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Commentary

Seeing through the public health smoke-screen in drug policy

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ABSTRACT

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

Introduction

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

By contrast, one element on which there appeared to be remarkable consensus, at least on a rhetorical level, is the need for a "balanced" approach to drug policy that includes a strong focus on public health, an idea repeatedly noted in the UNGASS outcome document (UN General Assembly, 2016a). Member states – from Norway to Guatemala, Nigeria to India and many in between – in the official record of the UNGASS asserted their commitment to health-centred drug policy (UN General Assembly, 2016b), including treating drug use as a health rather than policing problem. Some, such as Thailand, explicitly endorsed the idea that "drug users should receive treatment and rehabilitation, not incarceration" (UN General Assembly, 2016b, Pt.4).

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

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

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

Public health approach to drug policy: UN and expert views

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

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

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

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

Public health approaches in practice

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

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

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

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