

MODULE 2

Effective drug policy – What needs to change?

Aim of Module 2

To introduce the principles of drug policy based on health, human rights and social inclusion.

Learning objectives

Participants will gain an understanding of the principles of cost-effective policies based on evidence, human rights, development and health and identify and discuss key barriers hindering the implementation of these principles.

In Module 1, we concluded that the global drug control system currently being implemented around the world has failed in reducing the scale of drug markets and use, and has led to serious negative consequences. In light of these observations, it is necessary to rethink the objectives of effective drug policy. This module will explore the objectives and principles of effective drug policy, as well as possibilities for reform.

SESSION 2.1: Activity:	Objectives of effective drug policy
SESSION 2.2: Activity:	'The tree of good drug policy'
SESSION 2.3: Interactive presentation:	Principles to guide effective drug policy
SESSION 2.4: Activity:	Key elements of a balanced drug policy
SESSION 2.5: Presentation:	Flexibilities in the UN drug conventions – what is allowed in the international drug control framework?

SESSION 2.1



Activity: Objectives of effective drug policy



15 min

Aim – To explore what participants consider to be the high-level objectives of more effective drug policy

1. Introduce the aim of the session.
2. Ask participants to work in pairs and identify five objectives that could be achieved by an effective drug policy, allowing 5 minutes for this.
3. Ask each pair in order to put forward one of the objectives that they have identified, writing the ideas on a flipchart. For each objective, ask other groups if they also identified a similar objective (this can be done by a show of hands) – noting where there is broad consensus among the participants.
4. Repeat this process until all the identified objectives have been exhausted, or until the available time has elapsed.

Example of what participants may come up with

- Protecting health
- Protecting human rights
- Preventing discrimination
- Promoting socio-economic development
- Ensuring social inclusion
- Increasing citizens security
- Ensuring adequate access to justice

Etc.

SESSION 2.2



Activity: 'The tree of good drug policy'



60 min

Aim – To explore the positive outcomes and potential barriers to the development and implementation of effective and balanced drug policies

1. Introduce the aim of the session.
2. Ask participants to work in small groups (3-5 people) and give each group flipchart paper and coloured marker pens.
3. Ask each group to draw a large tree with roots, a trunk, and branches. Explain to the participants that this time the tree represents 'good drug policy'. This tree will focus on alternative to the 'bad policy' on which the participants focused in Session 1.5; i.e. if we focused on criminalisation, we could focus on decriminalisation; if we focused on crop eradication, we would focus on sequenced alternative livelihoods; if we focused on compulsory treatment, we would focus on evidence-based drug dependence treatment; etc. However, if they prefer to do so, groups may choose to focus on an issue that is not necessarily related to their previous tree of bad drug policy.
4. Explain that the roots are the beliefs and ideals that 'feed' the tree – in this context they represent the principles of 'good drug policy' (human rights, public health, harm reduction, etc.).
5. Explain that each branch of the tree represents an example of policies and programmes that

could be developed in the framework of 'good drug policy' – i.e. HIV prevention, hepatitis C prevention, needle and syringe programmes (NSPs), opioid substitution therapy (OST), increased access to healthcare services, etc. Ask participants to write these examples on the branches of the tree.



Facilitators' note

To facilitate the drawing of fruits and worms, the facilitator can bring pre-printed copies of each to distribute to the participants (see Annexes 2 and 3).

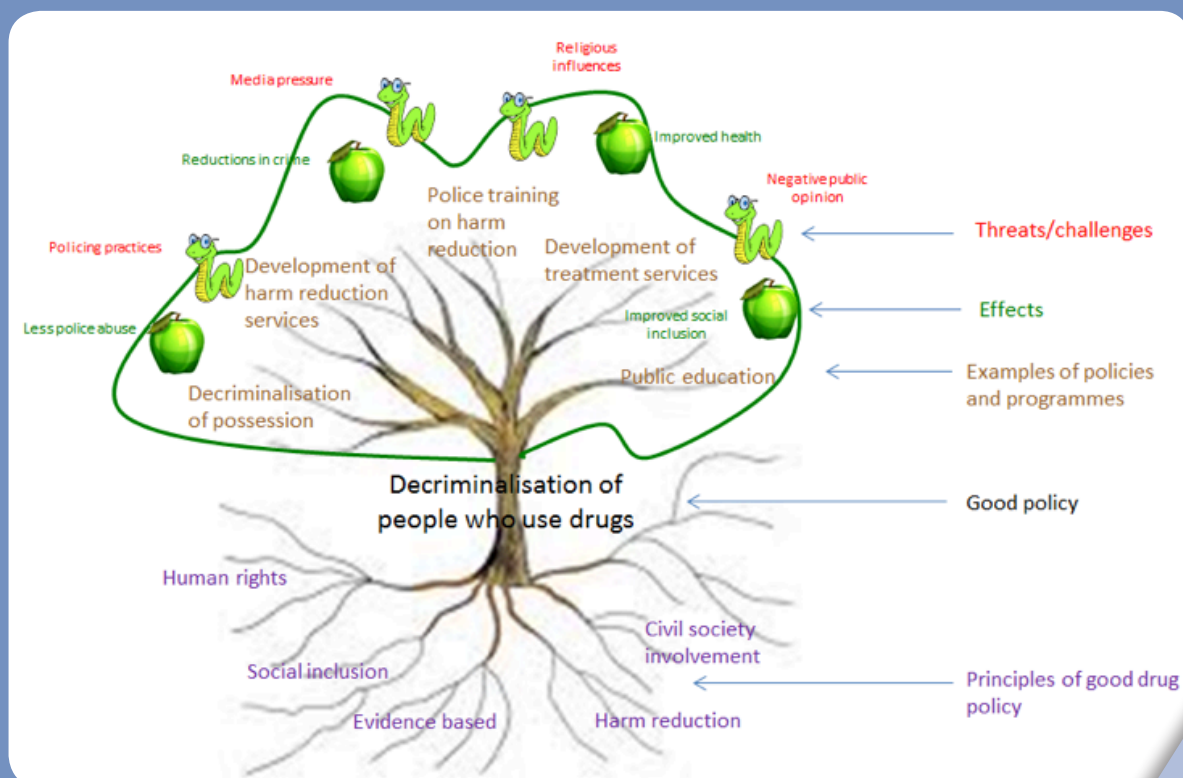


Facilitators' note

In case of time constraints, it is possible to conduct this activity at the same time as activity 1.5 (the 'Tree of bad drug policy') by splitting the participants into four groups and ask two groups to work on the tree of bad drug policy while the two other groups work on the tree of good drug policy. The discussions can then focus on comparing the findings of all groups on what they consider good and bad policies.

6. Explain that participants should draw fruits to represent the results of 'good drug policy' (examples, though not to be given at the start, can include: improved public health, reduced crime, less imprisonment, etc.). Ask participants to pay particular attention to the consequences of the chosen intervention on the lives of people who use/grow drugs (i.e. in terms of stigma, discrimination, social marginalisation, service uptake and self-esteem).
7. Explain that participants should draw worms to depict the threats and obstacles to achieving a 'good drug policy' (e.g. public opinion, media, policing practices, religious influences, etc.)
8. Ask each group to present their 'tree of good drug policy', allowing time for discussion after each group's presentation.

Example of tree of good drug policy



Example of 'tree of good drug policy' from civil society workshop in Nairobi, Kenya, November 2012



Example of 'tree of good drug policy' at civil society seminar in Manila, Philippines, December 2011

SESSION 2.3



Interactive presentation: Principles to guide effective drug policy



30 min

Aim – To introduce principles for developing effective drug policy and to explore how these can be applied, or already apply, to national and international responses

1. Introduce the aim of the session linking it to the work done by participants in the previous session.
2. Present Slides by making a strong link to the principles included in the trees drawn by the participants.
3. Explore the participants' understanding of these principles and what they think about them. (You may want prepare for this session by reading Chapter 1 (<http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Guide-HTML/Chapter-1whole.pdf>) of the IDPC Drug Policy Guide and the EHRN Position Paper, available here: http://www.harm-reduction.org/images/stories/library/drugpolicy_position.pdf).
4. Explore how they might apply to the local context.
5. Explain that these principles underpin this training and will provide a useful source of reference throughout, particularly in the sessions where participants will be encouraged to set their own advocacy goals.



Information to cover in this presentation:

This session considers a set of principles for the review, design and implementation of effective drug policies. Each country will need to develop drug policy responses that are relevant to their specific needs, cultural context, and available resources. However, IDPC has developed core principles, which have been developed in response to the failure of prohibition-led policies to impact meaningfully on the problems caused by drug use and drug markets.

IDPC high-level principles¹

1. Drug policies should be developed through a structured and objective assessment of priorities and evidence: These priorities and objectives should flow from an assessment of which consequences of drug markets are the most harmful to society. Civil society organisations are key to identify those. Governments then need to define which activities, based on evidence, will be most effective to achieve those objectives, which government departments should be involved, which resources should be articulated, and how the strategy will be evaluated and reviewed.
2. All activities should be undertaken in full compliance with international human rights law: A number of the most common elements of prohibitionist policies, in criminal justice settings (e.g. the use of disproportionate punishment) and elsewhere (lack of access to or the punitive application of treatment and care), are in direct contravention with the obligations of all governments with regard to the promotion and protection of human rights. Compliance with these obligations should be at the heart of any review and development of drug policy. All drug policies should focus on promoting public health, development and human security.
3. Drug policies should focus on reducing the harmful consequences rather than the scale of drug use and markets: Harm reduction measures aim to reduce the health, social and economic harms of drug use and drug markets on individuals, communities and the overall population. This is a pragmatic

¹ These policy principles are detailed on the IDPC website at: <http://www.idpc.net/policy-principles> and on the IDPC Drug Policy Guide at: <http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Guide-HTML/Chapter-1whole.pdf>

approach in which we recognise that the reduction of the scale of drug markets and use is not the only, or even the most important objective of drug policy. It is therefore necessary that governments start by assessing the drug-related harms that have the most negative impact on their citizens, and then start designing strategies that tackle those specific problems.

4. Policy and activities should seek to promote the social inclusion of marginalised groups: Harsh living conditions and the associated trauma and emotional difficulties are major factors in the development of drug problems. Evidence shows that programmes focusing on harsh penal sanctions towards people who use drugs have had little deterrent effect, and only serve to increase the exposure of users to health risks and criminal groups. The same phenomenon can be observed when harsh penalties and systematic crop eradication campaigns are conducted against subsistence farmers – these interventions simply exacerbate their poverty, social marginalisation, and access to services. IDPC promotes an approach that challenges the social marginalisation and stigmatisation of individuals at higher risk, in particular women and young people, who face specific social and cultural stigmas.
5. Governments should build open and constructive relationships with civil society in the discussion and delivery of their strategies: NGOs, especially those representing people who use or grow drugs, are an invaluable source of expertise because of their understanding of drug markets and drug-using communities. They have extensive experience and expertise on these issues and play a major role in analysing the drug phenomenon and in delivering programmes and services. Governments should therefore engage meaningfully with these groups.

To view the EHRN policy principles, please visit:

http://www.harm-reduction.org/images/stories/library/drugpolicy_position.pdf

SESSION 2.4



Activity: Key elements of a balanced drug policy



60 min

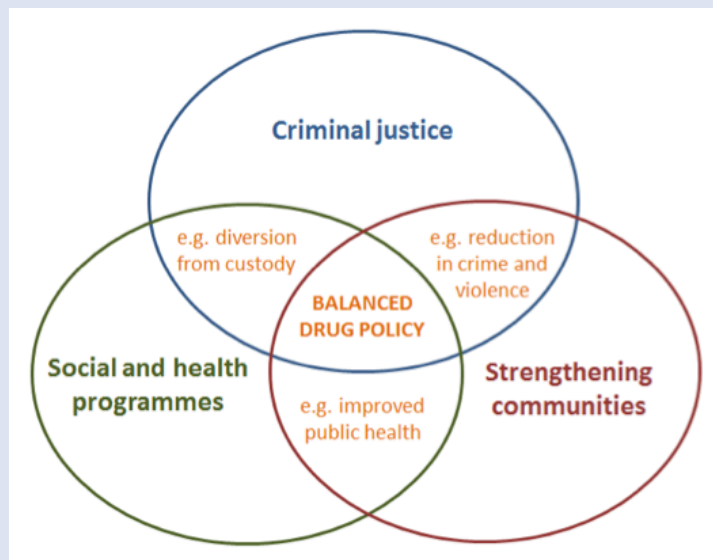
Aim – To present and discuss the elements of a balanced drug policy – ensuring that activities are coordinated; do not impact negatively on each other; and, above all, are focused on the reduction of harms caused by drug markets, rather than the elimination of the drug market itself as the only marker of success

1. Introduce the aim of the session.
2. Split the participants into three groups.
3. Give each group two of the case studies included in Annex 4, ideally giving each group one 'positive' case study, and a 'negative' one on similar policy issues (for example: Portugal/Russia on HIV prevention; Plan Colombia/Thailand on producing issues, etc.). Ask each group to read the case studies and respond to the following questions:
 - What is the focus of this policy?
 - What are the positive elements of this policy?
 - What are the negative elements of this policy?
 - Do you think that the policy is respectful of the five IDPC policy principles?
4. Back in plenary, each group will present their two case studies to the wider group, on the basis of the questions above. Allow time for discussions.
5. Drawing from the conclusions of each group, present the information below, allowing time for participants to feed into the discussion.



Information to cover in this presentation:

While criminal justice interventions tended to dominate over much of the 20th century, there has recently been a growing recognition that effective policies require a re-balancing away from an over-reliance on law enforcement tactics and toward a greater role for health, social and development components. Experience has showed that three main component can be balanced adequately to ensure that drug policies are based on the high-level policy principles presented earlier. These include:



Criminal justice activities are centred on interdiction, prosecution and punishment. Traditionally, criminal justice activities have focused primarily on mass arrests and severe punishments of people who use drugs, crop eradication campaigns, etc. We are proposing here that these activities are re-focused to be more effective and less harmful, while fully integrating the other two core components – social and health interventions and community strengthening. Criminal justice can, for instance, focus on dangerous and violent organised crime, rather than targeting low level dealers and people who use drugs, as is the case in Portugal (indeed, the UN drug conventions do not require that governments impose criminal sanctions against people who use drugs – this will be discussed in Session 2.5 below). In other cases, people who are considered to be dependent on drugs and are arrested for other crimes are no longer sent to prison but diverted to treatment services, as is the case in Scotland. In other countries, however, governments continue to be reluctant to move away from repressive approaches towards people involved in the drug trade, in particular people who use drugs. This is the case in Russia, where OST continues to be prohibited in national drug laws.

Health and social programmes are directed primarily at people who use drugs, in order to provide them with harm reduction, counselling, drug dependence treatment, and other services that they may need to respond to overdoses, HIV and hepatitis C, for example. Such programmes are now widely developed around the world, and are now being scaled up in countries such as Malaysia and China, in order to respond to the high increase in HIV infections among people who use drugs. Countries are increasingly moving away from criminal sanctions with regards to people who use drugs in order to ensure adequate access to these programmes, without fear of arrest.

Strengthening communities focuses on wider social and economic development strategies to reduce the harms associated with drug markets. In some areas, such as in Brazil, this had led governments to move away from militarised law enforcement and towards community policing, social and economic opportunities, education, employment, housing, etc. In drug producing areas, crop eradication campaigns have, in certain regions, been replaced by alternative livelihoods strategies that aim at providing viable alternative sources of income to subsistence farmers involved in the drug trade, including aid to develop new forms of agriculture, sequenced reduction in illicit crop production, access to infrastructure and markets, etc. This has notably been the case in Thailand for opium farmers. Finally, strengthening communities also includes the protection of the rights of vulnerable indigenous groups to grow and consume plants deemed illicit for ancestral, spiritual, medicinal and traditional purposes. Bolivia has recently moved in this direction in order to protect the right of Bolivians to chew the coca leaf.

It is therefore important that drug policies demonstrate a coherent mix between these three complementary components, but that these are adequately balanced to respond to the various issues related to drug markets (i.e. production, high level trafficking, low level dealing, drug use, etc.)

SESSION 2.5



Presentation: Flexibilities in the UN drug conventions – what



30 min is allowed in the international drug control framework?

Aim – To understand what types of reforms are possible within the current UN drug control system, and be able to use this knowledge in national advocacy strategies

1. Introduce the aim of the session.

2. Present slides.



Information to cover in this presentation:

As explained earlier in this Module, a growing number of countries have started exploring the development of policies that shift away from prohibition-led approaches. However, when developing these new strategies, governments must pay close attention to the UN drug control system to ensure that they do not violate their international obligations.

To understand the flexibilities² within the drug control treaties, it is necessary to break down drug offences into two types:

1. Cultivation, trafficking and possession offences on a commercial basis
2. Cultivation, production, purchase, possession and even importation for personal use, consumption, and social supply or the sharing of drugs

Under the conventions, the first type of offences should be criminalised and punished with imprisonment and confiscation. However, there is considerable flexibility, or 'wiggle room', within the UN drug control treaties that enable governments to adopt alternative policies for the second type of offences. This session applies a 'traffic light' analogy to explain which of these policies and programmes are currently possible within the drug control framework.



red, stop or challenge the conventions;
orange, proceed with caution; and
green, please proceed.

Policies considered to operate inside the UN drug control obligations



Consumption and possession for personal use

The main obligation under the conventions is to 'take such legislative and administrative measures as may be necessary... to limit exclusively to medical and scientific purposes the production, manufacture, export and possession of drugs'. However, this article does not include any specific obligation for governments to criminalise drug use, as confirmed by a Commentary on the 1988 Convention (Commentary E/CN.7/590).

Drug consumption is predicated upon possession. Here again, there is some flexibility in the treaties. The 1961 Convention makes a distinction between possession for personal use and trafficking. For trafficking, the convention clarifies that possession should be criminalised, but nothing is indicated for possession for personal use.

In addition, article 3, para 2 of the 1988 Convention states that: 'Subject to its constitutional principles and the basic concepts of its legal system, each party shall adopt such measures as may be seen necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase

² Information and traffic light analogy adapted from: Bewley-Taylor, D. & Jelsma, M. (2012), TNI/IDPC Series on Legislative Reform of Drug Policies Nr. 18 – The UN drug control conventions: The limits of latitude, http://dl.dropbox.com/u/64663568/library/limits-of-latitude-tni-idpc_0.pdf

or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention'.

Therefore, the UN drug conventions allow governments to decriminalise (i.e. remove activities from the realm of criminal law; e.g. in Portugal) or depenalise (i.e. offences continue to be criminalised, but penalties are reduced; e.g. in the UK) drug consumption, or drug possession for personal use.

Finally, article 3, para 4 of the 1988 Convention offers the possibility to impose, 'either as an alternative to conviction or punishment, or in addition to it, measures for the treatment, education, aftercare, rehabilitation and social reintegration of the offender'. This gives considerable flexibility for governments to establish diversion mechanisms from prison to treatment for people dependent on drugs. There is therefore some scope to provide health care or social support instead of punishment for people caught up in minor offences.

Provision of harm reduction services

There is some 'wiggle room' in the treaties because of the lack of clear definition of what constitute 'medical and scientific purposes'. It can be argued that certain harm reduction interventions such as OST can be considered as for medical purposes. In a 2002 report by the Legal Affairs Section (LAS) of the then UN International Drug Control Programme (the predecessor of UNODC) concluded that most harm reduction measures, including NSPs and OST, were in line with UN drug control treaty obligations.³ The most common harm reduction measures can therefore operate lawfully within the UN drug control system.

Drug consumption rooms (DCRs)

Although DCRs have been heavily criticised by the INCB, most of the jurisdictions that have introduced them have justified that they were in accordance with their international obligations. In Germany, for example, it was concluded that DCRs were compatible with the conventions so long as they did not permit the sale and acquisition of drugs, and responded to risk reduction. In Canada, the Federal Supreme Court also ruled in favour of Insite, Vancouver's drug consumption room. The 2002 LAS report also supports DCRs. However, the use of DCRs remains controversial in some countries which have sought to build a legal case against this practice.⁴

Contested policy options under the current treaty system



Medical cannabis

The INCB has also been very critical of medical cannabis. All controlled drugs can be used for medical purposes, including heroin prescription and medical cannabis; what constitutes medical use is left to the discretion of the state parties. The 1961 Convention requires that, where medical marijuana schemes are in operation, a government agency must award all licences and take 'physical possession' of all crops. Most countries allowing medical marijuana abide by these procedures. However, this is clearly not the case in California, for example.

Impermissible policy options under the current treaty system



A regulated market for non-medical purposes

It is clear under the UN drug control conventions that a regulated market for controlled substances is not an option. This would require a drastic revision of the international drug control framework. However, legal tensions exist with other international legal obligations such as those stemming from human rights or indigenous rights – This is the case for Bolivia, which is the first country to have ever withdrawn from the 1961 Convention to re-accede with a reservation because of the prohibition of the treaty on coca leaf chewing. Growing doubts and the inherent inconsistencies and ambiguities of the drug control framework provide legitimate ground for demanding more space for experimentation with alternative control models than the current systems allows.

³ Legal Affairs Sections, UNDCP (2002), *Flexibility of treaty provisions as regards harm reduction approaches* (Decision 74/10), <http://www.tni.org/sites/www.tni.org/archives/drugsreform-docs/un300902.pdf>

⁴ For more information about drug consumption rooms, please read: Schatz, E. & Nougier, M. (2012), *IDPC Briefing Paper – Drug consumption rooms: Evidence and practice* (London: International Drug Policy Consortium), http://dl.dropboxusercontent.com/u/64663568/library/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf

Resources / Further reading

European Commission, Trimbos Instituut, Rand Europe (2009), *A report on global illicit drug markets 1998-2007 (European Communities)*, http://ec.europa.eu/justice_home/doc_centre/drugs/studies/doc/report_short_10_03_09_en.pdf

Global Commission on Drug Policy (2011), *War on drugs*, <http://www.globalcommissionondrugs.org/reports/>

Latin American Commission on Drugs and Democracy (2009), *Drugs and democracy: Toward a paradigm shift*, <http://idpc.net/publications/2009/03/latin-american-commission-on-drugs-democracy>

Bewley-Taylor, D. & Jelsma, M. (2012), *TNI/IDPC Series on Legislative Reform of Drug Policies Nr. 18 – The UN drug control conventions: The limits of latitude* (Transnational Institute & International Drug Policy Consortium), http://dl.dropbox.com/u/64663568/library/limits-of-latitude-tni-idpc_0.pdf

Bewley-Taylor, D. (2012), *TNI/IDPC Series on Legislative Reform of Drug Policies Nr. 19 – Towards a revision of the UN drug control conventions: The logic and dilemmas of like-minded groups* (Transnational Institute & International Drug Policy Consortium), http://dl.dropbox.com/u/64663568/library/the-logic-and-dilemma-of-like-minded-groups-tni-idpc_0.pdf

World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2013), *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision* (Geneva: WHO), <http://idpc.net/publications/2013/01/who-unodc-unaid-technical-guide-for-countries-to-set-targets-for-universal-access-to-hiv-prevention-treatment-and-care-for-injecting-drug-users-2012-revision>

United Nations Press Release (10 March 2009), *High Commissioner calls for focus on human rights and harm reduction in international drug policy*, <http://www.unhchr.ch/huricane/hurricane.nsf/view01/3A5B668A4EE1BBC2C12575750055262E?opendocument>

Harm Reduction International (2011), *The UN human rights system and harm reduction advocacy: A training package for civil society organisations*, http://www.ihra.net/files/2011/03/29/IHRA_Training_Pack_Final.pdf

Kaplan, K. (2009), *Human rights documentation and advocacy: A guide for organizations of people who use drugs* (New York: Open Society Institute Public Health Program), http://www.opensocietyfoundations.org/sites/default/files/hrdoc_20090218.pdf