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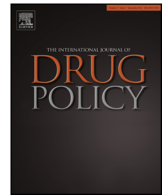

Commentary

HIV, drugs and the legal environment

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ABSTRACT

A large body of scientific evidence indicates that policies based solely on law enforcement without taking into account public health and human rights considerations increase the health risks of people who inject drugs (PWIDs) and their communities. Although formal laws are an important component of the legal environment supporting harm reduction, it is the enforcement of the law that affects PWIDs' behavior and attitudes most acutely. This commentary focuses primarily on drug policies and policing practices that increase PWIDs' risk of acquiring HIV and viral hepatitis, and avenues for intervention. Policy and legal reforms that promote public health over the criminalization of drug use and PWID are urgently needed. This should include alternative regulatory frameworks for illicit drug possession and use. Changing legal norms and improving law enforcement responses to drug-related harms requires partnerships that are broader than the necessary bridges between criminal justice and public health sectors. HIV prevention efforts must partner with wider initiatives that seek to improve police professionalism, accountability, and transparency and boost the rule of law. Public health and criminal justice professionals can work synergistically to shift the legal environment away from one that exacerbates HIV risks to one that promotes safe and healthy communities.

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Introduction

When asked why they shared a syringe, a common response from people who inject drugs (PWIDs) is "I had no choice." Sharing syringes and other injection paraphernalia, which increase the risk of acquiring HIV and viral hepatitis are behaviors that do not occur in a vacuum. These and other risk behaviors are shaped by factors at macro, meso and micro level of the physical, social, legal and policy environment (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005) that affect PWIDs' access to syringes and addiction treatment. In this commentary, we discuss factors in the macro and micro-legal environment that are known to increase transmission of HIV and viral hepatitis among PWIDs, as well as structural interventions that can be used to prevent these infections.

There is now a large body of empirical evidence demonstrating that formal laws and policies are critical aspects of the environment influencing HIV risks among PWID. At the macro-level, most countries have laws and policies that dictate whether drug possession and use are punishable by law and to what extent. In response to numerous and consistent indicators that the 'war on drugs' is ineffective (Beyrer et al., 2010; Reuter, 2009; Wood et al., 2010; Wood, Werb, Marshall, Montaner, & Kerr, 2009), including unchanging availability and use of drugs and various severe health-related harms (Werb et al., 2013), at least 30 countries are reforming drug policies to align them more closely with public health goals (Cozac, 2009; Hughes & Stevens, 2007; Moreno, Licea, & Ajenjo, 2010), and even some U.S. states. On the other hand, harsh penalty-based drug policies remain in place in many other countries, and in some cases have been strengthened of late. In twelve countries, legislation allows judicial corporal punishment for drug and alcohol offences (e.g., death penalty), which is a violation of international law (IHRA, 2011). Some countries maintain compulsory 'drug detention' programmes (Global Commission on Drugs, 2012; HIV and the Law, 2012) which often operate as forced labor or military training camps, and where evidence-based addiction treatment is entirely absent. These punitive policies have been associated with elevated risk behaviors and detrimental health outcomes among PWID (Degenhardt et al., 2010). Human rights elements of these policies (Wolfe & Cohen, 2010) are addressed in the thematic paper by Kamarulzaman and colleagues in this issue.

In 2009, the World Health Organization, UNODC and UNAIDS identified nine HIV interventions as scientifically proven, essential components of a combination package to prevent HIV among PWID. These include provision of sterile syringe access through

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needle and syringe programmes (NSPs), opioid substitution treatment (OST; i.e., methadone and buprenorphine maintenance), HIV counseling and testing, ART, prevention and treatment of sexually transmitted infections (STIs), condom distribution programmes, information and education campaigns, vaccination and treatment of viral hepatitis, and prevention and treatment of tuberculosis (World Health Organization, 2009). NSP and OST can also reduce the risk of acquiring viral hepatitis (i.e., Hepatitis B and C). Yet at the meso- or community level, laws and policies exist surrounding syringe purchase and possession, including over-the-counter sales and authorization of needle/syringe programmes (NSPs). Laws and policies also govern access to addiction treatment, including OST and treatment diversion. Such laws vary by country, state and sometimes between or even within cities. For example, despite a plethora of evidence demonstrating effectiveness and cost-effectiveness, and the fact that methadone is on the WHO Essential Drugs List, OST is widely unavailable in most Eastern European countries. At least due in part to these kinds of laws and policies, coverage of NSP and OST worldwide is exceedingly low (Mathers et al., 2010). The UNODC has explicitly clarified that harm reduction policies, including OST are fully consistent with international drug control conventions (UNODC, 2014a). Yet, despite an established international consensus about best practices, some policy decisions about harm reduction interventions to PWID continue to be driven by moral concerns rather than empirical evidence (Strathdee, Shoptaw, Dyer, Quan, & Aramrattena, 2012).

At the micro-level (within communities), policing practices directly influence the behavior, perceptions, and health outcomes among PWIDs. Such practices include arrests for drug/syringe possession, confiscation of syringes, conducting surveillance at NSPs and OST clinics (Hayashi, Small, Csete, Hattirat, & Kerr, 2013), and random urine drug screening (Beletsky, Lozada, et al., 2013; Bluthenthal, Lorvick, Kral, Erringer, & Kahn, 1999; Hammett, Bartlett, & Chen, 2005; Pollini et al., 2008; Shannon et al., 2008; Small, Kerr, Charette, Schechter, & Spittal, 2006; Strathdee et al., 2011). While police sometimes engage in these behaviors in accordance with formal laws, research indicates that 'laws on the books' do not necessarily correspond to 'laws on the streets' (Burris et al., 2004). In other words, police conduct within community settings are often not consistent with established laws and policy, and often undermine health and human rights. Drug policy reforms can create even wider gaps if police are not informed about public health reforms authorizing harm reduction programmes, and/or if they oppose them (Banta-Green, Beletsky, Schoeppe, Coffin, & Kuszler, 2013; Beletsky, Macalino, & Burris, 2005). Although formal laws are an important component of the legal environment supporting harm reduction, it is the enforcement of the law that affects PWIDs' behavior and attitudes most acutely. This paper will focus primarily on drug policies and policing practices that increase PWIDs' risk of acquiring HIV and viral hepatitis, and avenues for intervention. We also refer briefly to policing practices that influence HIV risk among sex workers that inject drugs who are an especially vulnerable subgroup (Rusakova, Rakhmetova, & Strathdee, 2014).

Drug-related laws and policies that influence HIV risk behaviors

The harms flowing from current legal and policy frameworks that criminalize drug use and drug users have been well described, and include various direct and indirect health-related harms, mass incarceration of drug users, stigma against drug users within society, and human rights violations (Global Commission on Drugs, 2012; HIV and the Law, 2012). A growing body of evidence has also revealed that the dominant approach to drug control, which focuses on reducing the supply and use of drugs, has failed to achieve its basic objectives (Beyrer et al., 2010; Werb et al., 2013; Wood et al., 2010). Importantly, in many settings that have employed aggressive drug control measures, the availability and purity of drugs has increased, while the price of drugs has remained stable or declined (Werb et al., 2013). These dynamics have often been accompanied by high rates of continued drug use. In contrast, drug use is lower in some settings that have employed alternative regulatory frameworks for responding to drug-related harms. A recent review of evidence derived from the WHO World Mental Health Survey concluded that "(t)he US, which has been driving much of the world's drug research and drug policy agenda, stands out with higher levels of use of alcohol, cocaine, and cannabis, despite punitive illegal drug policies... The Netherlands, with a less criminally punitive approach to cannabis use than the US, has experienced lower levels of use, particularly among younger adults" (Degenhardt et al., 2008).

Given the known harms and limitations associated with conventional drug control laws, a growing number of countries have begun experimenting with alternative regulatory frameworks. In most instances this has involved the de-penalization of drug possession for personal use, use of fines for possessing small amounts of drugs, legalization of some illicit drugs, and the use of referral to treatment instead of arrest and incarceration (Cozac, 2009; Hughes & Stevens, 2007; Moreno et al., 2010). To clarify the status of these reforms under international law, UNODC has recently restated its position that de-penalization and harm reduction policies are fully consistent with the Single Convention and its progeny (UNODC, 2014a). While some evidence of benefit of such reforms has been documented, there is still a need for ongoing evaluation of such approaches, given their potential to offset the harms associated with conventional drug control measures.

Policing practices and HIV risk

Laws and policies can be critical to facilitating harm reduction and public health prevention, but the practices of police and other government actors serve as the critical link to policy implementation on the ground. International research has consistently shown that law enforcement practices have both direct and indirect effects on behaviors that increase PWIDs' risk of acquiring HIV and viral hepatitis (Beletsky, Lozada, et al., 2013; Bluthenthal et al., 1999; Hammett et al., 2005; Pollini et al., 2008; Shannon et al., 2008; Small et al., 2006; Strathdee et al., 2011). Policing practices that *directly* influence PWIDs' risk of acquiring blood borne infection include syringe confiscation and arrests. By confiscating syringes, PWIDs resort to buying, renting or loaning someone else's used syringe, or using discarded syringes. In a variety of settings, police have charged PWIDs participating in harm reduction programmes with drug possession based solely on drug residue in a used syringe, or charged PWIDs for carrying drug paraphernalia. These arrest practices have been reported even in the absence of laws that prohibit syringe purchase and possession. In Mexico, where it is legal to purchase syringes at pharmacies without a prescription and there are no drug paraphernalia laws, over half of PWIDs in Tijuana and Ciudad Juarez reported that police confiscated their sterile and used syringes in the prior 6 months, which was associated with a 3-fold higher risk of syringe sharing (Pollini et al., 2008). Syringe confiscation was independently associated with HIV infection among female sex workers who inject drugs (Strathdee et al., 2011). Fear of police discourages PWIDs from carrying syringes, even for the purpose of syringe exchange, pressures them to inject hurriedly in the street or inject in shooting galleries where needles are rented or sold. In a study undertaken in Bangkok, 67% of PWID had been subjected to random urine testing, and those had been tested in this

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