drug-dependent individuals, particularly those who are youngest and most vulnerable. Exposure to the prison environment facilitates affiliation with older criminals and criminal gangs and organizations. It also increases stigma and helps to form a criminal identity. It often increases social exclusion, worsens health conditions, and reduces social skills. Costa also points out the necessity of providing comprehensive alternatives to incarceration within the community (outpatient or residential therapeutic setting), such as psychosocially supported pharmacological treatment for opiate dependence; unfortunately, such services do not currently exist in Georgia.

Hughes and Stevens (2010) have argued that most studies have found no significant increases in use as a result of decriminalization. They have also suggested that it is difficult to make any certain judgment on the effects of decriminalization on drug use, given the absence of adequate comparators. However, the financial and other costs associated with a focus on law enforcement and incarceration can be high, and reducing the cost of arresting and punishing drug users would enable resources to be focused on maximizing the other factors that protect against drug abuse, such as prevention and treatment. It has been argued that one of the biggest impacts of changes in the law has been the reduction of pressure on overburdened penal systems and prison overcrowding (Jelsma, 2009). A study that considered data from the Netherlands, the United States, Australia, and Italy concluded that the removal of criminal penalties appeared to produce positive but slight impacts. The primary impact was reducing the burden and cost in the criminal justice system. This also reduced the intrusiveness of criminal justice responses to users (Hughes & Stevens, 2010, p. 1000).

It is important to note, however, that there is little evidence that the removal of criminal penalties on its own is likely to lead to significant increases or decreases in the overall prevalence of drug use or drug-related health harms (Hughes & Stevens, 2010, p. 1000). The Portuguese experience has been arguably the most studied example of drug policy review. For example, Portugal is the only country that has fully decriminalized personal drug use (in 2001) and it has reported outcomes that include reductions in drug use among young people and reductions in use of opiates, the most problematic type of usage. It has also noted the lack of negative outcomes, such as increased street drug use or drug tourism. However, the Portuguese legislative changes cannot be considered in isolation from the country's corresponding investment in a range of social and health support services, which are intended to offer support to drug users where it is needed while retaining the intention to deter drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system while also reducing problematic drug use. Outcomes that have been reported include

- small increases in reported illicit drug use amongst adults;
- reduced illicit drug use among problematic drug users and adolescents, at least since 2003;
- reduced burden of drug offenders on the criminal justice system;
- increased uptake of drug treatment;
- reduction in opiate-related deaths and infectious diseases;
- increases in the amounts of drugs seized by the authorities; and
- reductions in the retail prices of drugs (Hughes & Stevens, 2010, p. 1017).

Opponents of the legal change had expressed concerns that decriminalization would lead to mass expansion of the drug market in Portugal. This did not happen; in contrast with market expansions in neighboring Spain, the numbers of problematic drug users and the burden on the criminal justice system in Portugal have been reduced. It is not possible to state that any of these changes were the direct result of the decriminalization policy. Overall, it is clear from the Portuguese experience that decriminalization does not necessarily lead to increases in the most harmful forms of drug use. Although small increases in drug use were reported by Portuguese adults, this was arguably less important than the major reductions in opiate-related deaths and infections, as well as reductions in drug use by young people.

Other countries, such as Sweden and Switzerland, have adopted different legislative approaches and have also claimed successful outcomes from their drug policies, but, as with Portugal, these countries' substantial investments in health and social care services must be considered to be at least as important as the legal framework.

In summary, possible outcomes from this amendment include the following:

- Georgia would be more in line with international practice in making the legal distinction between drug use and supply and trafficking, with penalties for the latter being more severe.
- There is little indication from international experience that this legal change on its own would have any significant impact, positive or negative, on drug use prevalence or drug-related harms.
- Georgia would still retain severe administrative penalties for personal drug use, although the evidence that this is an effective deterrent to drug use is extremely limited (Reuter & Stevens, 2007, p. 57).
- As elsewhere, Georgia would need to invest in public information campaigns to reinforce the message that drug use is not regarded as acceptable and also to direct people to sources of advice and support.
- Moreover, to achieve international standards in human rights and to achieve reductions in drug harms, alongside the legal change Georgia would still need to make substantial investments to improve health and social care provision for drug users.

Proposed amendment: Article 13 of the Law of Georgia on Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Care establishes the Drug-related Policy Council:

- 1. To ensure efficient and coordinated interdepartmental work against country-wide expansion of drug abuse and illicit traffic of narcotic drugs the Narcotic Drug-related Policy Council is established.**
- 2. Composition and guidance on activities of the Council is determined by regulation which is presented by the Council and approved by the President of Georgia.**

Commentary: This proposal was included in Georgia’s national Anti-Drug Strategy (2006). The establishment of a high-level council to review, develop, and implement national drug policy is welcome. It is recommended that membership should include NGOs and that active steps should be taken to engage with civil society in line with the “Beyond 2008” recommendations (Vienna NGO Committee on Narcotic Drugs, 2008b). The work plan of the council should include not only a review and update of national drug legislation but also the development and implementation of a new national Anti-Drug Action Plan and a revised and updated Anti-Drug Strategy.

Proposed amendment: Article 40.6 and 40.7 of the Law of Georgia On Narcotic Drugs, Psychotropic Substances, Precursors and Narcological Care, which relate to mandatory treatment are withdrawn.

Commentary: This is a welcome amendment, bringing Georgia in line with acceptable international human rights standards. Improving the range and standards of treatment services is also necessary. In addition to insisting that all treatment for drug dependence

must be evidence-based, according to established principles of medicine, and arguing that detention and/or isolation for the purposes of “forced detoxification” are unlikely to be effective, Costa, has argued that non-voluntary treatment or testing infringes a range of possible rights, including the right to health, the right to freedom from inhuman or degrading treatment, the right to liberty and security of person, and the right not to be subjected to arbitrary or unlawful interference with privacy (Costa, 2010, p. 11). Costa writes:

“Under the right to health, the starting point is that any treatment or testing for drugs shall be subject to full informed consent...With respect to drug treatment, in line with the right to informed consent to medical treatment (and its ‘logical corollary,’ the right to refuse treatment), drug dependence treatment should not be forced on patients. Only in exceptional crisis situations of high risk to self or others can compulsory treatment be mandated for specific conditions and for short periods that are no longer than strictly clinically necessary. Such treatment must be specified by law and subject to judicial review. Where treatment is offered as an alternative to imprisonment or penal measures for drug possession/use, although this involves a degree of coercion, the patient is entitled to reject treatment and to choose the penal measure instead. Such measures should never preclude, however, the access of those subject to detention or other penal measures to appropriate treatment for drug-dependence, where required” (Costa, 2010, p. 11).

Proposed amendment: Amendments were introduced to Article 260 of the Criminal Code. The legislator differentiated between these two categories and imposed relatively reduced sanctions on those who illegally prepare, produce, purchase, keep, transport, or carry psycho-active drugs for individual use only, whereas enhanced sanctions are imposed on those who undertake similar activities for distribution.

Commentary: The distinction between the two groups is in line with other countries’ practice and UN guidance; the issues relating to proportionality apply.

Proposed amendment: Article 274 of the Criminal Code: Avoidance of Compulsory Treatment is withdrawn.

Commentary: This is in line with UN guidance, as discussed earlier.

Proposed amendment: Article 45 of the Administrative Code is newly formulated envisaging penalties for illegal storage in small amounts, production, purchase, or use without a doctor’s prescription of under control drugs for individual use, whereas in case of repeatedly undertaking same infringements the offender will be granted an opportunity to undergo treatment with penalty money, as follows:

Article 45. Illegal production, purchase, storage, use without doctor’s prescription of small amounts of psycho-active substances under control in Georgia for individual use.

Illegal production, purchase, storage, use without doctor’s prescription of small amounts of psycho-active substances under control in Georgia for individual use, will result in a penalty of 300 GEL.

The same action, undertaken repeatedly will result in a penalty of 600 GEL.

Actions envisaged by part 1 of this article, undertaken by the person more than twice in a year charged by an administrative payment for such violation. This will result in:

- 1. penalty of amount of 2000 GEL; or**
- 2. administrative imprisonment for about 30 days' duration.**

Upon paying the penalty amount envisaged by part 3 of this article, the penalised person is given the opportunity to undergo a course of treatment in a relevant specialised medical facility for the amount paid as penalty.

Commentary: This amendment retains the presumption that strict sanctions reduce drug consumption by directly lowering demand. However, it has been argued that there is little evidence that fear of arrest and sanctions is a major factor in an individual’s decision of whether to use drugs; for example, drug use patterns in Amsterdam and San Francisco have been found to be remarkably similar, despite the significantly different law enforcement regimes in these cities (Mena & Hobbs, 2010, p. 68). Diversion into appropriate advice and support services would be preferable; 300 GEL seems a large amount for a first offense. In addition to questions about proportionality, there is a danger of the unintended consequence of driving a young experimenter into criminal activities to pay the fines.

By not distinguishing between different types of substances, these penalties continue to deal with users of different drugs as though they were the same. Some countries consider drugs such as heroin to be more damaging to health and public order than others, such as cannabis, and therefore users incur heavier penalties for offenses involving such drugs. In other countries, such as the United Kingdom, other options have been explored for first or minor offenses, such as those involving “less serious” drugs or those with contributory factors. These alternate options include caution or warning and referral to counseling, support, and treatment services. It is recommended that the new legislation afford judges a significant degree of discretion in selecting a course of action.

The same arguments apply to the second fine.

It is a good principle to introduce an option of diversion into treatment rather than imprisonment. In some countries, the criminal justice budget includes the purchasing of drug treatment for people accused or convicted of drug use or related crimes, because it is a cheaper and more effective means of crime prevention than incarceration. When facing a conviction for drug use or related offenses, many people with drug dependence will voluntarily choose treatment if they are offered the option of affordable, humane, and effective treatment in the community as a proportionate alternative to criminal justice

sanctions. It is now proposed that people should be able to pay a fine and access treatment rather than going to prison if arrested for a third time. However, the United Nations believes that treatment should be available for all who need it (Costa, 2010, p. 10). There is considerable evidence that effective drug dependence treatment offering clinical interventions (inpatient or outpatient) as an alternative to criminal justice sanctions substantially increases recovery, including a reduction in crime and criminal justice costs. This improves outcomes both for the person with drug dependence and the community when compared to the effects of criminal justice sanctions alone. It is therefore recommended that this diversion to appropriate treatment services should be considered in the case of all persons convicted of drug-related offenses (UNODC, 2010b, p. 7).

There are some additional problems with the diversionary proposal:

- Not all drug use requires treatment.
- Treatment does not exist for all drug use (e.g., cannabis use).
- Georgia has a shortage of drug treatment service provision.

The financial modeling exercise to compare options to incarceration should take into consideration that most people in Georgia who are incarcerated for drug-related offenses would not likely be involved in other crimes. The overwhelming majority of people convicted for drug-related crimes are in prison for possessing small amounts of narcotics or other psychoactive substances without intention to sell (Otiashvili, Sarosi, & Somogyi, 2008, p. 6). In Georgia, almost a quarter of those convicted of drug-related crimes are there for simple drug use. Therefore, by reducing the criminal justice-related costs for these people would allow a direct investment in health and social care provision.

It should be noted that Georgian law currently includes an option for an alternative to prison by a “procedural deal,” which allows a person charged with a drug-related crime to pay a certain amount of money to be released from imprisonment. A person detained for repetitive drug use during 1 year may be offered the choice of imprisonment or payment of a sum decided by the court. There is no limit set in the law. One fine determined by the court was as high as 4,000 GEL.

Proposed amendment: Amendments and Addenda to the Code of Criminal Infringements of Georgia. The Code is supplemented by Article 159¹⁰ with the following content:

Article 159¹⁰. Promotion or advertising of psycho-active substances under control in Georgia or dissemination of information on their production, use, application, places of purchase:

- 1. Promotion or advertising of psycho-active substances under control in Georgia or dissemination of information on their production, use, application, places of purchase by a physical person will result in a penalty in the amount of 500 GEL.**

2. The same action undertaken by a legal person will result in a penalty in the amount of 5,000 GEL.

Commentary: From discussions, it is understood that this amendment is mainly intended to prevent the media’s direct or indirect promotion of illicit drug taking.

It would be useful to include in the legislation a requirement for public officials to provide adequate information and early warning systems, particularly about emerging new substances.

Reassurances have been given that there is no intention to inhibit the provision of harm reduction advice (e.g., safer injecting advice), and it is recommended that this reassurance be included in the final legislation. However, an unintended outcome could be that health promotion advisers and drug advisers self-censor because of their fear of prosecution.

5. Georgian Anti-Drug Strategy review proposal

5.1 Context

Costa has written that drug policy needs to be based at the “intersection of health, security, development and justice” (UNODC, 2010c, p. 4). Drug strategies need to ensure that drug users have access to drug treatment services and sick people have medical access to drugs that can relieve pain and suffering. Strategies also need to include action to intervene to disrupt the organized crime of illegal drug trafficking and supply. Above all, Costa has argued that we must move human rights into the mainstream of drug control. This means that practices must be changed whereby millions of people (including children) who take drugs are sent to prison rather than being referred to treatment services. This also means that those arrested for drug-related offenses need to be treated fairly and humanely. All of these principles should inform Georgian drug policy.

Georgia’s current Anti-Drug Strategy was drafted in 2006 and adopted by the Georgian Parliament in February 2007. In the intervening period, the country experienced a range of challenges, including a war with Russia. Although there was a clear commitment to shifting toward a more strategic and comprehensive approach to dealing with the drugs problem, the INL has reported that the Anti-Drug Strategy established by the Georgian Parliament in 2007 “only outlined main priorities; it lacks specifics to guide implementation. Coordination among institutions involved in drug related issues is also a problem. There is a lack of systemic drug preventive measures; treatment methods are developed with little or no attention given to social rehabilitation following detoxification. Information about dangerous drugs is inadequate, and statistics about drug use are limited and unreliable” (INL, 2011, p. 257).

With the establishment of the National Council on Drugs and the engagement of key policymakers in reviewing legislative arrangements, it is now timely to review the Anti-

Drug Strategy in light of the current situation with reference to international guidance, commitment, and experience. In drafting the new Anti-Drug Strategy, it will be useful to make reference to the existing Anti-Drug Strategy, reviewing the priorities and setting up a fully costed Action Plan with “SMART” (specific, measurable, achievable, relevant, and time-limited) objectives.

5.2 Proposed timescale

National drug strategies usually last between 4 and 8 years. It is therefore proposed that Georgia should plan to establish a new Anti-Drug Strategy to run from 2013 to 2018, supported by an initial 3-year Action Plan to run from 2013 to 2015. This would fit with EU planning arrangements. Between now and the end of 2012, a systematic review could be conducted of the situation in Georgia, including progress made since the adoption of the current Anti-Drug Strategy. Work could also be undertaken to achieve consensus around the assessment of the current position, the process through which to build a new plan, and what the new plan should contain. In setting a suitable timetable, planners will have to take into consideration issues such as elections.

According to EMCDDA (2010b), the renewal of drug policy documents is a complex process that comprises several steps and usually takes between 6 months and 2 years. The main steps are as follows:

1. Conduct a final evaluation of the existing or recently expired strategy or action plan, including review of epidemiological and other data.
2. Consult stakeholders, and sometimes the public, during the development phase of the new policy.
3. Submit successive drafts of the drug strategies and action plans to different ministries in order to coordinate the role of various government departments.
4. Receive approval by the government or Parliament.

5.3 Lining up EU Priorities with Georgian strategic objectives

In line with UN Conventions, countries have to view the drug problem with a global perspective. With this in mind, it would make sense for the revised Georgian Anti-Drug Strategy to align with the EU Action Plan on Drugs. The EU Action Plan on Drugs 2009–2012 identified five priority areas, which fit well with the strategic objectives laid out in the Georgian 2006 national Anti-Drug Strategy, as show in Table 1.

Table 1. Alignment of EU Priority Areas and Georgian Strategic Objectives

| EU priority | Georgian strategic objective |
|--|--|
| 1. Improving coordination, cooperation, and raising public awareness | • Mobilizing the public effort to limit the spread of drug use |

| EU priority | Georgian strategic objective |
|---|--|
| | <ul style="list-style-type: none"> Promoting the improvement of the logistical base and professional staffing of the organizations working on limitation of the supply of and demand for drugs |
| 2. Reducing the demand for drugs | <ul style="list-style-type: none"> Setting the limitation of the spread of the use of drugs as one of the main priority strategies of the government Reduction of the use of drugs in the population of Georgia Prevention of the use of drugs among adolescents and young people Launching an effective system for the treatment, medical and social rehabilitation, and reintegration of drug dependants Reduction of the health (HIV/AIDS, hepatitis, mortality, etc.) and social damage caused by the use of drugs Promoting a drug-free lifestyle |
| 3. Reducing the supply of drugs | <ul style="list-style-type: none"> Stepping up a coordinated drive of law enforcement structures to reduce the availability of drugs Streamlining the legislative base related to the use of drugs and bringing it in line with the current demands and needs |
| 4. Improving international cooperation | <ul style="list-style-type: none"> Raising the level of coordination of the anti-drug efforts on national and international levels |
| 5. Improving understanding of the problem | <ul style="list-style-type: none"> Improvement and development, institutionalization, and effective operation of the integrated system to monitor the consequences of the supply of, demand for, and use of drugs |

5.4 Review of fundamental principles

The following have been stated as underpinning the existing Georgian Anti-Drug Strategy. These should now be revisited to establish whether they are still considered as fundamental.

5.4.1 Goal

The main goal of the Georgian Anti-Drug Strategy is to reduce the illicit circulation, spread, and related consequences on the territory of Georgia.

5.4.2 Values

The Georgian Anti-Drug Strategy is based on the following basic values:

- promotion of harmonious development of the individual,
- protection of individual safety,
- respect for human dignity,
- promotion of the education and development of society,
- protection of human rights,
- protection of the safety of the family, and
- protection of the rights of the child.

5.4.3 Fundamental principles

The Georgian Anti-Drug Strategy states the following as fundamental principles:

- a holistic and balanced approach;
- an evidence-based approach supported by research;
- a local, national, and international partnership approach;
- effective public communication; and
- long-term planning.

5.4.4 Priority target groups and Priority areas

The Georgian Anti-Drug Strategy has identified several priority target groups and priority areas (see Table 2). It should be decided whether these should remain as such and what that decision implies in terms of action.

Table 2. Anti-Drug Strategy Priority Target Groups and Areas

| Priority target groups | Priority areas |
|--|---|
| <ul style="list-style-type: none">• Children and young people | <ul style="list-style-type: none">• Primary prevention of drug usage |
| <ul style="list-style-type: none">• Women | <ul style="list-style-type: none">• Treatment and rehabilitation of drug dependents |
| <ul style="list-style-type: none">• People with “dual diagnosis” (drug and mental health problems) | <ul style="list-style-type: none">• Reduction of drug-related harm |
| <ul style="list-style-type: none">• HIV-infected adults | <ul style="list-style-type: none">• Reduction of supply of drugs |
| <ul style="list-style-type: none">• Drug users in prisons | <ul style="list-style-type: none">• Professional staff training |
| | <ul style="list-style-type: none">• Effective communication with the public |
| | <ul style="list-style-type: none">• International cooperation |
| | <ul style="list-style-type: none">• Monitoring and research |

The new Georgian Anti-Drug Strategy should be concise, with content including the following:

- a. a summary description of the activities that the government will pursue and support to help meet these objectives,
- b. the involvement and collaboration of departments or agencies responsible for these activities,
- c. the resources that will need to be made available by the government to spend on these activities, and
- d. a clear articulation of the scope and timescale of the Georgian Anti-Drug Strategy and how and when its progress will be measured.

The new Action Plan should detail how the Georgian Anti-Drug Strategy will be operationalized, with clear and measurable targets, identified responsibilities, funding arrangements, performance indicators, and review arrangements.

6. Suggested priorities for action

Table 3 presents the proposed priorities under the areas of improving coordination, cooperation, and raising public awareness; reducing the demand for drugs; and improving understanding of the problem. It is not possible to indicate in this paper a precise timetable. Many actions may be underway already and a detailed and fully costed work plan would need to be drawn up with clear deadlines and responsibilities.

Table 3. Proposed Priority Actions

| Strategic theme | Priority action | Commentary |
|---|---|--|
| <p>Improving coordination, cooperation, and raising public awareness</p> <ul style="list-style-type: none"> Mobilizing the public effort to limit the spread of drug use <p>Promoting the improvement of the logistical base and professional staffing of the organizations working on limitation of the supply of and demand for drugs</p> | <p>Develop a government website to provide reliable information on drugs and drug services for the general public.</p> <p>Establish national minimum workplace standards and training and resources for staff professional development.</p> | <p>The general public need to be well informed about drugs, drug harms, and where to get help.</p> <p>Investment is required to ensure that services provided are effective and that staff are supported in their work.</p> |
| <p>Reducing the demand for drugs</p> <ul style="list-style-type: none"> Setting the limitation of the spread of the use of drugs as one of the main priority strategies of the government Reduction of the use of drugs in the population of Georgia Prevention of the use of drugs among adolescents and young people Launching an effective system for the treatment, medical and social rehabilitation and reintegration of drug dependants Reduction of the health (HIV/AIDS, hepatitis, mortality, etc.) and social damage caused by the use of drugs Promoting a drug-free lifestyle | <p>Review existing prevention, treatment, and care services against international evidence of effective practice.</p> | <p>The Georgian Anti-Drug Strategy should include</p> <ul style="list-style-type: none"> universal approaches targeting entire populations, selective approached targeting specific risk groups, and indicative approaches targeting individuals with identified risk factors. <p>Treatment should be evidence-based and focus on dependent users. (WHO defines “dependent use” as a strong desire or compulsion to take drugs, difficulties in controlling drug use, a physiological withdrawal state, tolerance, progressive neglect of alternative pleasure or interests, and persisting with drug use despite clear evidence of overtly harmful consequences. Treatment should be seen as part of a package supporting the individual’s recovery and reintegration into society and it should include</p> <ul style="list-style-type: none"> detoxification, |

| Strategic theme | Priority action | Commentary |
|-----------------|-----------------|---|
| | | <ul style="list-style-type: none"> • substitution therapy, • psychosocial interventions, and • mutual aid support groups. <p>Certain treatment practices should not be implemented:</p> <ul style="list-style-type: none"> • electro-convulsive therapy, • forced detoxification, or • regimes based on physical or psychological punishment or denial of liberty. <p>Treatment systems need to be organized so that they encourage individuals to accept treatment. Routes for access to treatment should include</p> <ul style="list-style-type: none"> • self-referral, • identification through general health and social service structures, • identification through specialist drug advice centers or street outreach services, and • identification through the criminal justice system. <p>Harm reduction services to be provided should include</p> <ul style="list-style-type: none"> • needle exchange programs, • injecting rooms, • overdose risk reduction programs, • treatment of dependence |

| Strategic theme | Priority action | Commentary |
|--|---|--|
| | <p>Establish minimum standards for prevention, treatment, and care service provision.</p> <p>. Establish contracts with service providers, including monitoring requirements to achieve these</p> <p>Establish national targets for service coverage and system to monitor and evaluate</p> | <ul style="list-style-type: none"> • prevention and treatment of HIV and other STIs, • prevention and treatment of Hepatitis B and C, and • prevention and treatment of Tuberculosis. • Specific attention should be given to supporting the needs of vulnerable groups, including young people, women, and minority ethnic groups. <p>Annex C suggests, as examples, possible minimum standards to be included in commissioning needle exchange and opioid detoxification services.</p> <p>It is essential to ensure that all services provided are both evidence-based and ethical</p> <p>Make sure that baselines are known so that targets can be SMART.</p> |
| <p>Improving understanding of the problem</p> <p>Improvement and development, institutionalization, and effective operation of the integrated system to monitor the consequences of the supply of, demand for, and use of drugs</p> | <p>Commission an independent review to assess the current drug situation in Georgia</p> | <p>Use EMCDDA guidance, including</p> <ul style="list-style-type: none"> • drugs used, by whom, and where; and • epidemiology, including: <ul style="list-style-type: none"> – prevalence and incidence of infections related to injecting drug use (e.g., Hepatitis C) and other problems caused by injecting drug use (e.g., number of people overdosing); – numbers, demographics, types of drugs used, and other characteristics of IDUs (e.g., the number of sex workers or homeless people); |

| | | |
|--|--|---|
| | <p>Establish a national drug information system to provide complex, objective, and reliable monitoring information about drugs, drug use, and consequences and service responses</p> <p>Evaluate achievements of the existing Georgian Anti-Drug Strategy.</p> <p>Review and develop a new Georgian Anti-Drug Strategy and Action Plan.</p> <p>Establish a process to evaluate impact of any legislative changes and to recommend any further changes.</p> | <ul style="list-style-type: none"> – prevention services: coverage, content, and budget; – treatment services: coverage, content, and budget; – and criminal justice interventions: coverage, content, and budget. <p>An underlying theme in all the documents accessed and discussions held as part of this project has been the lack of reliable information in Georgia.</p> <p>This is necessary to plan next steps</p> <p>This should involve a wide range of stakeholders across government and NGOs and should aim to match the EU's Strategy and Action Plan in its content and timetable.</p> <p>This should involve a wide range of stakeholders across government and in the criminal justice system and should include NGOs and drug users.</p> |
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Annex A. Summary of UN Conventions on Drugs

| The UN 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol | The 1971 UN Convention on Psychotropic Substances | The UN 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances |
|--|---|---|
| <ul style="list-style-type: none"> • Replaces previous international drug controls enacted in the 20th century. • The focus is on plant-based drugs (opiates, cocaine and cannabis). • Objective: to restrict the use of narcotic drugs to medical and scientific purposes. • This objective involves twin elements: to ensure the suppression of illicit drug production, distribution and use; and to provide for and regulate the licit supply for medical and research purposes. • Restricted substances are classified according to a fourfold system of Schedules, with the strictest provisions applying to those in Schedules 1 and 4. • Suppression is largely focused on supply rather than demand. • The Single Convention obliges Parties to criminalize the unauthorized production, distribution and possession of narcotic drugs. It explicitly recommends imprisonment for “serious offences.” • Also obliges Parties to make prevention, treatment and aftercare services available, and to use these as either an alternative (in “less serious cases”) or a supplement to penal measures. | <ul style="list-style-type: none"> • The focus is on manufactured drugs, such as amphetamines, barbiturates, hallucinogens (LSD) and minor tranquilizers. • The 1971 Convention was drawn up using the Single Convention as a template, and it has many of the same structural features. However, it is less severe in its general tone and less restrictive in certain of its provisions. For example, with the exception of Schedule I drugs, it does not criminalize possession. • Objective: to restrict the production, distribution and use of psychotropic drugs to medical and scientific purposes. • The objective again comprises two thematic elements: the suppression of the illicit manufacture, distribution and possession of these substances; and the regulation and control of their licit supply. • Substances are subject to a fourfold system of classification. • Obliges Parties to criminalize unauthorized production and distribution, subject to their own constitutional principles. • Extends system of licenses and | <ul style="list-style-type: none"> • The 1961 and 1971 Conventions were intended primarily to counter diversion from the licit drug producing and manufacturing sectors. They were felt to be insufficient to counter the influence of the dynamic and flexible illicit trafficking networks that grew up in the 1970s and 1980s: hence the 1988 Convention. • Objective: to harmonize the drug laws of Member States and enforcement actions across the globe, and to restrict illicit drug trafficking by recourse to criminalization, punishment and enhanced international cooperation. • Parties are obliged to enact a specific body of legislation to prohibit illicit trafficking. It includes provisions related to money laundering, asset seizure, extradition, mutual legal assistance, intelligence sharing, law-enforcement training and cooperation, etc. • Establishes a control regime for precursors, reagents and solvents frequently used in the illicit manufacture of narcotic drugs and psychotropic substances. • CND can add, delete or move chemicals to any of the Convention’s two tables, on recommendations of INCB. • The cornerstone of the Convention is Article 3, “Offences and Sanctions,” which obliges Parties to criminalize all supply- |

- All penal measures are subject to the constitutional imperatives of signatory states. “Medical and scientific” purposes are not defined.
- Establishes a system of estimates of drug requirements, statistical returns, licenses and import and export controls on licit drug trade.
- Enshrines the functions of two important drug control bodies, the Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB).
- INCB is the organization responsible for overseeing compliance with the UN drug control system.
- CND is a functional commission of ECOSOC, and is the central policy-making authority for the UN drug control system, with power to amend Conventions.
- CND can add, delete or move drugs to any of the Schedules, on recommendations from WHO.
- The Single Convention has universal application—some of its provisions apply to all states, even if they have not signed the treaty.

import and export controls to psychotropic substances listed in Schedules I and II. [Although not required by the Convention, the system of estimates of drug requirements, statistical returns, licenses, import and export has been extended to all scheduled drugs through resolutions of CND.]

- Requires medical prescriptions for supplies of Schedule II, III and IV drugs to individuals.
- CND can add, delete or move drugs to any of the Schedules on recommendations from WHO.
- Control system is overseen by INCB.
- Makes more attempt than does the Single Convention to balance controls and sanctions against harm and dependence-producing effects of substances, taking into account their therapeutic utility.

related activities; to “legislate...to establish a modern code of criminal offences relating to the various aspects of illicit trafficking”; and to ensure that they are prosecuted and punished as serious criminal offences.

- Article 3.1 obliges Parties to criminalize all forms of unauthorized production, manufacture, extraction and distribution/transport of narcotic and psychotropic drugs; the cultivation of opium poppy, coca bush and cannabis plant for such purposes; the possession or purchase of narcotic or psychotropic drugs for such purposes; the manufacture, transport or distribution of equipment or substances to be used in the above; and the organization, management and financing of trafficking-related activities.
- In addition, Article 3.2 obliges Parties to criminalize “when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption”, contrary to the 1961 and 1971 Conventions. The provision is subject to Parties’ own constitutional principles.
- Parties are obliged to “respect fundamental human rights” when taking measures in line with Article 14, which deals with the illicit cultivation and eradication of narcotic plants. This is the sole mention of human rights in the three treaties.

Annex B. Country case studies: Sweden, Switzerland and Portugal

Sweden

Introduction: The Swedish drugs situation

A relatively small, wealthy country, Sweden enjoyed for more than 70 years, up to the 1980s, a broad Social-Democratic popular consensus about the role of the state, including a belief that to have a fair society it was necessary to invest in a strong welfare system and to have high tax levels to support this. Sweden has always been a country with a low prevalence of drug use. At the very north of Europe, Sweden is not on any major trafficking routes. It has a strong temperance (alcohol) tradition dating back to the nineteenth century, and temperance movement MPs still sit in the national Parliament. Traditionally, Swedes have been very health conscious. Income inequality, which has been cited as a risk factor in leading to the emergence of problematic drug use within communities (Wilkinson & Pickett, 2007) has always been very low. The increased prevalence of drug use, particularly the sharp increase in problematic drug use, and the doubling of drug-related deaths in the 1990s caused the Swedish public and politicians considerable concern. The main drug-related problems were related to injection of amphetamines and heroin (Hallam, 2010).

Swedish drug policy

In Sweden, as in most European countries, the popularity of all drugs increased in the 1960s. Sweden briefly experimented with a “liberal” drug policy, but as the influence of medical doctors in drug policy was superseded by popular social movements and the professional social worker association, a more “conservative” approach was adopted. From the outset until the present day, there appears to have been a broad popular consensus in support of Sweden’s national drug policy.

This national drug policy included legislation such as the 1968 Narcotic Drugs Punishment Act and the government’s introduction, in 1969, of a 10-point policy against drugs. In 1978, the Swedish Parliament set the vision a drug-free society as the basis of the national drug policy. Controversially, in contrast to many other countries, enforcement activities in Sweden are focused as much on the end user as on traffickers and suppliers. In 1988, drug use was made a criminal offense with three categories:

- minor : with a penalty of a fine or up to 6 months’ imprisonment,
- ordinary: with a penalty of up to 3 years’ imprisonment, and
- serious: with a penalty of 2 to 10 years’ imprisonment.

In 1993, the police were given new powers to test people they suspected of using drugs, and the drug-free society theme was championed again in the Action Plan on Narcotic Drugs in 2008.

Sweden briefly experimented with a “liberal” drug policy, but for almost 40 years a more conservative approach has been followed. There has consistently been a broad popular consensus in support of Sweden’s national drug policy, which includes a vision of a drug-free society with the establishment of severe criminal justice sanctions against drug use. However, at the same time, Sweden has consistently invested heavily in drug treatment services. It spends around 0.5% of its GDP on its drug policy, making it the EU’s second highest such expenditure after the Netherlands (0.66%) the second highest in the European Union (UNODC, 2007, p. 21, 35). Harm reduction does not factor into Swedish service provision or in public discourse, other than as an external dogma to be resisted. There has been some access to methadone substitution treatment since 1966, but it is not widely used and has restrictive entry protocols. The history of needle exchange programs is also limited. Needle exchanges were first made nationally available in 1988 but were then banned in 1989. They were permitted again beginning in 2006, but there are still only two in the entire country. Social workers play a central role in the Swedish *care chain*, which includes outreach, detoxification, institutional facilities, aftercare, and rehabilitation. The current national drug strategy has three programmatic areas:

- prevention, referred to as “Recruitment to drug abuse must decrease”,
- treatment, referred to as “Drug abusers must be induced to give up their abuse”, and
- supply reduction.

The United Nations has been rather contradictory in its commentaries on Swedish drug policy. For example, in the same year that UNODC published its report *Sweden’s Successful Drug Policy* (UNODC, 2007), citing Swedish policy as a model that others could learn from, the United Nations Special Rapporteur on the Right to Health criticized the country for its lack of provision of needle exchange services: “The Special Rapporteur emphasizes that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm-reduction policy, including counseling, advice on sexual and reproductive health, and clean needles and syringes” (Hallam, 2010, p. 8).

Outcomes

Sweden, supported by UNODC, claims success for its policy in a number of areas:

- There are fewer reported drug users in Sweden now that there were in the 1960s. The lower prevalence includes young people. For example, in 2006 prevalence of lifetime drug use at ages 15–16 was 22% across Europe, but in Sweden it was 8%. However, it is noteworthy that across different drugs, prevalence levels of use in Sweden are broadly similar to Portugal, despite the latter’s totally different drug policy.
- There are low rates of HIV/AIDS among IDUs (UNODC, 2007).

However, although drug use prevalence is low in Sweden, problem drug use is only slightly below the EU average. This means that a far higher proportion of Sweden’s drug users fall into the “problem” category than in other countries. Moreover, it has been noted

that increases in the number of heavy drug users coincide with periods of budget cuts for treatment services (Hallam, 2010).

Policy implications

Despite resisting international pressure to provide harm reduction services, Sweden has been able to claim success in keeping the prevalence of drug use and of HIV/AIDS among IDUs low. However, the fact that prevalence in Portugal, with its very different policy, is similar in terms of prevalence leads one to question any causal relationship between policy and individual drug use. It is also very concerning that the ratio of problem to non-problem drug users in Sweden is so high.

As elsewhere, the Swedish experience shows us that policy is based on ethical and political positions as well as scientific evidence and legislation. It is clear that public support for Sweden's drug policy has enabled it to continue over time; this has included substantial investment in drug treatment services. Given the reported increase in heavy drug use during times of budget cuts, as referred to above, a persuasive argument may be made that it is the substantial investment in drug treatment services, rather than the nature of national policy, that has contributed to Sweden's "success" in dealing with drug issues.

Switzerland

The Swiss drugs situation

In the early 1990s, Switzerland was disturbed by the emergence of open drug scenes in several of its main cities, particularly in Zurich, which threatened public order and security. In connection with this, due to the practice of needle sharing, the country also experienced a huge rise in levels of HIV infection among injecting drug users (Savary, Hallam, & Bewley-Taylor, 2009, p. 7). There was also considerable concern about drug-related crime. For example, it was estimated that between 1992 and 1995, three-quarters of purse snatchings and one-third of burglaries in Zurich were drug-related. From these concerns about public health and public order, Switzerland moved toward developing a new drug policy focused on public health measures and harm reduction. This policy remains within the existing international drug regime, but, along with measures such as expansion of needle exchange programs, introduced innovative new treatment services, including substitute heroin prescription for heroin users.

Process for policy review and change

As in many countries, the process for policy review and change took place over a considerable period of time, with exploration of different approaches. Several key stages have been identified in the Swiss process, as described below.

Switzerland is a federal country, with much of the political decision making undertaken at the local level in "cantons." The country also has a tradition of holding national referenda to determine public policy. In the 1980s, the Swiss "Four Pillars" drug policy

emerged, which envisaged comprehensive and balanced drug policy, including Law enforcement, Prevention, Treatment and Harm Reduction. The policy was developed from the “bottom up,” the most important factor being the building of consensus between community organizations, social workers, doctors, and the criminal justice system.

One of the key components in shaping national consensus in Switzerland to support the Four Pillars policy was the commitment to continued evaluation and review of the experience as the policy was implemented. To support this process, in 1997 the government established an external expert body, the Federal Commission for Drug Issues, to advise the government on drug policy. In 1998, the Federal Council passed an executive order that created a permanent legal and policy basis for heroin-assisted treatment (HAT). However, this should not be understood as an implication that drug use was condoned within Switzerland; rather, it represented a pragmatic response to a public health problem based on evidence. As a reflection of this, in the same year, a national referendum proposing full legalization and regulation of drug use was rejected.

In 1999, the HAT program received a positive evaluation from WHO, although not without some concerns. In a referendum the same year, 54% of people supported the policy. In later years, there developed some political opposition to the policy based on ideological reasons. This led to another referendum in 2008 in which the Four Pillars policy was ratified in legislation by 68% of voters, demonstrating overwhelming public support for this practical, public health–focused approach. At the same time, continued public opposition to drug use was underlined by the rejection in a parallel referendum of a proposal to depenalize cannabis. However, there is a movement toward most drug offenses being treated as administrative rather than criminal offenses.

Outcomes

As indicated above, the establishment of monitoring and evaluation systems in Switzerland and a commitment to research has been a crucial component in building and maintaining support for the Four Pillars approach among professionals, in the criminal justice system, and among the general public. Since the policy was introduced, Switzerland has experienced a significant decrease in problems related to drug consumption, including the following (Hallam, 2010; Csete, 2010):

- There have been substantial reductions in drug-related crime.
- Growth in heroin consumption, by far the greatest problem in the late 1980s, was halted and has steadily declined since the early 1990s (e.g., in Zurich, the number of new heroin users plunged from 850 new users in 1990 to 150 new users in 2005).
- The HAT trials in 1992 showed that it was possible to stabilize the dosage of heroin within 2–3 months. The trials reported significant improved health outcomes and reduction in criminal acts such that the estimated benefits of providing treatment well exceeded the costs. Moreover, predictions that prescribed heroin would find its way into the illegal market did not occur. Rather, the provision of heroin by prescription has taken the problem off the streets.

- Between 1991 and 2004, the drug-related death toll in Switzerland fell by more than 50%.
- Levels of drug-related HIV infection were divided by eight within 10 years.

Policy implications

The Swiss experience demonstrates the importance of

- scientifically rigorous investigation of new programs,
- communicating with scientific evidence to policymakers,
- bringing together policing and public health and working out the best balance between them,
- investing in public education about drug policy and consulting on an ongoing basis,
- opening new experiences to independent review, and
- facing down ideological criticisms with evidence and pragmatism (Csete, 2010, p. 8).

Portugal

Introduction: The Portuguese drugs situation

Portugal has attracted a great deal of international attention since its decision in 2001 to decriminalize all drug use. However, it is arguably not the decriminalization of drug use that has been the most revolutionary aspect of Portugal's approach to drug control; rather, it has been the introduction of a holistic approach to dealing with drug issues, dominated by a public health approach but with a recognition that recovery relies not just on pharmacological approaches but also on addressing social and environmental factors that lead to drug problems.

Historically, Portugal has had a low prevalence of drug use in the general population. In the 1990s, however, concerns arose because of an escalating drug problem, with the development of open drug markets and large numbers of IDUs. Related to the latter, Portugal experienced huge increases in rates of infection of HIV, Tuberculosis, and Hepatitis B and C. For example, by 1999, Portugal had the highest rate of drug-related AIDS in the EU and the second highest rate of drug-related HIV (Greenwald, 2009). At the same time, there was growing political concern about the social exclusion of drug users and a perception that the national legislation that criminalized drug use was creating barriers that kept people from accessing treatment services. Moreover, the resources invested in criminal justice interventions were using funds that might be spent on prevention and treatment services.

Process for policy review and change

The change in Portuguese drug policy took place over an extended period of time. Nonetheless, the following were key stages: In 1987, recognizing that drug issues required a holistic approach and local responses, the National Drug Abuse Prevention

Program decentralized drug issues and spread responsibilities for drug issues across six ministries. In the mid 1990s, addiction treatment centers and needle exchanges were set up across the country. From this point on, although drug use remained a criminal offense, in practice, most minor offenders routinely received non-criminal sanctions. Political support for a policy review came when the Presidents of Parliament and the Supreme Court declared their support for harm reduction and in 1998 a government-appointed expert commission introduced the country's first national drug strategy with the explicit goal of providing more comprehensive and evidence-informed approach to drug use. With the new drug strategy, more resources were released to spend on drug prevention and treatment. In 2001, personal drug use was decriminalized and a new support system was set up to refer drug users into treatment and other support services. The 2001 law applies to use/possession of all illicit drugs, including cannabis, heroin, and cocaine; it is restricted to use/possession of up to 10 days' worth of a drug. This was estimated in practice to amount to 0.1 g heroin, 0.1 g ecstasy, 0.1 g amphetamines, 0.2 g cocaine or 2.5 g cannabis (Hughes & Stevens, 2010, p. 1002).

The new policy

The new policy sought to take a holistic approach, linking the legislative framework and the national drug strategy. Special attention was given to prevention, harm reduction, treatment, social reintegration and supply reduction, and channeling minor drug offenders into drug treatment. Prior to 2001, drug possession, acquisition, and cultivation for personal use were criminal offenses punishable by up to 1 year's imprisonment; under the new policy, drug possession and acquisition became a public order or administrative offense. As a central component of the new arrangements, new Commissions for the Dissuasion of Drug Addiction (CDTs) were established. These were regional panels made up of three people, including lawyers, social workers, and medical professionals. They were supported in their activities by the Institute for Drugs and Drug Addiction, the central government agency on drugs. Under the new law police, would not arrest minor drug users but could dispose of drugs found, take the offenders' name and address, and refer them to the CDTs within 72 hours. The CDTs could then discuss with the offender the motivations for and circumstances surrounding their offense and provide a range of sanctions, including community service, fines (as a last resort), suspensions of professional licenses, and bans on attending designated places. CDTs were given the authority to determine whether individuals were drug dependent. If individuals were deemed to be drug dependent, the CDTs could recommend treatment or an education program, rather than applying a sanction. If they were deemed to be non-dependent, the CDTs could order provisional suspension of proceedings, attendance at a police station, psychological or educational service, or impose a fine (Hughes & Stevens, 2010).

It is important to bear in mind that the Portuguese policy was not intended to make drug use acceptable. On the contrary, its primary aim was to dissuade drug use and to encourage dependent drug users to get treatment. Gaining and maintaining political and public approval has been crucial for its overall success. Demonstrating a commitment to

transparency by ensuring that all evaluation materials have been officially published has helped with this.

Outcomes

There have been no reviews of Portugal's drug policy to date in peer-reviewed journals. However, since 2001, the following outcomes have been noted (Hughes & Stevens, 2010, p. 28):

- Overall, the policy has had no adverse effects on the country's drug usage rates, which, in numerous categories, are among the lowest in the EU. There has been a small increase in overall reported illicit drug use amongst all adults, but this is in line with European trends. However, although there has been an increase in the use of cannabis, there has been a decrease in the use of heroin, which is far more harmful.
- Illicit drug use among problematic drug users has decreased as have opiate-related deaths.
- Illicit drug use among 15- to 19-year-olds has also decreased. This is particularly significant because experimentation at this age has been cited as an important determinant in predicting future life-long use.
- There have been reported reductions in injecting drug use and, related to this, a significant decrease in newly reported HIV/AIDS cases, drug-related mortality, and infectious diseases.
- Along with a substantial increase in the uptake of drug treatment, there has been a reduced burden of drug offenders on the criminal justice system. The proportion of drug-related offenders in the Portuguese prison population dropped from 44% in 1999 to 21% in 2008.
- At the same time, there have been huge increases in the amount of drugs seized by authorities. This may indicate that by not having to police individuals' drug use, authorities are better able to focus on supply reduction.
- Despite decriminalization and reductions in the retail prices of drugs since 2001, there has not been a mass expansion of the drug market, as was feared by opponents of the drug policy reform. It is difficult, however, to draw clear conclusions about the overall impact of the policy change on crime.

Policy implications

Portugal provides an excellent example of a reorientation of drug policy toward a public health focus and experience of provision of more integrated and effective responses to drug use. The Portuguese authorities have consistently asserted that they do not condone drug use. They regard drug use primarily as a public health and social problem, which requires a range of complex responses at the individual and societal levels.

Drug policy provokes strong emotions, and it is important to build and maintain consensus and confidence between policymakers and the general public. The Portuguese

experience shows that it takes time to develop an infrastructure and collaboration between criminal justice and health systems, which can support progressive legislative change.

Annex C. Possible minimum standards for commissioning needle exchange and opioid detoxification services

These are taken from National Institute for Health and Clinical Excellence 2009 and National Institute for Health and Clinical Excellence 2007. They are cited only as hopefully useful examples. They are not intended to be either prescriptive or comprehensive in relation to these clinical areas.

Minimum standards for needle exchange service providers

- Provide people who inject drugs with needles, syringes, and other injecting equipment. The quantity dispensed should not be subject to an arbitrary limit but, rather, should meet their needs. Where possible, needles and syringes should be made available in a range of sizes.
- Ensure that service users are provided with sharps bins and advice on how to dispose of needles and syringes safely.
- Ensure that safer injecting advice and information are available when providing long needles and other equipment that could be used for more dangerous practices. (Long needles, for example, could be used for injecting into the groin.)
- Provide other injecting equipment associated with illicit drug use and encourage people who inject drugs to switch to other methods of drug use.
- Encourage people who inject drugs to mark their syringes and other injecting equipment or to use easily identifiable equipment to prevent mix-ups.
- Encourage people who inject drugs to use services that aim to reduce the harm associated with injecting drug use, encourage them to stop using drugs or to switch to non-injecting methods (for example, opioid substitution therapy), and address their other health needs. Advise them where they can access these services.

Minimum standards for opioid detoxification services

Detoxification should be a readily available option for people who are opioid dependent and have expressed an informed choice to become abstinent.

Assessment for detoxification

Assess people presenting for detoxification to establish the presence and severity of opioid dependence and use of other substances, including alcohol, benzodiazepines, and stimulants.

- Use urinalysis. Other near-patient testing methods such as oral fluid or breath testing may also be considered.

- Clinically assess any signs of opioid withdrawal (consider formal rating scales only as an adjunct).
- Take a history of drug and alcohol misuse and any treatment.
- Take a history of physical and mental health problems and any treatment.
- Consider the risks of self-harm, loss of opioid tolerance, and the misuse of drugs or alcohol as a response to opioid withdrawal symptoms.
- Consider the person’s social and personal circumstances.
- Consider the impact of drug misuse on family members and any dependants.
- Develop strategies to reduce the risk of relapse, taking into account the person’s support network.

If opioid dependence or tolerance is uncertain, use confirmatory laboratory tests in addition to near-patient testing, particularly when

- a young person first presents for detoxification,
- a near-patient test result is inconsistent with clinical assessment, or
- complex patterns of drug misuse are suspected.

Near-patient and confirmatory testing should be conducted by appropriately trained health care professionals in accordance with standard operating and safety procedures.

Providing information and advice

Provide detailed information about detoxification and the associated risks, including

- physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms and their management,
- the use of non-pharmacological approaches to cope with withdrawal symptoms,
- loss of opioid tolerance following detoxification and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines,
- the importance of continued support, as well as psychosocial and pharmacological interventions, to maintain abstinence, treat co-morbid mental health problems, and reduce the risk of adverse outcomes (including death).

Advise service users on aspects of their lifestyle that need attention during detoxification, including diet, hydration, sleep, and exercise.

Encourage people considering self-detoxification to seek detoxification in a structured treatment program or, at a minimum, to maintain contact with a drug service.

Provide information about self-help groups (such as 12-step) and support groups and consider facilitating engagement.

Provide families and caregivers with information about detoxification and the settings in which it may take place.

Pharmacological interventions in opioid detoxification

Choice of medication

Offer either methadone or buprenorphine as first-line treatment.

- Normally start detoxification with the same medication used for any maintenance treatment.
- Consider the preference of the service user.

Lofexidine may be considered for people

- who have made an informed and clinically appropriate decision not to use methadone or buprenorphine for detoxification, or to detoxify within a short time period, or
- who have mild or uncertain dependence (including young people).

Do not routinely use clonidine or dihydrocodeine.

Dosage and duration

When determining starting dose, duration, and regimen (for example, linear or stepped), take into account, in discussion with the service user, the

- severity of dependence (exercise caution if dependence is uncertain),
- stability of the service user (including polydrug and alcohol use, and co-morbid mental health problems),
- pharmacology of the detoxification medication and adjunctive medications, and
- setting of detoxification.

Detoxification should normally last

- up to 4 weeks in an inpatient/residential setting, and
- up to 12 weeks in the community.

Adjunctive medications

Only use adjunctive medications when clinically indicated, such as when agitation, nausea, insomnia, pain, and/or diarrhea are present.

Use the minimum effective dosage and number of drugs needed to manage symptoms.

Be alert to the risks of adjunctive medications as well as the interactions between them and with the opioid agonist.

Monitoring

Be aware that medications used in opioid detoxification are open to misuse and diversion.

Consider monitoring concordance and methods of limiting the risk of diversion, including supervised consumption.

Special considerations

Do not routinely offer detoxification to people

- with a medical condition needing urgent treatment,
- in police custody or serving a short prison sentence or a short period of remand (consider treating opioid withdrawal symptoms with opioid agonist medication), or
- who present in acute or emergency settings (address the immediate problem, treat withdrawal symptoms, and refer to drug services if appropriate).

For women who are opioid dependent during pregnancy, detoxification should only be undertaken with caution.

Treat co-morbid physical or mental health problems alongside opioid dependence.

Accelerated detoxification

Do not use ultra-rapid detoxification under general anesthesia or heavy sedation (where the airway needs to be supported) because of the risk of serious adverse events, including death.

Do not routinely offer ultra-rapid or rapid detoxification using precipitated withdrawal.

Rapid detoxification should be considered only for people who specifically request it, clearly understand the associated risks, and are able to manage the adjunctive medication.

In these circumstances, ensure during detoxification that

- the service user is able to respond to verbal stimulation and maintain a patent airway,
- adequate medical and nursing support is available to monitor the service user's level of sedation and vital signs, and
- staff have competence to support airways.

Do not routinely offer accelerated detoxification using opioid antagonists at lower doses to shorten detoxification.

People who also misuse alcohol

If a person presenting for opioid detoxification also misuses alcohol, consider the following:

- Even if the person is not alcohol dependent, attempt to address their alcohol misuse.
- If the person is alcohol dependent,

- offer alcohol detoxification before starting opioid detoxification in a community or prison setting, and
- consider offering alcohol detoxification concurrently with opioid detoxification in an inpatient setting or with stabilization in a community setting.

Psychosocial interventions during and after detoxification

Contingency management

Consider contingency management aimed at reducing illicit drug use both during and for up to 3–6 months after opioid detoxification.

Continued treatment and support after detoxification

After successful opioid detoxification, and irrespective of the setting in which it was delivered, offer all service users continued treatment, support, and monitoring to help maintain abstinence. This should normally last for at least 6 months.