MODULE 2

Balanced and effective drug policy – what needs to change?

Aim of Module 2

To introduce the principles of a balanced and effective drug policy that is 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.

Introduction

In Module 1, we concluded that under the global drug control system currently being implemented around the world, the scale of drug markets and levels of use have not declined, and prohibition-led drug policies been associated with violations of human rights and negative consequences. In light of these observations, it is necessary to rethink the objectives of balanced aqnd effective drug policy. This module will explore the objectives and principles of balanced and effective drug policy, as well as possibilities for reform.

SESSION 2.1:

Activity: Objectives of balanced and effective drug policy

SESSION 2.2:

Activity: "The tree of balanced 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: Recommendations from the West Africa Commission on Drugs

SESSION 2.6:

Presentation: Flexibilities in the UN drug conventions – what is allowed in the international drug control framework?

MODULE 2

Session 2.1

Activity: Objectives of balanced and effective drug policy

15 min

Aim – To explore what participants consider to be the high-level objectives of more balanced and 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 a balanced and 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.

MODULE 2

Session 2.2

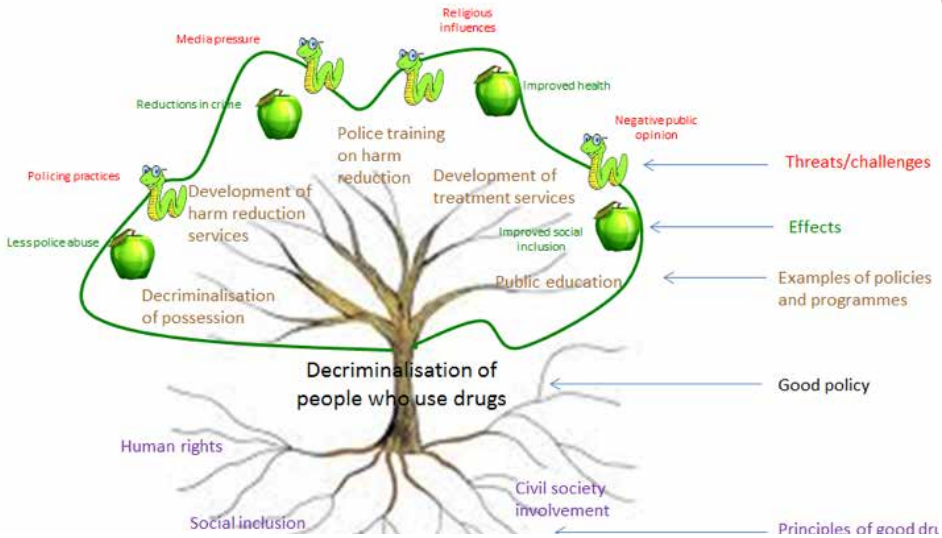
Activity: "The tree of balanced drug policy"

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 flip-chart 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 "balanced drug policy". This tree will focus on an alternative to the "prohibition-led 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 "balanced drug policy" (human rights, public health, harm reduction, etc.).

Example of tree of balanced drug policy



Facilitators' note

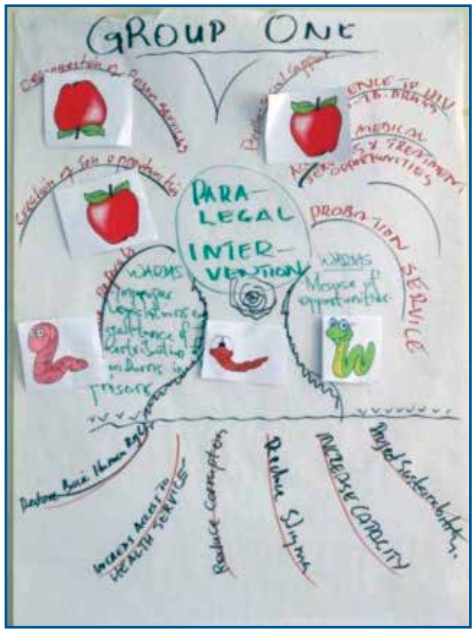
In case of time constraints, it is possible to conduct this activity at the same time as activity 1.5 (the "Tree of prohibition-led drug policy") by splitting the participants into four groups and ask two groups to work on the tree of bad drug policy while the two other groups work on the tree of good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

Please also note that Sessions 1.5, 2.2 and 3.9 include a similar activity (the "tree" exercise"). To avoid repetitions, we advise the facilitator to use this exercise only once during the training.

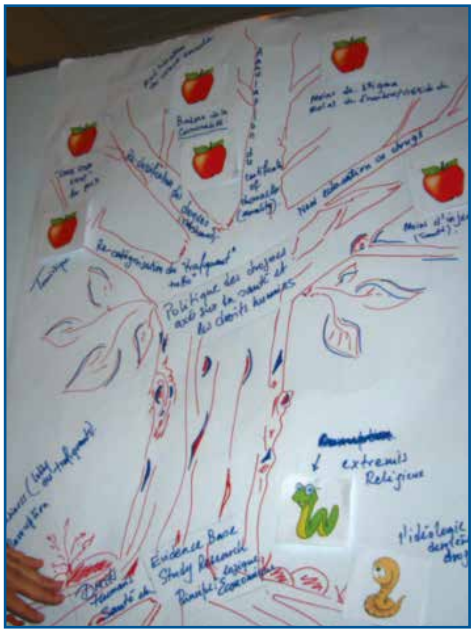
5. Explain that each branch of the tree represents an example of policies and programmes that could be developed in the framework of "balanced drug policy" – i.e. evidence-based drug treatment, sustainable alternative livelihood programmes, harm reduction approaches (such as needle and syringe programmes and opioid substitution therapy), increased access to healthcare services, removing criminal penalties for the possession of small amounts of drugs, increasing security, promoting responsive and accountable governance, reducing corruption and impunity, etc. Ask participants to write these examples on the branches of the tree.
6. Explain that participants should draw fruits to represent the results of "balanced drug policy" (examples, though not to be given at the start, can include: improved public health, reduced crime, increased public security, reduced corruption, less imprisonment, etc.). Ask participants to pay particular attention to the consequences of the chosen intervention on the lives of people who use/transport/grow drugs (i.e. in terms of stigma, discrimination, social marginalisation or status, income or livelihood, service uptake and self-esteem).
7. Explain that participants should draw worms to depict the threats and obstacles to achieving a "balanced drug policy" (e.g. public opinion, media, policing practices, strong and moralistic religious beliefs, etc.)
8. Ask each group to present their "tree of balanced drug policy", allowing time for discussion after each group's presentation.

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.



Example of "tree of effective and balanced drug policy" from civil society workshop in Nairobi, Kenya, November 2012



Example of "tree of effective and balanced drug policy" at civil society seminar in Mauritius, November 2013

MODULE 2

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.
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.

Facilitators' note

You may want prepare for this session by reading Chapter 1 of the IDPC Drug Policy Guide: http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition

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 principles[1]

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 polices, in criminal justice settings (e.g. the use of disproportionate punishment) and elsewhere (e.g. 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 f**ocus on reducing the harmful consequences** rather than the scale of drug use and markets. This may include policies that seek to reduce corruption, insecurity and organised crime associated with drug supply chains (see Module 5 for further exploration of this topic). It may also include harm reduction measures to reduce the health, social and economic harms of drug use and drug markets on individuals, communities and the overall population. These are pragmatic approaches 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 and vulnerable groups: Harsh living conditions and the associated trauma and emotional difficulties are major factors in the development of drug problems, and for low-level involvement in drug markets. Evidence shows that programmes focusing on harsh criminal sanctions have had little deterrent effect, and only serve to increase the exposure of people to health harms and other risks, and to criminal groups.[2] 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.

1. These policy principles are detailed on the IDPC website at: http://www.idpc.net/policy-principles and on the IDPC Drug
2. See, for example: Stevens, A. (March 2013), *Applying harm reduction principles to the policing of retail drug markets* (London: International Drug Policy Consortium), https://dl.dropboxusercontent.com/u/64663568/library/MDLE-report_3_applying-harm-reduction-to-policing-of-retail-markets.pdf ; UK Drug Policy Commission (October 2012), *A fresh approach to drugs – The final report of the UK Drug Policy Commission*, http://www.ukdpc.org.uk/wp-content/uploads/a-fresh-approach-to-drugs-the-final-report-of-the-uk-drug-policy-commission.pdf

MODULE 2

Session 2.4

Activity: Key elements of a balanced drug policy

60 min

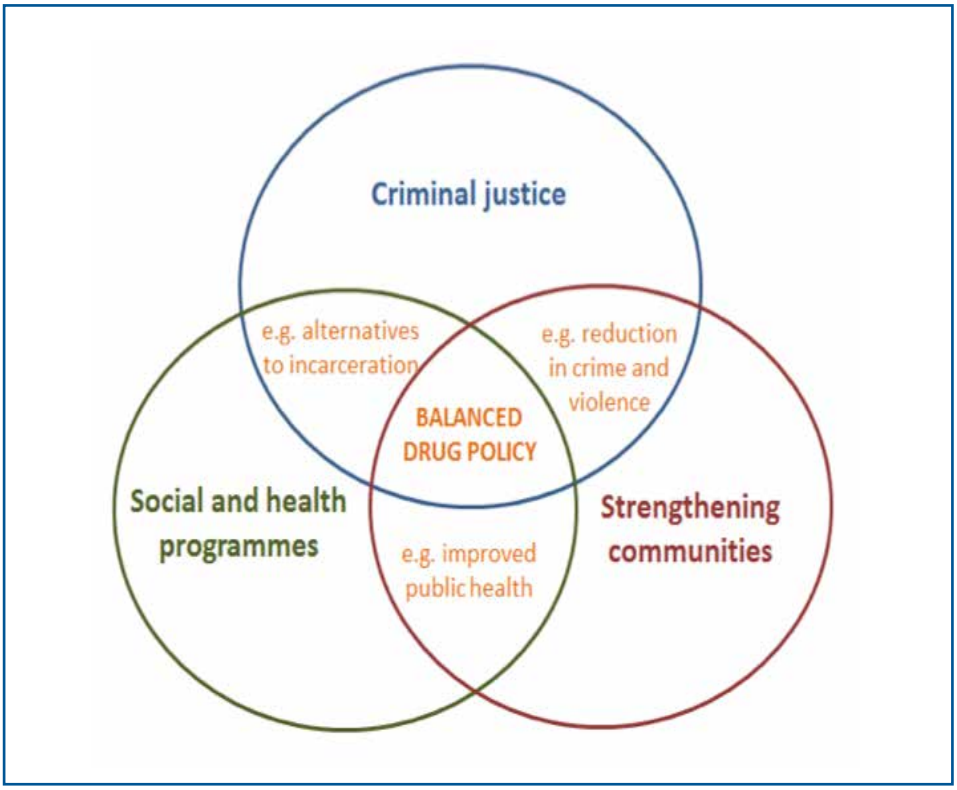
Aim - To introduce principles for developing effective drug policy and to explore how these can be applied, or already apply, to national and international responses

1. Introduce the aim of the session.
2. Split the participants into three groups.
3. Give each group two of the case studies included in the handout "Case studies to be used for Session 2.4", ideally giving each group one "positive/balanced policy" case study, and a "prohibition-led" 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 last 100 years, 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 shown 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, arresting drug mules, 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 high-level, high-impact cross-border cooperation to target the elements of the drug market and organised crime that are the most dangerous, violent and/or corrosive to good governance, rather than targeting low-level dealers,



drug mules and people who use drugs (indeed, the United Nations (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. 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.

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, China, Mauritius or Tanzania, 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, and to prevent people becoming engaged in drug markets – as low-level dealers, "drug mules" and/or consumers. In some countries, 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 some drug producing countries, crop eradication campaigns have 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.

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.).

One interesting example of an attempt to balance a modern drug policy comes from the Africa Union (AU). In 2012, the AU approved its "Plan of Action on Drug Control 2013-2017", which focuses on four "priority areas":

- Continental, regional and national management, oversight, reporting and evaluation.
- Evidence-based services to address health and social impact of drug use.
- Countering drug trafficking and related challenges to human security.
- Capacity building in research and data collection.[1]

The Plan of Action (and the accompanying Implementation Matrix[2]) commits member states to – among other things – conduct baseline studies on drug use, deliver policy advocacy campaigns, implement "the UN comprehensive package on HIV prevention, treatment and care" for people who inject drugs (also widely referred to as the "harm reduction package"), and provide alternatives to incarceration. Speaking at the time, Dr. Jean Pierre Onvehoun (the AU Commissioner for Human Resources, Science and Technology) stated that drug use is a public health issue, and that law enforcement efforts should focus on high-level organised criminals rather than people who use drugs. Advocating for the balanced approach contained within the Plan of Action, Dr Onvehoun reminded the participants that some African countries "have been quietly implementing evidence-based programs that deal with the harms of drug use… the war on drugs is shifting fronts".[3]

1. African Union Plan of Action on Drug Control (2013-2017), p. 4, http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20English.pdf
2. http://sa.au.int/en/sites/default/files/AUPA%20on%20DC%20%282013-2017%29%20-%20Implementation%20Matrix%20-%20English.pdf
3. Bridge, J. (21 December 2012), *African Union agrees: "Support. Don't Punish"*, IDPC Blog, http://idpc.net/blog/2012/12/african-union-agrees-support-don-t-punish

MODULE 2

Session 2.5

Presentation: Recommendations from the West Africa Commission on Drugs

30 min

Aim – To present and discuss the findings of the West Africa Commission on Drugs

1. Introduce the aim of the session.
2. Present slides.

Facilitators' note

See Session 1.6 for a selection of related videos from the West Africa Commission on Drugs, which may be shown alongside this activity if time allows.

Information to cover in this presentation:

Deeply concerned by the growing threats of drug trafficking and consumption in West Africa, Kofi Annan, the former Secretary General of the United Nations, convened the West Africa Commission on Drugs (WACD) in January 2013. The Commission's objectives are to:

- mobilise public awareness and political commitment around the challenges posed by drug trafficking
- develop evidence-based policy recommendations
- promote regional and local capacity and ownership to manage these challenges.

Chaired by former President Olusegun Obasanjo of Nigeria, the Commission comprises a diverse group of West Africans from the worlds of politics, civil society, health, security and the justice sector. The Commission is an independent body and can therefore speak with impartiality and directness. Their report – "Not Just in Transit"[1] – is the culmination of one and a half years of engagement by the Commission with national, regional and international parties including the African Union (AU), the Economic Community of West African States (ECOWAS), and the United Nations Office on Drugs and Crime (UNODC). Based on this research, the Commission have made the following recommendations for drug policies in West Africa:

1. Treat drug use as a public health issue with socio-economic causes and consequences, rather than a criminal justice matter.

1.1 Adopt drug treatment policy frameworks in line with the core principles and the minimum legal and policy standards referenced in this report such as the expansion of drug treatment and related health services and facilities and the establishment of community-based prevention programmes and decentralised treatment.

1.2 Adopt harm reduction approaches in order to minimise the worst harm relating to drug consumption, while also ensuring that they are integrated into national development strategies.

2. Actively confront the political and governance challenges that incite corruption within governments, the security services and the judiciary, which traffickers exploit.

2.1 Support the establishment of inter- and intra-party platforms to discuss the impact of drug trafficking and illicit party funding on political systems in the West African region with the aim of establishing mechanisms to buffer these systems from illicit funding.

2.2 Strengthen the oversight role of parliaments with regard to the drafting and implementation of drug legislation.

2.3 Support the conduct of national, regional, or inter-regional (South-South) meetings of independent electoral bodies or electoral tribunals to discuss avenues to protect electoral processes from drug trafficking, and share lessons on building resilience against drug trafficking (and other forms of organized crime) into the electoral system. Existing networks of electoral management bodies should be encouraged to take on this issue.

2.4 Support efforts aimed at developing the capacity of civil society, media and academia to monitor and assess the links between drug trafficking and party and campaign financing, while also providing them with the relevant safeguards.

2.5 Actively explore options for the establishment of a panel or a special regional court to investigate or try high-target offenders, including state and security officials suspected of being complicit in, or facilitating, drug trafficking. Such efforts should not replace the need to ensure that national justice systems have the independence, specialised expertise and the resources to prosecute these kinds of cases.

3. Develop, reform and/or harmonise drug laws on the basis of existing and emerging minimum standards and pursue decriminalization of drug use and low-level non-violent drug offences.

3.1 Ensure that efforts to develop, reform and/or harmonise drug laws are carried out on the basis of existing and emerging minimum standards in which the protection of the security, health, human rights and well-being of all people is the central goal.

3.2 Pursue decriminalisation of drug use and low-level non-violent drug offences through reform of national legislation as a means to reduce the enormous pressures on overburdened criminal justice systems and protect citizens from further harms.

4. Strengthen law enforcement for more selective deterrence, focusing on high-level targets.

4.1 Support further efforts to develop vetted units within specialised agencies, while also ensuring that safeguards are put in place to protect these units against infiltration by organized crime or abusive practice.

4.2 Improve intelligence gathering and processing techniques; and develop more sustainable operational mechanisms for sharing intelligence within and between regions.

4.3 To ensure more effective integration of anti-narcotics efforts with anticorruption and anti-money laundering efforts in the region, and achieve a better alignment of resources, further strengthen efforts to review the patterns, priorities and effectiveness of external assistance while ensuring that significant action is expended in understanding what specifically has not worked in terms of external assistance to date, and precisely why. This will require investment in developing ECOWAS capacity to monitor and assess results; and ensuring that the outcome of efforts by partner organisations and countries to assess progress and setbacks are shared and discussed with a broader range of actors straddling the security, development and governance fields, and civil society. Information about who is doing what in the region should be centralized in one entity at the regional and national levels, and made publicly available.

5. Avoid militarisation of drug policy and related counter-trafficking measures, of the kind that some Latin American countries have applied at great cost without reducing supply.

6. Ensure that the shared responsibility of producer, transit and consumer countries is translated into operational strategies, including the sharing of experience among leaders from affected countries within and beyond West Africa.

6.1 Seek humane ways to reduce demand for those drugs, especially for nations whose citizens consume large amounts of illicit drugs.

7. Balance external assistance between support for security and justice efforts on the one hand, and support for public health efforts on the other, particularly with regard to the provision of treatment and harm reduction services.

8. Invest in the collection of baseline data and research on drug trafficking and drug consumption.

8.1 Ensure sustained support of initiatives such as the ECOWAS West African Epidemiological Network on Drug Use (WENDU) and deepen research (and strengthen regional research capacity) on the different impacts – security, governance, development – of drug trafficking and drug consumption in the region.

1. West Africa Commission on Drugs (2013), *Not just in transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/wp-content/uploads/2013/04/WACD_report_June_2014_english.pdf

MODULE 2

Session 2.6

Presentation: Flexibilities in the UN drug conventions – what is allowed in the international drug control frameworks?

30 min

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. Split the participants into three groups.

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.

red, stop or challenge the conventions

orange, proceed with caution; and

green, please proceed

To understand the flexibilities[1] 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.

Policies considered to operate inside the UN drug control obligations

- **Decriminalising the consumption and possession of drugs 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 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 is widely argued, for example, that interventions such as opioid substitution therapy (OST) can be considered as drug use for medical purposes. In a 2002 report by the Legal Affairs Section of the then UN International Drug Control Programme (the predecessor of UNODC) concluded that most harm reduction measures, including OST and needle and syringe programmes, were in line with UN drug control treaty obligations.[2] The most common harm reduction measures can therefore operate lawfully within the UN drug control system – and are in fact openly endorsed by the UN itself through a "comprehensive package" of interventions for people who inject drugs[3] Harm reduction services will be further discussed in Module 4.

Although safer injecting facilities (or drug consumption rooms) 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 these facilities 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 UN Legal Affairs Section report also supports these services. However, their use 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 policies and systems – such as those that are commonplace across the USA. According to the international conventions, all controlled drugs can be used for medical purposes, and 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.

- **Indigenous coca production**

Additional legal tensions exist between the drug control conventions and other international legal obligations, such as those stemming from indigenous rights. This is the case for Bolivia, which is the first country to have ever withdrawn from the 1961 Convention to protect the right of Bolivians to chew the coca leaf (a drug that is widely used in Bolivia for indigenous, spiritual, medicinal and traditional purposes). Bolivia later re-joined the convention with an additional "reservation" that allows for coca production and sale in the country. Although the conventions themselves do not seem to permit such a market for coca leaf in Bolivia, their formal "reservation" (one of a large number of "reservations" that several countries inserted when they signed up to the conventions) seems to have been an effective mechanism to overcome this.
Impermissible policy options under the current treaty system

Impermissible policy options under the current treaty system

- **Regulated markets for non-medical purposes**

It is clear under the UN drug control conventions that a regulated market for the non-medical use of controlled substances is not an option, and that this would require a drastic revision of the international drug control framework. However, since 2013, we now have exactly this kind of market for cannabis in Uruguay and several parts of the USA – which is stretching the current treaty system to its limit.

Both Uruguay and the USA claim to not be contravening the treaties – citing clauses on national sovereignty and, in the case of the USA, the fact that cannabis remains illegal under national law even if it has been legalised in some States. This debate is ongoing, and the INCB has spoken out on several occasions5 against both countries (although in a notably more reserved way when addressing the USA!).

The situation with regulated cannabis markets in the USA has forced their government to redefine its position on international drug control – which is now captured within a "four-pillar" approach set out by Ambassador William Brownfield: (Assistant Secretary of State for International Narcotics and Law Enforcement):

1. Respect the integrity of the existing UN Drug Control Conventions.
2. Accept flexible interpretation of those conventions, as "Things have changed since 1961" [when the first of the three drug conventions was passed].
3. Tolerate different national drug policies, to accept the fact that some countries will have very strict drug approaches, while other countries will legalize entire categories of drugs.
4. All these countries must work together in the international community, striving for agreement and consensus that, whatever our approach and policy may be, we all agree to combat and resist criminal organisations.[6]

This represents a major shift in discourse from the USA, which had previously been one of the key proponents of the "war on drugs" approach – and is an attempt to reconcile "a treaty breach it does not wish to admit within a system it wishes to protect".[7] While welcomed by some, this new four-pillar approach concerns for others – perhaps appearing to embrace reform while actually changing nothing of substance. For example, it is notable that the flexibility and tolerance does not stretch to Bolivia's attempts to allow indigenous coca leaf production and sale at the domestic level – which has been openly criticised by the USA, who also attempted to block their withdrawal and re-ascension to the 1961 convention.[8]

1. 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
2. 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
3. http://www.who.int/hiv/pub/idu/targets_universal_access/en/
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
5. Barrett, D., Jelsma, M. & Bewley-Taylor, D.R. (18 November 2014), 'Fatal attraction: Flexibility doctrine and global drug policy reform', *Huffington Post Blog*, http://www.huffingtonpost.co.uk/damon-barett/drug-policy-reform_b_6158144.html
6. Ibid

Handout: Case studies to be used for Session 2.4

Introduction

The following selected case studies provide examples of drug policies that have been developed around the world, some of which continue to be anchored in the principles of deterrence and harsh penalties towards people involved in the drugs trade, others that seek to move towards greater emphasis on human rights, public health and/or social inclusion, and others that have shown positive moves towards reform but continue to impose severe punishments towards vulnerable groups involved in the drug trade.

These case studies constitute a basis for discussions among the participants in Session 2.4 on the need to achieve a balance between the complementary demands of criminal justice, health and social programmes, and community.

The facilitator can choose from these case studies (or use their own examples) in order to adapt the exercise to the participants' local context. Each case study is accompanied by a key reference in case the facilitator and/or the participants need more information.

Portugal

In 2001, Portugal introduced a new national law that decriminalised the illicit possession of all controlled drugs for personal use. Instead of being considered as a criminal offence, the possession of controlled drugs for personal use is now an "administrative offence". Drug supply remains a criminal offence. When individuals are caught in possession of small amounts of drugs (defined as a maximum of 10 doses of a particular drug), they are referred to a Dissuasion Commission. Each region in Portugal has its own Commission, composed of a medical professional, a legal advisor and a social worker supported by a team of technical experts.

The Commissions provide an individually tailored response, and their primary objective is to dissuade people from drug use, promote social inclusion and employment opportunities, and to encourage access to health care and drug dependence treatment for those who need it. Although administrative penalties such as fines, and community orders can be imposed, referral to the Commissions does not result in a criminal record.

This policy has led to reductions in drug-related health harms, including lower levels of HIV and hepatitis B and C transmission among people who inject drugs, reductions in overdose deaths, and a significant reduction in prison overcrowding. This has also enabled the police to focus law enforcement efforts towards major drug traffickers in the country.

Key resource: Hughes, C. and Stevens, A. (2010), *What can we learn from the Portuguese decriminalization of illicit drugs?* http://kar.kent.ac.uk/29910/1/Hughes%20%20Stevens%202010.pdf

Scotland

The Scottish National Diversion from Prosecution scheme was established in 2000-2001, and is designed to prevent relatively minor and non-violent offenders from entering the criminal justice system. Once an individual is reported by the police, a prosecutor is responsible for identifying whether or not they are suitable for diversion into social work interventions. The scheme targets primarily people who use drugs, young people and women.

Those diverted away from the criminal justice system can access individual and group sessions to address their drug use, as well as social skills, education, employment, training and problem-solving. Considerable success has been achieved, particularly in the reduction of youth re-offending.

Key Resource: Scottish government website, http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/examples/6827

Bolivia

Bolivia has a long tradition of coca chewing for social, medicinal and spiritual purposes, although coca chewing is internationally banned under the 1961 Single Convention on Narcotic Drugs. In 2009, the Government and President Evo Morales decided to enshrine the practice of coca chewing within its new constitution, with an obligation to "protect native and ancestral coca as a cultural patrimony". The banning of coca by the 1961 Convention was driven largely by Western geopolitics and ideology, and marginalised the cultural practices of native Amerindian people. After a failed attempt to remove the ban on coca chewing from the 1961 Convention, the Bolivian government formally withdrew from the 1961 Convention, before re-joining in 2013 with a reservation that allows the traditional use of coca within the country's territory (despite the attempts of the INCB and the USA to prevent it doing so). Today, the Bolivian government has adopted a strategy that ensures the cultivation, trade and use of the coca leaf within its territory for traditional purposes, and has engaged in a community-led approach to reduce the illicit coca market.

Key Resource: The Transnational Institute's Drugs and Democracy programme, http://www.undrugcontrol.info/en/home/tag/2-bolivia

Switzerland

In 1994 the Swiss government adopted a new drug strategy that integrated public security, health and social cohesion objectives. This strategy comprises four pillars: prevention, treatment, harm reduction and law enforcement. The strategy was developed on the basis of consultations with members from the law enforcement, public health and community sectors, and continues to have strong backing among the general public.

The Swiss Four Pillars Policy is one of the best examples of a balanced, integrated drug policy (both in policy and implementation) that meets the demands of law enforcement (directed at major criminals involved in violence and/or trafficking), while also supporting health and social programmes. As a result, Switzerland has a comprehensive harm reduction approach that includes drug consumption rooms and the prescription of pharmaceutical heroin for treating drug dependence.

The progressive implementation of this policy resulted in a significant decrease in harms related to drug consumption. For example, the drug related death toll fell by 50 per cent between 1991 and 2005.

Key Resource: Csete, J. (2010), From the mountaintops: What the world can learn from drug policy change in Switzerland (Open Society Foundations Global Drug Policy Program), http://idpc.net/publications/2010/11/from-the-mountaintops-switzerland

Malaysia

Malaysia has been a longstanding supporter of incarceration and the use of capital punishment for drugs offences and the compulsory detention of people who use drugs. In 2010, Malaysia reconfigured its drug policies – initiating a major transformation toward voluntary services through a "Cure and Care" model. This move acknowledges the need for a range of treatment approaches for different individuals. Treatment options now include Opioid Substitution Therapy (OST), and clients can access services without conditions and choose their own objectives against which treatment progress is measured.

Needle and Syringe Programmes (NSPs) were also developed in Malaysia. However, fear of arrest constitutes a significant barrier to accessing these services, as drug use and the possession of clean needles are still heavily criminalised in the country.

Key Resource: Tanguay, P. (2011), *Policy responses to drug issues in Malaysia* (International Drug Policy Consortium), http://idpc.net/publications/2011/06/policy-responses-to-drug-issues-in-malaysia

Brazil: Rio de Janeiro

Rio de Janeiro has a long history of high levels of violence associated with the illicit drug market, organised crime and police repression. The drug trade is concentrated in the city's favelas (slums), where social and economic disadvantage and poverty are endemic. In 2008, the city of Rio introduced a new response, starting in the favela of Santa Marta: the Unidades de Policía Pacificadora (UPP), or "Pacifying police units". The deployment of these units takes place within a public security policy that combines law enforcement with social, economic and cultural interventions to tackle the violence associated with the drugs market. They are focused on areas where the market is at its most harmful, and acknowledge that some level of trafficking will be tolerated elsewhere. The process of 'pacification' entails four steps: invasion, which deploys military force to "retake" the territory; stabilisation, in which the military forces remains until community policing (i.e. the UPPs) is established in the territory; occupation, whereby the UPPs seek to restore the rule of law through community policing; post-occupation, in which relations of trust are forged between the community and the UPPs, based on social programmes that bring educational and employment opportunities. However, criticisms have been raised about the fact that this strategy remains small scale (there are over 900 favelas in Rio, and less than 20 of them have been pacified). Others have also criticised the fact that large police forces did remain within the favelas after the UPPs had been pacified. Finally, concerns have been raised regarding corruption among police forces involved in the UPP process.

Key Resources: International Drug Policy Consortium (2012), *Drug Policy Guide, 2nd Edition,* http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition ; Washington Office on Latin America (June 2011), Tackling urban violence in Latin America: reversing exclusion through smart policing and social investment (Washington, DC: Washington Office on Latin America), http://idpc.net/sites/default/files/library/WOLA_Tackling_Urban_Violence_in_Latin_America.pdf

Cannabis regulation in Washington and Colorado

In November 2012, the US states of Washington and Colorado voted for the legal regulation of cannabis production, sale and consumption, even though cannabis is banned under the 1961 Single Convention on Narcotic Drugs and under US federal law. The two states are now working on the complex set of rules and regulations that will define how cannabis is grown, transported, advertised, sold and consumed. The reform was aimed not only at protecting consumers from life-altering criminal penalties and prison sentences, but also reducing incentives for violence associated with unregulated markets. Profits from marijuana consumption will also benefit legitimate economies, rather than fuel violence in producer or transit countries. Finally, the measure seeks to promote drug dependence treatment for those who need it without fear of arrest, stigma and discrimination. Additional US states have now turned to similar policies on cannabis. Although it is too soon to assess the impact of this policy, preliminary results in Colorado show a decrease in crime rates, in traffic fatalities, an increase in tax revenue and economic output from retail cannabis sales, as well as an increase in jobs.

Key resource: Open Society Foundations (2012), *The implications of marijuana legalization in Colorado and Washington*, http://idpc.net/alerts/2012/11/the-implications-of-marijuana-legalization-in-colorado-and-washington ; Drug Policy Alliance (2015), *Status report: Marijuana legalization in Colorado after one year of retail sales and two years of decriminalisation*, http://idpc.net/publications/2015/01/marijuana-legalisation-in-colorado-after-one-year-of-retail-sales-and-two-years-of-decriminalisation

Thailand

In 1969 the Thai government adopted policies that sought to tackle high levels of opium cultivation, by integrating highland communities into mainstream national life, rather than through traditional crop eradication campaigns. Opium cultivation and use was a tradition amongst some of these communities, and any development plan therefore required an alternative livelihoods component. The integration of the crop replacement element into broader national and local development projects, which included social programmes (e.g. education and healthcare) and economic infrastructure (e.g. transport and water) lay behind the successes of this approach. Local communities were also involved in the design and delivery of these policies.

A key factor in Thailand's pattern of alternative livelihoods was the adequate sequencing of these measures: poppy crop reduction only commenced in 1984, 15 years into the programme. Poppy cultivation was reduced only when new sources of income were established, thus avoiding the problem of re-planting. This developmental process took more than 30 years, but the results appear to have been sustained.

Key Resource: Youngers, C. & Walsh, J. (2010), *Development first: A more human and promising approach to reducing cultivation of crops for illicit markets* (Washington Office on Latin America), http://idpc.net/publications/2009/12/development-first-wola-report

United States: Plan Colombia

Beginning in 2000, "Plan Colombia" involved the US government spending around US$ 8 billion to support the Colombian government's attempt to suppress the production of cocaine and heroin. The project was overwhelmingly centred on law enforcement, with the heavy involvement of the Colombian military. Cocaine use among US citizens (considered to be a key driver of the Colombian market), was not considered as a priority in this strategy, with little money going into drug demand reduction.

While the USA argues that it succeeded in reducing violence and cocaine production, the project generated severe negative consequences. Extending the government's presence across the country translated in practice into a military presence, which was associated with a large rise in extra-judicial killings and human rights violations. As crop eradication was not accompanied by sufficient attempts to provide alternative livelihoods, the resulting social and environmental destruction focused disproportionately on Afro-Caribbean and indigenous minorities. Coca farmers responded to crop spraying by moving into remote areas, leading to deeper social marginalisation and additional destruction of fragile ecosystems.

Key Resource: Haugaard, L., Isacson, A., Stanton, K., Walsh, J. & Vogt, J. (2005), *Blueprint for a new Colombia policy* (Washington Office on Latin America, Latin America Working Group Education Fund, Center for International Policy, US Office on Colombia), http://www.wola.org/sites/default/files/downloadable/Andes/Colombia/past/blueprint_new_colombia_0305.pdf

Indonesia

Indonesia's rapidly expanding HIV epidemic has been largely driven by the sharing of needles and injecting equipment. The Indonesian government has traditionally responded with harsh law enforcement measures, resulting in overcrowded prisons where drugs continue to be used, and injecting equipment to be shared. Local activists and UN agencies pressed the government to respond to drug use as a health issue rather than a criminal justice one, and their advocacy has led to the development of harm reduction measures (including Opioid Substitution Therapy (OST) and Needle and Syringe Programmes (NSP)) directed at people who use drugs. However, drug use remains heavily criminalised under Indonesian drug laws and people who use drugs constitute a large proportion of Indonesia's prison population. Under national laws, people dependent on drugs should report themselves to Indonesian authorities to enter treatment or are imposed a prison penalty or a fine. Relatives of a person dependent on drugs are also obliged to refer that person to authorities.

As a result of the increased drug use in prison and high levels of harms associated with drug use in closed settings, Indonesia has started to develop harm reduction interventions in prisons. The Kerobokan prison in Bali led the way, becoming the first prison to offer methadone treatment in 2005. By 2009, it had treated 322 patients, combining OST with a range of harm reduction measures including needle and syringe exchange, bleach for cleaning equipment, and condoms. However, these and other OST and harm reduction interventions need to be scaled up, as they presently only accessible for a small minority of the drug using population. In the Banceuy prison, Bandung, for example, harm reduction is less integrated into the prison programme, and only 9 patients accessed OST between 2007 and 2009. Nonetheless, the introduction of these measures represents a positive direction away from exclusive reliance on law enforcement toward the inclusion of health and social programmes and community measures.

Key resource: Lai, G., Asmin, F. & Birgin, R. (2013), *Drug policy in Indonesia* (International Drug Policy Consortium), http://idpc.net/publications/2013/01/idpc-briefing-paper-drug-policy-in-indonesia

Russia

Russia's drug policy is focused overwhelmingly on law enforcement efforts and severe punishments handed out by the courts. Although there are drug treatment services in Russia, they have inherited the "narcology" approach from the former Soviet Union – with the objective of achieving rapid detoxification (often under conditions that resemble prison rather than medical treatment facilities). Contrary to medical evidence accepted by the global scientific community, Russia's government and much of its medical profession claim that OST with methadone or buprenorphine is not an effective treatment. Methadone and buprenorphine remain prohibited under national laws. The country remains committed to the principle that severe punishments against drug use will deter potential users from starting to consume drugs.

It should be noted that Russia has very high levels of drug use: there are an estimated 1.8 million people who inject drugs in the country – 37 per cent of whom are living with HIV and 72.5 per cent of whom are living with hepatitis C.

Key reference: Human Rights Watch (2004), *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation*, http://www.hrw.org/sites/default/files/reports/russia0404.pdf

China

China has a long history of drug use. Today, there are an estimated 2.3 million people who inject drugs in the country, the majority of whom inject heroin. The government has responded to drug use and trafficking through tough drug law enforcement efforts and severe sanctions against people involved in the drug trade, ranging from the compulsory detention of people who use drugs (which includes forced labour, beatings and humiliations) to the use of the death penalty for drug trafficking offences. Every year, China celebrates the International Day against Drug Trafficking and Drug Abuse with the execution of major drug traffickers to deter people from involvement in the drug trade.

For years, injecting drug use has been a major HIV transmission route. This has led the government to review its policies towards people who use drugs to reduce risks of infection and of drug-related deaths. This includes Needle and Syringe Programmes (NSPs), Opioid Substitution Therapy (OST) and overdose prevention. China has made significant progress in scaling up harm reduction programmes, with 753 methadone maintenance treatment clinics in 28 Chinese provinces and 941 NSPs in 19 provinces. More than 98 million syringes having been distributed since NSPs started operating in 1999.

Today, methadone maintenance treatment clinics function alongside compulsory detention centres, which the government is seeking to phase down and replace with community based treatment centres. People who use drugs also continue to be registered as drug users in government and police registries. Harsh penalties continue to be imposed on people involved in drug production and trafficking.

Key reference: Li, J., Ha, T.H., Zhang, C. & Liu, H. (2010), *The Chinese government's response to drug use and HIV/AIDS: A review of policies and programs,* http://www.harmreductionjournal.com/content/7/1/4; Data from IDPC scoping visit to China, February 2013

Mauritius

Mauritius has one of the highest prevalence of drug use per capita, with high rates of heroin injection. The government has responded to drug use with harsh punitive sanctions against users and drug offenders. The 2000 Dangerous Drugs Act punishes people caught for drug use with a maximum of 2 years' imprisonment and/or a fine of a maximum of 50,000 rupees (USD 1,640). Data shows that this has not led to a decrease in drug use, while a number of negative consequences have emerged, in particular in terms of public health – in 2005, 92% of new HIV infections in Mauritius was among people who inject drugs.

To respond to this worrying trend, some NGOs opened the first needle and syringe programme (NSP) in the country – illegally at the time, since the possession of a syringe is considered as a criminal offence under Mauritian drug laws. The first methadone maintenance treatment programmes also opened in 2006. That year also marked a change in the country's legislation, with the adoption of the HIV and AIDS Act which officially supported NSPs, and providing that a person should not be criminalised on the basis only of possession of a syringe, if the syringe was obtained from an accredited NSP facility. Today, a number of NGOs, as well as the Ministry of Health, are offering a range of harm reduction services across Mauritius.

These harm reduction services have been effective at responding to the public health challenges caused by drug use. In 2013, the incidence rate of new HIV infections among people who inject drugs had already fallen at 44% (from the high levels of 92% only eight years earlier).

However, many challenges remain. Biggest among those is the fact that there is a clear contradiction between the harm reduction approach promoted by the HIV and AIDS Act and the repressive approach adopted by the Dangerous Drugs Act – and therefore, many people continue to be arrested and sent to prison for simple drug use while caught in possession of a syringe, despite the HIV and AIDS Act.

Key reference: Nougier, M. (2013), 'Drug policy and harm reduction in Mauritius: Some progress but challenges remain', *IDPC Blog,* http://idpc.net/blog/2013/12/drug-policy-and-harm-reduction-in-mauritius-some-progress-but-challenges-remain

MODULE 2

Handout: Resources/Further reading

Full texts of the three UN Drug Control Treaties

Single Convention on Narcotic Drugs, 1961, as amended by the 1972 protocol, http://www.unodc.org/unodc/en/treaties/single-convention.html

Convention on Psychotropic Substances, 1971, http://www.unodc.org/unodc/en/treaties/psychotropics.html?ref=menuside

United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, http://www.unodc.org/unodc/en/treaties/illicit-trafficking.html?ref=menuside

Discussion and analysis of the drug control system

West Africa Commission on Drugs (2014), *Not Just in Transit: Drugs, the State and Society in West Africa*, http://www.wacommissionondrugs.org/report/

Global Commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies That Work*, http://www.globalcommissionondrugs.org/reports/

Global Commission on Drug Policy (2013), *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic*, http://www.globalcommissionondrugs.org/reports/

International Drug Policy Consortium (2012) *Drug Policy Guide (2nd Edition)*, http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition

Global Commission on Drug Policy (2012), *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*, http://www.globalcommissionondrugs.org/reports/

Organization of American States (2012), *Scenarios for the drug problem in the Americas 2013 – 2025*, www.oas.org/documents/eng/press/Scenarios_Report.PDF

Bewley Taylor, D. & Jelsma, M. (2012), *The UN drug control conventions: The limits of latitude* (International Drug Policy Consortium & Transnational Institute), http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude

Global Commission on Drug Policy (2011), *War on Drugs: Report of the Global Commission on Drug Policy*, http://www.globalcommissionondrugs.org/reports/

Jelsma, M. (2011), *The development of international drug control: Lessons learned and strategic challenges for the future*, http://www.druglawreform.info/en/publications/legislative-reform-series-/item/1158-the-development-of-international-drug-controls