



CONNECTED HEALTH

A Joint Solidarity Project



**STAY CLEAN &
EQUALITY RIGHTS GROUP**



Introduction

This project is testament to the synergy and economies that are possible when solidarity between community NGOs becomes a reality.

In essence, Stay Clean and Equality Rights Group meet substantially in areas of both approach and outcomes in important areas of their concern; Stay Clean (SC) is driven to meet a real demand within the community for effective and therapeutic support for people with problems of addiction; and Equality Rights Group (ERG) seek to establish a sexual health clinic to deal with the issue of sexually transmitted infections in Gibraltar.

The two organisations coincide and agree on various strands:

1. Community health issues become that more entrenched and difficult to tackle when social attitudes of stigma and fear are an important contributing factor. The only antidote is an open and positive approach to the problems (medical or otherwise) which we aim to alleviate or eradicate altogether. The services provided must align with this aim of positivity and approach in every aspect they present – from ambiance of the location and service, to the staff's approach and attitudes.
2. The need for a holistic, joined-up approach to the service to be offered. A number of links may be necessary to different strands of support and assistance across the health and institutional system.
3. The need for active and on-going advocacy in the community in order to educate and raise awareness with the aim of better tackling and reducing the scale of the problems that face us.
4. The need to overcome stigma, shame, and fear related to these, essentially, medical/psychological conditions both in society at large but also in individuals themselves.

Discussions between the two groups have been productive, and have allowed us to reach the view that sufficient overlaps exist between the two groups' aims for a joint project to make a great deal of sense; and not only because the joining of forces means a concentration of minds and purpose, but because economies of function can reduce costs and maximise benefits in the area of both addiction treatment and sexual health. It was, indeed, the realisation of the crossover between sexual and addiction behaviours that proved to be the germ of realisation that brought both our organisations together with a common purpose: to make a difference and to improve upon a situation experiencing difficulties. This, then, is how 'Connected Health' has arisen from a situation of need and support. It is a primary example of how Civil Society, working hand in hand with Government, can achieve more – and for less!

As heads of our respective groups, and in the following pages, we present proposals and considerations for discussion, hoping thus to meet with the serious consideration we trust they merit. In these we tackle two holistically common aspects of this Project as one single issue: 1) the necessary medico-therapeutic organizational considerations to be taken into account and 2) the legislative provisions that frame and support that more positive and open way of managing substance abuse.

Damian Broton
Stay Clean

28 September 2016

Felix Alvarez
Equality Rights Group

“The soft minded man always fears change. He feels security in the status quo, and he has an almost morbid fear of the new.

For him the greatest pain is the pain of a new idea...There is little hope for us until we become tough minded enough to break loose from the shackles of prejudice, half truths and downright ignorance...

A nation or a civilisation that continues to produce soft minded men purchases its own spiritual death on an instalment plan.”

Martin Luther King – ‘Strength to Love’

CONNECTED HEALTH: D1

Holistic network of medical, law enforcement and therapeutic support: sexual health & addiction-related community services.

Primary Care Wellness Centre

- Initial assessment (Counsellor)
- Blood specimen analysis
- GP check-up & evaluation

1

Client referral or self-referral

Client referral or self-referral

Bruce's Farm

- Admissions: 24/7 availability & phone line
- 12 weeks rehab course
- Full time staff: 1 x Day Nurse & 1 x Night Nurse

2

Stay Clean

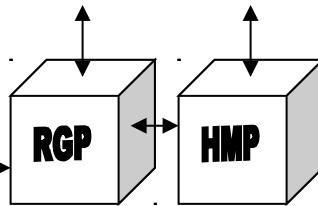
- Community NGO advocacy
- Drop-in Centre – pre & after-care
- 1 x Full Time Counsellor
- 2 x Full Time Carers

3

Infections Control Dept

Laboratory & specialist consultancy

4



5

6

Clean & Staying Clean: addiction rehabilitation and management

Bruce's Farm (BF), inaugurated in September 1999, is located historically at the important point when the community of Gibraltar begins to insist on attending to matters internal to Gibraltar and which, perhaps, the trauma of frontier closure has relegated as of less urgency than the issues of Sovereignty which had so occupied Gibraltar's energies from 1969 to 1984.

In the span of one year, some pivotal social groups begin to appear: Bruce's Farm, with its call for attention to the worrying issues of addiction, Equality Rights Group (launched as Gib Gay Rights – GGR) bringing a focus on injustice to the LGBT community specifically, and to human and civil rights generally; and the Environmental Safety Group, responding to concerns on the ecology of Gibraltar. The new century opened us up to new concerns, and a number of symptom-centred humanitarian groups also emerged (multiple sclerosis, breast cancer etc).

During this time, BF has been of much value and support to the community; according to its website:

'Since its inauguration in September 1999, Bruce's Farm has helped over 350 people struggling with serious problems of addiction i.e. drugs, alcohol, gambling and other addictions. We are a non-profit making organisation...funded by the Government of Gibraltar and run by The New Hope Trust. We form part of the Government Drug Strategy and work very closely with Social Services, the Community Mental Health Team and the Drug Strategy Coordinator. We emulate ourselves on Broadway Lodge our Sister Rehabilitation in UK, which runs a similar programme, although we have adapted the programme to our local environment. Our aim is simple, to provide a high standard of treatment for all patients and their families whilst taking into account their individual needs. We foster the belief that leading a full life is best achieved with the help and support of The Twelve Step Programme and others going through the same process.'

In other words, as can be seen, BF is a well-established service; its infrastructure linkage to a range of service strands is firm and important.

So what do we propose?

Time does not stand still for any one of us. We need to revisit our rehabilitation system and take an objective look at whether, 17 years on from first establishment, we may do more to improve our service to the community.

'Connected Health' aims to look at how best to foster a healthy, open social approach to rehabilitation issues. In this, the 'connectedness' of the person and relevant institutions takes centre stage at all times. Primary in our concern therefore are the following:

1. The maintenance and upgrading of Bruce's Farm as an essential element in the treatment and service cycle. BF can be extended as a source of revenue by providing a quality pay-service to non-residents who qualify for free treatment. Study of this element could be of much interest.

2. The open and direct implication of the Primary Care Centre in the catchment network.
3. The establishment of both before- and after-care provision via the Stay Clean Drop-In Centre.
4. The avoidance of a 'broken experience' for the client; the flow between Primary Care, Bruce's Farm, and the Stay Clean Drop-in (before- and after-care) service must be smooth.
5. We would argue that the introduction of Ocean Views into the system flow is a negative to be avoided. The two-week detoxification process intended to be undertaken at Ocean Views would be more beneficially handled within the stable relationships and dynamics already established by the client during their 12-week stay at BF. The break in the client experience that moving to Ocean Views supposes is, at best, destabilising and, at worst, detrimental at a fragile and delicate stage on the road to rehabilitative change.
6. Resources need to be increased to ensure a) swift attention to referrals and self-referrals b) efficient and early admissions processing; additionally, c) staff levels at BF need to be increased to allow for 24/7 availability in order to deal with emergencies as well as daily routines.

With these factors taken into consideration, we believe BF requires:

- 1 x Full Time Day Nurse
 - 1 x Full Time Night Nurse
 - 1 x On Call Psychiatric Nurse
 - 1 x On Call Psychiatrist
7. Admissions Process: In accordance with our above diagram (D1), admissions occur when four specific steps are undertaken:
 - i) An individual self-refers or is referred for attention
 - ii) A qualified Counsellor initially assesses the client at the PCC (Stay Clean can provide this service)
 - iii) A blood analysis is undertaken without delay
 - iv) A GP is able to examine the client with minimal delay and authorises an admission to BF

Whereas admissions are only currently possible on Fridays, we propose that they should not only be open every day of the week, but that a maximum delay of 48 hours should be effected in both policy and practice so as to provide both the opportune and timely intervention required not just by the client themselves, but by affected family members, who are often also victims. Dealing effectively with the rehabilitation issue can also often have the beneficial effect of relieving psychological and medical issues collaterally affecting the family of the addict.

8. The Royal Gibraltar Police & The Prison Service:
 - **RGP:** We recommend and envisage that at least one full time Arrest Referral Officer be specifically trained and qualified to deal with the identification and handling of

individuals suspected of addiction behavioural problems. A separate cell facility for the holding of such individuals may also be helpful.

- **HM Prison Windmill Hill:** The question of drugs in prisons is a perennial problem everywhere. Whilst the administration of internal systems to minimise or avoid the filtering of abusive substances into the Prison, the need to deal with sentenced offenders whose primary delinquency derives from substance abuse. The reinsertion remit of the justice system's rationale for imprisonment obliges us to provide effective treatment to addict inmates. Close linkage between the Prison Service and the Primary Care Centre support team will enhance the mutual functioning of both strands of this part of the cycle.

9. Doctor Awareness & Practise:

Too often a number of medical symptoms hide an underlying substance abuse problematic. We are only too aware of cases where affected individuals are being treated for the symptoms yet medical staff are unaware of root causes. Promoting greater medical staff awareness is certainly useful; more useful, however, is the requirement for blood testing in given relevant cases for signs of possible substance abuse. The revelation of such an underlying history will then assist in better treatment options.

10. Drug-Free Workplace Policies:

It is important that Government, Unions and Employers cooperate to properly establish working policies and practices in the workplace to both foster awareness against substance abuse and train key staff in the identification and management of significant behavioural and other signs, thus ensuring a sufficient understanding of the advantages to both workers and employers in enforcing a consensual, compassionate and practical approach to the problems around these issues.

11. **Before- and after-care: the role of Stay Clean in multiplying success**

SC's approach transmits a powerful message to those who need it most: we are here, we will continue to be here, and you are not alone – whatever happens! We too have been there, and we understand.

SC provides support to both individuals and to institutional players in one connected system aiming to work together in all its facets to provide the hope and practice of rehabilitation to persons whose lives have been disrupted by addiction in its various forms.

SC staff aim to build a friendly and positive atmosphere and drop-in network of new friendships and supportive relationships to replace the often damaged networks of social contacts and relationships which have spurred the individual in a downhill journey of substance abuse.

SC will play an important and active role in advocating within the community through education and communication in favour of social attitude change and towards a wider understanding of the positive role all of us can play in the elimination of this phenomenon.

SC will therefore act as a support and complement to Government, key actors such as the GHA and the Primary Care Centre and its professionals (nurses, doctors, psychiatrists), the Royal Gibraltar Police and the Prison Service (see proposals above).

SC will, itself, need support and funding to carry out its work. We identify the following:

- 1 x Full Time qualified Counsellor
- 2 x Full Time Carers
- Premises for permanent location of a well-placed Drop-In Centre (currently at Nazareth House).
- Core running costs

12. The Legislative Proposals: the thinking base and addiction

Current Gibraltar legislation relative to drugs (both licit and illicit) is long and wide and spans well over half a century. For the purposes of this Report, however, it is the *Criminal Procedure and Evidence Act 2011* and the *Crimes Act 2011* (in particular, Part 21 on drugs misuse) which are of special note and relevance.

Gibraltar has followed the global War on Drugs approach in terms of frameworks for enforcement in the struggle against substance abuse, and the legislative tools which our statute books provide are set within this paradigm. It is this which we need to re-consider.

This Report, however, advocates two parallel and necessary strands combining one holistic system. Despite the fact that the treatment infrastructure has already been touched upon above, we make the point of reiterating it here briefly once more to emphasise the holistic approach of this Report's proposals which, in effect:

- i) submit for consideration an upgrade to the operational system infrastructure dealing with rehabilitative services in the treatment of addiction in Gibraltar, and
- ii) propose moving away from a Prohibition-centred approach and incrementally adopting a legislative framework public health axis which promotes and supports harm reduction through calibrated and differential regulatory legislative. It is precisely because drug use can be dangerous, and not because it is safe, that we consider regulation paramount. It is not because we promote a free-for-all in drug use, but rather because, in dealing with a social reality which has not gone away but rather increased problematically under the War on Drugs paradigm, that use has grown in freefall over the decades; and control of supplies been abdicated by Governments to the profit interests of organised crime worldwide. Governments must be simultaneously bold *and* cautious in such an enterprise.

- Legislative design must accommodate and be tailored towards the specifics of the local environment for which they are intended. No two social environments will replicate the exact same conditions.
- Development can be incremental and science-based rather than on any ideological view.
- Operational evidence should form the basis for tailoring provisions and measures as they are tested against on-the-ground experience. Periodic feedback, monitoring and adjusting/readjusting of policy and practice is a necessary complement to these proposals.
- Determinations made, again based on available evidence, as to whether marijuana use in Gibraltar can and should be decriminalised and regulated.
- Determinations of a similar order must also be established with regard to the use of other substances where blanket 'one size fits all' historical approaches have, perhaps, been proved inadequate. Fine-tuning known differentials in light of scientific information may provide a more objective treatment for policy and enforcement purposes than earlier, coarser approximations allowed.

The war on drugs, we submit, creates massive costs, resulting from an enforcement-led approach that puts organised crime in control of the trade. It is time to count these costs and explore the alternatives, using the best available evidence, to deliver a safer, healthier and more just world.

The Law: wresting control from organised crime

The professional expertise required for informed decisions on the issues contained in this Report are wide and deep. Proper consideration needs to be given not only to medical and health issues, but also to questions of licensing of suppliers and outlets, the control of markets in pricing, product range and consumer presentation, as well as to the scientific and sociological evidence that only professional expert campaigners can provide in the required depth. In order to provide the context and rationale behind the proposals contained in this Report vis-à-vis new legislation we will turn to such a source.

What follows, therefore, replicates information published by the Counting the Costs campaigning organisation (<http://www.countthecosts.org/>) in one of their various publications advancing the argument in favour of change. With full thanks and acknowledgment, the online publication below cited may be obtained at <http://www.countthecosts.org/sites/default/files/Health-briefing.pdf>

The War on Drugs: Threatening public health, spreading disease and death

Over the past half-century, the war on drugs has been promoted primarily as a way of protecting public health. In reality, however, it has achieved the opposite. It has failed to control or eliminate use, and has increased the potential risks and harms associated with drug taking. By fuelling the spread of disease – often with fatal consequences – drug-war policies have had a devastatingly negative impact on the health of a growing population of users.

It is worth noting, however, that the treaty which underpins the global drug control framework, the **1961 UN Single Convention on Narcotic Drugs**, has two parallel functions. Alongside punitive, criminal justice-led controls on non-medical drug use, it put in place a strict regulatory framework for the production and supply of the same drugs for medical and scientific purposes. This has led to the emergence of two parallel markets: firstly, the non-medical drug trade, controlled by violent criminal entrepreneurs, paramilitaries and insurgents; and secondly, the medical drug trade, regulated by various government agencies.

The contrast between the health and social harms associated with these twin markets could not be more stark, or more instructive. The crusading rhetoric of the war on drugs, as outlined in the preamble to the Single Convention, describes drugs as an “evil” we must “combat”. Yet in reality, enforcement is focused on some of the most vulnerable and marginalised populations – those from socially deprived communities, young people, people with mental health problems, people who are dependent on drugs, and people who inject drugs. **The war on drugs punishes those most in need – patients and clients. It can more accurately be described as a war on drug users; a war on people.**

This criminalisation of people who use drugs leads to increased stigmatisation and marginalisation, limiting the potential effectiveness of health interventions, particularly for problematic users. So although the health harms of problematic drug use and addiction are important, there is an urgent need to examine and find solutions to the public health problems created or exacerbated by the war on drugs itself, namely:

- Maximising the risks associated with use, such as unsafe products, behaviours and using environments.
- The health harms created or fuelled directly by drug law enforcement, or indirectly through the wider social impacts of the violent illegal trade it creates, including disastrous impacts on international development and security
- The political and practical obstacles for health professionals in doing their job addressing drug-related health problems and reducing harms, and how they are obliged to work within a legal and policy framework that is often in direct conflict with fundamental medical ethics – not least the commitment to “first, do no harm”.

Maximising harms to users

Encouraging risky behaviours and using environments

Criminalising people who use drugs, particularly young people, whilst having, at best, marginal impacts on demand, can exacerbate overall health harms by encouraging high risk behaviours and push drug use into unhygienic and unsupervised “underground” environments.

- Authorities seeking to educate young people about drug risks are simultaneously seeking to arrest and punish them. The resulting alienation and stigma undermines outreach to those most in need. Combined with prevention messages more often driven by politics than science, this leads to distrust in even the best drug education efforts.
- Enforcement against possession of drug injecting paraphernalia can encourage needle sharing, increasing blood-borne virus transmission risk. Higher levels of enforcement are also associated with hurried and higher-risk injecting.
- The choice of high-risk injecting over safer forms of administration (e.g. snorting or smoking) to maximise “bangs for bucks” can be caused by enforcement-related price inflation.
- Displacement from one drug to another can also follow enforcement efforts. The impacts are unpredictable, but as experience with amphetamine-type stimulants demonstrates, can lead to the use of new “designer” drugs about which little is known (a risk factor in itself), creating challenges for police, forensics, harm reduction, treatment and emergency services.
- In the Eurasian region economic pressures combined with enforcement against more established drugs have fuelled the emergence of high-risk, domestically manufactured and injectable amphetamine-type stimulants, such as *boltushka* in Ukraine, and *vint* and opiates such as *krokadil* in Russia.
- Inadequate access to information can encourage high risk behaviours such as poly-drug use and bingeing, and increase risks in crisis situations.

Promoting more dangerous products

Criminal markets are driven by economic processes that encourage the creation and use of more potent or concentrated drugs that generate greater profits. This is comparable to how, under 1920s US alcohol prohibition, consumption of beer and wine gave way to sales of more concentrated, profitable and dangerous spirits – a process that was reversed when prohibition was repealed.

Under current prohibition, smoked opium has been replaced by injectable heroin, and cocaine markets have evolved towards smoked or injected crack cocaine.

More recently, the cannabis market has become increasingly saturated with more potent varieties. Illegally produced and supplied drug products lack any health and safety information, and are of unknown (and highly variable) strength and purity, creating a range of risks not associated with their counterparts on the licit market.

- Risks of overdose are increased, particularly for injectors, when drugs are unexpectedly potent
- There are poisoning risks associated with the adulterants and bulking agents used by criminal suppliers to maximise profits. Recent examples include Levamisole, a potentially toxic de-worming and cancer treatment pharmaceutical, widely used as a cocaine adulterant (the DEA reported its presence in 69% of seized cocaine in the US in 2009). Even illicit cannabis has been bulked up by other substances, such as lead, which in Germany resulted in 29 hospital admissions for lead poisoning in 2007.
- There is a particular infection risk amongst injecting drug users from biological contaminants. The UK for example, has witnessed clusters of infections associated with contaminated heroin, including 35 deaths in 2000 from *Clostridium novyi* bacterium, and over 30 infections with *Bacillus anthracis* (anthrax) leading to ten deaths in 2009-10.

Creating obstacles to effective harm reduction

A new policy model emerged in the 1980s that pragmatically focused on reducing overall drug related harms, rather than the war on drugs' narrower focus on attempting to eliminate use. This harm reduction approach is summarised by Harm Reduction International (HRI) as:

“policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.”

However, the emergence of harm reduction can be seen, to a significant degree, as a response to harms either created or exacerbated by the war on drugs. There now exists an unsustainable internal policy conflict – with health professionals caught in the middle. Evidence-based harm reduction approaches are evolving and gaining ground across the globe, but operating within the politically driven harm-maximising drug-war framework.

Key interventions such as needle and syringe programmes (NSP) and opioid substitution therapy (OST) expanded primarily in response to HIV transmission risk from injecting, although the approach has grown to encompass a much wider range of drugs, using behaviours and related harms. NSP and OST are now recognised by UN human rights monitors as a requirement of the right to health for people who inject drugs, while methadone and buprenorphine for OST are on the World Health Organization's essential medicines list. Despite becoming increasingly well established, in 2010 harm reduction “remains very limited, particularly in low and middle-income countries”:

- In Russia, although 37% of the 1.8 million people who inject drugs are infected with HIV, NSP is severely limited and OST is illegal. By comparison, HIV rates amongst people who inject drugs in countries with long-established harm reduction programmes, such as the UK, Australia and Germany, are below 5%
- Of countries/territories where injecting drug use is reported, 76 have no NSP, and 88 have no OST.

- In Central Asia, Latin America and Sub-Saharan Africa, OST coverage equates to less than one person for every 100 people who inject drugs. The obstacles to improved provision are more a failure of politics than of resources, as harm reduction is highly cost-effective. Merely using the term “harm reduction” remains a contentious political issue in high-level international fora.

This conflict has led to a widening of harm reduction thinking to include longer-term systemic policy and law reform issues, as demonstrated by initiatives such as the *Vienna Declaration* and the *Official Declaration of the 2011 International Harm Reduction Conference*, and their high profile supporters.

Spreading infectious diseases: HIV/AIDS, hepatitis and tuberculosis

From the outset of the HIV epidemic, transmission amongst people who inject drugs via sharing of needles has been a serious and growing problem:

- Injecting drug use occurs in at least 158 countries/ territories. An estimated 15.9 million people inject drugs globally, of whom three million are HIV+ in 120 countries

- In eight countries – Argentina, Brazil, Estonia, Indonesia, Kenya, Myanmar, Nepal and Thailand – HIV prevalence among people who inject drugs is estimated to be over 40%

- Injecting drug use causes one in ten new HIV infections globally, and up to 90% of infections in regions such as Eastern Europe and Central Asia.

- Provision of antiretroviral therapy, already limited in many low and middle income countries, is effectively unavailable for the vast majority of HIV+ people who inject drugs. Hepatitis B (HBV) and hepatitis C (HCV) are the most common blood borne virus infections affecting people who share injecting equipment. HCV is much more robust than HIV, and so can be transmitted even more easily. Both HBV and HCV can cause cirrhosis and cancer of the liver, and are significant causes of death. Whilst the urgency of preventing and treating HIV infection has overshadowed what some call the ‘silent’ epidemic of viral hepatitis, it is increasingly recognised as a major public health problem, particularly where people living with HIV are co-infected with HBV and/or HCV.

- Brazil, China, Indonesia, Italy, Kenya, the Russian Federation, Thailand, the US, Ukraine and Vietnam account for half of the global population of injecting drug users (8.1 million) and two-thirds of people who inject drugs and are living with HIV (2.1 million). The average HIV prevalence among people who inject drugs in these countries is approximately 25%, HCV prevalence is up to 60%.

- China, the Russian Federation and Vietnam have rates of HIV/HCV co-infection in populations of injectors of over 90%. Crucially both HBV and HCV can be effectively prevented, treated and potentially cured. However, it is clear that treatment uptake remains extremely low among people who inject drugs, even where it is available. Whilst treatment for HCV and HBV remains (or is perceived to be) prohibitively expensive in the short term, in many middle or low income countries prevention measures are relatively inexpensive and of proven cost effectiveness. Yet they remain underdeveloped – despite being strongly supported by the WHO, UNAIDS and UNODC. Tuberculosis only affects impoverished and marginalised groups, with people already infected with HIV or HCV at particularly great risk. 30% of injecting drug users in Western Europe, 25% in Central Europe and well over 50% in Eastern Europe have tuberculosis.

Bringing drug use into prisons

The war on drugs has directly fuelled the expansion of the prison population in recent decades (see the Count the Costs Crime and Human Rights briefings at www.countthecosts.org). This growing population therefore has a disproportionate number of current or past drug users. Lifetime prevalence of injecting drug use in EU prisoners ranges from 15-50%. Some try to portray prison as a useful environment for recovery from drug problems, but the reality is more often the exact opposite. High levels of drug use continue in prisons (unsurprisingly, given the co-imprisonment of dependent users with drug dealers and traffickers), in an environment that creates a range of additional risks, including initiation into high-risk drug using behaviours. As a general principle of international law, prisoners retain all rights except those that are necessarily limited by virtue of their incarceration. The loss of liberty alone is the punishment, not the deprivation of fundamental human rights including the right to health. As Harm Reduction International note: “Failure to provide access to evidence-based HIV and HCV prevention measures (in particular NSP and OST) to people in prison is a violation of prisoners’ rights to the highest attainable standard of physical and mental health under international law, and is inconsistent with numerous international instruments dealing with the health of prisoners and with HIV/AIDS.” Yet despite clear guidance on such provision from WHO, the UNODC and UNAIDS, prison-based NSPs are currently available in only ten countries, and OST is available (in at least one prison) in fewer than 40 countries.

Increasing overdose risks

Overdose deaths, primarily related to opioids, have become a growing problem in recent decades.

- Overdose is commonly the leading cause of death among people who use drugs.
- Around two-thirds of people who inject drugs will experience an overdose at some point, with around 4% of overdose events resulting in death.
- Overdose is a leading cause of death among all youth in some countries, and the leading cause of accidental death among all adults in some regions. The last 15-20 years have established a range of interventions shown to be effective in reducing incidence of overdoses, overdose mortality rates, or both. These include investment in education and awareness building, and increased provision of naloxone (an opiate antagonist) both in a take-home formulation and for use by medical personnel. OST provision has also been shown to reduce overdose. For example, there was a 79% reduction in opioid overdose over the four years following introduction of buprenorphine maintenance in France in 1995. Similarly, supervised injection facilities (SIFs) in eight countries have overseen millions of injections and experienced no overdose deaths. Such services are only available in a very limited number of locations; whilst there are 25 SIFs in Germany there are none in the UK, and only two in the whole of North America. As with harm reduction more broadly, the issue of overdose shows how the war on drugs both fuels the emergence of a health harm and then creates obstacles to health professionals developing and implementing interventions that reduce it.

Wider health impacts of the war on drugs

Undermining development and security

The war on drugs is actively undermining development, human rights and security in many of the world's most fragile regions and states – from Afghanistan and the Andes, to the Caribbean and West Africa, with catastrophic public health impacts in the affected regions (see the Count the Costs Development and Security briefing at www.countthecosts.org) The criminal entrepreneurs that control drug production and trafficking naturally seek out regions with little economic infrastructure and poor governance, then use corruption and violence to consolidate and expand their interests. Since the Mexican government's 2006 military crackdown on the drug cartels (which has had negligible impacts on production and trafficking), more than 50,000 people have died in drug market-related violence, including over 4,000 women and 1,000 children. The profitability of illegal drugs encourages traffickers to lock producing or transit areas into multi-dimensional underdevelopment, deterring investment and restricting the activities of international health and development NGOs and other bodies. It also diverts large amounts of valuable aid and other resources from health or development efforts into police and military enforcement.

Direct health and human rights impacts of enforcement

Drug law enforcement itself is associated with a range of human rights abuses that involve direct health harms, including: health impacts of chemical eradication, arbitrary detention, torture, corporal punishment, and, in extreme cases, use of the death penalty (see the Count the Costs Human Rights briefing at www.countthecosts.org for more detail).

- In some countries in East and Central Asia, drug users are routinely sent to drug detention facilities, without trial or due process. Whilst sometimes termed “treatment” or “rehabilitation” facilities, they are often indistinguishable from prisons, run by security forces and staff with no medical training, and rarely providing evidence-based treatment. Instead, military drills and forced labour are often mainstays, and detainees are denied access to essential medicines and effective treatment. In China there were approximately 700 mandatory drug detoxification centres and 165 “reeducation through labour” centres, housing a total of more than 350,000 people.
- At least 12 countries maintain corporal punishment (including flogging and caning) as a sentence for drug and alcohol offences, including for their consumption. Judicial corporal punishment is absolutely prohibited in international law because it constitutes torture or cruel, inhuman and degrading punishment.
- In violation of international law, 32 jurisdictions currently retain the death penalty for drug offences, with most executions occurring in China, Iran, Saudi Arabia and Vietnam. Current estimates put the numbers of such executions at over 1,000 a year. Methods of execution include hanging, firing squads, beheading and use of lethal injections.

Reducing access to pain control

Global drug control efforts aimed at non-medical use of opiates have had a chilling effect on medical uses for pain control and palliative care. Unduly restrictive regulations and policies – such as those limiting doses and prescribing, or banning particular preparations – have been imposed in the name of controlling illicit diversion of drugs. Instead, according to the World Health Organization, these measures simply result in 5.5 billion people – including 5.5 million with terminal cancer – having low to nonexistent access to opiate medicines. More powerful opiate preparations, such as morphine, are unattainable in over 150 countries.

Are there benefits?

The theory behind the “war on drugs” is not complex; on the demand side punitive enforcement against users aims to act both as a deterrent to use, and as support for health and prevention initiatives (by “sending a message” about the risks/unacceptability of drug use). At the same time, supply side enforcement aims to reduce or eliminate drug availability, as well as increasing prices so that drugs become less attractive. The dominant measure of benefits of the war on drugs is therefore reduced use, and, for many states, specifically the creation of a “drug-free world”. This theory can now be tested against 50 years of drugwar experience, and it is clear that it is not supported by the evidence. Despite fluctuations between types of drug, regions and populations, drug availability and use globally have risen over the past half-century, albeit stabilising in much of the developed world during the past decade.

Given the centrality of the deterrent effect in drug war thinking there is a striking absence of evidence in its favour, and comparative analysis between countries or jurisdictions with different levels or intensity of punitive user-level enforcement show no clear link. The limited available research points to any deterrent effect being marginal, with other social, cultural and economic variables playing a far more significant role in determining demand. Whilst enforcement clearly increases prices and restricts availability to some degree, it is also clear that, even if some hurdles need to be negotiated and expense incurred, drugs are available to most people who want them, most of the time. Supply has generally kept pace with rising demand, and the interaction between the two has kept prices low enough to not be a significant deterrent to use. When supply has fallen below demand (whether due to enforcement or other factors), the result will tend to be falling drug purity or displacement to other drugs (both with unpredictable health consequences), or new entrants to the market until a new equilibrium is established. Regardless of the actual impacts of the war on drugs, the consensus and shared purpose that the international drug conventions represent – the need to address the problems associated with drug misuse – at least holds the potential to develop more effective international responses guided by the principles of the United Nations – improving human rights, human development and human security. This could deliver huge health benefits nationally and internationally.

How to Count the Costs?

Whilst an enormous amount of money is poured into drugs and health research, especially in the US, this has been skewed towards studying drug toxicity and addiction. This work can help establish risks, develop treatments, and support rhetorical justifications for a war against the drugs “threat”, but tends to avoid meaningful scrutiny and evaluation of the negative health impacts of the drug war itself. So whilst it remains important to fully explore and understand drug-related health harms, this needs to be complemented by careful evaluation of all the policies intended to mitigate such harms. Indeed, policy outcomes and policy alternatives should be carefully evaluated and explored. The responsibility for this has historically fallen largely to NGOs, using a range of established evaluative tools to build up the clear, but admittedly patchwork, understanding that we now have. Government and UN agencies’ more systematic participation and support of this area of research – for example by using health impact assessments – would support development of new policies and modification of existing ones. This would ensure the most efficient mitigation of policy related harms at a local, national and international level, both in the short and long term.

Conclusions

A great irony of the war on drugs is that although it was launched with the intention of protecting public health, it has achieved the exact opposite. Not only are impacts of supply- and user-level enforcement measures at best marginal in terms of reducing availability and deterring use, but they have created new harms and hindered proven public health responses.

Failed and counterproductive enforcement is hugely expensive (over \$100 billion a year globally and continues to absorb the majority of drug budgets at the direct expense of established public health interventions that remain desperately under funded. It is now clear that responding to a serious and growing public health challenge within a punitive criminal justice framework has been a public health catastrophe, the costs of which have barely begun to be acknowledged by policy makers. For medical and public health professionals the war on drugs approach presents an acute dilemma as they are required to operate within a legal and policy environment that creates and exacerbates health harms, and is associated with wide scale human rights abuses - directly at odds with public health principles and basic medical ethics. Public health and human rights always suffer in war zones, and the drug war contributes to a culture in which both are marginalised.

The drugs issue has become a political football, hijacked by a series of unrelated political agendas including race and immigration, law and order populism, and the war on terror. Science and pragmatic public health thinking has given way to political posturing and moral grandstanding. The resulting public debate has, in the past, pushed meaningful evaluation and rational discussion to the margins.

But it is also clear that the war on drugs is a policy choice.

A reorientation towards a public health approach needs to be more than mere rhetoric; other options, including decriminalisation and models of legal regulation, should, at the very least, be debated and explored using the best possible evidence and analysis.

Not only are health professionals perfectly positioned to lead this process, but with ever more senior figures all over the globe calling for change, the moment for a genuine debate has come.

We all share the same goals – a safer, healthier and more just world. It is time for all sectors affected by our approach to drugs, and particularly those concerned with public health, to call on governments and the UN to properly Count the Costs of the War on Drugs and explore the alternatives.

Sexual Health: the way forward



The core elements for progress on Sexual Health policy and treatment/services are practically duplicate to those essential for a positive approach on substance abuse:

- Positive leadership
- Positive openness
- Shame-free approach
- Statistical transparency
- Qualified professional staff

With respect to sexual health, ERG and the Minister for Health, Dr. Cortes/GHA have been in discussions for nearly four years. Those discussions have focused on the question of establishing a Sexual Health Clinic in Gibraltar; and establishing it within the pro-active umbrella of the above, positive approach.

ERG acknowledges that some steps towards the overall goals have been undertaken: a one-off publication of some sexual health statistics was achieved; the GHA needs to continue this practice annually not only as a democratic exercise towards the community, but also to keep awareness alive. HIV+ patients have been migrated to Gibraltar from La Linea-based services for periodic obtainment and analysis of blood; an HIV+ consultancy service in Gibraltar has now been established.

Both of these are real, practical improvements to the experience of HIV+ individuals.

Yet, as indeed we have discussed over time, the issue of sexual health is much, much wider than the question of HIV/Aids alone. We have identified the GHA's ongoing concern with many other Sexually Transmitted Infections (STIs) in the community of Gibraltar.

And the crossover between issues of substance abuse/addiction and sexual health is a similar point of encounter. This awareness of 'crossovers', or using medical terminology 'co-morbidity', needs to be raised several notches. It is an explicit aim of the Connected Health Project to bring light to this area.

We need to continue improving our offering, and Connected Health is offering a possible linking model for implementation.

Under diagram D1 above, Stage 1 covers the open community approach needs we originally envisaged to satisfy the provision of a Sexual Health clinical service but which, under a joined-up Connected Health approach, can prove even more effective: a friendly Counsellor and GP-centred style, with (as far as STI issues) are concerned, access to the Infections Control Department as a referral.

To summarise: the proposal, therefore, is that this first stage as illustrated in DI above may cover both sexual health *and* addiction issues. It is at the next, referral stages that more specialist referral occurs – yet the crucial 'human touch' friendliness, trust and connectedness will already have been established at the earliest point of contact.

In the first instance, presentation is of great importance to success: 'Infections Control' is unlikely to appeal or transmit the positive openness that is likely to make the step of readily presenting yourself within the tiny community of Gibraltar to a check-up! We need to re-brand the offering more optimistically; possibilities may include:

- Primary Care Wellness Clinic
- Well Man/Woman Clinic
- Connected Health Clinic

Importantly, the GHA's official website needs to openly and explicitly address its services and approach to issues of sexual health. This omission currently generates a regular flow of confused enquiries to ERG. The official website is the Authority's face to the world; the omission is seen as significant by its enquiring visitors, and a correction is in order.

Similarly addressing the GHA'S website with regard to substance abuse is also to be recommended.

In respect of sexual health services, therefore, the proposed model already illustrated in diagram D1 (box 1) neatly summarises all the beneficial approaches which ERG foresees would be practical and economical for the Gibraltar Health Authority to establish and launch.

The model proposes the following benefits, in our view:

- A walk-in open service
- A central, easy location
- A friendly non-secretive or stigmatised environment
- A beacon of new public attitudes inviting health awareness and prevention in areas previously difficult
- A venue of initial assessment, blood analysis, and referral. Specialist staff, possibly drawn from the Infections Control Department, can either assist or be placed at the next stage of contact and assistance to the client.

Adopting the 'Connected Health' model and approach brings the following advantages:

- Killing two birds with one staff – less cost
- Streamlining health services to the peripheries
- Placing the GHA in a pro-active community role

What does full access and full choice in family planning mean?



Acknowledgment & thanks to <https://maristopes.org>

Full access and full choice means delivering services for women on their terms, reflecting their preferences.



Acknowledgment & thanks to <https://maristopes.org>

Whether or not to use contraception



Acknowledgment & thanks to <https://maristopes.org>

Having the full range of options available

We believe people should be able to choose the method which suits their needs and lifestyle so we focus on improving the range of contraception available. For example, expanding method choice to include long-acting contraception.



Acknowledgment & thanks to <https://maristopes.org>

In brief

The following extracts from ERG's publication 'From Town to City' (downloadable from the Library at www.equalitygib.org) succinctly summarise the continuing approach that Connected Health pursues:

'The problem is not that there is no sexual health service at all in Gibraltar. The problem is, if you were a person facing the possibility of a sexual infection, how encouraged would you be to be proactive and seek treatment? How friendly is it to reach the service and the professionals? How positive, open and amenable are we making it for young (and old) to reach medical help? And, above all, how much do you get to know about what the dangers are, and how prevalent they are out there in your community and elsewhere? Other than as an ultimate recourse, would you be more likely to consult and check into an open Sexual Health or Well Man/Woman Clinic, or an Infections Control Department or Office behind a special door? '

'Sexual health care for all our community (regardless of gender, sexual orientation or age) needs a sane and sensible attitude to function, and it can only truly do so through leadership by example. It cannot work under a veil of shame. It needs to be science-led; the issues are medical, not judgemental, and the whole system must transmit that. Open services, open information, and education; these are what it takes for us to claim we are actually succeeding in our sexual health policy. Complementing a real programme of open services with education and awareness building, furthermore, is the icing on the cake.'

RECOMMENDATIONS:

1. **New Legislation: Establish a Commission** to study, analyse and provide GoG with all necessary information and materials necessary for a best practice consideration as regards addiction issues. For sexual health questions, the Minister for Health/GHA may consider existing local expertise to suffice. We therefore envisage as follows:
 - **Short, limited timescale** of 6-9 months. Prevent open-ended lagging timing.
 - **Addiction: Arrange a 2-3 Day Symposium:** Chief Minister, Ministries of Health, Justice and Equality/relevant Depts to participate; Civil Society stakeholders (Stay Clean, Equality Rights Group, Gibraltar Women's Association, Unite the Union, GGCA, NASUWT/GTA)
 - **Addiction: Panel of UK Experts** to make presentations and lead discussions and exploration of detailed, technical issues: Transform, Release etc
2. **Drug Free Workplace Policies:** Establish a programme for both the Public and Private sectors to adopt constructive, consensual policies reinforcing the need for workplace best practices to identify and support individuals with substance abuse issues. Government and Unions to play important roles.
3. **Introduce open Connected Health Clinic** to deliver and promote open healthy approach to addiction and sexual health in the community. Adopt organizational and resource requirements vis-à-vis staff and operational procedures as per diagram D1 above.

APPENDIX 1: STAY CLEAN JOB DESCRIPTION

Coordinator Stay Clean Drop-In Centre

1. Screening
2. Assessment
3. Crisis intervention
4. Documentation and record keeping
5. Counselling
6. Group therapy
7. Relapse prevention work
8. Arrest, referral work and treatment planning
9. Awareness on a drugs free workplace policy
10. Home visits
11. Drug testing service for government and the private sector .
12. Liaison with release for support and a kind of agreement .
13. Provide a Full Time (24/7) On Call Duty service, to include both home visits and support for affected families.
14. Provide lectures on chemical dependency and relapse prevention
15. Advocacy in the Community on addiction issues.
16. Harm reduction work
17. Assist service users in meeting their needs in housing, employment, or other relevant support

APPENDIX 2: STAY CLEAN JOB DESCRIPTION

Carer

Stay Clean Drop-In Centre

1. To provide appropriate and relevant care and assistance.
2. To be genuine, empathic, patient, and non judgemental .
3. To assist coordinator in awareness campaigns in liaison with Government departments and other relevant sectors.
4. Maintenance of the Drop-In Centre and cleaning of kitchen & toilet facilities in general.
5. Opening and closing of the Drop-In Centre.
6. Organising and participating in leisure activities.
7. Shopping for food and cleaning materials to provide a catering service in the Centre.
8. To provide service users with free meals to whoever is in need of this .
9. To answer telephone calls and to liaise with the Coordinator in all matters
10. To report any suspicious or untoward activity or behaviour to the Coordinator .
11. To accompany the Coordinator to meetings with the relevant Government ministers and other agencies to include but not be limited to the GHA, the police, the law courts and the prison service.
12. To consent to being drug screened at random whenever it is felt that a drug test is required .
13. To be able to write progress daily reports of who attends and of what has happened during their shift .
14. To sign an agreement of confidentiality to be determined by the Coordinator.
15. Holders of the Carer post must possess a motorcycle (or acceptable means of transport) and a driving licence .
16. Carer post holders should have personal past experience as a using drug addict. They must also be able to provide satisfactory proof of a good healthy recovery. .
17. As part of their training and experience, Carer post holders are expected to assist the Coordinator in giving talks and lectures, attend and participate in group therapy environments and 1 to 1 sessions.
18. To continue further development studies and training to become addiction therapists whether it be abroad or in the University of Gibraltar or via some other agency .
19. To assist the Coordinator in crisis intervention work as part of experience.
20. To assist the Coordinator and service users in matters of housing, court cases, and employment
21. To assist service users in their homes at times when intervention is required to provide or restore dignified living conditions.