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For a European drug convention on promoting public health policy in drug control

Report
Social, Health and Family Affairs Committee
Rapporteur: Mr Paul FLYNN, United Kingdom, Socialist Group

Summary

Since the late 1960s, considerations of public health have played an increasing role in pragmatic, evidenced-based drug policy-making in many member States of the Council of Europe. The right to health provides the cornerstone principle on which such considerations are based.

In order to develop public health-orientated responses to problem drug use, the rapporteur calls upon member states to work together to design a new drug policy framework convention. This convention should complement existing legal frameworks in the areas of drug control, human rights and public health. It should consolidate scientific and medical knowledge in a framework document which could form the basis for the design of national drug strategies.

The report also stresses the importance of drug demand reduction programmes, which should be complementary to the existing framework of national drug policies in Council of Europe member states. Governments should extend the scope of drug demand reduction programmes, assess them and disseminate the best practices identified.

Furthermore, the member states should improve access to prevention programmes in schools and make them more effective. They must also improve prevention methods and the detection of risk factors in certain target groups, especially young people, as well as the dissemination of these data to the professionals in order to implement early intervention programmes.

Similarly, they should also ensure that targeted treatment, re-education and social reintegration programmes are available and accessible which incorporate tested psychosocial and pharmacological strategies and include drug addicts not reached by existing services, with particular attention being paid to specialised services for young people. The rapporteur also recommends developing further alternatives to imprisonment for addicts and the setting-up of prevention, treatment and reintegration services for prisoners.

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A. Draft resolution

1. Drug addiction is a complex biological, psychological and societal problem. Scientific research and practical experience have made it possible to broaden our knowledge of it. Increasingly, this improved knowledge allows the implementation of a drugs policy focused on preserving public health, for individual addicts and for society. Although many scientific questions concerning dependency remain unanswered, the aspects linked to public health, the effectiveness of prevention and of medical treatments and improved protection of society against the resulting health risks are now better known.

2. Since the late 1960s, considerations of public health have played an increasing role in pragmatic, evidenced-based drug policy-making in many member states of the Council of Europe. The right to health provides the cornerstone principle on which such considerations are based. This right is recognised in the Council of Europe *acquis* (Articles 11 and 13 of the Revised European Social Charter) as well as in numerous other international and regional human rights treaties. It grants every individual the right to the enjoyment of the highest attainable standard of health, defined by the World Health Organization as a state of complete physical, mental and social wellbeing.

3. A number of key public health responses to "problem drug use" have emerged in past decades, including substitution treatment, needle exchange programmes and psychosocial treatment. These measures have had a marked effect on the successful long-term rehabilitation of drug users and their reintegration into society. The resultant benefits have been felt by society as a whole, through reductions in the incidence of criminal behaviour, reduced costs for health and criminal justice systems, reduced risks of transmission of HIV and other blood-borne viruses, increased productivity and ultimately reduced drug use levels.

4. However, these responses have so far been employed only on a fragmentary basis across Europe. This is despite the fact that their utility and cost-effectiveness is now widely documented. According to estimates cited by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), for example, every dollar invested in opioid dependence treatment programmes may yield a return of between $4 and $7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.

5. Moreover, recent world trends have provided additional proof of the abject failure of efforts to reduce the production and supply of drugs. The current illegal drugs market in Afghanistan, the world's largest producer of heroin, provides ample evidence of the ineffectiveness to address the drugs problem in a comprehensive manner. Despite six years of military action to restrict the poppy crops in the country, the United Nations have confirmed that poppy crop production in Afghanistan has increased by 60% for the year 2006-2007 compared to the previous year.

6. Steps being taken in the European Union as part of the EU Drugs Strategy 2005-12 aim to achieve a high level of health protection by complementing EU member states' action in preventing and reducing drug use and dependence and drug-related harm to health and society. In particular, the strategy places a high priority on improving access to a range of public health orientated responses that can reduce the morbidity and mortality associated with drug dependence. However, it is clear that special efforts need to be taken in relation to Eastern Europe and Central Asia, where political and infrastructural obstacles have hindered the implementation of such responses. The escalating HIV/AIDS pandemic in these regions provides an added urgency to this imperative: 80% of HIV cases with a known route of transmission in Eastern Europe and Central Asia are due to injecting drug use.

7. The geographic sphere of influence of the Council of Europe makes it the ideal forum to undertake such efforts and send an unequivocal signal giving a framework to its member states to develop public health-orientated responses to problem drug use. In pursuit of this end, which has been emphasised by the Pompidou Group and the International Federation of Red Cross and Red Crescent Societies, the Parliamentary Assembly calls upon member states to work together to design a convention promoting public health policy in drug control. This convention should complement existing legal

instruments in the areas of drug control, human rights and public health. It should consolidate scientific and medical knowledge in a framework document which may form the basis for the design of national drug strategies.

8. The Council of Europe convention should be predicated on the following three inter-related objectives:

8.1. to promote, as a fundamental human right, the right to health in the context of problem drug use;

8.2. to clarify the scope of the right to health as it applies to problem drug use;

8.3. to help identify good practices for the operation of the right to health as it applies to problem drug use, at the community, national and international levels.

9. In pursuit of these objectives, the convention, which should be complementary to the existing framework of national drug policies, should incorporate the following four elements:

9.1. prevention and education, including measures targeting the special needs of marginalised and vulnerable groups;

9.2. treatment, covering a range of treatment methods, including substitution treatment and needle exchange programmes, and incorporating a psychosocial component as integral to the various treatment methods;

9.3. rehabilitation and social reintegration, including treatment alternatives to imprisonment and labour market rehabilitation;

9.4. monitoring and evaluation, aimed at identifying best practices.

10. Insofar as many of the negative consequences of drug use are felt at local levels, the convention should also seek to reaffirm the principle of subsidiarity, by encouraging consideration of the ways that more local government agencies may act effectively. In this way, it is intended that health-driven drug policy responses be guided by scientific evidence as well as local conditions.

11. In order to promote the effective implementation of the convention, the Assembly calls on member states to:

11.1. extend the scope of drug demand reduction programmes, assess them and disseminate the best practices assessed;

11.2. improve access to prevention programmes in schools and make them more effective;

11.3. improve prevention methods and the detection of risk factors in certain target groups, especially young people, as well as the dissemination of these data to the professionals in order to implement early intervention programmes;

11.4. ensure that targeted treatment, re-education and social reintegration programmes are available and accessible. These programmes should incorporate tested psychosocial and pharmacological strategies, and include drug addicts not reached by existing services with particular attention being paid to specialised services for young people, and rehabilitation of drug addicts in the labour market;

11.5. develop further alternatives to imprisonment for addicts and the setting-up of prevention, treatment and reintegration services for prisoners;

11.6. improve access to harm reduction services and treatment and set up programmes preventing the propagation of the AIDS virus, hepatitis C and other blood-borne diseases and endeavour to reduce the number of drug-related deaths;

11.7. encourage research into the factors underlying dependency and such questions as the effects of certain drugs and effective health measures;

11.8. implement operational enforcement programmes in order to reduce the production of heroin, cocaine and cannabis, as well as synthetic drugs and trade in them, in particular by devising operational joint programmes, collecting intelligence on third countries involved in manufacturing and trading in such drugs, sharing best practice and exchanging information;

11.9. devise and implement measures targeted at money laundering and the seizure and re-use of financial products connected with drugs, in particular through exchanges of information and best practices;

11.10. encourage co-operation with international organisations such as the International Federation of Red Cross and Red Crescent Societies and the EMCDDA, as well as with civil society and community groups from areas most affected by problem drug use;

11.11. encourage the creation, in national parliaments, of mechanisms and structures which promote public health responses to problem drug use in the national context, such as all-party parliamentary groups;

11.12. provide appropriate financial support.

B. Draft recommendation

1. The Parliamentary Assembly refers to its Resolution ... (2007) entitled "For a European convention on promoting public health policy in drug control" and recommends that the Committee of Ministers:

1.1. forward this resolution to the governments of member states and request them to take it into account when developing their national drug policy strategies;

1.2. invite the Pompidou Group and other relevant European partners to:

1.3. promote an exchange of best practices between member states on public health-orientated responses to problem drug use;

1.4. promote dialogue on problem drug use in the context of public health policymaking;

1.5. support the collection of comparable data and the development of indicators on effective responses to problem drug use;

1.6. formulate and adopt a drug policy framework convention which consolidates existing scientific and medical knowledge and which may subsequently form the basis of member states' national drug policies.

C. Explanatory memorandum by Mr Paul Flynn, Rapporteur

1. In June 2005, 19 members of this Committee voted in favour of a Motion for a Resolution entitled 'For a European Convention on the Promotion of Public Health Measures in the Fight against Drugs'. This report represents the next stage in the articulation and adoption of a Council of Europe convention that codifies a humanitarian and evidenced-based drug policy framework, based on the fundamental human right to health.

2. Although the pattern and scale of drug consumption has always varied amongst Council of Europe Member States, there are no data to suggest a fall in drug use prevalence. In relation to what is termed 'problem drug use',[1] in Eastern Europe and Central Asia, the number of injecting drug user (IDUs) has risen dramatically over the past decade to an estimated 3.1 million injectors by the end of 2003.[2]

3. The mortality of IDUs is up to 20 times that of the general population of the same age. Factors other than drug use per se, including homelessness and mental illness, contribute substantially to this high mortality. Mortality among psychiatric patients is four times higher than that of the general population[3] and mortality among homeless people is three to four times higher than in the general population.[4]

4. Since the late 1960s, the public health imperative has become a major impetus for pragmatic drug policy-making in many Member States of the Council of Europe. Although there are considerable differences amongst Member States in terms of both the drug problems faced as well as the nature and scale of interventions, there is a growing political commitment towards the development of a balanced and evidenced-based response, in line with international commitments. The key responses that have emerged are: substitution/maintenance treatment, needle syringe programmes (NSPs) and psychosocial treatment. Best practices are also emerging as it is recognised that these responses must be integrated with other healthcare and social services, and must target marginalised and socially excluded groups.

5. Whereas, twenty years ago, such responses were still at an experimental stage, it is clear that they have now reached maturity. The efficacy and utility of adopting a health approach to drug policy is widely documented and underpins the rationale behind this report. The initiative being proposed here aims at prompting the Council of Europe to take a more visible and concrete action in the formulation of drug policy.

6. The growing HIV/AIDS pandemic has given this imperative a renewed urgency. The 6th United Nations Millennium Development Goal sends a call to "halt and begin to reverse the spread of HIV/AIDS". The link between increasing numbers of drug injectors and HIV/AIDS epidemics is well established[5] and in Eastern Europe and Central Asia, 80% of HIV cases with a known route of transmission are due to injecting drug use.[6] In some transitional countries in these regions, notably Estonia, the Russian Federation and Ukraine, estimated HIV prevalence in adults now exceeds 1%. Healthcare systems in these regions have proven incapable of addressing the new epidemics of HIV/AIDS. Population-based approaches, for example mass screening, have been adopted in preference to targeted interventions. Vertical programming remains dominant, with distinctly separate services for HIV/AIDS, other infectious

[1] 'Injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' (EMCDDA Annual Repot 2005)

[2] Aceijas C, Stimson GV, Hickman M, Rhodes T. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS* 2004;18:2295–303.

[3] Korkeila, J. (2000), *Measuring aspects of mental health*, Themes 6/2000, STAKES: Helsinki.

[4] Hwang, S. (2001), 'Mental illness and mortality among homeless people', Acta Psychiatrica Scandinavica 103, pp. 81–2

[5] Aceijas C, Stimson GV, Hickman M, Rhodes T. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS* 2004;18:2295–303.

[6] European Centre for the Epidemiological Monitoring of AIDS (EuroHIV). *HIV/AIDS surveillance in Europe,* End-year Report 2003. Saint Maurice: Institut de Veille Sanitaire, No 70, 2004.

diseases and, vitally for countries where HIV is predominantly transmitted by drug injection, specialised services for IDUs.

7. Steps being taken in the EU as part of the EU Drugs Strategy 2005-12, adopted by the European Council in December 2004, aim to achieve a high level of health protection, well-being and social cohesion by complementing its Member States' action in preventing and reducing drug use and dependence and drug-related harm to health and society. In particular, the Strategy places a high priority on improving access to a range of services that can reduce the morbidity and mortality associated with drug dependence. It is clear, however, that special efforts need to be taken in relation to Eastern Europe and Central Asia, where the lack of democratic structures has acted as a barrier to the implementation of such services.[7]

8. The geographic sphere of influence of the Council of Europe, which extends to these regions, makes it the ideal forum to undertake such efforts, and to send an unequivocal signal giving legal sanction to its Member States to develop health-orientated responses to problem drug use. In pursuit of this end, it is proposed that the Council of Europe adopt a new convention that consolidates the extensive socio-medical knowledge which has evolved and codifies this knowledge in a legal framework of best practices.

Respecting the right to health of problem drug users

9. The key tenet of international law on which this convention should be formulated is the right to health. This is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It is an inclusive right, extending not only to the availability of health care, but also to the underlying determinants of health, such as access to a healthy environment, and access to health-related education and information.[8] The right confers freedoms – including the right to control one's health, as well as entitlements – including the right to a system of health protection (i.e. health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.[9]

- Sources of the right to health:

International law:

Adopted in 1946, the Constitution of WHO states:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[10]

10. Two years later, article 25 (1) Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. It states:

> Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.

11. The right to health has since been codified in numerous international and regional human rights treaties. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)

[7] McKee M, Nolte E. Lessons from health during the transition from communism. *BMJ* 2004;329:1428–9.
[8] See, for example, Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14, (E/C.12/2000/4), para. 8.
[9] Ibid.
[10] The full text of the Constitution of the WHO is available at: http://www.whosea.org/aboutsearo/pdf/const.pdf

provides the cornerstone protection of the right to health in international law, introducing legally binding provisions applicable to all individuals in the 146 ratifying States.[11]

- Regional legal instruments

12. The right to health is also recognized in regional human rights treaties, including the African Charter on Human and Peoples' Rights (art. 16); the African Charter on the Rights and Welfare of the Child (art. 14); the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the "Protocol of San Salvador" (art. 10); and the European Social Charter (art. 11).

- Domestic laws

13. According to the preliminary findings of a WHO commissioned survey by the International Commission of Jurists, over 60 constitutional provisions include the right to health or the right to health care.[12] Further, a large number of constitutions lay down duties such as to develop health services from which it may be possible to infer health entitlements.

Cost effectiveness

[11] Additional right-to-health protections for marginalized groups are contained in group-specific international treaties. Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) provides protections for racial and ethnic groups in relation to "the right to public health (and) medical care". The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) provides several provisions for the protection of women's right to health, in particular articles 11 (1) f, 12 and 14 (2) b. The Convention on the Rights of the Child (CRC) contains extensive and elaborate provisions on the child's right to health, including article 24, which is fully dedicated to the right to the health of the child, and articles 3 (3), 17, 23, 25, 32 and 28, which contain protections for especially vulnerable groups of children. Far-reaching commitments relating to the right to health have also been made in the outcome documents of numerous United Nations world conferences. Of particular note are:
1. Johannesburg Declaration and Plan of Implementation of the World Summit for Sustainable Development (2002).
2. Monterrey Consensus of the International Conference on Financing for Development (2002).
3. Political Declaration and Madrid International Plan of Action on Ageing of the Second World Assembly on Ageing (2002).
4. "A World Fit for Children" adopted by the United Nations General Assembly Special Session on Children (2002); Declaration and Plan of Action of the World Summit for Children (1990).
5. Declaration of Commitment on HIV/AIDS, "Global Crisis-Global Action", adopted by the United Nations General Assembly Special Session on HIV/AIDS (2001).
6. Durban Declaration and Programme of Action of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (2001).
7. United Nations Millennium Declaration, adopted by the United Nations General Assembly "Millennium Assembly of the United Nations" (2000).
8. Beijing Declaration and Platform for Action of the Fourth World Conference on Women (1995) and its follow-up, Beijing Plus 5 (2000).
9. Rome Declaration on World Food Security and World Food Summit Plan of Action of the World Food Summit (1996) and its follow-up, Declaration of the World Food Summit: Five Years Later, International Alliance Against Hunger (2002).
10. Istanbul Declaration and the Habitat Agenda of the Second United Nations Conference on Human Settlements (Habitat II) (1996), and the Declaration on Cities and Other Human Settlements in the New Millennium of the Special Session of the General Assembly for an overall review and appraisal of the implementation of the Habitat Agenda (2001).
11. Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development (1995) and its follow-up, Copenhagen Plus 5 (2000).
12. Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993).
13. Rio Declaration on Environment and Development and Agenda 21 of the United Nations Conference on Environment and Development (1992).
14. Stockholm Declaration of the United Nations Conference on the Human Environment (1972).

[12] ICJ, Right to Health Database, Preliminary Proposal 2002

14. There is significant scientific evidence that health-based responses to problem drug use (notably, substitution treatment and NSPs) are cost-effective treatment modalities with cost–effectiveness measures comparing favourably with other health care interventions, such as medical therapy for severe hypertension or for HIV/AIDS.

15. According to several conservative estimates cited in the EMCDDA Annual Report 2005, every dollar invested in opioid dependence treatment programmes may yield a return of between $4 and $7 in reduced drug-related crime, criminal justice costs and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.

Convention objectives

16. The Council of Europe convention should be predicated on the following three inter-related objectives:

- To promote, as a fundamental human right, the right to health in the context of problem drug use.

- To clarify the scope of the right to health as it applies to problem drug use.

- To help identify good practices for the operation of the right to health as it applies to problem drug use, at the community, national and international levels.

17. The overarching objective of the convention should be a measurable reduction in the adverse consequences of problem drug use at both the individual and societal levels. This should be achieved through the codification of a comprehensive evidenced-based drug policy framework that may form the basis of national drug strategies and which may be integrated into a country's broader social welfare and health promotion policies.

18. The convention must recognise that even within one country, the application of legislation and treatment practices can vary significantly between actors, centres or regions. National legislation must be flexible to allow local policy-makers and fieldworkers to tailor treatment for drug users according to specific situations and localities. In order to create such flexibility, the convention should be formulated as a framework convention in the sense that of establishing broad commitments and a general system of governance. It should thereby aim at creating an institutionalized forum for cooperation and negotiation.

19. The framework should include the following complementary elements, offered in an integrated manner using all the options available according to the latest state of scientific knowledge:

- Prevention and education
- Treatment
- Rehabilitation and social reintegration
- Monitoring and evaluation

20. The following sections set out the key components of each of these elements:

Prevention and education

- Influencing perceptions of 'normality'

21. Sociological research indicates that individual's values and behaviours are influenced by perceptions of what is considered normal in their social environment. This is especially true as regards young people.[13] Prevention strategies must therefore provide young people with social and cognitive strategies to manage these influences.

[13] Botvin, G.J (2000), 'Preventing drug use in schools: social and competence enhancement approaches targeting individual-level etiological factors'. *Addictive Behaviours* 25 pp. 887-97

- Establishing wide-ranging and practicable prevention programmes

22. The convention should consolidate existing EU initiatives that aim to establish wide-ranging and widespread prevention programmes. In addition, it should draw on elements of the Action Plan for the Implementation of the Declaration on the Guiding Principles of Drug Demand Reduction.[14] Prevention strategies should take account of local ethics and cultural values, including information, education and communication, aimed at reducing risk-taking behaviour and expanding access to essential commodities including condoms and sterile injecting equipment. Strategies should also seek to increase the availability of voluntary and confidential counselling.

23. Member States should be urged to take all practicable measures for the prevention of problem drug use, for the reduction in the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved.

- Targeted prevention

24. Prevention programmes are most inclined to fail where the people targeted are not likely candidates for developing serious drug addictions. Targeted interventions are woefully inadequate in scale and coverage in Eastern Europe and Central Asia. Prevention programmes should principally be targeted at vulnerable groups, such as adolescents, marginalized groups and prisoners. Close attention must be paid to the handling of drug addicts in the justice system, including issues such as identification of drug addicts following arrest, alternatives to prison, and treatment facilities within the penal system.

- Prevention education

25. Prevention and education programmes should not be exclusively focused on the goal of reducing prevalence, i.e. establishing programme effects on whether adolescents use drugs. Instead and in addition, emphasis should be laid on the amounts, styles and types of drug use, as well as the harmful consequences of that use.

- Peer education

26. The convention should urge Member States to support peer education schemes at NSP units and other facilities or institutions where IDUs come into contact with each other, whereby active IDUs are trained to educate other IDUs about HIV risks, safe injecting and safe sex practices, and where they are involved in all aspects of design, planning, implementation and evaluation of programmes.

- Prevention in prisons

27. It is clear that drug users are strongly overrepresented among the prison population compared with the general population. In most studies in the EU, lifetime prevalence of drug use among prisoners is reported to be over 50 %. EMCDDA statistics indicate that between 8 % and 60 % of inmates report having used drugs while in prison, and 10–42 % report regular drug use. Although systems are in place in much of Europe to ensure that assistance for drug users in prison is available, the variety of services and their availability differs considerably. The convention should assert the principle of equivalence, i.e. that prisoners have the same rights as the rest of the population concerning access to healthcare, including assistance and treatment for drug users.

Treatment

- Range of treatment modalities

[14] Resolution S-17/2, paragraph 12.

28. No single treatment is effective for all individuals. Individuals seeking treatment for problem drug use will have different patterns of risk and protective factors, and different psychological and social problems. Therefore, the convention should create a framework that allows for diverse treatment options to be made available. The type of measures available should be determined at local level and reflect local need. They should include, though not be limited to, substitution/maintenance treatment, safe-injection sites and NSPs.

- Substitution/maintenance treatment

29. Substitution/maintenance treatment is one of the most effective treatment options for opioid dependence. This is explicitly recognized by the WHO, the UNODC and UNAIDS.[15] Provision of substitution/maintenance treatment – guided by research evidence and supported by adequate evaluation, training and accreditation – should be thus be promoted as an important treatment option in communities with a high prevalence of opioid dependence.

30. Substitution/maintenance treatment should have as its primary goals, initiation, maintenance and stabilisation. Abstinence, (and thereby cessation of substitution prescription) may be a long-term goal for some patients.

31. During the 1980s and 1990s, substitution/maintenance treatment underwent a rapid expansion in Europe. Currently, more than half a million heroin users in the EU – which is between one quarter and half of the estimated target group of heroin users – are enrolled in substitution/maintenance treatment.

32. There is overwhelming evidence that substitution/maintenance treatment can help reduce HIV transmission, drug use, risk of overdose and drug-related crime, as well as improve the general health of addicts. Methadone treatment dramatically reduces levels of HIV infection and AIDS.[16] It also cuts the frequency of heroin injection, the sharing of injecting equipment and sex work to buy drugs. A four-year German study[17] of outpatient methadone treatment showed that drug consumption fell while social skills and relationships improved. A Greek evaluation of methadone substitution in Athens[18] demonstrated a large fall in parallel use of heroin.

33. A range of substitution/maintenance treatment programmes are currently undertaken, involving most notably, methadone (which accounts for just under 80 % of substitution treatment in Europe), and buprenorphine which is becoming an increasingly popular. Member States should thus be encouraged to make available a full range of substitution treatment programmes. In addition, the convention should provide Member States with authority, subject to their own domestic laws, to extend the range of possible substitution substances to include controlled heroin or opium prescription for chronic opiate users.[19]

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[15] See 2004 WHO/UNODC/UNAIDS position paper, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Available at:
http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf.

[16] Drucker, E., Lurie, P., Wodak, A.and Alcabes, P. (1998), 'Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV', AIDS, 12 (suppl. A), pp. 217–230.

[17] Küfner, H., Vogt, M. and Weiler, D. (1999), Medizinische Rehabilitation und Methadon-Substitution, Schneider Verlag
Hohengehren, Baltmannsweiler.

[18] EDDRA database entry (2001), Second unit of the methadone substitution programme in Athens (http://www.reitox.emcdda.org:8008/eddra), EMCDDA, Lisbon.

[19] In the EMCDDA report, "Legal Aspects of Substitution Treatment: an Insight into Nine European Countries" (2003), the expert group concluded that "the range of possible substitution substances should be extended, in particular to include the introduction of controlled heroin or opium prescription as a means of substitution treatment for the most problematic and marginalized patients who are not able to stay in substitution treatment programmes". The use of heroin to stabilise chronic opiate users has been under trial in Switzerland since 1994, in the Netherlands since 1997 and in Germany and Spain more recently. Heroin has been prescribed on a small-scale selective basis in the UK for several decades.

- Needle Syringe Programmes (NSPs)

34. NSPs are available in most European countries, many of whom have achieved full geographic coverage. Scientific research into the effectiveness of NSPs in reducing HIV/AIDS among IDUs dates back to the 1980s. There is compelling evidence that increasing the availability of sterile injecting equipment by IDUs reduces HIV infection substantially and that there is no evidence of any major unintended negative consequences.[20] In a recent comprehensive review of the cost-effectiveness of NSPs, de Wit and Bos[21] concluded that in addition to their cost-effectiveness in preventing the spread of HIV, a major benefit of NSPs was that they brought a difficult-to-reach population of drug users into contact with health and social services.

35. The convention should encourage Member States to establish NSPs. Procedural provisions should be included which provide for the safe collection and disposal of used needles and syringes. Member States should also ensure, so far as possible, that the NSP units are embedded in the community by means of regular community consultations, both pre- and post-establishment of each unit, on such factors as location site, opening hours etc. Further, that they are free to operate without police harassment of clients and/or staff. Continuity of funding and service of the each NSP unit is vital to the NSPs success in attracting and maintaining relationships with IDUs. The closure of a NSP can have a serious impact on HIV risk behaviours among IDUs.

- Psychosocial component to treatment

36. Present evidence is clear that although different pharmacological approaches aimed at detoxification are effective, a majority of patients relapse, posing a major obstacle to their rehabilitation. Some studies suggest that the symptoms most distressing to addicts during detoxification are psychological rather than physiological. As a result, psychosocial treatments offered in addition to pharmacological detoxification treatments yield far greater successes in terms of completion of treatment, results at follow-up and compliance.[22]

- Access and retention

37. The Committee on Economic, Social and Cultural Rights has observed that health facilities, goods and services, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality. The term “accessible” has been seen as having four dimensions: accessible without discrimination, physically accessible, economically accessible (i.e. affordable), and accessible health-related information.[23]

38. In its 2005 Annual Report, the EMCDDA observed the results of several longitudinal studies examining changes in HIV risk behaviours for patients currently in treatment. These studies found that longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviours associated with drug-taking. IDUs who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. The death rate for problem drug users in methadone maintenance treatment is one-third to one-quarter the rate for those not in treatment.[24]

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[20] WHO (2004), ‘Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users’, Evidence for action technical papers, WHO, Geneva.

[21] De Wit, A. and Bos, J. (2004), ‘Cost-effectiveness of needle and syringe exchange programmes: a review of the literature’, In Hepatitis C and injecting drug use: impact, costs and policy options, EMCDDA Monographs 7, European Monitoring Centre for Drugs and Drug Addiction, Lisbon, pp. 329–43.

[22] See, for example, Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. . Amato L., Minozzi S., Davoli M., Vecchi S., Ferri M., Mayet S. The Cochrane Database of Systematic Reviews 2005 Issue 4. Also by the same authors; Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. The Cochrane Database of Systematic Reviews 2005 Issue 4.

[23] See CESCR General Comment No. 14, para 12

[24] EMCDDA 2005 Annual Report

39. In consonance with these positions, the convention should aim to ensure that treatment strategies provide an easy access, low-threshold and user-friendly service, maximizing the access and retention of all problem drug users.

Rehabilitation and social reintegration: integrating drug policy responses strategies into national health services and social programmes

- Terminology

40. "Rehabilitation" refers to measures intended to improve the personal qualities of the problem drug user (such as physical and mental health, vocational skills).[25] 'Social integration' includes measures intended to make it possible for the problem drug user to live in an environment that is more favourable to him or her.[26]

- "Right to health" as one of several related human rights

41. Rehabilitation and social integration should constitute a key component of the convention since the right to health is closely related to the enjoyment of a number of other human rights and fundamental freedoms. These include the rights to food, housing, work, education, life, non-discrimination, equality, the prohibition against torture, privacy and participation.[27]

42. In recognition of this, and in order that an ongoing commitment to humanitarian drug policies is more likely, the convention should urge Member States to link and integrate national drug policy responses (prevention, care, treatment and support) into primary, general and mental health services as well as into social programmes (for instance those concerning unemployment, housing, education, counselling, social exclusion, law enforcement and crime prevention). A necessary corollary of this will be for Member States to strengthen national health and social infrastructures for the effective delivery of prevention, treatment, care and support services.

- Alternatives to prison

43. Alternatives to prison, such as community service, may be considered as a valid measure of social reintegration. Prison is a particularly detrimental environment for problem drug users and since the 1960s, UN and EU agreements, strategies and action plans have several times reaffirmed and strengthened the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for drug-related offences. This has already been translated into national legislation in many European countries, whose criminal justice systems as well as health and social services systems have been adapted accordingly.

44. The key difficulties faced in the implementation of alternative measures to imprisonment, arise due to the different administrative systems involved and their different underlying principles. Member States must be encouraged to bridge the gap between the judicial and the health and social services systems through coordination structures and initiatives, i.e. between police, courts and prisons and drug treatment services.

45. Although there is little evaluation data of treatment as an alternative to prison, retention in treatment is a key indicator of success. Evidence suggests that it is the quality of treatment provided and not the route of the client into treatment that determines the success of treatment. In particular, treatment

[25] See Commentary on the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, para. 3.111 and 3.112
[26] Ibid.
[27] See for example Vienna Declaration and Programme of Action, 1993, Part 1, paragraph 5, and CESCR General Comment No. 14, paragraph 3.

as an alternative to prison appears to work best where problem drug users are motivated for treatment and if care facilities follow good clinical standards and have enough and qualified staff.

Monitoring and evaluation

46. In order to provide clear indications as to the merits and shortcomings of the types of interventions being encouraged, evaluation should be an integral part of this initiative. National periodic reviews should be conducted, involving the participation of civil society, vulnerable groups and caregivers, of progress achieved in realizing drug policy commitments. Evaluation should aim at identifying best practices and be conducted against a number of clear criteria using appropriate methodological tools and parameters. The monitoring and evaluation criteria and techniques prepared by the EMCDDA should be considered, as should the Council of the European Union Recommendation on the prevention and reduction of health-related harm associated with drug dependence.[28] Lessons should also be drawn from existing monitoring programmes in various European countries. For example, in Germany: Prevnet, in Norway: National Prevention Database, and in Hungary: 'Lights and Shadows', which collects information on the content, objectives, methodology, target groups and coverage of school-based prevention programmes.

47. During an exchange of views with the Committee in October 2006, Mr. Christopher Luckett, the Executive Secretary of the Pompidou Group emphasised the following aspects as important when developing approaches and policies to deal with drug addiction:.

(i) Cultural responses to drug problems. Policies cannot be simply transplanted from one country or region to another. Adaptation which takes into account cultural diversity is always necessary to ensure success.

(ii) Continuity of care. Often programmes are developed to deal with specific groups in society but there are serious problems created if the program ends, or an individual moves to a different societal group, i.e. a prisoner who is released into the community without a continuation of treatment / programme.

(iii) Ethics relating to the treatment of an individual, compulsion, the real needs of society rather than the perceived needs. Mr. Luckett raised concerns that developing techniques / technology (vaccinations, tests, screening etc) can divert attention away from the drug user and towards inanimate objects.

48. Mr Luckett emphasised that all existing conventions were currently focused on control rather than demand reduction. It was realistic to attempt to produce a convention on this issue however there were serious difficulties. Finally he referred to a paper by the Berkeley Foundation which stressed the importance of integrating abstinence and harm reduction services to provide care. He further stated that the Pompidou Group had a different approach to the UN. As an example he cited the life skills programme that the Group had piloted for school children in Russia. There was evidence that it is working and this could be adapted for use in other countries

49. Yet the rapporteur feels that Mr Luckett has made no assessment of possible difficulties or incompatibility between his first and last points, namely the difficulty of seeking to find an approach that recognised and respected cultural diversity whilst seeking to find a common ethical approach. While accepting the importance of cultural differences the spread of the mis-use of drugs world-wide has followed near identical patterns world-wide. The collapse of the Iron Curtain led to the spread of drugs in the former Communist countries in a manner similar to those elsewhere in Europe and the Americas.

Conclusion

[28] Brussels, 7 May 2003, Doc.8069/03, paragraph 2.

50. Recent world trends have provided additional proof of the abject failure of efforts to cut off drugs on the supply side. The United Nations have confirmed that six years of military action to restrict the poppy crops in Afghanistan has resulted in the 2006-07 crop being the largest ever – a 60% increase on that of last year. In spite of massive expenditure by the US on Plan Colombia, the production of cocaine increased in that country in the past year. Previously reduced crops from Colombia were replaced by new harvests from the Peru and Bolivia.

51. This report stresses the importance of drug demand reduction programmes which should be complementary to the existing framework of national drug policies in Council of Europe member States. They should extend the scope of drug demand reduction programmes, assess them and disseminate the best practices assessed.

52. Furthermore, the member states should improve access to prevention programmes in schools and make them more effective. They must also improve prevention methods and the detection of risk factors in certain target groups, especially young people, as well as the dissemination of these data to the professionals in order to implement early intervention programmes.

53. Similarly, they should also ensure that targeted treatment, re-education and social reintegration programmes are available and accessible which incorporate tested psychosocial and pharmacological strategies and include drug addicts not reached by existing services, with particular attention being paid to specialised services for young people. The rapporteur also recommends developing further alternatives to imprisonment for addicts and the setting-up of prevention, treatment and reintegration services for prisoners.

54. As regards the prevention and reduction of health-related harm associated with drug dependence, the rapporteur believes that Council of Europe member States must also improve access to harm reduction services and treatment and set up programmes preventing the propagation of the AIDS virus, hepatitis C and other blood-borne diseases. They should also endeavour to reduce the number of drug-related deaths.

55. As regards supply reduction, national action plans should also contains measures to reduce the production of heroin, cocaine and cannabis, and synthetic drugs and trade in them, in particular by implementing operational joint programmes, collecting intelligence on third countries involved in manufacturing and trading in such drugs, sharing best practice and exchanging information.

56. Insofar as many of the negative consequences of drug use are felt at local levels, the convention must reaffirm the principal of subsidiarity, by encouraging consideration of the ways that more local government agencies may act effectively. In this way, it is intended that health-driven drug policy responses measures may be guided by contextual, scientific evidence and that the objects of the convention can be better reconciled with local conditions.

57. It will be vital to the effective implementation of the convention that the Council of Europe encourages multi-agency co-operation and the involvement of civil society and community and voluntary groups from areas most affected by problematic drug use. It must also act in concurrence with the efforts of international humanitarian organizations, notably the International Federation of Red Cross and Red Crescent Societies.

58. The convention being proposed in this report is intended to enable the development and implementation of multisectoral national strategies for combating problem drug use that address the phenomenon in forthright terms; confront stigma; eliminate discrimination and marginalization; involve partnerships with civil society and the full participation of problem drug users; and fully promote and protect all human rights and fundamental freedoms.

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Members of the Committee: Mrs Lajla Pernaska (Présidente), **Mrs Christine McCafferty** (1st Vice-chair), Mr Cezar Florin Preda (2nd Vice-chair), **Mr Michael Hancock** (3rd Vice-chair), Mr Farkhad Akhmedov (Alternate: **Mrs Tatiana Popova**), Mr Vicenç Alay Ferrer, Mrs Sirpa Asko-Seljavaara, Mr Jorodd Asphjell, Mr Zigmantas Balčytis, Mr Miguel Barceló Pérez, Mr Andris Berzinš, Mr Jaime Blanco García, Mrs Raisa Bohatyryova, Mrs Monika Brüning, **Mr Igor Chernyshenko**, Mr Dessislav Chukolov, Mrs Minodora Cliveti, Mr Imre Czinege, Mrs Helen D'Amato, Mr Dirk Dees, Mr Stepan Demirchyan, Mr Karl Donabauer, Mr Ioannis Dragassakis, Mr Claude Evin, **Mrs Daniela Filipiová**, **Mr Paul Flynn**, **Mrs Doris Frommelt**, Mr Renato Galeazzi, Mr Jean-Marie Geveaux, Mr Stepan Glăvan, **Mr Marcel Glesener**, Mrs Claude Greff, Mr Tony Gregory, Mr Ali Riza Gülçiçek, Mr Jean-Marie Happart, Mrs Olha Herasym'yuk, Mr Ali Huseynov, Mr Fazail Ibrahimli, **Mr Mustafa Ilicali,** Mrs Halide Incekara, Mr Denis Jacquat, Mrs Corien W.A. Jonker (Alternate: **Mr Tiny Kox**), **Mrs Krinio Kanellopoulou**, Mr Marek Kawa, Mr András Kelemen, **Baroness Knight of Collingtree**, Mr Slaven Letica, **Mr Jan Filip Libicki,** Mr Ewald Lindinger, Mr Gadzhy Makhachev, Mr Andrija Mandic, **Mr Bernard Marquet**, Mr Ruzhdi Matoshi, Mr Philippe Monfils, Mr Donato Mosella, Mrs Maia Nadiradzé, **Mrs Carina Ohlsson**, **Mrs Vera Oskina**, **Mrs Marietta de Pourbaix-Lundin,** Mr Adoración Quesada Bravo, Mr Vjerica Radeta, **Mr Walter Riester**, Mr Andrea Rigoni, Mr Ricardo Rodrigues, **Mrs Maria de Belém Roseira**, Mr Alessandro Rossi, Mrs Marlene Rupprecht, Mr Indrek Saar, Mr Fidias Sarikas, Mr Walter Schmied (Alternate: **Mr John Dupraz**), **Mr Ellert Schram,** Mr Gianpaolo Silvestri, Mr Hans Kristian Skibby, Mrs Michaela Soidrova, **Mrs Darinka Stantcheva**, **Mrs Ewa Tomaszewka**, Mr Oleg Tulea, Mr Alexander Ulrich, Mr Milan Urbáni, **Mrs Ruth-Gaby Vermot-Mangold**, Mrs Nastaša Vučković, Mr Victor Yanukovych (Alternate: **Mr Ivan Popescu**), Mrs Barbara Žgajner-Tavš.

N.B. The names of the members who took part in the meeting are printed **in bold**

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