The Global Drug Policy Index

The Global Drug Policy Index Methodology

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The Global Drug Policy Index: Methodology

Compiled by Dr Matthew Wall[1] and Professor David Bewley-Taylor[2]

[1] Associate Professor of Politics and Head of the Department of Politics, Philosophy and International Relations, Swansea University. Corresponding author, for any queries about the content of this document, please email: m.t.wall@swansea.ac.uk

[2] Professor of International Relations and Public Policy and founding Director of the Global Drug Policy Observatory, Swansea University.

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Overview

This document provides a detailed account of the methodology developed in order to create the Global Drug Policy Index (GDPI). It accompanies the November 2021 release of the GDPI data for 30 states and is designed to maximise transparency around the index results and to facilitate and analysis of the results presented on the project website.

The GDPI team envision that this release (which captures states' drug policy in the calendar year 2020) will be the first in a series of GDPI iterations, with future releases expanding the number of states evaluated and, over time, permitting a longitudinal analysis of the evolution of states' drug policy. Future iterations of the GDPI will be obliged to take account of the evolving nature of drug policy and how it is analysed and evaluated. As such, the overarching goal of this document is to equip those interested in engaging with the GDPI's onward evolution with a clear account of what it measures and how it arrives at its results in order to encourage informed discussion and debate.

The document is structured as follows. An introduction section provides background on the project's goals and introduces the GDPI's Methodology and Index Development team. This is followed by a detailed account of the process through which the index methodology was developed, including an account of the data collection process that took place for each of the 30 states covered in the 2021 GDPI release. This document should be read in tandem with both the Appendices to this document and the project dataset, which is published on the project website. The Appendices provide *inter alia* full details of the coding rules and the text of the expert survey used to collect data for the 2021 GDPI release.

Introduction

This section outlines the goals pursued in the creation of the GDPI, focusing on how those goals bear on the development and presentation of the GDPI methodology. It also introduces the team that led the development and implementation of the index's methodology.

Project Goals

The goal of the GDPI project was to produce an index that measures the extent to which national drug policies align with the core UN principles of human rights, health, and development. It was this goal that was supported in the funding that has made the GDPI possible, provided by the Robert Carr Fund via its Strategic Opportunity Funding. Because of the inherent complexity of drug policy, the GDPI is a composite index, producing a set of scores and rankings based on the evaluation of many state policies. Vital to the credibility of any composite index are the twin desiderata of transparency and reproducibility (see, for detailed analysis: Saez et al., 2020).

These criteria are central to any social science research and their importance is all the more pronounced for a project designed to inform public policy debates. It is with these considerations in mind that this document summarises the processes through which the methods underlying the GDPI were arrived at and provides a detailed description of the methods themselves. It is our hope that this will serve to render the GDPI methodology explicit, codified, and public.

Methodology and Index Development Team

Team leads

The GDPI's methodology and index development team was led by Professor David Bewley-Taylor and Dr Matt Wall, both members of Swansea University's Department of Politics, Philosophy and International Relations. As we detail throughout this document, the team leads drew on a wide range of expertise, however, responsibility for final decisions on this methodology rests with David and Matt.

David is Professor of International Relations and Public Policy at Swansea University and is the founding Director of the Global Drug Policy Observatory (GDPO). He was the founding Secretary of the International Society for the Study of Drug Policy (2006-7) and is currently on the Editorial Board of The International Journal of Drug Policy. He is also a member of the International Advisory Committee of the International Centre on Human Rights and Drug Policy (University of Essex), a member of the International Advisory Board of the International Centre for Drug Policy Studies (Shanghai University), and a technical advisor to the Centre on Drug Policy Evaluation. David has played an advisory role to governments and international

organisations and collaborated with and produced policy reports for a range of international non-governmental organisations. At present he is a Senior Associate of the International Drug Policy Consortium and a Research Fellow of the Transnational Institute's Drugs and Democracy Programme.

Matt's contribution to the GDPI project centres on his expertise in social science methodology. He received extensive training in quantitative methods in the course of completing a PhD in Political Science at Trinity College Dublin, where he also received a Postgraduate Diploma in Statistics. Since joining Swansea University in 2012, Matt has taught courses centring on methodology and methods in the social sciences at the undergraduate, masters, and postgraduate research levels. He is currently the Head of Swansea University's Department of Politics, Philosophy, and International Relations and is a co-director of Swansea University's Politics and Governance Research Group as well as being the Director of the Wales Institute of Social and Economic Research and Data Politics and Governance Research Network. Matt is a GDPO Swansea University Associate Member.

Scientific Advisory Group (SAG)

In January 2021, a Scientific Advisory Group (SAG) to the GDPI was created (see: Index Construction Process section for details of the Group's terms of reference and activities on the project). In terms of membership, the group combines individuals with expertise in the academic study and evaluation of global drug policy; individuals with experience of policy advocacy at national regional and global levels; and individuals with specific expertise in the construction and evaluation of composite indices (in many cases, SAG members combined several of these dimensions of expertise in their profile).

In total, this group met 6 times over the course of 2021, at each point providing insight and feedback on the development of the GDPI methodology. Individual meetings and email exchanges between the methodology and index development leads and SAG members also took place across the methodology development process. Furthermore, members of the SAG were centrally involved in the process of arriving at aggregation and weighting rules for the index (see Data Collection and Data Aggregation sections of this document for further details). Table 1 provides a full listing of members of the SAG and their institutional affiliations ordered alphabetically by members' surnames is provided.

Harm Reduction International – Funding work package

Research on levels of Harm reduction funding (indicator 39 in the project dataset) was conducted by Charlotte Davies, a consultant to Harm Reduction International (HRI) with

technical input from Colleen Daniels, Catherine Cook, Sam Shirley-Beavan and Naomi Burke-Shyne from HRI.[3]

GDPI Project Research Assistants

The project research assistant was Mr Jack Tudor, who is a PhD candidate in the Politics programme at Swansea University. He holds an MA (Distinction) in International Relations from Swansea and a BA(Hons) in History from Lancaster. Jack transcribed and analysed the results of consultations with a range of experts in the project's first phase, drafted the project interim report, and undertook a considerable portion of the content analysis of state's drug policies (including consultation with experts in each state's drug policy) in the data collection phase. During the content analysis of state policies, further research assistance was provided by a team of three interns at the Global Drug Policy Observatory: Ms Daisy Evans; Mr Fin Oades; and Mr Ladislav Zeman. Daisy and Ladislav are both MA students with Swansea University's International Security and Development Program and were successful in securing placements with the project as part of Swansea Paid Internship Network (SPIN) program. Fin is currently studying for a master's degree in Social Research and Social Policy at University College London.

Table 1. Names and Relevant Institutional Affiliations of the GDPI's Scientific Advisory Group

Name	**Relevant Institutional Affiliation**
Sandeep Chawla	Former Research Director: United Nations Office on Drugs and Crime (Currently retired/independent)
Colleen Daniels	Deputy Director and Public Health Lead at Harm Reduction International
Professor Cees van der Eijk	Professor of Social Science Research Methods at the University of Nottingham
Dr Vivienne Moxham-Hall	Research Associate at the Policy Institute, King's College London
Nazlee Maghsoudi	Manager of the Policy Impact Unit at the Centre on Drug Policy Evaluation and Doctoral Candidate in Health Services Research at University of Toronto
Isabel Pereira	Research coordinator of the Drug Policy area of the Center for Law, Justice and Society Studies (Dejusticia) and member of the Research Consortium of Drugs and the Law (CEDD).

[3] Please direct any queries about the Harm Reduction Funding indicator (indicator 39 in the project dataset) to: office@hri.global.

Luciana Pol	Senior Investigator (International Security and Human Rights Policy) at the Centre of Legal and Social Studies (CELS)
Professor Alison Ritter	Professor and Director of the Drug Policy Modelling Program (DPMP) at the University of New South Wales
Mat Southwell	Project Executive at European Network of People who Use Drugs (EuroNPUD)

Index construction process

This section elaborates the process through which the GDPI methodology was developed. It begins with an overview of the entire process, which is broken into a series of five phases. The detail of each phase is subsequently discussed in turn.

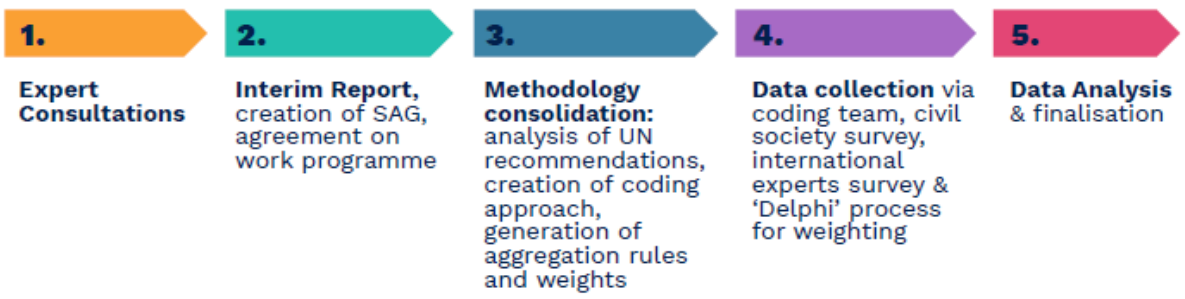
Process overview

In order to make sense of a complex project such as the GDPI, it is helpful to break it down into a series of phases. These phases capture the over-time development of the GDPI methodology and mirror, to an extent, the steps for constructing a composite index laid out in the OECD's (2008) Handbook on Constructing Composite Indicators.

The starting point for an endeavour such as the GDPI is to develop a theoretical framework that 'define(s) the phenomenon to be measured and its sub-components' (ibid., p. 22). This was the task with which the GDPI project began, and it took the form of a series of consultations with a wide range of experts. At the end of this phase, the normative documents laying out policy recommendations that would lie at the heart of the theoretical framework of the GDPI were agreed. In the second phase, the process leading to this agreement and its implications were outlined in two interim reports (Soderholm, 2020; Tudor 2021). The SAG was also created during this phase, and its first meeting reflected on the interim reports and agreed on a work programme.

Implementing this work programme was the third phase of the GDPI's development, which involved the development and consolidation of the GDPI methodology, building on the theoretical framework that had already been established. Once the methodology was established, the fourth phase (data collection) was undertaken. Finally, once the data was collected, it was analysed to ensure accuracy and robustness, and, following this, finalised and published. This overall process is visualised in Figure 1 below.

Figure 1. Overview of Index Construction Process Phases



Phases 1 and 2: Expert consultations phase and interim report: Agreement on foundational normative documents and work programme

A full account of the expert consultations that took place over the course of the calendar year 2020 is provided in two interim reports (Soderholm, 2020; Tudor 2021). At the end of this process, and aware of the need for an underpinning normative framework within which to construct the Index, it was agreed that the GDPI would evaluate states' realisation of selected policies recommended in: *What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters*; a report produced by the UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters (hereafter, we refer to this document as the 'Task Team report'). While there is clearly no perfect definition of drug policy for all purposes, we judged that this approach offers a strong balance of conceptual clarity, substantive relevance, and international acceptance.

With this decision made, the SAG was appointed to consult with the GDPI Methodology and Index Development team leads (that is, Prof. Bewley-Taylor and Dr Wall) with the following terms of reference:

1. To advise on technical/scientific issues of index construction including variable operationalisation, data collection (including quality/reliability), scaling and weighting variables, and the presentation of the index results.

2. To advise on the process of index creation to assure scientific transparency and replicability.

3. To advise on the technical documentation that will accompany the publication of the index.

4. To advise on dissemination of the index and underlying data to the scientific research community.

At the first meeting of this group, in February 2021, a work programme was agreed. The immediate priority in this work programme was developing and consolidating a methodology for measuring states' realisation of the policy recommendations enshrined in the Task Team Report. It was agreed that this would be an iterative process, in which a 'long list' of options would be developed and brought to the SAG for consultation and feedback. This 'methodology consolidation' represented the next phase of the GDPI's development process.

Phase 3: Methodology consolidation

In the very early phases of the Methodology Consolidation phase, it was recognised that we would need to develop rules and processes to deal with what OECD (2008: 5) refers to as the 'selecting variables' and 'weighting and aggregation' steps of composite index construction. While, in the course of consolidating the GDPI's methodology, developments on both aspects occurred in parallel across the project timeline, the selection of indicators was a logical precursor to the elaboration of rules for indicator aggregation, hence we treat these aspects separately in the account that follows.

Indicator selection

Prof Bewley-Taylor and Dr Wall conducted an analysis of the Task Team report in order to identify concrete policy proposals that could be evaluated as part of a drug policy index. This analysis resulted in the identification of 53 substantive policy recommendations (these are listed in full in Appendix 1). All 53 recommendations were evaluated with a view to including them in the Index. In consultation with the SAG, a subset of 19 were excluded on either the basis that the policy recommendation was too ambiguous or due to a lack of extant data and the difficulties associated with creating indicators that could capture these recommendations. Examples of topics excluded due to a lack of clarity as to the nature of the policy recommendation being made were: The use of 'Drug Courts' and the treatment of opioid addiction via detoxification followed by relapse-prevention treatment using the opioid antagonist naltrexone. Examples of topics excluded due to a lack of data and the difficulty that would be associated with generating data included recommendations around the adoption of effective prevention programmes, levels training and expertise of medical professionals regarding pain relief medication, some forms of harm reduction intervention that are relatively rare and/or on which the availability of globally comparable data are problematic (psychosocial interventions for stimulant users, heroin-assisted treatment, linkage of condom distribution and HIV/HEP-C testing to harm reduction interventions), some aspects of policing practice (use of data and research, operational use of joint interventions to target systemic issues), and some of the more in-depth aspects of the functioning of the legal system for individuals accused of drug offences.

In this way, we arrived at a set of 34 concrete policy recommendations as a basis on which to create indicators with regard to the Health and Law Enforcement aspects of global drug policy. In the course of developing these indicators, it became apparent that, within the overarching domains of Health and Law Enforcement, there were important delineations to be taken account of. Regarding Health, we noted that several of the recommendations pertained to Harm Reduction - in the sense that they were aspects of policy that focused on reducing the harms experienced by individuals using illicit drugs without necessarily requiring abstinence. However, there were also a range of recommendations pertaining to controlled

(but not illicit) drugs - here the focus was on policy that facilitated appropriate access to pain medication.

In terms of Law Enforcement - we noted a distinction between recommendations on aspects of drug policy that represented an 'extreme' response (such as, for instance, the use of the death penalty) where the recommendation was clear that such responses should not be used, versus those that focused on balancing different goals and sought proportionality in considering the human rights implications of law enforcement. As such, we identified four separate dimensions of drug policy based on the Task Team Report as follows: The Absence of Extreme Responses, Proportionality of Criminal Justice Response, Health and Harm Reduction, and Access to Controlled Medicines for Pain Relief.

For each of these dimensions, we developed a set of indicators that was consonant with the policy recommendations contained in the Task Team Report. This was a complex process, involving, in the first place, identifying existing data that spoke directly to the recommendations against which we sought to assess state's performance. Examples of data that met these criteria included: The International Narcotics Control Board's (INCB) (2021) reporting on opioid availability and consumption in terms of defined daily doses for statistical purposes (S-DDD); Harm Reduction International's (2020a) Global Overview of the Death Penalty for Drug Offences and (2020b) Global State of Harm Reduction Reports; and the World Bank's (2021) Fair Trial Indicator.

Having carefully considered utilizing available UN and other datasets concerning drug market trends, drug use prevalence, law enforcement issues, health consequences of drug use and so on, it was decided that gaps in data and comparability problems necessitated a different approach. Therefore, we developed a bespoke dataset for the GDPI.

In developing the sets of indicators, we consulted closely with the SAG. An important principle that we developed during these consultations was that our sets of indicators should combine both policy frameworks *and* policy implementation. This is because both aspects of policy are necessary in order to evaluate the extent to which the Task Team recommendations are fulfilled by individual states. Consequently, we devised a system that combined content analysis of state's drug legislation and policy documents with an expert survey approach that drew on civil society expertise and focused on perceptions of implementation.

In the process of generating bespoke indicators on each dimension, we considered a range of sources cited in the Task Team report, including: the UN Joint Statement on Ending Discrimination in Health Care (2017); UNODC and WHO (2011) guidelines on policy and implementation in assuring availability of and access to controlled medicines; The UN's (2010) 'Bangkok Rules' and 'Tokyo Rules' (1990) concerning minimum standards for non-custodial measures; as well as recent iterations of the UNODC's World Drug Report (2017; 2018; 2019; 2020; 2021). We also consulted with individuals with expertise in one or more of our policy

dimensions, including Olivia Rope (Penal Reform International), Niamh Eastwood (Release), Diederik Lohman (Associate director with the Health and Human Rights Division at Human Rights Watch), Katherine Pettus, (International Association for Hospice and Palliative Care), Colleen Daniels and Catherine Cook (Harm Reduction International). On this basis, and after an internal process of pairing down, we generated a 'wish list' of over 90 indicators, which we presented to a SAG meeting in April 2021. From this, we sought to identify indicators that would be particularly difficult to measure or had a more tangential connection to the Task Team policy advice. The overall direction of the process was to compress the number of indicators towards a number that was manageable within the temporal and logistical bounds of the project. There was also a wider concern that an over-abundance of indicators might crowd out the messages that could be drawn from the Index. On the basis of this process, we arrived at a final list of 65 policy indicators on the four dimensions of: The Absence of Extreme Responses, Proportionality of Criminal Justice Response, Health and Harm Reduction, and Access to Controlled Medicines for Pain Relief.

In addition to Health and Law Enforcement, the Task Team Report devotes a section[4] to recommendations regarding Alternative Development (AD). However, relative to the other sections, the set of policy recommendations on AD is limited in terms of detail (the AD section is only 481 words long). This perhaps relates to the ongoing debates within the UN system on the long-term effectiveness of AD and its relationship to broader development policy. That said, as well as offering contextualizing discussion concerning the dominant drivers for the 'cultivation of illicit crops' and the practice of 'alternative crop cultivation', the report identifies a number of key policy approaches.

These draw predominantly on evidence presented in the UNODC's (2015), *World Drug Report*, which devotes a full chapter to the issue. Crucial messages to come from the Task Team report include those relating to the recognition that if 'development interventions are not sensitive to the vulnerabilities of communities to specific drug issues, they may inadvertently trigger dynamics that increase illicit cultivation,' the need to integrate alternative development into a 'broader development and human rights agenda,' the importance of socioeconomic development of communities and improvement of livelihood of rural households, the centrality of involvement of local communities or beneficiaries, and the empowerment of women. The report also highlights the importance of proper sequencing in relation to the implementation of AD interventions. While highlighted in the *World Drug Report* 2015, the Task Team report draws this critical aspect of the approach from a more recent Report of the Office of the United Nations High Commissioner for Human Rights (2018).

In developing the GDPI's approach to measuring AD policy we used both reports as well as a wide selection of other UN system documents and frameworks to inform the identification of indicators not explicitly mentioned in the Task Team report. These included the 2016 UNGASS

[4] We note here that any key recommendations contained in the 'Cross cutting (or topical) issues' section of the Report were integrated into either Health or Law Enforcement in our analysis.

Outcome Document (UNGASS, 2016: paragraphs 7-9), the (2013) United Nations Guiding Principles on Alternative Development, the revised UNODC Annual report Questionnaire (2019), the UNDP's (2015) report *Addressing the Development Dimensions of Drug Policy*, and Sustainable Development Goal 8, 'Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.' Having identified an array of candidate indicators, consultations were undertaken with a number of development-oriented drug policy experts or individuals familiar with the situation on the ground and the intersection between development and drug policy more generally. Conscious again of the need to limit the number of indicators within the Development dimension, decisions were made by the GDPI team to reduce what was effectively an ideal list to something more manageable yet inclusive enough to capture the core considerations of the issue area. Consequently, the final Index includes indictors on the protection of the environment, the operation of AD within militarized/security sector frameworks, the provision of aerial eradication, the benefit of AD policies and programmes to younger people and AD policies and programmes as a successful 'pro-poor' strategy. As an examination of all 10 Development indicators reveals, in many ways the final selection of indicators assesses the effectiveness of alternative development from a development perspective.

In summary, following from our analysis of the Task Team Report and a process of refinement, we identified a total of 75 policy indicators on which we would need to collect data in order to evaluate states for the GDPI. Apart from those existing data sources identified above, our indicators required a mixed-methods approach to data generation. That is to say a system that combined content analysis of state's drug policy legislation and documents with a civil society expert survey that focused on perceptions of implementation. These instruments are more fully elaborated in the discussion within phase 4. However, in order to understand how these indicators feed into states' GDPI scores, an elaboration of our approach to indicator aggregation is required.

Approach to indicator aggregation

As described in Figure 2, the process of moving from indicator values to an overall GDPI score involves several intermediary steps. The 75 policy indicator values combine into scores across 21 thematic policy clusters. The policy cluster scores combine through a weighted average across 5 policy dimensions. The overall GDPI score, finally, represents the weighted average of a state's score across all relevant policy dimensions. At each step in this process, weighting data is required. This section outlines the methodological approach that the GDPI developed in order to generate the weights that drive the data aggregation process.

Figure 2. Overview of data aggregation approach developed for the GDPI

In the first place, we needed a process for normalising the data, in order to arrive at an arrangement wherein they could be readily aggregated. The nature of existing data and our approach to collecting data meant that data were scaled in several ways, including dichotomous/categorical variables and ordinal variables. The first step in the normalisation process involved combining individual variables into thematic policy clusters in such a way that each state being evaluated could receive a score from 0-100 within each cluster. For those clusters which only featured a single variable (for example, 'Prevalence of Extra-Judicial Killing') the normalisation process was straightforward. It involved scaling the range of this variable so that the extreme scores were 0 and 100 (the directionality of the scaling depended on the substantive relationship between the indicator and the policy recommendation), and mapping intervals between these points at even increments across the range of the indicator. This process led to the following scoring rule for the Prevalence of Extra Judicial Killing cluster.

Table 2. Cluster Scoring Rules for: 'To what extent is the practice of extra-judicial killing prevalent in the course of military and police anti-drug activity?'

Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent
100	75	50	25	0

However, out of the 21 policy clusters examined in the GDPI, only 3 featured a single indicator. In all others, multiple indicators combined to produce a cluster score. Where this was the case, we had to arrive at an approach to data aggregation that captured the relative contribution of each indicator to the policy cluster within which it was located. We agreed to do so on the basis of an expert survey, given the large volume of indicators and clusters involved. We were interested here in individuals with expertise in the analysis of drug policy and sought to collect data from such individuals on a global basis. In practice, this resulted in the generation of data by the SAG and what might be called a 'SAG+ group' (see next section for details on respondents to this survey). We agreed to take the mean indicator weightings arising from this survey as the basis on which we would combine indicators to arrive at cluster scores for clusters containing multiple indicators.

In order to aggregate data to produce a score, we used the weights assigned to each indicator to devise a system whereby each possible outcome on that indicator was assigned a value. This involved setting the score for maximum compliance with the Task Team recommendations at the assigned weight of the indicator, and a minimum compliance score at zero. For ordinal indicators with multiple categories, intermediary values were then spread

across the scale of the indicator at even increments. For example, consider the Indicator: To what extent are there disparities in access to harm reduction services due to individuals' sexual and/or gender orientation? This indicator (which is Indicator number 55 in the project dataset was part of a cluster of 3 indicators (others focus on ethnicity and access for women, including during pregnancy) called: 'Equity of Access to Harm Reduction Services'. This cluster was part of the 'Harm Reduction' policy dimension (other clusters are: Harm Reduction Intervention Availability and Coverage, Harm Reduction Funding, and the Extent to which State Policy Prioritises Harm Reduction for People Who Use Drugs). The sexual/gender orientation indicator received an average weight within its cluster of 32% in the expert survey. So, we stretched the response range over 32% as demonstrated in Table 3 below.

Table 3. Indicator Scoring Rules for: 'To what extent is the practice of extra-judicial killing prevalent in the course of military and police anti-drug activity?'

Not At All	To a small extent	To a moderate extent	To a large extent	To a very large extent
32	24	16	8	0

The other 2 indicators were scored using the same approach and all three are summed to produce a cluster score. The cluster score runs from 0-100 (this is the case with all clusters).

In order to aggregate from the cluster scores to scores for each dimension, and to aggregate the dimension scores to an overall GDPI score, we again needed to generate a set of weights for each stage of the operation. It was agreed that this would be undertaken by SAG members via an iterative 'Delphi method' collaborative weighting process. The term 'Delphi method' refers to a framework for aggregating diverse perspectives based on the results of multiple rounds of questionnaires sent to a panel of experts where, after each round, the experts are presented with an aggregated summary of the panel's responses (see, for a detailed discussion: Okoli and Pawlowski, 2004). This is done to allow each expert to adjust their answers in the light of the panel's group response when undertaking subsequent rounds. In devising weights for the GDPI, we conducted three rounds of weighting with SAG members and disseminated panel data between each round. In advance of the final round, we also held a discursive session via Zoom with the panel to ensure that the substance of disagreements on weights as well as the aggregated summary were shared with all members.

Summary

Through the processes outlined in this section, we created a set of indicators and a system through which they could be aggregated in order to produce a global drug policy index. The 'Indicator list' tab in the dataset that accompanies this document provides a full accounting of the 75 variables, the 21 clusters into which they aggregate, and the dimensions within which they sit. In the next section, we elaborate the methods and results deployed in collecting both indicator data and the weighting data required for aggregation.

Phase 4: Data collection

In this section, we elaborate the data collection phase of the GDPI methodology. As outlined above, this was a complex endeavour, given the different types of data that our methodological approach entailed. In what follows, we therefore breakdown the data collection process according to the type of data being collected. The major distinction here falls between data that enabled us to code each state on each indicator (indicator data) and data that allowed us to assess the relative importance of different aspects of policy for aggregation (weighting data).

Indicator data

As described above, we developed a mixed-method approach to data collection for this project. Apart from the above-described instances where indicators were drawn from extant data, we made a distinction from indicators that could be measured through content analysis of states' legislative and policy documents versus those that would require expert evaluation.

For the former category, we developed a coding protocol for each state (see Appendix B for full protocol). A team of research assistants at Swansea University (see 'GDPI Project Research Assistants' above for details), led by Prof Bewley-Taylor and Dr Wall worked to code the 30 states in the 2021 iteration of GDPI over this protocol. In each case, the team members contacted and were supported by individual members of the Harm Reduction Consortium identified by colleagues at the International Drug Policy Consortium (IDPC) as having 'on the ground' expertise in the operation of drug policy in that state. This coding process proceeded from July-September 2021, resulting in a full coding of each state in this release.

The harm reduction financing indicator[5] was generated by Harm Reduction International and categorises countries based on the extent to which identified harm reduction resource needs are met. This requires data on harm reduction resource needs and harm reduction expenditure. For lower- and middle-income countries (LMICs), the indicator uses the 2021 UNAIDS resource needs estimates (RNE) for harm reduction as the denominator. These were provided at an individual country level to Harm Reduction International (HRI) by UNAIDS in July 2021. For higher income countries, resource needs estimates were calculated where possible using a similar method to that used for the UNAIDS estimates.

For needle and syringe programmes, the RNE was calculated as:

Estimated number of people who inject drugs x Unit cost for NSP x Coverage target

[5] An important caveat is that data on harm reduction resource needs and expenditure are far from perfect and while the indicator attempts to use a unified methodology, some degree of flexibility is required in order to calculate estimates. Furthermore, the indicator relies on the quality of the underlying data and few, if any, countries report consistently on harm reduction expenditure nor do they calculate resource needs at a national level. This indicator also focuses primarily on injecting drug use and opioid use and may be less appropriate for countries where stimulant and non-injecting use is more common.

For opioid agonist therapy, the RNE was calculated as:

Estimated number of people who use opiates x Unit cost for OAT x Coverage target

The coverage target was set at 90% for needle and syringe programmes and 50% for opiate agonist therapy as per the UNAIDS 2025 AIDS targets.

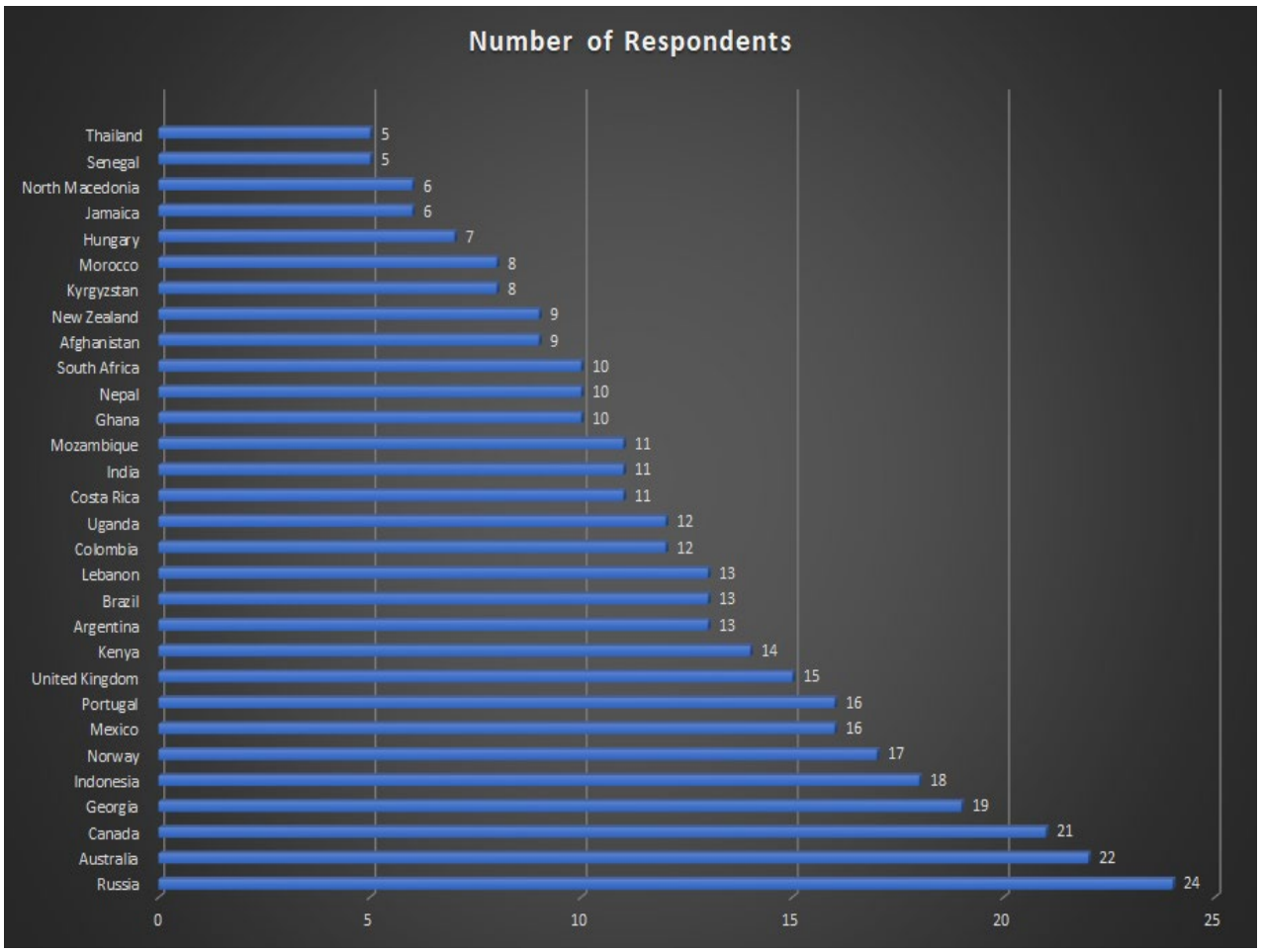
For the majority of high-income countries, unit costs were taken from published sources or calculated from official statistics on expenditure and activity. Where unavailable at a national level, regional costs were used as appropriate, in line with UNAIDS methodology. For harm reduction expenditure, the key source of information for LMICs was HRI's research undertaken for the 2021 Failure to Fund report. Where no expenditure data were available, key informants were contacted to check the extent of funding. This confirmed very little funding or small amounts of funding in the LMICs with missing data. For high income countries, data on harm reduction expenditure were often only available for certain interventions or not at all. Published expenditure data were supplemented by estimates of expenditure using activity data and unit costs data. Where activity data were unavailable, research on coverage levels was used to estimate expenditure. Out-of-pocket costs for service users were excluded from estimates.

For the remaining indicators, we undertook a survey of members of civil society with substantial expertise in each state's drug policy - employing a snowball sampling approach based on an initial contact list of contacts 'on the ground' in each state through the Harm Reduction Consortium. In this way, those individuals deemed to possess appropriate levels of expertise were identified by in-country civil society networks rather than selection judgments being made by the GDPI academic team. The full text of this survey (English Version) is made available in the Appendices to this document. For the data collection process itself, the Survey was deployed, and responses collated via SoGo survey software, with analysis conducted using STATA 17 software. We would like to draw attention to the detailed guidance notes that accompany each of the questions that involve comparative judgement. Because we were aware that cross-national differences in norms and expectations surrounding drug policy may colour our findings, we were careful to provide clear guidelines on both the substantive focus of each question and the meanings of individual response categories. Furthermore, the final section of the survey (items 87-97, inclusive) contained a battery of questions that will be used in research arising from the GDPI to assess the effects on respondents' personal preferences for drug policy regimes influence their evaluations as well as to explore the extent to which assessments of an identical situation (described in a survey vignette) differed cross-nationally.

Respondents to the first wave of the survey could either recommend other experts in the state being evaluated for us to contact or share the survey link with them directly. To facilitate high response rates, this survey was translated into the following languages: Arabic, French, Portuguese, Russian, and Spanish all of which were available to respondents. A minimum

threshold of 5 survey responses was established for a state to be eligible for inclusion in the Index. Figure 3 below details the breakdown of the survey's 371 respondents by state.

Figure 3. Number of respondents to GDPI Civil Society Expert Survey by state



Weighting data

As described in the previous section, the weighting data was compiled through two processes. The data used to weight each of the 75 indicators within their respective clusters was collected via a survey that included all SAG members (listed in Table 1) as well as the following list of drug policy analysts: Adeeba Kamarulzaman (Universiti Malaya & International AIDS Society), Ahsan Ahmad (Universiti Malaya & Yale University), Axel Klein (ECOWAS), Caroline Chatwin (University of Kent), Alex Stevens (University of Kent), Catherine Appleton (University of Leeds), Catherine Neill Harris (Rice University), Coletta Youngers (IDPC), Constanza Sanchez (ICEERS), Craig Reinarman (University of California Santa Cruz), Damon Barrett (University of Gothenburg), David Mansfield (Independent Consultant), Diederik Lohman (Consultant), Diego Garcia Devis (OSF), Dirk van Zyl Smit (University of Nottingham, Leverhulme Emeritus Professor), Ediomo-Ubong Nelson (International Blue Cross/GDPO), Gernot Klantschnig (University of Bristol), Gloria Lai (IDPC), Heloisa Broggiato Matter (IAHPC & Swansea University), John Walsh (WOLA), Julia Buxton (University of Manchester), Julie Hannah

(University of Essex), Karen Joe Laidler (Hong Kong University), Katherine Pettus (IAHPC), Khalid Tinasti (Global Commission on Drug Policy), Lisa Sanchez (MUCD), Maria-Goretti Loglo (IDPC), Mikhail Golichenko (HIV Legal Network), Monica Barrett (RMIT University), Naomi Burke-Shine (HRI), Neil Carrier (University of Bristol), Niamh Eastwood (Release), Olivia Rope (PRI), Pedro Arenas (Corporación Viso Mutop), Peter Sarosi (RRF), Rick Lines (Swansea University), Ricky Gunawan (OSF), Steve Rolles (Transform Drug Policy Foundation), Summer Walker (GI-TOC), Tripti Tandon (Indian Lawyers Collective), Yong-an Zang (Shanghai University), Zara Snapp (Instituto RIA) and Zoe Pearson (University of Wyoming).

The average value for each indicator within each cluster was derived from this survey and comprised the basis of the indicator weighting used when combining indicator values to produce cluster scores for each state. The full set of weights produced by this process can be found in the 'Indicators to Clusters' tab of the project dataset that accompanies this document. Their integration into scoring rules can be found in the 'Scoring Rules' tab of the same dataset.

The second process used to generate weighting data involved the SAG membership, who engaged in an iterative 'Delphi Method' process. During this process, SAG members provided three sets of weights capturing the relative importance of each of the clusters to the dimension that they contribute to, and for each dimension to the overall score. After each set of weights was provided, Wall and Bewley-Taylor presented a summary of the group average to all participants. Between the second and final weighting round, a Zoom meeting was held with participants, and the below notes were circulated to all members:

> The discussion began by focusing on the dimensions-to-index weighting, which is likely to be the element of the index methodology that attracts the widest attention from end users. A recurring theme throughout our deliberation was the existence of several underlying logics that could inform this weighting, even in the light of the clarification about what the index is measuring that took place in the last round.
>
> The following different (and, at times, competing) logics were discussed:
>
> 1) A logic of comparability
>
> 2) A logic of egregiousness (combined with evidence-base in a negative sense)
>
> 3) A logic of evidence-base in a positive sense
>
> 4) A logic of the political/advocacy effects of index design
>
> An important substantive point that emerged in the discussion is that we, as a group, are not obliged to adopt a single overarching logic, rather the goal of this phase in the Delphi exercise is to understand that these logics exist and to have a sense of their make-up.

1) A logic of comparability – one way of thinking about these weights that was advanced is to consider the extent to which the dimensions apply equally across as many states as possible. This logic tends to favour high weights for 'Proportionality of Criminal Justice Response' as this issue arises in all states and can thus serve as a good 'measuring stick' allowing us to emphasize a comparison of like with like (which is no bad thing given the inherent ranking function of an index). This logic bodes less well for Harm Reduction in particular, given the different drug use configurations in different states and our focus on interventions to do with opioids in terms of how we measure this.

2) A logic of egregiousness (combined with evidence-base in a negative sense) – this way of thinking considers the type of rights at stake in the first instance. It combines this approach with heavily weighting those policies that are either actively harmful to the most fundamental rights and/or infringe them with little evidence that they are generally effective. This way of thinking tends to prioritise Use of Extreme Sentencing and Responses (including the Death Penalty) which compromise individuals' right to life with little or no evidence-based return.

3) A logic of evidence-base in a positive sense – this way of thinking prioritises those policies which are shown to be effective in the sense of delivering palpable benefits. Thinking about it this way tends to favour a heavier weight on the Harm Reduction Dimensions as well as the Access to Essential Medicines Dimension.

4) A logic of the political/advocacy effects of index design – this logic chimes well with the 'evidence-base in a positive sense' counterpart – in that both can be seen as using the 'soft' power of the index to encourage countries to adopt policies for which there is widespread evidence of efficacy. However, this advocacy logic also can be invoked as strengthening considerations around egregiousness in terms of human rights violations.

One other theme that emerged is that it's important to bear in mind in presenting our approach to measuring harm reduction that we focus mainly on opioid interventions – which will vary in its relevance depending on a state's drug usage patterns. This point invited a wider discussion of future iterations of the GDPI and the general tenor of the discussion was that we shouldn't be too rigid when planning future iterations, as the emergence and evaluation of policy is something that is always evolving.

In discussing the clusters-to-dimensions weights, there were some interesting debates within the Development dimension concerning the relative importance of its three component clusters. There was some disagreement as to the relative focus on crop eradication (which entails a lot of the rights violations in the policy area) versus efficacy for beneficiaries.

More generally, the discussion at this level introduced a consideration of the evaluation of 'upstream' policy design versus 'downstream' outcomes. One danger that was identified with giving the upstream aspects a high weight is that they can encourage a 'check the box' attitude. On the other hand, the point was made that solid policy design may take time to bear fruit. Again, we didn't seek to agree a formal resolution to this issue, but I think that it does bring out the different underlying logics that can be brought to bear in deciding on a weight.

The set of weights submitted by all participants in the third round of this process comprised the data on which the final set of weights were drawn up. This final set of weights represents the mean weight of all members of the SAG in this third round. Full details of all of these weights can be found in the 'Clusters to Dimensions' and 'Dimensions to Index' tab on the dataset that accompanies this document.

Phase 5: Data Analysis and Finalisation

Following completion of the data collection phase, a process of analysis and finalisation was undertaken. In terms of the indicator data, this process involved the following steps:

A close analysis by the GDPI Methodology Leads as well as colleagues at the IDPC of coding decisions and, where necessary, a re-checking of these decisions and the underlying documentation, in some instances, this also involved confirmation of difficult coding decisions with country experts.

An analysis of the GDPI Civil Society survey data to produce confidence-adjusted median values for indicators measured using the survey. In the first place, this data was parsed to ensure that no duplicate responses were entered, nor were any responses in which identical values were chosen for all indicators.

With this 'data cleaning' complete, an analysis was conducted using STATA 17 software and involved creating a weight capturing respondents' confidence levels in each evaluation.

The weighting scheme used was as follows:

Not at all confident: 1

Somewhat confident: 1.33

Confident: 1.66

Very Confident: 2

The weighted median was calculated as the 50th percentile value of the weighted distribution of evaluations in each state. In the rare instances in which this was not a whole number, the value of the weighted mean was used to determine whether to round up or down.

The values for all indicators captured via the GDPI's Civil Society expert survey represent the result of this calculation.

With all data collected, state scores on each cluster, dimension, and overall were calculated using the scoring rules and weights listed in the project dataset.

Finally, a close checking of the final project dataset was carried out between Dr Wall, Prof. Bewley-Taylor, and colleagues at the IDPC before release.

Country selection

In this first iteration of the Global Drug Policy Index, resource limitations necessitated the decision to focus on the development of a solid methodology, and on a realistic number of countries (30), as a proof of concept. In order to ensure the geographical spread of those countries, we employed the regional groupings used by the United Nations Office on Drugs and Crime.

For each of the 17 sub-regions, the Harm Reduction Consortium, with support from additional civil society partners in selected regions, agreed upon between one and four countries on the basis of three criteria:

1- Relevance of drug policy for the selected country
2- Data availability on drugs and drug policy in the selected country
3- Presence of civil society organisations working on drug policy advocacy, alongside a risk assessment of whether utilising the Index might make them targets of reprisals by their government.

Region	**Countries (selected in yellow)**
1. East Africa	Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Mauritius, Rwanda, Seychelles, Somalia, South Sudan, Uganda, United Republic of Tanzania and Mayotte
2. North Africa	Algeria, Egypt, Libya, Morocco, Sudan and Tunisia
3. Southern Africa	Angola, Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Zambia, Zimbabwe and Reunion
4. West and Central Africa	Benin, Burkina Faso, Cabo Verde, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, Togo and Saint Helena

5. Caribbean	Antigua and Barbuda, Bahamas, Barbados, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago, Anguilla, Aruba, Bonaire, Netherlands, British Virgin Islands, Cayman Islands, Curaçao, Guadeloupe, Martinique, Montserrat, Puerto Rico, Saba, Netherlands, Sint Eustatius, Netherlands, Sint Maarten, Turks and Caicos Islands and United States Virgin Islands
6. Central America	Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama
7. North America	Canada, Mexico and United States of America, Bermuda, Greenland and Saint Pierre and Miquelon
8. South America	Argentina, Bolivia (Plurinational State of), Brazil, Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay, Venezuela (Bolivarian Republic of), Falkland Islands (Malvinas) and French Guiana
9. Central Asia and Transcaucasia	Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan
10. East and South-East Asia	Brunei Darussalam, Cambodia, China, Democratic People's Republic of Korea, Indonesia, Japan, Lao People's Democratic Republic, Malaysia, Mongolia, Myanmar, Philippines, Republic of Korea, Singapore, Thailand, Timor-Leste, Viet Nam, Hong Kong, China, Macao, China, and Taiwan Province of China
11. South-West Asia	Afghanistan, Iran (Islamic Republic of) and Pakistan

12. Near and Middle East	Bahrain, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, State of Palestine, Syrian Arab Republic, United Arab Emirates and Yemen
13. South Asia	Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka
14. Eastern Europe	Belarus, Republic of Moldova, Russian Federation and Ukraine
15. South-Eastern Europe	Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Montenegro, North Macedonia, Romania, Serbia, Turkey and Kosovo
16. Western and Central Europe	Andorra, Austria, Belgium, Cyprus, Czechia, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, Faroe Islands, Gibraltar and Holy See
17. Oceania (comprised of four sub-regions)	Australia and New Zealand, Cook Islands, Niue, Samoa, Tonga, Tuvalu, French Polynesia, Tokelau and Wallis and Futuna Islands, Fiji, Papua New Guinea, Solomon Islands, Vanuatu and New Caledonia, Kiribati, Marshall Islands, Micronesia (Federated States of), Nauru, Palau, Guam and Northern Mariana Islands

Limitations

The relative paucity of objective, comparable data on many of the most important aspects of drug policy created a significant challenge for this project: while it is possible to objectively verify formal/legal aspects of drug policy, many of the significant recommendations of the UN System Common Position on drug-related matters and associated Task Team report centre on (or at least require) effective implementation.

In responding to this challenge, a 'mixed methods' research design was developed, drawing on the perceptions of individuals with specialist knowledge of drug policy in each country to complement the coding of countries' formal/legal policies. While the approach to survey design included extensive guidelines for each question in order to minimise cultural differences in interpretation, it is likely that some deep-seated cross-national differences in perceptions surrounding issues such as racial and gender-based discrimination, levels of police violence and so on are expressed in the data that relies on expert perceptions.

Furthermore, we were unable to measure every aspect of drug policy that we might have liked to. This is partly because of the scope and complexity of the project: the Global Drug Policy Index is global both in the range of states covered and in the aspects of drug policy considered. In reality each of the dimensions of drug policy captured in the Index would be candidates for their own indices. In some instances (for example, prevention policy), a lack of data availability and the difficulty inherent in evaluation meant that a policy area identified within the project's foundational documents does not feature in this iteration of the Global Drug Policy Index. In other areas, such as harm reduction, we chose to focus on widely-accepted interventions about which reliable data already exists, while paying less attention to other interventions.

Finally, it is, of course, inevitable that there is a loss of fidelity when reducing complex political and societal phenomena to numerical representations. Moreover, as with indicator selection, the methodology inexorably involves a series of trade-offs. It is our hope, however, that this process is worth the endeavour in that it facilitates comparative and within-country insights about the state and future of drug policy that might have otherwise proven elusive. The final tally of 75 drug policy indicators over 30 countries is the outcome of an attempt to create an index that is 'simple' (i.e., transparent and intuitive) without being 'simplistic' (i.e., overly reductive). Others may have chosen a different balancing point, and it is hoped that this first iteration of the Global Drug Policy Index will spur debate and engagement on how best to capture and compare states' drug policies.

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Appendices

Analysis of policy recommendations in Task Team report

(Note that policies to be developed/implemented are coded green, those to be avoided are coded in red, ambiguous policy recommendations are coded amber).

Drug policy domain	Policy recommendation	Inclusion decision
Health	Implementation of WHO prevention guidelines	Exclude: Lack of available data and/or problems generating necessary data.
Health	Screening and brief interventions for hazardous and harmful alcohol (and other drugs) use in primary health care settings.	Exclude: Lack of available data and/or problems generating necessary data.
Health	Commercial determinants of health in the case of legally produced and distributed substances: dependence producing drugs, allowing for the promotion of products and choices detrimental to health.	Exclude: Lack of available data and/or problems generating necessary data.
Health	Antidiscrimination laws or provisions that apply to people who use drugs and accounting for gender, health status (including pregnancy) or disability.	Include: through lens of 'equity' in Harm reduction
Health	Services to reduce the harm of nonmedical use of drugs that are accessible, available, acceptable and of good quality	Include: Harm reduction intervention provision and coverage
Health	Review punitive laws that have been proven to have negative health outcomes and that counter established public health evidence, including laws that criminalize or otherwise prohibit drug use or possession of drugs for personal use	Include: Focus on proportionality of criminal justice response
Health	Alternatives to incarceration within the community (outpatient or residential therapeutic setting), such as psychosocially supported pharmacological treatment for opiate dependence.	Include: measure alternatives to incarceration.
Health	Punitive enforcement or treatment regimens (in themselves, and by creating stigma).	Include: Focus on proportionality of criminal justice response and (where applicable) nature of alternatives to incarceration/treatme

		nt regimes
Health	Limited access to services, including health services, and exclusion from relevant host population programmes – especially for females (and pregnant females)	Include: Focus on equity of access to harm reduction services.
Health	Policing practices ranging from surveillance to use of excessive force, particularly when they target vulnerable and marginalized populations.	Include: Focus on extreme sentencing and responses, as well as equity of criminal justice response
Health	Conformity to regulatory requirements for controlled essential medicines.	Include: policy-making process for access to controlled essential medicines
Health	Integration of evidence-based content on use of pain medications in university medical curricula.	Exclude: Lack of available data and/or problems generating necessary data.
Health	Limited capacity of health care professionals due to lack of university curricula on the use of pain medications that are evidence-based.	Exclude: Lack of available data and/or problems generating necessary data.
Health	National policies that may not meet the regulatory requirements across the full spectrum of the supply chain for controlled essential medicines.	Include: policy-making process for access to controlled essential medicines
Health	Opioid substitution therapy (OST) with long-acting opioids (methadone and buprenorphine) combined with psychosocial assistance.	Include: Harm reduction intervention provision and coverage
Health	Opioid treatment involving detoxification followed by relapse-prevention treatment using opioid antagonist (naltrexone).	Exclude: Unclear policy guidance.
Health	Psychosocial assistance for stimulant use	Exclude: Lack of available data and/or problems generating necessary data. .
Health	Health service capacity to deal with increases in less common types of drugs (opioids or stimulants)	Include: Harm reduction intervention provision and coverage
Health	Community distribution of naloxone; Management of opioid overdose with naloxone; integration of naloxone use/distribution with effective treatment	Include: Harm reduction intervention provision and coverage

	strategies.	
Health	Heroin-assisted treatment (prescription of synthetic, injectable or smokable heroin) to a minority of people with opioid dependence who do not respond to treatment with one of the established medications used in long-acting agonist maintenance therapy.	Exclude: Exclude: Very limited uptake by authorities and lack of available data.[6]
Health	Public health approach to drug treatment	Include: Harm Reduction funding and policy prioritisation
Health	Availability in prisons of package of 15 interventions defined by UNODC, ILO, UNDP, WHO and UNAIDS	Include: Harm reduction intervention provision and coverage
Health	Compulsory detention on the basis of drug use or dependence alone/non-consensual confinement in compulsory drug treatment centres	Include: capture prevalence of non-consensual confinement as part of 'treatment'.
Health	Uneven access to (and/or discrimination and stigma within) treatment for women and girls, displaced persons or refugees, Lesbian, gay, bisexual, transgender, and intersex persons.	Include: Equity of access to harm reduction interventions.
Health	WHO-defined package of evidence-based prevention, diagnosis and treatment services for HIV and hepatitis that include needle and syringe programmes, opioid substitution therapy and community distribution of naloxone, as well as testing and treatment of HIV, viral hepatitis B and C and TB.	Include: Harm reduction intervention provision and coverage
Health	Reviewing laws and legislation that criminalize behaviours such as drug use and possession for personal use, reducing stigma and discrimination, including in the health sector, and addressing violence, as well as supporting the empowerment of people who use drugs.	Include: proportionality of criminal justice response, including alternatives to incarceration and decriminalisation for personal drug use.
Health	HIV and hepatitis C prevention via needle and syringe programmes offered in combination with opioid substitution therapy. Requirements for coverage:	Include: Harm reduction intervention provision and coverage

[6] Within this initial version of the GDPI, data on core harm reduction interventions rely heavily on Harm Reduction International, *The Global State of Harm Reduction 2020 (7th Edition).* While this does not include heroin-assisted treatment (HAT) in a systematic fashion as with other interventions (I.e., 'At least one' operational needle and syringe programme, opioid agonist therapy programme, drug consumption room, as well as peer distribution of naloxone, OAT in at least one prison, and NSP in at least one prison), the report notes that HAT is available in only six Western European countries: Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the UK. (p. 178).

	more than 300 needles or syringes per person who injects drugs per year, and more than 40 per cent of people who inject drugs undergoing opioid substitution therapy.	
Health	Needle and syringe exchange programmes plus OST closely linked to condom programming, testing and treatment of HIV (ART) and viral hepatitis.	Exclude: Lack of available data and/or problems generating necessary data.
Health	Prioritizing people who use drugs in testing and treatment programmes for Hepatitis C Virus.	Include: Harm Reduction policy prioritisation
Health	Punitive drug policies that do not recognize the unique vulnerability of persons with psychosocial disabilities who use drugs.	Include: proportionality of criminal justice response, including alternatives to incarceration and decriminalisation for personal drug use.
Law Enforcement	Joint interventions targeting overlapping risk factors (individual, familial, community, societal) for violent crime.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Inclusive and sustainable economic growth (SDG 8 target realisation)	Include: Effectiveness of Alternative Development policy for key beneficiaries.
Law Enforcement	Criminal justice response to drug-related crime that are transparent, avoiding arbitrariness and consistent with international human rights norms and standards.	Include: Use of extreme sentencing and responses, human rights aspect of criminal justice response
Law Enforcement	Structural changes in legislation and law enforcement practices can facilitate the delivery of services, including minimizing the adverse consequence of drug use.	Include: proportionality of criminal justice response, including alternatives to incarceration and decriminalisation for personal drug use.
Law Enforcement	Criminalization of drug use and possession for personal use for purposes other than medical and	Include: decriminalisation

	scientific	policy
Law Enforcement	Criminalisation of possession of needles or syringes without a prescription	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Law enforcement and policing that target the protagonists and elements of the drug trafficking chain that generate the highest profits and the most violence.	Include: proportion of non-violent offenders.
Law Enforcement	Data-driven policing, problem-oriented policing and community policing.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Investment in data and evidence-based research.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Conformity with UNODC, WHO and UNAIDS standards on drug epidemiology and drug supply and trafficking.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Conformity with OHCHR guidance on a human rights-based approach to data collection in the implementation of the Sustainable Development Goals.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Adoption of a phased approach to NPS prioritization, with the two main criteria for consideration being evidence of harm (or potential harm) of a substance, and the prevalence (or proxies for prevalence) of its use.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	The provision of evidence-based treatment and care services to drug-using offenders, as an alternative to incarceration – taking into account mitigating factors (especially regarding women)	Include: Harm reduction intervention provision and coverage to people in prison; alternatives to incarceration; mandatory minimum sentencing regimes.
Law Enforcement	Provision and preference for non-custodial sentences for pregnant women and women with dependent children.	Include: Alternatives to incarceration; mandatory minimum sentencing regimes.
Law Enforcement	Drug courts	Exclude: Unclear policy

		guidance.
Law Enforcement	Overuse of imprisonment for minor drug related cases	Include: proportionality of criminal just response; (where applicable) efficacy of decriminalisation in reducing contact with criminal justice system.
Law Enforcement	Punishment of low-level offences such as small-scale drug dealing or with harsher penalties than other serious crime.	Include: mandatory minimum sentencing for drug offences
Law Enforcement	The application of the death penalty for drug-related offences	Include: Use of extreme sentencing and responses
Law Enforcement	Access to legal aid, with special measures for people who use drugs and HIV and other infectious disease sufferers.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	“Trial waiver” systems for personal possession and drug use offences.	Exclude: Lack of available data and/or problems generating necessary data.
Law Enforcement	Pretrial detention for minor drug related offences.	Include: Use of mandatory pre-trial detention
Law Enforcement	The use of legal presumptions relating to drug offences that reverse the burden of proof.	Include: 'Fair trail' data
Law Enforcement	Achievement of SDG 16, especially Targets 16.1–16.6	Include: evaluation of alternative development policy through wider 'development' lens.

State drug policy coding guidelines used by Swansea University coding team

Life sentencing policy 1: Do the state's drug laws or legal frameworks include mandatory minimum sentences for any drug offences?

Yes = 1, No = 0 (list the policy document(s) and cite provision(s)).

Life sentencing policy 2: If 'yes', does this relate to first offences or multiple offences? (I.e., individual, and cumulative offences).

1 = First offences, 2 = Multiple offences. List the policy document(s) and cite provision(s).

Alternatives to Arrest, Prosecution, Conviction and/or Punishment Policy 1: Is there any provision in state criminal justice policy for alternatives to arrest, prosecution, conviction and/or punishment for drug-related offences??

Yes = 1, No = 0. List the policy document(s) and cite provision(s).

Alternatives to Arrest, Prosecution, Conviction and/or Punishment Policy 2: Do alternatives exist at the point of initial contact with law enforcement (i.e., the police or other law enforcement officers) – before arrest and/or prosecution?

Yes = 1, No = 0.

Note to coding team: Examples of such alternatives include caution/warning/no action, diversionary measures into treatment and care, or non-criminal sanctions such as fines, drug confiscation or community service.

Alternatives to Arrest, Prosecution, Conviction and/or Punishment Policy 3: Do alternatives exist after the point of arrest, but before conviction or formal criminal court proceedings?

Yes = 1, No = 0. List the policy document(s) and cite provision(s)).

Note to coding team: Examples of such alternatives include suspension of investigation/prosecution and suspension of court proceedings as well as Drug Courts.

Alternatives to Arrest, Prosecution, Conviction and/or Punishment Policy 4: Where individuals are convicted with a final sentence (courts), are there alternatives to incarceration for drug offences?

Yes = 1, No = 0 (list the policy document(s) and cite provision(s)).

Note for coding team: Examples include suspended sentence with 'Treatment Element' (TE), restriction of liberty with TE, furlough (home leave) and halfway houses with TE, drug treatment, probation, early release schemes with TE.

Mandatory Pre-Trial Detention: Do the state's laws include mandatory pre-trial detention for drug offences?

Yes = 1, No = 0 (list the policy document(s) and cite provision(s)).

World Bank Fair Trial Indicator Score: (Source: World Bank Fair Trial Data): What is the country's score on the World Bank's 'Fair Trial' indicator?

Death Penalty Policy (Source: The Death Penalty for Drug Offences Global Overview, 2020): Does the country retain the death penalty for drug offences?

Yes = 1, No = 0.

Death Penalty Implementation (Source: The Death Penalty for Drug Offences Global Overview, 2020): What is the extent of death penalty application for drug offences in the country:

1 = High Application; 2 = Low Application; 3 = Symbolic Application; 4 = Insufficient data.

Life Sentencing Policy 1: Is there provision in legislation or sentencing frameworks for the imposition of life imprisonment for drug offences?

Yes = 1, No = 0. List the policy document(s) and cite provision(s)).

Life Sentencing Policy 2: What is the nature of life sentences in the state?

Symbolic LWP = 1; Life with eligibility for parole (LWP) = 2; Life Without Parole (LWOP) = 3; Irreducible Life without Parole (LWOP) = 4; Unknown/Missing = 99. List the policy document(s) and cite provision(s)).

Decriminalisation Policy 1: Is there a provision in national legislation or in official national policy documents for the decriminalisation of drug use and the possession of drugs for personal use?

1 = Yes; 0 = No. Provide details of any legislation or national policy documents cited.

Guidance and definitions:

'Decriminalisation' refers to the removal of sanctions under the criminal law, with optional use of administrative sanctions (e.g. provision of civil fines or court-ordered therapeutic responses)' – Hughes, C., & Stevens, A., What can we learn from the Portuguese decriminalization of illicit drugs? British Journal of Criminology 2010; 50. Pp. 999–1022.

Our focus here is on 'de jure' decriminalisation, that is where decriminalisation is formal and legal (i.e., not where it is simply a matter of low-enforcement or 'looking the other way').

Finally, note that in some states there is no provision in the legislation or in official national policy documents that make drug use or possession for personal use a crime. These states will be classed as 'Yes' in our system.

Decriminalisation Policy 2: What % of the population live in a state/territory with decriminalisation provisions?

Coding notes, in these instances, we need estimates of the % of population living in territories where decriminalisation isn't nationwide. National census data would be ideal but look online for alternatives if this is unavailable.

Decriminalisation Policy 3: For states or sub-national units with decriminalisation, what substances are decriminalised?

1 = Cannabis only; 2 = Cannabis plus Several (but not all) drugs; 3 = All drugs. Provide details of any legislation or national policy documents cited.

Explicit Reference to Harm Reduction Support: (Source: Global State of Harm Reduction Report): Is there an explicit supportive reference to harm reduction in national policy documents?

1 = Yes; 0 = No. List the policy document(s) and cite provision(s)).

People Who Use Drugs - HIV National Strategic Plan 1: Are people who use drugs included in the HIV national strategic plan?

1 = Yes; 0 = No; -1 = There is no HIV national strategic plan. List the policy document(s) and cite provision(s)).

People Who Use Drugs - HIV National Strategic Plan 2: Are people who use drugs specified as key and vulnerable populations to be targeted for services in the HIV national strategic plan?

1 = Yes; 0 = No. List the policy document(s) and cite provision(s)).

People Who Use Drugs - Hepatitis C National Strategic Plan 1: Are people who use drugs included in the Hepatitis-C national strategic plan?

1 = Yes; 0 = No; -1 = There is no Hepatitis-C national strategic plan. List the policy document(s) and cite provision(s)).

People Who Use Drugs - Hepatitis C National Strategic Plan 1: Are people who use drugs specified as key and vulnerable populations to be targeted for services in the Hepatitis-C national strategic plan?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s)).

People Who Use Drugs - Tuberculosis National Strategic Plan 1: Are people who use drugs included in the Tuberculosis national strategic plan?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s)).

People Who Use Drugs - Tuberculosis National Strategic Plan 2: Are people who use drugs specified as key and vulnerable populations to be targeted for services?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s)).

Needle and Syringe Programme Availability (Source: Global State of Harm Reduction Report/Data): At least one needle and syringe programme operational?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s)).

Opioid Agonist Therapy Availability (Source: Global State of Harm Reduction Report/Data): At least one opioid agonist therapy programme operational?

1 = Yes; 0 = No.

Drug Consumption Room Availability (Source: Global State of Harm Reduction Report/Data): At least one drug consumption room?

1 = Yes; 0 = No.

Naloxone Peer Distribution Availability (Source: Global State of Harm Reduction Report/Data): Peer distribution of naloxone?

1 = Yes; 0 = No.

Opioid Agonist Therapy in Prison - Availability (Source: Global State of Harm Reduction Report/Data): OAT in at least one prison?

1 = Yes; 0 = No.

Needle Syringe Programmes in Prison - Availability (Source: Global State of Harm Reduction Report/Data): NSP in at least one prison?

1 = Yes; 0 = No.

Obligation of government to make adequate provision: Is there an explicit provision in national legislation (or in official national policy documents and regulatory instruments) that establishes the government's obligation to make adequate provision to ensure the availability of controlled medicines for the relief of pain and suffering?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s).

Importance of adequate provision recognised in national medicines policy plan: Is there an approved national medicines policy plan that recognises the importance of the availability and accessibility of controlled medicines for the relief of pain and suffering?

1 = Yes; 0 = No; list the policy document(s) and cite provision(s)).

Levels of consumption of narcotic drugs: global consumption of opioids, expressed in millions of defined daily doses for statistical purposes (S-DDD) (source: INCB 2021 Report):

No Access (<1); very low access (1 – 100); low access (101 – 1000); moderate access (1001 – 5000), high access (5,001 – 20,000); very high access (>20,0000).

Filter Question for 'Development' Dimension: Does the country include 'alternative development' or 'sustainable development' programmes to provide alternatives to the cultivation of crops used for illegal drug production?

1 = Yes; 0 = No. Provide details of any legislation or national policy documents cited. Note that this is cross validated with data from expert surveys.

Embedding of alternative development in wider development policy: Is AD embedded within a broader development programme?

1 = Yes; 0 = No. Provide details of any legislation or national policy documents cited.

Forced crop eradication policy provision 1: Does AD policy include provisions for forced crop eradication?

1 = Yes; 0 = No. Provide details of any legislation or national policy documents cited.

Forced crop eradication policy provision 2: Does AD policy make provision for aerial spraying in forced crop eradication?

1 = Yes; 0 = No. Provide details of any legislation or national policy documents cited.

Civil society survey text

* Required Information

Survey of Experts in States' Drug Policy: Global Drug Policy Index

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Welcome to the Global Drug Policy Index's Survey of Experts in States' Drug Policy. You are either a member of the Harm Reduction Consortium or a person from Civil Society identified by a member as having the expertise to evaluate a state's drug policy. The project takes a broad definition of Civil Society to include those working in drug policy advocacy groups, academic and think tank members with drug policy expertise in at least one of the states being evaluated, and others with drug policy expertise who do not work for the state and/or law enforcement agencies.

In all evaluations, we ask that you consider the calendar year 2020 - rather than longer-term trends or events in 2021. This will enable us to develop over-time comparisons in future iterations of the GDPI.

We would like to thank you for taking the time to engage with this survey. We estimate that the survey should take 30-40 minutes to complete. Before we begin, we need to obtain your informed consent to take part in this research, which requires that you read the project information below.

About the project

This survey is a key component of the Global Drug Policy Index (GDPI) project, which centres on the development and delivery of a new composite index to document, measure, and compare government policies related to illicit drugs. The project is funded by the Robert Carr Fund and is being carried out by the Harm Reduction Consortium. You can find out more about the project at this link.

The data that you enter in this survey will be used alongside a coded set of state policies as well as external data sources to create a composite index, the GDPI. The index will provide each country with a score and ranking to show the extent to which their drug policies align with the evidence and rights-based approaches outlined in the UN Common Position on Drugs and detailed in the 2019 report of UN system coordination Task Team on the Implementation of the UN System Common Position on drug-related matters; What we have learned over the last ten years: A summary of knowledge acquired and produced by the UN system on drug-related matters.

This includes collecting data across four dimensions – criminal justice response proportionality, health and harm reduction, the availability of controlled medicines, and (where relevant) development. The GDPI tracks policies and their implementation and you will be asked to provide evaluations of both of these aspects of drug policy in this survey.

For most of these questions, we have written guidance notes to assist with the interpretation of the concepts involved and the response categories. Where this is the case, you will see a small black box with a question mark at the end of the question. You can access the guidance notes by clicking on this box.

Informed consent

The survey is being operated by Dr Matthew Wall and Prof. David Bewley-Taylor (both of Swansea University) who are acting as the GDPI technical leads. If you have any questions or concerns about the survey, please contact Dr Wall at: m.t.wall@swansea.ac.uk.

Below are a series of checkboxes that allow you to provide informed consent to participate in this survey. All of these boxes must be ticked for the survey to proceed.

*** 1. Please indicate that you have read the project information above. (Select one option)**

◯ I have read the project information

*** 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. (Select one option)**

◯ I understand these rights

*** 3. I understand that sections of any of the data obtained may be looked at by responsible individuals from Swansea University (Dr Matthew Wall and Prof. David Bewley-Taylor). (Select one option)**

◯ I give permission for these responsible individuals to have access to these records.

*** 4. Informed consent (Select one option)**

◯ I agree to take part in the above-described study.

5. **Which state's drug policy are you evaluating in this survey? (Select one option)**

- ○ Afghanistan
- ○ Argentina
- ○ Australia
- ○ Brazil
- ○ Canada
- ○ Colombia
- ○ Costa Rica
- ○ Georgia
- ○ Ghana
- ○ Hungary
- ○ India
- ○ Indonesia
- ○ Jamaica
- ○ Kenya
- ○ Kyrgyzstan
- ○ Lebanon
- ○ Mexico
- ○ Morocco
- ○ Mozambique
- ○ Nepal
- ○ New Zealand
- ○ North Macedonia
- ○ Norway
- ○ Portugal
- ○ Russia
- ○ Senegal

- ◯ South Africa
- ◯ Thailand
- ◯ Uganda
- ◯ United Kingdom

6. Please indicate the nature of your expertise on this state's drug policy (tick as many as apply)

- ☐ I work in a civil society organisation that focuses on drug policy
- ☐ I have academic expertise in the study of drug policy
- ☐ I work in a think-tank or consultancy that examines drug policy
- ☐ Other (Please specify) _____

The next questions are used so that we can identify trends and potential biases driven by respondent demographics as well as assuring respondent diversity. They are for internal analysis only and these aspects of the data will not be published on the GDPI website.

7. How would you describe your gender? (Select one option)

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Other
- ◯ I prefer not to say

8. In what year were you born? (Select one option)

- ◯ I prefer not to say
- ◯ 2003 or later
- ◯ 2002
- ◯ 2001
- ◯ 2000
- ◯ 1999

- ○ 1998
- ○ 1997
- ○ 1996
- ○ 1995
- ○ 1994
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- ◯ 1952
- ◯ 1951
- ◯ 1950
- ◯ 1949
- ◯ 1948
- ◯ 1947
- ◯ 1946
- ◯ 1945
- ◯ 1944
- ◯ 1943
- ◯ 1942
- ◯ 1941 or earlier

9. Which of the following describes your ethnic identity? (Select one option)

- ◯ I prefer not to say
- ◯ Arabic

- ○ Asian
- ○ Black
- ○ Hispanic or Latino
- ○ Mixed or multiple ethnic identity
- ○ Indigenous
- ○ White
- ○ Other (Please specify) _____

Proportionality of Criminal Justice Response

Sub -Dimension 1: Use of Extreme Sentencing and Responses (Including the Death Penalty)

10. To what extent is the practice of extra-judicial killing prevalent in the course of military and police anti-drug activity? (Select one option)

Tip: In this question, we are referring to both summary executions by the military and police and the unnecessary use of lethal force in the context of drug enforcement. The response scale refers to the prevalence of such incidents.

We ask that you use the following definitions to guide your response:

Not at all: There are no or, at least, no widely agreed-upon instances.

To a small extent: Instances are present but rare, 3 or less in 2020.

To a moderate extent: Instances are quite regular, but not widespread, 4 - 20 in 2020.

To a large extent: Instances are both widespread and regular, 21-40 in 2020.

To a very large extent: Instances are endemic, more than 40 in 2020.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#10 is 1 OR 2 OR 3 OR 4 OR 5

11. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

12. To what extent are military or special security forces are involved in drug operations? (Select one option)

Tip: We ask that you use the following definitions to guide your response:

Not at all: There are no or, at least, no widely agreed-upon instances of military or special security forces being involved in drug operations in 2020.

To a small extent: Instances of military or special security forces being involved in drug operations are present but very rare, occurring less than 3 times in 2020.

To a moderate extent: Instances of military or special security forces being involved in drug operations are quite frequent, occurring between 4 and 20 times in 2020.

To a large extent: Instances of military or special security forces being involved in drug operations are regular, occurring between 21 and 40 times in 2020.

To a very large extent: Instances of military or special security forces being involved in drug operations are endemic, occurring more than 40 times in 2020.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#12 is 1 OR 2 OR 3 OR 4 OR 5

13. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

14. To what extent is there a practice of non-consensual confinement in compulsory drug treatment centres? (Select one option)

Tip: We ask that you use the following definitions to guide your response:

Not at all: There are no or, at least, no widely agreed-upon instances.

To a small extent: Instances are present but rare.

To a moderate extent: Instances are quite regular, but not widespread.

To a large extent: Instances are both widespread and regular.

To a very large extent: Instances are endemic.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#14 is 1 OR 2 OR 3 OR 4 OR 5

15. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

16. How frequently are formal life sentences imposed for drug use and personal possession offences? (Select one option)

Tip: We are focusing here on formal life imprisonment where courts explicitly impose a sentence of imprisonment for life. We are asking you to evaluate the likelihood that a personal possession offence results in such a sentence.

We ask that you use the following definitions to guide your response:

Never: 0% of use and personal possession offences result in life sentences

Very rarely: 1 - 5% of use and personal possession offences result in life sentences Rarely: 6- 10% of use and personal possession offences result in life sentences

Frequently: 11 - 30% of use and personal possession offences result in life sentences

Very Frequently: 31 - 80% of use and personal possession offences result in life sentences

Always or nearly always: 81 - 100% of use and personal possession offences result in life sentences

1	2	3	4	5	6
○	○	○	○	○	○
Never	Very Rarely	Rarely	Frequently	Very Frequently	Always or Nearly Always

☐ I don't know

NOTE : Answer the below question only if answer to Q#16 is 1 OR 2 OR 3 OR 4 OR 5 OR 6

17. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

18. How frequently are formal life sentences imposed for drug supply offences (production, dealing, or trafficking)? (Select one option)

Tip: We are focusing here on formal life imprisonment where courts explicitly impose a sentence of imprisonment for life. We are asking you to evaluate the likelihood that a drug supply offence results in such a sentence. Our definition of 'drug supply offences' includes the production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation, or exportation of drugs.

We ask that you use the following definitions to guide your response:

Never: 0% of drug supply offences result in life sentences

Very rarely: 1 - 5% of drug supply offences result in life sentences

Rarely: 6 - 15% of drug supply offences result in life sentences Frequently: 16 - 40% of drug supply offences result in life sentences

Very Frequently: 41 - 80% of drug supply offences result in life sentences Always or Nearly Always: 81 - 100% of drug supply offences result in life sentences

1	2	3	4	5	6
○	○	○	○	○	○

Never	Very Rarely	Rarely	Frequently	Very Frequently	Always or Nearly Always

☐ I don't know

NOTE : Answer the below question only if answer to Q#18 is 1 OR 2 OR 3 OR 4 OR 5 OR 6

19. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

Proportionality of Criminal Justice Response

Sub -Dimension 2: Criminal Justice Response

20. To what extent does enforcement of drug policy disproportionately impact certain ethnic groups? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to be stopped on suspicion of a drug offence, to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: No ethnic groups are impacted disproportionately compared to any other group in society.

To a small extent: Members of certain ethnic groups may experience occasional instances of disproportionate impact, but this affects less than 10% of group members.

To a moderate extent: Members of certain ethnic groups often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of certain ethnic groups frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of certain ethnic groups are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#20 is 1 OR 2 OR 3 OR 4 OR 5

21. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

22. To what extent does enforcement of drug policy disproportionately impact women? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to be stopped on suspicion of a drug offence, to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: This group is not impacted disproportionately compared to any other group in society.

To a small extent: Members of this group may experience occasional instances of disproportionate impact, but this affects less than 10% of group members stopped on suspicion of a drug offence.

To a moderate extent: Members of this group often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of this group frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of this group are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#22 is 1 OR 2 OR 3 OR 4 OR 5

23. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

24. To what extent does enforcement of drug policy disproportionately impact low-income groups? (Select one option)

Tip: There is no internationally recognised definition of 'low income.' Here we work on the basis of it being a relative measure relating to incomes below the national median. In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to be stopped on suspicion of a drug offence, to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: This group is not impacted disproportionately compared to any other group in society.

To a small extent: Members of this group may experience occasional instances of disproportionate impact, but this affects less than 10% of group members stopped on suspicion of a drug offence.

To a moderate extent: Members of this group often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of this group frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of this group are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not At All	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#24 is 1 OR 2 OR 3 OR 4 OR 5

25. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

26. To what extent does the pursuit of state drug policy result in the imprisonment of non-violent offenders? (Select one option)

Tip: In this question, we seek an evaluation of the scale and targeting of imprisonment in the state. The term 'non-violent offenders' refers to convictions for drug-related offences that do not involve either direct (e.g., robbery, assault, murder) or systemic (e.g., gang-related) violence.

We ask that you use the definitions below in your response:

Not at all: People are never or very rarely imprisoned for non-violent drug-related offences. Such individuals make up less than 5% of the prison population.

To a small extent: Non-violent drug-related offences sometimes result in imprisonment, and those imprisoned for such offences make up 6-15% of the prison population.

To a moderate extent: Non-violent drug-related offences often result in imprisonment, and those imprisoned for such offences make up 16-25% of the prison population.

To a large extent: Non-violent drug-related offences are likely to result in imprisonment, and those imprisoned for such offences make up 26-40% of the prison population.

To a very large extent: Non-violent drug-related offences are very likely to result in imprisonment, and those imprisoned for such offences make up more than 40% of the prison population.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#26 is 1 OR 2 OR 3 OR 4 OR 5

27. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

28. How often are suspects in drug cases subject to violence or torture by the police? (Select one option)

Tip: We ask that you use the following definitions to guide your response:

Never: 0% of suspects in drug cases are subjected to violence or torture by the police

Very rarely: 1 - 10% of suspects in drug cases are subjected to violence or torture by the police

Rarely = 11 - 25% of suspects in drug cases are subjected to violence or torture by the police

Frequently = 26 - 50% of suspects in drug cases are subjected to violence or torture by the police

Very Frequently = 51 - 80% of suspects in drug cases are subjected to violence or torture by the police

Always or Almost Always = more than 80% of suspects in drug cases are subjected to violence or torture by the police

1	2	3	4	5	6
○	○	○	○	○	○
Never	Very Rarely	Rarely	Frequently	Very Frequently	Always or Almost Always

☐ I don't know

NOTE : Answer the below question only if answer to Q#28 is 1 OR 2 OR 3 OR 4 OR 5 OR 6

29. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

30. To what extent does arbitrary arrest and detention for drug offences exist? (Select one option)

Tip: Here we aim to capture the extent to which drug policy leads to a violation of the right to liberty. Arbitrariness should not be equated simply with 'against the law.' It must be interpreted more broadly to include elements of inappropriateness, disproportionality, injustice, lack of predictability and due process of law. Arbitrary arrest and detention include, therefore, not only unlawful actions but also those that violate international human rights standards. As such, arbitrary arrest and detention may not be considered unlawful by courts in the state you are evaluating.

We ask that you use the following definitions to guide your response:

Not at all = There are no or, at least, no widely agreed-upon instances.

To a small extent = Instances are present but rare.

To a moderate extent = Instances are quite regular, but not widespread.

To a large extent = Instances are both widespread and regular.

To a very large extent = Instances are endemic and frequent.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#30 is 1 OR 2 OR 3 OR 4 OR 5

31. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

32. Do alternatives to arrest, prosecution, conviction and/or punishment for drug-related offences include treatment or care elements?

☐ Yes

☐ No

☐ I don't know

NOTE : Answer the below question only if answer to Q#32 is Yes

33. Where alternatives to arrest, prosecution, conviction and/or punishment for drug-related offences include treatment or care elements, is relapse / non-attendance / treatment "failure" associated with subsequent imprisonment or punishment?

☐ Yes

☐ No

☐ I don't know

NOTE : Answer the below question only if answer to Q#32 is Yes

34. Where alternatives to arrest, prosecution, conviction and/or punishment for drug-related offences include treatment or care elements, are a range of treatment options and modalities made available to people based on their clinically assessed need or preferences?

- ☐ Yes
- ☐ No
- ☐ I don't know

Proportionality of Criminal Justice Response

Sub –Dimension 3: Criminalisation/Decriminalisation of the possession of drugs for personal use

35. Does the state that you are evaluating have either state-wide or sub-state (that is, within certain states or territories, but not national) decriminalisation? (Select one option)

Tip: Decriminalisation refers to the removal of sanctions under the criminal law, with optional use of administrative sanctions (e.g. provision of civil fines or court-ordered therapeutic responses). Our focus here is on 'de jure' decriminalisation, that is where decriminalisation is formal and legal (i.e., not where it is simply a matter of low-enforcement discretion or 'looking the other way').

- ◯ Yes
- ◯ No
- ◯ I don't know

NOTE : Answer the below question only if answer to Q#35 is Yes

36. To what extent has decriminalisation in this state been effective in diverting people who use drugs away from the criminal justice system? (Select one option)

Tip: In responding to this question, we ask that you interpret the response scale as relating to whether decriminalisation has reduced contact with the punitive elements of the criminal justice system (prosecutors, judges, and prisons) for people who use drugs.

For states with decriminalization in sub-state units, but not statewide, please evaluate the efficacy of decriminalization in the jurisdiction(s) where it is in force. Among such states, where decriminalisation is operative in multiple sub-state units, please evaluate the overall trend across these jurisdictions.

We ask that you use the following definitions to guide your response:

Not at all = There has been no reduction (or even an increase) in contacts with the criminal justice system for people who use drugs.

To a small extent = There has been an observable, but minor reduction (10% or less) in contacts with the criminal justice system

To a moderate extent = There has been an observable, but modest reduction (11-20%) in contacts with the criminal justice system

To a large extent = There has been a pronounced reduction (21-50%) in contacts with the criminal justice system

To a very large extent = There has been a dramatic reduction (more than 50%) in contacts with the criminal justice system

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#36 is 1 OR 2 OR 3 OR 4 OR 5

37. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#35 is Yes

38. Where there are administrative (non-criminal) sanctions for drug use and possession for personal use, how would you rate the severity of these sanctions? (Select one option)

Tip: In this question, we are seeking to evaluate how onerous the state's non-criminal sanctions (such as fines and community service) are to the typical person who is sanctioned for drug use and/or possession for personal use.

We ask that you use the following definitions to guide your response:

Mild: Representing an inconvenience or minor proportion of one's monthly income.

Moderate: Representing a significant inconvenience and portion of one's monthly income.

Severe: Representing an onerous obligation that may result in a deterioration of life circumstances and/or substantial loss of income.

Very severe: Representing a very onerous obligation that is likely or very likely to result in a substantial deterioration of life circumstances and/or severely affect income.

1	2	3	4
○	○	○	○
Mild	Moderately Severe	Severe	Very Severe

☐ Does not apply/I don't know

NOTE : Answer the below question only if answer to Q#38 is 1 OR 2 OR 3 OR 4

39. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

Dimension 2: Harm Reduction

40. Which of the following best describes the sustainability of harm reduction funding in the country over the next 3-5 years? (Select one option)

Tip: In this question, we are seeking to measure the sustainability and reliability of Harm Reduction funding. We understand that this may vary according to service type, however, we ask that you make an overall evaluation across all harm reduction funding. Please note that we are not asking you to rate either the level or adequacy of funding, which will be measured separately by the GDPI project team.

1	2	3	4	5	6
○	○	○	○	○	○
Funding is secure	Funding is mostly secure	Funding is somewhat unstable	Funding is uncertain	Funding is likely to be reduced	Severe reductions to funding are anticipated

☐ I don't know

NOTE : Answer the below question only if answer to Q#40 is 1 OR 2 OR 3 OR 4 OR 5 OR 6

41. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

42. Which of the following best describes the availability of needle and syringe programmes for people who inject drugs? (Select one option)

Tip: In responding to this question, we ask you to consider the approximate number of needle-syringes distributed per person who injects drugs per year (recall that the year being evaluated is 2020).

We ask that you use the following definitions to guide your response:

Unavailable: 0 needle-syringes per person who injects drugs (either because it is not permitted by the state or because there are no providers).

Very limited availability: Less than 100 needle-syringes per person who injects drugs.

Limited availability: 100-199 needle-syringes per person who injects drugs.

Wide availability: 200-300 needle-syringes per person who injects drugs.

Very Wide Availability: More than 300 needle-syringes per person who injects drugs.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#42 is 1 OR 2 OR 3 OR 4

43. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

44. Which of the following best describes the availability of opioid agonist therapy programmes for people who use opioid drugs? (Select one option)

Tip: In responding to this question, we ask you to consider the proportion of people who use opioid drugs who can access Opioid Agonist Therapy programmes.

We ask that you use the following definitions to guide your response:

Unavailable: This intervention is not available to people who use opioid drugs (either because it is not permitted by the state or because there are no providers).

Very limited availability: This intervention is available to 1-19% of people who use opioid drugs.

Limited availability: This intervention is available to 20-39% of people who use opioid drugs.

Wide availability: This intervention is available to 40-60% of people who use opioid drugs.

Very Wide Availability: This intervention is available to more than 60% of people who use opioid drugs.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#44 is 1 OR 2 OR 3 OR 4

45. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

46. Which of the following best describes the availability of naloxone for people who use opioid drugs? (Select one option)

Tip: When answering this question, consider the full range and extent of use of different routes for accessing naloxone, including via emergency services, via prescription from authorised health care professionals, distribution of take-home naloxone from drug service providers and for sale over the counter in pharmacies, as well as peer-distribution. In responding to this question, we ask you to consider the proportion of people who use opioid drugs who can access this harm reduction intervention.

We ask that you use the following definitions to guide your response:

Unavailable: This intervention is not available to people who use opioid drugs (either because it is not permitted by the state or because there are no providers).

Very limited availability: This intervention is available to 1-10% of people who use opioid drugs.

Limited availability: This intervention is available to 11-40% of people who use opioid drugs.

Wide availability: This intervention is available to 41-60% of people who use opioid drugs.

Very Wide availability: This intervention is available to more than 60% of people who use opioid drugs.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#46 is 1 OR 2 OR 3 OR 4

47. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

48. Which of the following best describes the availability of opioid agonist therapy to people in prison? (Select one option)

Tip: In responding to this question, we ask you to consider the proportion of people who use drugs to whom this harm reduction intervention is available while in prison.

We ask that you use the following definitions to guide your response:

Unavailable: This intervention is not available while in prison (either because it is not permitted by the state or because there are no providers).

Very limited availability: This intervention is available to 1-10% of people who use drugs while in prison.

Limited availability: This intervention is available to 11-40% of people who use drugs while in prison.

Wide availability: This intervention is available to 41-60% of people who use drugs while in prison. Very Wide Availability: This intervention is available to more than 60% of people who use drugs while in prison.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#48 is 1 OR 2 OR 3 OR 4

49. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

50. Which of the following best describes the availability of needle and syringe programmes to people in prison? (Select one option)

Tip: In responding to this question, we ask you to consider the proportion of people who use drugs to whom this harm reduction intervention is available while in prison.

We ask that you use the following definitions to guide your response:

Unavailable: This intervention is not available while in prison (either because it is not permitted by the state or because there are no providers).

Very limited availability: This intervention is available to 1-10% of people who use drugs while in prison. Limited availability:

This intervention is available to 11-40% of people who use drugs while in prison.

Wide availability: This intervention is available to 41-60% of people who use drugs while in prison.

Very Wide Availability: This intervention is available to more than 60% of people who use drugs while in prison.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#50 is 1 OR 2 OR 3 OR 4 OR 5

51. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

52. Which of the following best describes the availability of drug checking services to people who use drugs? (Select one option)

Tip: Drug checking is a harm reduction measure that allows people who use drugs to identify the substance they intend to take and therefore prevent the possible harms associated with consuming an unknown substance. Examples of drug checking services include access to reagent or spectroscopy/spectrometry technologies for people who use drugs. In responding to this question, we ask you to consider the proportion of people who use drugs to whom this harm reduction intervention is available.

We ask that you use the following definitions to guide your response:

Unavailable: This intervention is not available to people who use drugs (either because it is not permitted by the state or because there are no providers).

Very limited availability: This intervention is available to 1-10% of people who use drugs.

Limited availability: This intervention is available to 11-40% of people who use drugs.

Wide availability: This intervention is available to 41-60% of people who use drugs.

Very Wide availability: This intervention is available to more than 60% of people who use drugs.

1	2	3	4	5
○	○	○	○	○
Unavailable	Very Limited Availability	Limited Availability	Wide Availability	Very Wide Availability

☐ I don't know

NOTE : Answer the below question only if answer to Q#52 is 1 OR 2 OR 3 OR 4

53. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

54. To what extent are there disparities in access to harm reduction services due to individuals' ethnicity? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which certain ethnic groups are more likely to be unable to access harm reduction services. In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: Ethnicity doesn't create any observable disparities in access to harm reduction services.

To a small extent: Members of certain ethnic groups experience disparities in access to harm reduction services, but this affects less than 10% of group members.

To a moderate extent: Members of certain ethnic groups experience disparities in access to harm reduction services, but this affects less than 25% of group members.

To a large extent: Members of certain ethnic groups frequently experience disparities in access to harm reduction services, affecting 25%-50% of group members.

To a very large extent: Members of certain ethnic groups are more likely than not to experience disparities in access to harm reduction services, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#54 is 1 OR 2 OR 3 OR 4 OR 5

55. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

56. To what extent are there disparities in access to harm reduction services for women, including during pregnancy? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which women are more likely to be unable to access harm reduction services. This includes limitations that women may face during pregnancy. In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: Women don't experience any observable disparities in access to harm reduction services.

To a small extent: Women may experience disparities in access to harm reduction services, but this affects less than 10% of women.

To a moderate extent: Women experience disparities in access to harm reduction services, but this affects less than 25% of women.

To a large extent: Women frequently experience disparities in access to harm reduction services, affecting 25%-50% of women.

To a very large extent: Women are more likely than not to experience disparities in access to harm reduction services, affecting more than 50% of women.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#56 is 1 OR 2 OR 3 OR 4 OR 5

57. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

58. To what extent are there disparities in access to harm reduction services due to individuals' sexual and/or gender orientation? (Select one option)

Tip: In this question, we ask you to consider whether individuals who are not heterosexual or cis-gender experience disparities in access to harm reduction services. We use the term 'LGBTQ+' to denote individuals in these categories. In responding to this question, we ask that you consider the extent to which people who are LGBTQ+ are more likely to be unable to access harm reduction services.

We ask that you use the following definitions to guide your response:

Not at all: LGBTQ+ individuals don't experience any observable disparities in access to harm reduction services.

To a small extent: LGBTQ+ individuals may experience disparities in access to harm reduction services, but this affects less than 10% of individuals.

To a moderate extent: LGBTQ+ individuals experience disparities in access to harm reduction services, but this affects less than 25% of individuals.

To a large extent: LGBTQ+ individuals frequently experience disparities in access to harm reduction services, affecting 25%-50% of individuals.

To a very large extent: LGBTQ+ individuals are more likely than not to experience disparities in access to harm reduction services, affecting more than 50% of individuals.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#58 is 1 OR 2 OR 3 OR 4 OR 5

59. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

Dimension 3: Availability of and acc internationally controlled substances relief of pain and suffering

60. To what extent are there geographic disparities in access to controlled drugs for the treatment of pain? (Select one option)

Tip: In this question, we are asking you to evaluate the extent to which individuals' location affects their access to controlled drugs for the treatment of pain (we ask that you focus on access to opioid analgesics in your answer). Such difficulties include a complete inability to access such drugs but may also include higher practical barriers to access and significant delays to access.

We ask that you use the following definitions to guide your response:

Not at all: Individuals throughout the country have similar access to controlled drugs for the treatment of pain.

To a small extent: In some areas, it is more difficult to access controlled drugs for the treatment of pain, but this affects only very rural areas.

To a moderate extent: In some areas, it is more difficult to access controlled drugs for the treatment of pain, this affects many rural areas.

To a large extent: In many areas, it is more difficult to access controlled drugs for the treatment of pain, this affects most areas outside of major population centres.

To a very large extent: Access to controlled drugs for the treatment of pain is limited to a small number of major population centres, outside of these areas, access is reduced.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#60 is 1 OR 2 OR 3 OR 4 OR 5

61. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

62. To what extent are there disparities in access to controlled drugs for the treatment of pain due to individuals' gender?
(Select one option)

Tip: In responding to this question, we ask that you consider the extent to which gender affects access to controlled drugs for the treatment of pain (we ask that you focus on access to opioid analgesics in your answer). In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: There aren't any observable gender disparities in access to controlled drugs for the treatment of pain.

To a small extent: Members of one gender may experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 10% of members.

To a moderate extent: Members of one gender experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 25% of members.

To a large extent: Members of one gender frequently experience disparities in access to controlled drugs for the treatment of pain, affecting 25%-50% of members.

To a very large extent: Members of one gender are more likely than not to experience disparities in access to controlled drugs for the treatment of pain, affecting more than 50% of members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#62 is 1 OR 2 OR 3 OR 4 OR 5

63. How confident are you of this assessment? (Select one option)

1	2	3	4

○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

64. To what extent are there disparities in access to controlled drugs for the treatment of pain due to individuals' socio-economic status?
(Select one option)

Tip: In responding to this question, we ask that you consider the extent to which socioeconomic status affects access to controlled drugs for the treatment of pain (we ask that you focus on access to opioid analgesics in your answer). In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: There aren't any observable socioeconomic disparities in access to controlled drugs for the treatment of pain.

To a small extent: People with lower socioeconomic status may experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 10% of the population.

To a moderate extent: People with lower socioeconomic status experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 25% of the population.

To a large extent: People with lower socioeconomic status frequently experience disparities in access to controlled drugs for the treatment of pain, affecting 25%-50% of the population.

To a very large extent: People with lower socioeconomic status experience disparities in access to controlled drugs for the treatment of pain, affecting more than 50% of the population.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#64 is 1 OR 2 OR 3 OR 4 OR 5

65. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

66. To what extent are there disparities in access to controlled drugs for the treatment of pain due to individuals' ethnicity?
(Select one option)

Tip: In responding to this question, we ask that you consider the extent to which ethnicity affects access to controlled drugs for the treatment of pain (we ask that you focus on access to opioid analgesics in your answer). In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: There aren't any observable ethnic disparities in access to controlled drugs for the treatment of pain.

To a small extent: Members of some ethnic groups may experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 10% of members.

To a moderate extent: Members of some ethnic groups experience disparities in access to controlled drugs for the treatment of pain, but this affects less than 25% of members.

To a large extent: Members of some ethnic groups frequently experience disparities in access to controlled drugs for the treatment of pain, affecting 25%-50% of members.

To a very large extent: Members of some ethnic groups are more likely than not to experience disparities in access to controlled drugs for the treatment of pain, affecting more than 50% of members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#66 is 1 OR 2 OR 3 OR 4 OR 5

67. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

68. To what extent are there disparities in access to opioid analgesics for the treatment of pain for people who use drugs?
(Select one option)

Tip: In responding to this question, we ask that you consider the extent to which being a person who uses drugs affects access to opioid analgesics for the treatment of pain. In evaluating this question, please consider both formal and informal/cultural barriers to access.

We ask that you use the following definitions to guide your response:

Not at all: People who use drugs are treated identically to those who do not, or any differences in treatment do not limit their ability to access opioid analgesics for the treatment of pain.

To a small extent: People who use drugs are able to access opioid analgesics for the treatment of pain, but face some additional barriers to access which are not severe.

To a moderate extent: People who use drugs are able to access opioid analgesics for the treatment of pain, but face additional barriers that render such access somewhat more difficult.

To a large extent: People who use drugs are able to access opioid analgesics for the treatment of pain, but face additional barriers that render such access considerably more difficult.

To a very large extent: People who use drugs are either formally unable to access opioid analgesics for the treatment of pain or face substantial additional barriers that render such access much more difficult.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#68 is 1 OR 2 OR 3 OR 4 OR 5

69. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

70. To what extent does the policy-making process relating to controlled medicines meaningfully include stakeholders such as medical boards, health professionals (including pharmacists), patients, and representatives of patients?
(Select one option)

Tip: In this question, we are asking about the breadth and quality of engagement with the above-listed stakeholders in the policy-making process relating to controlled medicines.

We ask that you use the following definitions to guide your response:

Not at all: Such stakeholders are excluded from the policy-making process.

To a small extent: The policy-making process involves a narrow range of stakeholders, and their participation has little impact on the policies that emerge.

To a moderate extent: The policy-making process involves a reasonable range of stakeholders, and their participation has a moderate impact on the policies that emerge.

To a large extent: The policy-making process involves a wide range of stakeholders, and their participation has a significant, but limited impact on the policies that emerge.

To a very large extent: The policy-making process involves a wide range of stakeholders, and their participation has a substantial impact on the policies that emerge.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know.

NOTE : Answer the below question only if answer to Q#70 is 1 OR 2 OR 3 OR 4 OR 5

71. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

Dimension 4: Development

72. Does the state drug policy include 'alternative development' or 'sustainable development' programmes to provide alternatives to the cultivation of crops used for illegal drug production? (Select one option)

- ◯ Yes
- ◯ No
- ◯ I don't know

NOTE : Answer the below question only if answer to Q#72 is Yes

73. To what extent are alternative development programmes sequenced to ensure that targeted households have adopted viable and sustainable livelihoods in advance of any crop eradication efforts? (Select one option)

Tip: This question focuses on the extent to which adoption of alternative viable and sustainable livelihoods proceeds any crop eradication efforts.

We ask that you use the following definitions to guide your response:

Not at all: Such sequencing is not a part of alternative development programmes either formally or in practice.

To a small extent: Such sequencing is included in alternative development programmes but, in practice, crop eradication efforts often commence in advance of targeted households adopting viable and sustainable alternative livelihoods.

To a moderate extent: Such sequencing is included in alternative development programmes but, in practice, crop eradication efforts sometimes commence in advance of targeted households adopting viable and sustainable alternative livelihoods.

To a large extent: Such sequencing is included in alternative development programmes, in practice, crop eradication efforts rarely commence in advance of targeted households adopting viable and sustainable alternative livelihoods.

To a very large extent: Such sequencing is included in alternative development programmes, in practice, crop eradication efforts very rarely or never commence in advance of targeted households adopting viable and sustainable alternative livelihoods.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#73 is 1 OR 2 OR 3 OR 4 OR 5

74. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

75. To what extent are local communities, participants, and (where applicable) indigenous and minority groups meaningfully included in the design, implementation, monitoring, and evaluation of alternative development policies and programmes? (Select one option)

Tip: In this question, we are asking about the breadth and quality of engagement with the above-listed stakeholders. We ask that you use the following definitions to guide your response:

Not at all: Such stakeholders are excluded from the design, implementation, monitoring, and evaluation of alternative development policies and programmes.

To a small extent: There is narrow access for some stakeholders in the design, implementation, monitoring, and evaluation of alternative development policies and programmes, but they have little real impact.

To a moderate extent: There is reasonable inclusion of these stakeholders in the design, implementation, monitoring, and evaluation of alternative development policies and programmes and their inclusion has a moderate impact.

To a large extent: There is wide inclusion of these stakeholders in the design, implementation, monitoring, and evaluation of alternative development policies and programmes and their inclusion has a significant, but limited impact.

To a very large extent: There is wide inclusion of these stakeholders in the design, implementation, monitoring, and evaluation of alternative development policies and programmes and their inclusion has a substantial impact.

1	2	3	4	5

○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know/Not Applicable

NOTE : Answer the below question only if answer to Q#75 is 1 OR 2 OR 3 OR 4 OR 5

76. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

77. To what extent do alternative development policies and programmes facilitate the empowerment of women? (Select one option)

Tip: Here, recognizing the crucial role of gender equality as a driver of development progress, we are seeking to capture the extent to which alternative development policy and programmes ensure full, effective, and equal participation and leadership, including within decision-making processes. As such, there is a close correlation to Sustainable Development Goal 5, Achieve gender equality and empower all women and girls.

We ask that you use the following definitions to guide your response:

Not at all: Alternative development policies and programmes fail to consider or fail to achieve the empowerment of women.

To a small extent: Alternative development policies and programmes seek the empowerment of women, but achieve little success.

To a moderate extent: Alternative development policies and programmes seek the empowerment of women, but their success in achieving this is patchy.

To a large extent: Alternative development policies and programmes seek the empowerment of women, with significant but partial success.

To a very large extent: Alternative development policies and programmes seek the empowerment of women, with substantial success.

1	2	3	4	5

○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#77 is 1 OR 2 OR 3 OR 4 OR 5

78. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

79. To what extent do alternative development policies and programmes benefit young people? (Select one option)

Tip: In answering this question, please consider not only the removal of young people from activities around the cultivation of crops used for illegal drug production but also opportunities generated. For example, young people being placed into the labour market through direct programme/project support or via vocational skills acquired and improved access to health care, education, etc.

We ask that you use the following definitions to guide your response:

Not at all: Alternative development policies and programmes fail to consider or fail to achieve specific benefits for young people.

To a small extent: Alternative development policies and programmes seek specific benefits for young people, but achieve little success.

To a moderate extent: Alternative development policies and programmes seek specific benefits for young people, but their success in achieving this is patchy.

To a large extent: Alternative development policies and programmes seek specific benefits for young people, with significant but partial success.

To a very large extent: Alternative development policies and programmes seek specific benefits for young people, with substantial success.

1	2	3	4	5
○	○	○	○	○

Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#79 is 1 OR 2 OR 3 OR 4 OR 5

80. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

81. To what extent is the protection of the environment prioritised in alternative development policy and programmes? (Select one option)

Tip: In this question, we ask you to consider the relative priority environmental protection is given in alternative development policy and programmes relative to other considerations.

We ask that you use the following definitions to guide your response:

Not at all: Environmental protection is not given any priority in alternative development policy and programmes (either formally or in practice).

To a small extent: Environmental protection is given low priority in alternative development policy and programmes

To a moderate extent: Environmental protection is given middling priority in alternative development policy and programmes

To a large extent: Environmental protection is given high priority in alternative development policy and programmes, with some inconsistencies

To a very large extent: Environmental protection is consistently given high priority in alternative development policy and programmes

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#81 is 1 OR 2 OR 3 OR 4 OR 5

82. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

83. To what extent does alternative development operate within a framework of militarized/security sector operations as part of security policy? (Select one option)

Tip: We ask that you use the following definitions to guide your response:

Not at all: Alternative development policies and programmes are completely separate from security policy and do not involve the military/security sector.

To a small extent: Alternative development policies and programmes fall largely outside of security policy, but have a small degree of military/security sector involvement in implementation.

To a moderate extent: Alternative development policies and programmes often operate with security policy goals in mind and have some military/security sector involvement in implementation.

To a large extent: Alternative development policies and programmes are an aspect of state security policy, with significant military/security sector involvement in implementation.

To a very large extent: Alternative development policies and programmes are an aspect of state security policy with heavy military/security sector involvement in implementation.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#83 is 1 OR 2 OR 3 OR 4 OR 5

84. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

NOTE : Answer the below question only if answer to Q#72 is Yes

85. To what extent do alternative development policies and programmes implement a successful 'pro-poor' strategy? (Select one option)

Tip: This question is about the extent to which the state's alternative policies and programmes enhance the ability of poor people to participate in, contribute to, and benefit from development and economic growth. The definition of poverty is notoriously difficult and contextual. The Sustainable Development Goals refer both to the international extreme poverty line figure of $1.90 per person per day but also refers 'poverty in all its dimensions according to national definitions'. We urge you to consider poverty in its broader sense (i.e., to use the second of these definitions).

We ask that you use the following definitions to guide your response:

Not at all: Alternative development policies and programmes fail to consider or fail to achieve specific benefits for people in poverty.

To a small extent: Alternative development policies and programmes seek specific benefits for people in poverty, but achieve little success.

To a moderate extent: Alternative development policies and programmes seek specific benefits for people in poverty, but their success in achieving this is patchy.

To a large extent: Not at all: Alternative development policies and programmes seek specific benefits for people in poverty, with significant but partial success.

To a very large extent: Alternative development policies and programmes seek specific benefits for people in poverty, with substantial success.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

NOTE : Answer the below question only if answer to Q#85 is 1 OR 2 OR 3 OR 4 OR 5

86. How confident are you of this assessment? (Select one option)

1	2	3	4
○	○	○	○
Not at all confident	Somewhat confident	Confident	Very confident

In this section, we ask about your personal beliefs about politics and drug policy as well as how you would evaluate some fictional example states. We will use these data to check that responses are consistent across respondents with different personal opinions as well as to account for differences in respondents' answering styles.

87. To what extent do you agree or disagree with the following statement:

The threat of criminal punishments is effective at deterring drug use (Select one option)

1	2	3	4	5
○	○	○	○	○
Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

☐ I'd rather not say

88. To what extent do you agree or disagree with the following statement: The threat of criminal punishments is effective at deterring individuals who sell drugs (Select one option)

1	2	3	4	5
○	○	○	○	○
Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

☐ I'd rather not say

89. To what extent do you agree or disagree with the following statement:

Drug use is best seen as a health issue that should be dealt with by health care professionals focused on reducing harm (Select one option)

1	2	3	4	5
○	○	○	○	○
Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

☐ I'd rather not say

90. Which of the following drug control regimes would you personally prefer to see enacted for cannabis? (Select one option)

Tip: This scheme for classifying drug control regimes is derived from a combination of the following sources: MacCoun, Robert, Peter Reuter, and Thomas Schelling. "Assessing alternative drug control regimes." Journal of Policy Analysis and Management 15.3 (1996): 330-352; Transform Drug Policy Foundation, "How to Regulate Cannabis - A Practical Guide" (2016) Available online at: https://transformdrugs.org/assets/files/PDFs/how-to-regulate-cannabis-full-text-2016.pdf

- ○ Prohibition of all production, supply, and use
- ○ Legal production and supply for medical use only, prohibition on production for non-medical use
- ○ Prohibition of production and supply — with decriminalisation of possession for personal use
- ○ Prohibition of production and supply — with decriminalisation of small-scale personal cultivation and cannabis social clubs
- ○ Regulated legal production and supply for non-medical use — entirely under government monopoly
- ○ Regulated legal production and supply for non-medical use — with a mix of commercial and government monopoly elements
- ○ Regulated legal production and supply for non-medical use — licensed producers and/or licensed vendors
- ○ Largely unregulated legal production and supply. Available to any adult
- ○ Largely unregulated legal production and supply. Available to any person
- ○ I prefer not to say
- ○ I don't know

91. Which of the following drug control regimes would you personally prefer to see enacted for heroin? (Select one option)

Tip: This scheme for classifying drug control regimes is derived from a combination of the following sources: MacCoun, Robert, Peter Reuter, and Thomas Schelling. "Assessing alternative drug control regimes." Journal of Policy Analysis and Management 15.3 (1996): 330-352; Transform Drug Policy Foundation, "How to Regulate Cannabis - A Practical Guide" (2016) Available online at: https://transformdrugs.org/assets/files/PDFs/how-to-regulate-cannabis-full-text-2016.pdf

- ○ Prohibition of all production, supply and use.
- ○ Legal production and supply for medical use only, including for relief of drug dependence; prohibition for non-medical use
- ○ Prohibition of production and supply — with decriminalisation of possession for personal use
- ○ Regulated legal production and supply for non-medical use — entirely under government monopoly

- ○ Regulated legal production and supply for non-medical use — with a mix of commercial and government monopoly elements
- ○ Regulated legal production and supply for non-medical use — licenced producers and/or licenced vendors
- ○ Largely unregulated legal production and supply for non-medical use - Available to any adult
- ○ Largely unregulated legal production and supply for non-medical use - Available to any person
- ○ I prefer not to say
- ○ I don't know

92. Which of the following approaches to possession of drugs for personal use would you personally prefer to see enacted for cannabis? (Select one option)

Tip: This scale is adapted from: Hughes, C., Stevens, A., Hulme, S. & Cassidy, R. (2018). Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences. A report for the Irish Department of Justice and Equality and the Department of Health. UNSW Australia and the University of Kent.

- ○ Criminalisation: Possession for personal use as a criminal offence enforced by the police
- ○ De facto depenalisation: Possession for personal use as a criminal offence, however there is little/no police enforcement (for example, issuing warnings instead of making arrests)
- ○ Police diversion de facto: Police divert those with possession for personal use to health/social services based on guidelines, but this is still a criminal offence.
- ○ Police diversion de jure: Police divert those with possession for personal use to health/social services based on law, but this is still a criminal offence.
- ○ Decriminalisation with civil sanctions: Possession for personal use is not a criminal offence, but can be sanctioned by fines or community service.
- ○ Decriminalisation with targeted diversion: Possession for personal use is not a criminal offence, and is met with targeted diversion to health/social services.
- ○ Decriminalisation with no sanctions: Possession for personal use is not a criminal offence and is not met with sanction or diversion.
- ○ I prefer not to say
- ○ I don't know

93. Which of the following approaches to possession of drugs for personal use would you personally prefer to see enacted for heroin? (Select one option)

Tip: This scale is adapted from: Hughes, C., Stevens, A., Hulme, S. & Cassidy, R. (2018). Review of approaches taken in Ireland and in other jurisdictions to simple possession drug offences. A report for the Irish Department of Justice and Equality and the Department of Health. UNSW Australia and the University of Kent.

- ○ Criminalisation: Possession for personal use as a criminal offence enforced by the police

- ○ De facto depenalisation: Possession for personal use as a criminal offence, however there is little/no police enforcement (for example, issuing warnings instead of making arrests)
- ○ Police diversion de facto: Police divert those with possession for personal use to health/social services based on guidelines, but this is still a criminal offence.
- ○ Police diversion de jure: Police divert those with possession for personal use to health/social services based on law, but this is still a criminal offence.
- ○ Decriminalisation with civil sanctions: Possession for personal use is not a criminal offence, but can be sanctioned by fines or community service.
- ○ Decriminalisation with targeted diversion: Possession for personal use is not a criminal offence, and is met with targeted diversion to health/social services.
- ○ Decriminalisation with no sanctions: Possession for personal use is not a criminal offence and is not met with sanction or diversion.
- ○ I prefer not to say
- ○ I don't know

Please consider the following four fictional states:

In state A members of minority ethnic groups are no more likely to be searched for drugs in their day-to-day lives and face a similar likelihood of imprisonment for drug offences to the rest of the population. There is little or no public perception that members of minority ethnic groups are more likely to be involved in drug offences.

In state B some members of minority ethnic groups face a public perception that they are more likely to be involved in drug offences. Although minority ethnic groups are not systematically targeted by law enforcement agencies, there are rare instances reported of ethnically insensitive language being used by police officers. Minority group members living in some areas report that they are more likely to be searched for drugs and arrested for drug offences, although such reports are not widespread.

In state C many members of minority ethnic groups face a public perception that they are more likely to be involved in drug offences. Although they are not formally targeted by law enforcement agencies, profiling and targeting arrests in areas with high ethnic-minority populations mean that in practice they are more likely to be searched for drugs and arrested for drug offences. There are numerous reports of ethnically insensitive language being used by police officers.

In state D, most members of ethnic minority groups face a public perception that they are more likely to be involved in drug offences. Such groups are severely underrepresented in law enforcement agencies and complaints about ethnically motivated police harassment and the use of ethnically insensitive language by police officers are widespread. While there is no formal policy of targeting minority ethnic groups, group members are significantly more likely to be searched for drugs and arrested in their day-to-day lives.

94. In State A: To what extent does enforcement of drug policy disproportionately impact minority ethnic groups? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: These groups are not impacted disproportionately compared to any other group in society.

To a small extent: Members of these groups may experience occasional instances of disproportionate impact, but this affects less than 10% of group members.

To a moderate extent: Members of these groups often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of these groups frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of these groups are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

95. In State B: To what extent does enforcement of drug policy disproportionately impact minority ethnic groups? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: These groups are not impacted disproportionately compared to any other group in society.

To a small extent: Members of these groups may experience occasional instances of disproportionate impact, but this affects less than 10% of group members.

To a moderate extent: Members of these groups often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of these groups frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of these groups are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

96. In State C: To what extent does enforcement of drug policy disproportionately impact minority ethnic groups? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: These groups are not impacted disproportionately compared to any other group in society.

To a small extent: Members of these groups may experience occasional instances of disproportionate impact, but this affects less than 10% of group members.

To a moderate extent: Members of these groups often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of these groups frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of these groups are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

97. In State D: To what extent does enforcement of drug policy disproportionately impact minority ethnic groups? (Select one option)

Tip: In responding to this question, we ask that you consider the extent to which individuals in this category are more likely to face imprisonment, harassment, loss of opportunities, or significant privations as a result of the enforcement of drug policy.

We ask that you use the following definitions to guide your response:

Not at all: These groups are not impacted disproportionately compared to any other group in society.

To a small extent: Members of these groups may experience occasional instances of disproportionate impact, but this affects less than 10% of group members.

To a moderate extent: Members of these groups often experience instances of disproportionate impact, but this affects less than 25% of group members.

To a large extent: Members of these groups frequently experience instances of disproportionate impact, affecting 25%-50% of group members.

To a very large extent: Members of these groups are more likely than not to experience instances of disproportionate impact, affecting more than 50% of group members.

1	2	3	4	5
○	○	○	○	○
Not at all	To a small extent	To a moderate extent	To a large extent	To a very large extent

☐ I don't know

Thank you! We would like to thank you very much for your participation in this survey, which is invaluable for the GDPI project.

As we are concerned to engage a wide range of expert opinions in each state, we ask if you could provide any contacts (including affiliations and email addresses) of individuals who you believe would have the requisite expertise to evaluate the state that you have just assessed below.

98. Please list contacts' names, affiliations, and email addresses below (please list as many contacts as possible)