1997 and 2009, whose thematic chapters were devoted to preventing drug abuse in an environment of illicit drug promotion and to primary prevention of drug abuse. The annual report for 2013 discussed how drug abuse could disproportionately affect specific populations such as women, low-income populations and children. **The Board stresses the importance of protecting the rights of persons with mental illness and improving mental health care in line with General Assembly resolution 46/119 of 1991 and the Convention on the Rights of Persons with Disabilities. The Board also highlights the need to protect children from drug abuse and prevent the use of children in the illicit production of and trafficking in illicit substances, in accordance with the Convention on the Rights of the Child, in particular its article 33.**

254. **The Board stresses the need to protect the rights of alleged drug offenders and drug users at all stages of the criminal justice process.** The prohibition of arbitrary arrest and detention, torture and other forms of ill treatment, the right to life, the prohibition of discrimination, the presumption of innocence and the right to a fair trial are among the important elements of an effective criminal justice system, as provided for in the international human rights instruments. Violations of these principles undermine the rule of law and are contrary to the aims of the international drug control treaties. The international drug control treaties, the Political Declaration adopted by the General Assembly at its twentieth special session and the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem all call for a balanced approach, respect for the principle of proportionality and respect for human rights.

255. **Under the international drug control treaties, States are required to be proportionate in their responses to drug-related offences and their treatment of suspected offenders.** The obligation under the international drug control conventions to establish certain types of conduct as punishable offences and to ensure that serious offences are liable to adequate punishment is subject to the constitutional principles of States and to the principle of proportionality. While serious offences may be punishable by incarceration, other forms of deprivation of liberty, pecuniary sanctions or confiscation, offences of lesser gravity are not necessarily subject to such punitive sanctions. In appropriate cases of a minor nature, States are encouraged to provide alternatives measures such as education, rehabilitation or social reintegration, in particular for persons affected by drug abuse.

256. **Extrajudicial responses to drug-related criminality are in clear violation of the international drug control conventions, which require that drug-related crime be addressed through formal criminal justice responses, as well as of the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, which require adherence to internationally recognized due process standards.**

257. **Although the determination of sanctions is a prerogative of States, the Board continues to encourage all States that retain the death penalty for drug-related offences to commute death sentences that have already been handed down and to consider the abolition of the death penalty for drug-related offences in view of the relevant international conventions and protocols, and resolutions of the General Assembly, the Economic and Social Council and other United Nations bodies on the application of the death penalty.**

258. States parties have achieved varying levels of progress in the adoption of drug control policies that are consistent with international human rights law. **The Board will continue to highlight the importance of respect for human rights and fundamental freedoms in the implementation of international drug control conventions and invites all States to seize the opportunity provided by the anniversaries noted above to reflect and to act on this important issue.**

2. The risk of long-term opioid use and the consumption of opioid analgesics

259. Based on its mandate, the Board has been drawing the attention of States parties to the importance of ensuring the availability of internationally controlled drugs for medical purposes, and has highlighted the great disparity in that availability around the world. The Board has encouraged countries to ensure adequate access to opioid analgesics in countries with low levels of consumption. The Board has continued to emphasize the importance of ensuring the rational medical use of opioid analgesics. However, despite the emphasis on the need for the adequate availability of controlled drugs for medical and scientific purposes, it remains of great importance for States parties to ensure rational prescribing and implement measures to prevent the diversion and the risk of abuse of these drugs.

260. Global consumption of opioid analgesics has been increasing in recent decades. In particular, the consumption of fentanyl increased considerably from 2000 to 2010. Since then it has fluctuated at relatively high levels. The largest consumer, the United States, has seen a decrease in consumption since 2013 due to the introduction of stricter

prescription requirements. Similar patterns were recorded for other opioid analgesics such as hydrocodone, hydromorphone morphine and oxycodone. Canada, Australia and Belgium have experienced a similar development in the consumption of fentanyl, albeit at lower levels. Some other countries, such as Germany, Spain and Italy, have not experienced the same level of consumption and some of its consequences (such as overdose deaths), and their consumption of fentanyl has been increasing steadily.

261. The strong increases in the consumption of opioid analgesics since 2000, particularly in high-income countries, does not seem to be related to a proportionate increase in the morbidity rate of cancer but rather to the increase in the prescription of strong opioid analgesics for the treatment of chronic non-cancer pain. There are a number of factors that have influenced this development, including social and economic issues that made certain demographic groups more vulnerable than others. Among the suggested causes of the extensive prescription and subsequent abuse of opioid analgesics are overprescribing by medical professionals, and aggressive marketing by pharmaceutical companies combined with the targeted training of practitioners by the same companies offering various incentives to prescribers. These are considered to be two of the most significant drivers in the increase in prescribing opioid analgesics.

262. Another factor contributing to the increasing prescription of opioid analgesics is the use of the limited findings of some studies on hospitalized cancer patients showing evidence that strong opioids had low risk of causing dependence. These findings were frequently quoted in peer-reviewed journals and were used to justify the widespread prescription of strong opioids for non-cancer chronic pain.

263. However, a more recent study by the Centers for Disease Control and Prevention of the United States on the characteristics of initial prescription episodes and the likelihood of long-term opioid use in the country between 2006 and 2015 highlighted the opposite, namely that people who received a prescription for opioid pain relievers for non-cancer pain were highly likely to develop opioid dependence.

264. Once the authorities in the United States intervened by introducing stricter regulations, many of those dependent on prescription opioids had difficulties in obtaining them switched to illicitly procured prescription opioids or heroin that in many cases was mixed with fentanyl and fentanyl analogues to reproduce the strength of the synthetic opioids previously used. The mixing of heroin with stronger synthetic opioids has exponentially increased the number of overdose deaths because users are not aware of the adulteration of heroin or do not understand the risk associated with even very small quantities of strong opioids.

265. The opioid overdose crisis has been most visible and received most publicity in the United States, but it has also affected Canada, Australia and, to a limited extent, the United Kingdom and some other European countries. In the United States, the number of deaths caused by overdoses of opiates has reached historical levels. Drug overdose deaths nearly tripled from 1999 to 2014. In 2014, among 47,055 drug overdose deaths, 61 per cent involved opioids. Drug overdoses killed about 64,000 people in the United States in 2016, according to the National Center for Health Statistics at the Centers for Disease Control and Prevention. From 2013 to 2014, deaths associated with the most commonly prescribed opioids (natural and semi-synthetic opioids) continued to increase slightly. However, the rapid increase in overdose deaths appears to have been driven by heroin and synthetic opioids other than methadone. From 2014 to 2015, the death rate from fentanyl and other synthetic opioids other than methadone increased by 72.2 per cent. The death rate for heroin increased by 20.6 per cent.

266. In Canada, the dispensing rate for high-dose opioid formulations such as morphine, oxycodone and fentanyl, increased by 23 per cent between 2006 and 2011. The 2013 tobacco, alcohol and drugs survey conducted by Health Canada found that nearly one in six Canadians older than 14 had used opioids in the preceding 12 months. Between 2009 and 2014 there were at least 655 deaths in Canada where fentanyl was determined to be a cause or a contributing cause, and at least 1,019 deaths where post-mortem toxicological screening indicated the presence of fentanyl.

267. A report published in Australia by the National Illicit Drug Indicators Project reported 597 accidental opioid overdose deaths for 2013 among those aged 15 to 54, compared to 564 reported for 2012, and 668 deaths across all ages for 2013 compared to 639 for 2012. In 2013, 32 per cent of accidental opioid deaths among Australians aged 15 to 54 were due to heroin, while the rest were due to prescription opioids.

268. EMCDDA reported the detection of 25 new synthetic opioids between 2009 and 2016 and 18 new fentanyls between 2012 and 2016. According to the 2017 European Drug Report, a total of 8,441 overdose deaths, mainly related to heroin and other opioids, were estimated to have occurred in Europe in 2015, a 6 per cent increase on the estimated 7,950 deaths in 2014. Increases were reported for almost all age groups. The United Kingdom accounts for 2,655 of those deaths, or 31 per cent. Germany is a distant second with 15 per cent.

269. The increase in the abuse of prescription opioids and the consequent increase in overdose deaths has so far been limited to certain countries. However, all Governments should be aware of the risks associated with the abuse of prescription drugs as they work to ensure that controlled substances are available for medical and scientific purposes. Some Governments have introduced measures and the Board would like to draw the attention of all Governments to this issue.

270. Several countries are requiring the prescription of controlled substances by medical and health professionals to be guided by a rational approach to prescribing as described in the WHO *Guide to Good Prescribing: A Practical Manual*,[83] which recommends that patients receive medications appropriate to their clinical needs and for a specific therapeutic objective, in doses that meet their own individual requirements, with information, instruction and warnings, for an adequate period of time during which the treatment is monitored and eventually stopped, at the lowest cost to them and their community. In addition, when prescribing controlled substances that may entail risks of generating dependence, medical practitioners should conduct clinical interviews to assess the risk of dependence and the concomitant presence of health conditions that may make the individual more vulnerable to the development of drug use disorders.

271. For patients suffering chronic non-cancer pain, national health authorities in some countries have developed guidelines recommending alternatives to opioid analgesics.

272. Some government agencies responsible for the safe use of controlled substances have introduced control measures to reduce and eliminate the misuse of prescription drugs. Those measures include programmes to monitor electronic or digital prescriptions to ensure that only the prescribed amount is dispensed to the patient.

273. Various countries have taken regular initiatives to take back prescription drugs to ensure that expired and/or unused medications are returned, properly disposed of and not used improperly.

274. In some countries, health-care professionals are required to receive adequate independent and unbiased training on the use of medications, including ways to avoid the associated risk of dependence and measures to mitigate those risks. In addition, national health authorities have put in place campaigns to raise public awareness of the risk of dependence and of the proper use of medications.

[83] WHO/DAP/94.11.

275. Some countries have expanded treatment services for opioid use disorders, while ensuring that opioid substitution therapies (such as medication-assisted treatments with methadone and buprenorphine) are available and accessible to patients and that first responders in areas affected by the abuse of opioids have access to overdose reversing medication (such as naloxone).

276. Abuse deterrent formulations are promoted by some companies as the solution to the problem of prescription drug abuse, despite the fact that to date there is virtually no evidence of their effectiveness in reducing the risk of abuse. Further research is required to find effective technological solutions to address the abuse of pharmaceutical formulations containing opioids, as such solutions appear to be still some distance away from being found.

277. **The Board encourages Governments to adopt, wherever appropriate to their national situation, some of the measures described in this section and work together with public health officials, pharmacists, manufacturers and distributors of pharmaceutical products, physicians, consumer protection associations and law enforcement agencies to promote public education about the risks associated with prescription drugs, their abuse and their potential to cause dependence, in particular those prescription drugs containing narcotic drugs and psychotropic substances under international control.**

3. National requirements for travellers carrying medical preparations containing internationally controlled substances

278. The international drug control system allows travellers to carry small quantities of preparations containing narcotic drugs and psychotropic substances for personal medical use only. The drug control treaties do not regulate this matter directly, but article 4 of the 1971 Convention permits Governments to introduce special provisions for international travellers to carry small quantities of preparations with psychotropic substances other than those listed in Schedule I of that Convention. The 1961 Convention as amended by the 1972 Protocol, does not contain any provision to that effect. In its report for 2000, INCB recommended the development of guidelines for national regulations concerning international travellers under treatment with internationally controlled drugs.