GLOBAL COMMISSION ON DRUG POLICY

THE WORLD DRUG PERCEPTION PROBLEM

COUNTERING PREJUDICES ABOUT PEOPLE WHO USE DRUGS

2017 REPORT

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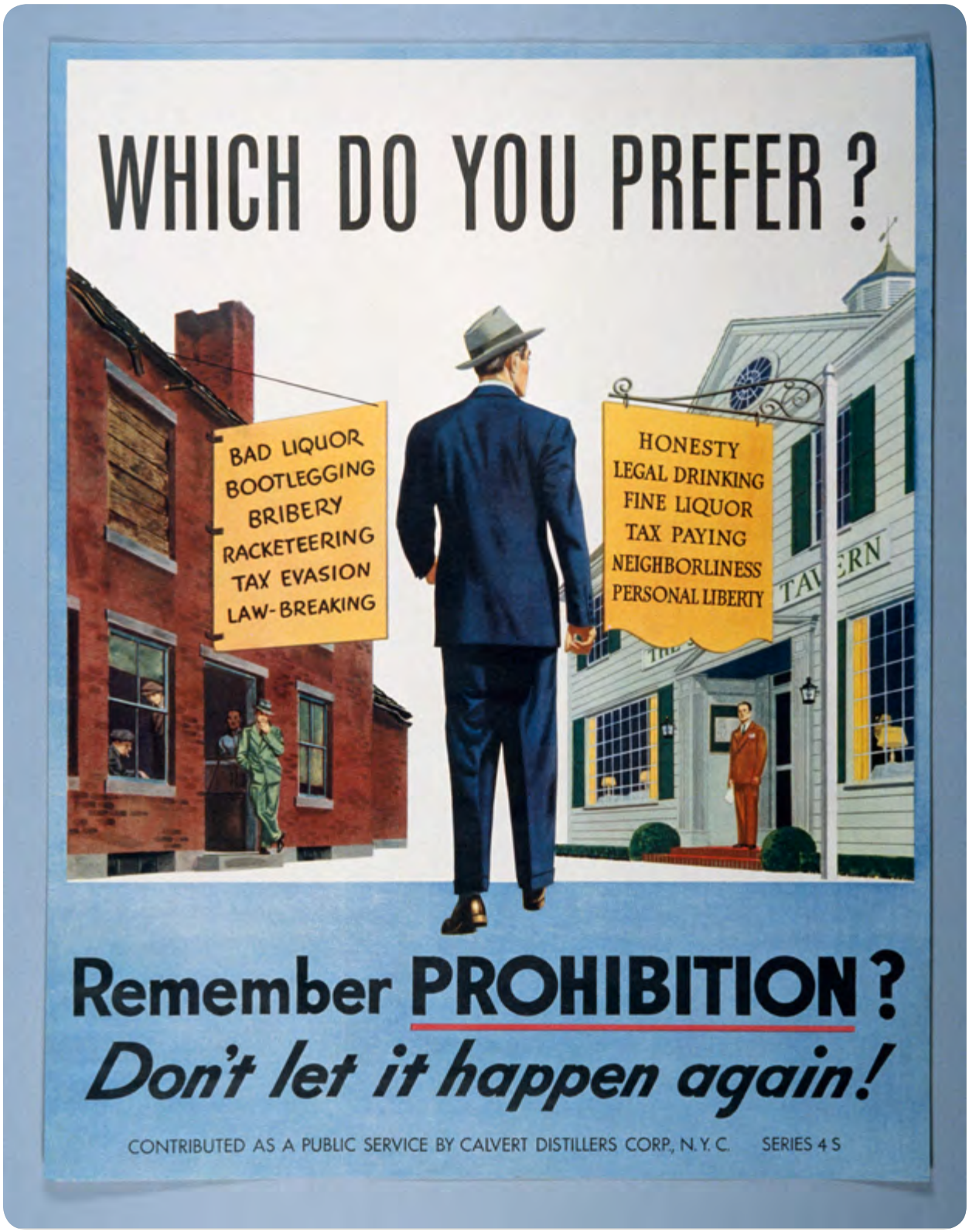


Poster sponsored by a US whiskey producer which opposed attempts to reinstate alcohol prohibition.

FOREWORD FROM THE CHAIR

Over the last six years, the Global Commission on Drug Policy has become a leading voice in the debate on the failures of the international drug control regime and the repressive laws that it has inspired, as well as on the reforms that are required to overcome the tragic consequences of prohibition. The 25 members of the Commission represent a wealth of experience as political, scientific and business leaders, as well as a permanent dedication to human rights and sustainable development.

In its previous six reports, the Global Commission has highlighted the human cost of misguided policies, their inability to reduce the production and consumption of illegal drugs, and to thwart criminal organizations. The Commission has also provided a comprehensive overview of the measures required to effectively address the consequences of these failed policies. These consequences include: the spread of infectious diseases, deaths from overdose and the use of adulterated substances, violence associated with repression and gang turf wars, corruption, a shortage of adequate drug treatment and pain relief, overcrowded prisons, and an absence of any perspective of social integration for people with a drug-related criminal record, including consumers and non-violent actors involved in the illegal production or sale of drugs. This list is far from exhaustive. Also affected are families and friends of those in direct contact with drugs, inhabitants of areas overrun by the illegal market, and even society as a whole. Governments waste great amounts of public money on repression rather than financing efficient prevention, treatment and harm reduction measures. Society is adversely impacted by policies that abandon the control of drugs to criminal organizations.

The situation portrayed above varies from one country and region to another, depending on whether there is a health crisis and how serious it is, the degree of prison overcrowding, the level of drug-related violence, and the weight of organized crime. Within each country, different populations suffer to varying degrees from the presence of drugs and the shortcomings of drug policies. Reforms should therefore not be the same from one country to the next, from one region to another. Drug policy reforms must take into account local parameters and the real needs of individuals and communities. Thus, it is essential for reforms to be based on an in-depth analysis of the problems that need to be solved; they must also mobilize all those who are involved in the process, and provide for an adequate evaluation of their impact.

Responses that are both rational and pragmatic, that relinquish ideology and renounce illusions about a drug-free society, are increasingly being implemented across the world. Governments are offering harm reduction services, decriminalizing use and possession for personal use, providing alternatives to punishment for non-violent, low-level actors involved in the production and sale of illegal drugs, and legally regulating cannabis and new psychoactive substances.

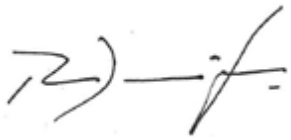
It is not easy, however, to change direction and navigate new waters. For too long, drugs have been considered as substances that must be avoided at all cost; people who use drugs have been rejected by society and perceived as asocial, depraved or deviant. Prejudices and fears surrounding drugs are expressed in stigmatizing language, stigmatization leads to social discrimination and repressive laws, and prohibition validates fears and prejudices. This vicious cycle must be broken. The Global Commission has therefore chosen to dedicate its seventh report to the World Drug PERCEPTION Problem.

Governments are responsible for correcting false perceptions of drugs and people who use them by providing evidence-based information, which is easily and widely accessible. In their speeches and by their very attitude, political and religious leaders must show their respect for the dignity and rights of all citizens, particularly the most vulnerable and those who are victims of social stigma.

Professionals who are in direct contact with people who use drugs – whether they are medical practitioners, social workers, or law enforcement officers – bear the responsibility to avoid conflating issues of race, crime and drugs. Countering false perceptions is necessary in order to fight arbitrary measures or barriers preventing people from accessing the services they need. Instead these professionals should share successes of public health and human rights approaches they are involved in.

All members of society must demand to be informed about the real costs of drug policies and how they impact lives, communities and the economy. Only in this way can each citizen engage with a full understanding of the facts in a debate about reforms.

We oppose prejudices with facts. We encourage a change in attitudes, language, and the way in which people who use drugs are treated. It is urgent to break the vicious cycle which brings harm to people and society.



Ruth Dreifuss
Former President of Switzerland

EXECUTIVE SUMMARY

Previous reports by the Global Commission on Drug Policy have shown how the potential harms of drugs for people and communities are exacerbated by repressive drug control policies at local, national and international levels. The present report, while fully acknowledging the negative impact that problematic drug use often has on people's lives, focuses on how current perceptions of drugs and people who use them feed into and off prohibitionist policies.

Indeed, drug policy reforms have sometimes been difficult to carry out, design or implement because current policies and responses are often based on perceptions and passionate beliefs, and what should be factual discussions – such as the efficiency of harm reduction – are frequently treated as moral debates. The present report aims to analyze the most common perceptions and fears, contrast them with available evidence on drugs and the people who use them, and on that basis recommend changes that can be enacted to support reforms toward more effective drug policies.

DRUGS, ADDICTION, AND THE AIM OF TREATMENT

Drugs are often presented as unnatural contaminants, pushed into a society from the outside or by deviant forces, and many people fear them. In reality, taking substances to alter one's mind seems to be a universal impulse, seen in almost all cultures around the world and across history (though the substances used vary). Furthermore, while there are certainly risks involved in all drug use, the legal status of a drug rarely corresponds to the potential harms of that drug. In addition, the potential harms of a substance are increased when it is produced, obtained and consumed illegally.

It is also widely believed that drug addiction is the result of someone simply taking a drug casually for pleasure, then becoming accidentally "hooked" on the chemical substances within the drug and thereafter "enslaved." However, this is based on a misunderstanding of addiction. Drug use is relatively common and, in 2016, an estimated quarter of a billion people used currently illegal drugs, while about 11.6% of these are considered to suffer problematic drug use or addiction. The most common pattern of use of psychoactive substances is episodic and non-problematic.

Addiction is often believed to be permanent and irreversible. If recovery is deemed possible, abstinence is generally perceived as the primary – and often only – goal of treatment. However, the primary goal of treatment should be to allow a person to attain, as far as possible, physical and mental health. From this perspective, abstinence is not necessarily the best objective for treatment for a particular person, nor even perhaps his or her aim. Even when it is, many people with problematic drug use only achieve abstinence after several attempts.

A large range of options is therefore needed to allow for doctors and their patients to freely decide on the appropriate treatment. Options include psychosocial support, substitution therapy, and heroin-assisted treatment. There is strong evidence for the effectiveness of these treatments.

In addition, many scientifically proven methods prevent many of the harms caused by drug use – foremost those caused by failed repressive policies – without aiming for abstinence. These harm reduction interventions include needle and syringe programs, safe injection facilities, provision of opioid-overdose antagonists, and drug checking.

PERCEPTIONS SURROUNDING PEOPLE WHO USE DRUGS

When considering the reasons why someone might take drugs, psychological and moral explanations generally prevail, primarily the assumption that the person is "weak" or "immoral." Thus, the general public often sees problematic drug use as an individual problem and not one that society needs to deal with. Another common stereotype of people who use drugs is that of people living on the margins of society, who are not equal members of it or entitled to the same rights as others.

These perceptions and stereotypes contrast with what experts consider to be the primary reasons for consuming drugs. These include youthful experimentation, pursuit of pleasure, socializing, enhancing performance, and self-medication to manage moods and physical pain.

Another widespread perception is that people who use drugs, and particularly people with problematic drug use, engage in criminal activities. But the vast majority of those who use drugs are not committing any crime other than the contravention of drug laws. Individuals with problematic drug use often cannot afford the drugs they need without resorting to crime themselves. In addition, people who use drugs are often forced out of the mainstream and into marginalized subcultures where crime is rife. Once they have a criminal record, they find it much harder to find employment, thus making the illegal market and criminal activity among their only means of survival.

PORTRAYALS IN THE MEDIA AND AMONG THE GENERAL PUBLIC

The perceptions discussed in the report are largely influenced by the media, which portray the effects of drugs as overwhelmingly negative. Two narratives of drugs and people who use them have been dominant: one links drugs and crime, the other suggests that the devastating consequences of drug use on an individual are inevitable.

Public opinion and media portrayals reinforce one another, and they contribute to and perpetuate the stigma associated with drugs and drug use. Commonly encountered terms such as "junkie," "drug abuser", and "crackhead" are alienating, and designate people who use drugs as "others" – morally flawed and inferior individuals.

Such stigma and discrimination, combined with the criminalization of drug use, are directly related to the violation of the human rights of people who use drugs in many countries. Therefore, in order to change how drug consumption is considered and how people who use drugs are treated, we need to shift our perceptions, and the first step is to change how we speak.

THE LINK BETWEEN PERCEPTIONS OF DRUGS, THOSE WHO USE THEM, AND DRUG CONTROL POLICIES

The link between the perception of drugs, the people who use them, and drug policy constitutes a vicious cycle. Under a prohibitionist regime, a person who uses drugs is engaging in an act that is illegal, which increases stigma. This makes it even easier to discriminate against people who use drugs, and enables policies that treat people who use drugs as sub-humans, non-citizens, and scapegoats for wider societal problems.

First, the fear of drugs has translated into messages for prevention that promote complete abstinence and state that all drugs are equally bad. However, providing information which is incomplete and often even incorrect lessens any chance of trust between the authorities and young people. A better way forward would be to offer honest information,

encourage moderation in youthful experimentation, and provide knowledge on safer practices.

Second, drug use is perceived as a moral issue, considered a public wrong, and is therefore criminalized, even though drug consumption itself is a non-violent act, and poses potential physical harm only to the person who engages in it. Yet in many countries the death penalty is applied to some non-violent drug offenses, placing them *de facto* on a similar moral ground to murder and other most serious crimes.

A change of perceptions and policies is already underway in some countries. Leadership and information have played a critical role in showing that the public can support more pragmatic and evidence-based drug policies when it has been given credible information. It has been possible to persuade people concerned about public order and security that alternative drug policies can be more effective at reducing drug-related harms for users, their immediate environment, and society as a whole.

PRINCIPLES FOR REFORMING DRUG POLICIES

With the adoption of the sustainable development agenda as the common policy framework for all, human rights, security and development become the basis of all policies. We therefore reiterate the principles of the Global Commission on Drug Policy:

1. Drug policies must be based on solid scientific evidence. The primary measure of success should be the reduction of harm to the health, security and welfare of individuals and society.

2. Drug policies must be based on respect for human rights and public health. The criminalization, stigmatization and marginalization of people who use drugs and those involved in the lower levels of cultivation, production and distribution needs to end, and people with problematic drug use need to be treated as patients, not criminals.

3. The development and implementation of drug policies should be a globally shared responsibility, but also needs to take into consideration diverse political, social and cultural realities, and allow experiments to legally regulate drugs at the national level. Policies should respect the basic rights of people affected by production, trafficking and consumption.

4. Drug policies must be pursued in a comprehensive manner, involving people who use drugs, families, schools, public health specialists, development practitioners and civil society leaders, in partnership with law enforcement agencies and other relevant governmental bodies.

Our final principle, informed by this report, is to call on all members of society to look for and share reliable, evidence-based information on drugs, people who use drugs, the ways and reasons they use them, as well as the motives behind current perceptions. Only a collective effort to change our perceptions will allow for effective drug policy reform. The six recommendations in this report provide pathways for policy makers, opinion leaders, the medical community, and the general public on how to work towards this.

Break the taboo on the problematic perceptions of drugs and the people who use them. The time to change our perceptions and attitudes is now.

DRUGS

WHAT IS A DRUG?[3]

In the broadest sense, a drug is any substance that has an effect on either mind or body. However, for substances that act on the mind (psychoactive), including stimulants, sedatives, hallucinogens, deliriants or dissociatives, the term drug has acquired a negative meaning. In the pharmacological sense, caffeine, nicotine and alcohol are drugs just as cocaine and heroin are.

In popular usage, "drug" has taken on a different meaning. Over the last century, "drug" has come to mean a psychoactive substance that is illegal. In this sense, cannabis is a drug while alcohol is not (in most countries); and substances such as morphine are "medicines" when used by doctors, and "drugs" when used recreationally. Psychoactive substances are more accepted by society when supplied as medicines. Whether a substance is a drug in this usage depends on the intention behind its use, the mode of administration and the social class of the user. And while in many cases the active substances remain the same, the perception is very distinct.

Drugs are often presented as unnatural contaminants, pushed into a society from the outside, or by deviant forces, and many people are afraid of them. In reality, psychoactive substances have been used throughout human history. Indeed, drug use is not limited to the human race, but extends to other species too: many animals deliberately pursue intoxication, such as cats seeking the ecstasy of catnip, migrating birds eating fermented berries or fruit, and baboons chewing tobacco.[1] Taking substances to alter one's mind seems to be a universal impulse, seen in almost all cultures around the world and across history. In anthropology, "mood- or consciousness-altering techniques and/or substances" are part of the list of "human universals" alongside music, language, play and others, forming the basic cultural toolkit.[2] And it holds true today: there are few individuals who never consume psychoactive substances, whether it be alcohol, tobacco, coffee, chocolate or khat. Therefore, most individuals and societies have an understanding of the appeal of psychoactive substances, at least of those that are socially acceptable in their culture.

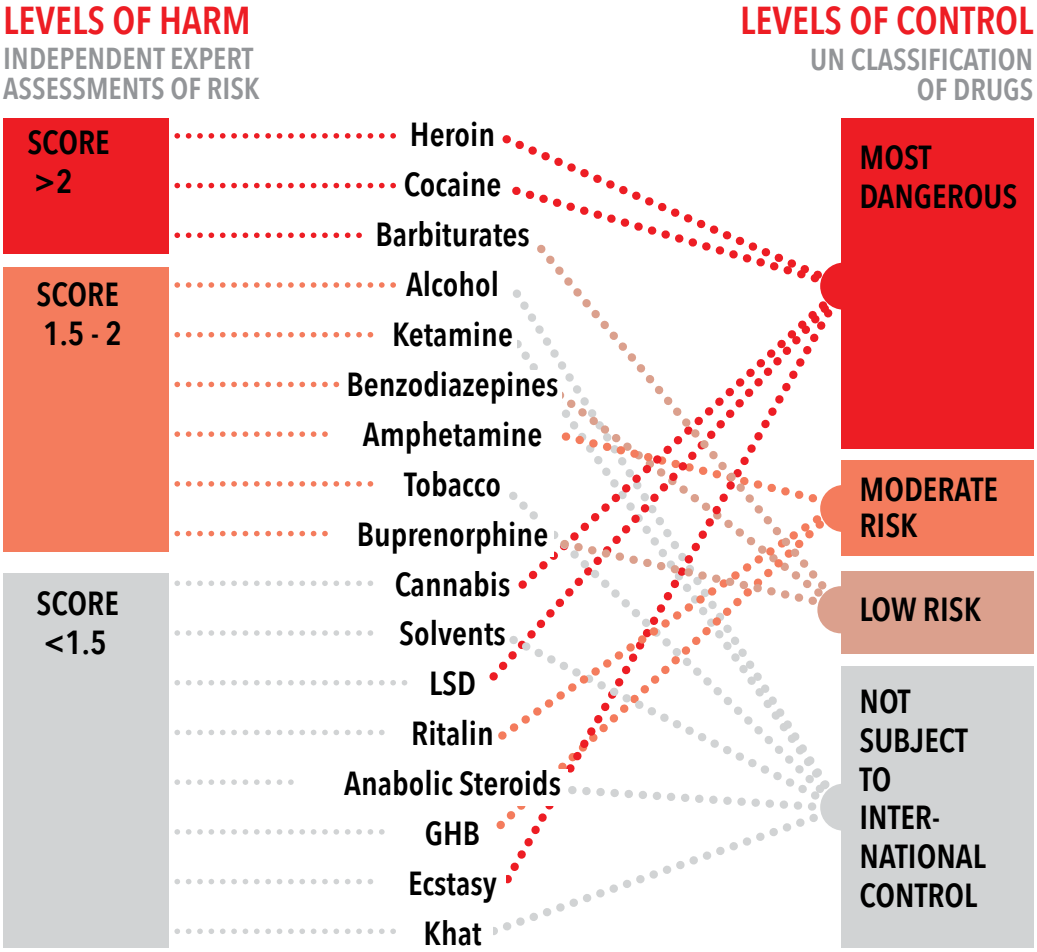
There are risks involved in drug use, regardless of whether the substances involved are legal or illegal. Drugs, including alcohol and tobacco, cause harm to individuals and societies – but there is a wide range of ways in which drugs cause harm and the relative harms differ.[4] Many citizens believe that drugs have been made illegal based on a rational analysis of the harm they cause. In fact, the decisions about what to ban and what to permit have generally not been made by scientific or medical panels alone.

A landmark study published by *The Lancet* in 2007 ranked drugs according to a variety of criteria, including physical harm (acute, chronic, intravenous harm) and psychological and social harms (including intoxication and health care costs).[5] Heroin ranked as the substance that presented the most risk of harm to the individual, but when individual and societal harms were also factored in, a legal substance – alcohol – was considered the

Medical heroin produced by Bayer pre-1913. Credits: courtesy photo.

Heroin of unknown purity and potency as sold on the streets today. Credits: © Snowbelle / Shutterstock.com

FIGURE 1: CLASSIFICATION OF DRUGS – LEVELS OF HARM VS LEVELS OF CONTROL



Sources: Nutt, D., King, L.A., Saulsbury, W., Blakemore, C. (2007); UNODC, Schedules of the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, as at 22 April 2017, and Schedules of the Convention on Psychotropic Substances of 1971, as at 18 October 2017

most harmful. In fact, little or no correlation has been found between the UN scheduling of substances (as 'most dangerous', 'moderate risk' and 'low risk') and their harms as assessed by this study.[6] The reality is that the legal status of a drug does not systematically relate to its potential harm.

Furthermore, the Lancet study assessed the current harms of different drugs within the legal system of the UK. However, in the case of drugs that are illegal, a part of the harm results from precisely this status because when a substance is prohibited, the risks involved in its use increase. Heroin, a potent drug with a comparatively high risk of problematic use, illustrates this point well. When buying heroin "on the street," the user does not know the potency and purity of what they bought, and for that reason overdoses are common and often fatal. In contrast, when a patient in a heroin-assisted

treatment program receives their dose of medical grade diamorphine, both the doctor and the patient are sure of the potency and adjust the dosage to the patient's tolerance level.[7] In over 20 years of heroin-assisted treatment in Switzerland, there has not been one fatal overdose. Similarly, many other serious harms are not intrinsic to the substance itself: when sterile injecting equipment is used, the risk of transmission of blood borne viruses such as hepatitis C and HIV is close to zero. Collapsed veins and vascular sclerosis common to long-term users of "street heroin" are mainly caused by improper injection techniques, the low quality of the heroin itself (e.g. crudely processed "black tar") and/or by what has been added along the supply chain (for instance, it is common to "cut" heroin with concrete, which does not dissolve well and blocks veins). Damage to the liver or kidneys is also primarily caused by additives in "street heroin" and by infections transmitted through needle sharing and other unsafe injection practices. The side effects that are due to heroin itself are constipation and decreased sexual function – as well as dependence.[8]

Edmond S. Fehoko, New Zealand

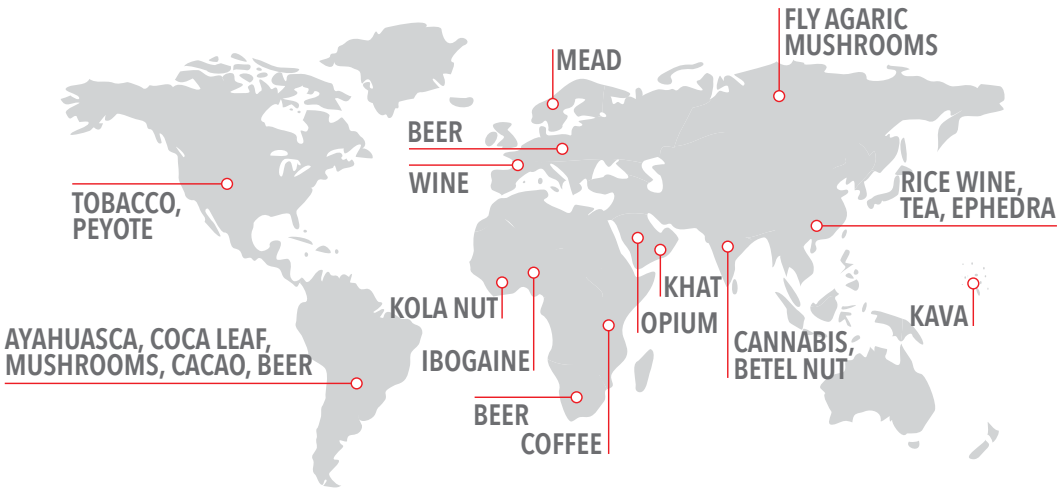
I am currently pursuing a PhD in Public Health at the Auckland University of Technology. My parents migrated to New Zealand from Ha'apai, Tonga, and the connection to my heritage is important for me both personally and in my academic work: my master's thesis explored the experiences and perceptions of 12 New Zealand-born Tongan males participating in the faikava (kava drinking circle). I can vividly recall when I participated in my first kava circle at my local church with my father, at the age of 14. When I consume kava, I feel sociable, yet at peace, with stress levels gradually subsiding, resulting in a state of tranquility.

Kava circles are a social and cultural space where Pacific communities, including Tongans, gather to share ideas, knowledge and experiences whilst drinking kava as a means of (re)-connecting back to the Pacific homelands. Kava is a drink made from the roots of the kava plant and it is well known and recognized within the Pacific for its mythical, narcotic, spiritual, medicinal and cultural value. Kava is a light anesthetic with anti-fungal qualities. It has been scientifically proven that kava also has mild antibiotic attributes. Kava has been a remedy, which has been used for illnesses such as headaches, leprosy, insomnia, migraine, tuberculosis and menstrual problems for female kava drinkers in Fiji. Thus, known for its medicinal properties, kava is considered as the "most imported and important psychoactive plant in the Pacific."[11]

Reactions to my use of kava have been both positive and negative. Positive reactions include when it is seen as an alternative to alcohol consumption. Kava has a different intoxication effect than alcohol. It generates a warm, pleasant and cheerful, but lazy, feeling, making people sociable without ineptness or interference with their reasoning. Kava use is also seen in a positive light as a diversion from possible youth gang affiliation. And my family appreciates the role it plays in ensuring my fluency and understanding of the Tongan language and culture and in engaging in harmonious talanoa (dialogue) with others in the circle.

On the downside, sometimes, after a long night of kava, my mind can be a bit lethargic. Negative stigma is linked to the time spent at a kava circle instead of with family or friends who do not use kava, which in some cases can mean that a father figure might lack at home. My wife and family have compared my participation and engagement in the kava circles to how British Ladies will gather and have tea parties or a group of academics will gather and drink coffee.

FIGURE 2: TRADITIONAL DRUG USE AROUND THE WORLD



Source: Adapted from Nutt, D. (2012) Drugs Without the Hot Air

Many drugs are an "acquired taste" as they have physical effects that are often initially unpleasant. For instance, beer is unpleasantly bitter when first tried; the first cigarettes produce coughing and nausea.[9] These practices need a cultural context in which people learn to enjoy them.[10] So while the consumption of drugs is a universal impulse, historically the drug or drugs commonly taken in any culture were often local and related to the availability of native plants – such as coca leaf in the Andes, kava in the Pacific, and opium in India and other parts of Asia. Partaking of the drugs that were part of one's culture was most often seen as unproblematic. Alcohol, for example, is commonly used in many countries and usually its non-problematic use is culturally sanctioned (with some exceptions, like public drunkenness). In contrast, the drug habits of another culture are often frowned upon, at least until the new drug is socialized and normalized. In Europe this was the case with coffee and tobacco when first introduced.

So the potential harms of the substance itself are increased when it is produced, obtained and consumed illegally and, as discussed earlier, the boundaries between legal and illegal substances do not correspond to their degree of harm according to experts. Different cultures also make different drugs illegal. For example, some cultures and religions forbid the use of alcohol and it is currently prohibited in an array of Asian and African countries, from Afghanistan to Mauritania.[12] This is in contrast to Western cultures, where alcohol is the primary socially acceptable psychoactive substance. Indeed, red wine is an integral part of weekly Christian religious ceremonies. Boundaries have also shifted within the same culture over time: in Morocco cannabis was legal and regulated under the French and Spanish Protectorates,[13] as was opium in India and Pakistan under British colonial rule and immediately after Partition.[14]

"ADDICTION"

It is critical to distinguish between two concepts that unfortunately are often conflated: addiction and dependence. **Dependence** means relying on a substance to function and to avoid suffering withdrawal symptoms on abrupt cessation. It is a natural result of taking certain medications (including opioids for pain relief, some blood pressure medications, and antidepressants) regularly. It will for example affect nearly all pain patients who take opioids daily for months. **Addiction**, in contrast, is defined by the US National Institute on Drug Abuse (NIDA) as a condition "characterized by compulsive drug seeking and use, despite harmful consequences."[16] Stable methadone and buprenorphine patients in opioid substitution therapy, for example, have dependence, not addiction.[17]

The World Health Organization's International Classification of Diseases (ICD), now ICD-10, however still uses "dependence" to mean compulsive use of a substance despite negative consequences,[18] rather than simply needing a drug to function.

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM) in the current manual (DSM-5) uses the term "Substance Use Disorder" qualified by "Severe."

In contrast, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) uses the term problematic drug use (or high-risk drug use) defined as "recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems), or is placing the person at a high probability/risk of suffering such harms."[19] The latter is useful as drug use can cause problems even without either the physical dependence or the compulsiveness.

THE ADDICTIVENESS OF PSYCHOACTIVE SUBSTANCES

It is widely believed that drug addiction is the result of someone simply taking a drug casually for pleasure, then becoming accidentally "hooked on" the chemical substances within the drug and thereafter "enslaved." Drugs are presented as "powerful, seductive, and rapidly addictive; that everyone is at risk for addiction, that drugs by themselves are sufficient to cause any imaginable deviant behavior and are directly responsible for most crime and violence."[15] However, this perception is based on a misunderstanding of addiction, or what is now more often referred to as "dependence," "substance use disorder," or "problematic drug use."

The reality is that drug use is relatively common around the world. An estimated quarter of a billion people (aged 15-64) used currently illegal drugs in 2016, of which about 11.6% are considered to suffer problematic drug use.[20] Another set of observations further disproves the assumption that all or most drug use leads to addiction: data collected by the European Union on both lifetime use (if an individual has ever tried a drug) and use in the past year. If drug use were inevitably and consistently problematic, these two sets of numbers should be similar. Yet the fact is that lifetime use figures are much higher than use in the past year for all substances: cannabis 87.7 million vs. 23.5 million; cocaine 17.5 million vs. 3.5 million; MDMA (ecstasy) 14.0 million vs. 2.7 million; amphetamines 12.5 million vs. 1.8 million.[21] This shows that the vast majority of people who have ever tried a substance have not used it in the past year. The most common pattern of the use of psychoactive substances is episodic and non-problematic.

This is true even for drugs that are widely regarded as the "hardest" illegal drugs, such as heroin, crack cocaine or methamphetamine: only a minority of users experience problems.[22] For heroin, it has been found that approximately 23% of those who try it will develop problematic use, and 77% will not; for cocaine the estimate is around 17% and for cannabis around 9%. About 15% of people who consume alcohol and 32% of those who try tobacco will develop problematic use of these substances, which are legally available in the majority of countries.[23]

Carmen, Germany

When I was 16, a friend helped her older brother bake "space cookies," i.e. cookies with hashish, and she shared a few with me and some friends. It was a pretty intense experience. We had cannabis in baked goods or hot chocolate a few times and later, when I had started smoking cigarettes, I also started smoking joints. We would share a joint when going out or sometimes if a whole group of us was at a friend's place. We would put some money together, each chipping in 10 Deutschmarks or so and a friend would buy the hashish in "bulk" for our group, enough for a couple of weeks or a month, as many dealers would not sell less than 5 or 10g. We would then split it up. It was only much later that I realized that what we were doing is called "social dealing" and that the friend whose turn it was to buy could have been considered as a low-level drug trafficker. I continued smoking joints while at university, mostly on weekends. Over the years, as I went out less and less, I also smoked less and less cannabis.

As I grew up in Bavaria – the federal state that enforces drug control policies most strictly within Germany – we were afraid of getting caught even with the equivalent of one joint and would only smoke in the car around the corner from the night club or at a friend's place before going out. Luckily none of us ever got into trouble with the police.

I am now married with three kids, work part-time in a job related to the field I did my degree in, and cannabis no longer has a place in my life – with the possible exception of a weekend trip with friends from high school every two years or so: there we might still smoke a joint to prove to ourselves that we are still "young."

Only occasionally will the reality of everyday, non-harmful drug use break through into the public consciousness. For example, reporters will often ask presidential candidates in the US about their experiences with drugs, famously leading Bill Clinton to claim he "didn't inhale."[24] Barack Obama offered a different response, publicly admitting to using both cannabis and cocaine and stating "I inhaled. That was the point."[25] In reality, stories such as President Obama's – of someone who used on occasion but never developed problematic use – are by far the most common experience that people have with drugs across the world. Yet, these are not the narratives that are prominent in people's minds.

"ADDICTION" AND RECOVERY

Just as there is a fear that any drug use will lead to "chemical enslavement," addiction is often believed to be permanent and irreversible. Or, if "recovery" is deemed possible, abstinence is generally seen as the primary and often only goal of treatment, while it should be to allow a person to attain, as much as possible, physical and mental health. There is the belief that substitution therapies, for example, just "replace one drug with another."[26] Contrary to popular belief, there is strong evidence of the effectiveness of treatments such as opioid substitution therapy, cognitive-behavioral therapy, contingency management, motivational enhancement, and mindfulness-based relapse prevention.[27]

From a medical perspective, only those with problematic drug use or dependence need treatment – which, as mentioned above, is a minority. Treatment of drug use disorders is first and foremost a therapeutic contract between a doctor and a patient based on trust and confidentiality. They should decide freely on the treatment process, on

Nicolas Manbode, Mauritius

I started using cannabis at the age of 16, and at 18 I started to inject heroin. As long as I could hide it from my family, everything was okay and my consumption was only on a recreational basis. I started working at a very young age in the construction sector with my dad. Construction is a tough world. Sometimes you get a contract and lots of work and sometimes not. At the end of one of our projects, we had no job, so I stayed home almost every day with not much to do and I started to inject more regularly.

I got arrested for the first time for possession of heroin at 21. At this point, my life changed completely. I had no job, no money and my drug consumption became a problem. There were more and more police cases against me, making my life more difficult each day.

At the age of 27, I had enough of this life, of spending my life in and out of prison. It was hard and I couldn't take it anymore. It was not the life I wanted to have. Being incarcerated is hard, drug consumption was also very hard, I wanted to quit. I tried several detox centers and abstinence-based treatment centers but none of them worked for me. The treatments were for 2 weeks. When I got home from them nothing had changed in my neighborhood and I went back to using. I then decided to try methadone treatment but before being able to start, in 2010, I was sentenced to 2 years' incarceration. In the prison, I learned that I was co-infected, with HIV and hepatitis. It was a shock. When I was released from prison in 2011, I started on a methadone program and stayed on it for two years. This program worked for me. During those two years, I was supported. I had an objective and I stuck to it. Abstinence only had not worked for me; I needed medical follow-up also. I wanted to focus mainly on my health and then I started to gradually decrease the methadone doses. It took me 3 months until I finally stopped in 2013.

Things got better with my family. They saw the effort I made to quit. I started to get some work with contractors within my family. The trust that was once lost was reinstated. But it did not last long. The stuff I had done caught up with me. In 2015, I received the verdict of a police case which had been pending since 2008. I was again sentenced to two years of prison.

Luckily, and with the help and intervention of many, the sentence was changed to community service. When I had decided to quit, I had started volunteering in several organizations and this helped me a lot. But on the professional side it was hard, my clients terminated their contracts. But I didn't go under, I persevered. At this same time, a local NGO, the Collectif Urgence Toxida (CUT), was looking for an outreach team leader for its peer unit. I applied and today I still work with them.

If I hadn't been through all that, I wouldn't be who I am today; it forged my personality. When I think about the time when I was injecting drugs, I know that I wouldn't have gone to prison and be co-infected if it had not been for the drugs. With time, I have developed good self-esteem and I am more confident in what I am doing. I want to help others through harm reduction programs, and I think that if I hadn't been through all this, I would have never gone on to help others. And today, whether society thinks good or bad about me, it doesn't affect me.

the interventions and services to pursue, and on the final objective,[28] whether that is abstinence or a different goal. While abstinence might be a desired outcome by some, many people with problematic drug use require several attempts before they succeed, and some need diverse forms of treatment and services to maintain their good health while accessing the illegal drug that they depend on, or a substitute substance. The UN has clearly stated that relapse during treatment is "not a weakness of character or will."[29] A range of options is needed – from abstinence-based rehabilitation, to psychosocial support, to substitution therapy, to heroin-assisted treatment – in order to allow for doctors and their patients to decide on the appropriate treatment.

COMPULSORY TREATMENT

The fears and misconceptions around addiction have contributed to a view that people who use drugs should be forced into treatment against their will. In a number of countries, this translates into state-mandated treatment. Compulsory drug treatment exists in parts of Southeast Asia, the Russian Federation, North America, Latin America, Europe, Australia and Africa.[30] Compulsory treatment centers are a violation of the trustful and voluntary relationship that should always exist between a patient and a care provider. In addition, compulsory treatment centers violate human rights. There is documented evidence (in Vietnam, China, Cambodia and Laos) of individuals being picked up by the police and detained without due process: without access to lawyers or formal hearings from judges and without a process by which they can appeal against their detention.[31] Reports on vigilante groups in Russia kidnapping people who use drugs from their home to "rehabilitate" them show a similar disregard for the people they label "animals": people have been chained to beds, deprived of food, pushed into forced labor, and tortured. As one report notes: "A drug user was not considered a human being there. That's how they treat you: they beat you all the time, humiliate you."[32] Forced treatment is not only appalling, it has also proven to be ineffective and to increase the likelihood of relapse.[33]

Mother receiving methadone doses, Ukraine. Credit: © Brent Stirton via Getty Images

Oxana, Russian Federation

I had been addicted to heroin for several years, but I was coping. I dreamed of having a child. I managed not to use drugs for two years before I became pregnant. I was happy and went to the doctors for pre-natal care. In the hospital, I was stunned when I was told that I would not be able to give birth, because I had used drugs and was HIV positive. I was upset, beyond words. My dream fell apart.

In my country you can get an abortion for free for up to 12 weeks. After that, you have to pay and it's only done in special cases. So I started looking for money for an abortion. Maybe there's another way to have it done for free, but the doctors didn't tell me. I cried all the time and stopped eating. I wanted to kill myself. I got pulled back into drugs, and grew so thin my body was little more than a skeleton. I wrote a letter to my sister, preparing to die.

To get an abortion at this late stage, I had to get a certificate from the narcology department [the Russian branch of medicine dealing with drug addiction] that I was a drug addict. But in my country they don't accept pregnant women in narcology: methadone substitution therapy which can help drug-dependent women during pregnancy is banned in Russia, and official detox programs are off-limits to pregnant women – because the drugs used are toxic to the fetus. The narcology staff only agreed to take me in after they learned that I would later have an abortion. Then, on the eve of my abortion, I found out from my girlfriends that when you are HIV positive it is entirely possible to give birth to healthy babies. So that means everything I'd just been through was purely at the whim of the doctors?!

I announced that I was having the child! The staff at the clinic yelled at me, calling me an irresponsible junkie, and they didn't want to return my money for the procedure. Due to everything I'd been through, I went into labor prematurely, and at 28 weeks I had a beautiful, healthy baby girl, Julia. It was such a joy, even though it came at such a heavy price.

I filed a complaint against the doctors. Then the police came to my home to harass me. They had an anonymous tip-off that I was neglecting my baby. So it looks like the doctors had the last laugh.

Nevertheless, our happiness lasted just over two years. I found a job to earn money for Julia. Taking care of her took a lot of my energy. I was tired at work, and when I came home, I had to deal with my scolding relatives, who took care of my daughter while I was away. Soon, Julia's father died and things got a lot more difficult. Problems at work, problems at home, the father's death and how everybody shunned me – I just broke. It drove me back into using drugs. Then the police came to my house again, with a fake warrant for drugs. They searched the house but didn't find anything. So they took some sugar from the cupboard, poured it on the table, called witnesses and told them they had found drugs. Then at the station, they snuck a syringe between my things.

I was given a sentence of three years and three months in a prison colony. The drug control service published an article on their website, portraying me as a horrible monster and revealed my drug dependency and HIV status. The article was removed only after I wrote a complaint to the prosecutor's office, but it was too late: almost all of my friends and relatives had read it.

I have been at the camp for one year now, two more to go. We work almost every day, with no days off. My HIV treatment is irregular as the supply of anti-retroviral drugs is intermittent at the camp. I'm worried about my health. I don't dare to think about my daughter or I'll start to cry. I only dream of one thing – to see Julia again. To never be separated again. But if you're a junkie, you can never guarantee that something won't destroy your plans.

HARM REDUCTION

There are many scientifically proven ways to prevent much of the harm caused by drug use without aiming for abstinence.[34] The range of services and policies that lessen the adverse consequences of drug use and protect public health is commonly known as "harm reduction." Unlike approaches that insist that people immediately stop using drugs, harm reduction acknowledges that many people are not able or willing to abstain from illegal drug use, and that abstinence should not be a precondition for help. Harm reduction encompasses policies and messages that seek to reduce harm without requiring that a person cease the potentially harmful behavior. The aim is to reduce the harms of the use of psychoactive drugs for those unable or unwilling to stop.[35] Harm reduction is also a tertiary prevention tool, averting the deterioration of physical and psychological health as well as providing for social reintegration. Essential harm reduction measures include needle and syringe programs, safe injection facilities, opioid-overdose antagonists, and drug checking, among others. Examples of harm reduction interventions outside the realm of illegal drug use include nicotine patches, light beer, condoms, seat belts, and protective gear in sports.

When combined with social and psychological support for the individual using drugs, harm reduction can also lead to a decline in problematic drug use. In the cities of São Paulo and Vancouver, the idea of "harm reduction" has been expanded in interesting ways, such as providing unconditional housing and social support to people with problematic drug use, to address not only problematic drug use but also the underlying forms of distress that contribute to the problem.[36]

PEOPLE WHO USE DRUGS

From hygienics to eugenics: when good intentions generate deadly perceptions

Hygienics, or the social hygiene movement, is a movement to prevent communicable infectious diseases by addressing the social roots of these diseases.[40] The concept of hygienism was born in the 19th century and gained momentum between the First and Second World Wars. Hygienics started as a movement of medical doctors and politicians controlling and dictating sanitary standards, educating people on the risk factors in their environment, and addressing the social issues that patients face in order to produce better health outcomes. This approach, which is based on a hygienic lifestyle, was accompanied by punishment of populations that do not subscribe to it, in order to correct human behavior and allow for more hygienic and healthy societies. Between the two World Wars, a period marked by an obsession with "decadent societies," some hygienists turned to eugenics, a movement concerned with the "improvement" of the human species by improving hereditary lines, resulting in extreme cases in the sterilization of individuals deemed useless to society.

In the mid-20th century, hygienics and social hygiene movements experienced a peak in popularity, as they were accompanied by important advances in curative medicine. During this period, two of the three international conventions on the control of drugs were drafted and adopted, calling for the preservation of the "health and welfare of humankind," and referring to addiction to illicit drugs as an "evil." Nevertheless, the hygienics model came into question with the advent of the HIV epidemic and the methods used to address it. Facing the impossible task of changing human behavior through restrictive measures (e.g. mandating the use of condoms), prevention instead emphasizes information, access to appropriate services, de-stigmatization, and the empowerment of vulnerable populations.

REASONS FOR USING DRUGS

In the early twentieth century, a theory arose accounting for what is now called "drug use disorder": doctors and the public increasingly adopted a psychological and moral explanation of addiction. If someone continued to use drugs despite legal prohibition and social disapproval, this was surely a manifestation of "an underlying psycho-pathology, a fundamental defect of character."[37] This provided a reason to pathologize and dismiss vulnerable individuals: their suffering was self-inflicted, and did not require a broader social remedy. This position perceives people who are in trouble as people who cause trouble. As one group of academics expresses it, "people did not so much abuse drugs because they were jobless, homeless, poor, depressed, or alienated; they were jobless, homeless, poor, depressed or alienated because they were weak, immoral, or foolish enough to use illicit drugs."[38] And if the individual is entirely to blame, then there is no urgency to address larger problems of inequality, poverty, breakdown of family, etc. This might also partially explain the apparent paradox where a majority of people in the US believe the "war on drugs" has failed, but they still continue to support greater resources for the same policies.[39]

This moralistic view of drug use and drug use disorder continues to influence public opinion even today. For example, a majority of US Americans do not believe that difficult social conditions are a major cause of drug use.[41] When asked to select terms that describe someone who uses cocaine, the most frequently selected terms were "no future," "lazy," and "self-centered."[42] In a 2016 survey in Scotland, almost half of the respondents believed drug dependence to be due to a lack of self-discipline and willpower (42%).[43] A review of UK newspapers found that heroin use was portrayed as mainly a personal and emotional issue – in contrast to cocaine, which was seen as a lifestyle choice.[44] And a kind of circular logic exists in Nigeria, where many people claim that drugs will drive people to insanity, while at the same believing that drugs are only taken by the insane.[45] Community leaders there refer to people who use drugs as "useless," "worthless people," "irresponsible," and state that they are an embarrassment to their families and their community as a whole.[46] Similarly, a survey conducted in Morocco, Tunisia, Egypt, Lebanon, Pakistan and Afghanistan found that the most-used terms to describe people who inject drugs are "should be punished," "evil/mean persons," "disrespected/disrespectful," and "guilty."[47]

A related common stereotype is that people who use drugs live on the margins of society and are not equal members of it. People who use drugs are thereby dehumanized and labeled

Queen Elizabeth II is offered a drink of Kava during a 1982 visit to Fiji. Credit: © 1982 Tim Graham via Getty Images

as belonging to a subordinate social category ("othering").[48] But when researchers conducted interviews of people in Zurich's "needle park," an open public space where people gathered in the 1980s and 1990s to buy and use drugs, their findings did not conform to this common stereotype.[49] Almost half of those interviewed (49.1%) attended work or school regularly, and lived in an "orderly fashion," either in their own apartment or sharing with friends. Only 1 in 5 of those that frequented the park did not have a job, and lived in a shelter or were homeless. Similar results have been found in a study of economic behavior in three Russian cities in 2004-2005, which found that people who injected drugs had a comparable level of education and employment, and their monthly work income was also comparable to the Russian average.[50]

The reasons experts advance to explain why people seek out psychoactive substances generally contrast with common perceptions. Young people especially might take drugs to experiment and seek a thrill, or to fit in with a peer group. People use drugs because intoxication (when expected) can be a pleasurable experience. Most drug use is social, and drugs are usually consumed in groups, where feelings of disinhibition and talkativeness, which many drugs generate, promote social bonding.[51] The majority of people who use illegal drugs therefore do so for much the same reasons as most of those who consume alcohol: to relax, socialize, for pleasure; and not because they have a dependency.[52]

Drugs are also taken to "feel better." People who suffer from depression, social anxiety, trauma (particularly childhood trauma stemming from sexual and/or physical abuse, rape, or abandonment), stress-related disorders, physical pain, or mental disorders, may take drugs to lessen these feelings of distress, to self-medicate and manage their moods. People also use mind-altering substances to help them forget or to help them cope with the dire circumstances they live in.[53] Someone with a physical dependence on a drug will take it to stave off withdrawal symptoms.

Eva, United States of America

In my early twenties, I was a very successful drug addict. I was living in New York City, working as a freelance magazine writer, and producing articles for well-known publications. I was well-known. I went to fancy parties with velvet ropes and interviewed many people who were world-renowned in the fields that I covered. I was often drunk, hung-over, or high on cocaine but took care to not let that affect the quality of my work.

I recognize that I grew up with a tremendous amount of privilege. I went to an Ivy League university, which is where I first discovered cocaine. I remember saying to a friend, "I should never try it because I know I'll like it." I loved anything that made me feel strong and sharp and smart and amped. The first time I tried cocaine was with two friends, both very wealthy, both very successful – it didn't seem like a huge deal. Everyone had access to it; a few of the cool kids would travel to New York, get some grams and bring them back for special events; then for regular weekends, and then just for regular weekdays.

When I had moved to New York to work in publishing, a friend of mine introduced me to his dealer. I understood, in an abstract way, that cocaine was illegal, but it didn't seem like that big of a deal. I had to text a number and ask for however many "tickets" (= grams of cocaine) I wanted. When my regular dealer was not available, I'd have to call a different one. I remember one night getting into the front seat of an SUV in the East Village. I had started turning around when a voice in the back said, "Don't turn around." I had to just put my hand out and he dropped the bags of cocaine into it. I gave the guy in the front my cash and got out.

There were times when I didn't have enough money; I would still call the dealer and try and get a discount. This never worked; but I heard about women who traded sexual favors for drugs. I didn't, and I'm glad that I didn't.

I got sober when I was 24. I thought that cocaine was my problem but I realized that whenever I drank, I wanted to buy drugs. I haven't had a drink or taken a drug in ten years.

I strongly believe in legal regulation. There was no way that I could have avoided cocaine: my temperament, my financial access, etc. It would have been easier for me to be safe and not have to get into terrifying situations in cars if there had been some legal way for me to access drugs. There were so many times that I knew what I was taking was cut with something, but I was desperate and so I did it anyway. After I got sober I developed a ton of health problems; sometimes I wonder if those were related, in part, to using impure drugs for so long.

I'm grateful to be sober, but I'm also grateful for having experienced being a drug addict. It gives me so much more compassion and a wider depth of understanding of the randomness of who becomes an addict and who doesn't. Almost all of my friends also used cocaine, but at a certain point before their use caused problems they stopped. I couldn't.

Lastly, in today's competitive societies, in which the pressure to perform professionally, athletically or academically can be intense, some will turn to certain drugs, such as illegal or prescription stimulants, to enhance or improve their performance.

These social explanations of drug use are not common knowledge, however, and value judgments still permeate the discourse around illegal drugs, be it in international law, by political or religious leaders, or in courts. For instance, addiction to illegal drugs is called "a serious evil" in the 1961 United Nations Single Convention on Narcotic Drugs, [53] a term not used in treaties on genocide, slavery, apartheid, torture or nuclear proliferation.[55] In India, the Supreme Court has declared that an "offense relating to narcotic drugs or psychotropic substances is more heinous than murder because the latter affects only an individual while the former affects and leaves its deleterious impact on the society, besides shattering the economy of the nation."[56]

Interestingly, in Portugal, drug policy changed when political leaders and civil society challenged the idea that drug use was evil and should always be condemned. The new laws they established in 2001 explicitly acknowledged that the vast majority of drug use had the same motives as the vast majority of alcohol use: to enhance the user's life, and not due to a pathology or underlying problem. This is why the law stipulates that the large majority of people who use drugs need only health advice, to know how to use their drugs as safely as possible.[57]

DRUG USE AS AN INDIVIDUAL PROBLEM

Even if some of the factors mentioned earlier that contribute to drug use are acknowledged, such as childhood trauma, problematic drug use continues to be seen as an individual problem and not one that society needs to deal with. Yet social factors play a much larger role than is widely known or accepted. This has been illustrated by a famous experiment known as "Rat Park," but has also been observed in humans.

The theory that drugs inevitably "hook" their users and enslave them was given some initial scientific backing by experiments in the early twentieth century where rats were placed in isolated cages and offered two bottles: one of pure water, and one of water laced with opiates or cocaine. The rats would heavily use the drugged water and usually overdose. But in the 1970s, researchers noticed a flaw in the experimental procedures: the rat was placed in isolation, with no alternative activities but drug use. They constructed an environment called "Rat Park," where rats lived collectively and had activities they enjoy, like running in wheels and playing with colored balls. Again they had access to both pure water and water laced with opiates. In this social environment, however, opiate use was very low and never caused an overdose.[58]

There is also a clear human illustration of this principle in the studies of American soldiers during and after the Vietnam War. Heroin and opium use was high among US soldiers while in Vietnam, with approximately 43% reporting use, most often by smoking, and just under half of those who used it did so heavily enough to experience dependence, i.e. suffered from physical withdrawal symptoms. It might have been expected, then, that heroin use would be a widespread problem in veterans who returned to the US after the war. However, although 10% had used an opiate since returning from Vietnam, only 1% exhibited a problematic use of heroin one year after returning. The vast majority of those who had consumed heroin regularly in Vietnam did not continue to do so when out of that stressful setting and back in their previous homes and lives.[59]

DRUGS AND CRIME

There is a widespread perception that people who use drugs, and especially people with drug use disorders, engage in criminal activities. There is, of course, an inbuilt circularity to linking crime and drug use. When certain drugs are illegal and their use and/or possession for personal use is a crime, people who use these drugs will by definition be committing crimes.

There are further linkages between drugs and crime, however they are also more a result of a prohibition framework than from drug use itself.

The US government conducted a study in the early twentieth century, before opiates and cocaine-based drugs became illegal, of people with problematic drug use. Three-quarters of self-described "addicts" had steady and respectable jobs.[60] Yet in the months and years after the crackdown, these figures changed and many resorted to other means of subsistence: property crime significantly increased among men, and sex work significantly increased among women.[61]

This was due to a range of mechanisms. When the supply of drugs is transferred from licensed doctors and pharmacies to criminal organizations, the price increases because criminal organizations charge a "risk premium for illegality."[62] Individuals with problematic drug use often cannot afford these inflated prices without resorting to crime themselves. In addition, people who use drugs are often forced out of the mainstream and into marginalized subcultures where crime is rife. Once they have a criminal record, they find it much harder to find employment, thus making the illegal market and criminal activity among their only means of survival.

Repressive drug policies also affect poor communities and those already marginalized even more harshly. This is especially evident when reviewing incarceration rates in the United States. African Americans and Latino populations represent 40% and 38% respectively of those incarcerated for drug-related offenses, while they represent only 13% and 17% of the US population, and the prevalence of use among them is similar to that of white Americans.[63] While the US probably has the best research on this issue, other examples of the special targeting of minorities can be found, with similar racial disparities in drug arrests and sentencing observed in the UK,[64] Canada,[65] and Australia.[66]

People sharing a marijuana cigarette while watching a movie. © Darrin Harris Frisby/Drug Policy Alliance.

This perpetuates a discriminatory mindset that was documented 100 years ago in South Africa, under the British colonial rule of Natal colony, with a state commission claiming that "the smoking of hemp […] renders the Indian Immigrant unfit and unable to perform […] that work for which he was specially brought to this Colony," and that they should therefore forego its use.[67]

There is further evidence that much of the criminality associated with drug use today is in fact a direct result of prohibition, as it has been shown that when there is a move towards some form of legal and licensed use, other forms of crime also decrease. A program of heroin prescription was introduced in Switzerland in 1994. Before entering the program, most participants were involved in drug dealing and other forms of illegal activities. In the six months before joining the program, 70% had committed a crime. The program resulted not only in a large reduction in use of illegal drugs but also in drug-related crime. Criminal involvement by participants fell substantially with respect to the most serious offenses, such as burglary, muggings, robbery and drug trafficking, namely by 50% to 90%.[68]

Yet it is important to note that even under prohibition, the vast majority of people with problematic drug use are not committing any crime other than contravening drug laws. And in fact, people who use drugs are themselves more at risk of being victims of crime than the population at large, e.g. they are eight times more likely to be victims of robbery.[69]

Teresa, Portugal

My name is Teresa, I'm 22 years old and I live in Lisbon, Portugal. I just completed my studies in social work. I love animals and am a fan of psy trance music.

It may be hard to believe, but I don't drink alcohol (ever) and I don't smoke cannabis. However, I'm a tobacco smoker and I occasionally (3-5 times a year) do illegal drugs. My favorite ones are speed (amphetamines), ecstasy (MDMA) and 2C-B, but I've also tried LSD, magic mushrooms, cocaine, mephedrone, and others.

I used to take a lot more drugs than I do now, but over time I learned to choose the right moments. I used to like psychedelics a lot, but nowadays I prefer stimulants. I always do a lot of research about the drugs I consume, and about the best way to do them – regarding the amounts, routes of administration and interactions between them.

All my friends know about this; I don't hide it from them because I'm not ashamed of it and I consider it to be an important part of my life. I would say that my family has some suspicions about my drug use but we never talk about it. Even though I'm sure it doesn't negatively affect my life, I know my family would be disappointed if I admitted it.

Fortunately, I am young enough never to have had to deal with criminalization of my use – in Portugal in 2001 all drugs were decriminalized for personal use. It would be nice to have a permanent place where I could have my drugs tested for purity/content before taking them, so that I would know for sure what I'm putting in my body. Drug checking is allowed under the Portuguese law, and we have it at some music festivals, but there isn't a permanent location that is open all year. This means that no matter how much I try to learn about the drugs I take, it can always go wrong because buying them on the street I don't really know what I'm taking.

MEDIA AND PUBLIC OPINION

Stigma is derived from a Greek word meaning a mark or stain, and it refers to beliefs and/or attitudes. Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. Stigma can be diminished when people believe that an individual is not responsible ("It is not their fault") or their behavior is beyond their control ("They cannot help it"). When stigma is acted upon, the result is discrimination.

Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. It is a human rights violation.

Criminalization means turning an activity into a criminal offense or an individual into a criminal by making the activity they engage in illegal.

The relationship between stigma, discrimination and criminalization is complex, as the social and political sphere, to which stigma and discrimination belong, interplays with criminal law and the judiciary.[79]

Media has a strong influence on how the public perceives drugs. In the US, it has been shown in detailed studies that the public's perceptions "are largely shaped by the content and magnitude of media coverage on the issue."[70] Unfortunately, "drug stories in newspapers and magazines, movies and television dramas, and talk shows frequently portray 'drugs' as instantly addictive, impossible to resist, and sure to bring violence, insanity, or economic and social ruin."[71] Even TV shows that ostensibly want to help "addicts" often perpetuate common beliefs such as the need for "tough love" in a confrontational family intervention, or that an individual needs to hit "rock bottom" in order to accept treatment.[72] The effects of drugs, when reported either for an individual or for society, are portrayed as overwhelmingly negative.[73]

Two narratives of drugs and people who use them have been dominant in the media: one links drugs and crime, the other portrays as inevitable the devastating consequences of drug use on an individual and their immediate environment.

Highlighting the first narrative, a study found that in the UK in 2010, the most frequent trigger for a newspaper headline about drugs were criminal justice stories such as court cases or arrests,[74] thus reinforcing among readers the mental link between the people who use drugs and criminality. Another "drugs and crime" trope is that of the criminal mad on drugs – reported in a sensationalist way and most often unfounded. For example, in May 2012, a homeless man in Miami was attacked by another man who bit into his face, causing severe harm to him. It was widely reported that the attacker, who was shot dead by police, had consumed a synthetic drug known as "bath salts." Following the incident, media reports widely claimed that bath salts are "the drug that's turning users into cannibals."[75] In the autopsy it emerged that the attacker had not used "bath salts" – but very few media outlets retracted their scare stories.[76]

The other dominant media narrative – that drug use consists of an unavoidable descent from early enjoyment to enslavement and a personal "drug hell"[77] – can be traced to the first famous book on the issue, *Confessions of an English Opium-Eater* by Thomas de Quincey, published in 1821.

There have been calls over the past 20 years, even in major media outlets, to take a different look at drug use and drug policies,[78] but these have generally been few and far between and lost within the dominant narratives. We may, however, now be experiencing a shift in media reporting, with encouraging developments such as the coverage of the UN General Assembly Special Session (UNGASS) on drugs held in April 2016. For the first time, the media focused more widely on the failure of the "War on Drugs," the inability of the international community to win this "war," and the need for new approaches.

Winy, mother of Guillermo, Chile

My son Guillermo was born in 2001 with an undiagnosed genetic disorder. At 5 months old, he started having seizures. At first we thought it was sudden infant death syndrome, because in the beginning the principal manifestation of a seizure was that Guillermo stopped breathing in his sleep. It was only when he was two years old that the doctors realized he was having epileptic seizures. We tried everything: a variety of medication, special diets, even brain surgery (callosotomy). Nothing helped. His refractory epilepsy was so bad it got to the point where he had an electrical discharge in his brain every 5 seconds.

In 2013 I started to read articles about cannabis oil and tried unsuccessfully to obtain some from the US. It was only a year later, when I heard about a foundation in Chile that helps in cases like his, that we actually got the oil for the first time. When I started giving it to him, Guillermo did not have seizures for 7 days. Then they returned, but much less frequently. Before he would have about 10 generalized tonic-clonic seizures a day; during the first treatment with cannabis oil he would have only 1 or 2.

In Chile, under the law 20.000, the cultivation and use of cannabis for personal or medical use is allowed. In 2015 the law was adapted, and now the import, sale and scientific investigation of cannabis extracts are also allowed. The pharmacies sell two products, but one bottle, which would last about 7-10 days for Guillermo, costs 200,000 Chilean Pesos [about 300 US Dollars] while the monthly minimum wage is 270,000 pesos [about 420 US Dollars].

To be able to provide Guillermo with the medical cannabis, I grow cannabis at home and then extract the resin – which works better for him than oil. In 2015, I found what I call the "magic strain," the most effective for my son. Guillermo did not have seizures for 4 months and then only had one every 10 days on average. It worked for almost 1 ½ years. Today, I continue to grow cannabis and look for the next magic strain. I never doubt what I am doing. I would do anything for my son that is not a crime. And by that I mean stealing or killing someone. How can it be a crime to grow something in my garden? Even though, in theory, what I do is legal in Chile, I am still afraid that the police might raid my home, claim that I am cultivating to sell, and take away the plants that I need for my son.

My family was shocked at first that I wanted to grow cannabis since it has a bad reputation. Only my mother stood by me. But when they saw the improvement in Guillermo's health, they came around. Same with the doctor. He initially said I was crazy to want to try this but I went ahead and kept him updated. Then one day he read an article in a medical journal about cannabis and epilepsy and changed his mind. He even wrote an article himself, using Guillermo and another patient as case studies, and sent other patients to see me so I could explain to them how to use medical cannabis. I find that things are happening in the reverse order: normally there should be scientific investigation and then a treatment is given to patients. Here, the patients are doing the experimentation and finding the best way to treat their conditions.

STIGMA AND LANGUAGE

The language used when speaking about or referring to people who use drugs has a tremendous impact on how they view themselves and how they are viewed by others.[80] Public opinion and media portrayals reinforce each other while contributing to and perpetuating stigma associated with drugs and drug use. No medical condition is more stigmatized than "addiction."[81] As shown above, public perception is that drug use, including problematic drug use, is a choice and that individuals choose not to control it, i.e. not to stop, and therefore the public generally does not allow for the presence of any mitigating factors.

Commonly encountered terms such as "junkie," "drug abuser," or "crackhead" are alienating, defining people who use drugs solely by their consumption of a particular substance and designating them as "others" – physically inferior or morally flawed individuals. Negative language use also extends to people in recovery who are referred to as "clean," implying they were previously unclean or dirty. And the term "drug abuse" can conjure associations with abhorrent behavior such as child abuse.

This misguided use of language and terminology is stigmatizing for people who use drugs. And stigma results in discrimination, which can be overt or systemic. In Nigeria, people who use drugs have reported being rejected by family and friends, and finding themselves in a condition of profound social isolation, where their network is reduced solely to other people who use drugs. This makes communication with members of the main community practically impossible.[82] Similar experiences have been documented in Tanzania. When individuals who use drugs were asked about their experiences, many reported stigma and resulting discrimination. ''You become a pariah,'' noted one, ''you are in complete default of society's norms.'' Another said, ''I lost my value as a human being.'' One woman summarized: ''Being a junkie causes you to lose all dignity."[83]

FIGURE 3: VICIOUS CYCLE OF PERCEPTIONS OF PEOPLE WHO USE DRUGS

Stigmatizing and discriminating against people who use drugs is not limited to the general public; it can directly impact clinical care.[84] In the US, researchers conducted a randomized study[85] where mental health clinicians were given identical case studies about individuals in court-ordered drug treatment programs. The individual was either referred to as "a substance abuser" or "someone with a substance use disorder." The trained mental health professionals who read about an "abuser" were more likely to believe that the individual in question was personally culpable for their situation and that punitive measures should be taken.

Stigmatization therefore has a perverse double effect: the more society stigmatizes and rejects people who use drugs, the fewer opportunities for treatment will be on offer; at the same time, stigma drives individuals who need help away from those services that are available. Indeed, according to UNODC, only one in six individuals with problematic drug use receives treatment.[86]

Stigma, discrimination and the criminalization of drug use are directly related to the violation of the human rights of people who use drugs, as documented in a 2015 report from the UN High Commissioner for Human Rights. The report gives several examples of clear human rights violations, such as the withholding of methadone or other treatments in order to extract confessions from convicted people who use drugs.[87] Similarly, people's right to life has been violated by extrajudicial executions and the use of the death penalty for drug-related offenses.[88] Women are particularly discriminated against, being imprisoned more for drug-related offenses than for any other crime.[89] Women who use drugs, whom society regards as not fit to be mothers, also face losing custody of their children, without any evidence of neglect other than their status as an individual who uses drugs. They can also be subjected to forced or coerced sterilization, abortion, or criminal sanctions for using drugs while pregnant.[90]

MORAL PANIC – THE CULMINATION OF POLITICS, MEDIA AND PUBLIC OPINION

Negative perceptions and fears of the general public, reinforced by negative media portrayals, have made drugs and people who use them an "easy target" for politicians and other elected officials who want to curry favor with their voters. The strongest example of this is what sociologists have called "moral panics", which designates the behavior of a group, such as a minority or a subculture, that is exaggerated or falsely portrayed as dangerous (often by presenting extreme cases as typical). A well-researched example is the interplay between the reporting in many media outlets in the US in the 1980s of a "plague" of crack cocaine use – without any statistics to back up their claims[91] – and the politicians that were feeding this panic. Several key misconceptions were promoted: that crack was uniquely addictive; that its use was exploding; and that pregnant women consuming crack would produce a generation of "crack babies," who would be severely emotionally, mentally, and physically disabled and would grow up to be "super-predators."[92] In May 1989, the *New York Times* published an editorial apocalyptically declaring that "crack poses a much greater threat than other drugs. It reaches out to destroy the quality of life, and life itself, at all levels of American society."[93] Politics also played a role. During the crack panic, when election campaigns focused on drugs and crack cocaine in particular, these were seen by the public as important social issues, but in the years when there were no elections, drugs were not rated as such an important issue.[94] Campaign promises of being "tough on drugs" translated into severe mandatory minimum sentences being triggered by amounts of crack one hundred times smaller than for powder cocaine.

Information and facts that would disprove their reports were omitted by most media in order to allow the "crack plague" narrative to dominate.[95] However, there was no factual basis for a panic of this magnitude. When scientific surveys were undertaken, it was observed that the overall use of cocaine had not risen but fallen, and the vast majority of users reported snorting cocaine rather than smoking it – meaning they were using powder cocaine, not crack.[96] It was revealed that the most famous report of "crack babies" by mainstream TV news had in fact filmed babies in hospital care whose mothers hadn't even used crack. There were no "crack babies" to be found. Instead of the expected disabilities, it is now thought that cocaine use during pregnancy has a similar effect as tobacco and a less severe effect than alcohol use.[97] The children whose mothers used crack during pregnancy have not grown up to be a generation of "super-predators."[98]

Those whose crack use did become problematic were stigmatized by this hysterical coverage. The changes in mandatory minimum sentencing promised by politicians during their campaigns led to many crack users and minor dealers serving long prison sentences, which in many cases only deepened their problems.[99]

CHANGING HOW WE SPEAK ABOUT DRUGS AND PEOPLE WHO USE THEM

In order to change perceptions, there is a need to change how we speak. As a group of American doctors explains: "In this case where the lives of a historically marginalized population are at stake, there is a need to sacrifice efficiency in favor of accuracy and the potential of minimizing the chances for further stigma and negative bias."[100] The call for language that reduces stigma has been issued by a great number of medical associations,[101] editors of scientific journals,[102] and government officials.[103] At the moment, as discussed before, the media often plays a negative role – but this can change as it has for other groups, e.g. lesbian, gay, bisexual, transgender and intersex (LGBTI) people in Western societies.

An indication of such a shift can be seen already: the *Associated Press Stylebook* of 2017, an important tool for journalists, provides better language to address "addiction" and drug use. The publication advises avoiding the use of words such as "addict," "abuser," or "alcoholic," and calls to replace them with "people who have an addiction," or "people who use drugs."[104] Changes in the language used by the media are still nascent, but they provide hope for more balanced reporting.

FIGURE 4: BETTER LANGUAGE

☑ USE	☒ DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

DRUG CONTROL POLICIES

Public perception and attitudes enable policies that treat people who use drugs as sub-human, non-citizens, and scapegoats for wider societal problems who need to be "punished."[105] And engaging in an act that is illegal in turn increases stigma, making it easier still to dehumanize people who use drugs.

This is revealed in laws and policies that address the "drug problem" and together constitute the "War on Drugs." These repressive policies and their failure according to every measure – including on their own terms – have been discussed elsewhere, including in previous reports by the Global Commission on Drug Policy.[106] They will only be mentioned briefly here to show how they relate to and result from negative perceptions and fears.

PREVENTION

Fear of drugs has translated into messages that all drugs are bad and "will mess up your life." Therefore, the primary message of prevention for many years now has been one of complete abstinence. This was seen most famously in the "Just Say No" campaigns of the 1980s in the US, which have been duplicated in Asia, Africa and Europe.[107] Not only is there little evidence of the effectiveness of such a message, it may in fact be counterproductive, with some studies suggesting that children exposed to this message are more likely to use drugs.[108] Even if the simplistic message – used in primary prevention – might deter use in some, it poses other risks: namely missing the opportunity to provide information on the real harms of drugs and, for those who will experiment nonetheless, to know the safest way of doing so. Furthermore, such messages undermine the possibility of trust between the authorities and young people.[109] Secondary prevention, concerned with the early detection and reduction of alcohol, tobacco, and other drug use once they have begun, is also hindered by the "Just Say No" message: young people who have extensive first-hand experience in their immediate environment of drug use that has not led to serious harm might then disregard all official information. When people mistrust official messages on the topic, seeking out accurate information becomes much harder.

There is evidence that the largest beneficial impact on life-time drug use comes not from public messaging but from programs that focus on early intervention within the close social environment (including school or family) and address issues other than drug use, namely social and behavioral development.[110] If there are to be public awareness campaigns on youth and drug use, a possible way forward is to give honest information, encouraging moderation in youthful experimentation, and prioritizing safety through knowledge. One inspiration for this is safer-sex classes, which have been shown to be significantly more effective than abstinence-only education in reducing harms.[111]

In the Philippines, the government is running a campaign explicitly stating that drug use is a colossal problem in the country, referring to 3.7 million people with problematic use (despite statistics from the Dangerous Drugs board in 2015 suggesting the number was far lower at 1.7 million people using in the past year, a third of them using only once; the number of people with problematic drug use is likely to be much lower). When talking about people who use "shabu," a methamphetamine-like drug, President Duterte has stated that rehabilitation is impossible, and referred to people who use shabu as "the walking dead." Horrific action has followed, with more than 7,025 killings of people who use drugs and "drug pushers" perpetrated by police and vigilante groups between July 2016 and January 2017.[112] Surveys of public attitudes suggested a general satisfaction with this violent crackdown on drugs.[113]

THE CRIMINALIZATION OF USE AND POSSESSION FOR PERSONAL USE

In most of the world, drug use or the possession of small amounts of drugs for personal use are criminal offenses.[114] In general, according to the rule of law that stipulates that laws should be just and protect fundamental rights, an act is declared a crime when it is harmful to one or more individuals and/or to a community, society or the state (a public wrong). Yet drug use is considered a public wrong even though drug use itself poses potential physical harm only to the person who engages in it. Drug use is criminalized as it is seen as a moral issue – even endangering the "social fiber"[115] – rather than one of individual or public health.[116]

Anonymous, Ghana

My neighbors and friends affectionately call me Togoman. I am 53 years old and was a cassava* farmer. I started using marijuana at the age of 19 and still do. I do not consider myself a problematic user. The herb is good, it helps me relax and carry on my work. I am a cool man, I don't drink alcohol and I don't fight in my community. I used to take the herb after a hard day's work to help me relax my aching body and once I take my herb, I eat and sleep.

I would always plant the herb [cannabis] among my cassava crops for personal use and I used to also provide it to some of my fellow farmers. Six years ago, a friend who I often smoked with informed the police about my drug use. I was arrested and charged for possession. I was convicted and sentenced to 10 years in prison. I have already done 6 years, 2 years on remand at Akuse prison and 4 years at the Nsawam medium security prison.

The sale of marijuana within prison walls is even higher than what goes on in open society. So while in prison, I am still able to purchase some from fellow prisoners peddling the drug – when I have money. But you need to be careful not to get caught, otherwise you will be given further punishment while serving your term.

Since my arrest and incarceration, life has been very difficult for me and my family. I am really suffering in prison, it is really tough for me. Prison is not a joke. Going to prison is like a dark cloud for me and my family. It has completely shattered the dreams of my children. They have dropped out of school. My first son, Korshie, was in high school and his younger sister was in junior high school. Both had to drop out of school because there was nobody to pay for their education. Our landlord sacked my family from our residence because my unemployed wife could not afford the annual rent. My boy, Korshie, ended up on the street, as a hawker. My daughter got pregnant and that ended her ambitions. That in all honesty crushed my family.

I pray something is done about the law regarding marijuana. I have never had a problem while using marijuana, neither have I heard someone has died taking the herb. Day in day out we hear about people dying of drinking akpeteshie** yet it is allowed to be sold to people. So why can't they allow us to take our herb? I think authorities must take a second look at the law and consider making it legal for people to use it. I think they should allow for people who desire to produce the substance to do so with close monitoring. I am not a criminal, I am a peace-loving citizen of Ghana. I have never stolen, killed or done anything bad.

** Cassava, also known as yuca, manioc, is a major staple food in West Africa and other parts of the tropics.*

*** Akpeteshie is an alcoholic spirit produced in Ghana.*

LONG SENTENCES AND THE DEATH PENALTY

In many countries, the death penalty is applied to some non-violent drug offenses. This severe punishment reinforces the idea that drug taking is "evil," morally wrong, and should be punished with sentences equivalent to those for the most serious and violent crimes.

In Malaysia, capital punishment is mandatory and automatic for drug trafficking offenses. The other crimes for which this is the case are murder and discharging a firearm with intent to cause death or injury, both crimes where death or injury to another is the intention. However, in Malaysia the tide of public opinion seems to be turning against the enforcement of the mandatory death penalty for non-violent drug crimes, and against the death penalty more generally. A 2012 study reported that the press was supportive of the abolition of the death penalty for drug couriers.[117] While a majority of respondents approved of mandatory death sentences for murder, only 25% approved of it for heroin trafficking.

In many countries, the use of the mandatory death penalty – which deprives judges of considering mitigating factors – for drug possession is triggered by very low thresholds. In Singapore, the mandatory death penalty is enforced for possession of 500 grams of cannabis, 15 grams of heroin, or 30 grams of cocaine.[118]

AS, Malaysia

My name is AS and I'm 38 years old. I'm from Pahang. I have been using drugs for almost 20 years. I inject and smoke and chase all kinds of drugs, but heroin and ice are my main drugs of choice. I've been sentenced to drug detention centers 8 times and 19 times to prison. My life is difficult and I worry about being arrested by the police and being sentenced to the death penalty.

Because of my daily drug use, I am myself a small drug dealer. This pays for my daily consumption, a little bit of food, rent for my room, and a little bit of extra things that can let me enjoy life sometimes. I don't make much money from dealing and if I had a choice to make, I would not be a drug dealer. In Malaysia, if you are arrested with 15g or more of heroin or morphine, or 200g or more of cannabis, you risk the death penalty. This should not happen – nobody should die for possession of drugs. I am not like a murderer or a traitor to the nation.

My family accepted me as a drug user and I managed to take drugs in the house with my mother's permission. But this was a long time ago and I chose not to go back to my house as I am not doing as well as they expected. I was married off when I was 20 years old: it was an arranged marriage. My marriage lasted 10 years and I have twin daughters. I had to let my wife and daughters go because of the pressure from my in-laws during my time in jail. Now I rarely meet my daughters, because of my drug problem.

The same goes for society. People always look at me as if I am useless, like some kind of garbage. They don't trust people who use drugs. They don't see me as a human being. At the moment, I am trying my best to survive in my daily life by doing all kinds of jobs offered by IKHLAS [a local Community-Based Organization], like unloading trucks, or cleaning jobs. But this is not enough to take care of my bills and I have to resort to dealing to make ends meet.

Society will always have a bad perception of us – the drug users. We are a burden for them. But did society ever think what would happen if drug problems concerned their own family members? Society needs to be informed about drug issues. They must know that they don't need to hang drug dealers, or those caught in the street with small amounts of heroin or cannabis for personal use. I am not selling because I want to, but because there is no other choice.

CHANGING PERCEPTIONS

In some areas, change is already underway. We highlight here two ways in which this has come about: leadership and information.

Political leaders have in some instances reviewed the evidence and then taken steps to change drug control policies. Vaclav Havel, president of Czechoslovakia, promoted the decriminalization of drug use and possession in 1990. In Portugal, a coalition of political leaders decided over 15 years ago to set up a scientific panel to make evidence-based recommendations for dealing with the country's drug problems, and agreed to abide by its recommendations whatever they may be.[119] This made possible the decriminalization of drugs that has produced broad positive results, and provides a useful model for other leaders. Indeed, Presidents Jorge Batlle and Jose Mujica in Uruguay, and Prime Minister Justin Trudeau in Canada have recently led their countries in the legal regulation of cannabis. They are leading the world in taking a different approach to drug control policy.

Good leadership and reforms can change public opinion, reversing the vicious cycle of discrimination and repression. In Portugal, since decriminalization, there has been a significant decrease in stigmatizing views of people who use drugs.[120] In the Netherlands, one of the principal motivations of the 1976 legislative changes in the drug law that allowed for *de facto* decriminalization of cannabis was to prevent the stigmatization and marginalization of people who use drugs.[121] Today, the Netherlands has the lowest level of problematic drug use in the European Union, and the overall prevalence of drug use in the general population is below the European Union's average and well below that in the United States.[122]

There is also evidence to suggest that the public supports more pragmatic and evidence-based drug policies when they have been given credible and evidence-based information about those policies, as was the case in Switzerland. In 1997, over 70% of Swiss voters supported the new national drug policy based on the "four-pillars" of prevention, treatment, harm reduction, and law enforcement.[123] Two years later, 54.3% voted in favor of allowing heroin-assisted treatment to continue.[124] A decade later, in 2008, a referendum on the "four-pillar" Swiss drug policy again passed with 68% of the vote.[125]

When voters were asked about their reasoning, pragmatic motives were most often stated, such as the proven effectiveness of the treatment and positive health outcomes. This was in contrast to previous years where basic beliefs and convictions were more often cited as motivating voters.[126] The Swiss experience is exemplary in how it amassed hard data to make the case for the public health impact of harm reduction,[127] and presenting evidence that crime had been reduced and that people using drugs were reintegrated into the workforce. It shows that it is possible to persuade people who are concerned about public order and security that alternative drug policies can be more effective in reducing drug-related harms.[128]

Opposite page: Nicolas Schorpp is a patient at the Geneva University Hospitals (HUG) who receives medical-grade heroin to manage his dependence on the drug and lead a balanced, healthy life. Credit: © 2017 Richard Juillart.

RECOMMENDATIONS

I Policy makers must aim to change current perceptions of drugs and people who use them by providing reliable and consistent information.

Good leadership strives to influence public opinion for the better. Political leaders are instrumental in shaping what the public believes, and have a moral responsibility to provide evidence-based and accurate information. Leaders must be bold when disputing perceptions about drugs which are not grounded in facts and which may be discriminatory towards people who use drugs, and stand their ground in the face of public opinion. When political leaders choose to stoke fears about drugs and drug use in order to retain or intensify prohibition, they are indirectly causing serious hardship to some of their most vulnerable citizens. When political leaders instead choose to challenge some of the current perceptions about drugs and people who use them, they can make a real difference. In the last two decades, principled actions from some political leaders in Europe and Latin America have already led to changes in attitudes towards drug control which have in turn led to harm reduction, decriminalization and regulation becoming public policy, and to improvements in public health in their countries.

II Opinion leaders must live up to their responsibility in shaping public opinions and perceptions on drugs, and promote the use of non-stigmatizing and non-discriminatory language.

Media, religious leaders, intellectuals, celebrities and other influencers have the potential to be powerful allies in correcting misinformation surrounding drug use and reducing the stigma towards people who use drugs. In particular, the use of degrading and inappropriate language – such as "junkies," "zombies," and "fix rooms" – should be addressed and corrected. They must restrain from further propagating misinformed beliefs which can potentially result in disastrous situations for people who use drugs, their communities, and the most vulnerable parts of society.

III Take part in the debate, sustain activism and advocacy, and keep governments, parliaments, the judiciary, mayors, media, healthcare and social professionals accountable.

Ordinary citizens have the capacity to transform this debate. Activism must be sustained, to develop the ability of civil society to hold governments, the media and other stakeholders accountable. The creation of national and regional networks of people who use drugs must be promoted to enable them to stand up effectively for their rights in every community. Other civil society actors in the areas of human rights, infectious diseases, criminal justice and non-communicable diseases need to come together to overturn the negative perceptions in society and reduce stigma, as well as denounce current drug policies and promote evidence-based reforms to the law. Some civil society groups have already developed a global vision to address the negative impacts of prohibition, and they have opened the debate within the health, criminal justice, security and enforcement, social justice and human rights sectors. Groups of citizens have been successful in influencing the global advocacy for drug policy reform and in coordinating and strengthening capacities at the global, national and local levels. This advocacy must be sustained.

IV **Stop acts of harassment based on negative perceptions of people who use drugs.**

Law-enforcement agents must stop acts of harassment against people who use drugs, such as intimidation, unwarranted searches, unwarranted seizure of property and racial profiling. Instead they should focus on the social role of law enforcement by directing them towards health and social services if they need it, and simply issue warnings for those who do not experience problematic drug use but have disturbed public order by using drugs in the public sphere. The judiciary system must consider drug dependence or problematic drug use as a mitigating factor in sentencing petty crime cases, instead of considering them as an aggravating factor. Incarcerating people that need medical and social support only exacerbates social ills and does not prevent them. Law enforcement plays a central role in the general population's perception of people who use drugs. In collaboration with other drug policy stakeholders, they can address the perception-based character of criminalization and ensure the rule of law.

V **Putting health and safety first requires the medical community and healthcare professionals to be vocal in promoting evidence-based prevention, treatment, and harm reduction services, and to urgently address perception-based stigma in healthcare settings.**

Doctors, nurses, and other healthcare workers who are in contact with people who use drugs have a major role to play in changing the perceptions on drugs. They are often the first point of contact with people who use drugs, and can be influential in feeding evidence back to the public. As they are in a position of trust, they must play an important advocacy role in improving the provision of services for people with problematic drug use. In particular, experienced healthcare professionals must be vocal in defending the usefulness of treatments that have proven effective – by speaking up in support of opioid substitution treatment, for example, which is still stigmatized by large portions of society.

VI **Take advantage of the opportunity presented by the upcoming UN Commission on Narcotic Drugs' Ministerial Segment in 2019 to review the use of language in international documents and in negotiations.**

Member States must review their use of language and their prejudices while negotiating international political agreements on drug control. The UN Secretary-General must ensure the UN system provides a consistent, people-centered language when addressing drugs, in line with the sustainable development agenda. UN entities must continue providing evidence-based publications and panels in order to inform diplomats, policy makers and citizens the world over on the facts and aim to change existing perceptions. To date, the UN political declarations and plans of action on drug policy have perpetuated demeaning and harmful language, referring to people as "drug users," and calling to "counter" and "fight" drugs. They also failed to include services that provide evidence-based tertiary prevention and risk mitigation, such as "harm reduction." Meanwhile, other international mechanisms have made more progress in providing better language and descriptions of drugs and people who use them. Those texts were for the most part not negotiated by Member States, but rather produced by UN entities such as specialized agencies, Funds and Programs.

REFERENCES

1 Jay, M. (2012) *High society*. London: Thames & Hudson.

2 Brown, D. E. (1991) *Human Universals*. New York: McGraw-Hill Education.

3 Adopted from Jay, M. (2012) *High society*. London: Thames & Hudson.

4 Nutt, D.J., King, L.A., Phillips, L.D., (2010) Drug harms in the UK: a multicriteria decision analysis. *The Lancet,* 376 (9752), pp. 1558–1565.

5 Nutt, D., King, L.A., Saulsbury, W., Blakemore, C. (2007) Development of a rational scale to assess the harm of drugs of potential misuse. *The Lancet*, 369 (9566), pp. 1047–1053.

6 UN scheduling comparison from Global Commission on Drug Policy 2011 "~~War~~ on Drugs" Report, as illustrated by Figure 1 in the present report.

7 Fischer, B., Oviedo-Joekes, E., Blanken, P., Haasen, C., Rehm, J., Schechter, M.T., Strang, J., van den Brink, W. (2007) Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics. *Journal Urban Health*, 84 (4), pp. 552–562.

8 National Addiction Centre (2003) *Dangerousness of Drugs: A Guide to the Risks and Harms Associated with Substance Misuse*. Available at: http://www.nta.nhs.uk/uploads/dangerousnessofdrugsdh_4086293.pdf (accessed on 23 November 2017)

9 Jay, M. (2012) *High society*. London: Thames & Hudson

10 For cannabis, a three-stage model for learning to use a drug for pleasure has been proposed: A new user first has to learn the technique, i.e. to smoke cannabis in a way that will produce effects; secondly he/she has to learn to recognize the effects, such as head-spinning and increased appetite, and connect them to the drug used; lastly he/she has to learn to redefine the effects and enjoy those sensations. In most cases, this learning process is accompanied by experienced users, i.e. it has a strong social element in the context of a subculture. See Becker, H.S. (1953) Becoming a Marihuana User. *American Journal of Sociology,* 59 (3), pp. 235-242.

11 For more on kava, see Fehoko, E. (2014) *Pukepuka fonua: An exploratory study on the faikava as an identity marker for New Zealand-born Tongan males in Auckland, New Zealand* (Unpublished Master's Thesis). Auckland: Auckland University of Technology; Aporosa, S. (2011) Is kava alcohol? The myths and the facts. *Pacific Health Dialog*, 17 (1), pp. 157-164; Aporosa, S. (2012) *Yaqona (kava) and education in Fiji: Investigating "cultural complexities" from a post-development perspective* (Unpublished PhD Thesis). Palmerston North, NZ: Massey University; Fehoko, E. (2015) Social space and cultural identity: The faikava as a supplementary site for maintaining Tongan identity in New Zealand. *New Zealand Sociology*, 30 (1), pp. 131-139; Finau, S., Stanhope, J., Prior, I. (1982) Kava, alcohol and tobacco consumption among Tongans with urbanisation. *Social Sciences and Medicine*, 16, pp. 35-41; Lebot, V., Merlin, M., Lindstrom, L. (1997) *Kava: The Pacific elixir: The definitive guide to its ethnobotany, history and chemistry.* Rochester, VT: Healing Arts Press; Lemert, M. (1967) Secular use of kava in Tonga. *Quarterly Journal of Studies on Alcohol*, 28 (2), pp. 328-341; Sarris, J., et al (2013) Kava in the treatment of generalised anxiety disorder: A double-blind, randomised, placebo-controlled study. *Journal of Clinical Psychopharmacology*, 33 (5), pp. 643-648; Singh, Y.N. (ed.) (2004) *Kava: From ethnology to pharmacology*. London: CRC Press; Singh, Y.N., Blumenthal, M. (1997) Kava: An overview. *Herbalgram*, 39 (1), pp. 34-56.

12 Nag, O. (2017) 14 Countries Where Drinking Alcohol Is Illegal. WorldAtlas. http://www.worldatlas.com/articles/14-countries-where-drinking-alcohol-is-illegal.html (accessed on 23 November 2017).

13 Blickman, T. (2017) *Morocco and Cannabis: Reduction, containment or acceptance*. Amsterdam: Transnational Institute. Available at: https://www.tni.org/files/publication-downloads/dpb_49_eng_web.pdf (accessed on 22 November 2017)

14 Windle, J. (2012) Insights for Contemporary Drug Policy: A Historical Account of Opium Control in India and Pakistan. *Asian Journal of Criminology*, 7 (1), pp. 55–74.

15 Speaker, S. L. (2004) Demons for the Twentieth Century – The Rhetoric of Drug Reform, 1920-1940. Pp. 203-224 in Tracy, S.W., Acker, C.J. (ed.) (2004) *Altering American Consciousness: The History of Alcohol and Drug Use in the United States, 1800-2000*. Amherst: University of Massachusetts Press.

16 National Institute on Drug Abuse (2016) *The Science of Drug Abuse and Addiction: The Basics*. https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics (accessed on 28 August 2017).

17 O'Brien, C.P., Volkow, N., Li, T.-K. (2006) What's in a Word? Addiction Versus Dependence in DSM-V. *American Journal of Psychiatry*, 163 (5), pp.764–765.

18 World Health Organization, (1992) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Available at: http://www.who.int/classifications/icd/en/bluebook.pdf

19 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2014) *High-risk drug use key epidemiological indicator.* Available at: http://www.emcdda.europa.eu/activities/hrdu (accessed on 28 August 2017).

20 United Nations Office on Drugs and Crime (UNODC) (2017) *World Drug Report 2017*, UNODC.

21 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2017) *European Drug Report 2017: Trends and Developments*. Luxembourg: Publications Office of the European Union.

22 Hart, C. (2013) *High Price: A Neuroscientist's Journey of Self-Discovery That Challenges Everything You Know About Drugs and Society.* Reprint edition, ed. Harper; also Nutt, D. (2012) *Drugs Without the Hot Air.* Cambridge: UIT Cambridge Ltd.

23 Of those who try heroin about 23 percent develop dependence. For cannabis, it is 9 percent, for cocaine it is about 17 percent. Out of those who try legal drugs, about 15 percent develop dependence

on alcohol and for tobacco it is about 32 percent. See Anthony, J., Warner, L., Kessler, R. (1994) Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: Basic findings from the National Comorbidity Survey. *Experimental and Clinical Psychopharmacology*, 2 (3), pp. 244-268.

24 Waxman, O.B. (2017) Bill Clinton Said He "Didn't Inhale" 25 Years Ago — But the History of U.S. Presidents and Drugs Is Much Older. *Time*. Available at: http://time.com/4711887/bill-clinton-didnt-inhale-marijuana-anniversary/ (accessed on 22 November 2017).

25 Seelye, K.Q. (2006) Barack Obama, asked about drug history, admits he inhaled. *The New York Times*. Available at: http://www.nytimes.com/2006/10/24/world/americas/24iht-dems.3272493.html (accessed on 23 November 2017).

26 This is such a widespread claim in the US and Britain that the NIH feels the need to rebut it on their website. https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/use-medications-methadone-buprenorphine (accessed on 28 November 2017).

27 Amato. L., Davoli, M., A.Perucci, C., Ferri, M., Faggiano, F., P. Mattick, R. (2005) "An overview of systematic reviews of the effectiveness of opiate maintenance therapies: available evidence to inform clinical practice and research." *J. Subst. Abuse Treat*, 28 (321) pp. 321-329; McHugh, R.K. et al. (2010). Cognitive-Behavioral Therapy for Substance Use Disorders. *Psychiatr. Clin. North Am.,* 33 (3), pp. 511-525; Hagedorn, H.J., Noorbaloochi, S., Simon, A.B., Bangerter, A., Stitzer, M.L., Stetler, C.B., Kivlahan, D. (2013) Rewarding early abstinence in Veterans Health Administration addiction clinics. *J. Subst. Abuse Treat.,* 45 (1), pp. 109-117; Petry, N.M., Carroll, K.M. (2013) Contingency management is efficacious in opioid-dependent outpatients not maintained on agonist pharmacotherapy. *Psychol. Addict. Behav.*, 27 (4), pp. 1036-1043; Dutra, L. ., Stathopoulou, G., Basden, S.L., Leyro, T.M., Powers, M.B., Otto, M.W. (2008) A meta-analytic review of psychosocial interventions for substance use disorders. *Am. J. Psychiatry*, 165 (2), pp. 179-187; Lussier, J.P. (2006) A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction* 101 (2), pp.192-203; Seigers, D.K., Carey, K.B. (2010). Screening and brief interventions for alcohol use in college health centers: a review. *J. Am. Coll. Health*, 59 (3), pp. 151-158; Burke, B.L., Arkowitz, H., Menchola, M. (2003) The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *J. Consult. Clin. Psychol.*, 71 (5), pp. 843-861; Slomski, A. (2014) Mindfulness-Based Intervention and Substance Abuse Relapse. *J. Am. Med. Ass'n*, 311 (24), p. 2472; Witkiewitz, K., Bowen, S. (2010) Depression, craving, and substance use following a randomized trial of mindfulness-based relapse prevention. *J. Consult. Clin. Psychol.*, 78 (3), pp. 362-374; Bowen, S. et al. (2009) Mindfulness-based relapse prevention for substance use disorders: a pilot efficacy trial. *Subst. Abus.*, 30 (4), pp. 295-305; Zgierska, A., Rabago, D., Chawla, N., Kushner, K., Koehler, R., Marlatt, A. (2009) Mindfulness meditation for substance use disorders: a systematic review. *Subst. Abus.*, 30 (4), pp. 266-294.

28 Fischer, et al. (2007) *Drug user involvement in treatment decisions*. Joseph Rowntree Foundation. https://www.jrf.org.uk/report/drug-user-involvement-treatment-decisions (accessed on 22 November 2017).

29 World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS (2004) *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 (accessed on 28 November 2017).

30 Venosa, A. (2016) Mandatory Treatment For Drug Addiction Is Ineffective, Violates United Nations Human Rights Treaty. *Medical Daily*. Available at: http://www.medicaldaily.com/drug-addiction-united-nations-human-rights-390207 (accessed on 22 November 2017).

31 Human Rights Watch (2012) Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and Lao PDR. Available at: https://www.hrw.org/report/2012/07/24/torture-name-treatment/human-rights-abuses-vietnam-china-cambodia-and-lao-pdr (accessed on 23 November 2017).

32 Id Dima, victim of a vigilante group, in Saucier, D.W., Kingsbury, R.K., Silva, P. (2011) *Russia: When Vigilantes Step In. Treated with Cruelty: Abuses in the Name of Drug Rehabilitation*. New York: Open Society Foundations. Available at: https://www.opensocietyfoundations.org/sites/default/files/treatedwithcruelty.pdf (accessed on 17 August 2017). For similar reports from Myanmar, see Jensema, E., Kham, N. P. E. (2016) Found in the dark. TNI drug policy briefing 47. Available at https://www.tni.org/en/publication/found-in-the-dark (accessed on 10 August 2017)

33 Amon, J.J., Pearshouse, R, Cohen, J.E., Schleifer, R. (2014) Compulsory drug detention in East and Southeast Asia: evolving government, UN and donor responses. *International Journal of Drug Policy*, 25 (1), pp. 13-20.

34 For example, the WHO/UNODC/UNAIDS *Evidence for Action* series and policy briefs (18). Available at: http://www.who.int/hiv/pub/idu/evidence_for_action/en/index.html; Institute of Medicine, Committee on the Prevention of HIV Infection Among Injecting Drug Users in High-Risk Countries (2006) *Preventing HIV infection among injecting drug users in high-risk countries: an assessment of the evidence*. Washington, DC: National Academies Press (14); Gowing, L. et al. (2008) Substitution treatment of injecting opioid users for prevention of HIV infection (review) *Cochrane Database of Systematic Reviews* (2); Degenhardt, L. et al. (2010) HIV prevention for people who inject drugs: why individual, structural, and combination approaches are required *The Lancet*, 376 (9737), pp. 285–301; Altice, F.L. et al (2010) Treatment of medical, psychiatric, and substance-use comorbidities in people infected with HIV who use drugs. *The Lancet*, 376 (9738), pp. 367–387; MacArthur, G. et al (2012) Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *BMJ: British Medical Journal*, 345 (137).

35 Lenton, S., Single, E. (1998) The definition of harm reduction. *Drug and Alcohol Review*, 17 (2), pp. 213–220.

36 Tinasti, K., Audoin, B., Jomier, B., Delfraissy, J.F., Lévy, Y., Barré-Sinoussi, F. (2016) Cities Central to HIV Response for People Who Use Drugs. *Lancet HIV*, 3 (5), pp. 197-199.

37 Tracy, S. W., Acker, C.J. (2004) Introduction. In Tracy, et al., *Altering American Consciousness: The History of Alcohol and Drug Use in the United States, 1800-2000*. University of Massachusetts Press.

38 Reinarman, C., Levine, H.G. (1997) The Crack Attack: Politics and Media in the Crack Scare, pp. 18-51, in Reinarman, C., Levine, H.G. (eds.) *Crack in America: Demon Drugs and Social Justice*. University of California Press.

39 Blendon, R. J., Young, J.T. (1998) The Public and the War on Illicit Drugs, *Journal of the American Medical Association*, 279 (11), pp. 827-832.

40 Curtis, V.A. (2007) A natural history of hygiene *The Canadian Journal of Infectious Diseases & Medical Microbiology*, 18 (1), pp. 11–14.

41 Blendon, R.J., Young, J.T. (1998) The Public and the War on Illicit Drugs. Journal of the American Medical Association, 279 (11), pp. 827-832.

42 Ibid.

43 Belcher, A., McGregor, D. (2016) *Public Attitudes Towards People with Drug Dependence and People in Recovery*. Scottish Government Progressive Partnership. Available at: http://www.gov.scot/Publications/2016/06/3496/1.

44 UK Drug Policy Commission (2010). *Representations of Drug Use and Drug Users in the British Press. A Content Analysis of Newspaper Coverage*. http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Representations%20of%20drug%20use%20and%20drug%20users%20in%20the%20British%20press.pdf

45 Klein, A. (2001) Have a Piss, Drink Ogogoro, Smoke Igbo, but don't take Gbana - Hard and Soft Drugs in Nigeria: A Critical Comparison of Official Policies and the View on the Street. *Journal of Psychoactive Drugs*, 33 (2), pp. 111-119.

46 NSRP and International Alert (2017) *Out of the shadows - Adopting a peacebuilding approach to the social effects of drug use in Nigeria*. Available at: http://www.international-alert.org/sites/default/files/Nigeria_DrugUse_EN_2017.pdf

47 Abaza, O. (2017) *Multicentre Operational Research on Drug Use and Harm Reduction among People living with HIV/AIDS in the Middle East and North Africa Region*. Beirut: Menahra. Available at: http://fileserver.idpc.net/library/Operational_Research_MENAHRA.pdf

48 Lunze, K., Lunze, F.I., Raj, A., Samet, J.H. (2015) *Stigma and Human Rights Abuses against People Who Inject Drugs in Russia–A Qualitative Investigation to Inform Policy and Public Health Strategies*. *PLoS ONE*, 8 (10).

49 Grob, P.J. (1994) The needle park in Zurich: the story and the lessons to be learned. *European Journal on Criminal Policy and Research*, 1 (2), pp. 48-60.

50 Wall, M., et al. (2011) Sex, drugs and economic behaviour in Russia: a study of socio-economic characteristics of high risk populations. *International Journal of Drug Policy*, 22 (2), pp. 133-139.

51 Nutt, D. (2012) *Drugs - without the hot air: Minimising the harms of legal and illegal drugs*. Cambridge: UIT Ltd.

52 See for example discussion in Kleiman, M.A.R., Caulkins, J.P., Hawken, A. (2011) *Drugs and Drug Policy: What Everyone Needs to Know*. Oxford: Oxford University Press.

53 Khoury, L., Tang, Y.L., Bradley, B., Cubells, J.F., Ressler, K.J. (2010) Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depress. Anxiety,* 27 (12), pp. 1077-1088.

54 United Nations (1961) *The Single Convention on Narcotic Drugs*. UNODC. Available at: https://www.unodc.org/pdf/convention_1961_en.pdf (accessed on 12 June 2016).

55 Lines, R. (2010) 'Deliver us from Evil?' – The Single Convention on Narcotic Drugs, 50 Years On. *International Journal on Human Rights and Drug Policy*, 1 (3), p. 7.

56 Pasayat. J.A (2003) Union of India vs Kuldeep Singh on 8 December, 2003. 2 SCC 590

57 Domosławski, A. (2011) *Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use*. Warsaw: Open Society Foundations.

58 Alexander, B.K., Coambs, R.B., Hadaway, P.F., (1978) The effect of housing and gender on morphine self-administration in rats. *Psychopharmacology*, 58 (2), pp. 175–179; Alexander, B.K., Beyerstein, B.L., Hadaway, P.F., Coambs, R.B., (1981) Effect of early and later colony housing on oral ingestion of morphine in rats. *Pharmacology Biochemistry and Behavior*, 15 (4), pp. 571–576.

59 Robins, L.N., Helzer, J.E. (1975) Drug use among Vietnam veterans; Three years later. *Medical World News,* 16, pp. 44-49; Robins et al., (1980) Vietnam veterans three years after Vietnam, pp. 213-230. In Brill, Winick (ed.). *The Yearbook of Substance Use and Abuse, 11*. Human Science Press.

60 US Treasury Department (1919) *Traffic in Narcotic Drugs. Report of Special Committee of Investigation appointed March 25, 1918, by the Secretary of the Treasury*. Washington D.C..

61 Williams, H. S. (1938) *Drug addicts are human beings: the story of our billion-dollar drug racket: how we created it and how we can wipe it out*. Washington D.C.: Shaw Publishing Co.

62 See e.g. Reuter, P., Kleiman, M.A.R. (1986) Risks and Prices: An Economic Analysis of Drug Enforcement. *Crime and Justice,* 7, pp. 289–340; Miron, J.A., Zwiebel, J. (1995) The Economic Case Against Drug Prohibition. *The Journal of Economic Perspectives,* 9, pp. 175–192.

63 African Americans represent 40% of federal and state prison populations while Hispanics make up 38% of federal prison populations. Drug Policy Alliance (2016) *The Drug War, Mass Incarceration and Race*. Available at: http://www.drugpolicy.org/sites/default/files/DPA%20Fact%20Sheet_Drug%20War%20Mass%20Incarceration%20and%20Race_%28Feb.%202016%29_0.pdf (accessed on 31 August 2017).

64 Eastwood, N., Shiner, M., Bear, D. (2013) *The Numbers In Black And White: Ethnic Disparities In The Policing And Prosecution Of Drug Offences In England And Wales*. London: Release. Available at: http://www.release.org.uk/publications/num-bers-black-and-white-ethnic-disparities-policing-and-prosecution-drug-offences (accessed on 13 April 2017).

65 Campbell, T. (2011) *Pros & Cons: A Guide to Creating Successful Community-Based HIV and HCV Programs for Prisoners* (Second Edition). Toronto: Prisoners with HIV/AIDS Support Action Network. Available at: http://librarypdf.catie.ca/pdf/ATI-20000s/26374.pdf (accessed on 13 April 17).

66 Australian Institute of Criminology (2012) *Australian crime: Facts and figures 2011*. Available at: http://www.aic.gov.au/media_library/publications/facts/2011/facts_and_figures_2011.pdf (accessed on 13 April 2017).

67 Natal (Colony), Indian Immigrants Commission. (1887). *Report of the Indian Immigrants Commission, 1885-1887*. (Wragg Commission). Pietermaritzburg, South Africa. Available at: http://scnc.ukzn.ac.za/doc/INDENTURE/Reports/Report_indian_immigrants_commission_1885_7_Wragg_Commission.pdf

68 Killias, M., Aebi, M. F. (2000) The Impact of Heroin Prescription on Heroin Markets in Switzerland Crime Prevention Studies. *Crime Prevention Studies*, 11, pp. 83-99.

69 McElrath, K., Chitwood, D.D., Comerford, M. (1997) Crime Victimization among Injection Drug Users. *Journal of Drug Issues*, 27, pp. 771–783.

70 Blendon, R. J., Young, J.T. (1998) The Public and the War on Illicit Drugs. *Journal of the American Medical Association JAMA*, 279 (11), pp. 827-832.

71 Speaker, S. L. (2004) *Demons for the Twentieth Century – The Rhetoric of Drug Reform, 1920-1940*, pp. 203-224 in Tracy, S. W., Acker. C.J. (eds.) *Altering American Consciousness: The History of Alcohol and Drug Use in the United States, 1800-2000*. Amherst: University of Massachusetts Press

72 Kosovski, J.R., Smith, D.C. (2011) Everybody Hurts: Addiction, Drama, and the Family in the Reality Television Show Intervention. *Substance Use & Misuse*, 46 (7), pp. 852-858.

73 UK Drug Policy Commission (2010). *Representations of Drug Use and Drug Users in the British Press. A Content Analysis of Newspaper Coverage*. http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Representations%20of%20drug%20use%20and%20drug%20users%20in%20the%20British%20press.pdf

74 Ibid.

75 Thompson, M. (2012) Drug that's turning users into cannibals: Mind-altering "bath salts" blamed for three zombie style attacks. *Mirror Online*.

76 Elfrink, T. (2014) Bath Salts Didn't Cause the Miami Cannibal Attack, Scientists Say. *Miami New Times*.

77 Jay, M. (2012) *High society*. London: Thames & Hudson.

78 For example, The Economist (2001) The case for legalization. *The Economist*. Available at: http://www.economist.com/node/709603 (accessed on 24 November 2017).

79 UNAIDS (2015) *UNAIDS Terminology Guidelines*. Geneva. Available at: http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf

80 See also van Boekel, L.C. et al (2013) Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug Alcohol Depend.*, 131, pp. 23-53; Brener, L. (2010) The role of physician and nurse attitudes in the health care of injecting drug users. *Substance Use & Misuse*, 45 (7-8), pp. 1007-1018.

81 Room, R., Rehm, J., Trotter, R. T., Paglia, A., Üstün, T. B. (2001). Cross-cultural views on stigma valuation parity and societal attitudes towards disability. pp. 247-253. In Üstün, T. B., Chatterji, S., Rehm, J., Saxena, S., Bickenbach, J. E. (ed.). *Disability and culture: Universalism and diversity,* 247–291. Seattle, WA: Hofgrebe & Huber; also Phillips, L.A., Shaw, A., "Substance use more stigmatized than smoking and obesity." *Journal of Substance Use*, 18 (4), 247-253. (2001).

82 NSRP and International Alert (2017) *Out of the shadows - Adopting a peacebuilding approach to the social effects of drug use in Nigeria*. Available at: http://www.international-alert.org/sites/default/files/Nigeria_DrugUse_EN_2017.pdf

83 Zamudio-Haas, S. et al (2016) Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania. *International Journal of Drug Policy*, 30, pp. 43-51.

84 Kelly, F. J., Saitz, R., Wakeman, S. (2016) Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an 'Addiction-ary.' *Alcoholism Treatment Quarterly*, 34 (1), pp. 116-123.

85 Kelly, J., Westerhoff, C. (2010) Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, 12 (3), pp. 202-207; See also Henderson, S. et al. (2010) Social stigma and the dilemmas of providing care to substance users in a safety-net emergency department. *Journal Health Care Poor Underserved*, 19 (4), pp. 1336-1349; McCreaddie, M. et al. (2010) Routines and rituals: a grounded theory of the pain management of drug users in acute care settings. *Journal of Clinic. Nursing*, 19, pp. 2730–2740.

86 UNODC (2014) *World Drug Report 2014*. Geneva: United Nations.

87 OHCHR (2015) *Study on the impact of the world drug problem on the enjoyment of human rights - Report of the United Nations High Commissioner for Human Rights*, A/HRC/30/65, paragraph 37.

88 Ibid., paragraph 41.

89 Ibid., paragraph 52.

90 Ibid., paragraph 53.

91 Reinarman, C., Levine, H.G. (1997) The Crack Attack: Politics and Media in the Crack Scare, pp. 18-51, in Reinarman, C., Levine, H.G. (eds.) *Crack in America: Demon Drugs and Social Justice*. University of California Press.

92 See for example Haberman, C. (2014) When Youth Violence Spurred 'Superpredator' Fear. *The New York Times*. Available at: https://www.nytimes.com/2014/04/07/us/politics/killing-on-bus-recalls-superpredator-threat-of-90s.html (accessed on 22 August 2017).

93 Reinarman, C., Levine, H.G. (1997) The Crack Attack: Politics and Media in the Crack Scare, pp. 18-51, in Reinarman, C., Levine, H.G. (eds.) *Crack in America: Demon Drugs and Social Justice*. University of California Press; *The New York Times (1989)* Crack; A Disaster of Historic Dimension, Still Growing, *The New York Times*. Available at: http://www.nytimes.com/1989/05/28/opinion/crack-a-disaster-of-historic-dimension-still-growing.html?pagewanted=all.

94 Reinarman, C., Levine, H.G. (1997) The Crack Attack: Politics and Media in the Crack Scare, pp. 18-51, in Reinarman, C., Levine, H.G. (eds.) *Crack in America: Demon Drugs and Social Justice*. University of California Press.

95 Ibid.

96 Ibid.

97 Slotkin, T.A. (1998) "Fetal Nicotine or Cocaine Exposure: Which One is Worse? *Journal of Pharmacol. Experimental Therapeutics*, 285 (3), pp. 931-945.

98 See for example Baum, D. (1997) *Smoke and Mirrors: The War on Drugs and the Politics of Failure*. Boston: Back Bay Books.

99 Palamar, J.J., Davies, S., Ompad, D.C., Cleland, C.M., Weitzman, M. (2015) Powder Cocaine and Crack Use in the United States: An Examination of Risk for Arrest and Socioeconomic Disparities in Use. *Drug Alcohol Depend.*, 149, pp. 108–116.

100 Kelly, F. J., Saitz, R., Wakeman, S. (2016) Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an 'Addiction-ary.' *Alcoholism Treatment Quarterly*, 34 (1), pp. 116-123.

101 American Medical Association (2015) *Patients with Addiction Need Treatment - Not Stigma* Available at: https://www.asam.org/resources/publications/magazine/read/article/2015/12/15/patients-with-a-substance-use-disorder-need-treatment---not-stigma; American Society of Addiction Medicine (2013) *Terminology related to the spectrum of unhealthy substance use*. Available at: http://www.asam.org/advocacy/find-a-policy-state ment/view-policy-statement/public-policy-statements/2014/08/01/terminology-related-tothe-spectrum-of-unhealthy-substance-use.

102 International Society of Addiction Journal (2015) *Statements and Guidelines Addiction Terminology*. Available at: http://www.isaje.net/addiction-terminology.html (accessed on 28 August 2017).

103 Botticelli, M., Director of the Office of National Drug Control Policy (2017). *Memorandum to Heads of Executive Departments and Agencies on Changing the Language of Addiction*, dated 9 January 2017. Available at: https://obamawhitehouse.archives.gov/sites/whitehouse.gov/files/images/Memo%20-%20Changing%20Federal%20Terminology%20Regrading%20Substance%20Use%20and%20Substance%20Use%20Disorders.pdf.

104 Associated Press (2017). *The Associated Press Stylebook 2017: and Briefing on Media Law*.

105 INPUD (2011) *Statement and Position Paper on Language, Identity, Inclusivity and Discrimination*. Available at: https://inpud.wordpress.com/position-papers/inpud-position-statement-on-language-identity-inclusivity-and-discrimination/

106 See, for example, ~~*War*~~ *on Drugs* (2011); *Taking Control:*

Pathways to drug policies that work (2014) and *Advancing Drug Policy Reform: a new approach to decriminalization* (2016). Available at: http://www.globalcommissionondrugs.org/reports/

107 While the US campaigns under Nancy Reagan are possibly the best-known example, other states have copied the approach. Singapore for example launches a month-long "Just say no"-type campaign every June. See: Central Narcotics Bureau. *Core Programmes. Singapore Government*. https://www.cnb.gov.sg/cnbpde/programmes/default.aspx (accessed on 10 August 2017).

108 Many academic studies back up this statement, including: Stockwell, T., Fishbein, D., Toumbourou, J. W., Tarter, R., Eldreth, D. (2005) *Preventing psychoactive substance use and related harms among children and adolescents: a review of theory and global best practices to address psychosocial and neurobiological factors*. Geneva: WHO; Babor, T., Caulkins, J., Edwards, G. et al. (2010). *Drug policy and the public good*. Oxford: Oxford University Press; Hawks, D., Scott, K., McBride, M. (2002) *Prevention of psychoactive substance use: a Selected Review of What Works in the Area of Prevention*. Geneva: WHO; Fishbein, M. et al. (2002) Avoiding the boomerang: Testing the relative effectiveness of antidrug public service announcements before a national campaign. *American Journal of Public Health*, 92 (2), pp. 238-235.

109 Rosenbaum, M. (2014). *Drug Policy Alliance. Safety First: A reality based approach to teens and drugs*. Available at: http://www.drugpolicy.org/sites/default/files/DPA_SafetyFirst_2014_0.pdf

110 Babor, T., et al. (2010) *Drug policy and the public good*. Oxford: Oxford University Press.

111 Rosenbaum, M. (2014). *Drug Policy Alliance. Safety First: A reality based approach to teens and drugs*. Available at: http://www.drugpolicy.org/sites/default/files/DPA_SafetyFirst_2014_0.pdf

112 Amnesty International (2017) "If you are poor, you are killed." Extrajudicial Executions in the Philippines' "War on Drugs." Available at https://www.amnestyusa.org/files/philippines_ejk_report_v19_final_0.pdf

113 See for example Baldwin, C., Marshall, A. (2017) More blood but no victory as Philippine drug war marks its first year. https://www.reuters.com/article/us-philippines-duterte-drugs-idUSKBN19G05D (accessed on 10 July 2017).

114 See for example Global Commission on Drug Policy (2016) *Advancing Drug Policy Reform: A New Approach to Decriminalization*.

115 NSRP and International Alert (2017) *Out of the shadows - Adopting a peacebuilding approach to the social effects of drug use in Nigeria*. Available at: http://www.international-alert.org/sites/default/files/Nigeria_DrugUse_EN_2017.pdf

116 Blendon, R., J., Young, J., John, T. (1998) The Public and the War on Illicit Drugs. *Journal of the American Medical Association*, 279 (11), pp. 827 -832.

117 Hood, R. (2013) *The Death Penalty in Malaysia – public opinion on the mandatory death penalty for drug trafficking, murder and firearms offences*. The Death Penalty Project. In November and December 2012, 1535 Malaysians were asked about their opinions on these laws. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212428/13_05_31_DPP_Malaysia_report_FINAL_single_pages.pdf

118 Singapore. *Misuse of Drugs Act*, No. 5 of 1973, Rev. 2008. Available at: http://statutes.agc.gov.sg/aol/search/display/view.w3p;page=0;query=DocId%3Ac13adadb-7d1b-45f8-a3bb-92175f83f4f5%20Depth%3A0%20Status%3Ainforce;rec=0

119 Domosławski, A. (2011) *Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use*. Warsaw: Open Society Foundations.

120 Surveys of around 1000 teenagers/young adults to be found in SICAD study (2008) *Perceptions and social representation on drugs and drug addiction, inquiry to the youth present in Rock in Rio – Lisboa*. Available at: http://www.sicad.pt/BK/EstatisticaInvestigacao/EstudosConcluidos/Lists/SICAD_ESTUDOS/Attachments/173/sinopse_rock_in_rio16_pt.pdf; http://www.sicad.pt/BK/EstatisticaInvestigacao/EstudosConcluidos/Lists/SICAD_ESTUDOS/Attachments/173/sinopse_rock_in_rio16_pt.pdf

121 Grund, J.P., Breeksema, J. (2013) *Coffee Shops and Compromise: Separated Illicit Drug Markets in the Netherlands*. New York: Open Society Foundations.

122 Ibid.

123 VOX 62. *Nachanalyse der eidgenössischen Abstimmung vom 28.09.1997*. Available at: http://www.gfsbern.ch/de-ch/Detail/vox-62-nachanalyse-der-eidgenoessischen-abstimmung-vom-28091997

124 VOX 68. *Nachanalyse der eidgenössischen Abstimmung vom 13.06.1999*. Available at: http://www.gfsbern.ch/de-ch/Detail/vox-68-nachanalyse-der-eidgenoessischen-abstimmung-vom-13061999

125 Savary, J-F., Hallam, C., Bewley-Taylor, D. (2009) *The Swiss Four Pillars Policy. An Evolution From Local Experimentation to Federal Law*. Beckley Foundation.

126 VOX 68. *Nachanalyse der eidgenössischen Abstimmung vom 13.06.1999*. Available at: http://www.gfsbern.ch/de-ch/Detail/vox-68-nachanalyse-der-eidgenoessischen-abstimmung-vom-13061999

127 Rihs-Middel, M., Hämmig, R. (2005) Heroin-assisted treatment in Switzerland: An interactive learning process combining research, politics and everyday practice. pp. 11-22. In Rihs-Middel, M., Hämmig, R., Jacobshagen, N. (ed.). *Heroin-assisted treatment: Work in progress*. Bern: Swiss Federal Office of Public Health.

128 Csete, J., Grob, P.J. (2012) Switzerland, HIV and the power of pragmatism: lessons for drug policy development. *International Journal of Drug Policy*, 23, pp. 82–86

ADDITIONAL RESOURCES:

www.beckleyfoundation.org
www.countthecosts.org
www.cupihd.org
www.druglawreform.info
www.drugpolicy.org
www.genevaplatform.ch
www.globalcommissionondrugs.org
www.hivlawcommission.org
www.hri.global
www.hrw.org
www.igarape.org.br
www.intercambios.org.ar
www.icsdp.org
www.idhdp.com
www.idpc.net
www.inpud.net
www.incb.org
www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblem.aspx
www.release.org.uk
www.talkingdrugs.org
www.tdpf.org.uk
www.unaids.org/en/topic/key-populations
www.unodc.org
www.wola.org/program/drug_policy
www.wacommissionondrugs.org
www.who.int/topics/substance_abuse/en/

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REPORTS BY THE GLOBAL COMMISSION ON DRUG POLICY

http://www.globalcommissionondrugs.org/reports/

- War on Drugs (2011)
- The War on Drugs and HIV/AIDS:
  How the Criminalization of Drug Use Fuels the Global Pandemic (2012)
- The Negative Impact of the War on Drugs on Public Health:
  The Hidden Hepatitis C Epidemic (2013)
- Taking Control: Pathways to Drug
  Policies That Work (2014)
- The Negative Impact of Drug Control on Public Health:
  The Global Crisis of Avoidable Pain (2015)
- Advancing Drug Policy Reform:
  a new Approach to Decriminalization (2016)

POSITION PAPERS BY THE GLOBAL COMMISSION ON DRUG POLICY

http://www.globalcommissionondrugs.org/position-papers/

- The Opioid Crisis in North America (October 2017)

GLOBAL
COMMISSION ON
DRUG POLICY

GLOBAL COMMISSION ON DRUG POLICY

The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science based discussion about humane and effective ways to reduce the harm caused by drugs tand drug control policies to people and societies.

GOALS

- Review the base assumptions, effectiveness and consequences of the 'war on drugs' approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform