

**ASSESSING THE APPLICABILITY  
OF DECRIMINALIZATION  
IN THAILAND**

July 2018

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## **ACKNOWLEDGEMENTS**

The author would like to thank Mr. Verapun Ngammee, Director of the Ozone Foudnation – the largest providers of harm reduction services in Thailand – for his invaluable assistance in collecting data and insights in the preparation of this report. Special thanks to colleagues who have contributed to the final report with comments and suggestions.

Lastly, the author would like to thank people who use drugs, especially those incarcerated for drug-related crimes, for sharing their personal experiences honestly and for their insights into their own experiences. Without the meaningful participation of people who use drugs and of people incarcerated for drug crimes, this book would not have been possible.

## ACRONYMS

AIDS	Acquired immune deficiency syndrome
ARUD	Arbeitsgemeinschaft für Risikoarmen Umgang mit Drogen
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
ATS	Amphetamine-type stimulant
CASIDU	HIV Prevention, Care and Support for Injecting Drug Use
CHAMPION	Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking
CHF	Swiss Franc
CND	Commission on Narcotic Drugs
CSO	Civil society organization
CZK	Czech Republic Koruna
DIC	Drop-in center
DOC	Department of Corrections
EKDF	Swiss Federal Commission for Drug Issues
EMCDDA	European Monitoring Center for Drugs and Drug Addiction
EU	European Union
EUR	Euro
GDP	Gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAT	Heroin-assisted therapy
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HRH	Her Royal Highness
IBBS	Integrated biological and behavioral survey
INCB	International Narcotics Control Board
IPDT	Portuguese Institute for Drugs and Addiction
MARP	Most-at-risk population
MOH	Ministry of Health
MOI	Ministry of the Interior
MOJ	Ministry of Justice
NARC	Narcotic Addict Rehabilitation Committee
NDC	National Drug Commission
NPS	New psychoactive substances
ONCB	Office of the Narcotics Control Board
OST	Opioid substitution therapy
PROVE	Projekt zur ärztlichen Verschreibung von Betäubungsmitteln
PWUD	People who use drugs
PWID	People who inject drugs
RTTR	Recruit, test, treat, retain
SICAD	Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias
STAR	Stop TB and AIDS through RTTR
TB	Tuberculosis

TDN	Thai Drug Users' Network
THB	Thai Baht
THC	Tetrahydrocannabinol
TIJ	Thai Institute of Justice
TTAG	Thai AIDS Treatment Action Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDCP	United Nations Drug Control Program
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar
WHO	World Health Organization

## EXECUTIVE SUMMARY

In recent years, increasing calls for alternative approaches to criminalization and for accelerated drug policy reform have fragmented the global drug control consensus. In 2016, it was estimated that more than 30 countries had taken advantage of the flexibilities provided in the international drug control conventions and implemented some form of official decriminalization.<sup>1</sup> Meanwhile, the vast majority of governments continue to implement a wide range of punitive measures rooted in the war on drugs approach.

The present report explores the evolution and implementation results of five European decriminalization models – from the Czech Republic, Germany, the Netherlands, Portugal and Switzerland. This report is designed to unpack and compare the components of existing decriminalization models from Europe, to support governments considering decriminalization of drug use and possession with the tools to identify existing mechanisms and processes, and to adapt those to best fit their national contexts. More specifically, the report includes an assessment of the potential applicability of various decriminalization components to the Thai context.

The report was developed after a comprehensive desk review of published materials and grey literature. A total of 37 variables grouped under eight broad categories were analyzed, namely: national context, decriminalization model, drug control strategy in terms of prevention; drug control strategy in terms of harm reduction; drug control strategy in terms of drug dependence treatment; drug control strategy in terms of law enforcement; results; and key actors for change.

Several limitations should be kept in mind while reading this report. First, the analysis rests on availability of published information. Very limited original data has been introduced in this report beyond the analysis. For example, few interviews were conducted or site visits were performed to further inform the content of the analysis. Second, many publications were not available to the authors in English – multiple national assessments and evaluations have been published in Dutch, Czech, Portuguese and German about the implementation of decriminalization. Only materials available in English, French and Thai could be analyzed. Third, not all relevant data could be included in the final analysis. The breadth of the desk review led to an overwhelming amount of relevant data that the authors prioritized for inclusion in the report. Fourth, limited information was available on specific variables. For example, data about prevention strategies and interventions and their effectiveness was rather limited for all countries.

Comparison of the evolution of the five European drug control models revealed important similarities and differences that are instrumental for the development and implementation of decriminalization models and approaches. To set the stage, *Table A* below provides an overview of the countries' overall population

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<sup>1</sup> Eastwood, N. et al. 2016. *A quiet revolution: Drug decriminalisation across the globe*. Release. ([https://www.tni.org/files/publication-downloads/a\\_quiet\\_revolution\\_march\\_31\\_2016.pdf](https://www.tni.org/files/publication-downloads/a_quiet_revolution_march_31_2016.pdf))

and resources. There are significant differences, especially when compared to Thailand – with a population of 67.7 million, Thailand is closest to Germany, but with a gross domestic product (GDP) per capita of \$15,520 in 2015,<sup>2</sup> Thailand is closer, yet still well below Portugal's per capita GDP. In that respect, the scale and scope of Thailand's drug problem is significantly different compared to Europe given significant differences in national population size, while available resources for drug control are likely to be much more limited in Thailand.

*Table A: Country population and GDP per capita*

	Czech Republic	Germany	Netherlands	Portugal	Switzerland
<b>Population</b> (OECD 2013-2014)	10.5 million	80.9 million	16.8 million	10.5 million	8.1 million
<b>GDP per capita</b> (OECD 2015)	\$33,753	\$47,999	\$49,570	\$29,688	\$59,150

*Motivation for decriminalization:*

The fundamental motivations for governments to implement decriminalization approaches have varied extensively, even within the five European countries analyzed in this report. Despite the differences, two major themes emerged: on the one hand, a number of European countries were compelled to change drug control strategies given the negative public health consequences that were being exacerbated by criminal justice responses. Germany, Portugal and Switzerland's motivation to reform drug policies was fueled by the rapid spread of HIV and viral hepatitis and by a significant burden of mortality associated with drug use. On the other hand, public perception of a growing drug problem and a challenge to the national self-image were important triggers for the Czech Republic, Portugal and Switzerland to initiate drug policy reforms.

In addition to public health and public perception, addressing growing visibility of public nuisance associated with drugs was also a driving factor for Germany and Switzerland, while a long history of authoritarian governments also stimulated change in drug control approaches in the Czech Republic and Portugal. In contrast, the Netherlands' motivation to decriminalize came earlier than for other European nations and was borne of a rational and pragmatic decision to reduce the reach of the black market and organized crime through a clear segregation of hard and soft drug markets. Meanwhile, it is worth highlighting that Switzerland has not officially decriminalized drugs but significant reforms have been introduced in drug policies since the 1990s.

*Decriminalization model and guiding principles:*

Except Switzerland, which has not officially decriminalized drugs, all four other European countries reviewed rely on a combination of official quantity thresholds and law enforcement discretion to divert non-violent drug law offenders away from the criminal justice system. In the case of quantity thresholds, data collected and summarized in *Table B* below shows that all four other European countries under review have decriminalized possession of small quantities of cannabis, although the thresholds vary significantly across countries: from 5 grams in the Netherlands to 25 grams in Portugal.

<sup>2</sup> World Bank. 2015. *Gross national income per capita 2015, Atlas method and PPP*. (<http://databank.worldbank.org/data/download/GNIPC.pdf>)



*Table B: Drug decriminalization quantity thresholds*

<b>Drug type</b>	<b>Czech Republic</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Portugal</b>
Methamphetamine	1.5g	5g	N/A	N/A
Amphetamines	N/A	0.5g - 3g	N/A	1g
Heroin (diacetylmorphine)	1.5g	1g	N/A	1g
Cocaine	1g	0.5g - 3g	N/A	2g
Medicines containing buprenorphine	N/A	N/A	N/A	N/A
Medicines containing methadone	N/A	N/A	N/A	1g
Ecstasy	5 tablets or 0.4g powder or crystals	20 tablets	N/A	1g (MDMA)
LSD	5 paper tabs, tablets, capsules, or crystals	N/A	N/A	0.1g
Cannabis	10g	6g	5g	25g
Hashish	5g	N/A	N/A	5g
Psilocybin mushrooms	40 fruiting bodies	N/A	N/A	N/A

In addition to these formal guidelines, law enforcement agencies involved in drug control in the four countries also benefit from a significant level of discretionary power that allows those agencies to divert cases away from the criminal justice system. Police in all four countries have some measure of discretionary power although this is not officially recognized in legal documents in Germany. In parallel, Czech, Dutch and German prosecutors also have the discretionary power to dismiss drug-related charges, suspend sentences and broker other arrangements without approval of the court. Courts in the Czech Republic also benefit from significant discretionary powers, while non-violent offenders arrested for possession are directly diverted away from the courts towards the dissuasion commissions in Portugal.

Overall drug control and specific efforts to divert non-violent drug offenders arrested for possession and/or consumption crimes are grounded on fundamental public health and human rights principles in all five European countries reviewed in this report. Official policy documents specifically mention these principles and government representatives from the five countries under review have often promoted these guiding principles as the cornerstone of drug policy at the international level. This has often implied, in practice, that client-centered public health strategies and interventions have been prioritized over criminal justice interventions and the political compulsion to punish. In addition, all five European countries' drug control policies have been solidly grounded on evidence; studies, reports, assessments and evaluations have been systematically

performed and government agencies consistently have integrated and followed expert recommendations from those evidence-based documents.

The Czech and Dutch drug control policies are explicitly guided by the *ultimum remedium* principle, where use of the criminal justice system is a means of last resort, further de-prioritizing criminal justice and law enforcement interventions in the context of drug control. Implementation of German and Dutch drug control policies are also explicitly guided by the expediency principle – or the empowerment of officials to dismiss drug-related charges before those are brought to court, when such charges would generate little or no public good or added-value – on which prosecutorial discretion is grounded and formalized into law. Promoting meaningful involvement of people who use drugs (PWUD) and civil society organizations (CSO) is an explicit guiding principle in both German (subsidiarity) and Swiss (participation) drug control policies. Meanwhile, the Dutch drug control policies are grounded on the core principle of segregation of soft and hard drug markets.

#### *Drug policymaking:*

In all five countries reviewed, control over and leadership in decision-making related to drug policy development, implementation, coordination, monitoring and evaluation was shifted from justice ministries to the ministries of public health around the time of decriminalization. This shift in the locus of control over drug policymaking was grounded on the formal principles described above and represented an official effort to practically initiate and sustain legislative and programmatic reforms to successfully implement decriminalization. It is also worth noting that in all five European countries reviewed in this report, drug policy reforms towards decriminalization led to a significant amount of legislative tinkering. The number of reforms, amendments, new laws and policies that were developed, proposed and approved was significant in that achieving effective decriminalization required a willingness to change official laws and policies that impede or limit such results.

Specific individuals and organizations have played important leadership roles that paved the way for decriminalization and drug policy reforms. Especially in the Czech Republic and Switzerland, the leadership of key individuals – in both cases medical professionals affiliated with CSO – triggered important efforts that eventually led to drug policy reforms. In all countries reviewed save the Czech Republic, an official national network of PWUD, managed by PWUD, was operating and contributed to drug policy development and implementation.

Implementation of decriminalization and associated drug policy reforms has implied the establishment of a number of new institutional structures in all five European countries reviewed. However, the nature of those new institutions and structures was relatively different across the five European countries. In the Czech Republic, in Germany and in Switzerland, a new government authority was created and mandated with overall drug policy development, implementation, coordination, monitoring and evaluation. In Portugal, the drug dissuasion commissions were established to substitute criminal justice courts in cases of possession of illicit drugs. In the Netherlands, the notorious coffeeshops were

established as licit commercial dispensaries for soft drugs. The establishment of new structures and institutions is particularly relevant given that, in the Czech Republic, the Netherlands and Portugal, this has been explicitly acknowledged as the result of the failure of previous institutions and structures to successfully address drug-related problems.

In addition to the new government structures and mechanisms, implementation of decriminalization models and associated drug policy reforms in all five European countries reviewed was consistently supported by CSO. Non-government agencies have played such an important role that governments in most of the five countries reviewed provided direct funding that allowed CSO to engage effectively and meaningfully in drug control to complement and add value to the national response. Many government officials – from all five European countries – have publicly acknowledged in global forums that the successes achieved by their national drug control efforts has been contingent on meaningful CSO involvement.

It also is worth noting that with the exception of Switzerland, all other four European countries reviewed report annually to the European Monitoring Center for Drugs and Drug Addiction (EMCDDA), a regional drug surveillance agency established in 1993. The comprehensive data collected by EMCDDA across all relevant aspects of drug control provides opportunities for comparisons across the European Union (EU), and generates reliable up-to-date information about drugs and drug policy implementation in Europe.

#### *Drug control policies:*

Drug control policies across the five European countries are largely, if not directly based on the Swiss *Four Pillars* policy, which has provided an elegant and effective framework for balancing prevention, harm reduction, treatment and law enforcement strategies and interventions. The Swiss *Four Pillars* model was developed and formally deployed in 1991, and the Czech and German drug policies were rapidly modeled on the Swiss approach. In contrast, the Portuguese drug control strategy has not formally included law enforcement although law enforcement remains an important component in the context of drug control, especially at market level. Similarly, the Dutch policy has not explicitly been grounded on the four pillars but the national drug control policy has prioritized strategies and interventions that belong to the four pillars listed above.

In all five European countries, drug control policies' strategic pillars are targeted at clear population segments and behaviors to maximize impact and generate success. Based on the Swiss model and approach, *Table C* below shows that prevention activities seek to prevent initiation among children and youth; that harm reduction is targeted at all PWUD in order to reduce negative consequences of drug use; that treatment activities seek to address dependence among those who are clinically dependent on drugs; and that law enforcement activities target organized crime outfits to reduce the overall drug market.

*Table C: Segmentation of drug control strategies by pillar*<sup>3</sup>

<b>Pillar</b>	<b>Population segment</b>	<b>Target issue / behavior</b>
Prevention	Children and young people	Initiation
Harm reduction	People who use and inject drugs	Adverse consequences of drug use
Treatment	People dependent on drugs and problem drug users	Drug dependence
Law enforcement	Producers, traffickers and dealers	Production, distribution and trafficking

While the *Four Pillars* model has provided an elegant framework to balance various drug control components, it is worth pointing out that where data is available, investments in law enforcement have continued to represent 50% or more of the total expenditure related to drug policy. For example, an estimated 50% of the Swiss drug control budget was invested in law enforcement,<sup>4</sup> compared to an estimated 65% to 70% in Germany.<sup>5</sup> In that sense, a balanced approach to drug control in Europe has not implied a significant de-funding of law enforcement but rather a more equitable distribution of resources allocated for drug control strategies and activities.

- *Prevention pillar:* Across all countries reviewed, there was limited relevant information about the nature and results of drug prevention activities. Data from Germany and the Netherlands – where independent prevention monitoring systems have been established – provided insight into the nature of activities implemented, although again, limited information was available regarding the overall impact of those activities. Despite those limitations, it is clear that school-based prevention has been a mainstay across all five European countries analyzed. Data about the Netherlands showed that school-based prevention programs need to be evidence-based in order to be effective, otherwise those efforts risk encouraging drug use instead. The Netherlands has also increasingly relied on targeted selective prevention interventions, mostly carried out by CSO in collaboration with government agencies. Virtually all European countries reviewed have set up a drug-related telephone helpline and an increasing number of countries have set up online web- and smartphone-based platforms to support prevention interventions.
- *Harm reduction pillar:* All five European countries have officially integrated harm reduction strategies and implement a comprehensive package of services aligned with the United Nations' (UN) recommendations and guidelines. Financial costs for such services are generally covered by government budgets, most often allocated to CSO to reach clients, deliver

<sup>3</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>4</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.  
(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>5</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at:  
<http://www.emcdda.europa.eu/countries/germany>.

services, and facilitate entry into drug treatment specifically and into the national health care system generally. Government support for harm reduction has also contributed to the development of important innovations in service delivery, where heroin-assisted therapy (HAT), drug consumption rooms, and distribution of gelatin capsules for people who inject methamphetamine were introduced and scaled up given their effectiveness. In virtually every country reviewed, early introduction of harm reduction interventions has contributed to reducing HIV and viral hepatitis transmission among people who inject drugs (PWID), to reducing the number of problem drugs users, to reducing overdoses, and to an overall improvement in health and social functioning of clients. In addition, harm reduction services have acted as a gateway that has facilitated access to drug dependence treatment among clients who were ready and willing.

- *Treatment pillar:* All five European countries offer a wide range of treatment services to address the needs of clients. In all five countries, services are client-centered and respect the fundamental human rights of clients. In all countries under review except Germany, abstinence is not an explicit objective of drug policy in general or treatment activities specifically – the objective is rather to empower clients to be able to manage their dependence in the short- to long-term. Both residential and outpatient treatment services are available, although all five European countries have increasingly relied on outpatient treatment services and de-prioritized and scaled down inpatient treatment. Since drug policy reforms towards decriminalization were introduced, the number of people volunteering for drug dependence treatment has increased in all five countries. Compulsory drug treatment is an option in the Czech Republic and in the Netherlands, although such interventions are rarely implemented in practice, while there is evidence that compulsory detention in the name of treatment was implemented in the mid-1990s in Switzerland.
- *Law enforcement pillar:* Even as the largest share of resources continued to support law enforcement interventions after decriminalization, the five European countries reviewed have clearly prioritized prevention, harm reduction and treatment interventions, over interventions led by the criminal justice system which is explicitly used as a measure of last resort in the Czech Republic and the Netherlands' national responses to drug issues. Interventions implemented under the national law enforcement pillar have been increasingly focused on drug production and trafficking as well as tackling organized crime across all five European countries, rather than on policing street-level consumption, possession and dealing. That said, Germany's drug control policy has continued to incorporate strong elements of street-level policing and has thus been qualified as the most repressive state among the five European countries reviewed.

Since decriminalization, the number of police contacts with drug law offenders has continued to increase, showing that law enforcement agencies have continued to act as an important mechanism in addressing drug-related issues. However, while the number of police contacts with drug offenders has

increased in the Czech Republic, Germany and Switzerland, the number of trafficking arrests has increased in all countries under review except for Germany, the number of people sentenced and incarcerated for drug-related offences has decreased in all five countries, the proportion of drug-related offenders in the overall prison population has decreased in all countries under review (save the Netherlands for which relevant data was not available), the overall prison population has dropped in Germany and the Netherlands, and the severity of punishments for possession/consumption offences has decreased in all countries. This could be interpreted to mean that law enforcement activities have been scaled up since decriminalization, but have been increasingly focused on controlling the drug market and tackling production and trafficking, rather than investing time and resources policing individual possession and consumption.

### **Evaluations and results:**

Data indicates that all European countries under review except Germany have systematically evaluated the implementation of their national drug control policies. Results from both internal and independent external evaluations have consistently indicated that drug policies have significantly contributed to achieving or have achieved their objectives and have consistently generated significant benefits for PWUD, their families, their communities and the country as a whole. In the Czech Republic, the impact of the return to criminalization was documented and evaluated, showing clearly that criminalization had exacerbated drug-related problems rather than solving them. Additional service specific evaluations have shown that innovative services such as HAT and drug consumption rooms have generated significant health benefits and social value with virtually no negative unintended consequences.

The impact of decriminalization on drug use patterns seems to be limited. Evidence showed that after decriminalization, consumption rates – especially for cannabis – tend to increase, but drop again after a few years, below the level of other countries that have not decriminalized. Evidence reviewed showed that when there has been an increase in drug use patterns among certain age groups in countries that have decriminalized drugs, similar and comparable increases were detected in other countries across Europe where drug control remains focused on prohibition led by law enforcement agencies. However, there was no evidence that showed that either decriminalization or specific services such as HAT or distribution of needles and syringes have encouraged non-users to start consuming illicit drugs. In that sense, such patterns could indicate that the severity of drug laws and the content of drug policies may have little impact on overall drug consumption patterns, and that such an indicators may not generate the evidence required to make sound decisions regarding drug control.

Data related to the financial investments in drug control for the five European countries reviewed was rather limited and no reliable conclusions could be made regarding the changes in investments prior to and after decriminalization. Available data showed that the cost of drug control has been significant. Important sums have been allocated each year to support implementation of drug control policies and the interventions under each of the four pillars. As

noted above, the largest share of funds has continued to support law enforcement activities but national governments have also allocated significant amounts for prevention, harm reduction and treatment without relying on external donors. In addition, available data showed that specific services, particularly harm reduction services, are especially cost-effective and generate significant return-on-investment in the long-term. It is also worth highlighting that in the Netherlands, coffeeshops have generated up to EUR 400 million per years in tax benefits for the national government.

### **Implications for Thailand**

During the 2016 UNGASS on the World Drug Problem, Minister of Justice General Paiboon Koomchaya emphasized Thailand's opposition to legalization and decriminalization "for serious offences,"<sup>6</sup> echoing support for the Association of South East Asian Nations (ASEAN) position on drug-related issues. However, shortly after the UNGASS, General Koomchaya publicly admitted that the global war on drugs, as well as Thailand's had failed,<sup>7</sup> contrasting sharply with ASEAN's preferred vision.

Prompted by increasing use of amphetamine-type stimulants (ATS) and other party drugs, by long and especially punitive sentences for drug-related offences that disproportionately affect women, as well as by overall soaring prison populations, General Koomchaya announced in 2016 that his office was ready to consider all drug control options – including decriminalization – that respect and adhere to the international drug control conventions.<sup>8</sup>

Thailand has often been singled out in the media and by human rights defenders for aggressive war on drugs campaigns. For example, the Global Commission on Drug Policies recently recognized that "aggressive law enforcement practices targeting drug users have also been proven to create barriers to HIV treatment," singling out "devastating consequences" in Thailand, Russia and the United States.<sup>9</sup> Human Rights Watch published damning reports of the 2003-2004 war on drugs that left over 2,000 people dead,<sup>10</sup> while other agencies have documented abuses carried out in compulsory drug detention centers.<sup>11</sup> The recent call for decriminalization and drug policy reform is therefore a significant change in strategic direction that could have a profound impact for Thailand.

The experiences of the five European countries documented in this report can provide some support to the Thai government in planning the way forward for national drug policies. The lessons learned from the Czech Republic, from

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<sup>6</sup> Koomchaya, P. 20 April 2016. *Statement by H. E. General Paiboon Koomchaya Minister of Justice of Thailand at the Thirteenth Special Session of the United Nations General Assembly on the World Drug Problem*. New York City, United States. (<http://statements.unmeetings.org/media2/7657420/thailand.pdf>)

<sup>7</sup> Lefevre, A. S. 18 July 2016. "Soaring prison population prompts Thailand to re-think 'lost' drug war" in *Reuter*. (<http://www.reuters.com/article/us-drugs-thailand-prisons-idUSKCN0ZX01J>)

<sup>8</sup> Pakkawan, A. 19 November 2016. "Paiboon stands by delisting pot, krathom plan" in *Bangkok Post*. (<http://www.bangkokpost.com/news/general/1138965/paiboon-stands-by-delisting-pot-krathom-plan>)

<sup>9</sup> Global Commission on Drug Policy. 2012. *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*. ([https://www.globalcommissionondrugs.org/wp-content/uploads/2012/03/GCDP\\_HIV-AIDS\\_2012\\_EN.pdf](https://www.globalcommissionondrugs.org/wp-content/uploads/2012/03/GCDP_HIV-AIDS_2012_EN.pdf))

<sup>10</sup> Human Rights Watch. 2004. *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights*. (<https://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf>)

<sup>11</sup> Canadian HIV/AIDS Legal Network. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

Germany, from the Netherlands, from Portugal and from Switzerland may provide Thailand with an opportunity to adapt some of the approaches, strategies and services to generate better results for Thai society as a whole. In planning the way forward, Thai officials could consider a number of options to align the national drug control efforts on the European experience, without necessarily decriminalizing drugs, much like in Switzerland. The analysis of the European experience documented in this report has provided a number of policy options that could be implemented in Thailand.

Shifting control over drug policies from the Ministry of Justice (MOJ) to the Ministry of Health (MOH) has been an instrumental step in each of the five European countries reviewed in this report. In the countries reviewed, MOH has continued to work closely with MOJ to develop and implement drug control policies. In parallel, new institutions and structures were established in all five European countries reviewed, often to coordinate drug control activities at the national level. In virtually all of European countries under review, CSO have been invited to play meaningful roles in drug control activities.

These would represent significant changes for Thailand whose drug control policy has been led and dominated by MOJ, where collaboration between MOH and MOJ in the context of drug control has been limited to delivering health services in closed settings, where challenging the traditional roles of key institutions generates significant resistance, and where collaboration with CSO has been extremely limited and significantly tense. That said, the shift in control to MOH, the establishment of new national coordination entities and improved collaboration with CSO are all feasible and relatively simple steps that could considerably improve the results generated by national drug policy activities.

Additional lessons learned from the European countries reviewed showed that there has been overwhelming consensus for drug control policies and activities to be guided and grounded on human rights and public health principles. Client-centered approaches that offer a comprehensive range of public health options have generated positive results in motivating PWUD to volunteer and enroll in drug dependence treatment, especially when their rights have been protected and their health has been prioritized. In addition, all five European countries reviewed made their drug policy decisions based on evidence generated by national and international experts rather than based on moral ideals, history or tradition.

Integrating these principles in Thai drug control policies would greatly enhance opportunities for more effective and balanced responses to drug issues. Specifically, significant evidence consistently points to the negative consequences caused by prohibition and overly punitive drug control policies; mountains of evidence consistently have shown that harm reduction services are effective, cost-effective and safe; and evidence has consistently shown that decriminalization does not lead to increased drug use, more crime or significant narcotourism. Integrating the lessons learned from the five European countries reviewed here as well as those found in the literature produced in the last decade alone represents a daunting challenge, yet investing in generating local



evidence through studies and evaluation, and a willingness to be guided by the results of these processes would provide opportunities to address some of the challenges Thailand faces in regards to illicit drugs.

Modeling Thailand's national drug control policies and practices on the Swiss *Four Pillars* model is an option that would contribute to balancing the national response to illicit drugs. Implementation of Thailand's national drug control policy has been focused explicitly on law enforcement responses and criminal justice efforts in order to deter further drug law offenders, and significant investments were made to support law enforcement's role in drug control each year. Prevention and rehabilitation have been secondary objectives that were focused on maintaining and achieving abstinence; treatment has often been compulsory and few treatment options have been available for patients. Harm reduction has not been supported by the national government, virtually 100% of funding for harm reduction activities has been sourced from international donors, and, although a national harm reduction policy was in place from 2014 to 2015, it expired and was not been renewed until February 2017.<sup>12</sup>

Modeling the Thai drug control response on the Swiss *Four Pillars* would thus prove an important challenge. For example, drug prevention education and activities in schools would need to be shored with evidence and implemented to empower rather than to scare or deter. Comprehensive harm reduction services would need to be rapidly scaled up and officially and financially supported by national government agencies while new and additional interventions could be piloted and evaluated to better meet the specific needs in the Thai context. Effective delivery of treatment services would require extensive retooling of the workforce in order to integrate a new approach focused on meeting client needs, by providing a range of treatment options ideally through outpatient mechanisms, rather than focusing on achieving abstinence and forcibly detaining PWUD in closed residential facilities in the name of treatment.

Adopting a drug control policy approach grounded on the *Four Pillars* model in Thailand would also imply a significant de-prioritization of law enforcement interventions, especially in the context of policing possession and consumption offences, where law enforcement efforts would be ideally refocused on containing the drug market by targeting production and trafficking offenders while undermining organized crime. While overcriminalization of illicit drugs and disproportionate punishments have been common,<sup>13</sup> such practices should rather become a measure of last resort when all other options have failed. In parallel, drug-related sentences should be proportional to the potential harm to the individual and to society caused by the offence.

All the options presented so far do not involve any form of decriminalization, but rather a rebalancing of drug policy objectives and efforts. The four European countries reviewed that decriminalized drugs all relied on a combination of

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<sup>12</sup> Tanguay, P. and Ngammee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>13</sup> Paungsawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

quantity thresholds and discretion as well as the segregation of soft and hard drugs markets. In this context, an American government report notes:

*Options for decriminalization include a diversity and common threads among these jurisdictions as to defining narcotics, distinguishing between “hard” and “soft” drugs, establishing special regulations concerning cannabis, refusing to prosecute personal use and/or possession of small quantities of drugs for personal use, giving law enforcement authorities the discretion not to prosecute minors and first-time offenders, applying alternative forms of punishment, and providing treatment opportunities.<sup>14</sup>*

These are all feasible options worth considering but implementation of decriminalization approaches would be most effective if the options presented earlier were implemented, well integrated, and supported by both government and the general population. However, these are not required, and a radical shift away from criminalization approaches towards those focused on public health objectives is possible as the experience in the Czech Republic shows. That said, introducing additional discretion across the criminal justice system would likely contribute to reducing the growing prison population. Consistent application of quantity thresholds would also reduce criminal justice bottlenecks created by overcriminalization of drug issues in Thailand, and would contribute to refocusing law enforcement efforts on targeting producers and traffickers while facilitating access to treatment and other health and social care services for PWUD. Implementation of the decriminalization options identified here, while possibly controversial for the general population and making for newsworthy media coverage, are in full compliance with the international drug control conventions, as proclaimed by the President of the International Narcotics Control Board (INCB) in regards to Portugal in 2015.

The Thai government has a historic opportunity to provide valuable leadership across Southeast Asia as options for new approaches to drug control are being considered. The models, approaches, strategies, interventions and services presented in this report have been identified as valuable evidence-based options that could add significant value to Thailand’s drug control efforts. While it is clear that the Thai context is considerably different from that of Europe, nonetheless the options identified in this report have generated significant positive results while virtually no major negative consequences have resulted from drug policy reforms towards decriminalization. Additional data and evidence is urgently required to further assess the potential impact of drug policy reforms presented here as well as other options proposed by other stakeholders in Thailand.

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<sup>14</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

## INTRODUCTION

For more than 50 years, governments across the globe have made significant efforts and invested immense sums of money to eliminate the illicit drug market and suppress the use, production and trafficking of such illicit substances. The vast majority of these efforts have emanated from the criminal justice system, focusing on strict policing, often leading to severe punishments of lawbreakers. Such approaches have often been labeled “war on drugs,” a term that was originally coined by United States President Richard Nixon in 1971.

The modern international drug control framework was established in 1961 with the ratification of the *United Nations Single Convention on Drugs*<sup>15</sup> that was designed to strictly limit the cultivation, production, distribution, trade, use and possession of narcotic substances to medical and scientific purposes. Article 36 of the *Single Convention* has not necessarily required the criminalization of all the above; it stated only that individuals caught for serious breaches of this requirement “shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.”

The 1988 *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychoactive Substances*<sup>16</sup> introduced requirements for governments to take legal action against individuals breaching drug laws. Article 3(2) stated that “each Party shall adopt such measures as may be 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.” However, that same article opened with an important caveat to the requirement for criminalization of drugs, noting that drug control measures implemented by national governments shall be “subject to its constitutional principles and the basic concepts of its legal systems.”

While more than 180 governments have ratified the Conventions, only a few have taken advantage of the flexibilities provided in these international treaties. Indeed, the vast majority of governments have implemented a wide range of punitive measures rooted in the war on drugs approach. The consequences of criminalization of illicit drugs, particularly of drug use and drug possession, have been dramatic around the world: facilitating the rapid spread of disease and infections, increasing drug-related mortality, reducing access to health and social care, fostering public disturbances, escalating to gang wars, as well as creating major bottlenecks for courts leading to overcrowded prisons. Meanwhile, a global estimate of USD 100 billion<sup>17</sup> has been invested annually in combating an ever-expanding drug market with little evidence that sustainable positive results have been achieved.

In recent years, the global consensus established over 50 years ago has eroded and become fragmented by increasing calls for alternative approaches to

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<sup>15</sup> See [https://www.unodc.org/pdf/convention\\_1961\\_en.pdf](https://www.unodc.org/pdf/convention_1961_en.pdf).

<sup>16</sup> See [https://www.unodc.org/pdf/convention\\_1988\\_en.pdf](https://www.unodc.org/pdf/convention_1988_en.pdf).

<sup>17</sup> Harm Reduction International. 2015. *10 by 20: A call to redirect resources from the war on drugs to harm reduction*. (<http://www.ihra.net/10by20>)

criminalization and for accelerated drug policy reform. The Global Commission on Drug Policy, a body composed of former heads of states, human rights and public health experts, business leaders, economists, and UN leaders, has repeatedly endorsed, promoted and celebrated efforts to decriminalize drug use and possession over the past five years. Several UN agencies, including the Joint UN Programme on HIV/AIDS (UNAIDS),<sup>18</sup> the UN Development Programme,<sup>19</sup> Office of the UN High Commissioner for Human Rights,<sup>20</sup> the World Health Organization (WHO),<sup>21</sup> and even the UN Office on Drugs and Crime (UNODC),<sup>22</sup> have also endorsed and promoted decriminalization. In addition, a number of Member States have acknowledged the failure of the war on drugs approach and the need for alternatives during the UNGASS on the World Drug Problem, held in New York, in April 2016.

However, decriminalization has often been confounded with depenalization or even legalization of drugs. To make matters more difficult, there is currently no universally accepted definition of these terms. For the purposes of this report, decriminalization will refer to the elimination of a conduct or activity from the sphere of criminal law.<sup>23</sup> *Box 1* also provides expanded definitions for the terminology introduced above.

### *Box 1: Definitions*

DECRIMINALIZATION is where a country retains its laws on drug offences but, either through an agreed policy change, or through new guidance to prosecuting authorities, decides to respond to certain of these offences through administrative processes rather than the criminal justice system. It should be noted that, in many cases, administrative penalties for drug offences have actually been harsher than criminal sanctions, so decriminalization can not always be seen as a less punitive approach to drug use.

DEPENALIZATION is where a country decides to cease punishing those involved in the possession, use or distribution of drugs. Laws will still exist prohibiting these activities, and offenders may still be arrested, but no sanctions (criminal or administrative) are applied. A similar approach to this, but not technically depenalization, is a policy of not arresting offenders.

LEGALIZATION is where the legislature of a particular country formally amends its laws to end the prohibition of the possession, use or distribution of any of the currently controlled drugs. Although there are some grey areas (some countries criminalize use, some possession; the status of possession for medical or religious uses of some drugs is

<sup>18</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International.

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>19</sup> United Nations Development Programme. 2015. *Addressing the Development Dimensions of Drug Policy*.

(<http://www.undp.org/content/dam/undp/library/HIV-AIDS/Discussion-Paper--Addressing-the-Development-Dimensions-of-Drug-Policy.pdf>)

<sup>20</sup> Office of the UN High Commissioner for Human Rights. 2014. *Study on the impact of the world drug problem on the enjoyment of human rights*.

(<http://www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblem.aspx>)

<sup>21</sup> World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. ([http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1))

<sup>22</sup> United Nations Office on Drugs and Crime. 2015 (Unreleased). *Briefing Paper: Decriminalisation of Drug Use and Possession for Personal Consumption*.

([http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/19\\_10\\_11\\_unodebriefing.pdf](http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/19_10_11_unodebriefing.pdf))

<sup>23</sup> Jelsma, M. 2011. *The development of international drug control: Lessons learned and strategic challenges for the future*. Global Commission on Drug Policies. ([http://www.globalcommissionondrugs.org/wp-content/themes/gcdp\\_v1/pdf/Global\\_Com\\_Martin\\_Jelsma.pdf](http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Martin_Jelsma.pdf))

uncertain), this has not been attempted by any UN Member State, and would be in clear contravention of the UN Conventions.

Source: Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: A current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

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A growing range of options have been piloted, assessed and scaled-up over periods of a few years to several decades. These options are available as feasible alternative models to criminalization of drug use and possession. Across the globe, decriminalization models vary considerably with governments adopting a *de jure* model defined by law while others have implemented *de facto* decriminalization by deprioritizing policing of drug possession and personal use. In 2016, it was estimated that more than 30 countries had implemented some form of official decriminalization.<sup>24</sup>

Almost a third of countries where decriminalization has been implemented are located in Latin America while a comparable number of such countries are located in the EU. A growing number of Eastern European countries have also implemented decriminalization. Even the United States, a traditionally repressive country and the uncontested leader in the global war on drugs, has implemented decriminalization models at state-level. In contrast, a very limited number of countries in Asia or in Africa have introduced any formal decriminalization,<sup>25</sup> although recent media reports indicate that Ghana may be on the verge of decriminalizing all illicit drugs,<sup>26</sup> while Thailand is considering alternatives to criminalization for cannabis, kratom and amphetamines.<sup>27</sup>

This report is designed to unpack and compare the components of number of existing decriminalization models from Europe to support governments considering decriminalization of drug use and possession with the tools to identify existing mechanisms and processes, and adapt those to best fit their national contexts. Ultimately, this report was designed to assess the potential applicability of various decriminalization components to the Thai context through a comparative analysis.

The present report will explore the evolution and implementation results of five European decriminalization models from the Czech Republic, Germany, the Netherlands, Portugal and Switzerland. The report was developed after a comprehensive desk review of published materials and grey literature. A total of 37 variables, grouped under eight broad categories, were analyzed, namely: national context, decriminalization model, drug control strategy in terms of prevention; drug control strategy in terms of harm reduction; drug control

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<sup>24</sup> Eastwood, N. et al. 2016. *A quiet revolution: Drug decriminalisation across the globe*. Release. (<https://www.tni.org/files/publication-downloads/a-quiet-revolution-march-31-2016.pdf>)

<sup>25</sup> Godwin, J. 2016. *A public health approach to drug use in Asia: Principles and practices for decriminalization*. International Drug Policy Consortium. (<https://dl.dropboxusercontent.com/u/566349360/library/Drug-decriminalisation-in-Asia-ENGLISH-FINAL.pdf>)

<sup>26</sup> Tharoor, A. 14 November 2016. "Elsewhere in the World, Progress: Ghana Is Close to Decriminalizing All Drugs" in *The Influence*. (<http://theinfluence.org/elsewhere-in-the-world-progress-ghana-is-close-to-decriminalizing-all-drugs/>)

<sup>27</sup> Lefevre, A. S. 18 July 2016. "Soaring prison population prompts Thailand to re-think 'lost' drug war" in *Reuter*. (<http://www.reuters.com/article/us-drugs-thailand-prisons-idUSKCN0ZX01J>); Pakkawan, A. 19 November 2016. "Paiboon stands by delisting pot, kratom plan" in *Bangkok Post*. (<http://www.bangkokpost.com/news/general/1138965/paiboon-stands-by-delisting-pot-kratom-plan>)

strategy in terms of drug dependence treatment; drug control strategy in terms of law enforcement; results; and key actors for change.

In the second section, after a presentation of the methodology used to prepare this report, an overview of the evolution of the decriminalization models of each country will be presented along with major findings from evaluations, academic studies and national reports to show the impact of legal and policy changes and other reforms that flowed from those. The third section will start with an introductory overview of Thailand's drug policies along the same lines as the five European countries. In the last section before the conclusion, the report will compare and analyze the different models across the six countries to identify commonalities and major differences. In the final section, the authors will conclude the report with considerations for drug policy reform based on the results of the analysis as well as a set of recommendations.

The analysis will reveal that decriminalization in Europe has led to numerous positive impacts and very few negative unintended consequences; that decriminalization has been largely predicated on a shift from Justice to Health in the national management of drug-related issues; that evidence-based drug dependence treatment and implementation of harm reduction services acted as precursors for decriminalization; that civil society groups played a critical role in supporting drug policy reform and the implementation of decriminalization components; that new government structures were established and mandated to manage national drug programs; and that criminal justice and law enforcement agencies have benefited from decriminalization in a number of ways.

However, the conclusions will also highlight that Thailand's drug laws can be modernized and made more effective by implementing reforms that do not necessarily imply decriminalization of drugs. Several reforms can be introduced into Thai drug policies without decriminalization while better positioning Thailand to do so in the future should its political leaders decide to endorse such an approach.

## METHODOLOGY

This report was developed following a comprehensive desk review of relevant and key policy and legal documents, official evaluations and assessment reports, academic studies, local, national and international reports, media reports and press releases, reports by CSO, and other grey literature. The desk review was initiated in October 2016 following extensive discussions between the authors and key stakeholders in Thailand in September 2016.

Country selection was driven by Thai stakeholders who identified Portugal as a key model to unpack and assess for Thailand's consideration. Further discussions led to the inclusion of Czech Republic, Germany, the Netherlands, and Switzerland. In contrast, the selection of variables for comparison was defined by the author who tracked 37 variables across the five European countries in order to generate the present report. The variables were grouped into broad categories. *Table 1* provides a list of the variables in each grouping.

*Table 1: Variables tracked for the purposes of this report*

Category	Variable
<b>National context</b>	GDP per capita
	National population
	Cultural values and national identity
	Law and policy documents relevant to drug issues
<b>Decriminalization model</b>	Drug use patterns
	Legal environment
	Motivation for policy change
	Decriminalization model
	Implementation of decriminalization approach
	Government structures
	Objectives of national drug policy/strategy
	Principles underpinning drug policy
	National position at UNGASS 2016
<b>Drug control strategy pillar 1: Prevention</b>	Drug control strategy pillar 1: Prevention
<b>Drug control strategy pillar 2: Harm Reduction</b>	Drug control strategy pillar 2: Harm Reduction
	Number of PWID
	National HIV prevalence (general population)
	HIV prevalence among PWID & risk behaviors
	Proportion of new HIV infections among PWID
	Prevalence of viral hepatitis
	Drug-related deaths / overdoses
<b>Drug control strategy pillar 3: Treatment</b>	Drug control strategy pillar 3: Treatment
	Compulsory treatment and extrajudicial detention
<b>Drug control strategy pillar 4: Law enforcement</b>	Drug control strategy pillar 4: Law enforcement
	Court sentencing process and results
	Number of prisons / closed settings
	Incarceration rate



	Prison population and capacity
	Proportion of prison pop incarcerated for drug crimes
<b>Results</b>	Policy evaluation results: positive
	Policy evaluation results: negative
	Financial results / cost-effectiveness
<b>Key actors for change</b>	Leadership / key actors
	Role of civil society / PWUD
	Presence of drug user network
	Civil society participation in policymaking
	Funding sources for CSO/PWUD

Preliminary results were presented by the author on 6 January 2017 at the Grand Centara Hotel in Bangkok, Thailand, at the *Drug Education: Social Skills for Harm Reduction* high-level meeting organized in partnership between the INSPIRE Project, the Ministry of Justice, Thai Health Promotion, and the International Drug Policy Consortium.<sup>28</sup>

Several limitations should be kept in mind while reading this report. First, the analysis rests on availability of published information. Very limited original data has been introduced in this report beyond the analysis. For example, few interviews were conducted or site visits performed to further inform the content of the analysis. Second, in the same vein, while much of data presented in this report is corroborated by multiple sources, some more recent data has not been corroborated by interviews or site visits. Third, many publications were not available to the authors in English – multiple national assessments and evaluations have been published in Dutch, Czech, Portuguese and German about the implementation of decriminalization. Only materials available in English, French and Thai could be analyzed. Fourth, not all relevant data could be included in the final analysis. The breadth of the desk review led to an overwhelming amount of relevant data that the authors prioritized for inclusion in the report. However, a significant quantity of data could not be included due to time limitations. Fifth, limited information was available on specific variables. For example, data about prevention strategies and interventions and their effectiveness was rather limited for all countries.

<sup>28</sup> Tanguay, P. and Ngammee, V. 6 January 2017. “Assessing the applicability of decriminalization components based on evidence and lessons learned for a sustainable national response to drugs in Thailand: Preliminary findings” presented at the *Drug Education (Methamphetamine): Social Skills for Harm Reduction Conference* in Bangkok, Thailand. See online summary at: <https://idpc.net/blog/2017/01/a-push-for-decriminalisation-and-harm-reduction-approaches-to-methamphetamine-in-thailand>.



## DECRIMINALIZATION IN EUROPE

The following section will retrace the major historical milestones in each country's path to drug policy reform towards decriminalization in parallel with relevant changes in drug use patterns. Each country section will also include a review of major efforts under each pillar of the national drug control strategy, as well as the results achieved. Additional analysis regarding the overall impact of the national drug control strategy will be provided through a summary highlighting the main findings based on this report's objectives, which will serve as conclusion to each country overview.

### The Czech Republic

#### Historical overview

In contrast to most European countries, a locally produced form of crystal amphetamines made from cough medicine and other ingredients, has been the source of most drug-related problems in former Czechoslovakia and the present-day Czech Republic.<sup>29</sup> Introduced in the 1970s,<sup>30</sup> the drug became increasingly popular over time until it dominated the national drug scene throughout the 1980s, though consumption and trafficking remained hidden away and the market remained relatively small.

In 1989, the Velvet Revolution marked the return to liberal democracy, away from the authoritarian Stalinist communist governments that were in place for the past 41 years. The history of repression commonly observed in communist countries left the Czech population particularly suspicious and distrustful of law enforcement and with little knowledge about or experience with illicit drugs, which had previously been strictly criminalized.<sup>31</sup> In 1990, several reforms were introduced to the penal code with *Amendment no. 175/1990*, including shifting possession of illicit drugs from a criminal offense to an administrative offense (misdemeanor). The *Amendment* also reinforced criminal provisions for smuggling and selling drugs; introduced a new crime – propagation of drug use – criminalizing the incitement of others to use illicit drugs; and abolished the death penalty.<sup>32</sup>

Czechoslovakia's openness to the world led to increased illicit drug trafficking and the rapid development of an increasingly visible illicit drug market. Pervitin remained the most popular drug in the 1990s, but cocaine was introduced and home-cooked brown heroin was replaced with white heroin from abroad.<sup>33</sup> By 1992, health professionals affiliated with a range of CSO, faced with growing

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<sup>29</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>30</sup> Zabransky, T. 2007. "Methamphetamine in the Czech Republic" in *Journal of Drug Issues*, 155-180. ([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

<sup>31</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf)); Jelsma, M. 2011. *The development of international drug control: Lessons learned and strategic challenges for the future*. Global Commission on Drug Policies. ([http://www.globalcommissionondrugs.org/wp-content/themes/gcdp\\_v1/pdf/Global\\_Com\\_Martin\\_Jelsma.pdf](http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_Martin_Jelsma.pdf))

<sup>32</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>33</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

demand for drug-related health services, jointly petitioned the national government in a letter known as the *Christmas Memorandum*, to expand access to evidence-based health services for PWUD and develop a coherent national response that addresses drug use as a social issue.<sup>34</sup>

*We must state that no law on addictive substances has been passed, there is no coordinated primary prevention, there is an acute lack of detoxification treatment and rehabilitation facilities for drug addicts, and the opportunities for foreign aid and cooperation have been missed... We acknowledge that the state authorities cannot resolve these issues on their own. This is why we declare that the nongovernmental sector is ready to participate in dealing with the problem of addictive substance abuse. However, this work is unthinkable without the underlying policymaking, technical, legislative and organizational involvement of the governmental sector, and particularly without drafting a fundamental framework drug policy.*<sup>35</sup> – Excerpt from the Christmas Memorandum

By 1993, the national government had established a National Drug Commission (NDC) as an inter-ministerial mechanism mandated to develop and coordinate national drug policy. Today, the NDC is composed of representatives from the ministries of interior (MOI), finance, education, youth and sport, defense, labor and social affairs, justice, and health. Additional members of the NDC include the national commissioner for human rights, representatives of the drug authorities from the 14 regions of the country and the city of Prague, as well as CSO representatives.

Again in 1993, the NDC rapidly hired a National Coordinator (one of the architects of the *Christmas Memorandum*) and developed the *Drug Policy Concept and Program for 1993–1996*, which was approved that same year. The new policy was largely modeled on the Swiss *Four Pillars* policy, focusing drug control on prevention of drug use, reducing harm among PWUD, drug treatment for problem drug users, and policing to curb production and trafficking of illicit drugs. The policy delegated authority for primary prevention activities to MOH, established local level drug coordinators to enhance collaboration, and recognized the fundamental value of CSO as partners in the national response to drugs. By 1995, the NDC was sourcing funds from the national government to financially support a range of CSO delivering health and social care services to PWUD.<sup>36</sup>

In the 1990s, the rapidly expanding drug market and the increasing visibility of drug use in the Czech Republic triggered a popular backlash in which news media characterized the issue as a social problem and an invitation for organized crime. Such sensationalist characterizations polarized political discussions which echoed in parliamentary debates. By 1995, the government invited the United Nations Drug Control Program (UNDCP) to conduct a national assessment of drug use in the country. The assessment concluded that additional treatment and harm reduction services were needed to meet the needs of a growing population of users and confirmed that pervitin remained the drug of choice across the

<sup>34</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>35</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>36</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

country.

Given growing popular and political concerns, proposals were submitted to parliament by the Christian Democrats in 1996 and the Communist Party in 1997, urging reforms towards the criminalization of drug possession. The Communist Party proposal also recommended the criminalization of people knowing of drug-related crimes, including possession, who were failing to report those acts to the police. Both proposals were defeated and, in 1998, the government developed the *Penal Code Amendment no. 112/1998* that criminalized possession of “greater than small” amounts of illicit drugs. The *Amendment* also prohibited judges from using repeated offenses of possession, even in amounts “greater than small,” as an aggravating circumstance. Formally undefined in policy documents, quantities “greater than small” were left to the discretion of judges, to the displeasure of many police officers.<sup>37</sup> *Penal Code Amendment no. 112/1998* was officially deployed in 1999.

The return to criminalization did not come without conditions. The NDC required that a comprehensive assessment of the criminalization approach be conducted and the *Impact Analysis Project of the New Drug Legislation* was published in 2001.<sup>38</sup> The study concluded that in the first two years, criminalization of possession of illicit drugs had not reduced problematic drug use or significantly reduced the availability of illicit drugs, while the total financial cost of unintended consequences was estimated at CZK 37 million (USD ~1 million at the time)<sup>39</sup>. In response, the government ratified *Resolution no. 1177/01*, which mandated several ministries to follow-up on the study’s recommendations. Based on these recommendations, a proposal from MOJ was endorsed to separate illicit drugs into two distinct categories: cannabis and other plant-drugs in one category, and all other drugs in the other.<sup>40</sup>

By 2002, the number of problematic drug users – people who use hard drugs, people who inject as well as those who are dependent on drugs – was estimated at 35,100,<sup>41</sup> and by 2004, the year the Czech Republic joined the EU, 1.5% of adults 15-34 had tried amphetamines at least once in their lives.<sup>42</sup> In 2005, methamphetamine was the third single drug causally involved in fatal overdoses.<sup>43</sup> That same year, the NDC published the *National Drug Policy Strategy for the period 2005 to 2009*, still firmly grounded on the four pillars approach. The objectives stated in the new policy included combating organized

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<sup>37</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>38</sup> Zabransky, T., et al. 2001. *Impact Analysis Project of the New Drug Legislation*. National Drug Commission. ([http://www.druglawreform.info/images/stories/documents/Czech\\_evaluation\\_2001\\_PAD\\_en.pdf](http://www.druglawreform.info/images/stories/documents/Czech_evaluation_2001_PAD_en.pdf))

<sup>39</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>40</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>41</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>42</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>43</sup> Zabransky, T. 2007. “Methamphetamine in the Czech Republic” in *Journal of Drug Issues*, 155-180. ([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

crime and enforcing national laws; and reducing the use of all drugs and reducing the potential risk or damage that occurs from their use.<sup>44</sup>

The new policy clearly mandated MOH as the lead agency responsible for legislation concerning the handling of narcotic and psychotropic substances, products and precursors.<sup>45</sup> However, it invited a wide range of stakeholders to play key roles in its implementation. The Ministry of Labour and Social Affairs was tasked with tackling social problems associated with the use of all types of drugs; the Ministry of Education, Youth, and Sport was made responsible for primary prevention; MOI was made responsible for the regulation of measures designed to combat the supply of illicit drugs, and for enforcing the law in relation to the distribution of legal drugs; MOJ was made responsible for drawing up legislative proposals in the field of criminal law, and created conditions for the activities of courts and public prosecutor's offices in matters related to drug crime; the Ministry of Defense was made responsible for the timely identification of problems connected with drug use by soldiers in active service; the Ministry of Finance provided the funds from the national; the police force was made responsible for the implementation of specific measures for combating the supply of illegal drugs, for inspections of the observance of legal regulations controlling the sale of legal drugs (alcohol and tobacco), for the protection of public order and safety, and for combating crime committed in connection with the use of all types of drugs at all levels.<sup>46</sup>

By 2008, 3.2% of Czech adults 15-34 had tried amphetamines at least once in their lives, and reports estimated a total of 21,200 problem methamphetamine users.<sup>47</sup> In 2009, reports indicated an estimated 37,400 problematic drug users living in the Czech Republic as well as an estimated 38.1% of Czech young people 18-24 who reported cannabis use in the previous year, one of the highest rates in Europe.<sup>48</sup> That same year, the 1961 *Criminal Law* was repealed and substituted with a new *Criminal Code*. The new *Criminal Code* formally deployed the means to implement *Resolution 1177/01* as intended by MOJ, allowing the differentiation between cannabis and other drugs.<sup>49</sup> The new *Code* also included provisions for reduced penalties for the use and cultivation of cannabis. The new 2009 Czech *Criminal Code* acknowledged that criminal justice approaches should be a means of last resort for protecting individuals and society and that when applied, criminal sanctions should be proportional to the gravity of the offense, and should take into consideration the individual circumstances of each offender.<sup>50</sup>

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<sup>44</sup> National Drug Commission. 2005. *National Drug Policy Strategy for the period 2005 to 2009*. (<http://www.drogy-info.cz/en/publications/drug-policy-strategy/national-drug-policy-strategy-for-the-period-2005-2009-the-czech-republic/>)

<sup>45</sup> National Drug Commission. 2005. *National Drug Policy Strategy for the period 2005 to 2009*. (<http://www.drogy-info.cz/en/publications/drug-policy-strategy/national-drug-policy-strategy-for-the-period-2005-2009-the-czech-republic/>)

<sup>46</sup> National Drug Commission. 2005. *National Drug Policy Strategy for the period 2005 to 2009*. (<http://www.drogy-info.cz/en/publications/drug-policy-strategy/national-drug-policy-strategy-for-the-period-2005-2009-the-czech-republic/>)

<sup>47</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>48</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>49</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>50</sup> Karabec, Z. et al. 2011. *Criminal Justice System in the Czech Republic*. (<http://www.ok.cz/iksp/docs/386.pdf>)

Also in 2009, the government introduced *Decree no. 467/2009 Coll.* which formally defined quantities “greater than small” with specific thresholds. Described as one of the “most pragmatic threshold limits of any country to have yet decriminalized,”<sup>51</sup> the threshold quantity levels for each drug are included in *Table 2* below.

*Table 2: Quantities “greater than small” defined by Czech penal code on drug possession, Government Decree no. 467/2009 Coll.*<sup>52</sup>

Drug type	Quantity “greater than small”	Smallest quantity of the active psychotropic substance that must be contained for a quantity under examination to be “greater than small”
Pervitin (methamphetamine)	2g	0.6g of base
Heroin (diacetylmorphine)	1.5g	0.2g of base
Cocaine	1g	
Medicines containing buprenorphine		52mg of base
Methadone		500mg of base
Ecstasy (MDMA/MDA/MDEA)	4 tablets or 0.4g powder or crystals	0.34g of base
LSD	5 paper tabs, tablets, capsules, or crystals	0.000134 of base
Marijuana (cannabis)	15g dry matter	1.5g of delta-9-THC
Hashish	5g	1g delta-9-THC
Psilocybin mushrooms	40 fruiting bodies	30.05g of base (psilocybin)

In 2010, the NDC published the *National Drug Policy Strategy for the period 2010 to 2018*, again based on the four pillars. The objectives pursued by the 2010–2018 *Strategy* included: (1) to reduce the level of experimental and occasional drug use, especially among young people; (2) to reduce problematic and intensive drug use; (3) to reduce drug-related harms and risks to people and society; and (4) to reduce drug supply. In addition, the *Strategy* was designed to encourage the active involvement of the largest possible proportion of Czech society in activities intended to facilitate the improvement of the situation concerning the supply and use of drugs and the adverse consequences this implies.<sup>53</sup> The new *Strategy* paved the way for the elaboration of a national mechanism to fund CSO for four-year periods, as opposed to the three-year terms allowed since 2010, or the year-by-year approach used prior to 2010.<sup>54</sup>

<sup>51</sup> Drug Policy Alliance. 2016. *Approaches to Decriminalizing Drug Use & Possession*. Drug Policy Alliance. ([https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA\\_Fact\\_Sheet\\_Approaches\\_to\\_Decriminalization\\_Feb2015\\_1.pdf](https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015_1.pdf))

<sup>52</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>53</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>54</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))



Two legal amendments were introduced in 2011, the first allowing police officers to issue fines on the spot for those caught in possession of small quantities of illicit drugs, much like when fines are issued for traffic violations.<sup>55</sup> The second sought to curb the rapid proliferation of new psychoactive substances (NPS) which were introduced in the Czech Republic in 2009 to address the growing popularity and availability across the country. The 2011 amendment brought 33 new substances under the control of national authorities.<sup>56</sup>

In 2013, the Czech Constitutional Court repealed *Decree no. 467/2009 Coll.*, noting that the Parliament did not have the authority to determine thresholds amounts for either criminal or administrative sanctions.<sup>57</sup> In that sense, the Court's ruling meant that thresholds were once again left to the discretion of judges, though the Constitutional Court did provide some new 'tentative threshold quantities' that reduced the allowable quantities for personal use to 1.5 grams of methamphetamines, 1.5 grams of heroin, 1 gram of cocaine, 10 grams of cannabis, 5 units of ecstasy, and 5 grams of hashish.<sup>58</sup> That same year, the government also passed a new law permitting possession of cannabis for medicinal use, allowing up to 180 grams per month with a physician's prescription.<sup>59</sup>

Data from national reports indicate that in 2013, both the lifetime and recent prevalence of drug use dropped. For example, last year use of methamphetamine among 15-34 year olds dropped to 0.7% while lifetime prevalence also fell from 7.8% to 2% between 2008 and 2013.<sup>60</sup> The same report also suggested a significant decrease in current levels of cannabis use in the general population, especially among younger age groups.<sup>61</sup> In 2014, high-risk methamphetamine use among adults (15-64 year olds) was estimated at around 0.51%.<sup>62</sup> That same year, controlled substances were moved under the authority of a government decree instead of parliamentary law in order to reduce the time required to introduce new substances for drug control, again in an effort to curb the NPS market.<sup>63</sup>

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<sup>55</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>56</sup> Vavrincikova, L., et al. 2016. *New Psychoactive Substances among People Who Use Drugs Heavily: Towards Effective and Comprehensive Health Responses in Europe: 5-country RAR report*. Department of Addictology, First Faculty of Medicine, Charles University / General University Hospital. ([http://www.npsineurope.eu/images/pdf/publication/NPS\\_5\\_country\\_rar\\_report.pdf](http://www.npsineurope.eu/images/pdf/publication/NPS_5_country_rar_report.pdf))

<sup>57</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>58</sup> Eastwood, N. et al. 2016. *A quiet revolution: Drug decriminalisation across the globe*. Release. ([https://www.tni.org/files/publication-downloads/a\\_quiet\\_revolution\\_march\\_31\\_2016.pdf](https://www.tni.org/files/publication-downloads/a_quiet_revolution_march_31_2016.pdf)); The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>59</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>60</sup> National Monitoring Centre for Drugs and Addiction. 2013. *Annual Report: The Czech Republic Drug Situation*. ([http://www.vlada.cz/assets/ppov/protidrogova-politika/AR\\_2013\\_CZE.pdf](http://www.vlada.cz/assets/ppov/protidrogova-politika/AR_2013_CZE.pdf))

<sup>61</sup> National Monitoring Centre for Drugs and Addiction. 2013. *Annual Report: The Czech Republic Drug Situation*. ([http://www.vlada.cz/assets/ppov/protidrogova-politika/AR\\_2013\\_CZE.pdf](http://www.vlada.cz/assets/ppov/protidrogova-politika/AR_2013_CZE.pdf))

<sup>62</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *European Drug Report: Trends and Developments*. (<http://www.emcdda.europa.eu/publications/edr/trends-developments/2016>)

<sup>63</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Perspectives on Drugs: Legal approaches to controlling new psychoactive substances*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_211257\\_EN EMCDDA POD 2013 Controlling%20new%20psychoactive%20substances.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_211257_EN EMCDDA POD 2013 Controlling%20new%20psychoactive%20substances.pdf))

At the April 2016 UNGASS on the World Drug Problem, the head of the Czech delegation, Minister of Health Dr. Svatopluk Nĕmeček, encouraged Member States to consider health focused approaches based on evidence and grounded on human rights principles in national responses to drug issues, as he had at the March 2016 Commission on Narcotic Drugs (CND).<sup>64</sup> Indeed, at the 2016 CND, Dr. Nĕmeček noted that all four pillars of the Czech national drug policy have been designed with the ultimate goal of safeguarding the welfare of Czech citizens as well as that of those living in the Czech Republic. In his official statement to the UNGASS 2016, he noted:

*Intended to protect people, but based on prohibition and criminalization, our efforts have had detrimental effects on public health in multiple ways and have undermined people's right to health. The war on drugs has fuelled an epidemic of infections particularly HIV, viral hepatitis, and tuberculosis and an epidemic of fatal overdoses among people who use drugs. The enforcement of prohibition exacerbates all these risks - and they affect not only drug users, but all citizens. The Czech Republic can and will use its own experience to demonstrate the public health and public security benefits of human rights oriented drug policy which is based on open discussion and scientific evidence.*<sup>65</sup>

### Implementation of the national drug control strategy

Every drug control policy since 1993 has been modeled on the Swiss *Four Pillars* policy, as noted above, which has included prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues. This sub-section will review the range of strategies and activities implemented in the Czech Republic under each pillar, as well as their impact.

#### *Prevention*

Limited information was available on drug prevention activities in the Czech Republic or their impact. As noted above, the responsibility for primary prevention activities was entrusted to MOH since 1993. The 2010-2018 policy emphasized the particular importance of prevention and specifically sought to reduce the level of experimental and occasional drug use, particularly among young people.<sup>66</sup> However, the Ministry of Education, Youth and Sports has had majority share in enforcing school-based primary prevention activities to reduce risky behaviors among youth.<sup>67</sup>

#### *Harm reduction*

Formally introduced with the 1993 policy, harm reduction has become a central pillar in the Czech national response to drug issues. At the 2009 CND, the Czech representative noted the central role of harm reduction as a strategic pillar that “cannot replace prevention, treatment and rehabilitation— and cannot be replaced by them.”<sup>68</sup>

<sup>64</sup> Nĕmeček, S. 14 March 2016. *Statement of the Head of the Czech Delegation at 59<sup>th</sup> Commission on Narcotic Drugs*. Vienna, Austria. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_59/Statements/10\\_Czech\\_Republic.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/Statements/10_Czech_Republic.pdf))

<sup>65</sup> Nĕmeček, S. 20 April 2016. *Statement of the Head of the Czech Delegation at Special Session of the UN General Assembly on the World Drug Problem*. New York City, United States. (<http://statements.unmeetings.org/media2/7657402/czech-rep.pdf>)

<sup>66</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*.

(<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>67</sup> Anyzova, P., Burianek, J., and Podana, Z. 2015. “The national policy toward alcohol and substance use among adults and juveniles - Czech Republic” in *AAA Prevent*. Verwey-Jonker Instituut.

([https://www.researchgate.net/publication/283788697\\_The\\_national\\_policy\\_toward\\_alcohol\\_and\\_substance\\_use\\_among\\_adults\\_and\\_juveniles\\_-\\_Czech\\_Republic](https://www.researchgate.net/publication/283788697_The_national_policy_toward_alcohol_and_substance_use_among_adults_and_juveniles_-_Czech_Republic))

<sup>68</sup> European Union. 11 March 2009. *Statement by Ivan Langer, Minister of the Interior of the Czech Republic on behalf of the European Union to the High-Level Segment of the 52<sup>nd</sup> Session of the*

As noted above, pervitin, a local form of methamphetamine, has been the drug of choice in the Czech Republic, and a significant proportion of users have been injecting: up to 80% of methamphetamine users entering treatment reported injecting as the main route of administration.<sup>69</sup> *Table 3* below provides a five-year overview of the number of problematic drug users.

*Table 3: Estimated number of problem drug users 2004-2008* <sup>70</sup>

	2004	2005	2006	2007	2008
Estimate of problem users in total	30,000	31,800	30,200	30,900	32,500
Estimate of problem opiate users	9,700	11,300	10,500	10,000	11,300
- including heroin users	-	-	6,150	5,750	6,400
- including Subutex <sup>®</sup> users	2,028	2,699	4,300	4,250	4,900
Estimate of problem pervitin users	20,300	20,500	19,700	20,900	21,200
Estimate of injecting users	27,000	29,800	29,000	29,500	31,200

*Table 3* also shows an increasing number of PWID from 2004 to 2008. Data from other sources shows that the overall rising trend persisted beyond 2008, with a recorded 30,000 in 2010,<sup>71</sup> down to 29,000 in 2012,<sup>72</sup> up to 38,700 in 2014,<sup>73</sup> and reaching 45,600 in 2016.<sup>74</sup>

According to the 2009-2018 policy, activities implemented under the harm reduction pillar have been designed to reduce potential drug-related risks to individuals and society.<sup>75</sup> The major service delivery components available have been aligned with UNAIDS, UNODC and WHO recommendations,<sup>76</sup> and have included needle and syringe distribution as well as opioid substitution therapy (OST). Many of the harm reduction services available to PWID in the Czech Republic have been deployed since the early 1990s or before, and have been scaled-up over time to prevent transmission of HIV and viral hepatitis as well as to reduce drug-related mortality.

A significant proportion of harm reduction services being delivered in the Czech Republic have been provided through CSO, and, in some regions, CSO were the

Commission on Narcotic Drugs. Vienna, March 11. (<http://eu2009.cz/assets/news-and-documents/statements-in-international-organisations/statement-by-the-czech-republic-at-the-high-level-segment-of-the-52nd-session-of-the-commission-on-narcotic-drugs.pdf>)

<sup>69</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf)); European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe* ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>70</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>71</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>72</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>73</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>74</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>75</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>76</sup> World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. (<http://www.who.int/hiv/pub/guidelines/keypopulations/en/>); Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime, and World Health Organization. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. ([http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf))



only organizations offering health or support services to PWUD.<sup>77</sup> The contributions of CSO in the context of the national response to drug issues have been described as “irreplaceable” and “immensely positive” by the Minister of Health at the 2016 CND.<sup>78</sup> Indeed, an extensive network of low-threshold drop-in centers (DIC or “contact centers”) has flourished with financial support from the national government, achieving significant coverage results among problem drug users, reaching above 80% of the target population during the 2004-2008 period, as shown in *Table 4*.

*Table 4: Number and proportion of problem drug users who have accessed low-threshold services*<sup>79</sup>

	2004	2005	2006	2007	2008
Number of problem drug users (PDUs) in contact with harm reduction programmes	24,200	27,800	25,900	27,200	28,300
Proportion of PDUs in contact	80.67%	87.42%	85.76%	88.03%	87.08%

Needle and syringe distribution was initiated in 1987,<sup>80</sup> six years before official policy documents recognized this approach as legitimate and valuable. There was little information about the implementation of needle and syringe distribution in the period following the approval of the 1993 policy. But, data from 2004 onwards shows that already, 86 needle and syringe distribution sites operating across 92 low-threshold programs reached 24,200 PWUD and 16,200 PWID and distributed more than 2.3 million needles and syringes in the span of one year (see *Table 5* below). In 2008, ten programs in Prague alone distributed approximately 2.1 million needles and syringes to an estimated 11,400 PWID.<sup>81</sup>

*Table 5: Low-threshold programs in the Czech Republic*<sup>82</sup>

	2004	2005	2006	2007	2008
Number of programmes	92	92	90	109	100
Number of drug users in contact	24,200	27,800	25,900	27,200	28,300
Number of contacts	317,900	403,900	322,900	338,100	329,466
Number of injecting drug users in contact with low-threshold facilities	16,200	17,900	18,300	20,900	22,300
Proportion of injecting drug users who have used low-threshold services	67%	64%	71%	77%	79%
Number of exchange programmes	86	88	93	107	98
Number of exchanges in exchange programmes	139,800	249,000	191,000	215,800	217,200
Number of syringes and needles exchanged	2,355,536	3,271,624	3,868,880	4,457,008	4,644,314

<sup>77</sup> Commission on Narcotic Drugs. 12-16 March 2012. *Improving the participatory role of civil society in addressing the world drug problem (E/CN.7/2012/CRP.1)*. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_55/E-CN7-2012-CRP1\\_V1251017\\_E.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP1_V1251017_E.pdf))

<sup>78</sup> Němeček, S. 14 March 2016. *Statement of the Head of the Czech Delegation at 59<sup>th</sup> Commission on Narcotic Drugs*. Vienna, Austria. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_59/Statements/10\\_Czech\\_Republic.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/Statements/10_Czech_Republic.pdf))

<sup>79</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>80</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>81</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>82</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

In 2009, 95 needle exchange programs across the country distributed 4.9 million needles.<sup>83</sup> Reports showed that in 2010, the number of needle and syringe distribution sites had increased to 109,<sup>84</sup> remained stable in 2012,<sup>85</sup> dropped slightly to 106 sites in 2014,<sup>86</sup> and dropped again slightly to 105 in 2016.<sup>87</sup> The Czech Republic has been acknowledged and praised for achieving one of the highest coverage rates with their needle and syringe program:<sup>88</sup> with 200 needles and syringes distributed per PWID per year in 2015,<sup>89</sup> down to 138 needles and syringes distributed per PWID per year in 2016.<sup>90</sup>

In addition to facilitating needle and syringe distribution, the DICs have also provided counseling, behavior change communication, HIV testing, crisis management, and other health and social services, while serving as a base from which outreach workers have operated.<sup>91</sup> CSO in the Czech Republic were also able to create innovative services to meet the specific needs of their clients who most often use pervitin. For example, some low-threshold facilities have provided empty gelatin capsules that were later filled with pervitin by users and ingested or shafted, reducing the risks associated with injecting.<sup>92</sup> Reports estimated that 30 capsule programs distributed almost 60,000 capsules across the Czech Republic in 2010.<sup>93</sup> Clients of the capsule distribution program reported that preparing the capsules was easy and were interested in obtaining more information about this alternative route of administration.<sup>94</sup> Oral ingestion of pervitin, especially on an empty stomach, has been reported to have an effect comparable to that of injection for certain people.<sup>95</sup> Other interventions that have been implemented in order to reduce the risks associated with use and injection of methamphetamine and other stimulants has included the provision of smoking equipment or safer-smoking kits through low-threshold sites.<sup>96</sup>

<sup>83</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>84</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>85</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>86</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>87</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>88</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>89</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>90</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>91</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>92</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>93</sup> Mravčík, V., et al. 2011. *Annual Report: The Czech Republic – 2010 Drug Situation*. Office of the Government of the Czech Republic. ([http://www.drogy-info.cz/data/obj\\_files/1343/632/czech\\_drug\\_situation\\_2010\\_annual\\_report\\_EN\\_new.pdf](http://www.drogy-info.cz/data/obj_files/1343/632/czech_drug_situation_2010_annual_report_EN_new.pdf))

<sup>94</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>95</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>96</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

In the late 1980s, willing physicians sometimes prescribed ethylmorphine to alleviate the withdrawal symptoms associated with drug dependence.<sup>97</sup> The 1993 policy introduced provisions to legitimize the prescription of opioids to substitute illicit drugs for people assessed as clinically dependent by competent health professionals. Similarly to data about needle and syringe programs, little information was available about OST implementation in the Czech Republic until 2004.

OST programs have offered a range of substitution drugs, including buprenorphine and methadone, though buprenorphine has been vastly more popular. Data from 2004 to 2008 shows that the estimated number of patients enrolled in buprenorphine substitution programs increased from 2,030 in 2004, to 2,670 in 2005, to 3,120 in 2006, down to 3,030 in 2007 and up to 3,280 in 2008.<sup>98</sup> By 2010, an estimated 45% of dependent opiate users were covered by opioid substitution,<sup>99</sup> mostly with buprenorphine, out of 47 sites across the country;<sup>100</sup> by 2014, OST coverage had decreased slightly to 35% of PWID.<sup>101</sup> As of 2012, in no year since initiation of methadone was there more than 700 patients enrolled.<sup>102</sup> The number of OST sites was scaled up rapidly: from 47 in 2010, to between 150 and 240 by 2012,<sup>103</sup> up to 372 in 2014,<sup>104</sup> remaining stable in 2016.<sup>105</sup> Cost related to buprenorphine substitution have been covered by the national health insurance scheme under certain conditions since 2010.<sup>106</sup>

In addition to services delivered in community settings, the Czech Republic has approved the delivery of OST services in prison settings, though no needles can be distributed. The national prison authorities have developed their own *Drug Policy Action Plan* that has specifically integrated harm reduction as a key strategy.<sup>107</sup> Moreover, prison authorities have allowed CSO to work inside prisons to provide support PWUD. In 2009, 15 CSO worked across 30 of the 36 prisons and closed centers,<sup>108</sup> while OST services were available in nine of these.

The impact of the Czech Republic's harm reduction strategy can be observed by looking at prevalence of HIV, viral hepatitis and overdoses. In 2016, HIV

<sup>97</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>98</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>99</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>100</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>101</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*.

([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>102</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>103</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>104</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>105</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>106</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>107</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>108</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

prevalence amongst PWID was recorded between 0.2% and 0.3%,<sup>109</sup> compared to a general population prevalence of 0.022%.<sup>110</sup> HIV prevalence amongst PWID has remained below 1% at least since 2010, and only 0.7% of PWID were living with HIV in 2016.<sup>111</sup> In 2015, only 3.9% of new cases of HIV were detected amongst PWID,<sup>112</sup> while an estimated 95% of new cases were attributable to sexual transmission.<sup>113</sup> Similarly, assessment of risk behaviors amongst PWID showed that 88.7% reported the use of sterile injecting equipment the last time they injected in 2012.<sup>114</sup> Reports from that same year showed that 51% of PWID who received an HIV test in the past 12 months knew their results.<sup>115</sup> Between 1985 and 2015, PWID have represented 3.8% of the total cumulative number of reported HIV cases.<sup>116</sup>

Similarly, prevalence of the hepatitis C virus (HCV) amongst PWID in the Czech Republic is one of the lowest in the EU.<sup>117</sup> HCV prevalence was reported between 21% and 59% in 2010,<sup>118</sup> at 13.6% in 2012,<sup>119</sup> at 18.6% in 2014 and again in 2016.<sup>120</sup> In 2007, an estimated 35% of pervitin injectors were living with HCV.<sup>121</sup> In contrast, prevalence of the hepatitis B virus (HBV) amongst PWID has been stable at 15.1%.<sup>122</sup>

The number of fatal overdoses has also generally been decreasing over time. Although data is available only for the period of 2004-2008, *Table 6* below shows a trend towards fewer fatal overdoses. In addition, it is worth pointing out that the rate of fatal overdoses has sometimes been twice as high amongst users of licit prescription medicines, compared to among those who use illicit drugs.

***Table 6: Fatal overdoses by specific drugs 2004-2008*** <sup>123</sup>

<sup>109</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>110</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>111</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>112</sup> Prochazka, I. 2015. *Czech Republic Testing Country Profile in 2015*. Network of Low Prevalence Countries of Central and South East Europe. (<http://www.nelp-hiv.org/countries/cz>)

<sup>113</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>114</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>115</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>116</sup> Sikolova, V. 2016. *The Czech Republic: Global AIDS Response Progress Report 2015*. ([http://www.unaids.org/sites/default/files/country/documents/CZE\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/CZE_narrative_report_2016.pdf))

<sup>117</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>118</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>119</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>120</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>121</sup> Zabransky, T. 2007. "Methamphetamine in the Czech Republic" in *Journal of Drug Issues*, 155-180. ([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

<sup>122</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>123</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)



Drug	2004	2005	2006	2007	2008
Inhalants	20	18	14	14	10
Opiates/opioids	19	24	10	14	15
Amphetamines (pervitin)	16	14	12	11	19
Cocaine	1	1	1	1	0
MDMA	0	2	0	0	0
Hallucinogens	0	0	0	0	0
Cannabis	0	0	0	0	0
<b>Illegal drugs and inhalants in total</b>	<b>56</b>	<b>59</b>	<b>37</b>	<b>40</b>	<b>39</b>
Psychotropic pills					
- including benzodiazepines	94	56	50	58	77
Not ascertained					
<b>Total</b>	<b>241</b>	<b>218</b>	<b>212</b>	<b>213</b>	<b>238</b>

### *Treatment*

Drug treatment services in the Czech Republic were rather limited during the Communist era. In 1948, Dr. Jaroslav Skála established a treatment center in Prague based on the therapeutic community model. Following visits to treatment centers in Poland, Czechoslovakia and the ex-USSR, a foreign colleague remarked positively on the approach developed by Dr. Skála.<sup>124</sup> Today, drug treatment services in the Czech Republic have been designed to reduce the level of problem and intensive drug use, specifically targeting problem drug users.<sup>125</sup>

An estimated 95% of patients enrolled into treatment for methamphetamine use across Europe are concentrated in the Czech Republic and Slovakia.<sup>126</sup> Given the widespread use of pervitin in the Czech Republic, it is not surprising that the majority of demand for such services has come from people who use methamphetamines. For example, in 2005, 60% of demand for first-time drug treatment came from people who use methamphetamines as their drug of choice (n= 2,605);<sup>127</sup> in 2009, a total of 8,763 people sought treatment for drug dependence, 60% of whom were using pervitin as their drug of choice, compared to 23% who used opiates and 18% used cannabis as their drugs of choice.<sup>128</sup> By 2010, reports indicated that the number of methamphetamine users seeking treatment dropped – to an estimated 4,700 patients – but the proportion of methamphetamine users against all PWUD in treatment increased compared to previous years, reaching 70%.<sup>129</sup> Table 7 below provides slightly different data points for 2005, though it provides a useful snapshot that shows a slow but steady rise in demand for drug treatment services.

<sup>124</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>125</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>126</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *European Drug Report: Trends and Developments*. (<http://www.emcdda.europa.eu/publications/edr/trends-developments/2016>)

<sup>127</sup> Zabransky, T. 2007. "Methamphetamine in the Czech Republic" in *Journal of Drug Issues*, 155-180. ([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

<sup>128</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>129</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

***Table 7: Number and proportion of problem drug users in treatment facilities, and injecting drug use***<sup>130</sup>

		2004	2005	2006	2007	2008
Number of problem opiate users	Psychiatric facilities	4,592	5,558	4,640	4,259	4,585
	Drug treatment demand register maintained by the Public Health Service	2,169	2,058	2,126	1,961	2,063
	Final reports of outpatient treatment programmes covered by subsidy proceedings administered by the GCDPC's Secretariat	223	517	350	372	503
Number of problem pervitin users	Psychiatric facilities	2,579	2,662	3,055	3,272	3,330
	Drug treatment demand register maintained by the Public Health Service	4,790	4,855	4,889	5,177	4,925
	Final reports of outpatient treatment programmes covered by subsidy proceedings administered by the GCDPC's Secretariat	540	540	771	511	456
Number of injecting users in treatment (drug treatment demand register maintained by the Public Health Service)		6,364	6,125	6,054	6,109	5,986
Proportion of injecting route of administration among heroin users in treatment (drug treatment demand register maintained by the Public Health Service)		90.8	90.0	90.4	86.5	88.9
Proportion of injecting route of administration among pervitin users in treatment (drug treatment demand register maintained by the Public Health Service)		84.9	82.9	80.7	81.0	79.8

Data collected from outpatient clients has revealed that 18% used pervitin daily, 39% used between one and six times per week, and 43% used occasionally.<sup>131</sup> An estimated 82% of patients seeking treatment for pervitin regularly injected.<sup>132</sup>

Detoxification is the primary treatment for methamphetamine dependence in the Czech Republic.<sup>133</sup> Both inpatient and outpatient treatment services have been available; while there have been many more outpatient facilities compared to inpatient facilities (see *Table 8*), the number of patients in residential versus outpatient treatment has been relatively balanced (see *Table 7*). Inpatient facilities have included government hospitals and private facilities,<sup>134</sup> and the cost of treatment has usually been covered by the national health insurance.<sup>135</sup> Reports indicate that in 2010, between 15 and 20 CSO-operated therapeutic community sites, modeled on Dr. Skála's work, were in place.<sup>136</sup> In 2004,

<sup>130</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>131</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>132</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>133</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>134</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>135</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>136</sup> Mravčík, V., et al. 2011. *Annual Report: The Czech Republic – 2010 Drug Situation*. Office of the Government of the Czech Republic. ([http://www.drogy-info.cz/data/obj\\_files/1343/632/czech\\_drug\\_situation\\_2010\\_annual\\_report\\_EN\\_new.pdf](http://www.drogy-info.cz/data/obj_files/1343/632/czech_drug_situation_2010_annual_report_EN_new.pdf))

EMCDDA acknowledged CSO SANANIM's therapeutic community service for young people aged 15 to 25 in Karlov as a model of good practice.<sup>137</sup> At the Karlov site, female patients have been allowed to remain with their children, and had access to parenting skills training. A training program for young people facilitated the development of work skills and life skills, and offered sports and other leisure activities.<sup>138</sup>

*Table 8: Number of certified drug treatment programs as of June 2009*<sup>139</sup>

Type of service	Number of programmes
Detoxification	4
Outreach programmes	58
Low-threshold and counselling services	59
Outpatient treatment	16
Day care programmes	1
Short- and medium-term inpatient treatment	3
Residential care in therapeutic communities	12
Outpatient aftercare programmes	17
Substitution treatment	7
<b>Total</b>	<b>177</b>

Reports have indicated that legal provisions for compulsory detention of PWUD in the name of treatment were in place in Czechoslovakia's *Criminal Law*,<sup>140</sup> and such provisions currently remain in place in Czech *Criminal Code* to compel PWUD to enroll in drug dependence treatment. Courts could use treatment orders (which are rarely used in practice) or suspend prosecution if the offender enrolls in certified treatment; voluntary enrollment in treatment programs is generally regarded positively in court proceedings.<sup>141</sup> For example, out of 137 cases of people dependent on drugs identified in the Probation and Mediation database, treatment was imposed for 43 individuals in 2009.<sup>142</sup>

### *Law enforcement*

Law enforcement related activities fall under the fourth pillar of the Czech drug control policy. Implementing those activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. In the context of drug control, the overall goal of the law

<sup>137</sup> European Monitoring Centre for Drugs and Drug Addiction. 2004. *Overview: Karlov therapeutic community (Best Practice Portal)*.  
([http://www.emcdda.europa.eu/modules/wbs/dsp\\_print\\_project\\_description.cfm?project\\_id=6197](http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=6197))

<sup>138</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations.  
([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>139</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*.  
(<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>140</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations.  
([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>141</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>142</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*.  
([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

enforcement pillar has been to reduce the availability of drugs, particularly among young people, and curb organized crime.<sup>143</sup>

Limited data was available about police contacts with individuals involved in drug-related crimes. However, a number of available data sets have provided useful insights. In 1986, a total of 1,890 people were arrested for drug crimes, but only six of these were arrested for a drug crime other than possession. The next available comparable data point is from 2005, when 2,128 people were arrested for drug crimes.<sup>144</sup> Arrest data from 2005 shows that 53% of those arrested for drug crimes were related to pervitin, compared to 32% for cannabis and 7% for heroin.<sup>145</sup> Note again that in 2011, legal reforms were introduced to allow police officers to issue fines to people caught in possession of small quantities of illicit drugs.<sup>146</sup>

More information was available regarding police interventions to reduce trafficking and production of illicit drugs in the Czech Republic. *Table 9* provides a year-by-year account of the number of arrests for trafficking, as well as the proportion of trafficking crimes against the total number of crimes in the country. The data indicates that a high of 4,114 drug trafficking crimes were recorded in 2002 compared to a low of 2,639 drug trafficking crimes recorded in 2007. While there was a regular drop in the number of trafficking crimes recorded by police between 2002 and 2007, the trend has reversed and the numbers of trafficking crimes recorded has climbed steadily until 2012. Similarly, the proportion of trafficking against total crime recorded by police dropped until 2007 and started to climb in 2008 to reach higher levels in 2012 compared than 2002.

**Table 9: Drug trafficking versus total crime in the Czech Republic, 2002-2012** <sup>147</sup>

Year	Total crimes recorded by police	Number of drug trafficking crimes recorded by police	Proportion drug trafficking versus total crime
2002	372,300	4,114	1.11%
2003	357,700	3,497	0.98%
2004	351,600	2,803	0.80%
2005	344,100	2,706	0.79%
2006	336,400	2,669	0.79%
2007	357,400	2,639	0.74%
2008	343,800	2,812	0.82%
2009	332,800	3,046	0.92%

<sup>143</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*.

(<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>144</sup> Zabransky, T. 2007. "Methamphetamine in the Czech Republic" in *Journal of Drug Issues*, 155-180.

([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

<sup>145</sup> Zabransky, T. 2007. "Methamphetamine in the Czech Republic" in *Journal of Drug Issues*, 155-180.

([https://www.researchgate.net/publication/221943289\\_Methamphetamine\\_in\\_the\\_Czech\\_Republic](https://www.researchgate.net/publication/221943289_Methamphetamine_in_the_Czech_Republic))

<sup>146</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*.

Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>147</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).



<b>2010</b>	313,400	3,010	0.96%
<b>2011</b>	317,200	3,635	1.15%
<b>2012</b>	304,500	3,814	1.25%

Significant numbers of drug – especially pervitin – production sites have been detected and dismantled in the Czech Republic compared to the rest of Europe. For example, in 2008, Europol reported a total of 483 production sites for methamphetamines across its jurisdiction in Europe,<sup>148</sup> 458 (94.8%) of which were located in the Czech Republic.<sup>149</sup> In 2013, a total of 294 methamphetamine labs were dismantled across Europe, out of which 261 (88.8%) were in the Czech Republic.<sup>150</sup> However, the vast majority of the Czech methamphetamine production sites have in fact been small-scale ‘kitchen labs’ operated by users to generate their own supply of pervitin.<sup>151</sup>

In the Czech Republic, possession of illicit drugs is either an administrative or criminal offense depending on whether the quantity is determined to be “greater than small.” For possession of illicit drugs in small amounts, Czech courts overwhelmingly avoid criminal punishment, recognizing possession as a misdemeanor to be addressed as an administrative offense. As a result, in 2007, courts most frequently imposed fines of up to CZK 15,000 (approximately USD 590), but the average fine has been closer to CZK 1,220 (approximately USD 47).<sup>152</sup> Fines have been processed through municipal mechanisms, much like tickets for traffic violations, and no criminal record was created for offenders.<sup>153</sup> In 2007, out of 966 recorded cases of possession of small quantities of illicit drugs, 315 cases (32.6%) were suspended, dismissed or referred to another authority (health), 11 cases (1.1%) were referred to law enforcement agencies, and 519 cases (53.7%) were addressed through administrative mechanisms. The remaining 121 cases (12.5%) were pending. Out of the 519 administrative cases, 449 (86.5%) were imposed a fine and 54 (10.4%) received a reprimand.<sup>154</sup>

Possession of illicit drugs in quantities “greater than small” can lead more severe penalties being imposed by the criminal justice system. For example, possession of cannabis in quantities “greater than small” can lead to a prison sentence of up to one year; possession of relatively large quantities of other illicit drugs could result in imprisonment of up to two years.<sup>155</sup> Data from 2007 has shown that a

<sup>148</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))

<sup>149</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>150</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *European Drug Report: Trends and Developments*. (<http://www.emcdda.europa.eu/publications/edr/trends-developments/2016>)

<sup>151</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *European Drug Report: Trends and Developments*. (<http://www.emcdda.europa.eu/publications/edr/trends-developments/2016>); European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))

<sup>152</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>153</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>154</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>155</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

total of 138 offenders were sentenced for possession of illicit drugs in quantities “greater than small”: 70% were sentenced to prison, 19% were sentenced to community work; sentences were waived for 5% of cases; 3% were fined; and an additional 3% received a juvenile sentence. Amongst those who received a prison sentence, 58% received a suspended sentence, 9% were incarcerated for up to one year, and 3% were imprisoned for a term of one to five years.<sup>156</sup> Only 12% of possession offences led to a prison sentence in the Czech Republic.<sup>157</sup>

Also in 2007, a total of 1,134 people were sentenced for a drug trafficking offence. Among them, 87% received a prison sentence, 5% were sentenced as juveniles, 5% were sentenced to community service, and 3% had their sentence waived. Amongst those sentenced to prison, incarceration was suspended for 54%, 3% were sentenced to a term of up to one year, 25% for terms ranging from one to five years, and 5% for terms of five to 15 years.<sup>158</sup> *Table 10* shows that between 2002 and 2008, the number of individuals charged for drug crimes decreased steadily while the number of individuals prosecuted and sentenced remained relatively stable. In contrast, *Figure 1* shows that the proportion of people charged, prosecuted and sentenced for drugs crime was increasing in 2008. *Figure 2* also provides regional context by comparing Czech Republic sentencing results for drug trafficking crimes with other countries in the region.

***Table 10: Number of persons prosecuted, charged, and sentenced in relation to drug-related offences in 2004-2008***<sup>159</sup>

	2004	2005	2006	2007	2008
Number of those prosecuted					
as reported by the National Drug Headquarters	2,157	2,168	2,198	2,031	2,322
as reported by the Police of the Czech Republic (Criminal Statistics Record System)	2,149	2,209	2,344	2,023	2,296
as reported by the Ministry of Justice	2,944	2,429	2,630	2,282	2,304
Number of those charged (Ministry of Justice)	2,589	2,157	2,314	2,042	2,100
Number of those sentenced (Ministry of Justice)	1,376	1,326	1,444	1,382	1,360

***Figure 1: Trends in the percentage of persons prosecuted, charged, and sentenced under Section 187a in the period 2002-2008***<sup>160</sup>

<sup>156</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>157</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>158</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>159</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>160</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

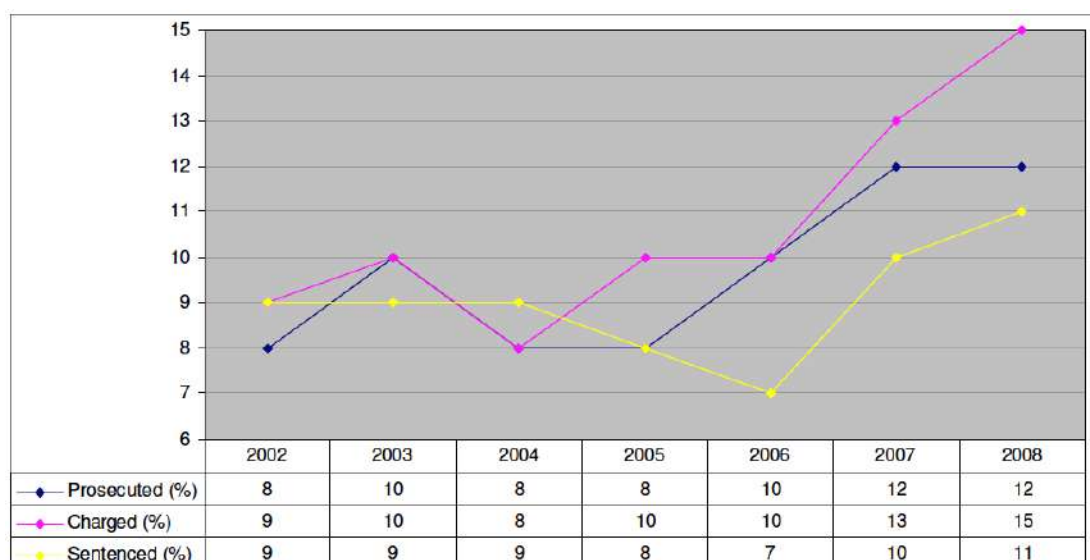
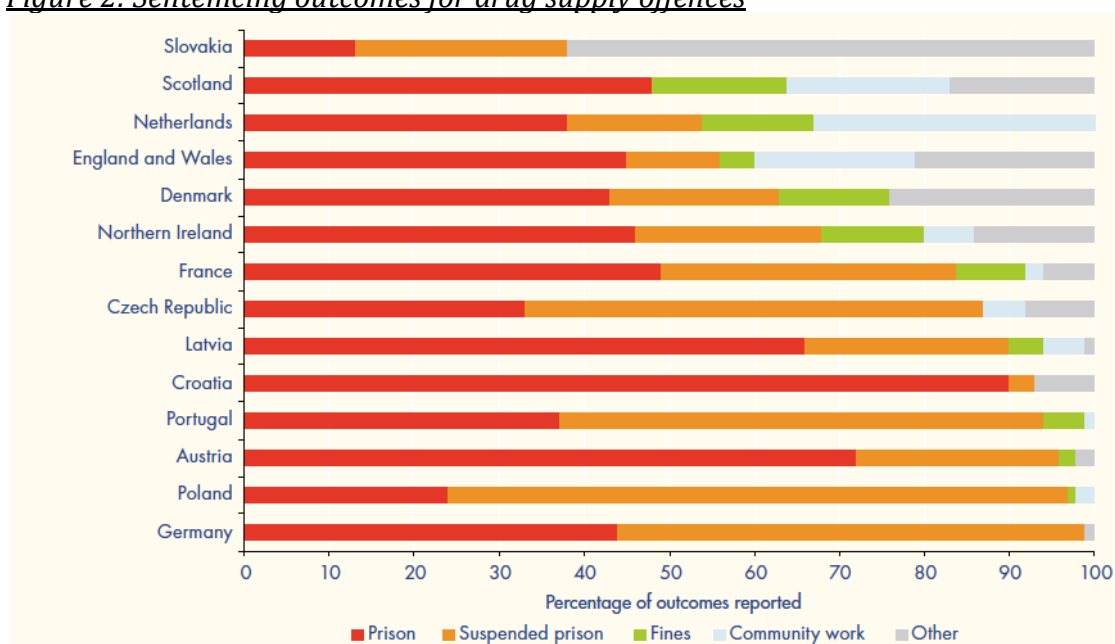


Figure 2: Sentencing outcomes for drug supply offences<sup>161</sup>



When sentencing results are analyzed by drug type across all drug crimes, results have shown that 47% of sentences involved pervitin, 18% involved cannabis, and 7% involved heroin. Sentencing led to incarceration in 97% of cases where heroin was involved, compared to 88% for pervitin and 68 % for cannabis.<sup>162</sup>

In 2016, the Czech Republic had a total of 35 prisons housing 20,738 prisoners, representing 108.2% of total official capacity.<sup>163</sup> In 2011, across the same 35 prisons, the 20,271 officially available beds were occupied by 22,836 prisoners,

<sup>161</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>162</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>163</sup> International Center for Prison Studies. 2016. *World Prison Brief - Czech Republic*. Online at: <http://www.prisonstudies.org/country/czech-republic>.

representing 112.65% of total official capacity).<sup>164</sup> Table 11 provides an overview of the evolution of the total prison population as well as the prison population rate, showing that the total prison population has increased steadily from the lowest point in 2002 when 16,597 people were incarcerated, until a peak of 23,111 prisoners was recorded in 2012. At the end of 2010, out of 19,449 persons serving prison sentences in the Czech Republic, a total of 2,016 (10.3%) of them were serving time for drug-related criminal offences.<sup>165</sup>

**Table 11: Total prison population and prison population rate 2000-2016** <sup>166</sup>

Year	Total prison population <sup>167</sup>	Prison population rate <sup>168</sup>
2000	21,538	210
2002	16,597	159
2004	18,303	179
2006	18,904	181
2008	20,471	196
2010	21,987	209
2012	23,111	215
2014	18,658 <sup>169</sup>	177
2016	20,738 <sup>170</sup>	195 <sup>171</sup>

### Concluding analysis

Official evaluation of the Czech 2005-2009 drug control policy showed that its three objectives were achieved. The full evaluation report is only available in Czech language but an abstract is available in English language, which provides virtually no information on the results of the evaluation itself.<sup>172</sup> However, from the data presented in the previous sub-sections, we can derive our own conclusions about the value of the Czech decriminalization model.

Motivation for policy change arose from a combination of factors including public perception that drug use was a major social issue; a history of authoritarian political rule that left the population with limited capacity to deal with illicit drugs and distrustful of law enforcement; as well as a rapidly emerging pervitin market combined with pressure to align with the EU as momentum for joining grew locally. However, it is noteworthy that significant amount of legislative tinkering took place to get to the current state of affairs. Box 2 summarizes all the relevant legislative milestones that are related to decriminalization and have been explored in this report.

<sup>164</sup> Karabec, Z. et al. 2011. *Criminal Justice System in the Czech Republic*. (<http://www.ok.cz/iksp/docs/386.pdf>)

<sup>165</sup> Mravčík, V., et al. 2011. *Annual Report: The Czech Republic – 2010 Drug Situation*. Office of the Government of the Czech Republic. ([http://www.drogy-info.cz/data/obj\\_files/1343/632/czech\\_drug\\_situation\\_2010\\_annual\\_report\\_EN\\_new.pdf](http://www.drogy-info.cz/data/obj_files/1343/632/czech_drug_situation_2010_annual_report_EN_new.pdf))

<sup>166</sup> International Center for Prison Studies. 2016. *World Prison Brief - Czech Republic*. Online at: <http://www.prisonstudies.org/country/czech-republic>.

<sup>167</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).

<sup>168</sup> International Center for Prison Studies. 2016. *World Prison Brief - Czech Republic*. Online at: <http://www.prisonstudies.org/country/czech-republic>.

<sup>169</sup> International Center for Prison Studies. 2016. *World Prison Brief - Czech Republic*. Online at: <http://www.prisonstudies.org/country/czech-republic>.

<sup>170</sup> International Center for Prison Studies. 2016. *World Prison Brief - Czech Republic*. Online at: <http://www.prisonstudies.org/country/czech-republic>.

<sup>171</sup> Walmsley, R. 2015. *11<sup>th</sup> World Prison Population List*. International Center for Prison Studies.

([http://www.prisonstudies.org/sites/default/files/resources/downloads/world\\_prison\\_population\\_list\\_11th\\_edition.pdf](http://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_11th_edition.pdf))

<sup>172</sup> Kissova, L. and Mravčík, V. 2011. "Evaluation of the 2005–2009 Czech Drug Policy Strategy: Research Design and the Summary of the Main Results" in *Adiktologie*, 11(2): 72-80. (<http://www.adiktologie.cz/cz/articles/detail/570/3135/Evaluation-of-the-2005-2009-Czech-Drug-Policy-Strategy-Research-Design-and-the-Summary-of-the-Main-Results>)

Box 2: Relevant Czech legal and policy documents and milestones

- Reform to *Penal Code* no. 175/1990 (1990)
  - Drug policy concept and program for 1993-1996 (1993)
  - *Amendment no. 112/1998* (1998)
  - Impact Analysis Project of the New Drug Legislation <sup>[1]</sup><sub>SEP</sub>(2001)
  - *Resolution no. 1177/01* (2001)
  - Czech Republic joins EU (2004)
  - *National Drug Policy Strategy* for the period 2005 to 2009 (2005)
  - *New Criminal Code* (2009)<sup>[1]</sup><sub>SEP</sub>
  - *Government decree no. 467/2009 Coll.* (2009)
  - Prison drug policy action plan
  - *National Drug Policy Strategy* for the period 2010 to 2018 (2010) <sup>[1]</sup><sub>SEP</sub>
  - *NPS Amendment* (2011)<sup>[1]</sup><sub>SEP</sub>
  - *Opinion of the Supreme Court* (2013)
  - Cannabis for medical use allowed by law (2013)
- 

The Czech Republic's decriminalization model has been grounded on a combination of thresholds, but especially on law enforcement discretion applied at police, prosecutorial and judicial levels. While it has remained up to police, prosecutors and judges to identify and bring to justice people who have broken the law, such a process has been applied only when it was in the best interest of the State – criminal sanctions for petty, non-violent possession offenses have rarely been applied.

In that respect, the Czech approach to drugs has been described as “pragmatic, rational and sometimes too liberal.”<sup>173</sup> But, even before decriminalization of drugs, the Czech Republic's drug policies had focused on public health approaches and there was little appetite for incarcerating people arrested for simple possession. In that sense, the decriminalization policy of the Czech Republic was an extension of common practices.

Decriminalization thus formally shifted the locus of control over drug policies to the health sector, deprioritizing the criminal justice approach. Such an approach started with the formal delegation of the prevention pillar but soon, the entire drug policy apparatus was being managed by MOH, with support from a number of other ministries and agencies. In addition, new structures were created – the NDC for example – to develop, implement and monitor activities mandated by the national drug policy.

In addition to government agencies, CSO have played a critical role, not only in service delivery as described above but also in policymaking. CSO have been funded by the Czech government, and have contributed in particular to the planning and implementation of drug policy measures and activities, to evaluations of these measures and activities, and to an increase in the quality

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<sup>173</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)



and efficiency of their services.<sup>174</sup> CSO have been represented in advisory bodies and commissions, and have become valued members of national working groups.<sup>175</sup> In parallel, a number of individuals have played leading roles in driving the drug policy agenda towards the reforms that led to decriminalization, particularly Dr. Jaroslav Skála, Dr. Viktor Mravčík and Dr. Tomáš Zabranský as well as the National Drug Coordinators Dr. Kamil Kalina and Dr. Pavel Bém.<sup>176</sup> No evidence of a national drug user or harm reduction network in the Czech Republic was found during this literature review.

The national drug control policy has remained firmly modeled on the four pillars approach and the policy's objectives have remained clearly targeted: prevention to reduce initiation amongst youth; harm reduction to address negative consequences on people who use and inject drugs; treatment to reduce problem and intensive drug use amongst problem drug users; and law enforcement to reduce the supply of drugs by targeting organized crime. The Czech drug policies have consistently been guided by core principles that include public health and human rights.

In terms of health impact, the Czech Republic has achieved the lowest number of fatal drug overdoses per capita globally; one of the lowest prevalence of HIV amongst PWID globally; a uniquely low prevalence of viral hepatitis B and C amongst PWID – probably the lowest globally; and, thanks to early introduction of harm reduction services, an estimated 85% of problem drug users have been in regular contact with health agencies, allowing for much earlier entry into abstinence-oriented treatment and into substitution treatment, and leading to higher recovery rates.<sup>177</sup> Harm reduction services have achieved high coverage, in terms of outreach, needle and syringe distribution, and OST. Demand for drug dependence treatment has increased moderately over time. Innovations have been introduced to better meet the special needs of clients. During the 2005-2009 period, the number of problem drug users stayed relatively stable and the service delivery infrastructure was sustained.<sup>178</sup> However, some challenges remain to be addressed: the number of PWID has been steadily climbing, and expansion of outpatient services is required to meet the need of clients.<sup>179</sup>

In terms of law enforcement, the data presented in this section has shown that police are making an increasing number of trafficking-related arrests. In addition, an increasing number of people sentenced for trafficking offences are being sent to prison. Meanwhile, fewer people in possession of illicit drugs are

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<sup>174</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*.

(<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>175</sup> Commission on Narcotic Drugs. 12-16 March 2012. *Improving the participatory role of civil society in addressing the world drug problem (E/CN.7/2012/CRP.1)*. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_55/E-CN7-2012-CRP1\\_V1251017\\_E.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP1_V1251017_E.pdf))

<sup>176</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations.

([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>177</sup> Němeček, S. 14 March 2016. *Statement of the Head of the Czech Delegation at 59<sup>th</sup> Commission on Narcotic Drugs*. Vienna, Austria. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_59/Statements/10\\_Czech\\_Republic.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/Statements/10_Czech_Republic.pdf))

<sup>178</sup> Anyzova, P., Buriánek, J., and Podana, Z. 2015. "The national policy toward alcohol and substance use among adults and juveniles - Czech Republic" in *AAA Prevent*. Verwey-Jonker Instituut. ([https://www.researchgate.net/publication/283788697\\_The\\_national\\_policy\\_toward\\_alcohol\\_and\\_substance\\_use\\_among\\_adults\\_and\\_juveniles\\_-\\_Czech\\_Republic](https://www.researchgate.net/publication/283788697_The_national_policy_toward_alcohol_and_substance_use_among_adults_and_juveniles_-_Czech_Republic))

<sup>179</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*.

(<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

ending up in prisons. These trends may indicate that a reduced workload generated by decriminalization may have contributed to focusing police efforts. Despite these results, Czech prisons have been and remain overcrowded.

The financial cost of the Czech strategy have been diligently recorded. *Table 12* provides an overview of funding from government sources for prevention, harm reduction and treatment of PWUD in the Czech Republic. Additional data points show that in 2002, EUR 6.3 million was allocated by the national government as well as EUR 952,000 from regional governments to implement country's drug policy.<sup>180</sup> By 2008, the contributions from the national government had increased to EUR 14.9 million and those from regional governments to EUR 6.5 million.<sup>181</sup> Out of 21 countries in Eastern Europe, 90% of the financial support for harm reduction services is provided domestically in Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania and Poland.<sup>182</sup>

*Table 12: Funding of public services comprising the prevention and treatment network in 1996-2010 (CZK million)*<sup>183</sup>

Budgets	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Ministry of Health	70.5	22.5	32.5	32	43.02	34	25.74	22.1	26.5	33.5	18	22.2	18,9	15,0	7,6**
Ministry of Education	30	14.8	14.8	8.03	4.78	17.05	9.5	9.3	10.1	9.4	10.8	12.6	12,4	9,3	9,3*
Ministry of Labour and Social Affairs	14.1	9.5	13.44	14.74	24.29	29.9	35.15	44.3	42.22	46.5	49.7	57,0	73,9	86,7	86,7*
GCDPC	0	35	40	150	57	84	91.89	103.9	100.6	105.7	108.8	104,4	100,0	97,5	85,5
Ministry of Justice (subsidies for NGOs)												0,6	0,6	0,6	0,6*
Central level – total	114.6	81.8	100.74	204.77	129.09	164.95	162.28	179,6	179.42	195.1	187.3	196,8	205,8	209,1	189,8
Regions							29.34	48.08	81.6	100.33	94.9	128.4	162,9	?	?
Municipalities							n.a.	n.a.	62.9	50.6	48.1	62.3	62,5	?	?
Local levels – total							29.34	48.08	144.5	150.93	143.1	190,6	225,4	?	?
Grand total	114.6	81.8	100.74	204.77	129.09	164.95	191.62	227.68	323.92	346.03	330.4	340,2	340,2	?	?

Czech drug policies have consistently been based on solid reliable evidence collected and analyzed to generate informed decisions about the way forward. The commitment to data collection and analysis as well as evidence-based decision-making has been recognized and praised by a number of agencies across the world. The Czech Republic's decision to decriminalize drug was not made on a whim but rather grounded on evidence of the local costs of criminalization.<sup>184</sup>

<sup>180</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>181</sup> Csete, J. 2012. *A balancing act: Policymaking on illicit drugs in the Czech Republic*. Open Society Foundations. ([https://www.opensocietyfoundations.org/sites/default/files/A\\_Balancing\\_Act-03-14-2012.pdf](https://www.opensocietyfoundations.org/sites/default/files/A_Balancing_Act-03-14-2012.pdf))

<sup>182</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>183</sup> National Drug Commission. 2010. *National Drug Policy Strategy for the period 2010 to 2018*. (<http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf>)

<sup>184</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

## Germany

### Historical overview

Cannabis appeared in Germany in the 1960s, through students involved in the youth counter-culture movement that was gaining popularity across Europe at the time.<sup>185</sup> Heroin use was first recorded in 1971,<sup>186</sup> while reports indicated that in the early 1970s, illicit amphetamines were already being produced and consumed, especially in Bavaria.<sup>187</sup> The passage of the German *Narcotics Act* in 1971 marked the beginning of a concerted effort to expand the national drug regulatory regime,<sup>188</sup> which had previously been governed under the 1929 *Opium Act*. The 1971 *Narcotics Act* aligned with the 1961 *Single Convention on Narcotic Drugs* as well as the draft of the new 1971 *Convention on Psychotropic Substances*,<sup>189</sup> prioritizing public health results that were focused exclusively on achieving abstinence,<sup>190</sup> while deploying significant controls to reduce supply and demand of illicit drugs.<sup>191</sup>

Within a few years, the number of problem heroin users had increased exponentially, with a national estimate of between 30,000 to 40,000 individuals.<sup>192</sup> With increasing reports from abroad relating OST's success, a pilot methadone service was implemented between 1973 and 1975 in Hanover.<sup>193</sup> The architects of the Hanover trial concluded that the project had been a failure due to the rapid relapse of heroin users and the rapid deterioration of their health condition after treatment cessation.<sup>194</sup>

Cocaine was introduced in the early 1980s,<sup>195</sup> and in response to an increase in drug-related problems throughout the 1970s, various government agencies called for a thorough revision of the *Narcotics Act*. The reforms that followed

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<sup>185</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>186</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>187</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))

<sup>188</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>189</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Germany Country Legal Profile*. Online at: [http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd\\_countryprofiles&country=DE](http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd_countryprofiles&country=DE).

<sup>190</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>191</sup> Euchner, E.-M., et al. 2013. "From 'morality' policy to 'normal' policy: framing of drug consumption and gambling in Germany and the Netherlands and their regulatory consequences" in *Journal of European Public Policy*, 20(3): 372-389. ([https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner\\_245622.pdf?sequence=2](https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner_245622.pdf?sequence=2))

<sup>192</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>193</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>194</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>195</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)



included the consolidation of drug control efforts and the approval in 1981 of the *Act to Regulate the Trade in Narcotics*, which was officially deployed in early 1982 and still serves as the main drug control policy in Germany today.<sup>196</sup>

By the mid-1980s, HIV prevalence amongst PWID had increased rapidly, public nuisance related to illicit drugs had become more visible, and the number of drug-related deaths was also on the rise, leading a small group of dedicated parents and medical doctors to aggressively advocate for expansion of service options for PWUD.<sup>197</sup> These combined factors paved the way for the establishment low-threshold DIC,<sup>198</sup> as well as the first needle and syringe exchange programs in Germany in 1984,<sup>199</sup> and the broader integration of harm reduction concepts and approaches in both policy and service delivery. The first large-scale methadone maintenance program was initiated in 1987, as a pilot project in the federal state of North-Rhine Westphalia.<sup>200</sup> And in 1989, Junkies, Ex-User, Substituierte, one of the world's oldest drug user organization, was established.<sup>201</sup>

In 1990, the federal government approved the *National Plan to Combat Narcotics*, focusing on measures to reduce the demand for illicit drugs; to improve the fight against drug crimes at national level through stronger legislative measures, and to facilitate international cooperation.<sup>202</sup> In 1992, a number of legal amendments to the *Act to Regulate the Trade in Narcotics* were made: provision of needles and syringes was specifically not considered as facilitating drug use, thus not a criminal offence;<sup>203</sup> with the *Regulation on the Prescription of Narcotics*, methadone was recognized for OST, an important service officially acknowledged for an effective response to illicit drugs use, especially heroin;<sup>204</sup> and prosecutors were given discretion to suspend sentences for people arrested for possession of small quantities of cannabis in cases where the offence was

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<sup>196</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Germany Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=DE>.

<sup>197</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>198</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>199</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>200</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>201</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>202</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>203</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>); Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>204</sup> Euchner, E.-M., et al. 2013. "From 'morality' policy to 'normal' policy: framing of drug consumption and gambling in Germany and the Netherlands and their regulatory consequences" in *Journal of European Public Policy*, 20(3): 372-389. ([https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner\\_245622.pdf?sequence=2](https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner_245622.pdf?sequence=2)); Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

considered minor and where prosecution was determined to go against public interest.<sup>205</sup>

In 1993, EMCDDA was formally established, as required by the 1990 *National Plan to Combat Narcotics*, with a specific mission: to provide objective, reliable and comparable information on drug and drug addiction-related problems and their consequences across Europe, and to contribute to facilitating improved cooperation in repression.<sup>206</sup> That year, the German MOH delegated drug-related reporting responsibility to three agencies: the Federal Centre for Health Education in Cologne, the German Centre for Addiction Issues in Hamm, and the Institute for Therapy Research in Munich.<sup>207</sup>

In 1994, the German Federal Constitutional Court ruled that criminalization of drugs was constitutional, but approved new prosecutorial standards for drug possession, reinforcing previous guidance to exercise discretion and to drop all criminal charges for small amounts.<sup>208</sup> Specifically, Section 31a of the *Act to Regulate the Trade in Narcotics* provided for the possibility to discontinue prosecution for possession of drugs when the offender had grown, produced, imported, exported, bought or received and possessed in any other way narcotic substances in small amounts exclusively for personal use, and when guilt was deemed as minor and there was no public interest in prosecution.<sup>209</sup>

That same year, the *Fifth Narcotics Amending Ordinance* legally approved methadone for substitution treatment.<sup>210</sup> Gaining epidemiological strength,<sup>211</sup> political confidence in OST grew stronger in the mid-1990s, repealing the concerns introduced through the 20-year old erroneous conclusions of the Hanover pilot.<sup>212</sup> In 1994, Germany opened the first drug consumption room.<sup>213</sup> In 1998, the *Tenth Narcotics Amending Ordinance* provided legal grounding for OST with codeine.<sup>214</sup>

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<sup>205</sup> Euchner, E.-M., et al. 2013. "From 'morality' policy to 'normal' policy: framing of drug consumption and gambling in Germany and the Netherlands and their regulatory consequences" in *Journal of European Public Policy*, 20(3): 372-389.

([https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner\\_245622.pdf?sequence=2](https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner_245622.pdf?sequence=2)); Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release.

(<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>206</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>207</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>208</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>209</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>210</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>211</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>212</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>213</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_.pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_.pdf/DKR07afIEng.pdf))

<sup>214</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

A new amendment was introduced to the *Act to Regulate the Trade in Narcotics* in 2000, providing a coherent national framework to address drug-related issues.<sup>215</sup> Notably, the amendment also introduced legal provisions for the operation of drug consumption rooms and defined minimum standards to guide implementation.<sup>216</sup> In 2002, the Drug Commissioner of the Federal Government published a report titled *Key points for the action plan on drugs and addiction*, which outlined key issues of consideration in the process of drug policy formulation and recommended the integration of prevention, treatment, harm reduction, and law enforcement strategies to achieve common objectives:<sup>217</sup> 1) to delay initiation of drug consumption; 2) to intervene early in order to reduce high-risk use patterns; and 3) to treat dependence with all available possibilities, ranging from abstinence therapy to medication-based treatment.<sup>218</sup> By 2003, the national *Action Plan on Drugs and Addiction* was deployed,<sup>219</sup> officially formalizing the four pillars, formally adding harm reduction for the first time.<sup>220</sup>

In 2007, new guidelines issued by state-level governments defined possession thresholds, where small quantities of cannabis below six grams would allow prosecutors to independently drop criminal cases.<sup>221</sup> In 2008, the German Federal Court of Justice lowered possession thresholds for methamphetamine, from 30 grams of methamphetamine base to five grams.<sup>222</sup> The *Act to Regulate the Trade in Narcotics* was again amended in 2009, this time to include provisions and strict regulations to prescribe medical heroin (diamorphine) in the context of drug dependence treatment where no success was achieved with methadone or buprenorphine (also known as heroin-assisted therapy or HAT).<sup>223</sup> That same year, data from general population surveys revealed that an estimated 4.8% of adults 18-64 years old had consumed cannabis in the last 12 months.<sup>224</sup>

A number of additional drug-related surveys were conducted in the period up to 2012. *Tables 13, 14 and 15* below summarize the results of those surveys,

<sup>215</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07af1Eng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07af1Eng.pdf))

<sup>216</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. (<http://www.drugpolicy.org/docUploads/Eckpunkte.pdf>)

<sup>217</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. (<http://www.drugpolicy.org/docUploads/Eckpunkte.pdf>)

<sup>218</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. (<http://www.drugpolicy.org/docUploads/Eckpunkte.pdf>)

<sup>219</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>220</sup> Euchner, E.-M., et al. 2013. "From 'morality' policy to 'normal' policy: framing of drug consumption and gambling in Germany and the Netherlands and their regulatory consequences" in *Journal of European Public Policy*, 20(3): 372-389. ([https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner\\_245622.pdf?sequence=2](https://kops.uni-konstanz.de/bitstream/handle/123456789/24562/Euchner_245622.pdf?sequence=2))

<sup>221</sup> Wade, M. 2009. "Prosecutors and Drugs Policy: A tale of six European systems" in *Utah Law Review*, 1: 153-174. (<http://epubs.utah.edu/index.php/ulr/article/viewFile/146/128>)

<sup>222</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>223</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchlev.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>224</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government. ([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

showing different drug patterns in German society by age group, by drug type, and by frequency of use. In addition, authorities reported an estimated 229,000 to 272,000 problem drug users in Germany.<sup>225</sup> Reports published around this time estimated that approximately 150,000 people were dependent on heroin and other opiates; an estimated 300,000 people were using cocaine regularly; and estimated half a million mainly young people were using “party drugs” such as ecstasy and other ATS.<sup>226</sup> However, cannabis remained the most popular illicit drug in Germany with an estimated two million regular users,<sup>227</sup> an estimated 600,000 exhibiting symptoms of problematic use,<sup>228</sup> and an estimated 200,000 affected by dependence.<sup>229</sup> A further 1.4 million individuals were estimated to be dependent on prescription drugs.<sup>230</sup>

*Table 13: Prevalence of illicit drug use in Germany* <sup>231</sup>

	Source	Age	Prevalence	Absolute <sup>1)</sup>
Lifetime	ESA 2012	18-64	23.9 %	12,351,000
	ESA 2009	18-64	26.7 %	13,729,000
	DAS 2011	12-17	7.2 %	344,000
12 Months	ESA 2012	18-64	4.9 %	2,532,000
	ESA 2009	18-64	5.1 %	2,622,000
	DAS 2011	12-17	4.9 %	234,000
30 Days	ESA 2012	18-64	2.6 %	1,344,000
	ESA 2009	18-64	2.6 %	1,337,000
	DAS 2011	12-17	2.0 %	95,000

*Table 14: Prevalence of consumption of illicit drugs by substance* <sup>232</sup>

<sup>225</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>226</sup> Michels, I. I., and Stover, H. 2012. “Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany” in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>227</sup> Anderson, S. 2012. “European Drug Policy: The Case of Portugal, Germany and the Netherlands” in *EIU Political Science Review*.

(<https://www.eiu.edu/polisci/pdf/EIU%20Political%20Science%20Review%20Vol%201%20issue%201%20article%202.pdf>)

<sup>228</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>229</sup> Anderson, S. 2012. “European Drug Policy: The Case of Portugal, Germany and the Netherlands” in *EIU Political Science Review*.

(<https://www.eiu.edu/polisci/pdf/EIU%20Political%20Science%20Review%20Vol%201%20issue%201%20article%202.pdf>)

<sup>230</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>231</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>232</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))



Source	DAS 2011		ESA 2009			ESA 2012		
	%;12-17 Y	%;18-25 Y	%; 18-64 Years			%; 18-64 Years		
Substance	12 M <sup>1)</sup>	12 M <sup>1)</sup>	LT <sup>1)</sup>	12 M <sup>1)</sup>	30 D <sup>1)</sup>	LT <sup>1)</sup>	12 M <sup>1)</sup>	30 D <sup>1)</sup>
Cannabis	4.6	13.5	25.6	4.8	2.4	23.2	4.5	2.3
Amphetamines	0.4	1.6	3.7	0.7	0.3	3.1	0.7	0.4
Ecstasy	0.2	1.0	2.4	0.4	0.2	2.7	0.4	0.2
LSD	0.1	0.3	2.4	0.1	0.1	2.2	0.3	0.1
Heroin	0.0	0.0	0.5	0.1	0.0	0.6	0.2	0.1
Cocaine	0.2	0.9	3.3	0.8	0.3	3.4	0.8	0.3
Crack	0.0	0.0	0.2	0.1	0.0	0.3	0.1	0.1
Mushrooms	0.4 <sup>2)</sup>	0.7 <sup>2)</sup>	2.8	0.1	0.1	2.6	0.3	0.1
Volatile substances	0.1	0.2	--	--	--	--	--	--
Any illicit drug	4.9	14.3	26.7	5.1	2.6	23.9	4.9	2.6
Illicit drugs besides cannabis	1.0	2.8	7.4	1.3	0.6	6.3	1.4	0.8

*Table 15: Lifetime, 12-month and 30-day prevalence of the consumption of illegal drugs, 18 to 64 age groups from 2012 national survey*<sup>233</sup>

Lifetime Prevalence	Total	Sex		Age Group						
		Men	Women	18-20	21-24	25-29	30-39	40-49	50-59	60-64
Any ill. drug <sup>1)</sup>	23.9	28.3	19.3	23.6	31.3	41.3	36.1	20.4	15.0	8.4
Cannabis	23.2	27.5	18.6	23.0	30.8	41.1	35.4	19.7	14.1	7.7
Drugs other than cannabis	6.3	7.8	4.8	3.3	7.8	12.1	11.0	4.9	3.6	2.6
Amphetamine	3.1	4.4	1.8	2.4	4.5	6.8	5.3	2.1	1.5	1.3
Ecstasy	2.7	3.6	1.8	1.2	3.4	6.7	6.6	1.4	0.6	0.4
LSD	2.2	3.0	1.3	0.7	1.2	3.9	4.4	1.4	1.5	1.1
Heroin	0.6	0.9	0.4	0.3	0.3	0.9	1.2	0.5	0.6	0.2
Other opiates	1.0	1.2	0.8	0.4	0.9	1.5	2.0	0.7	0.9	0.3
Cocaine	3.4	4.4	2.3	1.7	3.0	7.6	6.6	2.8	1.3	0.7
Crack	0.3	0.5	0.2	0.0	0.3	1.2	0.3	0.2	0.2	0.2
Mushrooms	2.6	3.9	1.3	1.2	3.2	7.1	4.9	2.0	0.7	0.4

The 2013 national report to EMCDDA highlighted a significant increase in media coverage related to methamphetamine use, especially near the Czech border.<sup>234</sup> By that year, only a few federal states had explicitly defined thresholds and guidelines for discontinuing prosecution in connection with narcotic drugs other than cannabis. The thresholds in force in 2012 were one gram for heroin, 0.5

<sup>233</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>234</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

grams to three grams for cocaine, 0.5 grams to three grams for amphetamines, and three to 20 ecstasy tablets.<sup>235</sup>

That same year, the National Drug Commissioner approved and published the *National Strategy on Drug and Addiction Policy*. Developed in collaboration with MOH, the policy aimed to reduce the consumption of licit and illicit drugs as well as the prevention of drug- and addiction-related problems.<sup>236</sup> That same year, at the 59<sup>th</sup> session of the CND, the German representative and UNODC presented a joint paper titled *Towards development-oriented drug policies: alternative development in the UNGASS 2016 process*, promoting alternative development approaches in the context of balanced drug policies.<sup>237</sup> In the same event, Germany underlined the critical role of civil society in delivery of health services for PWUD as well as in drug policymaking, especially when meaningfully and respectfully involved in the national response.<sup>238</sup>

In 2013, the Common Federal Committee approved amendments to the *Statutory Health Insurance Approved Treatment Guidelines* for HAT, providing for additional support to expand such facilities and supplement human resources.<sup>239</sup> The following year, the National Drug Commissioner reconvened the National Board on Drugs and Addiction as the federal entity responsible for drug policy development, implementation, and coordination. The Board has been composed of representatives from federal departments and agencies, ministers of the federal states, municipal associations, the German Pension Fund, the Federal Employment Agency, the umbrella organizations of the health insurance providers as well as stakeholders from addiction support, addiction prevention and research.<sup>240</sup>

At the 2016 UNGASS on the World Drug Problem, the head of the German delegation emphasized the success of the *Four Pillars* approach:

*We need effective law enforcement to control drug trafficking, money laundering and corruption - in fact, our agencies must be even better networked and coordinated internationally. Prevention, counseling, harm reduction, substitution treatment - this approach has an excellent reach record in Europe. The success is obvious - lower crime rates, less HIV, less hepatitis cases. Let us agree to only punish drug offences in line with the proportionality rule and make it clear that the death penalty can never be a tool of human rights based drug policy.*<sup>241</sup>

<sup>235</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>236</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>237</sup> Commission on Narcotic Drugs. 14-22 March 2016. Paper submitted jointly by Germany and UNODC entitled “Towards development-oriented drug policies: Alternative development in the UNGASS 2016 process.”

([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_59/ECN72016\\_CRP3\\_V1601407.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/ECN72016_CRP3_V1601407.pdf))

<sup>238</sup> Commission on Narcotic Drugs. 12-16 March 2012. *Improving the participatory role of civil society in addressing the world drug problem (E/CN.7/2012/CRP.1)*. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_55/E-CN7-2012-CRP1\\_V1251017\\_E.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP1_V1251017_E.pdf))

<sup>239</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>240</sup> Pfeiffer-Gerschel, T. et al. 2015. *National Report: Germany – Workbook drug policy*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.dhs.de/fileadmin/user\\_upload/pdf/Reitox\\_Jahresberichte/WB01\\_Policy\\_2015\\_Germany\\_EN.pdf](http://www.dhs.de/fileadmin/user_upload/pdf/Reitox_Jahresberichte/WB01_Policy_2015_Germany_EN.pdf))

<sup>241</sup> Mortler, M. 20 April 2016. *Statement by Marlene Mortler, Drug Commissioner of the Federal Government of Germany in the General Debate of the Special Session of the General Assembly on the world drug problem*.

(<http://statements.unmeetings.org/media2/7657398/germany.pdf>)

### Implementation of the national drug control strategy

Germany's drug control policies have been modeled on the Swiss *Four Pillars* model since 2003, as noted above, which include prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues. This sub-section will review the range of strategies and activities implemented in Germany under each pillar, as well as their impact.

#### *Prevention*

The primary objectives of activities implemented under the prevention pillar of Germany's drug control policy have included promoting the health of each individual, maintaining abstinence, preventing and reducing the negative consequences of drug abuse and dependence.<sup>242</sup> The agencies responsible for the implementation of the prevention activities mandated by the *National Strategy on Drug and Addiction Policy* have included the Federal Centre for Health Education, state governments, communal administrations and social insurance funds.<sup>243</sup>

The majority of Germany's prevention interventions have been monitored and tracked through a management of information system called Dot.sys, which provides comprehensive information within one calendar year.<sup>244</sup> For example, a 2013 national report to EMCDDA showed that 16,373 prevention sessions had taken place in 2010, compared to 18,904 in 2011, and 19,942 in 2012. Among those, out of all substances, the majority of prevention interventions have focused on alcohol. In terms of illicit drugs, the majority of interventions have focused first on cannabis and second on amphetamines.<sup>245</sup> The number of prevention activities targeting cannabis and amphetamines both seem to have increased over time. The breakdown of prevention interventions by type of drug addressed is summarized in *Figure 3* below.

*Figure 3: Number of prevention activities recorded in Dot.sys by substances between 2010 and 2012*<sup>246</sup>

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<sup>242</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>243</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>244</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

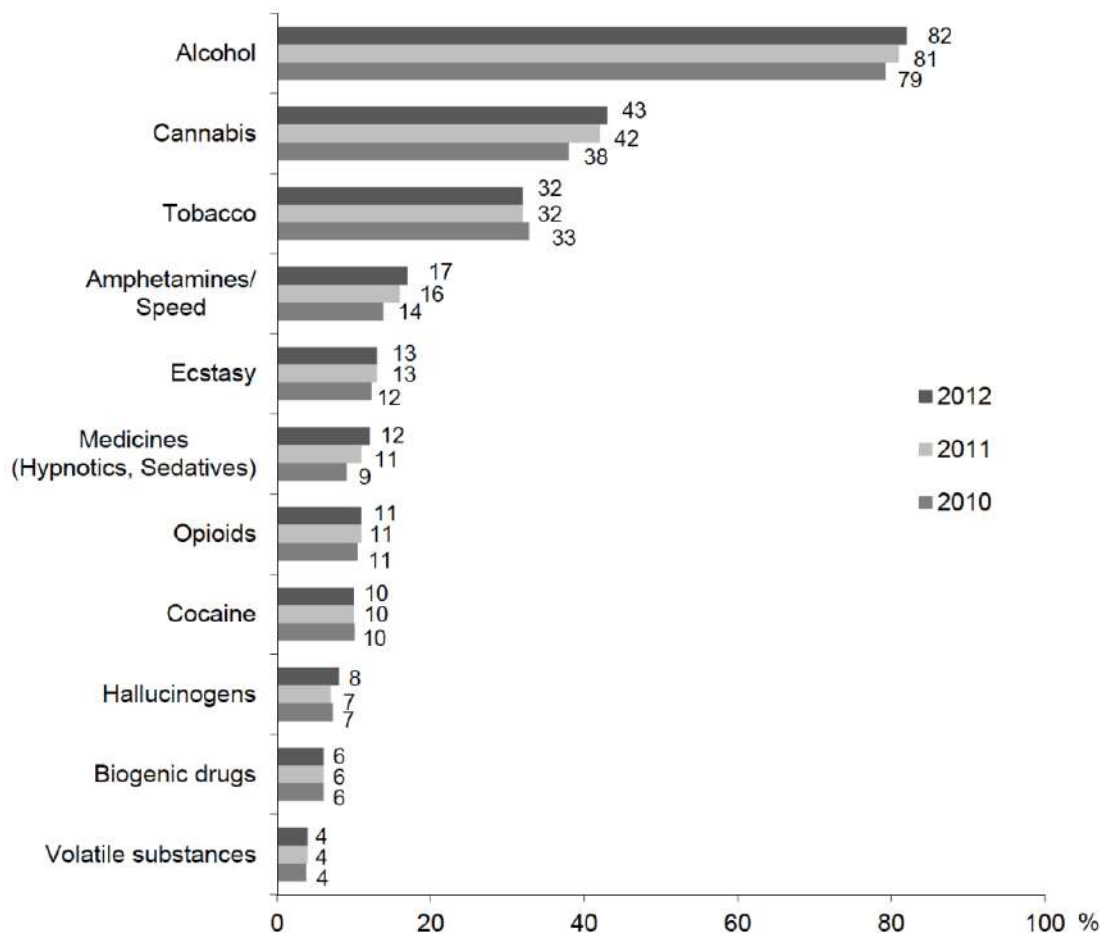
([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>245</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>246</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))



Out of a grand total of 32,845 prevention sessions recorded in Dot.sys in 2012, 44% were implemented in schools. *Figure 4* below summarizes the range of settings in which those interventions were implemented, showing a great diversity but also a great concentration. Indeed, prevention and health promotion in school settings was acknowledged as a critical component of the 2012 drug control strategy, calling on targeted and focused efforts to better reach high-risk groups, especially among children and adolescents. Prevention efforts were often designed to build self-confidence and develop strong personalities.<sup>247</sup> Other mechanisms used to disseminate prevention messages have included an internet portal, training for youth staff, and use of the media.<sup>248</sup>

*Figure 4: Settings for all recorded prevention interventions in 2012* <sup>249</sup>

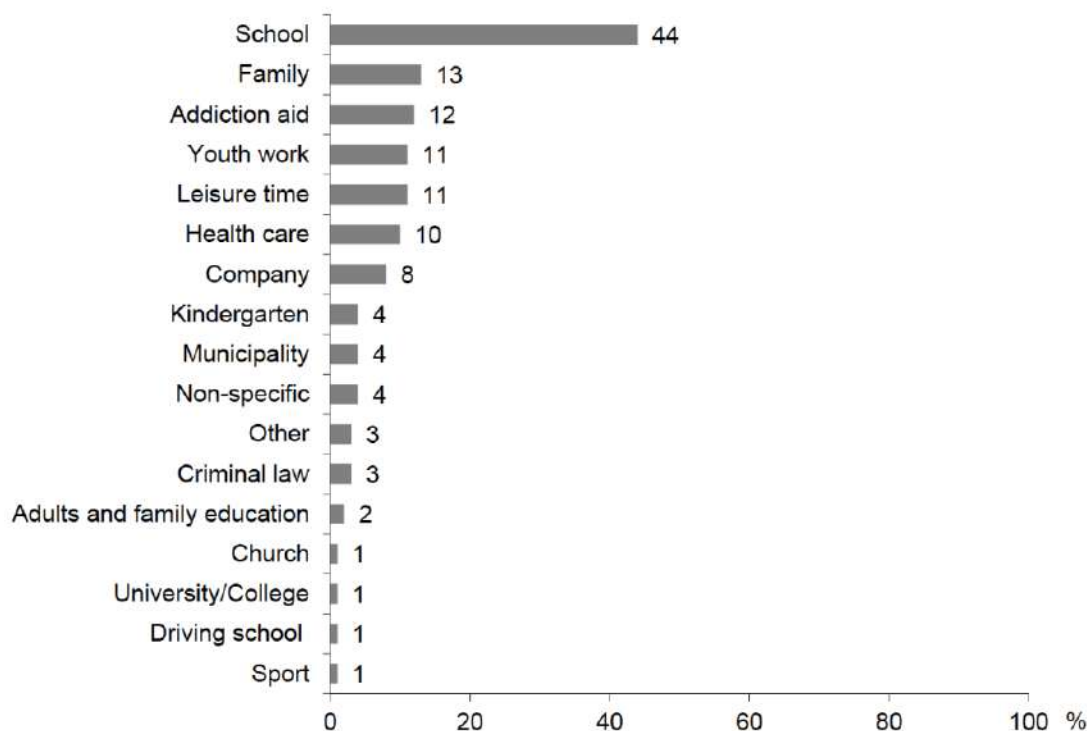
<sup>247</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>248</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07af1Eng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07af1Eng.pdf))

<sup>249</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))





Out of the same 32,845 prevention activities recorded in Dot.sys in 2012, 57% took a universal prevention approach, 18% were classified as “indexed prevention measures,” and 14% as “selective prevention measures;” 11% of the measures were defined as “structural” or “situational prevention” interventions.<sup>250</sup>

### *Harm reduction*

Harm reduction was officially introduced in the German drug control policy as one of the four core pillars of the national *Action Plan Drug and Addiction* in 2003. Interventions implemented under the harm reduction strategy of Germany’s drug control policy have been designed to provide day-to-day survival assistance and to contribute to stabilizing the health and social conditions of PWUD, a critical precondition to overcoming dependence and achieving social reintegration.<sup>251</sup> Harm reduction measures have included distribution of sterile injecting equipment, OST, HAT, and drug consumption rooms. Promoting low-threshold services, increasing the number of drug consumption rooms, reducing the number of drug-related emergencies, and reducing transmission of infections in closed settings have been critical components of the harm reduction strategy.<sup>252</sup>

There was limited data on the number of problem drug users or PWID in Germany. Reports show that the population of problem drug users has been

<sup>250</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>251</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>252</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

dropping against three major indicators: treatment entries, police contacts, and drug related deaths. *Table 16* below summarizes the evolution of the population size estimate for problem drug users in Germany from 2005 to 2011. While the number of PWID was estimated between 120,000 and 150,000 in 2008,<sup>253</sup> the estimate has been revised to 94,250, which continues to be reported as the national estimate in 2016.<sup>254</sup>

***Table 16: Estimated size of problem opiate user population in Germany, 2005-2011***

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Indicator	2005	2006	2007	2008	2009	2010	2011
Treatment	155,000 - 184,000	136,000 - 162,000	131,000 - 156,000	155,000 - 184,000	144,000 - 171,000	154,000 - 185,000	N/A
Police contacts	128,000 - 166,000	117,000 - 159,000	108,000 - 149,000	99,000 - 137,000	89,000 - 127,000	81,000 - 117,000	79,000 - 106,000
Drug-related deaths	79,000 - 96,000	103,000 - 130,000	99,000 - 113,000	117,000 - 178,000	91,000 - 119,000	82,000 - 137,000	63,000 - 91,000

Distribution of sterile injecting equipment was initiated in 1984 but the intervention was legally endorsed only in 1992. Sterile injecting equipment has been available through outreach, through some of the estimated 300 low-threshold services and counseling facilities spread out across Germany,<sup>256</sup> through drug consumption rooms, as well as in one prison. The prison has one vending machine, which has been operational since 1996.<sup>257</sup> Reports indicate that Germany has the highest number of needle and syringe vending machines in the world – approximately 160 spread across nine federal states.<sup>258</sup> Data from 2010 and 2011 has shown that a little more than 10% of the total volume of needles and syringes has been distributed via vending machines.<sup>259</sup>

Fixed needle and syringe distribution facilities have also been available, and reports have shown that at least 25% of rural and urban districts have such a facility in place or at least a vending machine.<sup>260</sup> Reports show that an estimated 250 sites distributed sterile injecting equipment across Germany in 2010 and

<sup>253</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFULLReport1.pdf>);

<sup>254</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf)); Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>255</sup> German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction. 2012. *2012 National Report to the EMCDDA by the Reitox National Focal Point: Germany: New Developments, Trends and In-Depth Information on Selected Issues - Drug Situation 2011/2012*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_213926\\_EN\\_Germany\\_NR2012.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_213926_EN_Germany_NR2012.pdf))

<sup>256</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>257</sup> Australian Injecting & Illicit Drug Users League. 2015. *Needle and Syringe Programs in Prisons: An International Review*. (<http://www.aivl.org.au/wp-content/uploads/NSP-in-Prisons-An-International-Review.pdf>)

<sup>258</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>259</sup> German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction. 2012. *2012 National Report to the EMCDDA by the Reitox National Focal Point: Germany: New Developments, Trends and In-Depth Information on Selected Issues - Drug Situation 2011/2012*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_213926\\_EN\\_Germany\\_NR2012.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_213926_EN_Germany_NR2012.pdf))

<sup>260</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

2012;<sup>261</sup> up to 391 sites in 2014;<sup>262</sup> and significantly down to 156 sites across all modalities in 2016.<sup>263</sup>

The number of OST sites in Germany has been relatively stable: reports published between 2010 and 2014 show a consistent 2,786 to 6,626 OST sites spread out across Germany. Available OST medications have included methadone, buprenorphine, levomethadone, dihydrocodeine, codeine, and diamorphine. *Table 17* below summarizes the distribution of all OST patients registered in Germany according to substitution drug.

*Table 17: Type and portion of the substitution drugs reported to the substitution register (2003-2011)* <sup>264</sup>

Substitution drug	2003	2004	2005	2006	2007	2008	2009	2010	2011
Methadone	70.9%	68.3%	66.2%	64.1%	61.4%	59.7%	58.9%	57.7%	54.8%
Levomethadone	14.8%	15.0%	15.8%	17.2%	19.0%	20.6%	21.8%	23.0%	25.4%
Buprenorphine	12.9%	15.6%	17.2%	18.0%	18.6%	18.9%	18.6%	18.6%	19.2%
Dihydrocodeine	1.2%	0.9%	0.7%	0.6%	0.5%	0.4%	0.3%	0.3%	0.2%
Codeine	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Diamorphine					0.4%	0.3%	0.3%	0.3%	0.4%

The number of opiate users registered in OST initially increased rapidly and stabilized in more recent years: in 1991 an estimated 1,000 individuals were registered in methadone programs,<sup>265</sup> rising to between 40,000 and 45,000 by 2001,<sup>266</sup> rising again to 77,400 in 2010.<sup>267</sup> Since then, the number of registered individuals has been stable although there has been a slight decrease year on year: down to 76,200 in 2011, to 74,500 in 2012,<sup>268</sup> and up to 77,000 in 2016.<sup>269</sup>

Today, OST is the first-line recommended intervention to address opioid use, abuse and dependence. Approximately 7,000 medical doctors undergo annual training courses to implement OST programs, while an estimated 2,700 are currently prescribing substitution drugs.<sup>270</sup> The cost of OST is absorbed for the

<sup>261</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International.

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International.

<sup>262</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>);

<sup>263</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>264</sup> German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction. 2012. *2012 National Report to the EMCDDA by the Reitox National Focal Point: Germany: New Developments, Trends and In-Depth Information on Selected Issues - Drug Situation 2011/2012*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_213926\\_EN\\_Germany\\_NR2012.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_213926_EN_Germany_NR2012.pdf))

<sup>265</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>266</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>267</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>268</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>269</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*.

(<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>270</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

majority of patients through the national health insurance scheme.<sup>271</sup>

Drug consumption rooms have offered safe spaces for people to consume illicit substances procured outside the facility in relative safety. The first drug consumption room in Germany was opened in 1994, but such facilities were only legally approved in 2000. By 2011, a total of 25 such facilities were operating across 16 cities and federal states;<sup>272</sup> in 2012, two drug consumption rooms closed, bringing the total to 23;<sup>273</sup> by 2016, a total of 24 drug consumption rooms were operating across Germany.<sup>274</sup> While there was no available aggregated evaluation of the impact of all Germany's drug consumption rooms, city- and state level evaluations and reviews have provided useful insights.

The results of the evaluation of the 12 drug consumption rooms in North Rhine-Westphalia showed that more than 1.2 million consumption events had been recorded between April 2001 and December 2009. Approximately 75,000 individual clients were referred to other facilities for additional support and treatment.<sup>275</sup> Out of 3,271 cumulative emergencies treated during the same period, 710 deaths were prevented.<sup>276</sup> Meanwhile, the evaluation showed that the number of supervised consumption events through injection was decreasing while the number of events through inhalation was rising.<sup>277</sup>

Documentation related to drug consumption rooms in Frankfurt showed an increasing number of supervised consumption events, attributed to greater acceptability of such facilities among PWUD. *Figure 5* below shows the gradual increase in the number of supervised consumption events between 2003 and 2009.<sup>278</sup> Further review of data from Frankfurt showed that, contrary to many other facilities which have successfully reduced injecting in favor of inhaling illicit drugs, the proportion of injecting has increased from 68% in 2003 to 82% in 2009.

*Figure 5: Number of supervised consumption events in Frankfurt, 2003-2009* <sup>279</sup>

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(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>271</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>272</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))

<sup>273</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>274</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

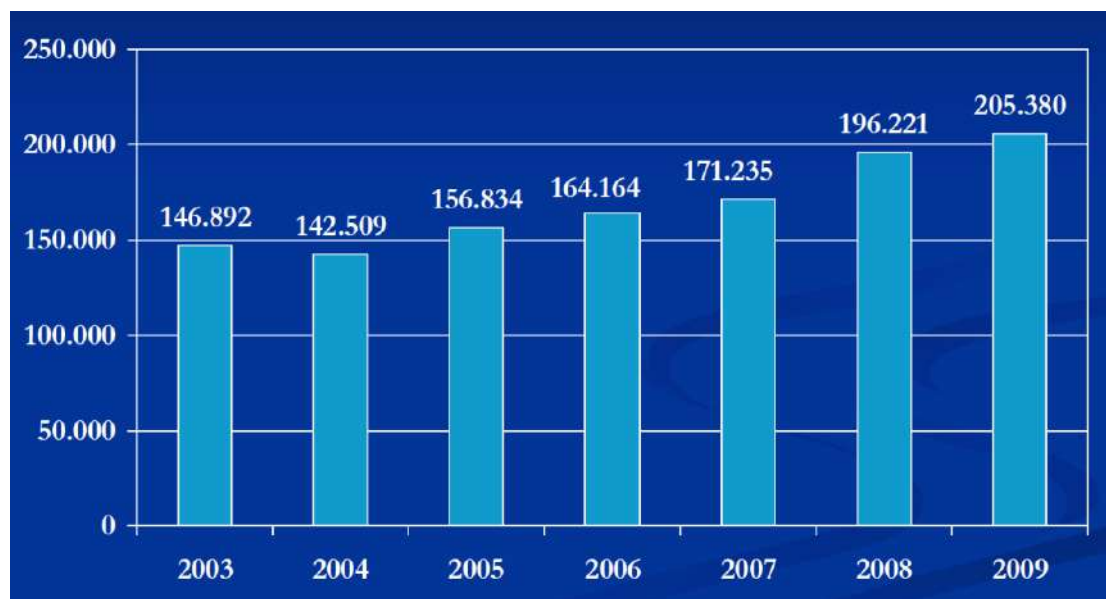
<sup>275</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))

<sup>276</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))

<sup>277</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))

<sup>278</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))

<sup>279</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07afIEng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07afIEng.pdf))



Finally, a 2003 evaluation concluded that drug consumption rooms had reached the intended target population of hard-to-reach, highly impoverished, long-term drug users; had not permitted access or facilitated drug use among minors and juveniles; had generated significant health improvements for their clients; had stimulated access to health care among its clients; and had improved collaboration and coordination between law enforcement and public health agencies responding to drug issues.<sup>280</sup>

HAT in Germany has been implemented under the same conditions and through the same mechanism as other forms of OST. Evaluations of the German HAT services have consistently highlighted the success of these interventions: successful recruitment of the most severely dependent heroin users for whom other substitution medicines did not produce sustainable results; significant improvements in health against several indicators; reduction in consumption of heroin procured from the black market; and no increase in cocaine use.<sup>281</sup> After 12 months, HAT clients demonstrated higher improvements in health compared to clients on methadone for the same duration.<sup>282</sup>

The impact of Germany's harm reduction strategy can be observed by looking at prevalence of HIV, viral hepatitis and overdoses. HIV rates amongst PWID have been steadily rising since 2010: from 5.6% in 2008,<sup>283</sup> to 2.9% in 2010,<sup>284</sup> to

<sup>280</sup> Poschadel, S., Hoger, R., Schnitzler, J., & Schreckenber, D. 2003. *Evaluation der Arbeit der Drogenkonsumräume in der Bundesrepublik Deutschland*. Schriftenreihe des Bundesministeriums für Gesundheit und Soziale Sicherheit.

<sup>281</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>282</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>283</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>284</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))



3.4% in 2012,<sup>285</sup> to 4.75% in 2014,<sup>286</sup> and to 5.3% in 2016.<sup>287</sup> Out of 2,954 new HIV cases detected in 2012, PWID represented 4% of the total (n=90) or the third largest group.<sup>288</sup> In 2012, adult HIV prevalence was reported at 0.2%,<sup>289</sup> demonstrating that HIV is still significantly and disproportionately concentrated amongst PWID in Germany. Meanwhile, an estimated 82.1% of PWID living with HIV are also co-infected with HCV.<sup>290</sup>

However, HCV prevalence among PWID has been dropping over the past years: from 75% as reported in 2008-2012,<sup>291</sup> down to 67.8% in 2014,<sup>292</sup> and down to 63.8% in 2016.<sup>293</sup> Nevertheless, 87% of new HCV cases were identified amongst PWID in 2011 and 2012.<sup>294</sup> Similarly, HBV prevalence seems also to have slightly decreased in recent years: from 7.2% as reported in 2012 and 2014,<sup>295</sup> down to a maximum of 6.3% in 2016.<sup>296</sup> Additional evidence shows that drug control efforts under the harm reduction pillar have resulted in positive behavior change amongst PWID, where 91% of PWID reported using a sterile needle at their last injection; 50% accessed HIV testing services and received their results in the past 12 months; and 31% had used a condom during the last risky sex session.<sup>297</sup>

Several datasets were identified in the literature regarding fatal overdoses and drug-related mortality in Germany. While the reported numbers do not align across datasets, all datasets clearly show a downward trend in the number of deaths related to drug use. The most complete set is presented in *Table 18* below.

**Table 18: Number of fatal overdoses per year in Germany, 1995-2014**<sup>298</sup>

Year	1995	1996	1997	1998	1999
Number of overdose deaths	1,227	1,305	1,088	1,280	1,337

<sup>285</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International.

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>286</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>287</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>288</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>289</sup> (No author). 2012. *Germany: Global AIDS Response Country Progress Report 2012*.

([http://www.unaids.org/sites/default/files/country/documents/ce\\_DE\\_Narrative\\_Report%5B1%5D.pdf](http://www.unaids.org/sites/default/files/country/documents/ce_DE_Narrative_Report%5B1%5D.pdf))

<sup>290</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*.

(<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>291</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International.

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International.

(<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>292</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>293</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>294</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>295</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>296</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>297</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*.

(<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>298</sup> European Monitoring Center on Drugs and Drug Addiction. 2016. *Statistical Bulletin: Overdose deaths*, online at:

<http://www.emcdda.europa.eu/data/stats2016>.

<b>Year</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
<b>Number of overdose deaths</b>	1,487	1,239	1,139	1,161	1,104
<b>Year</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
<b>Number of overdose deaths</b>	1,223	1,169	1,284	1,326	1,276
<b>Year</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>
<b>Number of overdose deaths</b>	1,205	1,076	1,079	1,179	N/A

### *Treatment*

Interventions deployed under the treatment pillar of the German drug control strategy have been designed to help people break the cycle of dependence.<sup>299</sup> Amongst others, proposed priority interventions include counseling, a telephone helpline, scaling up abstinence-focused treatment, expanding the role of self-help groups, and expanding OST and HAT.<sup>300</sup> Drug dependence treatment has been available through both residential and outpatient programs. Family doctors have often been the first point of contact for problem drug users and at-risk individuals who can refer clients to approximately 1,300 dependence counseling and treatment centers, including approximately 300 psychiatric outpatient institutes, approximately 800 facilities for social reintegration, and about 500 (all-day) outpatient and 320 inpatient therapy facilities.<sup>301</sup> A detailed breakdown and number of facilities that provided drug treatment services in Germany in 2012 is summarized in *Table 19* below.

***Table 19: Types and number of drug dependence treatment facilities in Germany***

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<sup>299</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>300</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>301</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>302</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

Type of facility	Number [rounded]	Places [rounded]
Counselling centres and services (per year) approx	< 1,300 <sup>51</sup>	> 500,000
Substitution treatment (registered)*	8,416	75,400
Low threshold facilities	> 300	
Specialist hospital departments	> 300	> 7,500
Psychiatric clinics	300	> 220,000
Psychiatric outpatient institutes	300	91,800
Withdrawal with motivational elements	190	> 2,000
(Whole day) outpatient rehabilitation	100	> 1,000
Inpatient rehabilitation	320	13,200
Adaption facilities	115	> 1,200
Social therapy inpatient facilities	268	> 10,700
Social therapy daycare facilities	112	> 1,200
Outpatient assisted living	460	> 12,000
Employment projects/qualification measures	250	> 4,800
Self help groups	8,700	No reliable figures

In 2012, there were a total of 198 facilities providing inpatient treatment services in the context of dependence, including alcohol, tobacco and gambling; a total of 47,079 individuals enrolled in treatment, of which 9,481 (20.1%) enrolled in a treatment program due to use of illicit drugs.<sup>303</sup> In 2010, approximately 300,000 inpatient drug dependence treatment sessions took place in psychiatric facilities, reaching an estimated 45% of problem opioid users compared to only 4% of problem cannabis users.<sup>304</sup>

In contrast, an estimated 300,000 outpatient treatment sessions took place every quarter for an annual total of approximately 1.2 million outpatient treatment interventions in 2010.<sup>305</sup> Out of these, coverage among problem opioid users was estimated at 60% compared to only 8% of problem cannabis users.<sup>306</sup> In 2012, a total of 41.1% of outpatient clients sought assistance in regards to opioid-related drugs, compared to 36.5% for cannabis, and 12.3% for stimulants, representing a slight decrease for opioids from 2011 (44.9%) but a slight increase for cannabis

<sup>303</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>304</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>305</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>306</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

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(34.7%) and for stimulants (10.5%).<sup>307</sup> *Table 20* provides an overview of the main problematic drug identified through medical diagnosis among outpatient clients in 2012. *Table 21* provides additional information about the frequency and duration of outpatient treatment by drug type in 2012.

***Table 20: Distribution of outpatient clients by main drug creating problems*** <sup>308</sup>

Main diagnosis harmful use/addiction ... (ICD10: F1x.1/F1x.2x)	All persons treated <sup>1)</sup>			Persons treated for the first time		
	Males <sup>2)</sup>	Females <sup>2)</sup>	Total <sup>2)</sup>	Males <sup>2)</sup>	Females <sup>2)</sup>	Total <sup>2)</sup>
Opioids	39.9 %	45.7 %	41.1 %	14.4 %	17.5 %	15.0 %
Cannabinoids	39.3 %	26.2 %	36.5 %	61.9 %	45.0 %	58.4 %
Sedatives/Hypnotics	1.2 %	5.6 %	2.2 %	1.2 %	5.8 %	2.2 %
Cocaine	6.5 %	3.9 %	6.0 %	6.6 %	3.9 %	6.0 %
Stimulants	11.2 %	16.3 %	12.3 %	14.3 %	25.3 %	16.6 %
Hallucinogens	0.2 %	0.3 %	0.2 %	0.3 %	0.2 %	0.2 %
Volatile substances	0.1 %	0.2 %	0.1 %	0.1 %	0.3 %	0.1 %
Multiple/other substances	1.6 %	1.7 %	1.6 %	1.3 %	2.1 %	1.4 %
Total (N)	50,084	13,595	63,679	14,522	3,790	18,312

***Table 21: Frequency and duration of outpatient treatment interventions*** <sup>309</sup>

Main Diagnosis	Number of times contacted (M)			Duration of treatment (M) <sup>1)</sup>		
	Males	Females	Total	Males	Females	Total
Opioids	19.4	24.7	20.7	52.8	60.0	54.5
Cannabinoids	10.0	11.7	10.2	25.9	25.2	25.8
Sedatives/Hypnotics	11.8	13.9	12.9	30.3	33.1	31.9
Cocaine	14.2	13.8	14.1	30.6	29.9	30.5
Stimulants	10.3	12.5	10.9	29.8	27.9	29.3
Hallucinogens	10.5	10.4	10.5	25.7	37.1	29.0
Volatile substances	7.1	9.2	8.0	21.4	16.3	19.3
Multiple/other substances	17.2	23.8	18.6	38.0	38.3	38.1

1) in weeks.

In Germany, the national health insurance scheme has been required to provide funds to any and all CSO whose mission is related to prevention or rehabilitation.<sup>310</sup> Based on the principle of subsidiarity, where a complex network of agencies provide resources for public services, no one can be turned

<sup>307</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>308</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>309</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>310</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

away from outpatient treatment services for any reason.<sup>311</sup> In that respect, a significant number of CSO have been delivering a large proportion of treatment services in Germany while government agencies have had a very limited role in this area.<sup>312</sup>

### *Law enforcement*

Law enforcement related activities fall under the fourth pillar of the German drug control policy. Implementing those activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. In the context of drug control, the overall goal of the law enforcement pillar has focused on reducing the supply of illicit drugs and enforcing the provisions of the *Act to Regulate the Trade in Narcotics*.<sup>313</sup>

Repression activities have remained grounded, to a large extent, on efforts to eliminate all drugs and achieve abstinence.<sup>314</sup> However, a significant proportion of German police officers have come to support the integration of the four pillars under the national drug control strategy. For example, a majority of police officers supported the implementation of drug consumption rooms, given that injecting drug use in public spaces had grown increasingly visible in many cities.<sup>315</sup> Ultimately, the focus of law enforcement in the drug control strategy has been placed on both undermining drug trafficking efforts as well as on reducing small-scale dealing to reduce access to illicit drugs.<sup>316</sup>

German police do not have formal discretionary powers, so they are compelled to report all drug-related crimes to the prosecutor.<sup>317</sup> However, police officers have used informal discretion to enforce the law in a rational and pragmatic manner. For example, police in some federal states have proactively refrained from arresting or responding to complaints involving small quantities of illicit drugs, especially in regards to cannabis and ecstasy.<sup>318</sup>

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<sup>311</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN\\_EMCDNA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN_EMCDNA_NR%202013_Germany.pdf))

<sup>312</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN\\_EMCDNA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN_EMCDNA_NR%202013_Germany.pdf)); Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>313</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government.

([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>314</sup> Anderson, S. 2012. "European Drug Policy: The Case of Portugal, Germany and the Netherlands" in *EIU Political Science Review*.

(<https://www.eiu.edu/polisci/pdf/EIU%20Political%20Science%20Review%20Vol%201%20issue%201%20article%202.pdf>);

Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>);

<sup>315</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

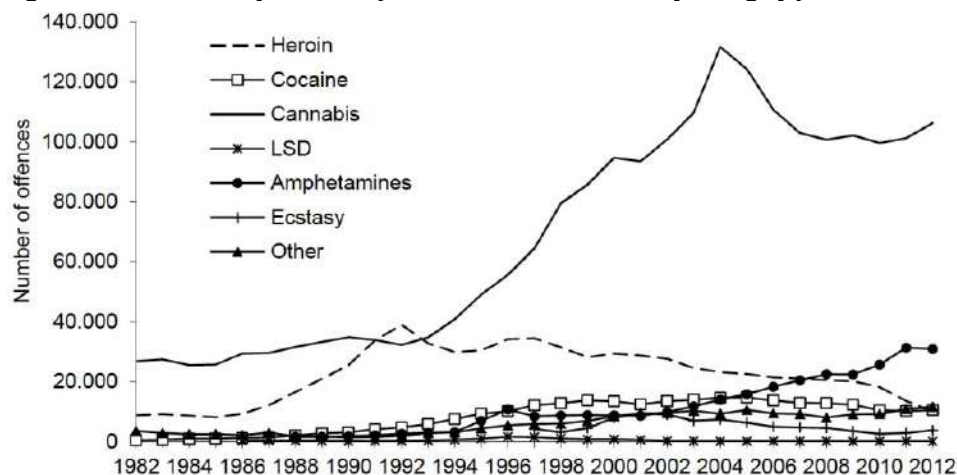
<sup>316</sup> Government of Germany. 2002. *Key points for the action plan on drugs and addiction*. Drug Commissioner of the Federal Government. ([http://www.drugpolicy.org/docUploads/Eckpunkte\\_.pdf](http://www.drugpolicy.org/docUploads/Eckpunkte_.pdf))

<sup>317</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SSentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SSentencing.pdf))

<sup>318</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

In 2010, a total of 237,150 drug-related crimes were registered, out of which 173,337 (73.1%) were for consumption and/or possession, and 45,040 (19.0%) were for dealing/trafficking.<sup>319</sup> In 2011, a total of 236,478 drug-related crimes were registered, out of which 48,291 (20.4%) were for dealing/trafficking.<sup>320</sup> In 2012, possession/consumption-related arrests were mostly linked to cannabis (61.3% of cases), increasingly to amphetamines (17.8%), to cocaine (6.1%), and to heroin (5.8%).<sup>321</sup> Figure 6 below shows the evolution of the number of consumption-related arrests over time by drug type.

**Figure 6: Number of consumption-related arrests by drug type, 1982-2012** <sup>322</sup>



The number of drug trafficking crimes and the proportion of trafficking against all crime in Germany have been consistently dropping since 2002: from a peak of 77,038 drug trafficking arrests (1.18% of total crime) in 2002, down to 47,667 arrests (0.80%) in 2012. Table 22 below summarizes the evolution on a year-by-year basis. In 2012, amphetamines were involved in 16.3% of reported trafficking crimes, compared to 59.8% involving cannabis, 8.0% involving heroin, 6.9% involving cocaine, and 1.7% involving ecstasy.<sup>323</sup> Figure 7 shows the evolution of the number of trafficking-related arrests over time by drug type.

**Table 22: Drug trafficking versus total crime in Germany, 2002-2012** <sup>324</sup>

Year	Total number of crimes recorded by police	Number of drug trafficking crimes recorded by police	Proportion drug trafficking versus total crime
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<sup>319</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>320</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>321</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

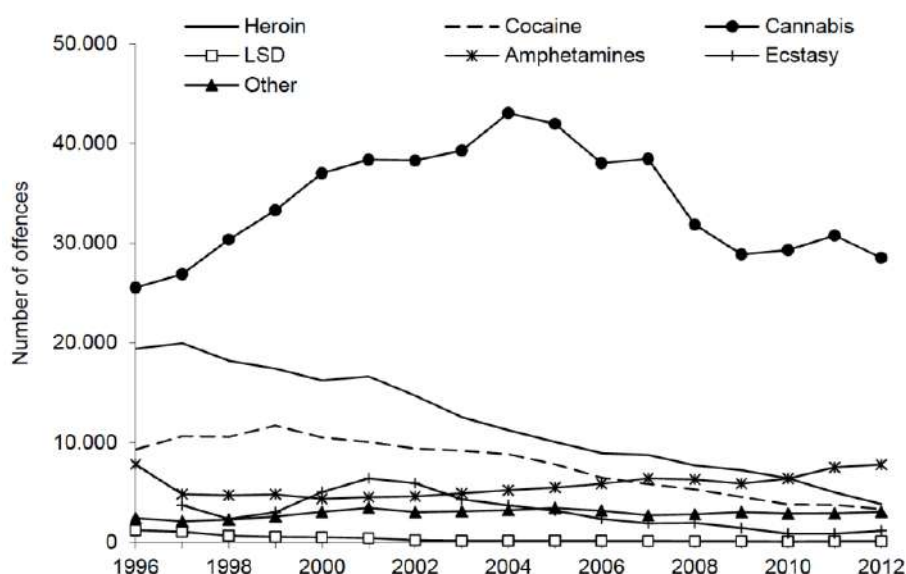
<sup>322</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>323</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA NR%202013_Germany.pdf))

<sup>324</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).

2002	6,507,400	77,038	1.18%
2003	6,572,100	73,375	1.12%
2004	6,663,200	75,347	1.13%
2005	6,391,700	72,002	1.13%
2006	6,304,200	64,865	1.03%
2007	6,284,700	64,093	1.02%
2008	6,114,100	55,095	0.90%
2009	6,054,300	50,965	0.84%
2010	5,933,300	49,622	0.84%
2011	5,990,700	50,791	0.85%
2012	5,990,700	47,667	0.80%

Figure 7: Number of consumption-related arrests by drug type, 1982-2012 <sup>325</sup>



Significant fluctuations have been recorded in frequency of seizures and quantities of illicit drugs seized by law enforcement agencies. Despite those variations, cannabis and other cannabis products have remained the most frequently seized illicit drugs. In 2012, the number amphetamine seizures overtook the number of hashish seizures. *Table 23* and *Figure 8* below provide a historical snapshot of seizures in Germany.

Figure 8: Number of seizures of illicit drugs in Germany, 2003-2012 <sup>326</sup>

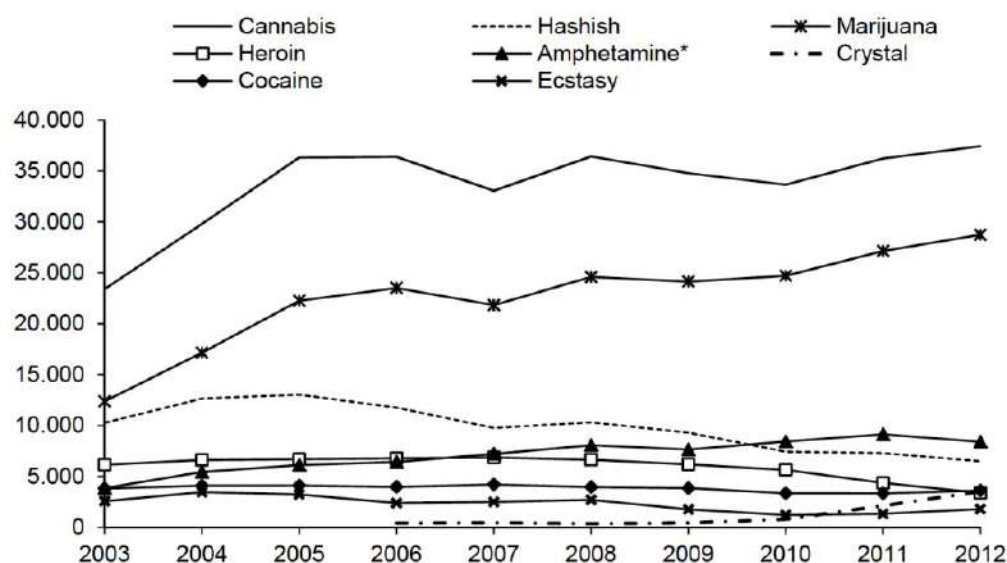
<sup>325</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

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<sup>326</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

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*Table 23: Quantity of illegal drugs seized in Germany, 2010-2012* <sup>327</sup>

Substance	2010	2011	2012	Change 2011-12
Heroin	474.3 kg	497.8 kg	241.7 kg	-51.4 %
Cocaine	3,030.8 kg	1,940.6 kg	1,258.4 kg	-35.2 %
Crack	3.2 kg	2.8 kg	0.5 kg	-81.9 %
Amphetamine	1,176.9 kg	1,368.4 kg	1,120.6 kg	-18.1 %
Crystal	26.8 kg	40.0 kg	75.2 kg	88.3 %
Ecstasy	230,367 CU	484,992 CU	313,179 CU	-35.4 %
Hashish	2,143.7 kg	1,747.5 kg	2,385.7 kg	36.5 %
Marijuana	4,874.7 kg	3,957.4 kg	4,942.0 kg	24.9 %
LSD	4,279 tr.	25,978 tr.	36,988 tr.	42.4 %
Khat	30,389.3 kg	45,913.8 kg	45,270.1 kg	-1.4 %
Mushrooms	16.0 kg	13.2 kg	17.3 kg	30.4 %

In 2014, the quantity of cannabis herb and cannabis plants seized increased compared to 2013, while the number of cannabis resin seizures slightly decreased; 2014 herb cannabis seizures of 8,514.64 kg represented almost twice the amount reported in 2012.<sup>328</sup> A total of 779.95 kg of heroin was seized, representing almost three times the amounts reported in 2012 and 2013 but on par with quantities seized prior to 2010 (758 kg in 2009).<sup>329</sup> In 2014, there were 3,905 seizures of crystal methamphetamine, and 73.171 kg was seized, compared to 75 kg in 2012 and 77 kg in 2013.<sup>330</sup> A total of 1,411.3 kg of amphetamines was seized in 2014, up from the 1,262 kg seized in 2013; a total of

<sup>327</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

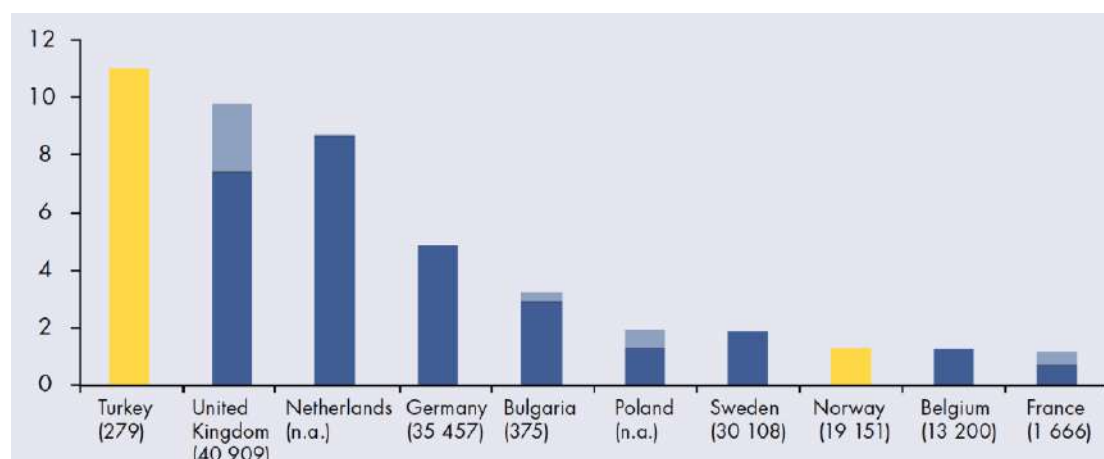
<sup>328</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>329</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>330</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

486,852 ecstasy tablets were seized in 2014 compared to 480,839 in 2013; and a total of 1,567.91 kg of cocaine was seized in 2014 compared to 1,315 kg in 2013.<sup>331</sup> In 2008, Germany was the sixth country in which the largest number of methamphetamine seizures had taken place.<sup>332</sup> As shown in *Figure 9* below, Germany ranked fourth in the EU for the highest quantities of illicit amphetamine products seized between 2005 and 2009.

*Figure 9: Largest quantities of illicit amphetamine products seized in the EU, Norway and Turkey, cumulative total, 2005–2009 (tons)* <sup>333</sup>



Illicit production of amphetamines in Germany was detected as early as the 1970s and was especially common in Bavaria, along the Czech border: 45 amphetamine laboratories were dismantled in that region alone between 2001 and 2010.<sup>334</sup> In 2007 and 2008, a respective total of three and 11 methamphetamine laboratories were dismantled in Germany, second only to the Czech Republic in both years.<sup>335</sup> Despite the increasing number of ATS production sites dismantled, despite the increasing number of ATS seizures, and despite the increasing quantities of ATS seized, those trends were reportedly not particularly significant given that there were no signs of overall increased domestic production.<sup>336</sup>

In 2005, out of 194,444 drug-related offences reported by the police, a total of 36,774 adults were accused in court (18.1%).<sup>337</sup> A total of 55,391 persons were convicted in a court of law in 2011 for drug-related offences, 48,573 of which

<sup>331</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>332</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>333</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))

<sup>334</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))

<sup>335</sup> European Monitoring Centre for Drugs and Drug Addiction. 2009. *Methamphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine\\_final\\_163584.pdf](http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine_final_163584.pdf))

<sup>336</sup> European Monitoring Centre for Drugs and Drug Addiction. 2014. *Exploring methamphetamine trends in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/787/TDAU14001ENN\\_460800.pdf](http://www.emcdda.europa.eu/system/files/publications/787/TDAU14001ENN_460800.pdf))

<sup>337</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachelements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachelements.cfm/att_93232_EN_TDSI09001ENC.pdf))

involved adults (87.7%).<sup>338</sup> Convictions for drug-related offences represented approximately 7% of all convictions imposed in 2011.<sup>339</sup> In 2006, 61% of those convicted for drug-related offences had already been sentenced at least once and 37% had been sentenced at least three times.<sup>340</sup>

As noted above, prosecutors in Germany have had the authority to dismiss drug-related cases when the quantity was insignificant and for personal use only, and if there was no public interest in pursuing prosecution. Guided by the expediency principle, such a provision could feasibly be applied to all cases related to possession of small amounts of any drug although, in practice, the principle has been applied mainly in cases involving cannabis.<sup>341</sup> In addition to prosecutorial discretion, penal orders can be used, albeit rarely applied in practice, to divert offenders away from the criminal justice system and into treatment facilities.<sup>342</sup> Indeed, in 2006, a total of 449 drug offenders were diverted as a result of being already enrolled or being prepared to enroll in an accredited drug treatment program, representing barely 1% of the total convicted drug offenders, the majority of who were convicted for trafficking, in that year.<sup>343</sup>

Out of all 280,877 drug-related offenses recorded in 2006, 36% were dismissed unconditionally, 24% were dismissed due to lack of evidence, 18% of offenders were charged, 8% were diverted through a penal order, and 12% had another outcome.<sup>344</sup> Comparatively, out of the 55,391 individuals convicted for possession/consumption offences in 2011, a total of 16,041 (29.0%) prison sentences were passed – out of which, 10,258 (69.9%) were suspended sentences – and 32,532 (58.7%) fines were imposed.<sup>345</sup> Germany is among six countries in the EU most likely to issue fines for possession related offences.<sup>346</sup>

Only a small proportion of convicted criminal offenders were sentenced to prison in Germany, estimated at 6% based on a 2013 report.<sup>347</sup> Across all crime categories, 75% of prison sentences in 2006 were for 12 months or less, and

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<sup>338</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

<sup>339</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

<sup>340</sup> [http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf)

<sup>341</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*.

<sup>342</sup> [http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN TDSI09001ENC.pdf)

<sup>343</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. [http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf)

<sup>344</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. <http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>

<sup>345</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. [http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf)

<sup>346</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. [http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf)

<sup>347</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction.

<sup>348</sup> [http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf)

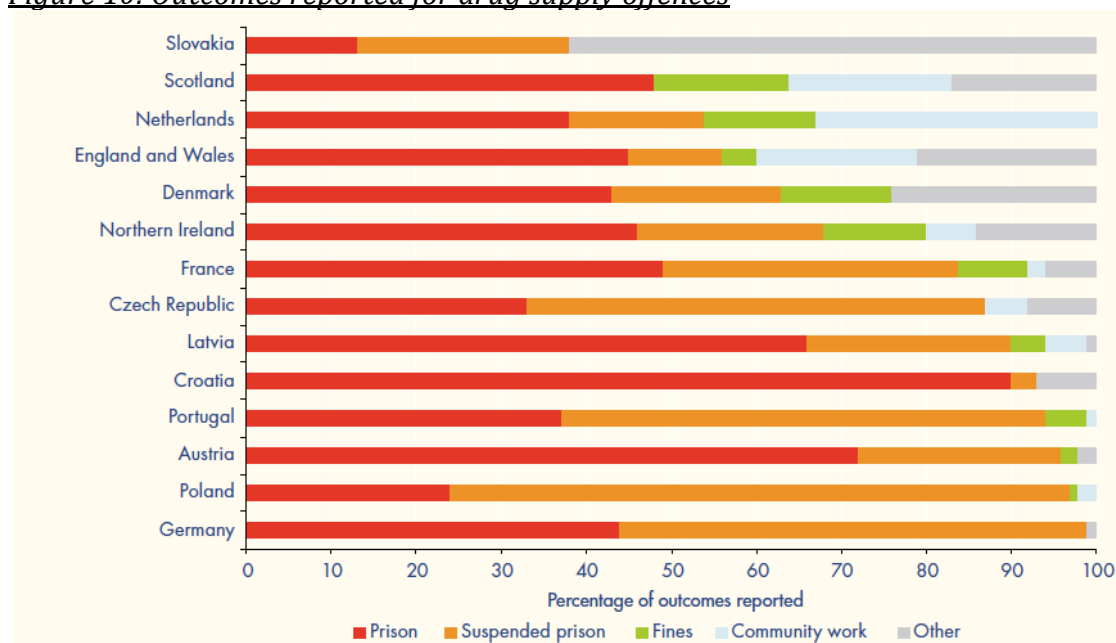
<sup>349</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. [http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf)

<sup>350</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. <http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>



92% of sentences were for two years or less.<sup>348</sup> However, as *Figure 10* shows below, while the majority of trafficking-related sentences have been suspended prison terms, a significant proportion of actual prison sentences have been meted out. In contrast, only 7% of possession/consumption offences have led to a prison sentence.<sup>349</sup>

*Figure 10: Outcomes reported for drug supply offences*<sup>350</sup>



In 2016, a total of 64,397 individuals were incarcerated across Germany's 183 prisons, representing an occupancy rate of 87.6%.<sup>351</sup> *Table 24* below provides an overview of the evolution of the total prison population and the population prison rate between 2000 and 2016. The overall decrease in the prison population and the prison population rate are paralleled by a comparable drop in the proportion of offenders incarcerated for drug-related crimes: from 21.9% in 2006,<sup>352</sup> down to 15% in 2009,<sup>353</sup> and down to 14% in 2012.<sup>354</sup>

*Table 24: Total prison population and prison population rate 2000-2016*<sup>355</sup>

<sup>348</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>349</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>350</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>351</sup> International Center for Prison Studies. 2016. *World Prison Brief - Germany*. Online at: <http://www.prisonstudies.org/country/germany>.

<sup>352</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922. (<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>353</sup> Government of Germany. 2012. *National strategy on drug and addiction policy*. Drug Commissioner of the Federal Government. ([http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale\\_Strategie\\_Druckfassung\\_EN.pdf](http://www.drogenbeauftragte.de/fileadmin/dateiendba/Presse/Downloads/Nationale_Strategie_Druckfassung_EN.pdf))

<sup>354</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

<sup>355</sup> International Center for Prison Studies. 2016. *World Prison Brief - Germany*. Online at: <http://www.prisonstudies.org/country/germany>.

Year	Total prison population	Prison population rate
2000	70,252	85
2002	70,977	86
2004	79,452	96
2006	76,629	93
2008	72,259	88
2010	69,385	85
2012	65,889	82
2014	61,872	76
2016	64,397	78

An estimated 75,000 PWID are incarcerated in Germany, representing approximately 21% of the total prison population.<sup>356</sup> Among all prisoners, surveys have shown that HIV prevalence is relatively low at 1.2% while HCV prevalence is estimated at 14.3%.<sup>357</sup> Surveys have also shown that a significant proportion of PWID continue to inject drugs while incarcerated.<sup>358</sup> As noted earlier, one needle and syringe vending machine is in operation in a prison in Germany, while six out of 16 federal states have allowed OST in prisons, for an estimated 3% to 5% coverage.<sup>359</sup>

### Concluding analysis

There was little evidence to show that the German drug policy had been evaluated as a whole. However, virtually all components of the drug control strategy have been documented, studied, analyzed, and evaluated. The German drug policy has and continues to emphasize the need for rigorous comparable documentation of activities implemented under the national drug control strategy. Various databases have been setup to aggregate and analyze data while various surveys and other instruments have been deployed to inform policy decision with reliable and relevant evidence. Overall, the evidence presented in this section shows that the German drug control policy has been successful against virtually every indicator.

Motivation for drug policy reform was prompted by a number of factors, including the rapid spread of HIV and the increasing number of drug-related deaths as well as the increasing visibility and nuisance associated with illicit drug use.<sup>360</sup> Ideally, effective implementation of the drug control policy would

<sup>356</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>357</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>)

<sup>358</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>359</sup> Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

<sup>360</sup> Michels, I. I., and Stover, H. 2012. "Harm Reduction: from a Conceptual Framework to Practical Experience: The Example of Germany" in *Substance Use & Misuse*, 47: 910-922.

(<http://www.ditchley.co.uk/assets/media/Harm%20Reduction%20-%20from%20a%20Conceptual%20Framework%20to%20Practical%20Experience%20The%20Example%20of%20Germany.pdf>); Gerlach, R. 2002. "Drug Substitution treatment in Germany: A critical overview of its history, legislation and current practice" in *Journal of Drug Issues*, 503-522. (<http://www.indro-online.de/gerlach.pdf>)

lead to a relocation of drug use to private, controlled settings.<sup>361</sup> A significant amount of legislative tinkering was required to establish the current drug control apparatus. Box 3 below summarizes selected relevant policy reforms that took place over the years in Germany.

*Box 3: Relevant German legal and policy documents and milestones*

- *Opium Act* (1929)
- *German Narcotics Act* (1971)
- *Act to Regulate the Trade in Narcotics* (1982)<sup>[L][T][L][T]</sup><sub>[SEP][SEP]</sub>
- *National Plan to Combat Narcotics* (1990)<sup>[L][T][L][T]</sup><sub>[SEP][SEP]</sub>
- *Regulation on the Prescription of Narcotics* (1992)
- *Fifth Narcotics Amending Ordinance* (1995)<sup>[L][T][L][T]</sup><sub>[SEP][SEP]</sub>
- *Tenth Narcotics Amending Ordinance* (1998)<sup>[L][T][L][T]</sup><sub>[SEP][SEP]</sub>
- *Publication of Key points for the action plan on drugs and addiction* (2002)<sup>[L][T]</sup><sub>[SEP]</sub>
- *National Action Plan on Drugs and Addiction* (2003)
- *National strategy on drug and addiction policy* (2012)
- *Amendment to the Statutory Health Insurance Approved Treatment Guidelines* (2013)

The German decriminalization model rests mostly on a combination of prosecutorial discretion combined with quantity threshold to divert non-violent drug offenders away from the criminal justice system. Already in 1992, prosecutorial discretion was encouraged and formalized in 1994; thresholds were introduced and modified in 2007. In addition, while law enforcement officers have been mandated to report all drug crimes to the prosecutor, many officers have exercised informal discretion and avoided arrests for possession of small amounts of illicit drugs.

Compared to other countries, Germany's drug policy reform and decriminalization model have attracted very little attention. There were no reports in the literature where the famous INCB raised concerns regarding Germany's approach; EU neighbors did not complain that national efforts would negatively impact their own countries; and national media and the general public were not particularly vocal about the direction the drug control strategy was taking locally. In that sense, Germany's decriminalization model has essentially been normalized and has not particularly been branded as "radical" or "exotic" as in other countries where such reforms were introduced.

Overall responsibility for drug policy development, monitoring and coordination was delegated to the MOH's Federal Drug Commissioner,<sup>362</sup> although it is not clear from the literature exactly when this shift occurred. The Federal Drug Commissioner has headed the National Board on Drugs and Addiction, whose members provide support to the Commissioner. This structure was designed to facilitate cooperation across municipal, state and federal levels and between a wide range of actors from public health and law enforcement sectors.

<sup>361</sup> Konsumraum, A. K. 2011. *Drug Consumption Rooms in Germany: A Situational Assessment*. Deutsche AIDS-Hilfe & Akzept. ([http://www.akzept.org/pdf/aktuel\\_pdf/DKR07af1Eng.pdf](http://www.akzept.org/pdf/aktuel_pdf/DKR07af1Eng.pdf))

<sup>362</sup> Ysa, T. et al. 2014. *Governance of Addictions: European Public Policies*.

The national drug control strategy has remained firmly grounded on the four pillars model since 2003, balancing efforts across prevention, harm reduction, treatment and law enforcement strategies. Policy implementation has been guided by several critical principles: public health that prioritizes access to harm reduction and treatment over criminal penalties; expediency that allows prosecutors to dismiss minor cases for which prosecution is not in the public interest; and subsidiarity, where government agencies provide the necessary support to guarantee treatment services to anyone in need.

The role of CSO is particularly important in Germany, where the majority of services have been offered through such agencies as opposed to being managed directly by government agencies. Meanwhile, no group or individual particularly stands out in Germany as having led efforts that prompted decriminalization or drug policy reform; such reforms seem to have taken place largely against a broad consensus, based on evidence rather than on the driving personality of a single individual or the work of a particular organization.

The health impact of the German decriminalization model has been impressive but not conclusive: the number of PWID and problem drug users has been reduced, but ATS use seems to be on the rise. While the proportion of new cases HIV amongst PWID is very small, prevalence rates are on the rise; in contrast, while prevalence of viral hepatitis amongst PWID has been decreasing, the number of new cases has remained concentrated among PWID. While a high proportion of PWID report using sterile injecting equipment at their last injection, condom use among this population is inconsistent. However, the number of drug-related deaths have decreased, and a significant proportion of PWID and problem drug users have been covered by some form of treatment, including OST. Innovative services such as drug consumption rooms and HAT have been integrated in the comprehensive package of interventions recommended by the German drug control policy, generating significant positive health and social benefits.

In terms of law enforcement, the decriminalization approach has reduced prison populations, and reduced the number of incarcerated drug offenders. A number of health and harm reduction services have been integrated in some prisons across Germany. Prisons in Germany have been organized around central principle of re-socialization and rehabilitation, emphasizing the need to allow those incarcerated access to privacy as well as opportunities for individual expression and self-regulation.<sup>363</sup>

The 2013 national report to EMCDDA indicated that between EUR 5.2 and 6.1 billion had been invested to address drug-related issues in 2006.<sup>364</sup> Within this purse, EUR 172 million was spent by the German National Statutory Pension Insurance on work-related benefits; EUR 1.4 billion was spent by medical

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<sup>363</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>364</sup> Pfeiffer-Gerschel, T. et al. 2013. *National Report: Germany – New Developments and Trends*. European Monitoring Centre for Drugs and Drug Addiction. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_228404\\_EN EMCDDA\\_NR%202013\\_Germany.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_228404_EN EMCDDA_NR%202013_Germany.pdf))

insurance institutions for medication, hospital treatment, rehabilitation, etc.; and between EUR 3.6 and 4.5 billion was invested in prevention, harm reduction and repression.<sup>365</sup> Other sources breakdown the financial allocation for drug-related activities as presented in *Table 25* below.

*Table 25: Total drug-related public expenditure, 2006*<sup>366</sup>

<b>Classification</b>	<b>Expenditure (EUR '000)</b>	<b>% of total</b>
Public order and safety	3,366,342 – 4,219,542	64.8% - 69.5%
Health and social protection	1,787,272 – 1,814,472	29.9% - 34.4%
General public services	40,285	0.7% - 0.8%
<b>Total</b>	5,193,899 – 6,074,299	100%
<b>% of GDP</b>	23 - 26%	

In 2009, an estimated 96% of financial resources spent on harm reduction services had been sourced domestically, compared to 3% from international sources. That year, harm reduction activities represented 22% of the total spending on HIV in Germany. Out of the total spending on HIV, 22.3% of resources were secured from domestic sources.<sup>367</sup> Cost-benefit analyses of HAT have shown that a net savings balance of EUR 5,966 is generated per client per year in Germany, compared to a net savings balance of EUR 2,069 for OST with methadone.<sup>368</sup>

<sup>365</sup> German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction. 2011. *National Report to the EMCDDA by the Reitox National Focal Point: Germany: New Developments, Trends and In-Depth Information on Selected Issues - Drug Situation 2010/2011*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_191753\\_EN\\_Germany\\_2011.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_191753_EN_Germany_2011.pdf))

<sup>366</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

<sup>367</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>368</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

## The Netherlands

### Historical overview

Until the 1950s, few people were using drugs in the Netherlands; hemp and hashish were controlled substances under the 1928 *Opium Act*, but an amendment introduced in 1953 made possession and production of cannabis a criminal offence.<sup>369</sup> Drug use proliferated in the 1960s, as in other European countries at the time, introduced and popularized through the youth counter-culture movement.<sup>370</sup> In 1969, the Public Prosecutor issued new law enforcement guidelines, directing police to concentrate their efforts on controlling trafficking of cannabis, LSD, amphetamines and opium.<sup>371</sup>

In 1970, the Holland Pop Festival in Rotterdam welcomed over 100,000 visitors in the Netherlands' first-ever large-scale outdoor festival, and local authorities consciously decided not to enforce provisions of the *Opium Act*, in line with the 1969 enforcement guidelines.<sup>372</sup> After the concert, police officers reflected that drug transactions became visible without the risk of arrest, and that different drugs were sourced from different individuals.<sup>373</sup> In 1971, the Hulsman Committee released a report commissioned by a non-governmental but influential advisory body as well as an authority on mental health; the report proposed abolishing all criminal penalties for all drugs over time, addressing drug problems through public health mechanisms, and that drug-related law enforcement should be proportional to the danger each substance posed to society.<sup>374</sup>

By 1972, heroin had been introduced in the Netherlands. That same year, the Baan Committee, another independent advisory body, released a report on cannabis, re-emphasizing the conclusion of the Hulsman Committee report that policing and punishment should be proportional to the potential harms caused by each substance, and proposed a differentiation between substances that carried an "unacceptable risk" and "other substances."<sup>375</sup> Ultimately, the report endorsed the recommendation to decriminalize cannabis given the negative individual and social consequences associated with arrests and prosecution of cannabis users, but also recommended that penalties for trafficking of hard drugs be increased.<sup>376</sup>

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<sup>369</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>370</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>371</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>372</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>373</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>374</sup> Commissie Hulsman. 1971. *Ruimte in het drugbeleid. Rapport van een werkgroep van de Stichting Algemeen Centraal Bureau voor de Geestelijke Volksgezondheid*.

<sup>375</sup> Werkgroep Verdovende Middelen (Commissie Baan). 1972. *Achtergronden en risico's van druggebruik: rapport van de werkgroep verdovende middelen*.

<sup>376</sup> Werkgroep Verdovende Middelen (Commissie Baan). 1972. *Achtergronden en risico's van druggebruik*.



Also in 1972, the first “teahouse” was opened in Amsterdam - the Mellow Yellow - illegally selling cannabis and hashish to its patrons, but the government tolerated the shop given that no other (hard) drugs were being sold there.<sup>377</sup> In 1975, The Bulldog, the first “coffeeshop,” was opened in Amsterdam’s famous red light district, also operating on the fence between legality and tolerance, but formalizing service hours and moving the service behind the counter.<sup>378</sup> That same year, an influential Dutch study was published, debunking the role of cannabis as a gateway drug, concluding that separation of cannabis from the black market would prevent such users from coming into contact with harder, more dangerous drugs.<sup>379</sup>

In 1976, the *Opium Act* was again amended, endorsing the recommendations of the Baan Committee and separating drugs into two categories based on risks: 1) cannabis products; and 2) substances with an unacceptable risk to the health of the user.<sup>380</sup> Possession of 30 grams or less of cannabis would now be dismissed or considered a misdemeanor, leading to no civil or criminal penalties.<sup>381</sup> In addition, the new policy formally shifted responsibility for development and implementation of drug policy from MOJ to MOH.<sup>382</sup> MOH was also made responsible for implementation of activities under the prevention, harm reduction and treatment pillars while MOJ was charged with enforcement of the law and MOI was delegated responsibility for matters relating to local government and the police.<sup>383</sup> Together, these agencies were responsible for balancing public health imperatives against the need to maintain public order, while remaining in compliance with international requirements.<sup>384</sup>

In 1977, national guidelines were revised to allow the city mayor, the chief of the police, and the prosecutor to decide whether or not to prosecute small-scale sales of cannabis.<sup>385</sup> The revision formalized the expediency principle, giving prosecutors the authority to independently assess the value of prosecution and

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*rapport van de werkgroep verdovende middelen.*

<sup>377</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>378</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>379</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>380</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>381</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>382</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>383</sup> Koopmans, F. “Going Dutch: Recent drug policy developments in the Netherlands” in *Journal of Global Drug Policy and Practice*. ([http://www.academia.edu/3655120/Going\\_Dutch\\_Recent\\_drug\\_policy\\_developments\\_in\\_the\\_Netherlands](http://www.academia.edu/3655120/Going_Dutch_Recent_drug_policy_developments_in_the_Netherlands))

<sup>384</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>385</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

ultimately dismiss charges, if not in the public's interest or if prosecution did not generate some form of social value, without approval from the court.<sup>386</sup> The revised national *Guidelines for Investigation and Prosecution* were deployed and came officially into force in 1979.<sup>387</sup> Some have suggested that the 1979 *Guidelines* have provided the legal leeway for coffeshops to operate, as long as sales of illicit drugs weren't openly and publicly advertised.<sup>388</sup>

Throughout the 1970s, heroin progressively flooded the Dutch market.<sup>389</sup> In the mid-1970s, as moral panic about drug problems grew, police stepped up raids in order to control the large open-air drug scenes in or near public establishments that were spreading across the country, from urban areas to more rural cities.<sup>390</sup> In 1980, the economic crisis impacted the Dutch heroin market, which pushed dealers to move into apartments from which they not only sold drugs but also where clients could consume in relative safety. Cocaine was introduced in 1982 and has since remained relatively contained among the heroin using community.<sup>391</sup> Because heroin dealers were also the main sources of cocaine and because consumption was possible on-location, the tools were available to produce crack. While there were significant negative health consequences associated with the combination of the Dutch heroin and cocaine markets at the time, one of the suggested benefits has been that such a confluence contributed to limiting the attractiveness of injecting.<sup>392</sup>

In 1984, HIV prevalence amongst PWID was estimated at 30%;<sup>393</sup> in 1985, there were an estimated 25,000 problem drug users in the Netherlands.<sup>394</sup> By that time, positive signs were reported that the heroin epidemic was in decline, especially in major cities. But the number of coffeshops was growing rapidly and the shops were spreading across the country, beyond major cities. In 1991, a set of criteria was developed to regulate operations of coffeshops and ensure minimum standards would be in place. Known as the AHOJ-G criteria, they prohibited coffeshop owners from advertising, from selling hard drugs, from

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<sup>386</sup> Korf, D. 2008. "An open front door: the coffee shop phenomenon in the Netherlands" in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)

<sup>387</sup> Korf, D. 2008. "An open front door: the coffee shop phenomenon in the Netherlands" in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)

<sup>388</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>389</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>390</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>391</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>392</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>393</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>394</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

generating nuisance, and from selling to under-aged youth. The AHOJ-G criteria also included a maximum quantity that could be sold to one person in a single day (initially 30 grams), and prohibited coffeeshop owners from keeping more than a maximum stock of 500 grams per shop.<sup>395</sup> However, those criteria were officially ratified only in 1994.

The following year, the Dutch coalition government published *Dutch Drug Policy: Continuity and Change*, an official inter-ministerial white paper that recognized the success of the segregation of soft and hard drug markets, acknowledged the important role of coffeeshops in achieving this success, and underlined the evidence that few people, especially youth, in the Netherlands were dependent on hard drugs compared to those in other European countries.<sup>396</sup> However, the paper also highlighted that coffeeshops remained dependent on organized crime and the black market, underlined that coffeeshops were often associated with public nuisance and some operated in close vicinity to schools, and expressed concern about the Netherlands' international reputation.<sup>397</sup> The paper also grounded the Dutch drug control policy on four objectives: to prevent drug use and to treat and rehabilitate drug users; to reduce harm to users; to diminish public nuisance caused by drug users; and to combat the production and trafficking of drugs.<sup>398</sup> The policy also codified the AHOJ-G criteria into law, and included new restrictions for coffeeshops, such as reducing daily transaction maximums to five grams per day per person.<sup>399</sup>

In 1996, the *Care Institutions Quality Act* was officially deployed with the particular intent to reduce public nuisance, recognizing that past efforts – and particularly structures – had been inadequate to address the issue. The policy facilitated the establishment of additional facilities and strengthened the capacity and effectiveness of the existing drug dependence treatment, care and support system.<sup>400</sup> By 1997, a total of 1,179 coffeeshops had been established across the Netherlands but that year, officials started closing some of those for non-compliance with the AHOJ-G criteria.<sup>401</sup>

In 1998, the *Penitentiary Principles Act* was approved with the primary objective of rehabilitating and re-socializing prisoners. Such a process was recommended to be carried out with as few restrictions as possible to closely mimic the conditions in the community where they would eventually return, based on the

<sup>395</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>396</sup> Kamer, T. 1995. *Dutch Drug Policy: Continuity and Change*. Ministerie VWS. (<http://www.emcdda.europa.eu/system/files/Ministerie%20VWS%20%281995%29%20Continuity%20and%20Change%2C%20Dutch%20drug%20policy.pdf>)

<sup>397</sup> Kamer, T. 1995. *Dutch Drug Policy: Continuity and Change*. Ministerie VWS. (<http://www.emcdda.europa.eu/system/files/Ministerie%20VWS%20%281995%29%20Continuity%20and%20Change%2C%20Dutch%20drug%20policy.pdf>)

<sup>398</sup> Kamer, T. 1995. *Dutch Drug Policy: Continuity and Change*. Ministerie VWS. (<http://www.emcdda.europa.eu/system/files/Ministerie%20VWS%20%281995%29%20Continuity%20and%20Change%2C%20Dutch%20drug%20policy.pdf>)

<sup>399</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>400</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *The Netherlands Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT#>.

<sup>401</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

principle of association rather than separation; as such, prisoners were encouraged and provided with the necessary space to enjoy personal privacy, to express their opinions and feelings, and to self-regulate their behavior.<sup>402</sup>

Approval of the *Damocles Act* in 1999 gave city mayors further, rather arbitrary powers to close coffeeshops when public order was disrupted or when the safety and health of local residents were in jeopardy.<sup>403</sup> This accelerated the closure of coffeeshops across the Netherlands, which numbered 846 that year,<sup>404</sup> down to 813 in 2000.<sup>405</sup> That year, the Dutch government was the first in the world to legalize cannabis for medicinal purposes.<sup>406</sup> In 2002, the passage of the *Victor Act* increased law enforcement powers to search, investigate, identify and enforce penalties for drug-related offences by intensifying law enforcement coordination with a broader range of agencies.<sup>407</sup>

Also in 2002, the social democratic “Purple” government coalition was replaced by a coalition of right-wing parties in national elections. While officially, MOH retained overall responsibility for drug policy, in practice, MOJ took the lead from this point forward.<sup>408</sup> In 2003, the *Public Administration Probity in Decision-Making Act*, also known as the BIBOB Act, was designed to prevent coffeeshop permits from being issued to individuals with ties to criminal organizations.<sup>409</sup> By 2004, only 737 coffeeshops were operating in the Netherlands.<sup>410</sup> Between 1988 and 2003, cannabis use among young people had risen, in line with trends in other European countries, but quickly stabilized as shown in *Figure 11* below.

*Figure 11: Cannabis use among secondary school pupils, aged 12 years, 1988–2003*

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<sup>402</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>403</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>404</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Models for the legal supply of cannabis: recent developments*. (<http://www.emcdda.europa.eu/publications/pods/legal-supply-of-cannabis>)

<sup>405</sup> Korf, D. 2008. “An open front door: the coffee shop phenomenon in the Netherlands” in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)

<sup>406</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

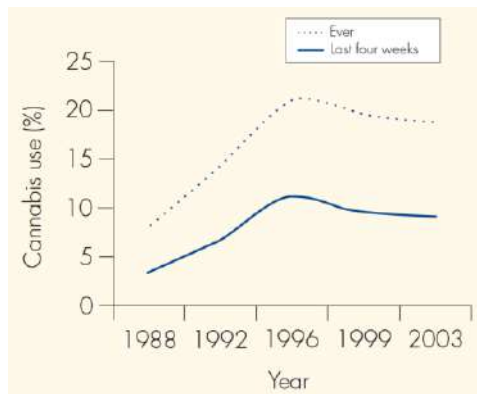
<sup>407</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>408</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>409</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

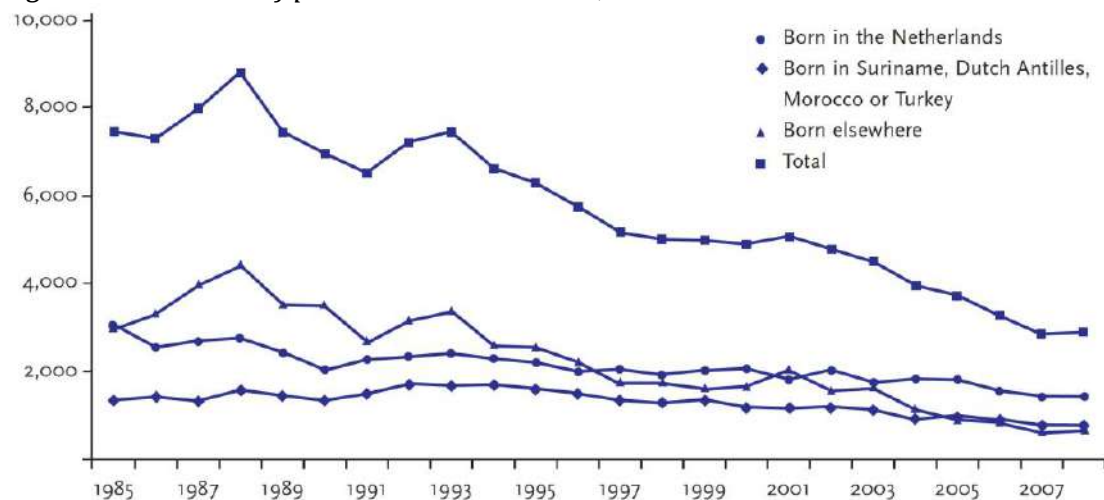
<sup>410</sup> Korf, D. 2008. “An open front door: the coffee shop phenomenon in the Netherlands” in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)

<sup>411</sup> Korf, D. 2008. “An open front door: the coffee shop phenomenon in the Netherlands” in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)



Also in 2004, the *Placement in an Institution for Habitual Offenders Act* was approved, building on the 2001 *Penal Care Facility for Addicts Act*, which allowed the compulsory committal and detention of repeat and habitual offenders to a special institution for intensive treatment for a period of at most two years.<sup>412</sup> The act also provided for the immediate suspension of detention in the event that the offender enrolled in an accredited treatment program.<sup>413</sup> By 2005, an estimated 33,500 problematic drug users were living in the Netherlands, only 10% of who injected drugs.<sup>414</sup> While the number of problematic drug users increased slightly compared to 1985, *Figure 12* below shows that the number of opiate users was decreasing in Amsterdam.

**Figure 12: Number of problem in Amsterdam, 1985-2008** <sup>415</sup>



first piloted in 1998, HAT was formally approved as a regular component of drug dependence treatment for poorly functioning , therapy-resistant heroin

<sup>412</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>413</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

<sup>414</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

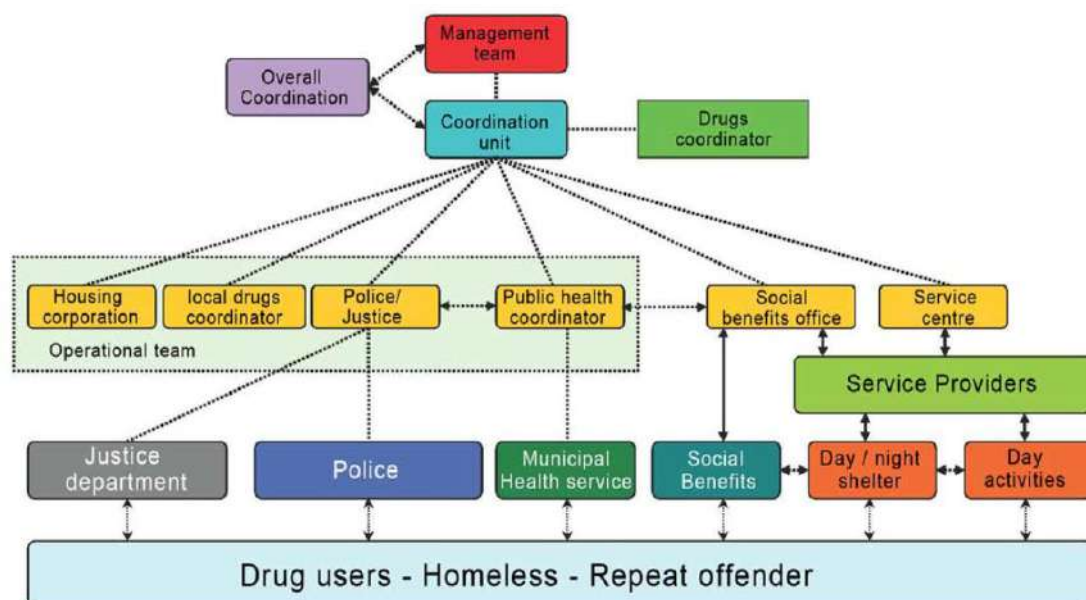
<sup>415</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)



dependent individuals, under strict conditions in 2006.<sup>416</sup> That same year, the two-year *Social Support Strategy* was implemented with the overall objective of guiding vulnerable individuals, such as PWUD, into public health services through which clients were to access medical care and treatment, housing, employment, reintegration, and social benefits.<sup>417</sup> Implementation of the strategy required the development of a complex mechanism, as summarized below and illustrated in *Figure 13*:

*An administrative management team (mayor, high-level administrative local officers) meets twice a year to reach agreements at the general level. An interdisciplinary working group, the operational team, is responsible for the implementation of the program. This group consists of representatives of the local government, representatives of the justice system and the police, and the managers of housing, healthcare and social benefit services. A program manager coordinates the implementation of the project and reports regularly to the working group. A 'veldtafel', consisting of local service providers, has regular meetings to monitor the progress of individual clients and to refer them to the appropriate services. A 'chain unit', consisting of the police and representatives from the justice department, monitors the clients within the judicial system.<sup>418</sup>*

**Figure 13: Social Support Strategy structural arrangements**<sup>419</sup>



<sup>416</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>417</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>418</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>419</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))



In 2009, MOJ announced the closure of eight prisons due to a significant drop in crime.<sup>420</sup> That same year, several significant reports were published. The report of the Van Donk Committee, *No Doors but Deeds*, concluded that the main objectives of the Dutch drug policy had been achieved, that significant health and social harms had been reduced, and that coffeeshops had played an important role in keeping drug markets segregated.<sup>421</sup> The report also underlined that coffeeshops had not contributed to problematic cannabis use, and that operational criteria had been effective mechanisms to control nuisance.<sup>422</sup>

The Trimbos Institute published its *Evaluation of the Dutch Drug Policy*, commissioned jointly by MOH, MOJ and the Ministry of Internal Affairs, concluding that implementation of the Dutch drug control policy had generated reasonably positive results, even by today's standards, leading to positive health impact, increasing demand for treatment, and leading to more effective drug policing.<sup>423</sup> Challenges were identified, for example, where the policy was not able to prevent an increase in drug use between the late 1980s and the mid-1990s, particularly among minors.<sup>424</sup>

The National Institute for Public Health published a risk assessment report called *A Ranking of Drugs*, assessing the toxicity, the potential for development of dependence, and the harmful individual and social effects associated with use of 19 substances, including alcohol and tobacco.<sup>425</sup> The report concluded that alcohol and tobacco were more harmful than most illicit drugs, except crack and heroin, all of which scored high on the total harm index; comparatively, cannabis and ecstasy use were moderately harmful to the individual user, whereas magic mushrooms, LSD and khat scored relatively low.<sup>426</sup>

In 2011, the Garretsen Committee produced a report that recommended that no modification be made to the two-category classification of illicit drugs, and that cannabis products be re-scheduled based on THC content.<sup>427</sup> That same year, the government officially amended the *Opium Act* to reflect the recommendations of the Garretsen committee, setting the THC threshold at 15%, above which

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<sup>420</sup> Hope, A. 26 May 2009. "Belgian Prisoners to move to Dutch Jail," in *Flanders Today*, online at: <http://www.flandertoday.eu/current-affairs/belgian-prisoners-move-dutch-jail>.

<sup>421</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>422</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>423</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>424</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>425</sup> van Amsterdam, J. G. C. 2009. *Ranking of drugs: A comparison of the harmful effects of drugs*. (<http://www.rivm.nl/bibliotheek/rapporten/340001001.pdf>)

<sup>426</sup> van Amsterdam, J. G. C. 2009. *Ranking of drugs: A comparison of the harmful effects of drugs*. (<http://www.rivm.nl/bibliotheek/rapporten/340001001.pdf>)

<sup>427</sup> Koopmans, F. "Going Dutch: Recent drug policy developments in the Netherlands" in *Journal of Global Drug Policy and Practice*. ([http://www.academia.edu/3655120/Going\\_Dutch\\_Recent\\_drug\\_policy\\_developments\\_in\\_the\\_Netherlands](http://www.academia.edu/3655120/Going_Dutch_Recent_drug_policy_developments_in_the_Netherlands))

cannabis products would be considered Schedule I offences.<sup>428</sup> That year, the number of coffeeshops had further declined to 651.<sup>429</sup>

In 2012, new criteria for the management of coffeeshops were piloted in three provinces, requiring that coffeeshops be small and closed establishments thereby restricting the number of registered members, and be accessible only to residents through an official registration card or “weed pass.”<sup>430</sup> The results were less than positive: nuisance increased, local residents stopped going and refused to register fearing for their privacy, more people procured drugs from the black market, communities reported feeling insecure, and the public, the police and the media vocally opposed such a measure.<sup>431</sup> The weed pass criteria were abolished when a new social democratic government took power in 2012, but those criteria remain codified in law today.<sup>432</sup> Only 15% of municipalities with a coffeeshop (representing approximately one third of all municipalities)<sup>433</sup> have enforced the resident criteria.<sup>434</sup> By 2013, a total of 613 coffee shops were operating in the Netherlands.<sup>435</sup>

In 2015, the *Opium Act* was amended to increase prohibition for activities related to the preparation or facilitation of the illegal cultivation and trafficking of cannabis.<sup>436</sup> While several attempts were made to resolve the “backdoor” problem, where coffeeshops have been dependent on the black market for the procurement of supplies of cannabis products for licit sales, through proposals for a regulated market all the way to full-blown legalization, none of those have been approved by the national government. In recent years, 25 municipalities applied to MOJ for permission to experiment with various forms of authorized cannabis production and wholesale supply.<sup>437</sup> In February 2017, the Dutch parliament formally approved legal cultivation of cannabis thereby allowing coffeeshop owners to procure cannabis from licensed growers who will operate in a closed system.<sup>438</sup>

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<sup>428</sup> Koopmans, F. “Going Dutch: Recent drug policy developments in the Netherlands” in *Journal of Global Drug Policy and Practice*. ([http://www.academia.edu/3655120/Going\\_Dutch\\_Recent\\_drug\\_policy\\_developments\\_in\\_the\\_Netherlands](http://www.academia.edu/3655120/Going_Dutch_Recent_drug_policy_developments_in_the_Netherlands))

<sup>429</sup> Rolles, S. 2014. *Cannabis policy in the Netherlands: Moving forwards not backwards*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>)

<sup>430</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>431</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>432</sup> Rolles, S. 2014. *Cannabis policy in the Netherlands: Moving forwards not backwards*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>)

<sup>433</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Models for the legal supply of cannabis: recent developments*. (<http://www.emcdda.europa.eu/publications/pods/legal-supply-of-cannabis>)

<sup>434</sup> Rolles, S. 2014. *Cannabis policy in the Netherlands: Moving forwards not backwards*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>)

<sup>435</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Models for the legal supply of cannabis: recent developments*. (<http://www.emcdda.europa.eu/publications/pods/legal-supply-of-cannabis>)

<sup>436</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Models for the legal supply of cannabis: recent developments*. (<http://www.emcdda.europa.eu/publications/pods/legal-supply-of-cannabis>)

<sup>437</sup> Rolles, S. 2014. *Cannabis policy in the Netherlands: Moving forwards not backwards*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>)

<sup>438</sup> Hardy, C. 21 February 2017. “Dutch vote to legalise marijuana production” in *EuroNews*, online at: <http://www.euronews.com/2017/02/21/dutch-vote-to-legalise-marijuana-production>.

In 2016, the government announced that an additional five prisons were to be closed due to low crime rates and too many empty cells,<sup>439</sup> adding to the 19 prisons that had been scheduled to close since 2013.<sup>440</sup> At the 2016 UNGASS on the World Drug Problem, the Dutch representative highlighted the need for evidence-based prevention programs, for client-centered drug dependence treatment services, for integrated low-threshold harm reduction services, and for focused law enforcement targeting organized crime instead of PWUD.<sup>441</sup> The Dutch representative also underlined the Netherlands' opposition to the use of the death penalty in all circumstances and without exception.<sup>442</sup>

### Implementation of the national drug control strategy

The Netherlands' drug control policies have been loosely aligned with the Swiss *Four Pillars* model since 1995, as noted above, which has included prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues. This sub-section will review the range of strategies and activities implemented in the Netherlands under each pillar, as well as their impact.

#### *Prevention*

Health promotion has remained an important aspect of the prevention strategy. Interventions implemented under the prevention pillar have focused on high-risk groups and young people, as well as on activities in recreational settings, especially for those addressing illicit and licit drug use. The policy now emphasizes implementation rather than research and communication. Prevention activities have been funded mainly by the Ministry of Health, Welfare and Sport. Local municipalities have been responsible for implementation of prevention interventions in close collaboration with schools, municipal care services, neighborhood centers, national health promoting institutes, and other agencies reaching individuals exposed to the greatest risks as well as young people.<sup>443</sup> A national database of prevention projects has been setup and is currently being managed by the Centre for Healthy Living of the National Institute of Public Health and the Environment.

Universal prevention interventions have been implemented in schools through the Healthy School and Drugs program, which is the oldest school-based prevention program in the Netherlands, started in the early 1990s. Under this program, several lectures are delivered in secondary schools on alcohol, tobacco and cannabis; e-learning modules for lower vocational education and on driving under the influence are available; and capacity building sessions for teachers are implemented to facilitate the early identification of drug use among students. A

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<sup>439</sup> 21 March 2016. "Five prisons to close as falling crime rate leaves cells empty" in *DutchNews.nl*.

(<http://www.dutchnews.nl/news/archives/2016/03/more-prisons-to-close-as-falling-crime-leaves-cells-empty/>)

<sup>440</sup> Barlow, E. 12 May 2014. "Why Netherlands' Prisons Are Closing" in *Before it's News*.

(<http://beforeitsnews.com/alternative/2014/05/why-netherlands-prisons-are-closing-2955372.html>)

<sup>441</sup> van Rijn, M. 20 April 2016. *Statement by H. E. Martin van Rijn, Minister of Health, Welfare and Sport of the Kingdom of the Netherlands at the Special Session of the United Nations General Assembly on the World Drug Problem*.

(<http://statements.unmeetings.org/media/27657399/netherlands.pdf>)

<sup>442</sup> van Rijn, M. 20 April 2016. *Statement by H. E. Martin van Rijn, Minister of Health, Welfare and Sport of the Kingdom of the Netherlands at the Special Session of the United Nations General Assembly on the World Drug Problem*.

(<http://statements.unmeetings.org/media/27657399/netherlands.pdf>)

<sup>443</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

2014 evaluation of the program showed that interventions had been ineffective in preventing onset of alcohol, tobacco and cannabis use, so it was discontinued from primary schools; the secondary school program was significantly revised to focus on skills and competency-based approaches to deliver more intensive, targeted interventions focused on social norms, self-regulation and impulse control, as well as professional training for educational staff.<sup>444</sup> Outside school settings, the Alcohol and Drug Prevention at Clubs and Pubs project has promoted a healthy and safe nightlife environment by focusing on reducing the high-risk use of substances and its related problems among young people. Electronic media and new applications have been increasingly used to provide information and counseling on drug-related issues, for example the Drugs Information Line setup in 1996.<sup>445</sup> However, the 2009 evaluation of the Dutch drug policy concluded that universal prevention interventions have at best a minor impact on attitudes to drugs, and have no or only short-lived impact on consumption; even a counterproductive effect has been identified.<sup>446</sup> In contrast, evidence-based knowledge about drugs has been found to have a positive effect on attitudes and behaviors.<sup>447</sup>

Selective prevention interventions, mostly carried out by CSO in collaboration with government agencies, have become increasingly important in the Netherlands over time. Specifically targeted at children whose parents use drugs as well as homeless youths from socio-economically deprived neighborhoods, young people in special institutional settings, as well as those engaged in recreational activities, interventions have focused on the implementation of safe clubbing regulations, person-to-person interventions, and the testing of substances at specialized care facilities.<sup>448</sup> Selective prevention interventions have most intensively focused on substance abuse in the family as well as on pupils with social and/or academic problems.<sup>449</sup>

In terms of indicated prevention, interventions focusing on early identification of substance use or dependence have been increasingly implemented. However, school-based indicated prevention has remained limited.<sup>450</sup>

### *Harm reduction*

Interventions implemented under the harm reduction pillar of the Dutch drug control strategy have been designed to improve the health and social functioning of PWUD by focusing on reducing harms to the individual and to society. The main objective has been to prevent drug use and to limit the risks to users, the

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<sup>444</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

<sup>445</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>446</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>447</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>448</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

<sup>449</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Prevention Profile*, online at: <http://www.emcdda.europa.eu/countries/prevention-profiles/netherlands>.

<sup>450</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Prevention Profile*, online at: <http://www.emcdda.europa.eu/countries/prevention-profiles/netherlands>

immediate environment and society as a whole.<sup>451</sup> In practice, the realization of this objective has implied that public health considerations have been prioritized, where facilitated access to health and social care services among hard-to-reach and hidden populations has taken precedence over punishing offenders.<sup>452</sup>

Harm reduction in the Netherlands was introduced first in practice and later codified into law. For example, the first HAT pilot was initiated in 1998; however, laws regulating such programs were only formalized in 2006. Even the famous Dutch coffeeshops started their operations in 1972 prior to being formally approved by law in the 1990s. The first methadone substitution program was initiated in 1968, the first drug consumption room was opened in 1974, and a CSO operated by recovering users initiated distribution of sterile injecting equipment in 1981.

While the number of problematic drug users has increased slightly over time – from an estimated 25,000 in 1985 to 33,500 in 2005<sup>453</sup> – the number of PWID has dropped significantly: from between 7,500 to 10,000 PWID in 1985, to an estimated 3,350 in 2005,<sup>454</sup> down to 3,115 for the period until 2012,<sup>455</sup> and further down to 2,390 which remains today's estimate.<sup>456</sup> Among problematic drug users, the proportion of injectors has dropped, from 30% to 40% in 2005 to 4% today.<sup>457</sup> *Table 6* below provides an overview of the number of problematic users associated with different substances.

*Table 6: Number of problem drug users, 2008/09* <sup>458</sup>

Substance	Cannabis	Cocaine	Crack	Heroin	Amphetamine
Number of problem drug users	70,000	30,000	15,400	17,700	6,000

<sup>451</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>452</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>453</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>454</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>455</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>456</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>457</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>458</sup> Grund, J.-P. and Breeksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)



Substance	Tobacco	Alcohol	Gambling	Internet	Other
Number of problem drug users	810,000	477,000	40,000	20,000	1,800

The major service delivery components of the Dutch harm reduction strategy are aligned with UNAIDS, UNODC and WHO recommendations,<sup>459</sup> and include needle and syringe distribution, OST, HAT and drug consumption rooms. A significant proportion of harm reduction services have been delivered through outreach, based out of low-threshold facilities such as DIC. Such facilities have offered daytime shelter, 'living room' projects and safe supervised spaces to use drugs whereas outreach interventions, often delivered by peers, include prevention, education and information, counseling, distribution of commodities, as well as interventions to reduce drug-related public nuisance.

The distribution of sterile injecting equipment to PWID was initiated more than two decades ago by the Rotterdam Junkie Union. By 2012, an estimated 150 sites were distributing needles and syringes across the Netherlands,<sup>460</sup> up to an estimated 175 in the period 2014-2016.<sup>461</sup> In addition to DIC and outreach-based distribution, pharmacies, to a lesser extent, also contributed to meeting the needs of PWID with targeted distribution of commodities.<sup>462</sup> Reports have shown that the number of needles and syringes distributed has been dropping over time, which has been attributed to a shrinking PWID population and decreasing popularity of injecting.<sup>463</sup>

Methadone has been the most common substitute in the context of OST, with an estimated 8,185 clients enrolled in 2013.<sup>464</sup> While buprenorphine was introduced in 1999, the number of people receiving this substitute is not available.<sup>465</sup> Methadone has been available through various outpatient treatment providers and other low-threshold services, including needle syringe distribution sites, office-based medical practitioners, and mobile units.<sup>466</sup> The average prescribed methadone dose was increased after Dutch research showed

<sup>459</sup> World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. (<http://www.who.int/hiv/pub/guidelines/keypopulations/en/>); Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime, and World Health Organization. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. ([http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf))

<sup>460</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>461</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>462</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Harm Reduction Profile*, online at: <http://www.emcdda.europa.eu/country-data/harm-reduction/Netherlands>.

<sup>463</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Harm Reduction Profile*, online at: <http://www.emcdda.europa.eu/country-data/harm-reduction/Netherlands>.

<sup>464</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Drug Treatment Overview for the Netherlands*, online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>465</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Drug Treatment Overview for the Netherlands*, online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>466</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Drug Treatment Overview for the Netherlands*, online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.



that a higher dose achieved a greater effect.<sup>467</sup> By 2000, 44% of Dutch heroin users were enrolled in OST programs, making the Netherlands the country in Europe with the highest OST coverage.<sup>468</sup> Most OST programs have not required abstinence, urine controls, or impose sanctions on clients for using illicit drugs.<sup>469</sup> As noted above, OST with heroin, or HAT was piloted in 1998 and formally approved in 2006. In mid-2007, approximately 400 people were enrolled in HAT across nine cities;<sup>470</sup> in 2012, 740 treatment places were available across 18 facilities in 16 municipalities across the Netherlands.<sup>471</sup>

The origins of the Dutch drug consumption rooms have their root in the 1980s when heroin dealers moved into apartments where people could consume illicit drugs in relative safety. Formalized within a public health approach, the Dutch drug consumption rooms have become safe spaces where people can use drugs in a hygienic environment. In 2010, a total of 37 drug consumption rooms were operating across the Netherlands, down to 30 in 2013,<sup>472</sup> and slightly up to 31 facilities in 25 municipalities in 2016.<sup>473</sup>

The impact of the Dutch harm reduction interventions can be observed by using HIV, viral hepatitis and overdoses as indicators. HIV prevalence amongst PWID has been decreasing for decades, from 30% in 1984, down to 26% in the 1990s,<sup>474</sup> down to 9.5% in 2008,<sup>475</sup> further down to between zero and 3.3% in 2014,<sup>476</sup> and finally reaching zero in 2016.<sup>477</sup> Against a general population prevalence estimate of 0.2%,<sup>478</sup> the steady reduction of HIV transmission amongst PWID is a remarkable achievement by any measure. In 2008, an estimated 4% of new HIV cases were detected amongst PWID compared to zero in 2015.<sup>479</sup> In contrast, HCV prevalence among Dutch PWID has remained high

<sup>467</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*.

(<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>468</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>469</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>470</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

<sup>471</sup> Van Laar, M. W., et al. 2013. *The Netherlands drug situation 2012: report to the EMCDDA by the Reitox National Focal Point*. Trimbos Instituut/WODC.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_213776\\_EN\\_2012%20Netherlands%20National%20report%20full.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_213776_EN_2012%20Netherlands%20National%20report%20full.pdf))

<sup>472</sup> Woods, S. 2014. *Drug Consumption Rooms in Europe – Organizational Overview*. European Harm Reduction Network.

([http://www.eurohrn.eu/images/stories/pdf/publications/dcr\\_in\\_europe.pdf](http://www.eurohrn.eu/images/stories/pdf/publications/dcr_in_europe.pdf))

<sup>473</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Perspectives on Drugs: Drug consumption rooms: an overview of provision and evidence*.

([http://www.emcdda.europa.eu/system/files/publications/2734/Drug%20consumption%20rooms\\_update%202016.pdf](http://www.emcdda.europa.eu/system/files/publications/2734/Drug%20consumption%20rooms_update%202016.pdf))

<sup>474</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>475</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>476</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>477</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>478</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>479</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

and seems to be on the rise: from 64.6% in 2008,<sup>480</sup> to 86.2% in 2014,<sup>481</sup> down to 66.7% in 2016.<sup>482</sup> However, HBV prevalence has dropped from an estimated 65% in the 1980s,<sup>483</sup> down to 3% in 2014,<sup>484</sup> and zero in 2016.<sup>485</sup>

In terms of drug-related deaths, there has been significant variation, but the overall number of drug-related fatalities has remained low. *Table 27* below shows that a low of 70 fatal overdoses were recorded in 1995 compared to a high of 144 in 2001 and 2013.

*Table 27: Number of drug-related deaths, 1995-2014*<sup>486</sup>

Year	1995	1996	1997	1998	1999
Number of drug-related deaths	70	108	108	110	115
Year	2000	2001	2002	2003	2004
Number of drug-related deaths	131	144	103	104	127
Year	2005	2006	2007	2008	2009
Number of drug-related deaths	122	112	99	129	139
Year	2010	2011	2012	2013	2014
Number of drug-related deaths	94	103	118	144	123

### *Treatment*

Interventions implemented under the treatment pillar of the Dutch drug control strategy have offered abstinence-based treatment options (“cure”) as well as options aimed at stabilizing clients (“care”), while policy emphasis has been placed on care, given that sustainable abstinence is not considered a realistic policy goal.<sup>487</sup> Overall responsibility for organization, implementation and coordination of drug treatment has been integrated in the mental health care system and structures under supervision of regional and local authorities: seven of 13 regular drug dependence treatment facilities have merged with a mental

<sup>480</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>481</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>482</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>483</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>484</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>485</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>486</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

<sup>487</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*. (<https://www.wodc.nl/onderzoeksdatabank/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

health institute and another with a social support facility. Municipal public health services, general psychiatric hospitals, several religious organizations and 10 private clinics also offer treatment and support services to PWUD.<sup>488</sup>

Recent economic constraints have forced mergers across the public health sector, significantly reducing the number of service providers as well as the number of beds for residential treatment; since 2012, efforts have been made to scale-up access to outpatient services through general practitioners and e-health interventions, reinforcing client self-regulation and empowering clients at the same time.<sup>489</sup> For example, the number of inpatient drug treatment clients with a primary opiate problem declined from 18,000 in 2001, to 14,000 in 2004, and to 12,700 in 2008.<sup>490</sup> *Table 28* below provides an overview of the proportion of problem drug users who were in treatment in 2007/08. The table shows that a significant proportion of opiate users have been covered by drug treatment services, including OST. *Figure 14* also shows that there has been an increase over time in the number of problem cannabis users enrolling in treatment.

*Table 28: Number of problem user and proportion in treatment in 2007/08*<sup>491</sup>

Substance	Number of problem drug users	Number of problem drug users in treatment	Proportion in treatment
Cannabis	70,000	10,971	15.7%
Cocaine	30,000	4,246	14.2%
Crack	15,400	5,190	33.7%
Heroin	17,700	12,313	69.6%
Amphetamine	6,000	1,504	25.1%
Tobacco	810,000	251	0.0%
Alcohol	477,000	36,203	7.6%
Gambling	40,000	2,673	6.7%
Internet	20,000	182	0.9%
Other	1,800	678	37.7%

*Figure 14: Trends in new cannabis treatment admissions, 1998-2007*<sup>492</sup>

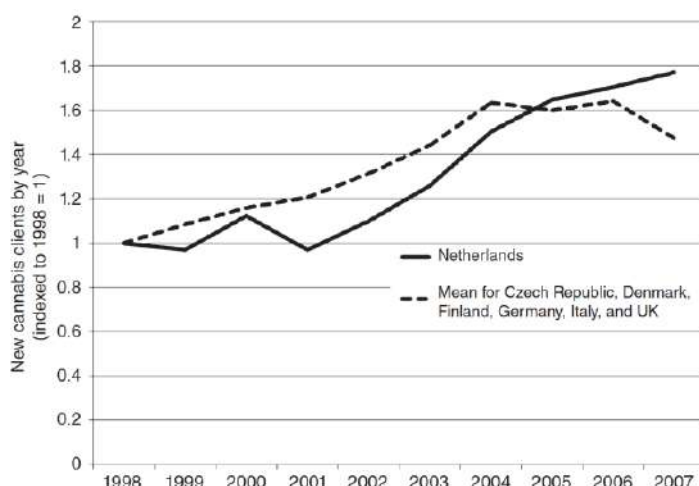
<sup>488</sup> European Monitoring Centre for Drugs and Drug Addiction. 2015. *Drug treatment overview for the Netherlands*. Online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>489</sup> European Monitoring Centre for Drugs and Drug Addiction. 2015. *Drug treatment overview for the Netherlands*. Online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>490</sup> Koopmans, F. "Going Dutch: Recent drug policy developments in the Netherlands" in *Journal of Global Drug Policy and Practice*. ([http://www.academia.edu/3655120/Going\\_Dutch\\_Recent\\_drug\\_policy\\_developments\\_in\\_the\\_Netherlands](http://www.academia.edu/3655120/Going_Dutch_Recent_drug_policy_developments_in_the_Netherlands))

<sup>491</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>492</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)



The options for drug treatment interventions in the Netherlands have been diverse. Outpatient OST has been the most common form of treatment for opiate users. Psychosocial interventions have been more frequently provided to complement OST, facilitating longer-term effectiveness, reducing relapses and promoting social reintegration. The psychosocial treatments that have frequently been used in drug treatment centers include motivational interviewing, relapse prevention techniques, cognitive behavioral therapies, and family, as well as community- and home-based treatment therapies. New treatment options have been introduced for young cannabis users, people with multiple (addiction and mental health) problems, and crack and GHB users.

Funding for drug dependence treatment has been sourced from the national health insurance purse while local and national social support budgets have funded special projects like HAT.<sup>493</sup> The Council for Care Insurance and the National Health Care Institute are currently responsible for assessing drug dependence treatment insurance claims against specific criteria.<sup>494</sup>

### *Law enforcement*

Law enforcement related activities fall under the fourth pillar of the Dutch drug control policy. Implementing those activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. In the context of drug control, the overall goal of the law enforcement pillar has been to maintain public order, focusing on reducing nuisance, and fighting drug-related crime, and on combating organized crime.<sup>495</sup>

Law enforcement and criminal justice responses in regards to drug-related issues have represented a last recourse, based on the principle of *ultimum remedium*, where such interventions are implemented only when all other

<sup>493</sup> European Monitoring Centre for Drugs and Drug Addiction. 2015. *Drug treatment overview for the Netherlands*. Online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>494</sup> European Monitoring Centre for Drugs and Drug Addiction. 2015. *Drug treatment overview for the Netherlands*. Online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>495</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

recourses have been tried without success.<sup>496</sup> In that respect, Dutch police officers have long enjoyed some measure of discretion in arresting individuals found in possession of small quantities of illicit drugs.<sup>497</sup> Indeed, police generally release first-time suspects in cases involving minor offences, although a note in the suspect's records is made, as provided by official *Enforcement Guidelines*.<sup>498</sup>

There was limited information about police contact with PWUD; however, comprehensive data on the total number of drug-related infractions between 1998 and 2014 is available (see *Table 29*). The pattern that emerges from the data is peculiar: from a low of 11,513 drug-related offences in 2000, up to a peak of 22,304 in 2004, down to a low of 14,905 in 2010, and up to another peak of 21,387 in 2014. In comparison, *Table 30* shows the evolution of all crime reported by the police against the total number of drug trafficking crime reported by the police. Data from 2007 has shown that 58% of drug offenders intercepted by police were repeat offenders, and 16% have more than 10 offences in their criminal records.<sup>499</sup>

***Table 29: Number of drug law offences per year, 1995-2014*** <sup>500</sup>

Year	1995	1996	1997	1998	1999
Number of registered drug offences	3,470 <sup>501</sup>	6,600 <sup>502</sup>	N/A	12,616	11,675
Year	2000	2001	2002	2003	2004
Number of registered drug offences	11,513	13,558	15,848	17,087	22,304
Year	2005	2006	2007	2008	2009
Number of registered drug offences	20,160	20,306	19,399	18,862	17,076
Year	2010	2011	2012	2013	2014
Number of registered drug offences	14,905	17,420	18,200	17,130	21,387

***Table 30: Drug trafficking versus total crime in Germany, 2002-2012*** <sup>503</sup>

Year	Total number of crimes recorded by police	Number of drug trafficking crimes recorded by police	Proportion of drug trafficking versus total crime
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<sup>496</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>497</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>498</sup> Winslow, R. 2015. "Netherlands" in *Crime and Society: A Comparative Criminology Tour of the World*, online at <http://www-rohan.sdsu.edu/faculty/rwinslow/>.

<sup>499</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>500</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

<sup>501</sup> Winslow, R. 2015. "Netherlands" in *Crime and Society: A Comparative Criminology Tour of the World*, online at <http://www-rohan.sdsu.edu/faculty/rwinslow/>.

<sup>502</sup> Winslow, R. 2015. "Netherlands" in *Crime and Society: A Comparative Criminology Tour of the World*, online at <http://www-rohan.sdsu.edu/faculty/rwinslow/>.

<sup>503</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).

<b>2002</b>	1,401,900	12,752	0.91%
<b>2003</b>	1,369,300	15,633	1.14%
<b>2004</b>	1,319,500	15,662	1.19%
<b>2005</b>	1,348,300	19,285	1.43%
<b>2006</b>	1,311,800	20,035	1.53%
<b>2007</b>	1,303,800	19,560	1.50%
<b>2008</b>	1,277,800	18,875	1.48%
<b>2009</b>	1,254,500	18,580	1.48%
<b>2010</b>	1,194,000	17,325	1.45%
<b>2011</b>	1,194,100	16,780	1.41%
<b>2012</b>	1,139,700	17,750	1.56%

Seizures of illicit drugs have generally been unreliable indicators of drug policy impact. However, evidence shows that in 2012, approximately 2,200 kilos of cannabis resin, 12,600 kilos of herbal cannabis, 1.4 million cannabis plants, 750 kilos of heroin, 10 tons of cocaine, more than 2.4 million ecstasy tablets, 680 kilos of amphetamines, and 0.5 kilos of crystal methamphetamine were seized in the Netherlands.<sup>504</sup>

More telling is the number of production sites that have been dismantled. Across the 26 methamphetamine laboratories dismantled in 2008 in the EU, three were in the Netherlands,<sup>505</sup> compared to 15 out of 39 amphetamine laboratories that same year.<sup>506</sup> In 2013 and 2014, more than 50 synthetic drug production locations were dismantled, compared to 42 dismantled in 2012, and 30 in 2011.<sup>507</sup> These numbers could indicate a trend of increasing production of ATS in the Netherlands over the past decade. The Netherlands is the third most important country in the EU in terms of quantities of amphetamines seized (see *Figure 15* below).

*Figure 15: Largest quantities of illicit amphetamine products seized in the EU, Norway and Turkey, cumulative total, 2005–2009 (tons)*<sup>508</sup>

<sup>504</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

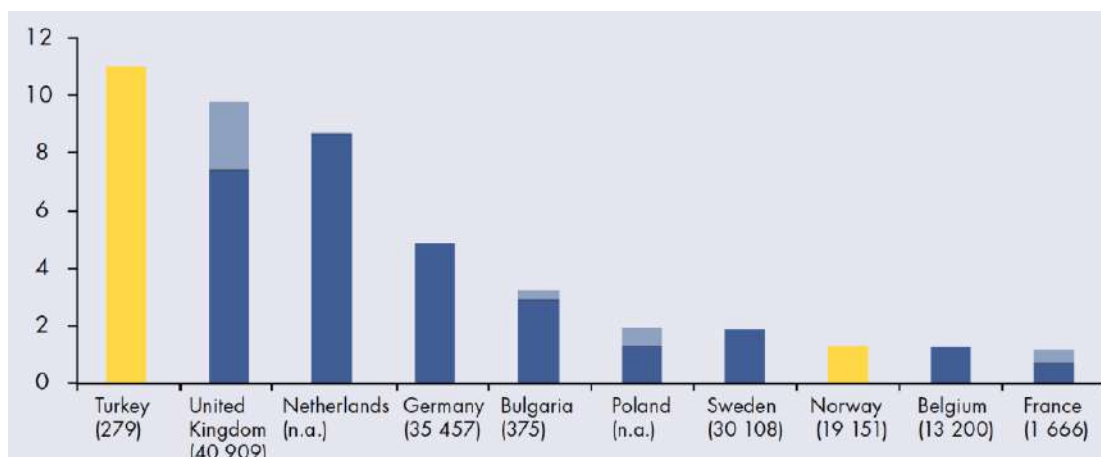
<sup>505</sup> European Monitoring Centre for Drugs and Drug Addiction. 2009. *Methamphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine\\_final\\_163584.pdf](http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine_final_163584.pdf))

<sup>506</sup> European Monitoring Centre for Drugs and Drug Addiction. 2010. *Selected Issues: Problem amphetamine and methamphetamine use in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA\\_SI10\\_Amphetamines\\_242746.pdf](http://www.emcdda.europa.eu/system/files/publications/578/EMCDDA_SI10_Amphetamines_242746.pdf))

<sup>507</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *The Netherlands Country Overview*, online at: <http://www.emcdda.europa.eu/countries/netherlands#prevention>.

<sup>508</sup> European Monitoring Centre for Drugs and Drug Addiction. 2011. *Amphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol\\_Amphetamine-joint-publication\\_319089.pdf](http://www.emcdda.europa.eu/system/files/publications/621/EMCDDA-Europol_Amphetamine-joint-publication_319089.pdf))





The volume of cases brought to the Prosecutor's attention, and in turn the number of drug-related cases brought before the courts have been increasing for some time, according to reports.<sup>509</sup> In 2007, the Public Prosecutor's office reviewed 18,723 drug-related cases, of which 66% were taken forward to a court of justice, 21% received a fine, 5% were dismissed for policy reasons, and 5% were dismissed for technical reasons.<sup>510</sup> In 2004, approximately 40% of drug-related cases were related to soft drugs and primarily to cannabis.<sup>511</sup>

According to the expediency principle, Dutch prosecutors are encouraged to dismiss charges for possession of small quantities of illicit drugs on their own, without approval from the court, particularly in regards to cannabis.<sup>512</sup> This prosecutorial discretion, in combination with quantity thresholds, and the Prosecutor's office *Enforcement Guidelines*, as described earlier, have helped police officers focus their efforts on combating production and trafficking crimes, and reduced the volume of cases in the criminal justice system.

Prosecutorial discretion has allowed for 'transactions,' 'penal orders,' and 'task penalties' which have been imposed directly by the Prosecutor when the maximum potential time and/or financial value of the penalty are below certain thresholds. In 2004, a third of all cases brought to the attention of the Prosecutor's office were resolved through a transaction.<sup>513</sup> Penal orders may lead to a fine, community service, compensation, driving restrictions, mediation, forfeiture, or confiscation of assets.<sup>514</sup>

<sup>509</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*.

(<https://www.wodc.nl/onderzoeksdatabank/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>510</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>511</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>512</sup> Korf, D. 2008. "An open front door: the coffee shop phenomenon in the Netherlands" in Sznitman, S., Olsson, B. and Room, R. *EMCDDA Monographs: A cannabis reader: Global issues and local experiences. Perspectives on cannabis controversies, treatment and regulation in Europe*. EMCDDA. (<http://www.emcdda.europa.eu/publications/monographs/cannabis>)

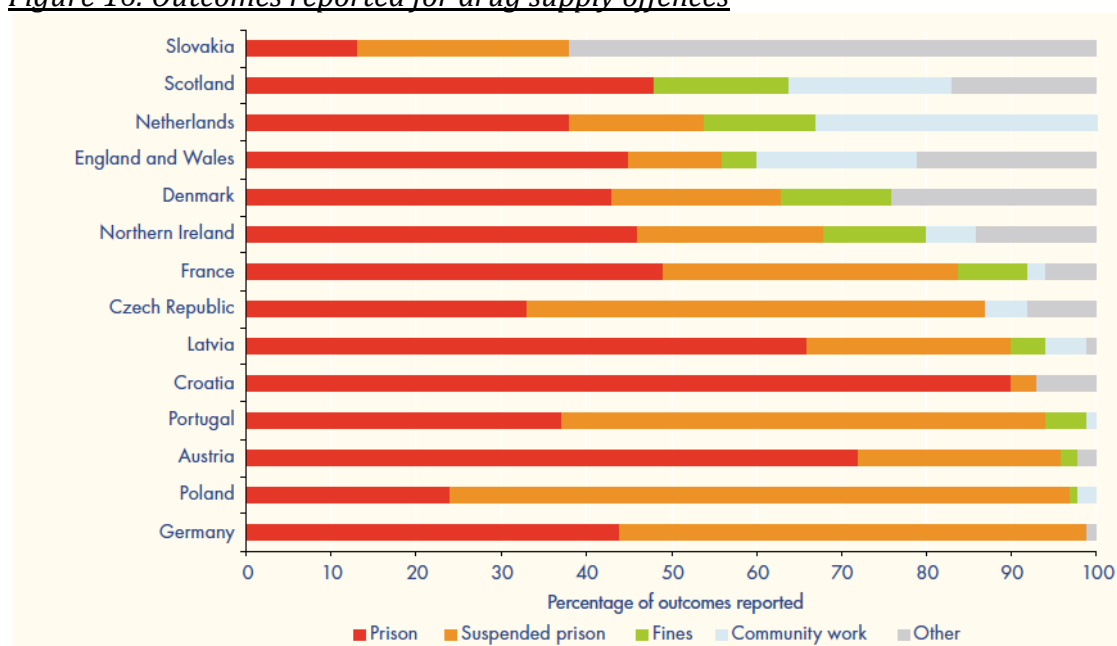
<sup>513</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>514</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

In 2007, out of the 18,723 drug-related cases reported that year, the combined decisions of the Public Prosecutor and the courts produced 1,412 fines and transactions for possession, 952 community service orders for possession, 322 suspended prison sentences for possession, and 704 immediate prison sentences for possession; in addition to 1,170 fines and transactions for dealing, 3,643 community service orders for dealing, 1,443 suspended prison sentences for dealing, 3,460 immediate prison sentences for dealing.<sup>515</sup> A total of 12,343 drug-related cases were brought to court.<sup>516</sup>

Possession offences generally lead to the imposition of a fine, either directly by the prosecutor, or following an appearance in court; the Netherlands is one of six EU countries most likely to issue a fine for such offences.<sup>517</sup> The median size of prosecutorial fines was EUR 250, compared to EUR400 for court fines.<sup>518</sup> Offenders sentenced to community service were sentenced for a mean duration of 106 days, compared to a mean prison sentence of 321 days.<sup>519</sup> The Netherlands was one of two countries to sentence more than 10% of drug supply offenders to community work.<sup>520</sup> Figure 16 below summarizes sentencing outcomes for supply related offences in Europe.

*Figure 16: Outcomes reported for drug supply offences*<sup>521</sup>



<sup>515</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>516</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>517</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>518</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>519</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>520</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>521</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes.* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

In special cases and under specific conditions, prosecutors and courts have also been empowered to compel individuals to undergo compulsory treatment since 2004. In such cases, the emphasis has been even more focused on a client-centered approach, instead of a case-oriented approach; in practice, this has implied that problem drug users can be detained for longer periods, screened more systematically, and targeted for behavioral interventions.<sup>522</sup>

Offenders compelled to undergo treatment must have been in contact with the police at least ten times, or have been sentenced at least three times in the last five years; problematic drug users with a long judicial history can also be sentenced to coercive drug withdrawal; after a six-month period, individuals may be allowed to continue treatment in another program, although failure to complete the program may lead to further detention.<sup>523</sup> Approximately 10% of admissions into treatment have been facilitated through the criminal justice system;<sup>524</sup> given low numbers combined with the host and complexity of reported issues exhibited by the individuals referred to compulsory treatment through the criminal justice system, the demands on health personnel have often exceeded institutional capacity and resources.<sup>525</sup>

In 2012, over 90% of prison sentences for all crimes were for a median duration of 12 months or less;<sup>526</sup> the average duration of prison sentences relating to drug offences was estimated at around 11 months.<sup>527</sup> Hard drug offenders have generally received longer prison sentences compared to soft drug offenders: out of all prison sentences, 14% related to hard drugs compared to 2% to soft drugs.<sup>528</sup> In 2004, prison sentences relating to soft drugs accounted for 2% of all incarceration-years imposed that year.<sup>529</sup>

In 2014, a total of 11,603 prisoners were being detained across the Netherlands' 77 prisons and closed detention centers, representing a total occupancy rate of 77%.<sup>530</sup> *Table 31* below provides an overview of the evolution of the total prison population and the population prison rate between 2000 and 2014. The overall rise-and-fall in the prison population and the prison population rate can be attributed to the position on drug issues of the governments in power at the time, but also reflect a decreasing crime rate, illustrated by sustained efforts to

<sup>522</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*.

(<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>523</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium.

([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>524</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910.

(<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>525</sup> Ministerie van Justitie. 2009. *Evaluatie van het Nederlandse drugsbeleid*.

(<https://www.wodc.nl/onderzoeksdatabase/evaluatie-drugsbeleid.aspx?cp=44&cs=6796>)

<sup>526</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>527</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*.

([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>528</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>529</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910.

(<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>530</sup> International Center for Prison Studies. 2016. *World Prison Brief – the Netherlands*. Online at: <http://www.prisonstudies.org/country/netherlands>.

close down empty prisons initiated in 2009. Still, an estimated 18.9% of the prison population is made up of PWUD.<sup>531</sup>

Management of the Dutch prison population has been grounded on principles of association, rather than separation, where prisoners are encouraged and provided with the necessary space to enjoy personal privacy, to express their opinions and feelings, and to self-regulate their behavior.<sup>532</sup>

*Table 31: Total prison population and prison population rate 2000-2016* <sup>533</sup>

Year	Total prison population	Prison population rate
2000	13,847	87
2002	16,239	100
2004	20,075	123
2006	20,463	125
2008	16,416	100
2010	15,235	92
2012	13,749	82
2014	11,603	69

### Concluding analysis

The Dutch drug control policy has been documented, reviewed and evaluated several times, with the overwhelming conclusion that the Dutch model has been successful in the Dutch context. In particular, the 2009 evaluation of the Dutch drug control policy led to the conclusion that the Dutch approach had produced significant positive health results, led to increased demand for health among hard-to-reach populations, and contributed to better law enforcement results. These findings were supported by a number of expert committee findings and recommendations produced in the decades leading up to this evaluation. Other reports indicate that the Dutch decriminalization model has not led to significant growth in drug use.

Motivation for policy change in the Netherlands arose from a pragmatic and rational decision to address issues related to possession of small quantities of cannabis and other drugs outside the criminal justice system, given that the potential harm to the individual and society were judged to be low. Tolerance for possession of small quantities of cannabis and other illicit drugs grew out of the principle of segregated markets, where controlled access to cannabis products would reduce contact with (and profits for) those controlling the illicit drug trade. Indeed, only 14% of Dutch cannabis users reported that other drugs are available from their usual cannabis source.<sup>534</sup> Segregation of markets has been the founding principle on which the Dutch decriminalization model has operated.

<sup>531</sup> AlcoholRehab. 2016. *Drugs and Incarceration*, online at: <http://alcoholrehab.com/drug-addiction/drugs-and-incarceration>.

<sup>532</sup> Subramanian, R. and Shames, A. 2013. *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States*. Vera Institute of Justice. (<http://archive.vera.org/sites/default/files/resources/downloads/european-american-prison-report-v3.pdf>)

<sup>533</sup> International Center for Prison Studies. 2016. *World Prison Brief – the Netherlands*. Online at: <http://www.prisonstudies.org/country/netherlands>.

<sup>534</sup> Rolles, S. 2014. *Cannabis policy in the Netherlands: Moving forwards not backwards*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>)

However, the Dutch decriminalization model also includes other tools: both police and prosecutors have enjoyed a significant degree of discretion in arresting and charging drug-offenders, where offenders can be diverted away from the criminal justice system at virtually every step of the process. In addition, thresholds have been in place to guide implementation of drug law enforcement interventions and to assist focus law enforcement intervention on priority issues such as production and trafficking.

Implementation of decriminalization in the Netherlands has generated a relatively unique institution to realize its policy principles relating to the segregation of markets: the coffeeshops. Once unofficially tolerated and now officially regulated, coffeeshops have become the main mechanism through which cannabis users are prevented from establishing contact with the black market. While coffeeshops have been widely advertised in the media across the globe and have been generally recognized as an effective component of the Dutch model, the approach still relies on supply of cannabis from the black market. Meanwhile, controls and criteria to regulate operations of coffeeshops have successfully decreased the number of such facilities, from over 1,500 down to just over 600 today.

Overall, all actors involved in the implementation of the Dutch decriminalization model have been guided by a number of principles. Of course, the segregation of markets has been a core element of the decriminalization model, but more importantly and superseding the value of the segregation of markets has been the principle of evidence-based public health, and by extension of human rights. These have been central elements of Dutch society for decades and are essentially cherished social values.

In addition, the Dutch decriminalization model has been grounded on the principle of *ultimum remedium*, where interventions of the criminal justice system should be a last recourse; on the principle of expediency, granting prosecutors and police the power to dismiss cases against drug offenders; on the principle of proportionality, where punishment should be commensurate with potential harm caused by the offence; and on the principle of association, where rehabilitation and social reintegration of offenders is facilitated through participation rather than confinement.

Significant legal tinkering took place to achieve the current state (see *Box 4* below), and the changing governments led to internal political tensions. Concerns that the Netherlands would become a hub for narcotourism, that cannabis use specifically and drug use in general would increase exponentially, and that decriminalization would tarnish the country's international image and reputation never materialized, yet represented significant hurdles along the way.

**Box 4: Relevant Portuguese legal and policy documents and milestones**

- *Opium Act* (1928)<sup>[1][2][3][4][5][6][7][8][9][10][11][12][13][14][15][16][17][18][19][20][21][22][23][24][25][26][27][28][29][30][31][32][33][34][35][36][37][38][39][40][41][42][43][44][45][46][47][48][49][50][51][52][53][54][55][56][57][58][59][60][61][62][63][64][65][66][67][68][69][70][71][72][73][74][75][76][77][78][79][80][81][82][83][84][85][86][87][88][89][90][91][92][93][94][95][96][97][98][99][100]</sup>
- *Opium Act* revised (1953)
- *Enforcement Guidelines of the Public Prosecutor's office* (1969)<sup>[1][2][3][4][5][6][7][8][9][10][11][12][13][14][15][16][17][18][19][20][21][22][23][24][25][26][27][28][29][30][31][32][33][34][35][36][37][38][39][40][41][42][43][44][45][46][47][48][49][50][51][52][53][54][55][56][57][58][59][60][61][62][63][64][65][66][67][68][69][70][71][72][73][74][75][76][77][78][79][80][81][82][83][84][85][86][87][88][89][90][91][92][93][94][95][96][97][98][99][100]</sup>
- *Opium Act* revised (1976)<sup>[1][2][3][4][5][6][7][8][9][10][11][12][13][14][15][16][17][18][19][20][21][22][23][24][25][26][27][28][29][30][31][32][33][34][35][36][37][38][39][40][41][42][43][44][45][46][47][48][49][50][51][52][53][54][55][56][57][58][59][60][61][62][63][64][65][66][67][68][69][70][71][72][73][74][75][76][77][78][79][80][81][82][83][84][85][86][87][88][89][90][91][92][93][94][95][96][97][98][99][100]</sup>

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Implementation of the Dutch decriminalization model and the national drug control policy has implied significant costs: for example, the budgetary allocation for implementation of the *Social Support Strategy* rose from EUR 61 million in 2006 to EUR 175 million in 2009.<sup>536</sup> In 2003, across all drug-related activities, a total of EUR 2,185 million was spent to implement the national drug policy: approximately EUR 42 million for prevention activities, EUR 220 million for harm reduction interventions, and EUR 278 million for treatment services; an additional EUR 1,646 million went to cover law enforcement and prison-related costs.<sup>537</sup> Other estimates have shown that approximately EUR 9,200 is spent for each problematic user per year in the Netherlands.<sup>538</sup>

Conservative estimates place the tax revenues generated by coffeeshops at around EUR 400 million per year.<sup>539</sup> Together, the Dutch coffeeshops sell between 50 and 150 metric tons of cannabis, generating a value of EUR 300 to 600 million per year.<sup>540</sup> Between four and five million tourists visit Amsterdam's coffeeshops every year, about 10% of who come specifically to visit a coffeeshop, generating additional revenues.<sup>541</sup> Reports have shown that further decriminalization and regulation of the cannabis market could generate additional savings for law enforcement in the order of EUR 160 million and generate an additional EUR 260 million in tax revenue.<sup>542</sup>

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<sup>536</sup> Schatz, E., Schiffer, K. and Kools, J. P. 2011. *The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam*. International Drug Policy Consortium. ([http://www.academia.edu/25833587/The\\_Dutch\\_Treatment\\_and\\_Social\\_Support\\_System\\_for\\_Drug\\_Users\\_Recent\\_Developments\\_and\\_the\\_Example\\_of\\_Amsterdam](http://www.academia.edu/25833587/The_Dutch_Treatment_and_Social_Support_System_for_Drug_Users_Recent_Developments_and_the_Example_of_Amsterdam))

<sup>537</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>538</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>539</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

<sup>540</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>541</sup> MacCoun, R. J. 2011. "What can we learn from the Dutch cannabis coffeeshop system?" in *Addiction*, 106(11): 1899-910. (<https://www.ncbi.nlm.nih.gov/pubmed/21906196>)

<sup>542</sup> Grund, J.-P. and Brecksema, J. 2013. *Coffee Shops and Compromise – Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/coffee-shops-and-compromise-20130713.pdf>)

## Portugal

### Historical overview

Psychoactive substances were introduced into Portugal during the 1960s through growing counterculture movements, although drug use remained relatively restricted to small pockets of artists.<sup>543</sup> In 1970, the Portuguese government introduced for the first time penal sanctions for the use of specific drugs with *Decree Law no. 420/70*, although drug trafficking was already a criminal offense at that time.<sup>544</sup>

Throughout the 1970s, drugs and drug use became more and more visible, most likely accelerated by the fall of the 48-old Salazar government in 1974.<sup>545</sup> The previously autarkic Portuguese society suddenly opened up to the rest of Europe and the world, but its citizens had little experience or knowledge about drugs. In 1976, the new government passed *Decree Law no. 792/76*; in its preamble, the new legislation invited further consideration for addressing drug use as an administrative rather than a criminal offense. In addition, the preamble recommended that criminal penalties should be replaced with measures that facilitate access to health services, without judgment of guilt.<sup>546</sup>

By the late 1970s, heroin had been introduced in Portugal, and in the early 1980s, reports show that the most commonly used drugs were cannabis and hashish.<sup>547</sup> In 1983, *Decree Law 430/83* was enacted which allowed the suspension of punishment for some drug-related offenses as long as the offender agreed to enter a treatment program. The new legislation was grounded on the principle that all people dependent on drugs were in need of medical support.<sup>548</sup>

In 1987, 20 fatal drug-related overdoses were recorded.<sup>549</sup> By between 1987 and 1989, the national government opened three specialized drug treatment facilities: the Centro das Taipas in Lisbon, as well as two other in Oporto and Faro respectively.<sup>550</sup> However, by the late 1980s and especially in the early 1990s, there was a growing perception that illicit drugs had become a major

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<sup>543</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>544</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>545</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>546</sup> Trigueiros, F., Vitoria, P. and Dias, L. 2011. "Rather treat than punish – The Portuguese decriminalization model" in Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>547</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>548</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>549</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>550</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

obstacle to the prosperity of Portuguese society.<sup>551</sup> A likely trigger for this perception was a surge in the number of open-air drug markets and a rise in public drug use, making the issue increasingly visible to the general population.<sup>552</sup> In the early 1990s, reports showed rapid growth in the Portuguese heroin market and a substantial influx of the drug across the country.<sup>553</sup> For example, Casal Ventoso was coined “the biggest supermarket of drugs in Europe.”<sup>554</sup> Meanwhile, estimates indicated that Portugal was home to approximately 100,000 problem drug users at the time.<sup>555</sup>

In 1990, overall responsibility for drug dependence treatment was moved from MOJ to MOH.<sup>556</sup> In 1992, MOJ’s Drug Fighting Office commissioned a multidisciplinary research project to assess the relationship between drugs and crime. In 1993, *Decree Law no. 15/93* came into force with provisions to increase criminal penalties for trafficking and diversion of controlled medicines, to decrease criminal penalties for drug possession, while sustaining the possibility of suspending sentences in the event the offender enrolled in drug dependence treatment.<sup>557</sup> *Decree Regulation no. 42/93* also allowed the certification and oversight of CSO delivering drug treatment services across the country, and formally allowed needle and syringe distribution as well as OST.<sup>558</sup>

In 1994 and 1995, two new legal provisions were ratified: the *Decree Law no. 43/94* and the *Decree Law no. 67/95* that provided the legal basis for the establishment of the Directorate on Prevention and Treatment of Drugs Addiction (or SPTT) as a national network of drug treatment service providers.<sup>559</sup> In 1996, *Decree Law no. 193/96* was approved, establishing the National Drug Abuse Prevention Program.<sup>560</sup>

The final study commissioned by the Drug Fighting Office in 1992, comprised of 12 reports available only in Portuguese, was released in 1996. It concluded that there was no direct relationship between drugs and crime; that social and economic conditions did not have a consistent and determining effect on the relationship between drugs and crime; that use of certain drugs were more

<sup>551</sup> Domoslawski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>552</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lse.12104/abstract>)

<sup>553</sup> Russoniello, K. “The devil (and drugs) in the details: Portugal’s focus on public health as a model for decriminalization of drugs in Mexico” in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=vjhple>)

<sup>554</sup> O’Brien, K. 16 January 2011. “Drug Experiment: What Happens When an Entire Country Legalizes Drug Use?” in *Boston Globe*. ([http://www.boston.com/bostonglobe/ideas/articles/2011/01/16/drug\\_experiment/](http://www.boston.com/bostonglobe/ideas/articles/2011/01/16/drug_experiment/))

<sup>555</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>556</sup> Trigueiros, F., Vitoria, P. and Dias, L. 2011. “Rather treat than punish – The Portuguese decriminalization model” in Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>557</sup> Russoniello, K. “The devil (and drugs) in the details: Portugal’s focus on public health as a model for decriminalization of drugs in Mexico” in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=vjhple>)

<sup>558</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>559</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>560</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

prevalent among certain socio-economic groups; and that people among certain population segments could use drugs and remain functional for more than a decade without being detected.<sup>561</sup> Other reports had similarly concluded that there was no relationship between the severity of penalties imposed by drug laws and the prevalence of drug use.<sup>562</sup> As a result of the study, the Prime Minister established the *Comissão para a Estratégia Nacional de Combate a Droga* (Commission for a National Drug Strategy), led by an eminent scientist from an unrelated sector and composed of academics and field workers from the drugs sector, with the objective of recommending new institutional structures coherent with an effective legal framework.<sup>563</sup>

In 1997, the national network of drug addiction treatment centers (or SPTT) was formally established.<sup>564</sup> That same year, a EuroBarometer survey among the general population showed that “drugs” was identified as the most important social problem.<sup>565</sup> By 1998, drug-related issues were commonly being covered by news media, fueling polarization of the political debates that raged across the government, in the parliament, in the media and even in the streets.<sup>566</sup> Also in 1998, the Commission for a National Drug Strategy released a comprehensive intervention strategy that acknowledged that criminalization was exacerbating the drug problem rather than leading to improvements,<sup>567</sup> and recommended a response grounded on three pillars: prevention, harm reduction, and social reintegration.

By 1999, the drug situation had reached critical levels. Prevalence of heroin use among youth 16-18 year olds was estimated at 2.5%.<sup>568</sup> The number of overdose deaths, which had tripled between 1991 and 1998,<sup>569</sup> reached almost 400 that same year.<sup>570</sup> And HIV prevalence rates amongst PWID peaked, making Portugal the country with the highest prevalence in the EU. Reports indicate that around

<sup>561</sup> Agra, Candido, M. M. da. 1996. *Droga e Crime: Relatório de Síntese do Programa de Estudos Interdisciplinares Sobre a Experiência Portuguesa*. Centro de Ciências do Comportamento Desviante da Universidade do Porto / Gabinete de Planeamento e de Coordenação do Combate a Droga.

<sup>562</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>563</sup> Trigueiros, F., Vitoria, P. and Dias, L. 2011. “Rather treat than punish – The Portuguese decriminalization model” in Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release.

(<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>564</sup> Trigueiros, F., Vitoria, P. and Dias, L. 2011. “Rather treat than punish – The Portuguese decriminalization model” in Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release.

(<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>565</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>566</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>567</sup> Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>); Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>568</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations’ Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>569</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>570</sup> Russoniello, K. “The devil (and drugs) in the details: Portugal’s focus on public health as a model for decriminalization of drugs in Mexico” in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

that time, an estimated 60% of all people living with HIV (PLHIV) were heroin users.<sup>571</sup>

That same year, major policy reforms were introduced in Portuguese drug laws. *Decree Law no. 31/99* established the Portuguese Institute for Drugs and Addiction (IPDT),<sup>572</sup> a central agency that was tasked with mobilizing and managing resources; overseeing the dissuasion commissions; appointing dissuasion commission members; collecting, processing, and disseminating data related to drug use and addiction; issuing regulations and guidelines for specific types of cases; and developing a database of information about the individuals brought before the dissuasion commissions and the decisions rendered in order to monitor effectiveness. The IPDT was also charged with promoting, planning, coordinating, and implementing the harm reduction programs across the country, as well as evaluating performance and results.<sup>573</sup>

*Resolution of the Council of Ministers no. 46/99* effectively ratified the *National Strategy for the Fight Against Drugs* as the national drug control policy until 2008.<sup>574</sup> The new policy, firmly aligned with the recommendations of the Commission for a National Drug Strategy, explicitly facilitated decriminalization of personal consumption and possession, based on core principles that included human rights and public health, while promoting a pragmatic, health-oriented approach in which PWUD went from being criminals to being patients and clients.<sup>575</sup> The *Action Plan 1999-2004*, also released in 1999, called for increased investments earmarked for prevention, harm reduction, treatment and the social reintegration of PWUD, along with more focused and targeted enforcement of laws prohibiting drug trafficking and distribution.<sup>576</sup> By that point, the Portuguese drug control policy was loosely modeled on the Swiss *Four Pillars* policy, formally integrating law enforcement as a fourth pillar and consolidating the social reintegration and treatment pillars into one.

Building on the momentum, the government proposed *Decree Law no. 30/2000* in 2000, which was ratified and deployed officially in 2001 with *Decree Law no. 130-A/2001*, essentially formalizing the legal framework to implement the strategy proposed by the Commission for a National Drug Strategy back in 1996. The new law essentially decriminalized the use and possession of drugs, considering such acts as administrative offenses, provided that the quantity of drugs remained below the consumption thresholds set for the equivalent of a 10-

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<sup>571</sup> Domoslawski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>572</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>573</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>574</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>575</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>576</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)



day stock (see *Table 32* below).<sup>577</sup> By so doing, the architects of the policy were hoping to de-stigmatize drug use and remove barriers to health services.<sup>578</sup> The new law called for the establishment of drug dissuasion commissions to replace the traditional criminal courts.

*Table 32: Ten-day threshold amount of illicit substance* <sup>579</sup>

Illicit substance	Grams
Heroin	1
Methadone	1
Morphine	2
Opium	10
Cocaine (hydrochloride)	2
Cocaine (methyl ester benzoilegonine)	0.3
Cannabis (leaves and flowers or fruited dons)	25
Cannabis (resin)	5
Cannabis (oil)	2.5
LSD	0.1
MDMA	1
Amphetamine	1

Additional legislative reform took place in 2000, with *Decree Law no. 88/2000* and *Decree Law no. 89/2000* respectively creating the National Board for Drugs and Drug Addiction and the Coordination Board for Drugs and Drug Addiction, while *Decree Law no. 90/2000* expanded the role of the IPDT.<sup>580</sup>

In 2001, *Decree Law no. 183/2001* was ratified to better regulate needle and syringe distribution services,<sup>581</sup> and opened the door to the establishment of drug consumption rooms.<sup>582</sup> Portugal's new harm reduction legislation was designed to "create programs and social and health structures to raise awareness amongst drug users and to guide them towards treatment, as well as to prevent and reduce risk, and to minimize the damage caused to individuals and society by drug addiction."<sup>583</sup> As such, the law formally allowed possession of injecting equipment but also provided management guidelines and

<sup>577</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>578</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lse.12104/abstract>); Fonseca, C. R. 2015. "The implementation of Portuguese drug policy: Issues for CDTs," in *Meeting on Portuguese drug policy – Domestic and international perspectives*. SICAD. (<http://www.issdp.org/wp-content/uploads/2015/09/Implementation-of-portuguese-drug-policy.-Issues-for-CDTs.-September-2015.pdf>)

<sup>579</sup> Domoslawski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>580</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>581</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>582</sup> Torre, C. 18-19 November 2010. "The Syringe Exchange Program in Portugal" in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))

<sup>583</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)



procedures that should be adhered to in order to ensure standardization and quality.<sup>584</sup>

That same year, the first comprehensive national assessment of drug use in the general population was conducted in Portugal.<sup>585</sup> The *Nationwide Survey on Psychoactive Substances Consumption* provided evidence that only 8% of respondents admitted to ever using illicit drugs, and only 0.7% had ever used heroin.<sup>586</sup> The evidence also showed that, relative to European neighbors, drug consumption rates in Portugal were among the lowest at the time, disproving the common perception that Portugal's drug issues were critical.<sup>587</sup> Indeed, the survey also revealed that the general population now considered "drugs" as the third most important issue for Portuguese society.<sup>588</sup> That same year, 80 drug-related overdoses were recorded.<sup>589</sup>

In 2005, the IPDT also undertook a nationwide assessment, this time to identify those at highest risk of developing drug problems. Based on the results, the IPDT developed prevention interventions focusing on youth that included universal drug education. Portuguese youth were bombarded with information about the negative consequences of drug use in schools, health clinics, sports and recreation centers, as well as in popular cultural events.<sup>590</sup> Data from 2005 shows that prevalence of heroin used among youth 16-19 year olds had dropped to 1.8%.<sup>591</sup> In 2006, a total of 290 overdose deaths were recorded.<sup>592</sup>

In 2007, the first national drug user network was established. Known locally as *Consumidores Associados Sobrevivem Organizados* (which translates roughly to Consumers Associated Survive Organized), the organization was legally registered in Portugal and implemented a range of activities designed to promote rights, health and dignity of PWUD.<sup>593</sup> Data from 2007 shows significant changes in patterns of drugs use in the general population, as summarized in Table 33 below.

Table 33: Reported use of alcohol and drugs among the general population (15–64)

<sup>584</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>585</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>586</sup> Balsa, C. et al. 2001. *Inquerito Nacional ao Consumo de Substancias Psicoactivas na Populacao Geral, Portugal*.

<sup>587</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>588</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>589</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.ungodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>590</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>591</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>592</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>593</sup> See [https://www.facebook.com/pg/CASO-Portugal-710942955699874/photos/?tab=album&album\\_id=815812735212895](https://www.facebook.com/pg/CASO-Portugal-710942955699874/photos/?tab=album&album_id=815812735212895).

	Lifetime		Last 12 Months		Last 30 Days	
	2001	2007	2001	2007	2001	2007
Alcohol	75.6	79.1	65.9	70.6	59.1	59.6
Tobacco	40.2	48.9	28.8	30.9	28.6	29.4
Tranquilizers or sedatives	22.5	19.1	14.4	12	11	9.9
Any illicit drug	7.8	12	3.4	3.7	2.5	2.5
Cannabis	7.6	11.7	3.3	3.6	2.4	2.4
Cocaine	0.9	1.9	0.3	0.6	0.1	0.3
Amphetamines	0.5	0.9	0.1	0.2	0.1	0.1
Ecstasy	0.7	1.3	0.4	0.4	0.2	0.2
Heroin	0.7	1.1	0.2	0.3	0.1	0.2
LSD	0.4	0.6	0.1	0.1	0	0.1
Hallucinogenic mushrooms	0	0.8	0	0.1	0	0.1

In 2009, the CATO Institute, an American libertarian think tank, was commissioned to conduct a formal impact evaluation of Portugal's decriminalization policy. The published report concluded that by all metrics, the Portuguese decriminalization model had been successful and remained aligned with international requirements as well as with trends in the EU that support a more balanced and evidence-based approach to drug policy.<sup>595</sup>

By 2012, the number of problem drug users had dropped to an estimated 50,000,<sup>596</sup> and the number of fatal overdoses dropped to 16 that year.<sup>597</sup> That same year, *Decree Law no. 17/2012* transferred almost all of the duties of the IPDT to the *Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias* (SICAD) (translates as Intervention Services in Addictive Behaviors and Addictions).<sup>598</sup> In essence, the formation of SICAD was the result of the consolidation of a number of ineffective organizations into a single agency. SICAD's role, similar to IPDT's, has focused on research, evaluation, implementation, and oversight of drug-related health programs. The new law also delegated authority over drug-related health services to regional governments, decentralizing decision-making yet stimulating harmonization across Portugal through issuance of national standards for drug-related health service delivery as well as for the dissuasion commissions.<sup>599</sup>

### *The National Plan for the Reduction of Addictive Behaviors and Dependencies*

<sup>594</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>595</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>596</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>597</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>598</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>599</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

2013–20 is the strategy that is currently guiding implementation of prevention activities. The strategy acknowledges the need for segmented and targeted prevention in a range of contexts that include the family, the school, recreational and sports settings, the community, in the workplace, on the road, and in prisons.<sup>600</sup> Similarly, the strategy has provided guidance for implementation of the harm reduction, the drug treatment and the social reintegration pillars.

In 2015, the INCB President significantly changed the organizational message regarding Portugal, fully endorsing the approach and celebrating this innovation as a model of good practice to be replicated abroad. Yet, in 1999,<sup>601</sup> 2001,<sup>602</sup> and again in 2004,<sup>603</sup> INCB had singled out Portugal in its *Annual Reports*, repeating concerns over the decriminalization approach. In the end, the 2004 report acknowledged that the Portuguese approach was consistent with the Conventions but continued to express concerns:

*[T]he acquisition, possession and abuse of drugs had remained prohibited. While the practice of exempting small quantities of drugs from criminal prosecution is consistent with the international drug control treaties, the Board emphasizes that the objective of the treaties is to prevent drug abuse and to limit the use of controlled substances to medical and scientific purposes.*

The 2015 Statement of the INCB President closed the discussion on the appropriateness of the approach once and for all:

*The INCB came to the conclusion that the Government of Portugal is fully committed to the objectives of the treaties [that] explicitly allow States, when abusers of drugs have committed such offences, to provide, as an alternative or in addition to conviction or punishment, that abusers undergo measures of treatment, education, after-care, rehabilitation and social reintegration. [...] The Portuguese approach can be considered as a model of best practices. It shows that a drug policy which is fully committed to the principles of the Drug Control Conventions, putting health and welfare at its centre and applying a balanced, comprehensive and integrated approach, based on the principle of proportionality and the respect for human rights, can have positive results - within the existing drug control system and without legalizing the use of drugs.* <sup>604</sup>

At the 2016 UNGASS on the World Drug Problem, the head of the Portuguese delegation emphasized the need for balanced drug policies based on principles of human rights and public health, and anchored on reliable evidence. The Portuguese representative noted that decriminalization had created a legal framework that reduced the harms to users and society and facilitated their access to health services. The Portuguese representative also underlined

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<sup>600</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevention>.

<sup>601</sup> International Narcotics Control Board. 1999. *Report of the International Narcotics Control Board for 1999*. ([https://www.incb.org/documents/Publications/AnnualReports/AR1999/AR\\_1999\\_E.pdf](https://www.incb.org/documents/Publications/AnnualReports/AR1999/AR_1999_E.pdf))

<sup>602</sup> International Narcotics Control Board. 2001. *Report of the International Narcotics Control Board for 2001*. (<http://www.incb.org/incb/en/publications/annual-reports/annual-report-2001.html>)

<sup>603</sup> International Narcotics Control Board. 2004. *Report of the International Narcotics Control Board for 2004*. ([https://www.incb.org/documents/Publications/AnnualReports/AR2004/AR\\_04\\_English.pdf](https://www.incb.org/documents/Publications/AnnualReports/AR2004/AR_04_English.pdf))

<sup>604</sup> Sipp, W. 9 December 2015. “A public health approach as a base for drugs policy: The Portuguese case” in *Statement of the President of the International Narcotics Control Board at the 58<sup>th</sup> session of the Commission on Narcotic Drugs special event*. ([https://www.incb.org/documents/Speeches/Speeches2015/statement\\_reconvened\\_CND\\_side\\_event\\_portugal.pdf](https://www.incb.org/documents/Speeches/Speeches2015/statement_reconvened_CND_side_event_portugal.pdf))

Portugal's "unrelenting opposition" to the use of the death penalty, including for drug-related offenses.<sup>605</sup>

### Implementation of the national drug control strategy

Portugal's drug control policies have been modeled on the Swiss *Four Pillars* policy since 1999, as noted above, which has included prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues. This sub-section will review the range of strategies and activities that have been implemented in Portugal under each pillar, as well as their impact.

#### *Prevention*

Limited information was available on drug prevention activities in Portugal or their impact. As noted above, the *National Drug Abuse Prevention Program* was established in 1996 but today, SICAD has overall responsibility for national coordination of prevention strategies and coordinates all prevention activities at the national level through the *National Plan for the Reduction of Addictive Behaviors and Dependencies 2013–20*.<sup>606</sup> The overall objective of the current prevention strategy is to prevent, dissuade, reduce and minimize the problems associated with the consumption of psychoactive substances, addictive behaviors and dependencies.<sup>607</sup> Portuguese prevention strategies have focused on adolescent and post-adolescent age groups (15–24 year olds) given that their behavior is known to be more malleable, and that behaviors initiated during this period can have long-term impacts.<sup>608</sup>

Universal drug prevention has been integrated in the school curriculum, generally as part of science, biology and civic education courses, which have been often also delivered through training sessions, awareness-raising activities and dissemination of printed information. Law enforcement officers have conducted regular patrols near schools and raised awareness with students, teachers and parents during special session as part of the "Safe School" program. Implemented since 2006, "Me and Others" has demonstrated positive results by focusing on the promotion of healthy development among children. "Kosmicare" is a new intervention tackling crisis events related to the use of psychoactive substances at music festivals. Counseling and information about drugs and available services has also been provided via a telephone hotline, and recently via the Internet. A range of other prevention programs currently operates across Portugal.<sup>609</sup>

In 2014, 16 integrated projects were implemented under the prevention pillar,

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<sup>605</sup> Araujo, F. 20 April 2016. *Statement of the Portuguese Secretary of State [...] Professor Fernando Araujo at the Special Session of the United Nations General Assembly on the World Drug Problem*. New York City, United States. (<http://statements.unmeetings.org/media2/7657417/portugal.pdf>)

<sup>606</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevention>.

<sup>607</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))

<sup>608</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>609</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevention>.

reaching over 21,000 people, mainly through awareness raising, information activities and educational interventions. There was limited information available about the impact of the Portuguese prevention strategy and the activities implemented under this pillar.

### *Harm reduction*

Harm reduction was introduced officially with *Decree Law no. 183/2001* but by 1993, reports have shown that needle and syringe distribution programs were operating to stave off the negative consequences of a growing heroin epidemic.<sup>610</sup> The *National Plan for the Reduction of Addictive Behaviors and Dependencies 2013–20* indicates that the Portuguese harm reduction strategy was designed to raise awareness and facilitate referral of PWUD to appropriate services and enhance the prevention and reduction of drug-related behaviors that lead to increased risks and harms for individuals and society.<sup>611</sup> The Portuguese harm reduction strategy evolved by addressing three core priorities: scaling up OST for heroin users and dependents; meeting the needs of PWID with additional services such as sterile injecting equipment; and addressing non-injecting drug use and use of licit medicines.<sup>612</sup> The main drug-related harms that the strategy has sought to reduce have included HIV and HCV transmission as well as overdoses.

While the most commonly used drugs in Portugal have included cannabis, ecstasy and cocaine, the majority of people who inject are injecting heroin.<sup>613</sup> Data shows that the population of problem drug users dropped from an estimated 100,000 in the early 1990s down to about 50,000 in 2012.<sup>614</sup> In 2012, there was a median estimate of 16,425 PWID, representing approximately a third of all problem drug users.<sup>615</sup> Data about the number of PWID shows that this group has been shrinking: from 32,287 in the period 2008–2010,<sup>616</sup> down to an estimated 16,425 in 2012,<sup>617</sup> and down to 4,426 in 2016.<sup>618</sup>

Harm reduction programs in Portugal include distribution of sterile injecting equipment, low-threshold OST programs, rapid HIV testing in community

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<sup>610</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>611</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))

<sup>612</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))

<sup>613</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevalence>.

<sup>614</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countheccosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>615</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>616</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>); Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>617</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>618</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))



settings, DIC/shelters/refuges complemented by outreach, psychosocial support, vaccinations, health education, and referrals to other health and social support services.<sup>619</sup> A national network links HIV, HCV, tuberculosis (TB) and drug dependency care services across integrated screening programs, referral mechanisms and informal arrangements for co-located treatment.<sup>620</sup> Overall, the package of available services largely corresponds to the package of interventions recommended by UNAIDS, UNODC and WHO.<sup>621</sup>

The majority of harm reduction programs have been implemented by CSO and official policy documents have recognized the value of CSO contributions to the reduction of drug-related harms, given their strategic position that facilitates client recruitment. In that respect, the government has provided financial support to such CSO; an estimated 90% of harm reduction services have been delivered by CSO.<sup>622</sup> *Table 34* below shows the availability of services for PWUD in a sample of CSO.

*Table 34: Distribution of services among CSO working on drug-related issues* <sup>623</sup>

Services (n=25)	Number (%)
Counseling and testing on site	
HIV	11 (44%)
HBV	5 (20%)
HCV	4 (16%)
HAV	4 (16%)
STI	3 (12%)
HBV vaccination	8 (32%)
HCV vaccination	2 (8%)
Primary care / nursing care	22 (88%)
Opioid substitution therapy	11 (44%)
ARV, TB and methadone treatment	11 (44%)
Referrals to drug treatment	25 (100%)
Personal hygiene	18 (72%)
Food	16 (67%)

Prior to *Decree Law no. 183/2001*, distribution of sterile injecting equipment remained largely small-scale and hidden given that such interventions were considered a criminal offense.<sup>624</sup> Reports indicate that CSO officially initiated

<sup>619</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment*. ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>620</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment*. ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>621</sup> World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. ([http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)); Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime, and World Health Organization. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. ([http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf))

<sup>622</sup> Domoslawski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

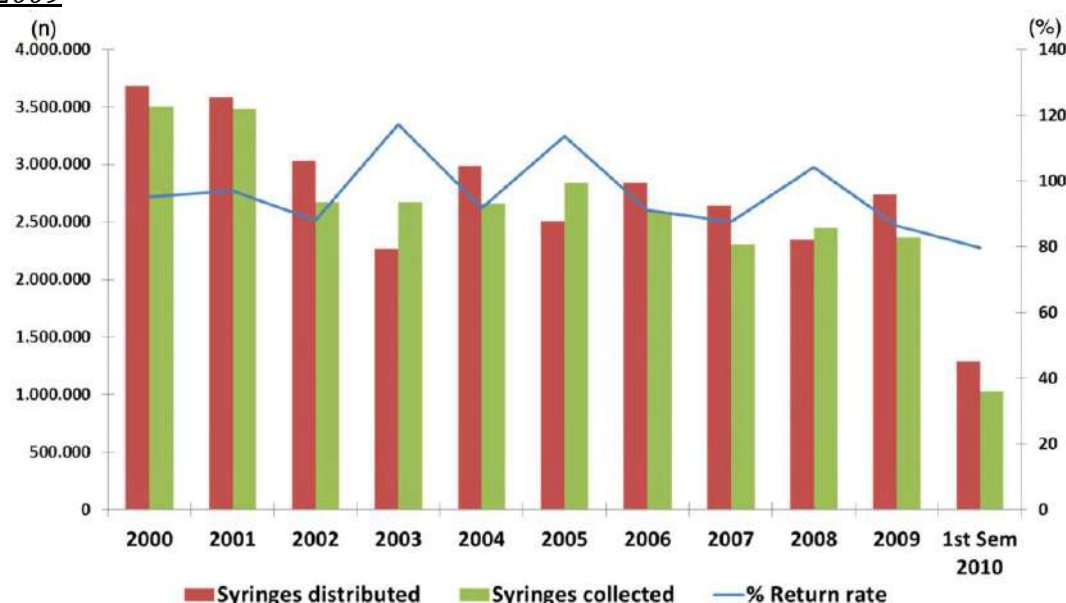
<sup>623</sup> Torre, C. 18-19 November 2010. "The Syringe Exchange Program in Portugal" in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))

<sup>624</sup> Domoslawski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)



distribution of sterile injecting equipment in 1999.<sup>625</sup> Figure 17 shows the total quantities of needles and syringes distributed across Portugal between 2000 and 2009. By 2016, reports show that 150 needle and syringes were being distributed to every PWID on an annual basis.<sup>626</sup> Note that discarding used needles and syringes is a criminal offense that can lead to a fine or imprisonment for up to one year.<sup>627</sup>

**Figure 17: Total distribution and return of needles and syringes in Portugal, 2000-2009**<sup>628</sup>



Additional reports have indicated that by 2008, approximately 50% of the Portuguese territory was covered<sup>629</sup> by an estimated total of 27 needle and syringe programs.<sup>630</sup> Figure 18 below shows the geographic distribution of CSO-sites involved in needle and syringe programs targeting PWID until 2007. By 2010, the number of needle and syringe distribution sites had remained stable at 27,<sup>631</sup> but exploded in 2012 with 1,620 sites,<sup>632</sup> dropped to 1,270 sites in 2014,<sup>633</sup> and to 590 sites in 2016.<sup>634</sup>

<sup>625</sup> Torre, C. 18-19 November 2010. "The Syringe Exchange Program in Portugal" in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))

<sup>626</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>627</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>628</sup> Torre, C. 18-19 November 2010. "The Syringe Exchange Program in Portugal" in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))

<sup>629</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>630</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

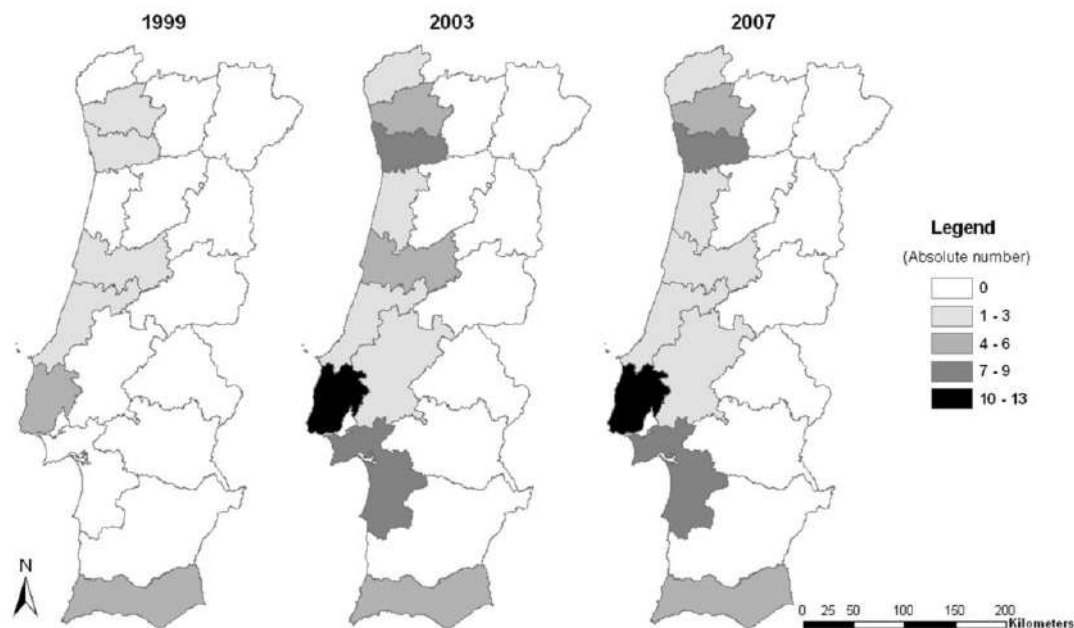
<sup>631</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>632</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>633</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>634</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

*Figure 18: Geographic distribution of needle and syringe distribution sites in Portugal, 1999-2007* <sup>635</sup>



The 1993 service was initiated by the National Association of Pharmacies (a CSO), which made sterile injecting equipment, condoms and referrals to health and social care services available to PWID enrolled in the “*SAY NO! to a used needle*” project.<sup>636</sup> Available data has revealed that out of 1,510 pharmacies across Portugal, 898 (59.4%) were actively participating in the project in 2010, compared to 376 (24.9%) that had participated but were no longer involved, and 236 (15.6%) that never participated in the project.<sup>637</sup>

Reports show that between 1993 and 2001, the pharmacy project reached an estimated 10,000 PWID, averted an estimated 7,000 new HIV infections, and generated financial savings estimated at EUR 400 million.<sup>638</sup> Figure 19 below shows the geographic distribution of participating pharmacies. However, the project was closed in late 2012 when the National Association of Pharmacies declined to renew their contract with MOH.<sup>639</sup>

*Figure 19: Geographic distribution of pharmacies participating in the SAY NO! to a used needle project, 1994-2007* <sup>640</sup>

<sup>635</sup> Torre, C. 18-19 November 2010. “The Syringe Exchange Program in Portugal” in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))

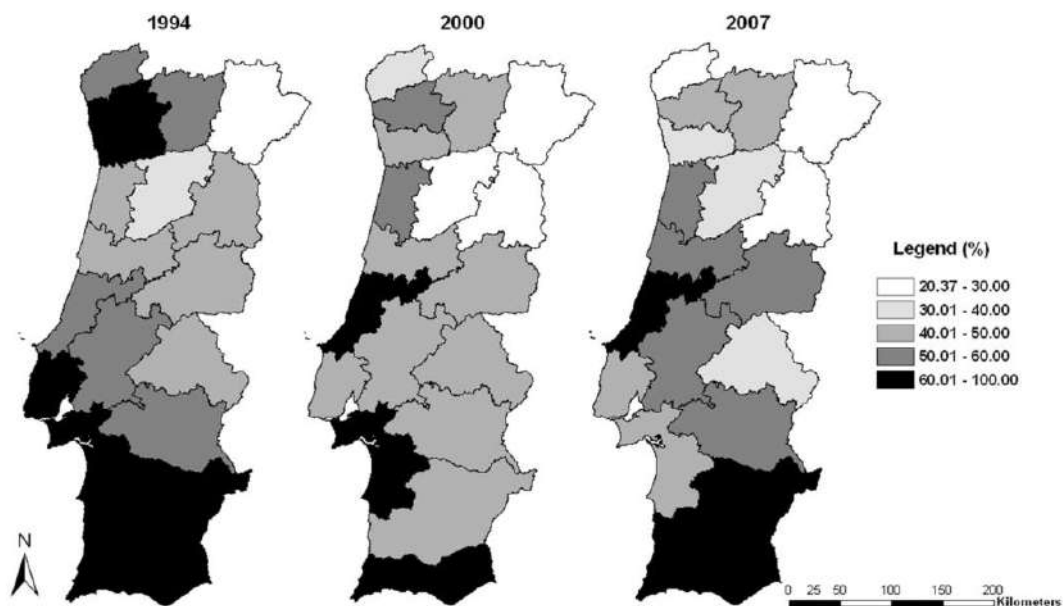
<sup>636</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevention>.

<sup>637</sup> Torre, C., Lucas, R., and Barros, H. 2010. “Syringe exchange in community pharmacies —The Portuguese experience” in *International Journal of Drug Policy*, 21(6): 514-517. ([http://www.ijdp.org/article/S0955-3959\(10\)00127-1/abstract](http://www.ijdp.org/article/S0955-3959(10)00127-1/abstract))

<sup>638</sup> 5 February 2013. “Portugal: Challenges of A Model Country with Harm Reduction” in *DrugReporter*, online at: [http://drogriporter.hu/en/Needle\\_exchange\\_Portugal\\_challenges](http://drogriporter.hu/en/Needle_exchange_Portugal_challenges).

<sup>639</sup> 5 February 2013. “Portugal: Challenges of A Model Country with Harm Reduction” in *DrugReporter*, online at: [http://drogriporter.hu/en/Needle\\_exchange\\_Portugal\\_challenges](http://drogriporter.hu/en/Needle_exchange_Portugal_challenges).

<sup>640</sup> Torre, C. 18-19 November 2010. “The Syringe Exchange Program in Portugal” in *Viral Hepatitis Prevention Board Meeting*, Lisbon, Portugal. ([http://www.vhpb.org/files/html/Meetings\\_and\\_publications/Presentations/LISS44.pdf](http://www.vhpb.org/files/html/Meetings_and_publications/Presentations/LISS44.pdf))



In 2007, approval of *Order no. 22 144/2007* allowed the initiation of a pilot needle and syringe program in selected prisons.<sup>641</sup> As of 2016, the prison-based needle and syringe program covered two sites, in Lisbon and in Paços de Ferreira prisons.<sup>642</sup>

OST has been widely available across Portugal through a range of outlets such as specialized treatment centers, health centers, hospitals, pharmacies (since 2004), and through CSO-operated projects.<sup>643</sup> OST was introduced in Portugal even before the concept of harm reduction had been integrated in policy documents. Methadone was introduced in 1977, buprenorphine in 1999 and a buprenorphine-naloxone combination in 2007.<sup>644</sup> *Decree Law no. 183/2001* and *Decree Law no. 15/93* specified that any medical doctor as well as treatment centers could initiate OST. While there was limited available data on the number of OST sites in Portugal, *Table 35* below summarizes available data on the number of clients enrolled in OST between 2010 and 2013, showing a high coverage of problem drug users and PWID.<sup>645</sup>

**Table 35: Opioid substitution treatment provision in Portugal, 2010-2013**<sup>646</sup>

Opioid substitution therapy	2010	2011	2012	2013
Number of clients in opioid substitution treatment	29,325	26,351	24,027	16,858
of which with methadone	23,067	N/A	20,395	11,256

<sup>641</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*, online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT#c6>

<sup>642</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#prevention>.

<sup>643</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#treatmentResponses>.

<sup>644</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#treatmentResponses>.

<sup>645</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>646</sup> European Monitoring Centre for Drugs and Drug Addiction. 2015. *Drug treatment overview for Portugal*. Online at: <http://www.emcdda.europa.eu/data/treatment-overviews/Portugal>.

of which with buprenorphine	6,258	N/A	3,632	5,602
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All costs related to OST with methadone have been absorbed by the government, while only 40% of the market value of buprenorphine-based medicines have been covered by the National Health System.<sup>647</sup> OST has also been available in prison settings, though there was limited information available about this service.

The impact of Portugal's harm reduction strategy can be assessed by observing trends related to HIV, viral hepatitis and overdoses. Prevalence of HIV among PWID was estimated at 16.25% in 2008,<sup>648</sup> at 15.6% in 2010,<sup>649</sup> at 11% in 2012,<sup>650</sup> at 5.7% in 2014,<sup>651</sup> and at 14.7% in 2016,<sup>652</sup> showing a progressive decrease until 2014, followed by a sudden upsurge in 2016, while remaining high above the European average.<sup>653</sup> In 2016, HIV prevalence amongst PWID was recorded at 14.7%,<sup>654</sup> compared to a general population prevalence of 0.6%;<sup>655</sup> prior to decriminalization, reports indicate that 60% of PWID were living with HIV,<sup>656</sup> compared to 17.1% in 2013.<sup>657</sup> Meanwhile, tracking the number of new HIV cases amongst PWID provides another metric to measure the impact of harm reduction services. In 1991, 73 new HIV infections were attributed to injecting drug use,<sup>658</sup> compared to 505 in 1998,<sup>659</sup> between 1,016<sup>660</sup> and 1,482 in 2001,<sup>661</sup> down to 116 in 2010,<sup>662</sup> and to 56 in 2012.<sup>663</sup> Despite significant

<sup>647</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#treatmentResponses>.

<sup>648</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>649</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>650</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>651</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>652</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>653</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>654</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>655</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>656</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>657</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>658</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>659</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>660</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>661</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lse.12104/abstract>)

<sup>662</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lse.12104/abstract>)

<sup>663</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

progress, important challenges remain in facilitating access to antiretroviral treatment amongst PWID living with HIV.<sup>664</sup>

Transmission of viral hepatitis is also an important indicator to assess the impact of activities implemented under the harm reduction pillar. HCV prevalence amongst PWID has been reported between 38.4% and 84.3% in 2008,<sup>665</sup> between 36.5% and 83.1% in 2012,<sup>666</sup> at 83.3% in 2014,<sup>667</sup> and at 84.4% in 2016.<sup>668</sup> HBV prevalence amongst PWID has been reported between 2% and 3.5% in 2012,<sup>669</sup> at 4.9% in 2014,<sup>670</sup> and at 5.2% in 2016.<sup>671</sup> Both HCV and HBV prevalence data show that viral hepatitis transmission amongst PWID has been increasing steadily over the years. Up to 60% of PWID living with HIV are co-infected with HCV.<sup>672</sup>

As noted in the historical overview, the number of fatal overdoses has changed significantly. Prior to decriminalization, between 1991 and 1998, the number of fatal overdoses tripled,<sup>673</sup> and peaked at 400 in 1999.<sup>674</sup> Following decriminalization, the number of fatal overdoses dropped significantly, to 80 in 2001,<sup>675</sup> to 290 in 2006,<sup>676</sup> and to 16 in 2012.<sup>677</sup>

### Treatment

As was the case for the prevention and harm reduction pillars, the strategic objectives of the treatment pillar are defined in *National Plan for the Reduction of Addictive Behaviors and Dependencies 2013–20*. Treatment interventions have been designed to reduce both mortality and morbidity associated with drug use.<sup>678</sup> Drug treatment services in Portugal have generally focused on

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<sup>664</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>665</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>666</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>667</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>668</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>669</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>670</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>671</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>672</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>673</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>674</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>675</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>676</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>677</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>678</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))



comprehensive integrated care that includes counseling, treatment, psychotherapy, OST as well as referrals to specialized health centers for complex cases.<sup>679</sup> Detoxification, OST and therapeutic communities were the most common treatment models identified in the literature, all of which have been available through both in- and outpatient outlets.<sup>680</sup>

An official reporting system was deployed in 1998 to collect data from agencies operating drug treatment services,<sup>681</sup> which was updated with the Multidisciplinary Information System, launched in 2010.<sup>682</sup> Despite this system, limited data was available about the results of drug treatment programs in Portugal. Data from 2012 collected from drug treatment centers in Portugal showed that access to such services was driven by heroin and other opioids for 44% of clients, compared to alcohol for 30% of clients, cannabis for 13%, and cocaine for 11%;<sup>683</sup> data from 2014 showed a slight change in this distribution, with 54% of clients seeking treatment for heroin and other opioids, 28% for cannabis and 14% for cocaine.<sup>684</sup>

Reports indicate that the number of treatment sessions increased from 56,438 in 1990 to 288,038 in 1999.<sup>685</sup> In 1998, a total of 23,654 people were treated for drug-related issues, compared to 29,204 in 2000, 38,532 in 2008,<sup>686</sup> and 37,983 in 2010.<sup>687</sup> The number of inpatient admissions peaked in 1999 with 9,991 individuals seeking treatment for drug-related issues, dropped to 4,844 in 2004, and rose to 7,643 in 2009.<sup>688</sup> Access to inpatient services has been reportedly limited due to challenges in accessing the necessary financial resources to cover costs.<sup>689</sup>

Reports have also shown that in addition to the three specialized inpatient centers built by the government between 1987 and 1989,<sup>690</sup> an additional 26 outpatient facilities were setup across the country, increasing from 53 facilities in 1998 to 79 in 2010,<sup>691</sup> (47 outpatient treatment centers and 32 decentralized

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<sup>679</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>680</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment*. ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>681</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>682</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#di>.

<sup>683</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment*. ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>684</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#di>.

<sup>685</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>686</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>687</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment*. ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>688</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>689</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>690</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>691</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)



consultation units),<sup>692</sup> down to 72 in 2016.<sup>693</sup> In 2010, 13 detoxification units were operating (4 public, 9 private units), as well as 69 therapeutic communities (3 public, 66 private units).<sup>694</sup> The number of clients in therapeutic communities has been rising steadily, from 3,167 in 2007, up to 3,385 in 2008 and again to 3,601 in 2009.<sup>695</sup>

Outpatient facilities have been offering OST and other drug dependence treatments and psychosocial support along with a range of other health services like diagnosis for HIV and viral hepatitis, all under the supervision of the IPDT prior to 2012, and under SICAD since 2012.<sup>696</sup> A multidisciplinary team of doctors, nurses, psychologists and social workers have typically managed outpatient facilities and developed client-centered programs to meet their needs.<sup>697</sup> The majority of clients have sought treatment voluntarily and by themselves (41%), through referrals from other health services (21%) and through the criminal justice system (18%).<sup>698</sup>

All drug treatment services in Portugal have been free of charge for the client.<sup>699</sup> There has been no compulsory treatment in Portugal; neither dissuasion commissions nor courts can forcibly impose drug dependence treatment on an individual.<sup>700</sup> However, the dissuasion commissions do have the power to coerce those brought before them into treatment as a means of diversion away from the criminal justice system or to avoid other administrative penalties.

Social reintegration, now integrated under the treatment pillar, has been designed to support self planning, access to housing, education and work, facilitate family reconciliation, and establish a support network linking clients with treatment and harm reduction services.<sup>701</sup> The *National Plan for the Reduction of Addictive Behaviors and Dependencies 2013–20* acknowledges that the pathway to reintegration for PWUD, especially those of problem drug users, can be slow and challenging, requiring the use of holistic and systemic approaches that contribute to empowerment of clients and sustainability of the

<sup>692</sup> Institute on Drugs and Drug Addiction. 2011. *National Report (2010 data) to the EMCDDA by the Reitox National Focal Point, "PORTUGAL: New Development, Trends and in-depth information on selected issues."* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_142534\\_EN\\_PT-NR2010.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_142534_EN_PT-NR2010.pdf))

<sup>693</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#tdi>.

<sup>694</sup> Institute on Drugs and Drug Addiction. 2011. *National Report (2010 data) to the EMCDDA by the Reitox National Focal Point, "PORTUGAL: New Development, Trends and in-depth information on selected issues."* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_142534\\_EN\\_PT-NR2010.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_142534_EN_PT-NR2010.pdf))

<sup>695</sup> Institute on Drugs and Drug Addiction. 2011. *National Report (2010 data) to the EMCDDA by the Reitox National Focal Point, "PORTUGAL: New Development, Trends and in-depth information on selected issues."* ([http://www.emcdda.europa.eu/attachements.cfm/att\\_142534\\_EN\\_PT-NR2010.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_142534_EN_PT-NR2010.pdf))

<sup>696</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment.* ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>697</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment.* ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>698</sup> World Health Organization. 2012. *Accessibility and integration of HIV, TB and harm reduction services for people who inject drugs in Portugal – A rapid assessment.* ([http://www.euro.who.int/\\_data/assets/pdf\\_file/0005/165119/E96531-v6-Eng.pdf](http://www.euro.who.int/_data/assets/pdf_file/0005/165119/E96531-v6-Eng.pdf))

<sup>699</sup> Trigueiros, F., Vitoria, P. and Dias, L. 2011. "Rather treat than punish – The Portuguese decriminalization model" in Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe.* Release.

(<http://www.coe.int/t/dg3/pompidou/Source/Activities/Justice/11CJ/Rather%20Treat%20Than%20Punish.pdf>)

<sup>700</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies.* Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>701</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use.* Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

overall response; such approaches, the strategy notes, must go “beyond the correction of the behaviors and attitudes of individuals.”<sup>702</sup>

While data about drug treatment services and their impact in Portugal was at best patchy, available data has shown an increase in access to drug treatment services, especially since decriminalization. More importantly, published reports have indicated that the proportion of PWID accessing drug treatment services dropped over time: from 21.9% of patients which reported injecting in 2006, to 19% in 2007, to 21.5% in 2008, to 12.5% in 2009, to 7% in 2010, and finally to 7.2% in 2011.<sup>703</sup>

### *Law enforcement*

Law enforcement related activities fall under the fourth pillar of the Portuguese drug control policy. Implementing such activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. Portugal’s dissuasion commissions have been central mechanisms in the implementation of the decriminalization policy. In the context of drug control, the overall goal of the law enforcement pillar has been to focus police resources on those people who profit from the drugs trade,<sup>704</sup> and ultimately reduce the availability of illicit drugs in the market.<sup>705</sup>

Limited data was available about police contacts with individuals involved with drug-related crimes. In 1998, more than 60% of drug-related arrests were for offenses related to use and possession rather than production, trafficking or distribution.<sup>706</sup> Arrests for drug-related offenses were recorded at 3,586 in 1990,<sup>707</sup> at 4,667 in 1991,<sup>708</sup> 6,280 in 1992,<sup>709</sup> at 11,395 in 1998,<sup>710</sup> and at 13,020 in 1999.<sup>711</sup> The number of drug-related offenses peaked in 2000 with a total of 14,276 drug-related arrests.<sup>712</sup> After decriminalization, sources provide different

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<sup>702</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))

<sup>703</sup> Institute on Drugs and Drug Addiction. 2011. *National Report (2010 data) to the EMCDDA by the Reitox National Focal Point, “PORTUGAL: New Development, Trends and in-depth information on selected issues*. ([http://www.emcdda.europa.eu/attachments.cfm/att\\_142534\\_EN\\_PT-NR2010.pdf](http://www.emcdda.europa.eu/attachments.cfm/att_142534_EN_PT-NR2010.pdf))

<sup>704</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>705</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2015. *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020 - Executive Summary*. ([http://www.sicad.pt/BK/Publicacoes/Lists/SICAD\\_PUBLICACOES/Attachments/97/NPRABD\\_2013\\_2020\\_executive\\_summary.pdf](http://www.sicad.pt/BK/Publicacoes/Lists/SICAD_PUBLICACOES/Attachments/97/NPRABD_2013_2020_executive_summary.pdf))

<sup>706</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>707</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>708</sup> Russoniello, K. “The devil (and drugs) in the details: Portugal’s focus on public health as a model for decriminalization of drugs in Mexico” in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>709</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>710</sup> Russoniello, K. “The devil (and drugs) in the details: Portugal’s focus on public health as a model for decriminalization of drugs in Mexico” in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>711</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>712</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

arrest data, ranging from 10,000 to 12,000 according to one source,<sup>713</sup> and between 5,000 and 5,500 according to another.<sup>714</sup> The EMCDDA reports that in 2014, a total of 14,733 drug-related arrests were made in Portugal.<sup>715</sup>

Since decriminalization, the role of the police has changed significantly. Legal provisions have created expectations that the police will continue to serve as the primary source of detection for drug-related crimes, but police are also expected to facilitate referrals to appropriate authorities. For example, the *Decree Law no. 30/2000* specifically authorized the police to search for drugs and seize any illicit substances found.<sup>716</sup> Police officers no longer have the authority to arrest users, but they have the mandate to seize any and all illicit drugs, collect the users' personal information and details, and forward the information to the dissuasion commission.<sup>717</sup> If deemed necessary, police can also "detain the offender in order to ensure that s/he appears before the Commission."<sup>718</sup> According to surveys and studies, a large proportion of police officers reported feeling encouraged by the additional options available to address drug-related issues and considered the new approach more effective.<sup>719</sup>

The number of cases referred by police to the administrative process has increased since the implementation of the decriminalization policy, suggesting that police contacts with people involved in drugs-related crimes have been maintained if not increased.<sup>720</sup> However, the number of people arrested and sent to criminal court for drug-related offenses has declined significantly since decriminalization, by an estimated 60% based on a 2012 publication.<sup>721</sup>

More data was available on the number of arrests for trafficking. The number of arrests for trafficking rose in the 1990s, especially related to heroin, dropped in the early 2000s, and has risen slightly between 2002 and 2012.<sup>722</sup> Table 36 below provides a year-by-year account of these arrests against the total number of crimes recorded from 2002 to 2012. By 2014, the number of trafficking arrests had risen to 5,674, representing 38.5% of drug-related arrests that

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<sup>713</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>714</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>715</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

<sup>716</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>717</sup> Allen, L. Trace, M. and Klein, A. 2004. *Decriminalisation of drugs in Portugal: a current overview*. The Beckley Foundation Drug Policy Programme. ([http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper\\_06.pdf](http://reformdrugpolicy.com/wp-content/uploads/2011/10/paper_06.pdf))

<sup>718</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>719</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>720</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>721</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>722</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

year,<sup>723</sup> compared to a yearly average ranging between 20% and 30% for the period 2005-2010.<sup>724</sup>

*Table 36: Drug trafficking versus total crime in Portugal, 2002-2012* <sup>725</sup>

Year	Total crimes recorded by police	Number of drug trafficking recorded by police	Proportion drug trafficking versus total crime
2002	391,600	4,053	1.03%
2003	417,400	3,739	0.90%
2004	416,400	3,654	0.88%
2005	392,700	3,536	0.90%
2006	399,600	3,610	0.90%
2007	398,600	3,265	0.82%
2008	430,500	3,710	0.86%
2009	426,000	4,260	1.00%
2010	422,600	4,546	1.08%
2011	413,700	4,210	1.02%
2012	403,200	4,635	1.15%

However, the overall numbers of cocaine and heroin seizures have been on the decline for the past 10 years, and arrests for trafficking of ecstasy and amphetamines have remained infrequent.<sup>726</sup> In 2014, the highest number of seizures was related to cannabis resin (61.2%), cocaine (18.3%) and heroin (12.2%).<sup>727</sup> Reports indicate that the amounts of drugs seized have increased: between 2000 and 2004, the quantities of illicit drugs seized represented five times the quantities seized between 1995 and 1999.<sup>728</sup> However, significant fluctuations between these data points and our limited dataset has prevented the formulation of reliable conclusions about quantities of illicit drug seized by police for this report.

Today, Portugal represents an important transit point in the web of international drug trafficking, especially for cocaine.<sup>729</sup> Methamphetamines-related trafficking offences are rare: in 2008, out of 26 methamphetamine production sites identified across Europe, only one was located in Portugal;<sup>730</sup> in 2013 an exceptional single seizure of 4.39kg was made at the Lisbon airport; and no methamphetamine seizures were reported in 2014.<sup>731</sup>

<sup>723</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

<sup>724</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>725</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).

<sup>726</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

<sup>727</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

<sup>728</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=vjhple>)

<sup>729</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emcdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>730</sup> European Monitoring Centre for Drugs and Drug Addiction. 2009. *Methamphetamine: A European Union perspective in the global context*. ([http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine\\_final\\_163584.pdf](http://www.emcdda.europa.eu/system/files/publications/542/Methamphetamine_final_163584.pdf))

<sup>731</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

Following contact with the police for a drug-related offence, the offender may follow the administrative process and end up in front of a drug dissuasion commission if the quantity of drugs falls below the legal thresholds indicated by *Decree Law no. 30/2000*. Failure to comply with an administrative order referring an offender to a dissuasion commission constitutes a criminal offense and can lead to criminal prosecution.<sup>732</sup> As opposed to criminal courts, which have been managed and overseen by MOJ, the drug dissuasion commissions have been operated and supervised by MOH.<sup>733</sup> Since the approval of the decriminalization policy, a total of 18 dissuasion commissions have been setup, one in each of the country's provinces.<sup>734</sup>

The commissions have been headed by two health professionals appointed by MOH – usually a doctor and a social worker – as well as a legal expert appointed by MOJ, though a team of additional health professionals has provided support to the commissioners.<sup>735</sup> Commission members must protect and safeguard confidentiality of the proceedings in which respect for the alleged offender is emphasized as part of a client-centered approach.<sup>736</sup>

Commission proceedings have been purposefully designed to reduce or eliminate the focus on the concept of guilt as well as the stigma that comes with a legal trial, rather emphasizing a process grounded on a dialogue between the alleged offender and the commissioners. For example, the offender sits on the same level, around the same table as the commissioners who also wear plain clothes rather than official uniforms or particular dress that visually differentiates the offender from the commissioners.<sup>737</sup> Offenders can also request that written notices not be sent to their home in order to preserve privacy.

Cases referred by the police to the dissuasion commissions must be assessed based on the following criteria: the type of drug; the level of drug use (whether an offender is dependent, an habitual or an occasional user); whether the use was in public or private; and the economic circumstances of the offender.<sup>738</sup> Minors compelled to appear before dissuasion commissions must always have legal representation when doing so.<sup>739</sup> In essence, the commissioners have

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<sup>732</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>733</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>734</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>735</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>736</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>737</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>738</sup> Hughes, C. and Stevens, A. 2007. *The effects of decriminalization of drug use in Portugal*. The Beckley Foundation Drug Policy Programme. ([https://kar.kent.ac.uk/13325/1/BFDPP\\_BP\\_14\\_EffectsOfDecriminalisation\\_EN.pdf](https://kar.kent.ac.uk/13325/1/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf))

<sup>739</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))



sought to facilitate an open discussion with alleged offenders and to make them conscious of the harms related to drug use as well as of the consequences of additional offenses, and to encourage and support referrals to appropriate treatment options.<sup>740</sup>

While the commissioners have worked to avoid operating like criminal courts, the commissioners still have the authority to impose a range of different sanctions on drug offenders. The commissioners may compel periodic appearance of the offender before the commission; compel community service; confiscation of assets; issue a warning/reprimand; issue a fine; forbid the offender from attending certain locations and meeting certain people; forbid travel abroad; suspend or terminate access to public benefits; restrict access to certain employment sectors; and prevent access to firearms.<sup>741</sup> However, the dissuasion commissions' authority has been rather limited, in that failure to comply with its rulings has not been considered a criminal offense.<sup>742</sup>

The dissuasion commissions have been increasingly active, as shown by the data collected in *Table 37* below. While the number of commission proceedings and the number of rulings have both been on the rise (the commissions held a total of 9,059 proceedings in 2014),<sup>743</sup> the decisions of the commissioners have been consistent, with the vast majority of cases being suspended. Virtually all cases concerning first-time offenders have been suspended.<sup>744</sup> An estimated 60% to 70% of suspended proceedings involved people who use but are not dependent on illicit drugs.<sup>745</sup> When the commissioners applied sanctions, they have generally avoided imposing fines on people dependent on illicit drugs, given that such additional financial constraints were perceived as a risk leading to increased drug use and petty crime.<sup>746</sup> For example, in 2007, out of all sanctions, fines represented less than 12% of penalties imposed on offenders.<sup>747</sup>

*Table 37: Results of drug dissuasion commission processes, 2005-2012*

Year	Number of processes	Number of rulings	Results of commission rulings		
			Suspended proceedings	Sanction	Acquittal

<sup>740</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>741</sup> Fonseca, C. R. 2015. "The implementation of Portuguese drug policy: Issues for CDTs," in *Meeting on Portuguese drug policy – Domestic and international perspectives*. SICAD. (<http://www.issdp.org/wp-content/uploads/2015/09/Implementation-of-portuguese-drug-policy-Issues-for-CDTs-September-2015.pdf>)

<sup>742</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>); Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>743</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Portugal Country Overview*, online at: <http://www.emcdda.europa.eu/countries/portugal#markets>.

<sup>744</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>745</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>746</sup> Fonseca, C. R. 2015. "The implementation of Portuguese drug policy: Issues for CDTs," in *Meeting on Portuguese drug policy – Domestic and international perspectives*. SICAD. (<http://www.issdp.org/wp-content/uploads/2015/09/Implementation-of-portuguese-drug-policy-Issues-for-CDTs-September-2015.pdf>)

<sup>747</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SSentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SSentencing.pdf))



2005 <sup>748</sup>	N/A	3,192	83%	15%	2.50%
2007 <sup>749</sup>	N/A	3,338	79%	17%	N/A
2009 <sup>750</sup>	7,549	5,508	85%	14%	1%
2014 <sup>751</sup>	8,573	7,394	82%	15%	3%

The dissuasion commissions have generally ruled within four<sup>752</sup> to 12<sup>753</sup> weeks following a referral by the police; comparatively, prior to decriminalization, delays of up to two years could take place between the moment the police issued a citation and the moment the alleged offender appeared before a criminal court.<sup>754</sup> However, reports have shown that the dissuasion commissions have been hampered by implementation issues such as lack of quorum, which have resulted in considerable delays.<sup>755</sup>

Prior to decriminalization, all people involved in drug crimes who came into contact with the police were referred to the criminal justice process. For example, in 1992, a total of 1,263 offenders were convicted for drug-related crimes, compared to 3,154 in 2000.<sup>756</sup> Another source indicates that over 14,000 drug offenders were channeled to criminal courts in 2000. During the 1990s, possession and distribution of small quantities of illicit drugs would generally lead to a maximum prison sentence of three months or a fine; larger quantities exceeding a three-day supply were punished by incarceration for a maximum of one year or a fine.<sup>757</sup>

However, following the approval of *Decree Law no. 30/2000*, only those individuals arrested for trafficking, distribution and production offences should technically be channeled to criminal courts. Possession of quantities above the legal thresholds implied by default more than simple possession or personal consumption. In that sense, the decriminalization policy considerably reduced the criminal courts' workload by diverting large proportions of offenders to the administrative process managed by the dissuasion commissions. Reports indicate that criminal courts now handle between 5,500 and 6,000 cases related

<sup>748</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>749</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>750</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>751</sup> Servico de Intervencao nos Comportamentos Aditivos e nas Dependencias. 2013. *National Report (2012 data) to the EMCDDA by the Reitox National Focal Point: PORTUGAL: New Development, Trends and in-depth information on selected issues*. ([http://www.sicad.pt/PT/RelacoesInternacionais/Documents/2013\\_NATIONAL\\_REPORT.pdf](http://www.sicad.pt/PT/RelacoesInternacionais/Documents/2013_NATIONAL_REPORT.pdf))

<sup>752</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>753</sup> Hughes, C. and Stevens, A. 2007. *The effects of decriminalization of drug use in Portugal*. The Beckley Foundation Drug Policy Programme. ([https://kar.kent.ac.uk/13325/1/BFDPP\\_BP\\_14\\_EffectsOfDecriminalisation\\_EN.pdf.pdf](https://kar.kent.ac.uk/13325/1/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf))

<sup>754</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

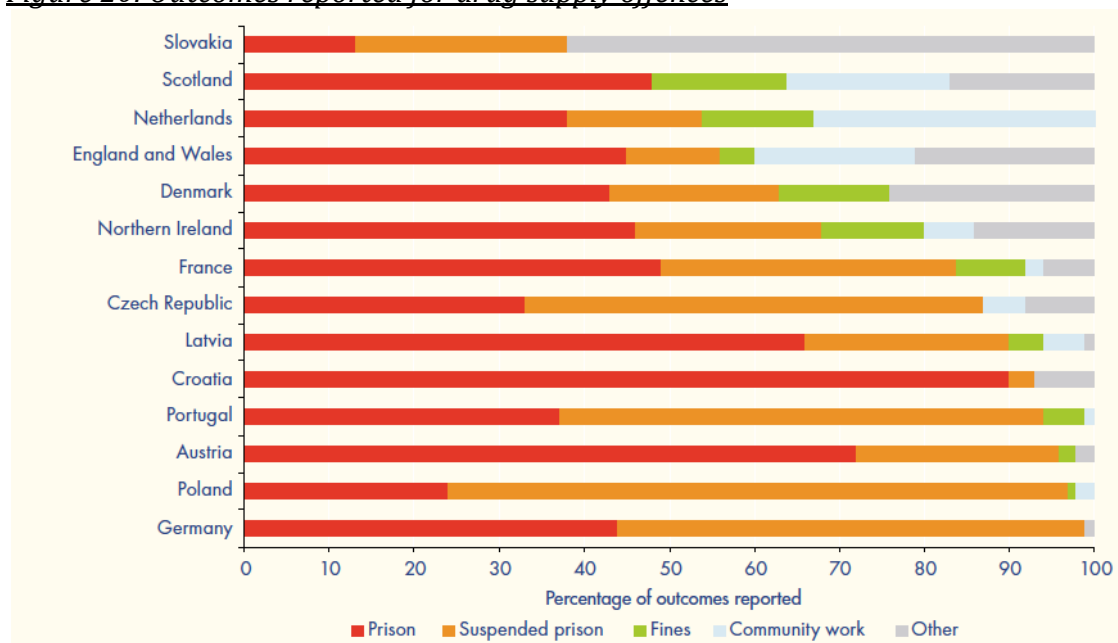
<sup>755</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>756</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>757</sup> Hughes, C. and Stevens, A. 2007. *The effects of decriminalization of drug use in Portugal*. The Beckley Foundation Drug Policy Programme. ([https://kar.kent.ac.uk/13325/1/BFDPP\\_BP\\_14\\_EffectsOfDecriminalisation\\_EN.pdf.pdf](https://kar.kent.ac.uk/13325/1/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf))

to drugs on a yearly basis since decriminalization.<sup>758</sup> Available data shows that in 2002, a total of 2,014 offenders were convicted for drug-related offences; among them, 49% received prison sentences and 44% received probation. By 2007, a total of 1,871 individuals were arrested on trafficking charges;<sup>759</sup> out of them, a total of 1,420 (76%) individuals were convicted and sentenced;<sup>760</sup> among them, 36% related to cannabis, 16% to cocaine, 14% to heroin and 1% to ecstasy.<sup>761</sup> Ultimately, 97% of those sentenced were convicted for traffic, 2% for traffic-use and 1% for cultivation, and their sentences led to suspended incarceration (57% of cases), immediate incarceration (37%), fines (5%) and community work (1%).<sup>762</sup> In 2010, only 28% of all drug-related criminal court sentences led to incarceration, compared to 48% who received probation, and 24% who received fines.<sup>763</sup> Figure 20 below provides regional context by comparing sentencing results for trafficking offences in other European countries. Indeed, Portugal is one of five countries in Europe where warnings and suspended sentences are most common outcomes of drug-related court decisions.<sup>764</sup>

*Figure 20: Outcomes reported for drug supply offences*<sup>765</sup>



It is worth highlighting that Portuguese law recommends the consideration of several criteria to mitigate prosecution and sentencing for drug trafficking

<sup>758</sup> Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>)

<sup>759</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>760</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>761</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>762</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes - Online annex: Results by country*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_92889\\_EN\\_onlineannex\\_SIsentencing.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_92889_EN_onlineannex_SIsentencing.pdf))

<sup>763</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>764</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

<sup>765</sup> European Monitoring Center for Drugs and Drug Addiction. 2009. *Drug offences: Sentencing and other outcomes*. ([http://www.emcdda.europa.eu/attachements.cfm/att\\_93232\\_EN\\_TDSI09001ENC.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_93232_EN_TDSI09001ENC.pdf))

offenses, including the type of drug (scheduling), the individual's relationship with drugs (assessment of dependence), whether the offender is involved in trafficking to finance a personal drug habit (assessment of trafficking), and the severity of the trafficking offence (discretion). Sentences are reduced if trafficking involves soft drugs (from 4-12 years to 1-5 years); if the offender sells soft drugs to finance consumption of drugs (from 1-5 years to 1 year); and if the offender sells hard drugs to finance his personal consumption (from 4-12 years to 3 years).<sup>766</sup> However, the same set of laws has also provided for more severe penalties under aggravating circumstances: criminal association (organized crime) leads to sentences of 10-25 years; and traffic of precursors attracts penalties up to 12 years of imprisonment.<sup>767</sup>

In 2015, there were 49 prisons across Portugal housing a total of 14,238 prisoners representing an occupancy rate of 110%.<sup>768</sup> *Table 38* below provides an overview of the evolution of the prison population in Portugal as well as the national prison population rate, showing that the prison population has increased slightly and steadily since decriminalization. The proportion of prisoners incarcerated for drug-related crimes has been dropping steadily: from 44% in 1999,<sup>769</sup> down to 43% in 2000,<sup>770</sup> down to 21% for the period 2008-2012,<sup>771</sup> and slightly up to 24% in 2013.<sup>772</sup> In 2010, approximately 90% of people incarcerated for drug crimes were sentenced in regards to a trafficking offense, 8% for a minor trafficking offence, and 2% for traffic-use offences.<sup>773</sup>

*Table 38: Total prison population and prison population rate 2000-2016* <sup>774</sup>

Year	Total prison population	Prison population rate
2000	12,944	126
2002	13,918	133
2004	13,152	125
2006	12,636	120
2008	10,807	102
2010	11,613	110
2012	13,614	130

<sup>766</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emecdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>767</sup> European Monitoring Centre for Drugs and Drug Addiction. 2012. *Portugal Country Legal Profile*. Online at: <http://www.emecdda.europa.eu/html.cfm/index5174EN.html?pluginMethod=eldd.countryprofiles&country=PT>.

<sup>768</sup> International Center for Prison Studies. 2016. *World Prison Brief - Portugal*. Online at: <http://www.prisonstudies.org/country/portugal>.

<sup>769</sup> Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>)

<sup>770</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>771</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>); Murkin, G. 2014. *Drug Decriminalisation in Portugal: Setting the record straight*. Transform. (<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Drug-decriminalisation-in-Portugal.pdf>); Rosmarin, A., & Eastwood, N. 2012. *A Quiet Revolution: Drug Decriminalisation Policies in Practice across the Globe*. Release. (<http://www.countthecosts.org/resource-library/quiet-revolution-drug-decriminalisation-policies-practice-across-globe>);

<sup>772</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>773</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>774</sup> International Center for Prison Studies. 2016. *World Prison Brief - Portugal*. Online at: <http://www.prisonstudies.org/country/portugal>.

<b>2014</b>	14,003	135
<b>2015</b> <sup>775</sup>	14,238	138

### Concluding analysis

The official evaluation of the Portuguese decriminalization policy published by the Cato Institute assessed the effects of the Portuguese model and concluded that by all metrics, the model has been successful while being in line with both international requirements as well as with trends in the EU that support more balanced and evidence-based approaches to drug policy.<sup>776</sup> However, analyses of the Portuguese decriminalization policy have been criticized for lacking sufficient evidence to draw reliable conclusions about impact; for the limited consideration of extraneous factors to explain similar trends in other countries that did not decriminalize; and given that drug consumption trends are not substantiated by evidence; and that evaluation methodologies have been inadequate.<sup>777</sup> Keeping this in mind, the data presented in this section allows us to further consider and better understand the success of the Portuguese approach.

Motivation for policy change arose from a combination of factors, especially the growing public perception in the 1990s that drug use was a major social issue; a history of authoritarian political rule that left the population with limited capacity to deal with illicit drugs and distrustful of law enforcement; as well as a rapidly expanding HIV epidemic combined with rising mortality among people who use and inject drugs. However, a significant amount of legislative tinkering took place to get to the current state of affairs. *Box 5* summarizes all the relevant legislative milestones that are relevant to decriminalization explored in this report.

### Box 5: Relevant Portuguese legal and policy documents and milestones

- Decree Law no. 420/70 (1970)
- Fall of the 48-old Salazar government (1974)
- Decree Law no. 792/76 (1976)
- Decree Law 430/83 (1983)
- Decree Law no. 15/93 (1993)
- Decree Regulation no. 42/93 (1993)
- Decree Law no. 43/94 (1994)
- Decree Law no. 67/95 (1995)
- Decree Law no. 193/96 (1996)
- Decree Law no. 31/99 (1999)
- Resolution of the Council of Ministers no. 46/99 (1999)
- Action Plan 1999-2004 (1999)
- Decree Law no. 30/2000 (2000)
- Decree Law no. 88/2000 (2000)
- Decree Law no. 89/2000 (2000)
- Decree Law no. 90/2000 (2000)

<sup>775</sup> Walmsley, R. 2015. *11<sup>th</sup> World Prison Population List*. International Center for Prison Studies.

([http://www.prisonstudies.org/sites/default/files/resources/downloads/world\\_prison\\_population\\_list\\_11th\\_edition.pdf](http://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_11th_edition.pdf))

<sup>776</sup> Greenwald, G. 2009. *Drug decriminalization in Portugal: Lessons for creating fair and successful drug policies*. Cato Institute. ([http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald\\_whitepaper.pdf](http://object.cato.org/sites/cato.org/files/pubs/pdf/greenwald_whitepaper.pdf))

<sup>777</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

- *Decree Law no. 130-A/2001* (2001)
  - *Decree Law no. 183/2001* (2001)
  - *Order no. 22 144/2007* (2007)
  - CATO Institute commissioned to evaluate the Portuguese drug policy (2009)
  - *Decree Law no. 17/2012* / Establishment of SICAD (2012)
  - *National Plan for the Reduction of Addictive Behaviors and Dependencies 2013–20* (2013)
- 

Portugal's *de jure* decriminalization model has been especially grounded on clearly defined thresholds, below which possession of any drug is considered an administrative offence. However, in the 1990s, police discretion was used to divert drug offenders away from the criminal justice system when quantities of illicit drugs represented small quantities,<sup>778</sup> while penal practices shows that a form of *de facto* depenalization was taking place at the same time, especially targeting PWUD.<sup>779</sup> Towards the end of the 1990s, there was little appetite to arrest or incarcerate PWUD.

However, the Portuguese decriminalization law has not legalized drugs and has not permitted, condoned or sought to regulate the use of drugs – rather, social disapproval of drugs was sustained by maintaining the illegality of drugs, but shifting the response from the criminal justice system to an administrative process. In fact, the decriminalization law merely codified pre-existing practices, which represents a symbolic and practical reinforcement of an alternative paradigm, rather than a “revolutionary” or dramatic” shift as some have suggested.

Indeed, well before the decriminalization law was approved, the Portuguese drug policies had been grounded on principles of public health and human rights, despite the fact that the prevailing mechanisms remained under management of law enforcement agencies. Already prior to decriminalization, control over the national response to drug-related issues had started to shift from law enforcement to health agencies, which was formally consolidated with the decriminalization law.

The decriminalization law mandated the establishment of new structures, particularly the drug dissuasion commissions that would become the administrative mechanism by which drug offenders in possession of small quantities of illicit drugs would be assessed and supported (instead of punished). The dissuasion commissions drastically reduced the workload of criminal courts and other law enforcement agencies, freeing up precious resources to pursue other objectives, including reducing the production, distribution and trafficking of illicit drugs. The Portuguese IPDT, later consolidated under SICAD, were established as central coordinating bodies at national level to facilitate implementation of the decriminalization policy.

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<sup>778</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

<sup>779</sup> Laqueur, H. 2014. “Uses and abuses of drug decriminalization in Portugal” in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)



In addition to government agencies, CSO have played a critical role, not only in service delivery but also in policymaking. CSO involved in the response to drug in Portugal have been funded by the government and have established effective partnerships with various government agencies that has led to an integrated set of accessible health options. For example, Portugal reported that IDPT has developed a cost-effective partnership with CSO to share knowledge and scale-up services.<sup>780</sup> In addition, a national drug user network was established in 2007 as well as a national harm reduction network.

The national drug control policy has grown more and more aligned with the four pillars approach and the policy's objectives have remained clearly targeted: prevention to reduce initiation among youth; harm reduction to prevent negative consequences to people who use and inject drugs; treatment to reduce intensive drug use among problem drug users; and law enforcement to reduce the supply of drugs by targeting organized crime. Portuguese drug policies have been consistently guided by core principles that include public health and human rights.

In terms of health impact, Portugal's decriminalization policy has been associated with drastically reduced HIV prevalence amongst PWID while the number of new infections among this group has dropped dramatically; with significantly reduced numbers of fatal overdoses; with reduced numbers of PWID and problem drug users; with an increase in enrollment in drug treatment services; with reduced stigma and fear amongst PWID that otherwise limited motivation to access health services; and with reduced drug use, especially among youth. In contrast, however, the prevalence of viral hepatitis amongst PWID has been increasing steadily.

In parallel with health impacts achieved, the national infrastructure to deliver those services has expanded significantly: coverage with needle and syringe programs and OST services has remained high; a vast referral network has been developed to facilitate access to services among clients; the number of drug treatment outlets has increased; needle syringe programs have been piloted successfully in prison settings; and pharmacies have played a significant role in legitimizing harm reduction services, especially needle and syringe distribution and OST.

In terms of law enforcement, the data presented in this section shows that police have been making a similar or increasing number of drug-related arrests, especially for trafficking, compared to before decriminalization. Assessments of police attitudes towards decriminalization have shown positive trends in support of the new policy. However, reports have shown that decriminalization may have reduced access among law enforcement agencies to information previously collected from PWUD, and made it harder to distinguish trafficker-

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<sup>780</sup> Commission on Narcotic Drugs. 12-16 March 2012. *Improving the participatory role of civil society in addressing the world drug problem (E/CN.7/2012/CRP.1)*. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_55/E-CN7-2012-CRP1\\_V1251017\\_E.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP1_V1251017_E.pdf))

users from traffickers,<sup>781</sup> as traffickers have adjusted their stocks to fit below legal thresholds.<sup>782</sup>

Dissuasion commissions have provided faster, more proportional results compared to the criminal justice approach deployed before decriminalization. The number of commission rulings has increased steadily, showing that the commissions are effective. However, commission rulings have overwhelmingly been linked to cannabis-related offences; given that the commissions were setup to address problematic drugs use driven by heroin, such a concentration on soft drugs that generate relatively fewer problems could be perceived as a critical weakness in the Portuguese model. In addition, the commissions have been criticized for being overly bureaucratic, financially costly and limited in their authority and in the scope of sanctions they can impose.

An increasing number of people sentenced for trafficking have been sent to prison while fewer people who use or are dependent on drugs have ended up in prisons. Overall, fewer drug offenders are being incarcerated. The workload in the criminal court has been drastically reduced by diverting cases to dissuasion commissions. However, prisons have remained slightly overcrowded.

There was limited information about the financial cost related to the implementation of the Portuguese strategy. Reports have shown that expenditures related to drug issues doubled between 1998 and 2004,<sup>783</sup> representing an estimated EUR 40 million in 2004 and for the following three years.<sup>784</sup> However, annual spending on drug related issues increased to EUR 57.4 million,<sup>785</sup> which climbed to EUR 75 million in 2010.<sup>786</sup> Such investments have covered funding for activities under the three health-focused pillars, including funding for CSO. In addition, studies have revealed that the comprehensive high-coverage harm reduction project operated through the national pharmacy association generated savings estimated at EUR 400 million over eight years.

Portuguese drug policies have been consistently based on solid reliable evidence collected and analyzed to generate informed decisions about the way forward. The commitment to data collection and analysis as well as evidence-based decision-making has been recognized and praised by a number of agencies across the world. Portugal's decision to decriminalize drug was not made on a whim but rather grounded on evidence that showed the success of practices in place before decriminalization.

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<sup>781</sup> Hughes, C. and Stevens, A. 2007. *The effects of decriminalization of drug use in Portugal*. The Beckley Foundation Drug Policy Programme. ([https://kar.kent.ac.uk/13325/1/BFDPP\\_BP\\_14\\_EffectsOfDecriminalisation\\_EN.pdf.pdf](https://kar.kent.ac.uk/13325/1/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf))

<sup>782</sup> Laqueur, H. 2014. "Uses and abuses of drug decriminalization in Portugal" in *Law and Social Enquiry*, 40:30, 746-781. (<http://onlinelibrary.wiley.com/doi/10.1111/lsi.12104/abstract>)

<sup>783</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>784</sup> Hughes, C. and Stevens, A. 2007. *The effects of decriminalization of drug use in Portugal*. The Beckley Foundation Drug Policy Programme. ([https://kar.kent.ac.uk/13325/1/BFDPP\\_BP\\_14\\_EffectsOfDecriminalisation\\_EN.pdf.pdf](https://kar.kent.ac.uk/13325/1/BFDPP_BP_14_EffectsOfDecriminalisation_EN.pdf.pdf))

<sup>785</sup> Russoniello, K. "The devil (and drugs) in the details: Portugal's focus on public health as a model for decriminalization of drugs in Mexico" in *Yale Journal of Health Policy, Law and Ethics*, 12:2, 371-431. (<http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1200&context=yjhple>)

<sup>786</sup> Domosławski, A. 2011. *Drug Policy in Portugal – The Benefits of Decriminalizing Drug Use*. Open Society Foundations' Global Drug Policy Program. (<https://www.opensocietyfoundations.org/sites/default/files/drug-policy-in-portugal-english-20120814.pdf>)

## Switzerland

### Historical overview

Psychoactive drugs were introduced in Switzerland in the 1950s,<sup>787</sup> but such substances became increasingly popular through the youth counterculture movement of the 1960s that favored cannabis,<sup>788</sup> and which eventually culminated in social upheaval that rocked Europe, including in Switzerland, in 1968.<sup>789</sup> By 1969, a total of 500 cannabis users had been officially recorded compared to very few opiate users.<sup>790</sup>

The first drug-related death was recorded in 1972,<sup>791</sup> and by 1974, a few cocaine users had been officially recorded. In 1975, the 1951 *Federal Act on Narcotics and Psychotropic Substances*<sup>792</sup> was revised and amended to increase law enforcement action to address the national drug issue,<sup>793</sup> but also compelled the cantons to undertake drug prevention activities as well as provide treatment to all PWUD.<sup>794</sup> The 1975 revision also increased provisions for abstinence-focused drug treatment, legally prohibited distribution of sterile injecting equipment, and imposed challenging standards for the provision of OST.<sup>795</sup> Despite increased policing efforts, drug use and especially heroin injection, continued to grow. Around the time of the revision of the federal drug laws, an estimated 4,000 people were injecting drugs in Switzerland.<sup>796</sup> Given the mounting concerns, discussions in parliament about resolving the situation introduced the concept of heroin substitution through medical prescriptions.<sup>797</sup>

The early 1980s were characterized by an explosion of public drug scenes.<sup>798</sup> In 1980, violent clashes again raged, especially in Zurich, over drug-related issues, where groups of young people demanded the establishment of an autonomous

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<sup>787</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>788</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>789</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>790</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>791</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>792</sup> Federal Assembly of the Swiss Confederation. 1951. *Federal Act on Narcotics and Psychotropic Substances*. (<https://www.admin.ch/opc/en/classified-compilation/19981989/index.html>)

<sup>793</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>794</sup> Federal Department of Home Affairs, and Federal Office of Public Health. *Switzerland's National Drugs Policy: The federal government's third package of measures to reduce drug-related problems (MaPaDro III) 2006–2011*. ([Switzerland's National Drugs Policy - Admin.ch](https://www.admin.ch/gov/de/dokumentation/08671/index.html))

<sup>795</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>796</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>797</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>798</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

center.<sup>799</sup> By 1982, such a center was unofficially established, governed and administered by PWUD, to provide a safe space for people to use drugs and to distribute health commodities, including needles and syringes, despite the fact that such acts were prohibited by law.<sup>800</sup> In 1983 (and again in 1989), the Federal Narcotic Commission's subcommittee on drugs published reports making recommendations for the future of Swiss drug policy.<sup>801</sup> The reports recommended a number of strategies and interventions with the aim of reducing the risks related to the use of illicit drugs, including decriminalizing drug use, diverting PWUD away from prisons and into treatment, and scaling up low-threshold services.<sup>802</sup> In 1985, an estimated 10,000 people were injecting drugs across the country; HIV prevalence was recorded at 38% among PWID; and 68% of new HIV cases were detected among the same group.<sup>803</sup>

In 1986, the country's first drug consumption room was opened, one of the first on the European continent.<sup>804</sup> That same year, the Cantonal Medical Association and the Public Prosecutor intervened to support harm reduction measures,<sup>805</sup> particularly distribution of sterile injecting equipment, when the Zurich canton's medical director threatened to revoke the licence of any physician caught distributing needle and syringes. Over 300 doctors signed a declaration, prioritizing public health responses over legal concerns.<sup>806</sup> In response, cantonal authorities in Zurich approved needle and syringe distribution.<sup>807</sup> And in 1987, the cantonal government also allowed people who use illicit drugs to gather and consume drugs in a defined place – the Platzspitz park – which became commonly known as the “needle park.”<sup>808</sup> At its peak, over 1,000 people per day would come to the needle park to use drugs.<sup>809</sup> Around this time, similar open drug scenes were popping up all over Switzerland, like in Bern for example.

In 1988, the CSO ZIPP-AIDS was established under the leadership of Dr. Peter Grob, to provide health services and emergency assistance to people in the

<sup>799</sup> Uchtenhagen, A. 2010. “Heroin-assisted treatment in Switzerland: A case study in policy change” in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>800</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>801</sup> Sub-committee on Drug Issues of the Federal Narcotic Commission. 1989. *Aspects de la situation et de la politique en matière de drogue en Suisse*. Federal Office for Public Health; Sub-committee on Drug Issues of the Federal Narcotic Commission. 1983. *Rapport sur la drogue*. Federal Office for Public Health.

<sup>802</sup> Uchtenhagen, A. 2010. “Heroin-assisted treatment in Switzerland: A case study in policy change” in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>803</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>804</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>805</sup> Uchtenhagen, A. 2010. “Heroin-assisted treatment in Switzerland: A case study in policy change” in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>806</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>807</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>808</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>809</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

Platzspitz park; the service was officially allowed to operate provided it collected extensive data about the situation in the park.<sup>810</sup> By then, the number of PWID had doubled, numbering an estimated 20,000,<sup>811</sup> and an estimated 50% of new HIV infections were detected amongst PWID.<sup>812</sup>

In 1989, a strategy paper prepared by an eminent politician and doctor working in the drugs sector in Zurich proposed a new drug strategy that included heroin prescription.<sup>813</sup> That same year, a member of the Sub-commission on Drugs was requested to review all scientific evidence relating to the prescription of heroin and morphine.<sup>814</sup> The report, published in 1990, reviewed experiences from the Netherlands, from Sweden, from the United Kingdom and from the United States to draw out the aims, outcomes and impacts of such programs. The report concluded with recommendations to initiate a scientific study about heroin prescription in Switzerland.<sup>815</sup> By the early 1990s, the annual number of drug-related deaths had risen to 350-400.<sup>816</sup> In parallel, drug-related law enforcement crackdowns had massively increased in the early 1990s.<sup>817</sup>

In 1990, in response to the 1989 and 1990 papers described in the paragraph above, the Zurich City Council formulated a new drug policy – the *Four Pillars Strategy* – that integrated harm reduction as a core approach alongside prevention, treatment and law enforcement.<sup>818</sup> That year, the citizens of Zurich were invited to vote on the legality of drug consumption rooms, which they rejected through a referendum; similarly, the following year, the citizens of Saint Gall also rejected drug consumption rooms through a similar political process.<sup>819</sup> Also that year, the federal government earmarked additional funds for drug-related law enforcement.<sup>820</sup>

In 1991, the parliament approved a national drug policy, based on the same four pillars as in the strategy developed in Zurich the year before, which delegated

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<sup>810</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>811</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>812</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>813</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>814</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>815</sup> Mino, A. 1990. *Analyse scientifique de la littérature sur la remise contrôlée d'héroïne ou de morphine*. Federal Office of Public Health.

<sup>816</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>817</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>818</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>819</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>820</sup> Federal Office of Public Health. 2000. *Swiss Drug Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)



authority for drug policy development and implementation to the Federal Office of Public Health.<sup>821</sup> That year, the *National Drug Program to Reduce Drug Problems 1991-1996* (also known as *MaPaDro*) was established by the federal government, defining the recommended package of interventions to address drug-related problems, with the aim of preventing PWUD from becoming dependent; facilitating access to health services amongst PWUD; and improving quality of life amongst PWUD and reducing the risks related to drug use.<sup>822</sup> Harm reduction and heroin prescription were included in the new policies – in the canton of Zurich and at federal level – as innovative components.

Also in 1991, the first national drug conference took place, seeking to build consensus about the state of affairs in Switzerland at the time, and opening further discussion on available and feasible policy options.<sup>823</sup> Again in 1991, the CSO ARUD (*Arbeitsgemeinschaft für Risikoarmen Umgang mit Drogen* or the Association for Reducing the Risks of Drug Use) was established under the leadership of Dr. André Seidenberg, one of the key actors who challenged the cantonal authorities in regards to distribution of sterile injecting equipment in 1986.<sup>824</sup>

By 1992, an estimated 30,000 people were injecting drugs across Switzerland.<sup>825</sup> That same year, the federal government approved new legislation to enable prescription of narcotics on very strict conditions, under tight controls, and with exceptional authorization from the Federal Office of Public Health.<sup>826</sup> Once the law in place, the government approved initiation of the famous heroin trials: rigorous scientific studies of the impact of heroin prescription to facilitate access to treatment among groups of people who were either unwilling or unable to enroll in existing programs.<sup>827</sup>

However, in reaction to those efforts, public opinion was rapidly souring and several attempts were made in 1992 to close down the needle parks in Zurich and Bern, which eventually succeeded.<sup>828</sup> But already by 1993, the users who

<sup>821</sup> Uchtenhagen, A. 2010. “Heroin-assisted treatment in Switzerland: A case study in policy change” in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>822</sup> Reinhard, U. (ed.). 2001. “Efforts to reduce drug problems” in *Spectra*, 25. Federal Office of Public Health (<http://ponce.inter.edu/acad/facultad/jvillasr/Suiza%20heorina%202.pdf>)

<sup>823</sup> Uchtenhagen, A. 2010. “Heroin-assisted treatment in Switzerland: A case study in policy change” in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>824</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations’ Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>825</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations’ Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>826</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report\\_of\\_the\\_External\\_Panel\\_on\\_the\\_Evaluation\\_of\\_the\\_Swiss\\_Scientific\\_Studies\\_of\\_Medically\\_Prescribed\\_Narcotics\\_to\\_Drug\\_Addicts\\_1999.pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf))

<sup>827</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report\\_of\\_the\\_External\\_Panel\\_on\\_the\\_Evaluation\\_of\\_the\\_Swiss\\_Scientific\\_Studies\\_of\\_Medically\\_Prescribed\\_Narcotics\\_to\\_Drug\\_Addicts\\_1999.pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf))

<sup>828</sup> Klingemann, H. K. H. 1996. “Drug treatment in Switzerland: Harm reduction, decentralization and community response” in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

had been meeting in the needle park in Zurich had found a new spot near the Letten train station, which rapidly became an open drug scene fueling concerns in the local community once again.<sup>829</sup> By 1994, the residents of Letten sent an ultimatum to the authorities: close down the open drug scene or the residents would do it themselves; having raised almost \$200,000 to do so, the residents were ready to take the law into their own hands and mete out their own brand of justice.<sup>830</sup> Desperate, the Zurich cantonal authorities took action, closing down the Letten scene in 1995.<sup>831</sup>

Back in 1994, the Swiss Federal Council formally endorsed and deployed the national *Four Pillars* policy after extensive consultation with experts and key stakeholders.<sup>832</sup> In its policy report, *The Position of the Federal Council on Current Problems Related to Drugs*, the Federal Council aligned its recommendations with the Federal Narcotic Commission's recommended approach based on the four pillars of prevention, harm reduction, treatment and law enforcement.<sup>833</sup> Shortly after approving the new policy, the famous Swiss heroin prescription studies were formally initiated with PROVE ('Projekt zur ärztlichen Verschreibung von Betäubungsmitteln' or project on medical prescription of narcotics), a multi-site prospective scientific cohort study implemented through randomized controlled trials,<sup>834</sup> initially planned to run for three years,<sup>835</sup> and piloted on a restricted scale in 18 centers in Zurich, Bern, Basel, and Geneva.<sup>836</sup> However, the implementation challenges led to a change in the study protocol which was simplified to focus on collection and analysis of prospective observational data.<sup>837</sup> While the study protocol was modified, the study's objective remained the same: to assess the individual and social therapeutic value of prescribed heroin among high-risk heroin users for whom such benefits could not be expected or achieved through existing treatment options.<sup>838</sup>

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<sup>829</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>830</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>831</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>832</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>833</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>834</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

<sup>835</sup> Federal Office of Public Health. 2000. *Swiss Drug Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>836</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>837</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

<sup>838</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

However, the INCB expressed concerns about the Swiss heroin studies in 1994.<sup>839</sup> A delegation of INCB representatives visited Switzerland's heroin prescription sites in 1994 and again in 1995.<sup>840</sup> At the end of 1994, the first national drug summit was held to stimulate discussion and buy-in around the new proposed options for effective drug policy implementation in Switzerland.<sup>841</sup>

By 1995, drug raids by the police were intensified,<sup>842</sup> and the open drug scene in Letten was closed officially.<sup>843</sup> Despite those repressive interventions, reports indicate that open discussion and constructive dialogue about the future of drug policy was well underway at that time,<sup>844</sup> and that same year, the second national drug conference was held, focusing on synthetic drugs and stimulants.<sup>845</sup> In 1995 and 1996, the Federal Narcotic Commission released two significant reports, one related to methadone services,<sup>846</sup> and the other presenting various drug policy scenarios.<sup>847</sup>

In 1997, an estimated 15% of all new HIV cases were detected amongst PWID.<sup>848</sup> That year, the Federal Council formally established the Federal Commission for Drug Issues (EKDF)<sup>849</sup> as an official drug policy advisory body to the federal government, effectively replacing the Federal Narcotics Commission. The new body was composed of 14 individuals, mostly medical doctors, health experts and academics.<sup>850</sup> Again that year, the Federal Office for Public Health renewed the national drug control program until 2001.<sup>851</sup>

<sup>839</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts 1999 .pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report%20of%20the%20External%20Panel%20on%20the%20Evaluation%20of%20the%20Swiss%20Scientific%20Studies%20of%20Medically%20Prescribed%20Narcotics%20to%20Drug%20Addicts%201999.pdf))

<sup>840</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>841</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>842</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>843</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>844</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>845</sup> Federal Office for Public Health. 2006. *Conférence nationale sur les drogues de synthèse et la cocaïne*. ([https://www.google.co.th/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiX9JTg5NDQAhUKuo8KHY58AIwQFggBMAA&url=http%3A%2F%2Fwww.infodrog.ch%2Ffiles%2Ftemplates%2FInfoDrog%2Fuser\\_upload%2Fschadensminderung\\_fr%2Fofsp\\_NaDeKo\\_fr\\_2006-02.pdf&usq=AFOjCNHS9jEHLm06jr6Ov-hrlUR2vTGKGw&sig2=G-7QaPuDI\\_ZU\\_N0ehr38ZQ](https://www.google.co.th/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiX9JTg5NDQAhUKuo8KHY58AIwQFggBMAA&url=http%3A%2F%2Fwww.infodrog.ch%2Ffiles%2Ftemplates%2FInfoDrog%2Fuser_upload%2Fschadensminderung_fr%2Fofsp_NaDeKo_fr_2006-02.pdf&usq=AFOjCNHS9jEHLm06jr6Ov-hrlUR2vTGKGw&sig2=G-7QaPuDI_ZU_N0ehr38ZQ))

<sup>846</sup> Federal Narcotic Commission. 1995. *Rapport sur la méthadone*.

<sup>847</sup> Federal Narcotic Commission. 1996. *Scénarios pour une politique de la drogue*.

<sup>848</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>849</sup> See [www.psychosaktiv.ch](http://www.psychosaktiv.ch).

<sup>850</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>851</sup> Zobel, F., et al. 2003. *Global evaluation of the Confederation's measures to reduce drug-related problems (ProMeDro)*. ([https://www.iunsp.ch/Publications/pdf/tox4\\_en.pdf](https://www.iunsp.ch/Publications/pdf/tox4_en.pdf))

That same year, the first results of the PROVE study were published, showing positive outcomes following heroin prescription in terms of acceptance, compliance, and retention of clients (who preferred heroin over morphine or methadone), as well as significant improvements in health and social status of participants, while approximately half of drop-outs went on to access abstinence-based treatment or OST.<sup>852</sup> Despite these significant successes, opposition to the new policy, and especially in regards to heroin prescription, led to two initiatives that triggered national referendums. Proposed in 1993, '*Youth without Drugs*' proposed legal amendments that would focus drug policy on the ultimate goal of achieving abstinence, emphasizing the role of law enforcement along with prevention and abstinence-focused treatment, and prohibiting the prescription of narcotics like methadone and heroin.<sup>853</sup> In 1994, '*For a Reasonable Drug Policy*' also proposed legal amendments, this time to decriminalize drug use and cultivation of plant-based psychoactive substances, to legalize possession, use and purchase of drugs, and to create a legal framework to regulate such substances.<sup>854</sup> Both initiatives were defeated in referendums in 1997 and 1998, with 70% and 74% of the vote respectively, confirming the general population's endorsement of the *Four Pillars* policy.<sup>855</sup> Again, despite growing evidence that the *Four Pillars* approach was generating significant positive outcomes, the Federal Council ordered an intensification of drug-related law enforcement activities, which became more and more aggressive between 1998 and 2007.<sup>856</sup>

In 1998, the Federal Council issued an executive order permanently endorsing HAT as a mainstay of the federal drug policy.<sup>857</sup> This new legislative order once again triggered a national referendum, held in 1999. At the end of the political process, the majority of Swiss voters (54%) had endorsed this intervention.<sup>858</sup> That same year, WHO was commissioned by the Swiss government to conduct an independent evaluation of the Swiss heroin studies, which had proliferated since the initiation of PROVE in 1994. The external evaluation supported the original study conclusions that medical prescription of heroin amongst PWID is feasible under highly controlled conditions where the prescribed drug is injected on site, in a manner that is safe, clinically responsible and acceptable to the community.<sup>859</sup> The evaluation also concluded that the original findings regarding

<sup>852</sup> Uchtenhagen, A., Gutzwiller, F., Dobler-Mikola, A. D., and Steffen, T. 1997. "Programme for a medical prescription of narcotics: A synthesis of results" in *Eur Addict Res*, 3: 160–163. ([http://bdoc.ofdt.fr/index.php?lvl=notice\\_display&id=31401](http://bdoc.ofdt.fr/index.php?lvl=notice_display&id=31401))

<sup>853</sup> Khan, R. et al. 2014. "Understanding Swiss Drug Policy Change and the Introduction of Heroin Maintenance Treatment" in *Eur Addict Res*, 20: 200–207. (<https://www.ncbi.nlm.nih.gov/pubmed/24513780>)

<sup>854</sup> Khan, R. et al. 2014. "Understanding Swiss Drug Policy Change and the Introduction of Heroin Maintenance Treatment" in *Eur Addict Res*, 20: 200–207. (<https://www.ncbi.nlm.nih.gov/pubmed/24513780>)

<sup>855</sup> Khan, R. et al. 2014. "Understanding Swiss Drug Policy Change and the Introduction of Heroin Maintenance Treatment" in *Eur Addict Res*, 20: 200–207. (<https://www.ncbi.nlm.nih.gov/pubmed/24513780>)

<sup>856</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998–2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>857</sup> Khan, R. et al. 2014. "Understanding Swiss Drug Policy Change and the Introduction of Heroin Maintenance Treatment" in *Eur Addict Res*, 20: 200–207. (<https://www.ncbi.nlm.nih.gov/pubmed/24513780>)

<sup>858</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>859</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. (<http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk->

the gains in health and social status of this intervention were indeed significant, adding that the studies had also led to a decrease in criminal behavior and in reported use of illicit heroin.<sup>860</sup>

In 1999, the EKDF published a report on cannabis,<sup>861</sup> given that repression interventions had been increasingly related to this drug.<sup>862</sup> By 2001, the federal government legally registered heroin for medicinal purposes, and, while progressively overcoming significant procurement challenges, instructed private insurance companies that they would be expected to cover the cost of HAT as part of the federal health insurance system.<sup>863</sup> However, again in 2003 and 2004 and coinciding with the rise of the far right in Switzerland, attempts were made to overturn the *Four Pillars* policy and return to drug policies that focused on criminalization, but without success.<sup>864</sup>

In 2003, a comprehensive independent evaluation of the second federal drug control program (*ProMeDro 1999-2002*) was performed, revealing that significant gains had been achieved in health and social functioning of PWUD.<sup>865</sup> In 2006, the Federal Office of Public Health approved the third national drug control program (*MaPaDro III - 2006-2011*)<sup>866</sup>

By 2007, federal authorities had conducted four nationwide general population surveys about lifetime prevalence of illicit drug use. The results of the surveys, summarized in *Table 39* below, show that use of cannabis was common among young people; that excluding cannabis, few people (fewer than 5%) had experience with illicit drugs; and that use of hard drugs had increased over ten years.<sup>867</sup>

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[pdfs/Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts 1999 .pdf](#)

<sup>860</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. (<http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts 1999 .pdf>)

<sup>861</sup> Federal Commission for Drug Issues. 1999. *Rapport sur le cannabis*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7t.Inp6I0NTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCEfYN3g2ym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7t.Inp6I0NTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCEfYN3g2ym162epYbg2c_JjKbNoKSn6A--))

<sup>862</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>863</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>864</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>865</sup> Zobel, F., et al. 2003. *Global evaluation of the Confederation's measures to reduce drug-related problems (ProMeDro)*. ([https://www.iumsp.ch/Publications/pdf/tox4\\_en.pdf](https://www.iumsp.ch/Publications/pdf/tox4_en.pdf))

<sup>866</sup> Federal Office for Public Health. 2006. *La politique Suisse en matière de drogue: Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue (ProMeDro III) 2006–2011*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.Inp6I0NTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCEfXx3f2ym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.Inp6I0NTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCEfXx3f2ym162epYbg2c_JjKbNoKSn6A--))

<sup>867</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)



*Table 39: Lifetime prevalence of use of specific drugs among 15-39 year olds, 1992 to 2007, by gender*<sup>868</sup>

Lifetime prevalence	Female 1992/93	Female 1997/98	Female 2002	Female 2007	Male 1992/93	Male 1997/98	Male 2002	Male 2007
Hallucinogen	1.2	1.7			3.0	3.8		
Amphetamine	0.6	0.8			1.5	1.7		
Ecstasy	N.A.	1.5	1.5		N.A.	2.8	2.9	
Methadone	0.3	0.3			0.5	0.5		
Cocaine	1.8	2.2	1.9		3.5	4.3	4.0	
Heroin	0.7	0.7	0.5		1.9	1.4	1.3	
Hard drugs*		3.3	3.0	4.3		6.0	5.4	8.1
Cannabis	11.1	19.9	21.1	23.7	21.5	33.4	34.2	39.5
Any Drug	11.5	20.4			22.0	33.8		

\*Hard Drugs were – according to BFS (2009, personal communication) – defined as all drugs other than cannabis.

Back in 2004, internal divisions regarding drug policy within the government became increasingly apparent when the Council of State twice voted for the decriminalization of cannabis for personal use, but the National Council vetoed these decisions.<sup>869</sup> Eventually, consensus was reached in 2008 when a new legal amendment to the narcotics law was introduced by the Federal Council, with support from both the Council of State and the National Council, which provided legal grounding for the four pillars and their activities, but did not include decriminalization of cannabis.<sup>870</sup> Again, the amendment triggered a national referendum, which tested the general population's understanding of the *Four Pillars* approach. In the lead up to the referendum, the Federal Commission for Drug Issues published a number of public statements emphasizing the consensus among health and social service professionals that favored the *Four Pillars* approach, and that young people would be best protected from the risks related to drugs by striking a balance between policing and comprehensive health services.<sup>871</sup> At the end of 2008, the Swiss people voted in an overwhelming majority (68%) in support of the *Four Pillars* policy.<sup>872</sup> That same year, the EKDF published another report on cannabis.<sup>873</sup>

By 2009, the proportion of new cases of HIV amongst PWID had dropped even further, down to 5%.<sup>874</sup> Throughout the 2000s, the number of drug-related

<sup>868</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>869</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>870</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>871</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>872</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>873</sup> Federal Commission for Drug Issues. 2008. *Cannabis 2008: Mise à jour du rapport 1999 sur le cannabis*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7tJnp6iONTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCGe4B3g2ym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7tJnp6iONTU042I2Z6In1ae2IZn4Z2qZpnO2YUq2Z6gpJCGe4B3g2ym162epYbg2c_JjKbNoKSn6A--))

<sup>874</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

deaths also plummeted, down to 150-200 cases per year.<sup>875</sup> In 2012, the Federal Office for Public Health extended the national drug control policy (*ProMeDro III*) for the period 2012-2016.<sup>876</sup> In 2013, the EKDF prepared another landmark report, released in 2014, which presented and proposed a range of models to regulate psychoactive substances, including licit drugs like tobacco and alcohol, in Switzerland.<sup>877</sup>

At the 2016 UNGASS on the World Drug Problem, the head of the Swiss delegation, Mr. Alain Berset, cautioned other Member States that drug policies must include interventions beyond those that focus exclusively on the goal of abstinence, that harm reduction is an indispensable pillar of Switzerland's drug control strategy, along with prevention and treatment, ideally coordinated with law enforcement agencies whose role should be guided by public health and human rights imperatives.<sup>878</sup> On behalf of Switzerland, Mr. Berset also emphatically opposed all forms of capital punishment, an ineffective intervention, including for cases related to drug offences.<sup>879</sup>

### Implementation of the national drug control strategy

Every drug control policy since 1991 has been modeled on the *Four Pillars* approach, as noted above, which has included prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues. This sub-section will review the range of strategies and activities implemented in Switzerland under each pillar, as well as their impact.

### *Prevention*

Limited information was available on drug prevention activities in Switzerland or their impact.<sup>880</sup> The objective of the prevention strategy has been to reduce the initiation of drug use, avoid drug dependence and reduce drug-related health problems.<sup>881</sup> The strategy has focused on early interventions targeting children and young people as well as on school-based interventions while targeting individual behaviors and social structures, rather than illicit substances

<sup>875</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Polices%20in%20Switzerland.pdf>)

<sup>876</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>877</sup> Hansjakob, T. 2014. *Modèles de régulation des substances psychoactives*. Federal Commission for Drug Issues. ([http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/00625/00791/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>878</sup> Berset, A. 19 April 2016. *Assemblée générale, première séance plénière, trentième session extraordinaire sur le problème mondial de la drogue*. (<http://statements.unmeetings.org/media2/7657352/switzerland.pdf>)

<sup>879</sup> Berset, A. 19 April 2016. *Assemblée générale, première séance plénière, trentième session extraordinaire sur le problème mondial de la drogue*. (<http://statements.unmeetings.org/media2/7657352/switzerland.pdf>)

<sup>880</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Polices%20in%20Switzerland.pdf>)

<sup>881</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

themselves.<sup>882</sup> In that context, the overall strategy has been more akin to general health promotion rather than a classic drug prevention approach.<sup>883</sup>

Early interventions proposed and prioritized in the policy include: support to cantons, communes, schools and nightlife programs; support for targeted advocacy; development of brochures, reports and other promotional materials; sharing and dissemination of relevant information and evidence; promotion of shared lessons learned; facilitated networking; and promotion and delivery of training related to early interventions.<sup>884</sup>

### *Harm reduction*

Harm reduction interventions were introduced officially through legal reforms in 1990 in the Zurich drug policy, and later in 1991, the federal government also formally integrated harm reduction in the national drug policy. Official policy documents have been explicit about the ultimate goal this strategic pillar: to reduce the social costs related to drug use and improve public security.<sup>885</sup> According to the policy, this goal can only be achieved by focusing on three priorities: reducing transmission of infectious diseases (HIV, viral hepatitis, etc.), stabilizing the health of PWUD, and facilitating social reintegration.<sup>886</sup>

Data shows that the population of PWID has waxed and waned over time. In 1975, an estimated 4,000 PWID were recorded,<sup>887</sup> increasing to an estimated 10,000 PWID in 1985,<sup>888</sup> to an estimated 20,000 PWID in 1988,<sup>889</sup> to an estimated 30,000 PWID in 1992,<sup>890</sup> and to an estimated 31,653 PWID in 1997.<sup>891</sup> By 2007, the number of PWID had dropped to an estimated 11,850,<sup>892</sup> further down to an estimated 10,640 in 2015.<sup>893</sup>

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<sup>882</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>883</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>884</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>885</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*. ([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2Yuq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>886</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>887</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>888</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>889</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>890</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>891</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>892</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>893</sup> Negro, F., et al. 17 November 2015. "Hepatitis C virus (HCV) prevalence among people who inject drugs (PWIDs) in Switzerland" in *AASLD LiverLearning*.

Interventions implemented under the harm reduction pillar have been grouped by modalities: health promotion; low-threshold services; medical services; social care; and development of an enabling legal environment.<sup>894</sup> Low-threshold services have included primary medical care; counseling; distribution of sterile injecting equipment in the community and in closed settings; drug consumption rooms; facilitated access to food, employment, housing and emergency shelter; gender-specific services to address the special needs of women and girls, especially those involved in sex work; referrals to specialized health services; and advisory centers targeting children and parents.<sup>895</sup> Interventions emphasize information sharing, raising awareness, improving quality of services and building capacity.<sup>896</sup> In Switzerland, OST and HAT are included under the treatment pillar.

The first DIC was opened in Zurich in 1970, providing medical emergency services for drug-related adverse events among young people.<sup>897</sup> The number of low-threshold facilities – including DIC – has increased significantly over time, although the exact number of such facilities was not available in the literature.<sup>898</sup> In 2004, media reports showed that up 15,000 needles and syringes has been distributed to PWID on a weekly basis.<sup>899</sup> In contrast, reports indicated that 101 needle and syringe distribution sites were operating in 2012.<sup>900</sup> By 2015, an estimated 4,320 PWID (47%) were being reached across Switzerland.<sup>901</sup> As indicated in the previous section, a number of CSO and other agencies had initiated harm reduction service delivery long before those were legally endorsed.

CSO have played an important role in initiating, delivering and scaling up harm reduction services in Switzerland. ZIPP-AIDS and ARUD were pioneers in this sector back in the 1980s. Since then, many more CSO have been involved in harm reduction, including policy advocacy and policymaking. While there is no

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(<http://liverlearning.aasld.org/aasld/2015/thelivermeeting/111062/francesco.negro.hepatitis.c.virus.28hcv29.prevalence.among.people.who.inject.html?f=p16m3t137016345>)

<sup>894</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>895</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>896</sup> Federal Office of Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMedro III 2012 – 2016*.

([Addiction, 91:5, 723-736.](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp610NTU04212Z6ln1ae2IZn4Z2qZpnO2Yug2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--)

([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>897</sup> Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37.

(<https://www.ncbi.nlm.nih.gov/pubmed/19922519>)

<sup>898</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736.

([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>899</sup> Foulkes, I. 2 January 2004. "Needle exchange curbs spread of Aids" in *Swissinfo.ch*. (<http://www.swissinfo.ch/eng/needle-exchange-curbs-spread-of-aids/3657406>)

<sup>900</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International.

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>901</sup> Negro, F., et al. 17 November 2015. "Hepatitis C virus (HCV) prevalence among people who inject drugs (PWIDs) in Switzerland" in *AASLD LiverLearning*.

(<http://liverlearning.aasld.org/aasld/2015/thelivermeeting/111062/francesco.negro.hepatitis.c.virus.28hcv29.prevalence.among.people.who.inject.html?f=p16m3t137016345>)

national harm reduction network, two regional networks have been operating in the German- and French-speaking regions of Switzerland respectively.<sup>902</sup> No evidence of a specific drug user network was identified in the literature, although there have been indications that PWUD have long organized their activities to meet the needs of their peers.<sup>903</sup>

Reports also indicate that private-sector pharmacies have played an important role in scaling up access to sterile injecting equipment in Switzerland, but their role has been declining over time.<sup>904</sup> For example, in the Canton of Vaud in 1996, pharmacies distributed over 15,000 needles and syringes per month, representing 60% of the total needles and syringes distributed in that canton that year; by 2003, the number of needles and syringes distributed dropped to 8,520 per month, representing only 20% of total distribution.<sup>905</sup>

In 1992, an informal needle and syringe distribution program was piloted in the Oberschongrun prison for men, without formal approval from prison authorities. The combined success of the pilot and the deployment of the 1994 *Four Pillars* policy facilitated the scale-up of this intervention: an additional pilot was initiated at the Hindlebank prison for women,<sup>906</sup> which was later scale-up to a total of seven prisons at the height of the program in 2014.<sup>907</sup> Only three such projects remain in operation today.<sup>908</sup> Inside prisons, needles and syringes have been distributed by official prison health workers at the cell door or in the medical unit as well as through automated vending machines that require one-to-one exchange.<sup>909</sup> Evaluations of the Swiss prison-based needle and syringe programs underline the success of these interventions which have reduced needle sharing, reduced transmission of blood-borne viruses, not increased drug use, not led to the use of injecting equipment as weapons, and improved overall prison management.<sup>910</sup>

Drug consumption rooms offer safe spaces for people who use and inject drugs to consume illicit substances procured outside the facility. The first drug consumption room was opened in 1986 (though it changed location several

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<sup>902</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>903</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>904</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562.

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

<sup>905</sup> Fischer, B., Haasen, C. and Strang, J. 2007. "Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics" in *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 84:4, 552-562.

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/>)

<sup>906</sup> Australian Injecting & Illicit Drug Users League. 2015. *Needle and Syringe Programs in Prisons: An International Review*. (<http://www.aivl.org.au/wp-content/uploads/NSP-in-Prisons-An-International-Review.pdf>)

<sup>907</sup> Australian Injecting & Illicit Drug Users League. 2015. *Needle and Syringe Programs in Prisons: An International Review*. (<http://www.aivl.org.au/wp-content/uploads/NSP-in-Prisons-An-International-Review.pdf>)

<sup>908</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>909</sup> Australian Injecting & Illicit Drug Users League. 2015. *Needle and Syringe Programs in Prisons: An International Review*. (<http://www.aivl.org.au/wp-content/uploads/NSP-in-Prisons-An-International-Review.pdf>)

<sup>910</sup> Australian Injecting & Illicit Drug Users League. 2015. *Needle and Syringe Programs in Prisons: An International Review*. (<http://www.aivl.org.au/wp-content/uploads/NSP-in-Prisons-An-International-Review.pdf>)



times due to community pressures),<sup>911</sup> and by 2003, a total of 13 such facilities operated across seven Swiss cities,<sup>912</sup> up to 2014.<sup>913</sup> A recent report published in 2016 indicated that the number of drug consumption rooms had dropped to 12,<sup>914</sup> although plans were in place to open an additional drug consumption room in Lausanne, in 2017.<sup>915</sup>

Prevalence of HIV, viral hepatitis and overdoses are useful indicators to assess the impact of Switzerland's harm reduction strategy. HIV prevalence amongst PWID was estimated at 38% in 1985,<sup>916</sup> down to 1.4% in 2007,<sup>917</sup> and up again to 7% in 2014.<sup>918</sup> HIV prevalence amongst PWID has remained very high compared to HIV prevalence among the general population, estimated at 0.2% in 2015.<sup>919</sup> New HIV cases amongst PWID have dropped systematically over time, largely attributed to the comprehensive range of harm reduction services across the country: from 68% in 1985, down to 50% in 1988-1989,<sup>920</sup> down to 15% in 1997, and further down to 5% in 2009.<sup>921</sup>

In terms of viral hepatitis, prevalence of HCV has varied significantly but few data points were available to understand historical trends. In 2008, HCV prevalence amongst PWID was reported at 91%,<sup>922</sup> at 78.3% in 2014,<sup>923</sup> and at 42% in 2015.<sup>924</sup> In contrast, only one data point for HBV prevalence amongst PWID was identified, published in 2014, estimating PWID prevalence at 4%.<sup>925</sup> Published data indicates that new HBV cases amongst PWID have dropped

<sup>911</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>912</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>913</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>914</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>915</sup> Muller-Baum, E. 22 June 2016. "Switzerland to Get New Supervised Injection Facility in 2017" in *TalkingDrugs.org*, online at: <http://www.talkingdrugs.org/switzerland-new-supervised-injection-facility-in-2017>.

<sup>916</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>917</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>918</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>919</sup> Kohler, P. et al. 2015. "The HIV care cascade in Switzerland: reaching the UNAIDS/WHO targets for patients diagnosed with HIV" in *AIDS*, 29(18): 2509-15. (<https://www.ncbi.nlm.nih.gov/pubmed/26372488>)

<sup>920</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>921</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>922</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>923</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>924</sup> Negro, F., et al. 17 November 2015. "Hepatitis C virus (HCV) prevalence among people who inject drugs (PWIDs) in Switzerland" in *AASLD LiverLearning*. (<http://liverlearning.aasld.org/aasld/2015/thelivermeeting/111062/francesco.negro.hepatitis.c.virus.28hcv29.prevalence.among.people.who.inject.html?f=p16m3t1370l6345>)

<sup>925</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

significantly, from 51% in the late 1980s and early 1990s to less than 10% in 2010.<sup>926</sup>

Similarly, the number of drug-related deaths has declined from an annual estimate of 350-400 down to an estimated 150-200 per year.<sup>927</sup>

### *Treatment*

The treatment pillar in the Swiss drug policy has been designed to help PWUD overcome their dependence, improve their physical and mental wellbeing, and assure their social reintegration.<sup>928</sup> In that respect, treatment services have included all medical and psychosocial interventions targeting people who are dependent on drugs.<sup>929</sup> All treatment modalities have been designed to focus primarily on building an effective therapeutic relationship and to take into consideration the person's socio-economic situation in order to be most effective.<sup>930</sup>

Essentially, the focus of Switzerland's drug treatment strategy has changed from one exclusively focused on achieving abstinence, to one that prioritizes a more pragmatic approach in which abstinence-related goals are balanced with complementary services to enhance demand and better meet the needs of people dependent on drugs.<sup>931</sup> This shift has implied that the time-consuming recruitment of motivated clients to enroll in mostly inpatient treatment has been deprioritized to facilitate access to a greater number of people in need to low-threshold and outpatient treatment services.<sup>932</sup>

The cantonal governments have been responsible for implementing these programs although a number of CSO have also been involved in delivering drug treatment services across Switzerland.<sup>933</sup> Treatment services on offer, through the country's coherent health system,<sup>934</sup> have included residential and outpatient drug dependence treatment services, HAT, OST, services in prison settings, and

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<sup>926</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>927</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/asmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>928</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>929</sup> Federal Office for Public Health. 2012. *Troisième programme de mesures de la Confédération en vue de réduire les problèmes de drogue: Plan d'action ProMeDro III 2012 – 2016*.

([http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2YUq2Z6gpJCKe3t7gWym162epYbg2c\\_JjKbNoKSn6A--](http://www.bag.admin.ch/themen/drogen/00042/00624/03048/index.html?lang=fr&download=NHZLpZeg7t.lnp6I0NTU042I2Z6ln1ae2IZn4Z2qZpnO2YUq2Z6gpJCKe3t7gWym162epYbg2c_JjKbNoKSn6A--))

<sup>930</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>931</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>932</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>933</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>934</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

viral hepatitis treatment programs.<sup>935</sup>

Inpatient treatment services have been designed to overcome dependence and ultimately to facilitate social reintegration.<sup>936</sup> Indicators for success of inpatient treatment have included improvements in health, abstinence from drug use, establishment of functional relationships and leisure activities, improvements in living conditions (housing), and reductions in criminal behavior.<sup>937</sup>

Residential treatment in Switzerland has been accessible through hospitals, clinics, halfway houses, sheltered group accommodation, and reintegration programs.<sup>938</sup> In 1993, an estimated 1,300 beds were available for inpatient treatment,<sup>939</sup> climbing to an estimated 2,150 beds in 1999 across approximately 110 sites.<sup>940</sup> By 2009, the number of inpatient beds dropped significantly to approximately 1,000, showing the decreasing importance and relevance of such services in the context of implementing the national drug policy.<sup>941</sup> Such treatment programs have generally required a minimum 12-month commitment while the majority of halfway houses have offered one- to six-month programs.<sup>942</sup>

In 1997, the drug of choice for over 60% of individuals enrolling in residential drug treatment programs was opiates, dropping to an estimated 30% by 2005.<sup>943</sup> During that period, cocaine grew increasingly more popular: in 1997, cocaine was the drug of choice for only 15% of residential treatment entrants, compared to 40% in 2005.<sup>944</sup>

Switzerland has over 200 community-based outpatient counseling centers designed to facilitate implementation of prevention and treatment interventions; approximately half of such centers also have medical professionals on staff to

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<sup>935</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>936</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>937</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>938</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>939</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed*

*Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf)

[berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts 1999 .pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf))

<sup>940</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>941</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>942</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>943</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>944</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

facilitate in-house access to OST.<sup>945</sup> Outpatient treatment services have been guided by psychosocial and education principles, and have generally provided counseling, referrals to residential treatment, and aftercare.<sup>946</sup> A report published in 2009 estimated that fewer than 6,000 individuals were enrolled in outpatient services,<sup>947</sup> but there was limited data to assess changes in enrollment over time. As with inpatient treatment, the drug of choice for individuals enrolling in outpatient drug treatment programs has remained opiates, but the proportion of opiate-related treatments has dropped from 80% in 1997 to fewer than 50% in 2004.<sup>948</sup>

OST with methadone was initiated in the mid-1970s,<sup>949</sup> and other substitution drugs – like buprenorphine – were introduced at a later date. However, OST initially focused on detoxification with the ultimate objective of achieving abstinence,<sup>950</sup> but the approach changed when the nation's HIV crisis became untenable in the late 1980s.<sup>951</sup> By 1987, fewer than 2,000 individuals were enrolled in OST.<sup>952</sup> This number rapidly rose when a client-centered approach was introduced and restrictions were drastically reduced, with the aim generating demand for long-term maintenance therapy: 12,000 individuals were enrolled in OST by 1993,<sup>953</sup> rising to reach between 16,000<sup>954</sup> and 18,000 individuals in 1999 (providing an estimated coverage of ranging between 53% to 60% of people dependent on drugs).<sup>955</sup> Extended data on enrolment in methadone programs is presented in *Figure 21* below. Data reported in 2009 showed that an estimated 40% of OST treatment took place in specialized clinics and an estimated 60% were supervised by one of the country's 2,500 private medical practitioners.<sup>956</sup> OST can only be provided by trained health workers,

<sup>945</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>946</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>947</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>948</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>949</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>950</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>951</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>952</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>953</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report\\_of\\_the\\_External\\_Panel\\_on\\_the\\_Evaluation\\_of\\_the\\_Swiss\\_Scientific\\_Studies\\_of\\_Medically\\_Prescribed\\_Narcotics\\_to\\_Drug\\_Addicts\\_1999.pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf))

<sup>954</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

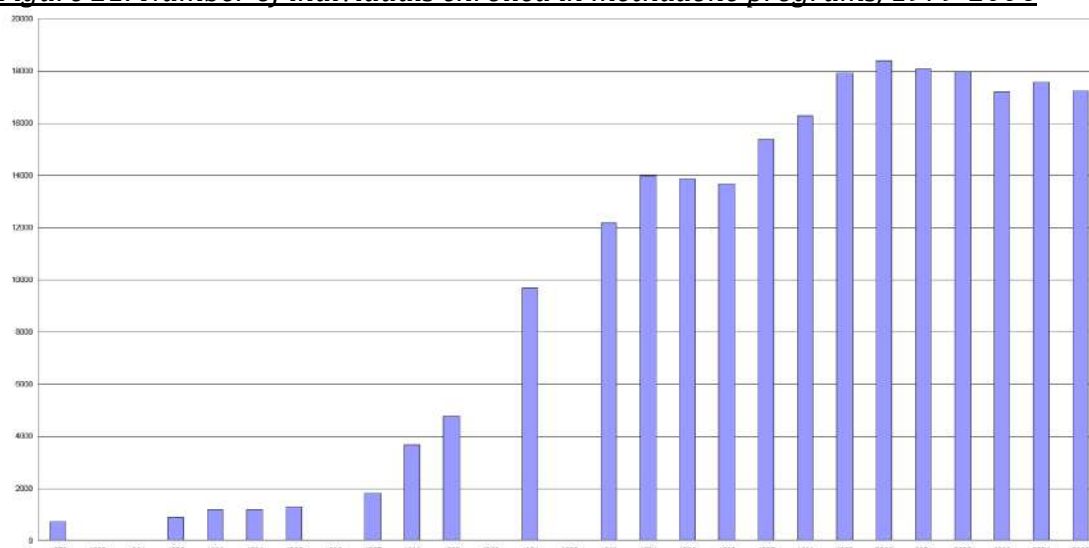
<sup>955</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>956</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

but CSO have also been involved in OST provision: ARUD started such a low-threshold OST service with methadone in 1992 attracting over 800 clients in the first year.<sup>957</sup>

**Figure 21: Number of individuals enrolled in methadone programs, 1979-2006**<sup>958</sup>



HAT was introduced in the early 1990s to meet the needs of the most severely dependent individuals who relapsed multiple times despite enrolling in several different treatment programs.<sup>959</sup> Specifically, HAT has sought to increase retention in drug treatment, facilitate social reintegration, improve health and well-being, reduce the risks of infection and transmission of blood-borne viruses, and encourage abstinence.<sup>960</sup> By 1999 – one year after the official endorsement of this service was codified into law – a total of 16 sites offered HAT across the country, providing for the enrollment of a maximum of 1,065 individuals.<sup>961</sup> Data reported in 2009 estimated approximately 1,200 individuals enrolled in HAT.<sup>962</sup> An estimated 60% of dropouts left the program to register in another treatment services, almost 40% of who sought abstinence-focused programs.<sup>963</sup>

Reports also indicate that compulsory treatment was in place in Switzerland in the early 1990s; however, there was little evidence to confirm whether this approach has continued, been scaled up or down. In 1992, the cantonal

<sup>957</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>958</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>959</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>960</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>961</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>962</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>963</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)



authorities in Zurich received a grant of \$300,000 to open a 100-bed detention facility to rapidly facilitate the transfer of people who were arrested for drug possession or consumption back to their communities within 24-48 hours.<sup>964</sup> The center was closed and moved to a new location in 1994 but no details were available in the literature about this center or others like it operating in Switzerland. In addition, no evidence was found in the literature concerning legislation supporting this approach.

### *Law enforcement*

Law enforcement related activities fall under the fourth pillar of the Swiss drug control policy. Implementing such activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. In the context of drug control, the goals of the law enforcement pillar have been to curtail the supply of drugs, eliminate illegal drug trade and associated financial transactions, and eliminate organized crime.<sup>965</sup>

The Swiss are well known for the rigor of policing activities, and law enforcement strategies and interventions have historically been prioritized in Swiss drug policies, until the mid-1990s, when the *Four Pillars* policy integrated prevention, harm reduction and treatment.<sup>966</sup> In that sense, the focus of the national drug-related law enforcement strategy has shifted its focus from PWUD, to drug producers, traffickers and dealers.<sup>967</sup> Since the deployment of the *Four Pillars* policy, police attitudes have changed in favor of the new approach; police reported improvements in public order, including a reduction in crime, a reduction in the number of problem drug users, and a reduction in the number and frequency of drug-related incidents.<sup>968</sup>

The number of drug-related arrests rose from an estimated 14,500 in 1990 to an estimated 32,000 in 2000, to 34,000 in 2006, and approximately 40,000 in 2009.<sup>969</sup> Arrests related to cannabis (compared to arrests for other drugs) dominated in law enforcement activities: a 2009 report shows that Switzerland made more arrests per capita for simple possession of cannabis than the United States.<sup>970</sup> The number of cannabis possession-related arrests rose by an

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<sup>964</sup> Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736.  
([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

<sup>965</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.  
(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>966</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>967</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.  
(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

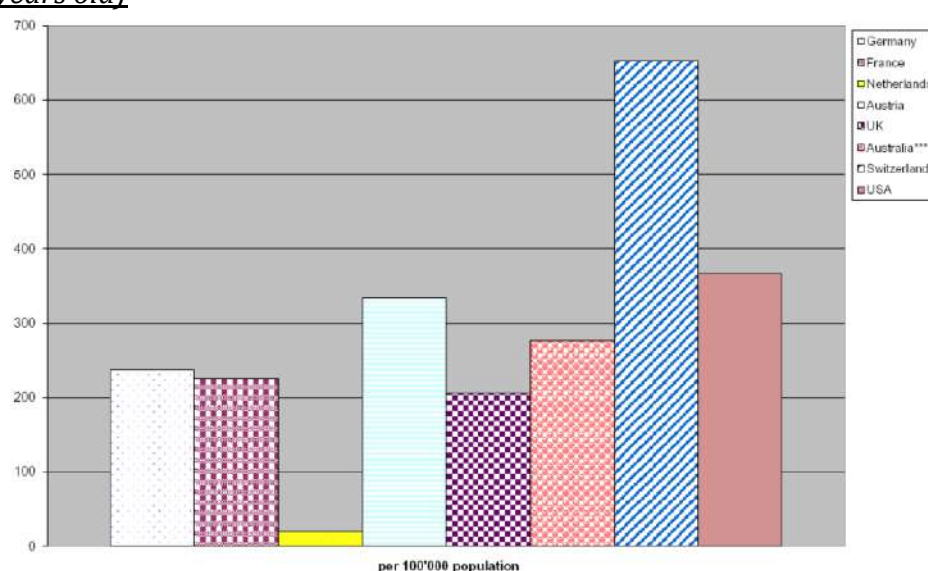
<sup>968</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>969</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>970</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

estimated 25% between 1998 and 2006. In contrast, arrests related to heroin possession dropped from an estimated 18,000 in 1997 to approximately 6,500 in 2006, while the number of arrests related to other drugs has remained relatively insignificant.<sup>971</sup> *Figure 22* below shows that, relative to other European countries and the United States, the number of arrests for cannabis possession in Switzerland is very high.

*Figure 22: Rate of arrest for cannabis possession per 100,000 population (15-64 years old)* <sup>972</sup>



Around 1992, Swiss police forces made a total of 5,731 arrests related to opiate dealing in a single year.<sup>973</sup> Between 2002 and 2008, the number of drug trafficking-related crimes remained relatively stable, with a range of 6,297 and 7,877, as shown in *Table 40* below. In 2009, the number of drug trafficking crimes reported by the police increased sharply to 18,346 and remained relatively stable until 2012. This trend is mirrored in the total number of crimes reported by the police over the same period, but the sudden rise in crimes is due to a change in the use of statistical instruments rather than changes in policing or in the drug market.<sup>974</sup> In parallel, the proportion of trafficking-related crimes reported by the police also increased over time, especially in the period of 2008-2012.

*Table 40: Drug trafficking versus total crime in Switzerland, 2002-2012* <sup>975</sup>

<sup>971</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>972</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>973</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>974</sup> Office Fédéral de la Statistique. *Police*, online at: <https://www.bfs.admin.ch/bfs/fr/home/statistiques/criminalite-droit-penal/police.html>.

<sup>975</sup> Eurostat. 2014. *Crime Statistics*. Online at [http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Crime_statistics).

Year	Total number of crimes recorded by police	Number of drug trafficking crimes recorded by police	Proportion drug trafficking versus total crime
2002	356,800	7,877	2.21%
2003	379,300	7,806	2.06%
2004	389,400	7,803	2.00%
2005	352,700	7,076	2.01%
2006	335,200	6,298	1.88%
2007	326,200	6,297	1.93%
2008	323,200	7,317	2.26%
2009	676,300	18,346	2.71%
2010	656,900	19,086	2.91%
2011	693,000	17,329	2.50%
2012	750,400	19,473	2.60%

Recorded drug seizures have been predominantly linked to cocaine, heroin and cannabis, and the results of annual seizures for these drugs are presented in *Table 41* below. Data about cocaine and heroin seizures in Switzerland are not considered representative indicators given that a small number of large seizures account for a high proportion of the total.<sup>976</sup> However, cannabis seizures are more informative, with a significant decline recorded between 2002 and 2007.<sup>977</sup> Speculative calculations have estimated that Swiss police intercepted a little more than a quarter of all heroin shipments in the country.<sup>978</sup>

*Table 41: Seizures of Cocaine, Heroin and Cannabis, 1997-2006 (kilograms)* <sup>979</sup>

	Cocaine	Heroin	Cannabis
1997	349	209	7,283
1998	251	404	15,001
1999	288	398	8,459
2000	207	372	19,572
2001	169	228	11,424
2002	186	209	23,211
2003	189	300	13,356
2004	361	178	6,179
2005	283	256	4,898
2006	354	231	2,694
2007	404	135	4,015

<sup>976</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>977</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>978</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>979</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

The Swiss federal government has been managing two significant databases, one recording drug dealing related data, and the other recording information on drug informants.<sup>980</sup>

Out of a total estimate of 40,000 drug-related arrests, fewer than 2,000 individuals have been sentenced to prison every year.<sup>981</sup> Between 1990 and 2006, the numbers of drug-related convictions and prisons sentences have hardly changed; during that period, fewer than 2,150 prison sentences per year were imposed.<sup>982</sup> The average length of prison sentences have been below 18 months and by 2006, average length of incarceration had dropped to below 12 months.<sup>983</sup> *Figure 23* below shows the proportion of drug-related sentences relative to the 18-month average incarceration sentence. A significant proportion of arrests for drug possession has led to the imposition of fines although the modal sentence, representing 40% of all drug-related sentences for possession, is supervised release (equivalent to probation).<sup>984</sup> *Figure 24* below shows the proportion of convictions to sentences in drug-related court rulings between 1990 and 2006.

*Figure 23: Average Length of Sentences and percentage greater than 18 months*<sup>985</sup>

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<sup>980</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>981</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>982</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>983</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>984</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

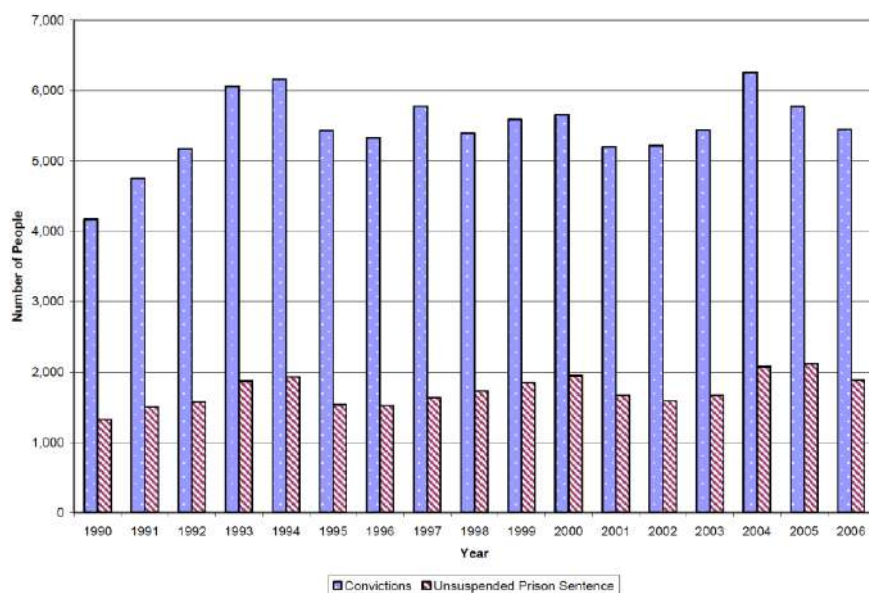
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<sup>985</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)



*Figure 24: Convictions and sentences for drug offenses in Switzerland, 1990-2006*  
986



In 2015, a total of 6,884 prisoners were detained across 117 prisons across Switzerland, representing an occupancy rate of 96%.<sup>987</sup> Table 42 below provides an overview of the evolution of the prison population in Switzerland as well as the national prison population rate, showing that the prison population has

<sup>986</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.  
(<http://www2.pr.gov/agencias/asmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>987</sup> International Center for Prison Studies. 2016. *World Prison Brief - Switzerland*. Online at: <http://www.prisonstudies.org/country/switzerland>.



increased slightly and steadily over time. Only 5% of the total prison population has been incarcerated for drug-related crimes.<sup>988</sup>

**Table 42: Total prison population and prison population rate, 2000-2015** <sup>989</sup>

Year	Total prison population	Prison population rate
2000	5,760	80
2002	4,937	68
2004	5,977	81
2006	5,888	79
2008	5,780	75
2010	6,181	79
2012	6,599	82
2014	6,923	84
2015	6,884	83

### Concluding analysis

The results of the implementation of the *Four Pillars* approach has been evaluated on a number of occasions, as have specific components like HAT. In addition, a number of studies and reports issued by government and UN agencies as well as academics have generated significant quantities of evidence that supports the success of the Swiss drug policy. The Swiss drug policy has been firmly grounded on evidence and periodic evaluations to adjust and improve results. It is noteworthy that Switzerland does not seem to report to EMCDDA.

The motivation to reform drug policies in Switzerland arose from a combination of factors, including the rapid spread of HIV and the explosion of open drug scenes across the country.<sup>990</sup> Both these factors challenged and tarnished the cherished self-image of a well-organized and pragmatic society. These unacceptable realities forced an acknowledgement that those issues could not be successfully addressed with more time and resources, but rather a rethink of the drug control strategies was warranted and needed. The implementation of the Swiss drug control strategy led to significant amount of legislative tinkering: between 1952 and 2013, the 1951 *Federal Act on Narcotics and Psychotropic Substances* was amended 23 times, as shown in *Table 43* below.

**Table 43: Number of amendments to the 1951 Federal Act on Narcotics and Psychotropic Substances by year**

Year	Number of amendments	Year	Number of amendments
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<sup>988</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>989</sup> International Center for Prison Studies. 2016. *World Prison Brief - Switzerland*. Online at: <http://www.prisonstudies.org/country/switzerland>.

<sup>990</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf)); Uchtenhagen, A. 2010. "Heroin-assisted treatment in Switzerland: A case study in policy change" in *Addiction*, 105(1): 29-37. (<https://www.ncbi.nlm.nih.gov/pubmed/19922519>); Klingemann, H. K. H. 1996. "Drug treatment in Switzerland: Harm reduction, decentralization and community response" in *Addiction*, 91:5, 723-736. ([https://www.researchgate.net/publication/14272435\\_Drug\\_treatment\\_in\\_Switzerland\\_Harm\\_reduction\\_decentralization\\_and\\_community\\_response](https://www.researchgate.net/publication/14272435_Drug_treatment_in_Switzerland_Harm_reduction_decentralization_and_community_response))

1952	1	2002	1
1970	1	2005	1
1975	1	2007	2
1981	1	2008	1
1985	1	2010	2
1991	1	2011	2
1992	1	2012	1
1996	1	2013	3
1998	2	<b>TOTAL</b>	23

While the Swiss government has not officially decriminalized drugs, the *Four Pillars* approach, with its comprehensive package of interventions that includes innovations such as HAT, has often been presented as a form of *de facto* decriminalization. What stands out in the Swiss drug policy reform process is the participation of ordinary citizens through numerous referendums, based on a long-standing tradition of direct democracy in Switzerland. Convincing the general population – which at first was reluctant to endorse, and sometimes opposed to a different paradigm – was achieved by progressive introduction of components on a small-scale pilot basis that were later scaled up as public opinion shifted.<sup>991</sup>

In that respect, introduction of new drug policy components like harm reduction and HAT were often considered “politically radical”<sup>992</sup> and “exotic;”<sup>993</sup> however, a closer analysis has shown that the Swiss model evolved gradually, and remained in line with the requirements of the international drug control conventions, despite attracting unwanted attention from the INCB as well as from the United States and other European neighbors. Combining the four pillars in an integrated framework proved very effective, both for generating positive results as well as for generating a new consensus across Swiss society. That said, building a new social consensus was a time-consuming and resource-intensive process that required significant coordination and patience.

Indeed, the combination of the four pillars of prevention, harm reduction, treatment and law enforcement in the drug control strategy was innovative at the time, and allowed for a more targeted response to drug issues. Specifically, activities under each of the pillars were focused on particular groups involved in the illicit drug market but covered the full spectrum of actors, from users to traffickers, as shown in *Table 44* below.

*Table 44: Segmentation of the Swiss drug control strategy by pillar*<sup>994</sup>

<sup>991</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>992</sup> Savary, J.-F., Hallam, C. and Bewley-Taylor, D. 2009. *The Swiss Four Pillars Policy: An Evolution From Local Experimentation to Federal Law*. Beckley Foundation. ([http://beckleyfoundation.org/wp-content/uploads/2016/04/paper\\_18.pdf](http://beckleyfoundation.org/wp-content/uploads/2016/04/paper_18.pdf))

<sup>993</sup> Khan, R. et al. 2014. “Understanding Swiss Drug Policy Change and the Introduction of Heroin Maintenance Treatment” in *Eur Addict Res*, 20: 200-207. (<https://www.ncbi.nlm.nih.gov/pubmed/24513780>)

<sup>994</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

Pillar	Population segment	Target issue / behavior
Prevention	Children and young people	Initiation
Harm reduction	People who use and inject drugs	Adverse consequences of drug use
Treatment	People dependent on drugs and problem drug users	Drug dependence
Law enforcement	Producers, traffickers and dealers	Production, distribution and trafficking

The *Four Pillars* policy officially shifted the locus of control over drug policies to the health sector, formally deprioritizing law enforcement interventions and emphasizing public health objectives. By the same token, the guiding principles underpinning Swiss drug policies shifted from repression to public health and human rights. Such a structural and ideological shift started at the cantonal level but was rapidly integrated in and officially endorsed at the federal level. Today, the federal drug policies and plans of action are jointly issued by the Federal Office of Public Health, the Federal Office of the Judiciary, and the Federal Office of the Police.<sup>995</sup> Such an arrangement has ensured multi-sectoral buy-in and facilitated coordination.

In order to better implement the strategy, a new structure was created, the Swiss Federal Commission for Drug Issues (EKDF), to assist with coordination and provide evidence-based advice to the federal government on the future of drug policies. In addition, a number of CSO have also been meaningfully involved in implementation of the *Four Pillars* strategy: delivering prevention, harm reduction and treatment services; collecting and sharing evidence and information; and even participating in policymaking at the national and cantonal level. In recognition of the importance of CSO in the response to drug issues, the Swiss government has often included CSO representatives as part of official delegations in international events and policy platforms.<sup>996</sup> Significant leadership was required to reform drug policies in Switzerland; CSO have played a critical role in pioneering services but a number of brave individuals in government agencies were also instrumental. For example, Dr. André Seidenberg and Dr. Peter Grob, both attached to CSO paved the way for individuals like Swiss President Ruth Dreifuss and Zurich Councilwoman Dr. Emilie Lieberherr to carry through the reforms from within the cantonal and federal governments.

In terms of health impact, the Swiss policy has generated a range of positive results: an important reduction in the number of PWID and a comparable reduction in the number of heroin users; a significant reduction in HIV prevalence among PWID as well as a reduction of new cases of HIV, HCV and HBV among PWID; a significant reduction in drug-related deaths; increased coverage of people who use and inject drugs and effective scale-up of a comprehensive package of services; and an increase in the number of people

<sup>995</sup> Csete, J. 2010. *From the Mountaintops – What the World Can Learn from Drug Policy Change in Switzerland*. Open Society Foundations' Global Drug Policy Program. ([https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524\\_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-english-20110524_0.pdf))

<sup>996</sup> Commission on Narcotic Drugs. 12-16 March 2012. *Improving the participatory role of civil society in addressing the world drug problem (E/CN.7/2012/CRP.1)*. ([https://www.unodc.org/documents/commissions/CND/CND\\_Sessions/CND\\_55/E-CN7-2012-CRP1\\_V1251017\\_E.pdf](https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP1_V1251017_E.pdf))

enrolled in OST and other outpatient programs as well as a significant drop in residential admissions.

The impact of drug control activities implemented under the law enforcement pillar are also indicative of positive changes: an increase in the number of drug-related arrests as well as a significant rise in the number of trafficking related arrests; improvement in the attitudes of police; reduced length of sentences; and small proportions of PWUD being incarcerated while the national prison population has been increasing.

However, caution should be exercised in attributing these changes and successes exclusively to the *Four Pillars* approach – data from other European countries that have neither decriminalized or embraced public health imperatives to guide drug policies have also recorded similar benefits.<sup>997</sup>

In the end, costs associated with the development and implementation of the *Four Pillars* approach were significant, but also generated cost-effective results. Annual investments of CHF 1 million (USD 980,000 in 2016) have been made to support implementation of the *Four Pillars* policy. The Swiss government invested approximately half of the drug control budget in law enforcement interventions while the other half covered the three health-focused pillars. *Figure 25* below provides a visual breakdown of the annual estimated investment made to support implementation of the drug control strategy. The cost of drug treatment with HAT has been estimated at CHF 51 (USD 50 in 2016) per patient per day or approximately CHF 18,600 (USD 18,275 in 2016) per year; approximately 70% of this cost has been absorbed by clients, by health insurance and by public funds.<sup>998</sup>

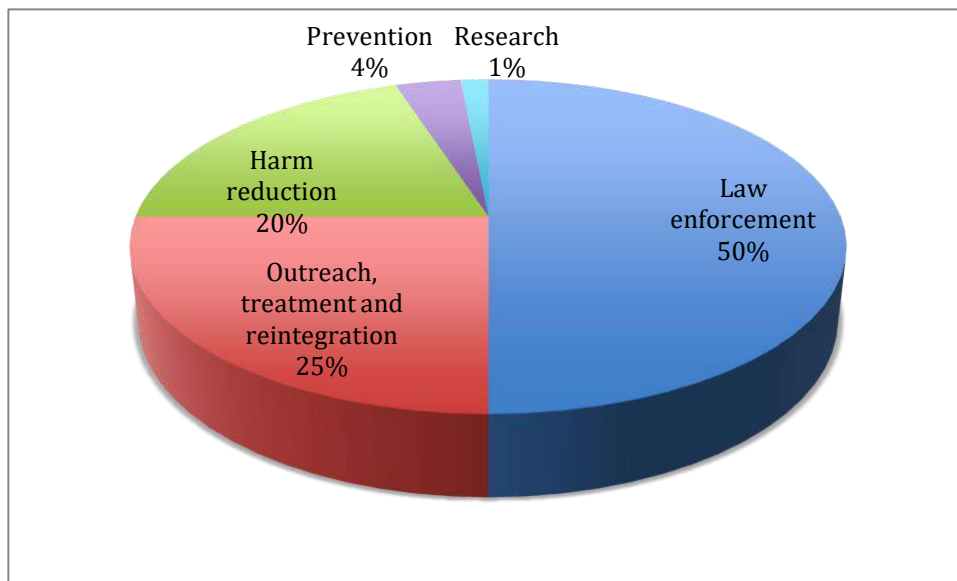
*Figure 25: Distribution of financial resources to implement the Four Pillars strategy, per annum*<sup>999</sup>

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<sup>997</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health. (<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>998</sup> Ali, R. et al. 1999. *Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts*. World Health Organization. ([http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report\\_of\\_the\\_External\\_Panel\\_on\\_the\\_Evaluation\\_of\\_the\\_Swiss\\_Scientific\\_Studies\\_of\\_Medically\\_Prescribed\\_Narcotics\\_to\\_Drug\\_Addicts\\_1999.pdf](http://www.ewi-psy.fu-berlin.de/einrichtungen/arbeitsbereiche/ppg/media/publikationen/dk-pdfs/Report_of_the_External_Panel_on_the_Evaluation_of_the_Swiss_Scientific_Studies_of_Medically_Prescribed_Narcotics_to_Drug_Addicts_1999.pdf))

<sup>999</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*. (<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)





## DRUG POLICIES IN THAILAND

In this section, the same analytical framework and approach that have been used in the previous section will be applied to Thailand. This section will describe the major historical drug policy milestones in parallel with relevant changes in drug use patterns, as well as a review of major efforts under each pillar of the national drug control strategy, including results achieved.

### Historical overview

In 1936, the *Penitentiary Act* was officially ratified by the national government, and additional *Ministerial Regulations* regarding management of prisons were approved in 1937.<sup>1000</sup> The national prison system has been managed by the Department of Corrections (DOC), which has also issued its regulations on dependent children in prison in 1938, as well as regulations on frisking prisoners before taking them to their cells in 1943.<sup>1001</sup> These documents and their respective amendments still represent the legal cornerstone for operations of the prison system in Thailand today.<sup>1002</sup>

In 1943, the national government ratified the *Kratom Act*, criminalizing the consumption, possession, production, and trafficking of the native psychoactive plant.<sup>1003</sup> At the time, the national government was levying heavy taxes from the sale of legal opium and was increasingly involved in its production in the north of the Kingdom. Reports indicate that taxes from opium sales provided between 8%<sup>1004</sup> and 20% of the Kingdom's national revenue at the time.<sup>1005</sup> Due to increasing costs related to opium consumption, many users had switched to kratom to manage their withdrawal symptoms.<sup>1006</sup> The 1942 launch of the Greater East Asia theater of World War II, combined with declining revenues from the opium trade, motivated the national government to suppress competition in the opium market by making kratom illegal.<sup>1007</sup>

Government factions vied for control over the opium market and the immense profits it conferred, leading to armed conflicts and significant regional political instability. In the late 1940s onwards, several failed attempts were made to deploy legal instruments to control and eliminate the opium market in Thailand.

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<sup>1000</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1001</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1002</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1003</sup> Tanguay, P. 2011. *Kratom in Thailand: Decriminalisation and Community Control?* International Drug Policy Consortium / Transnational Institute. (<https://www.tni.org/files/download/kratom-briefing-dlr13.pdf>)

<sup>1004</sup> McCoy, A. 2003. *The Politics of Heroin: CIA complicity in the global drug trade, Afghanistan, Southeast Asia, Central America, Colombia*. Lawrence Hill Books.

<sup>1005</sup> Stolberg, V. B. 2016. *Painkillers: History, Science, and Issues*.

<sup>1006</sup> Tanguay, P. 2011. *Kratom in Thailand: Decriminalisation and Community Control?* International Drug Policy Consortium / Transnational Institute. (<https://www.tni.org/files/download/kratom-briefing-dlr13.pdf>)

<sup>1007</sup> Tanguay, P. 2011. *Kratom in Thailand: Decriminalisation and Community Control?* International Drug Policy Consortium / Transnational Institute. (<https://www.tni.org/files/download/kratom-briefing-dlr13.pdf>)

By the 1950s, a total of 72,000 people were registered with government authorities as “opium addicts.”<sup>1008</sup> In 1959, the *Harmful Habit Forming Drugs Act* was deployed, formally criminalizing opium consumption, production and sale in an effort to elevate the moral value of Thai society.<sup>1009</sup> The act also identified those who failed to conform as “enemies of the state” that needed to be separated from law-abiding citizens.<sup>1010</sup>

By the 1960s, drug-related issues were being addressed through foreign affairs and national security mechanisms.<sup>1011</sup> Significant efforts were made starting in 1960 to eradicate opium production through repressive approaches implemented by law enforcement but, by 1968, politicians had grown increasingly dissatisfied with the lack of progress.<sup>1012</sup> Combined with the results of the 1965-1966 socio-economic surveys of highland opium farmers in the north showing that respondents were willing to grow crops other than opium provided that their income remained stable, alternative approaches were initiated.<sup>1013</sup> Data for 1965-1966 also showed that a total surface of 17,900 hectares was used for poppy cultivation in Thailand.<sup>1014</sup> By the late 1960s, heroin was being refined from opium in jungle laboratories in the border region of Thailand, Burma and Laos.<sup>1015</sup>

In 1969, HRH King Bhumibol Adulyadej established a Royal Project to develop agricultural alternatives to opium poppy cultivation in Thailand. At its peak in 1970, Thailand produced about 200 tons of opium every year, then representing 8% of the world’s opium supply.<sup>1016</sup> For more than a decade, the Royal Project sought to identify viable alternatives to poppy cultivation. Much of the work in that period was done without the involvement or participation of the community or farmers, and reports have indicated that the project design had largely been developed by international donors.<sup>1017</sup> By 1977, the Royal Project had developed sufficient expertise to scale-up its approach and introduce alternative crops more systematically.<sup>1018</sup>

It was in the early 1970s that the Thai government acknowledged drug-related issues as a domestic concern,<sup>1019</sup> as a greater proportion of the opium produced

<sup>1008</sup> Web video. Accessed 19 January 2017. “Opium: Government ban in Thailand, 1950s” in *Encyclopædia Britannica Online*. (<https://www.britannica.com/topic/history-of-Thailand/images-videos/In-the-late-1950s-a-government-ban-in-Thailand-led/145151>)

<sup>1009</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1010</sup> Chaloeontiarana, T. 1979. *Thailand: The Politics of Despotism*.

<sup>1011</sup> LePoer, B. L. (ed). 1987. *Thailand: A Country Study*. GPO for the Library of Congress. (<http://countrystudies.us/thailand/>)

<sup>1012</sup> Windle, J. 2016. *Drugs and Drug Policy in Thailand*. Center for 21st Century Security and Intelligence. (<https://www.brookings.edu/wp-content/uploads/2016/07/WindleThailand-final.pdf>)

<sup>1013</sup> Windle, J. 2016. *Drugs and Drug Policy in Thailand*. Center for 21st Century Security and Intelligence. (<https://www.brookings.edu/wp-content/uploads/2016/07/WindleThailand-final.pdf>)

<sup>1014</sup> United Nations on Drugs and Crime. 2016. *World Drug Report*. ([https://www.unodc.org/documents/scientific/WORLD\\_DRUG\\_REPORT\\_2016\\_web.pdf](https://www.unodc.org/documents/scientific/WORLD_DRUG_REPORT_2016_web.pdf))

<sup>1015</sup> Kramer, T. et al. 2014. *Bouncing Back: Relapse in the Golden Triangle*. Transnational Institute. (<https://www.tni.org/files/download/tni-2014-bouncingback-web-klein.pdf>)

<sup>1016</sup> Williamson, M. 2005. “The History, Operations and Achievements of the Royal Project” in *Eastern Horizons*, 10-11. UNODC. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern\\_horizons/EH21.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern_horizons/EH21.pdf))

<sup>1017</sup> Jelsma, M. and Kramer, T. 2008. *Withdrawal Symptoms: Changes in the Southeast Asian drugs market*. (<https://www.tni.org/files/download/debate16.pdf>)

<sup>1018</sup> Williamson, M. 2005. “The History, Operations and Achievements of the Royal Project” in *Eastern Horizons*, 10-11. UNODC. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern\\_horizons/EH21.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern_horizons/EH21.pdf))

<sup>1019</sup> LePoer, B. L. (ed). 1987. *Thailand: A Country Study*. GPO for the Library of Congress. (<http://countrystudies.us/thailand/>)

in the region was converted to heroin and exported abroad. Thailand was identified as the region's primary heroin outlet.<sup>1020</sup> Locally, drug use was on the rise again since the opium ban had been enforced: reports indicated an estimated 130 problem drug users (66.9% heroin / 14.6% opium) in 1972, rising up to 953 problem users (78.7% heroin / 16.7% opium) in 1974.<sup>1021</sup>

By the mid-1970s, the Thai government had developed a number of legal instruments to improve management of drug-related issues across the Kingdom. In 1975, the *Psychotropic Substances Act* created the legal framework for controlling production, distribution and possession of psychoactive drugs for medical purposes, entrusting overall responsibility for implementation of the act to MOH. That same year, the Psychotropic Substances Committee was established with members coming from MOH, MOJ and MOI, including from the Royal Thai Police, from the Attorney General's Office, from the Customs Department, from the Juridical Council, and from the Mental Health Division.<sup>1022</sup> It was given the mandate to regulate access to psychotropic substances for medical purposes as well as to review applications for exemptions to the application of drug laws for medical purposes which could be obtained whilst under the supervision of an accredited medical professional.<sup>1023</sup>

In 1976, the *Narcotics Control Act* was ratified, establishing the formal framework for criminalization of drug-related offences. The act was designed to provide guidance on "measures for preventing and suppressing the offenders under the laws relating to narcotics," including the provision of treatment and rehabilitation.<sup>1024</sup> That same year, the Office of Narcotics Control Board (ONCB) was established,<sup>1025</sup> overseen by a committee composed of the Prime Minister, the Minister of Health, the Director of the Royal Thai Police, the Director General of the Customs Department, and the Attorney General.<sup>1026</sup> ONCB remains the lead authority coordinating all anti-drugs efforts in Thailand today.<sup>1027</sup>

In 1979, the *Narcotics Act* was ratified, detailing a comprehensive set of punishments and sentences to be implemented in response to drug law offences and against offenders. The act entrusted overall charge and control of its execution to the Minister of Health, and provided for the establishment of the National Narcotics Control Committee, established that same year.<sup>1028</sup> The act mandated representatives from the Medical Service Department, from the Medical Science Department, from the Health Department, from the Royal Thai

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<sup>1020</sup> Chouvy, P.-A. 2013. "Drug tracking in and out of the Golden Triangle. An Atlas of Tracking in Southeast Asia. The Illegal Trade in Arms, Drugs, People, Counterfeit Goods and Natural Resources in Mainland" in *IB Tauris*, p. 1-28. (<https://halshs.archives-ouvertes.fr/hal-01050968/document>)

<sup>1021</sup> Suwanwela, C. and Poshyachinda, V. 1986. "Drug Abuse in Asia" in *Bulletin on Narcotic Drugs*, 38(1-2): 41-53. United Nations. (<https://www.ncjrs.gov/pdffiles1/Digitization/119677NCJRS.pdf>)

<sup>1022</sup> Government of Thailand. 1975. *Psychotropic Substances Act*. (<http://narcotic.fda.moph.go.th/english/wp-content/uploads/2012/11/Psychotropic-Substances-Act-B.E.2518.pdf>)

<sup>1023</sup> Government of Thailand. 1975. *Psychotropic Substances Act*. (<http://narcotic.fda.moph.go.th/english/wp-content/uploads/2012/11/Psychotropic-Substances-Act-B.E.2518.pdf>)

<sup>1024</sup> Government of Thailand. 1976. *Narcotics Control Act*. ([http://thailaws.com/law/t\\_laws/tlaw0151.pdf](http://thailaws.com/law/t_laws/tlaw0151.pdf))

<sup>1025</sup> United Nations Office on Drugs and Crime. 2007. *Opium Poppy Cultivation in South East Asia*. (<https://www.unodc.org/documents/crop-monitoring/2007-opium-SEAsia.pdf>)

<sup>1026</sup> Government of Thailand. 1976. *Narcotics Control Act*. ([http://thailaws.com/law/t\\_laws/tlaw0151.pdf](http://thailaws.com/law/t_laws/tlaw0151.pdf))

<sup>1027</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1028</sup> Government of Thailand. 1979. *Narcotics Act*. (<http://www.thailawforum.com/laws/Narcotics%20Act%202522.pdf>)

Police, from the Public Prosecutors Office, from the Customs Department, from the Council of State, from the Narcotics Control Board, from the Ministry of Defense, and from the Food and Drug Board as official members of the National Narcotics Control Committee.<sup>1029</sup>

The act also clearly scheduled various psychoactive substances into five distinct categories (see *Box 6*). Severity of punishments for drug law offences was tied to drug schedules, where infractions relating to category I substances were punished most harshly and offences involving category V substances were punished least harshly, recognizing that not all illicit drugs carry the same potential for harm.

***Box 6: Categories of illicit drugs according to the Narcotics Act (1979)*** <sup>1030</sup>

- *Category I consists of dangerous narcotics such as heroin, amphetamine, methamphetamine, ecstasy and LSD;*
  - *Category II consists of ordinary narcotics such as morphine, cocaine, codeine, medicinal opium, methadone, coca leaf, and cocaine;*
  - *Category III consists of narcotics which are in the form of medicinal formula and contain narcotics of category II as ingredients;*
  - *Category IV consists of chemicals used for producing narcotics of category I or category II such as acetic anhydride, acetyl chloride;*
  - *Category V consists of narcotics which are not included in category I to category IV such as marijuana, kratom.*
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In 1977, the 1936 *Penitentiary Act* was modified to introduce a "good time allowance system," allowing prisoners to earn points for good behavior towards potential early release, designed to relieve overcrowding prisons.<sup>1031</sup> In 1979, additional amendments to the 1936 *Penitentiary Act* enabled a change of prisoner status, and in 1980, the "public works allowance system" was introduced to motivate participation of prisoners in public work activities in order to earn sentence remissions.<sup>1032</sup>

By 1984, the number of problematic users escalated substantially and reached an estimated 39,974 (85.7% heroin / 8.7% opium).<sup>1033</sup> That same year, authorities launched a repressive nationwide campaign to eradicate opium in order to reduce heroin trafficking,<sup>1034</sup> negatively impacting on alternative development projects, even though government officials – including law enforcement representatives – had been increasingly involved in such crop

<sup>1029</sup> Government of Thailand. 1979. *Narcotics Act*. (<http://www.thailawforum.com/laws/Narcotics%20Act%202522.pdf>)

<sup>1030</sup> Government of Thailand. 1979. *Narcotics Act*. (<http://www.thailawforum.com/laws/Narcotics%20Act%202522.pdf>)

<sup>1031</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1032</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1033</sup> Suwanwela, C. and Poshychinda, V. 1986. "Drug Abuse in Asia" in *Bulletin on Narcotic Drugs*, 38(1-2): 41-53. United Nations. (<https://www.ncjrs.gov/pdffiles1/Digitization/119677NCJRS.pdf>)

<sup>1034</sup> Chouvy, P.-A. 2013. "Drug tracking in and out of the Golden Triangle. An Atlas of Tracking in Southeast Asia. The Illegal Trade in Arms, Drugs, People, Counterfeit Goods and Natural Resources in Mainland" in *IB Tauris*, p. 1-28. (<https://halshs.archives-ouvertes.fr/hal-01050968/document>)

substitution projects, especially since the launch of the Royal Project.<sup>1035</sup> By 1985, the Royal Project had expanded and had established 31 development centers as technical assistance mechanisms to support Thai farmers undertaking the transition from growing opium to alternative crops.<sup>1036</sup> Despite those efforts, by the late 1980s, reports indicated that up to 500,000 people were dependent on heroin and opium in Thailand.<sup>1037</sup>

By the 1990s, the crop substitution projects that were still multiplying and expanding across northern Thailand started to provide opportunities for meaningful participation of farmers.<sup>1038</sup> UNDCP acknowledged that the success of the Thai approach rested, at least in part, on efforts to stimulate meaningful participation of farmers and local communities.<sup>1039</sup>

In 1991, the *Drug Addicts Rehabilitation Act* was approved but went largely unimplemented.<sup>1040</sup> Overall responsibility for implementation of the act was to be delegated to the Minister of Justice, including provisions for the establishment of a Narcotic Addict Rehabilitation Committee whose members should have included representatives from MOJ, from the Department of Medical Services, from the Department of Communicable Disease Control, from the Royal Thai Police, from the Department of Public Welfare, from DOC, from the Attorney General's Office, from juvenile and family courts, from the Food and Drug Administration, from the Narcotics Control Board, and from the Office of Judicial Affairs.<sup>1041</sup>

By 1994, academics had estimated the number of PWID across Thailand at 160,000 for the period of 1980-1995.<sup>1042</sup> By the mid-1990s, consumption of ATS, particularly amphetamines and methamphetamines, had become increasingly popular in Thailand and across Southeast Asia, coinciding with a global rise in ATS consumption; the “epidemic” impacted the US, Japan, Australia, and particularly Thailand.<sup>1043</sup> In 1996, reacting to growing public concerns regarding ATS, the Thai government criminalized the use of all amphetamine products across the Kingdom, including those previously approved for medical purposes.<sup>1044</sup> And despite the continued implementation of repressive measures and intensifying law enforcement crackdowns, ATS consumption continued to

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<sup>1035</sup> Jelsma, M. and Kramer, T. 2008. *Withdrawal Symptoms: Changes in the Southeast Asian drugs market*. (<https://www.tni.org/files/download/debate16.pdf>)

<sup>1036</sup> Williamson, M. 2005. “The History, Operations and Achievements of the Royal Project” in *Eastern Horizons*, 10-11. UNODC. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern\\_horizons/EH21.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/eastern_horizons/EH21.pdf))

<sup>1037</sup> International Business Publications. 2011. *Thailand Air Force Handbook: Volume 1 – Strategic Information and Weapon Systems*.

<sup>1038</sup> Jelsma, M. and Kramer, T. 2008. *Withdrawal Symptoms: Changes in the Southeast Asian drugs market*. (<https://www.tni.org/files/download/debate16.pdf>)

<sup>1039</sup> United Nations Drug Control Programme. 1993. *Technical Information Paper #5: Alternative Development as an Instrument of Drug Abuse Control*. ([http://www.unodc.org/pdf/Alternative%20Development/AD\\_DrugControlInstrument.pdf](http://www.unodc.org/pdf/Alternative%20Development/AD_DrugControlInstrument.pdf))

<sup>1040</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1041</sup> Government of Thailand. 1991. *Drug Addicts Rehabilitation Act*. ([http://thailaws.com/law/t\\_laws/tlaw0149.pdf](http://thailaws.com/law/t_laws/tlaw0149.pdf))

<sup>1042</sup> Manop, K. 2015. “Size Estimation of Injecting Drug Users through the Network Scale-Up Method in Thailand” in *J Med Assoc Thai*, 98 (Suppl. 6): S17-S24. (<http://www.thaiscience.info/journals/Article/JMAT/10971236.pdf>)

<sup>1043</sup> European Monitoring Centre for Drugs and Drug Addiction. 2014. *Exploring methamphetamine trends in Europe*. ([http://www.emcdda.europa.eu/system/files/publications/787/TDAU14001ENN\\_460800.pdf](http://www.emcdda.europa.eu/system/files/publications/787/TDAU14001ENN_460800.pdf))

<sup>1044</sup> Paungsawad, G. et al. 2016. “Bangkok 2016: From overly punitive to deeply human policies” in *Drugs and Alcohol Dependence*, 167: 233-234.



increase well into the early 2000s.<sup>1045</sup>

In 2001, the Academic Committee on Substance Abuse conducted the first national household survey to assess prevalence and patterns of drug use in Thailand. Results showed that an estimated 3.5 million people aged 15 to 60 had ever used methamphetamines.<sup>1046</sup> That same year, PWID population size estimates were also revised downwards, to 70,000.<sup>1047</sup> Another PWID population size estimate was calculated in 2002, dropping again to 57,000.<sup>1048</sup> That same year, UNODC declared Thailand “opium free,” given that national production had dropped significantly.<sup>1049</sup>

In 2002, the Thai government approved a new *Narcotic Addict Rehabilitation Act* and repealed the 1991 act bearing a similar title. Overall responsibility for implementation of the new act was delegated to the Minister of Justice, as intended in the 1991 act,<sup>1050</sup> even though the fundamental intent and objective of the new policy was to divert people who use and are dependent on illicit drugs to treatment and rehabilitation services. The act identified as one of the core guiding principles that people who are dependent on illicit drugs are to be treated as patients rather than criminals.<sup>1051</sup> In essence, the 2002 *Narcotic Addict Rehabilitation Act* represented the first effort in Thailand to divert people who are dependent on drugs to treatment services by creating alternatives to incarceration. The act focused on three strategic priorities: reducing supply (law enforcement targeting production and trafficking), reducing demand (law enforcement targeting users and dealers, treatment and rehabilitation), and reducing potential demand (prevention among non-users).<sup>1052</sup>

The new policy included provisions for the establishment of a National Narcotic Addict Rehabilitation Committee (NARC) whose members include representatives from MOJ, from MOH, from the Ministry of Education, from the Royal Thai Police, from the Army, from the Office of Justice, from the Department of Employment Provision, from the Department of Local Administration, from the Department of Community Development, from the Department of Medical Services, from the Department of Communicable Disease Control, from the Department of Public Welfare, from the Department of Skill Development, from DOC, from the Department of Medical Science Services, from the Department of

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<sup>1045</sup> Baldwin, S. 2013. *Drug policy advocacy in Asia: Challenges, opportunities and prospects*. International Drug Policy Consortium. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-report-drug-policy-in-South-East-Asia.pdf>)

<sup>1046</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1047</sup> FHI360. 2008. *The Asian Epidemic Model (AEM): Projections for HIV/AIDS in Thailand: 2005-2025*. ([http://www.aidsdatahub.org/sites/default/files/documents/The\\_Asian\\_Epidemic\\_Model\\_Projections\\_for\\_HIVAIDS\\_in\\_Thailand\\_2005\\_2025.pdf](http://www.aidsdatahub.org/sites/default/files/documents/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf))

<sup>1048</sup> FHI360. 2008. *The Asian Epidemic Model (AEM): Projections for HIV/AIDS in Thailand: 2005-2025*. ([http://www.aidsdatahub.org/sites/default/files/documents/The\\_Asian\\_Epidemic\\_Model\\_Projections\\_for\\_HIVAIDS\\_in\\_Thailand\\_2005\\_2025.pdf](http://www.aidsdatahub.org/sites/default/files/documents/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf))

<sup>1049</sup> Windle, J. 2016. *Drugs and Drug Policy in Thailand*. Center for 21st Century Security and Intelligence. (<http://www.brookings.edu/wp-content/uploads/2016/07/WindleThailand-final.pdf>)

<sup>1050</sup> Government of Thailand. 2002. *Narcotic Addict Rehabilitation Act*. ([http://thailaws.com/law/t\\_laws/tlaw0149\\_2.pdf](http://thailaws.com/law/t_laws/tlaw0149_2.pdf))

<sup>1051</sup> Jinawat, P. 2008. “Thailand’s Experiences of Sustainable Alternative Development and Opium Reduction” in *Sustaining Opium Reduction in Southeast Asia: Sharing Experiences on Alternative Development and Beyond*, 125-132. UNODC. ([https://www.unodc.org/documents/alternative-development/UNODC\\_Layout.pdf](https://www.unodc.org/documents/alternative-development/UNODC_Layout.pdf))

<sup>1052</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

Mental Health, from the Narcotics Control Board, from the Food and Drug Administration and from the Department of Probation.<sup>1053</sup>

The National Committee was designed to oversee operations of all provincial level NARCs, including providing oversight on the review of arrest records and assessments of treatment needs of alleged offenders. These assessments were particularly important, given that not all offenders were eligible for diversion.<sup>1054</sup> Only those charged with drug consumption, drug consumption and possession, drug consumption and possession for disposal, or drug consumption and disposal have been eligible for diversion, provided that the amount of drugs involved was below specific threshold quantities defined in the act. *Table 45* below outlines the quantity thresholds set for major illicit drugs in Thailand.

*Table 45: Illicit drug quantity thresholds for potential diversion to treatment*<sup>1055</sup>

Illicit drug	Quantity threshold
<b>Category I</b>	
Heroin	100mg
Methamphetamine	500mg or fewer than five units
Amphetamine	500mg or fewer than five units
MDA	1,200mg or fewer than five units
MDMA	1,200mg or fewer than five units
NMDA/MDE	1,250mg or fewer than five units
<b>Category II</b>	
Cocaine, pure weight	200mg
Opiate, pure weight	5g
<b>Category V</b>	
Cannabis, pure weight	5g

Provincial NARCs have been expected to render a decision within 45 days of arrest: either make a referral to compulsory minimum 4-month treatment to be conducted in a detention center, make a referral to community-based supervised outpatient cognitive-behavioral therapy, release the individual back to the community with no further action, or recommend criminal prosecution.<sup>1056</sup> The majority of people arrested for drug-related offences spent the full 45-day assessment period incarcerated with little or no medical support.<sup>1057</sup> The provincial NARCs have usually been composed psychologists, psychiatrists, community health workers, and key community leaders.<sup>1058</sup>

While the *Narcotic Addict Rehabilitation Act* (2002) was a landmark policy

<sup>1053</sup> Government of Thailand. 2002. *Narcotic Addict Rehabilitation Act*. ([http://thailaws.com/law/t\\_laws/tlaw0149\\_2.pdf](http://thailaws.com/law/t_laws/tlaw0149_2.pdf))

<sup>1054</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1055</sup> Government of Thailand. 2002. *Narcotic Addict Rehabilitation Act*. ([http://thailaws.com/law/t\\_laws/tlaw0149\\_2.pdf](http://thailaws.com/law/t_laws/tlaw0149_2.pdf))

<sup>1056</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1057</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1058</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

instrument that introduced new approaches, the *Narcotics Act* (1979) has remained in place and has continued to compel criminalization of drug possession and consumption, in clear contradiction with the intent of the 2002 act. In addition, NARC representatives had noted that a significant proportion of PWUD who were not clinically dependent were nonetheless diverted into treatment at great cost to the state, the community and the individuals detained in the name of treatment.<sup>1059</sup>

In 2002, DOC oversight changed from MOI to MOJ.<sup>1060</sup> However, the *Ministerial Regulations* (1937), along with its amendments, still referred to MOI's authority in matters related to prison management. Additional concerns have been raised regarding Thai prison policies, especially in relation to articles and rules that clearly violate international guidelines and minimum standards,<sup>1061</sup> such as the *United Nations Standard Minimum Rules for the Treatment of Prisoners*.<sup>1062</sup>

In 2002, the Thai Drug Users' Network (TDN) was established when community activists banded together with the objective of documenting human rights abuses against Thai PWUD.<sup>1063</sup> By 2003, TDN and other CSO were awarded a non-Country Coordinating Mechanism grant worth USD 1.3 million over two years by the Global Fund to Fight AIDS, Tuberculosis & Malaria (Global Fund) in order to implement Thailand's first peer-driven national-level harm reduction program,<sup>1064</sup> an approach that the national government refused to endorse at the time. Led by PWUD, CSO secured international funding to support the delivery of peer-based health and social services targeting PWID, including the establishment of four harm reduction DIC without the explicit support of the Thai government.<sup>1065</sup>

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Also in 2003, a second national household survey was conducted. Results revealed that one million people had used methamphetamine in Thailand in the previous year; and that 450,000 people had used methamphetamines in the last 30 days.<sup>1066</sup> That same year, the total surface area used for opium poppy cultivation dropped to a historical low of 129 hectares.<sup>1067</sup> Opium poppy

<sup>1059</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1060</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1061</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1062</sup> United Nations. 1977. *United Nations Standard Minimum Rules for the Treatment of Prisoners*. ([https://www.unodc.org/pdf/criminal\\_justice/UN\\_Standard\\_Minimum\\_Rules\\_for\\_the\\_Treatment\\_of\\_Prisoners.pdf](https://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf))

<sup>1063</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned))

<sup>1064</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

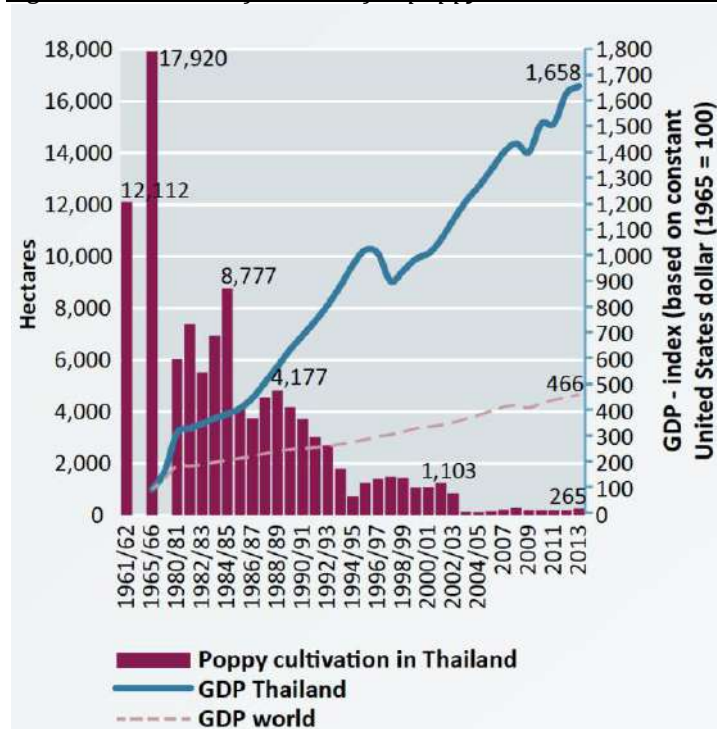
<sup>1065</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned))

<sup>1066</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1067</sup> United Nations on Drugs and Crime. 2016. *World Drug Report*. ([https://www.unodc.org/documents/scientific/WORLD\\_DRUG\\_REPORT\\_2016\\_web.pdf](https://www.unodc.org/documents/scientific/WORLD_DRUG_REPORT_2016_web.pdf))

cultivation trends are captured in Figure 26 below.

Figure 26: Total surface area for poppy cultivation in Thailand vs GDP, 1961-2013 <sup>1068</sup>



In early 2003, Prime Minister Thaksin Shinawatra launched a campaign to eliminate drugs,<sup>1069</sup> relying on law enforcement action that led to the extrajudicial killings of more than 2,000 drug suspects.<sup>1070</sup> The Thai war on drugs involved increasing penalties for drug possession and consumption; forcing people into compulsory centers in the name of rehabilitation; developing “blacklists”; deploying arrest and seizure targets and quotas to measure performance of law enforcement agencies; as well as a system of rewards and penalties to incentivize government officials.<sup>1071</sup> Even though human rights violations were perpetrated during the war on drugs and attracted condemnation from various international organizations, particularly from human rights groups,<sup>1072</sup> the government’s popularity levels remained extremely high: throughout the campaign, public opinion polls showed widespread support – up to 90% – for the Prime Minister’s efforts.<sup>1073</sup>

While the size of PWID population was being adjusted further downwards – to

<sup>1068</sup> United Nations on Drugs and Crime. 2015. *World Drug Report*.

([https://www.unodc.org/documents/wdr2015/World\\_Drug\\_Report\\_2015.pdf](https://www.unodc.org/documents/wdr2015/World_Drug_Report_2015.pdf))

<sup>1069</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1070</sup> Human Rights Watch. 2004. *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights*. (<https://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf>)

<sup>1071</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1072</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1073</sup> Bionat, M. 9 July 2016. “Gains from Thailand’s bloody war on drugs proved fleeting” in *The Inquirer*, available online at: <https://globalnation.inquirer.net/140782/gains-from-thailands-bloody-war-on-drugs-proved-fleeting>.



38,380 in 2004<sup>1074</sup> – based on assumptions of the impact of the war on drugs, Thai researchers conducted a study that concluded that 85% of PWID had stopped injecting, and 70% of those who had stopped injecting cited the government war on drugs policy as the main reason. However, the study further revealed that approximately a third of participants had simply switched to smoking opium or methamphetamines and increased use of alcohol and benzodiazepines.<sup>1075</sup> This had a deleterious effect on users' health and safety, who were pushed further underground, away from health services.<sup>1076</sup>

In 2005, a nationwide drug monitoring system was deployed to function as an early warning system for emerging drug trends.<sup>1077</sup> That same year, DOC issued a new set of regulations, formally revoking the use of flogging in prison settings.<sup>1078</sup> By 2006, former Senator and Chairman of the Foreign Affairs Committee Kraisak Choochavan presided over an independent commission tasked with investigating the extrajudicial killings perpetrated during the 2003-2004 war on drugs.<sup>1079</sup> In 2007, a new household survey was conducted and revealed that 2.5 million people (5% of the national population) aged 12-65 had used illicit drugs in the previous year.<sup>1080</sup>

PWID have been disproportionately affected by the transmission of HIV since the virus was first detected in Thailand in 1984. HIV prevalence amongst PWID peaked in 1987-1988 at 49%,<sup>1081</sup> hovered between 30% and 50% from 1989 to 2006,<sup>1082</sup> was recorded between 20% and 56% in 2008,<sup>1083</sup> at 42.5% in 2010,<sup>1084</sup> down to 21.9% in 2012,<sup>1085</sup> up to 25.2% in 2014,<sup>1086</sup> and finally down to 21% as of 2016.<sup>1087</sup> In 2007, the Thai government for the first time officially recognized

<sup>1074</sup> FHI360. 2008. *The Asian Epidemic Model (AEM): Projections for HIV/AIDS in Thailand: 2005-2025*.

([http://www.aidsdatahub.org/sites/default/files/documents/The\\_Asian\\_Epidemic\\_Model\\_Projections\\_for\\_HIVAIDS\\_in\\_Thailand\\_2005\\_2025.pdf](http://www.aidsdatahub.org/sites/default/files/documents/The_Asian_Epidemic_Model_Projections_for_HIVAIDS_in_Thailand_2005_2025.pdf))

<sup>1075</sup> Vongchak, T., et al. 2005. "The Influence of Thailand's 2003 'War on Drugs' Policy on Self-Reported Drug Use Among Injection Drug Users in Chiang Mai, Thailand" in *International Journal of Drug Policy*, 16 (2): 115-121.

(<http://www.sciencedirect.com/science/article/pii/S095539590400132X>)

<sup>1076</sup> Kramer, T. et al. 2014. *Bouncing Back: Relapse in the Golden Triangle*. Transnational Institute.

(<https://www.tni.org/files/download/tni-2014-bouncingback-web-klein.pdf>)

<sup>1077</sup> Jinawat, P. 2008. "Thailand's Experiences of Sustainable Alternative Development and Opium Reduction" in *Sustaining Opium Reduction in Southeast Asia: Sharing Experiences on Alternative Development and Beyond*, 125-132. UNODC.

([https://www.unodc.org/documents/alternative-development/UNODC\\_Layout.pdf](https://www.unodc.org/documents/alternative-development/UNODC_Layout.pdf))

<sup>1078</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice.

([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1079</sup> Tanguay, P. et al. 2009. "Civil Society Reflections on 10 Years of Drug Control in Myanmar, Thailand and Vietnam: A Shadow Report" in *At What Cost? HIV and Human Rights Consequences of the Global War on Drugs*, 140-163. Open Society Institute. ([www.opensocietyfoundations.org/reports/what-cost-hiv-and-human-rights-consequences-global-war-drugs](http://www.opensocietyfoundations.org/reports/what-cost-hiv-and-human-rights-consequences-global-war-drugs))

<sup>1080</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1081</sup> AIDS Data Hub for Asia Pacific. 2009. *Thailand at a glance: country profile*, online at:

[http://www.aidsdatahub.org/files/country\\_reviews/thailand\\_country\\_review.pdf](http://www.aidsdatahub.org/files/country_reviews/thailand_country_review.pdf); Phoolcharoen, W. et al. 1998. *Thailand: lessons from a strong national response to HIV/AIDS*. AIDS Division, Communicable Disease Control Department, Ministry of Public Health.

<sup>1082</sup> Razak, M.H. et al. 2003. "HIV Prevalence and risks among IDUs in northern Thailand: Need for comprehensive HIV prevention programs" in *J Acquir Immune Defic Syndr*, 33(2): 259-66.

<sup>1083</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>1084</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>1085</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>1086</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>1087</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)



the link between drug use and the spread of HIV: the *2007-2011 National AIDS Plan* was the first official document to recognize the government's failure to respond effectively to a growing crisis amongst PWID. The *National AIDS Plan* proposed a package of interventions aligned with UN recommendations to reduce transmission among this group.<sup>1088</sup>

The following year, a new national drug control strategy, the *Three Minuses, Three Pluses and Three Focuses Strategy* (2008), was approved to address the reemergence of drug-related problems, using the same war on drugs framework as in 2003, with a further increase in the scope of law enforcement engagement in the response, though without resorting to violence.<sup>1089</sup> The objectives defined by the strategy included reducing the factors associated with drug use, increasing multi-sectoral collaboration to enhance the national response, and focusing anti-drug efforts on high-priority areas. Aligned on the three strategic pillars defined in the 2002 *Narcotics Addict Rehabilitation Act*, the strategy prioritized interventions by law enforcement to reduce supply, treatment and rehabilitation services for people dependent on drugs and prevention of drug use especially among children and youth.<sup>1090</sup> Later that same year, the government approved a new strategy, the *Ninety Days Away from Drugs Operation Strategy*, further targeting high-priority areas contributing to the drug problem.<sup>1091</sup>

A new drug control strategy, the *Clean and Seal Strategy*, was deployed in 2009, encouraging village authorities across the Kingdom to surrender people suspected of being involved with drugs in their jurisdictions in order to receive awards, and to avoid penalties.<sup>1092</sup> In effect, the policy objective was to literally “clean out” people who were involved with drugs from schools, from their families and from the community, further fueling stigma and discrimination.<sup>1093</sup> Once sufficient numbers of drug suspects were identified in the three-month period, villages would be officially designated drug-free; traffickers were arrested and prosecuted, and people caught using drugs were sent to detention centers operated by MOI.<sup>1094</sup> In the end, the strategy expanded the role and power of law enforcement agencies in the context of national drug control.

Later that year, CSO operating in Thailand received another significant grant from the Global Fund, this time worth USD 16.3 million, again to support HIV

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<sup>1088</sup> Kaplan, K. and Schleiffer, R. 2007. *Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand*. Human Rights Watch / Thai AIDS Treatment Action Group. (<https://www.hrw.org/sites/default/files/reports/thailand1107.pdf>)

<sup>1089</sup> Jinawat, P. 2008. “Thailand’s Experiences of Sustainable Alternative Development and Opium Reduction” in *Sustaining Opium Reduction in Southeast Asia: Sharing Experiences on Alternative Development and Beyond*, 125-132. UNODC. ([https://www.unodc.org/documents/alternative-development/UNODC\\_Layout.pdf](https://www.unodc.org/documents/alternative-development/UNODC_Layout.pdf))

<sup>1090</sup> Jinawat, P. 2008. “Thailand’s Experiences of Sustainable Alternative Development and Opium Reduction” in *Sustaining Opium Reduction in Southeast Asia: Sharing Experiences on Alternative Development and Beyond*, 125-132. UNODC. ([https://www.unodc.org/documents/alternative-development/UNODC\\_Layout.pdf](https://www.unodc.org/documents/alternative-development/UNODC_Layout.pdf))

<sup>1091</sup> Kaplan, K. and Schleiffer, R. 2007. *Deadly Denial: Barriers to HIV/AIDS Treatment for People Who Use Drugs in Thailand*. Human Rights Watch / Thai AIDS Treatment Action Group. (<https://www.hrw.org/sites/default/files/reports/thailand1107.pdf>)

<sup>1092</sup> Tyndall, M. 2010. *Harm Reduction Policies and Interventions for Injecting Drug Users in Thailand*. World Bank. (<http://documents.worldbank.org/curated/en/678211468310529526/pdf/646420Revised00ion0for0IDUs00final0.pdf>)

<sup>1093</sup> 2011. *Joint NGO Submission to the Universal Periodic Review of Thailand on Drug Users in Thailand*. Thai Drug Users Network / PSI Thailand Foundation / Alden House / Foundation for AIDS Rights / Mitsampan Harm Reduction Centre / Raks Thai Foundation. (<http://lib.ohchr.org/HRBodies/UPR/Documents/session12/TH/JS2-JointSubmission2-eng.pdf>)

<sup>1094</sup> Human Right Watch. December 2009. *Press release: Thailand: Convictions of Police in Drug Campaign Abuse a ‘First Step’ - Stronger Government Action Needed Against Police Brutality*. Online at: <https://www.hrw.org/news/2009/12/14/thailand-convictions-police-drug-campaign-abuse-first-step>.

prevention interventions among PWID over the course of five and a half years.<sup>1095</sup> Even though the CHAMPION-IDU project operated only in 19 of Thailand's 76 provinces, the project essentially acted as the national harm reduction program from 2009 to the end of 2015, representing one of the only sources of harm reduction services targeting PWID in Thailand.<sup>1096</sup> That year, CHAMPION-IDU project partners convinced the National AIDS Prevention and Alleviation Committee to approve a draft harm reduction policy prepared by the National AIDS Management Centre of the Department of Disease Control.<sup>1097</sup>

In late 2009, the *National Narcotics Control Policy on Five Fences Strategy (2009-2010)* was approved with the objective of solving all drug problems across the country by reducing trafficking in border areas, by targeting traffickers and pushers, by scaling up drug treatment and rehabilitation, and by reducing the perception of the severity of the drug problem at the national level, all largely relying on law enforcement interventions.<sup>1098</sup> Again, the new policy expanded the power and scope of law enforcement engagement in the national drug control response. The five fences defined in the strategy – the border fence, the community fence, the social fence, the school fence, and the family fence – are meant to “immunize” vulnerable segments of Thai society against the risk factors that lead to drug use.<sup>1099</sup>

In 2010, a new household survey was conducted to estimate the number of PWID across the country. The results showed that there were between 40,300 and 97,300 PWID,<sup>1100</sup> and an official government process vetted and approved the lowest estimate.<sup>1101</sup> By 1 November 2010, the draft national harm reduction policy was submitted to the Prime Minister's Office for review and approval.<sup>1102</sup>

On 21 December 2010, the United Nations General Assembly approved the *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders*. Also known as the *Bangkok Rules*, these represented the first international instruments that provided specific and detailed guidelines on responding to the gender-specific needs of women and those of their children in the criminal justice system. The government of Thailand, guided by HRH Princess Bajrakitiyabha, initiated and played a key role in the development, promotion and adoption of the *Bangkok Rules*.<sup>1103</sup>

<sup>1095</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned))

<sup>1096</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1097</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1098</sup> Government of Thailand. 2009. *National Narcotics Control Policy on Five Fences Strategy 2009-2010*.

<sup>1099</sup> Government of Thailand. 2009. *National Narcotics Control Policy on Five Fences Strategy 2009-2010*.

<sup>1100</sup> Manop, K. 2015. “Size Estimation of Injecting Drug Users through the Network Scale-Up Method in Thailand” in *J Med Assoc Thai*, 98 (Suppl. 6): S17-S24. (<http://www.thaiscience.info/journals/Article/JMAT/10971236.pdf>)

<sup>1101</sup> MacDonald, V. and Nacape, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1102</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1103</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice.

By July 2011, the Council of State of Thailand, acting in a legal advisory capacity, noted that harm reduction services, particularly the distribution of sterile injecting equipment, were in contravention with the 1979 *Narcotics Act*, and such behaviors were equivalent to ‘inciting drug use’ which is a criminal offence.<sup>1104</sup> The Council of State's advice to the Office of the Prime Minister terminated the process to approve the *National Harm Reduction Policy* drafted in 2009. The policy would have mandated the establishment of a National Harm Reduction Committee under the joint supervision of the National AIDS Prevention and Alleviation Committee and of the Narcotics Control Board.<sup>1105</sup> Overall authority over the National Harm Reduction Committee was to be entrusted to MOH with further support from ONCB, MOJ, MOI, the Attorney General's Office, the Royal Thai Police, the Government Public Relations Department, the Bangkok Metropolitan Administration, the Pattaya City Administration and CSO.<sup>1106</sup>

The establishment of the Thailand Institute of Justice (TIJ) under MOJ in 2011 was prompted by the adoption of the *Bangkok Rules*, the promotion and implementation of which have been central to its programs. In addition, TIJ has been serving as a centre of excellence for justice research for the ASEAN Community and beyond, while contributing to the strengthening of the rule of law, in line with UN standards and norms, by supporting and facilitating reform in the fields of law enforcement, criminal justice, and corrections.<sup>1107</sup><sup>[17]</sup><sub>SEP</sub>

In late 2011, the *Kingdom's Unity for Victory over Drugs Strategy* was approved, again firmly grounded on the war on drugs approach that expanded the role and powers of law enforcement agencies in the national response to illicit drugs.<sup>1108</sup> Defining the widespread use of illicit drugs, particularly ATS, as a “national crisis,” the strategy encouraged all sectors to unite as a “national force” to reverse the situation by facilitating access to drug treatment for at least 400,000 individuals,<sup>1109</sup> an arbitrary number established as a formal performance target.<sup>1110</sup>

During the 2008-2011 period, four different national drug control strategies were approved and deployed, all providing for expanded scope and power of law enforcement agencies in the response. However, evidence shows increasing availability of illicit drugs in Thailand during that period despite the

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([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1104</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1105</sup> Government of Thailand. 2010. *Draft national harm reduction policy – Unofficial translation*.

<sup>1106</sup> Government of Thailand. 2010. *Draft national harm reduction policy – Unofficial translation*.

<sup>1107</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice.

([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

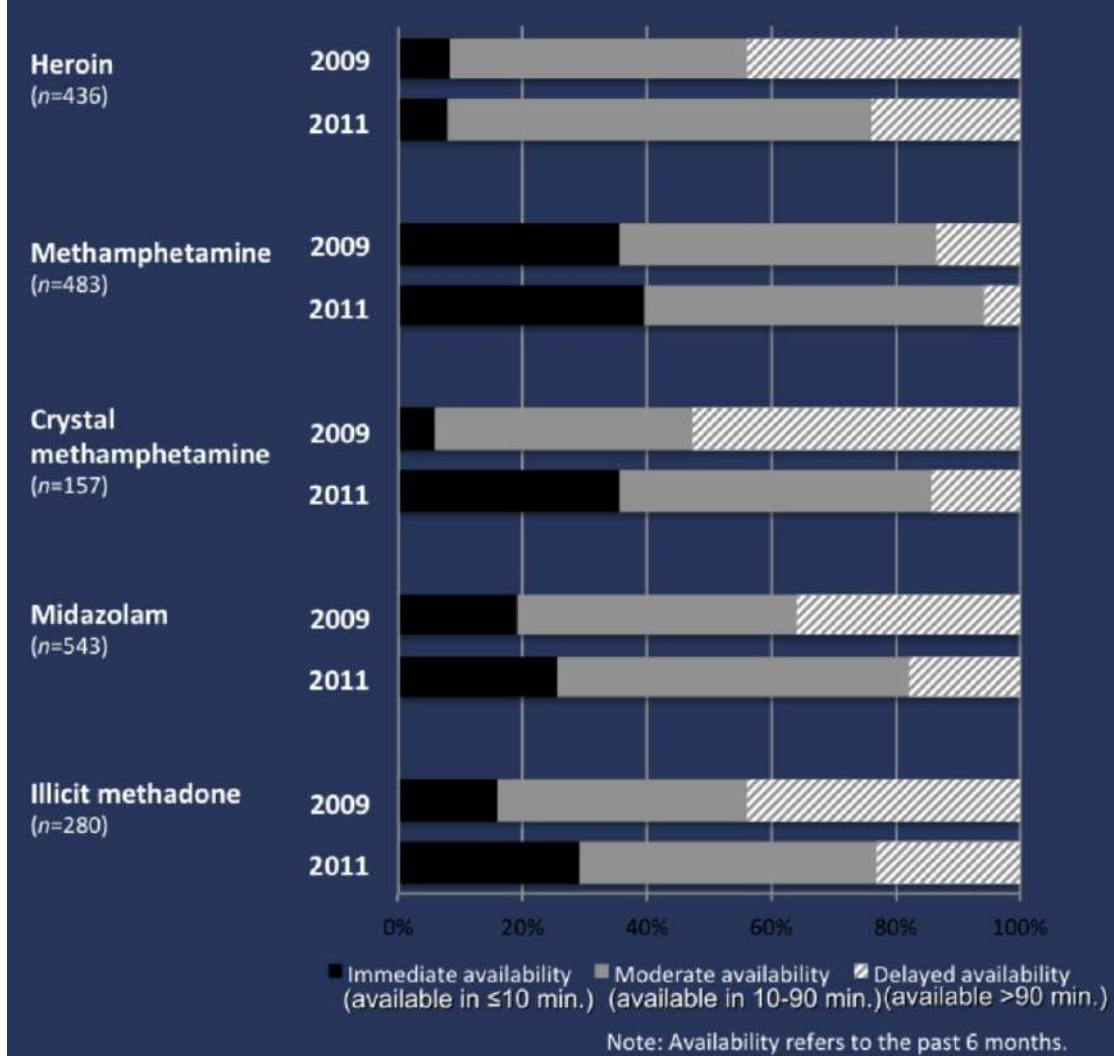
<sup>1108</sup> Hayashi et al. 2013. “Increasing availability of illicit drugs among people who inject drugs in Bangkok, Thailand” in *Drug Alcohol Depend*, 132(1-2): 251-6. (<https://www.ncbi.nlm.nih.gov/pubmed/23490451>)

<sup>1109</sup> Government of Thailand. 2011. *Kingdom's Unity for Victory over Drugs Strategy*.

<sup>1110</sup> MacDonald, V. and Nacapev, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

government’s focus on law enforcement-driven supply and demand reduction strategies.<sup>1111</sup> Figure 27 below shows how the illicit drugs market has grown and how drugs have become more readily available during the time when the four national strategies were being operationalized.

Figure 27: Increasing availability of licit and illicit drugs, 2009-2011 <sup>1112</sup>



Over the same period, reports indicate that the use of methamphetamines also increased across Thailand and by 2010, 80% of admissions in drug treatment were related to methamphetamines.<sup>1113</sup> In parallel, data collected through the Integrated Bio-Behavioral Survey (IBBS) in 2010 shows that methamphetamine injecting was on the rise. Specifically, results revealed that 30.3% of PWID surveyed in the Bangkok Metropolitan Area were injecting methamphetamines, compared to 29.9% in Chiang Mai and 18.1% in Songklha.<sup>1114</sup> Another household

<sup>1111</sup> Hayashi et al. 2013. “Increasing availability of illicit drugs among people who inject drugs in Bangkok, Thailand” in *Drug Alcohol Depend.* 132(1-2): 251-6. (<https://www.ncbi.nlm.nih.gov/pubmed/23490451>)

<sup>1112</sup> Hayashi et al. 2013. “Increasing availability of illicit drugs among people who inject drugs in Bangkok, Thailand” in *Drug Alcohol Depend.* 132(1-2): 251-6. (<https://www.ncbi.nlm.nih.gov/pubmed/23490451>)

<sup>1113</sup> United Nations Office on Drugs and Crime. 2011. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific.* ([https://www.unodc.org/documents/scientific/Asia\\_and\\_the\\_Pacific\\_2011\\_Regional\\_ATS\\_Report.pdf](https://www.unodc.org/documents/scientific/Asia_and_the_Pacific_2011_Regional_ATS_Report.pdf))

<sup>1114</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand.* International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)



survey conducted in 2011 estimated that over 3.5 million Thais between 12 to 65 years old had ever used an illicit drug in their lifetime.<sup>1115</sup> Among them, approximately 32% had ever used ATS (26% used methamphetamine pills; 4% crystal methamphetamine; 2% ecstasy). Of the close 600,000 persons who had used drugs in the past year, approximately 15% had used methamphetamine pills and 6% had used crystal methamphetamine.<sup>1116</sup> Of the close to 340,000 people who had used a drug in the last 30 days, roughly 11% had used methamphetamine pills and 4% had used crystal methamphetamine.<sup>1117</sup> An estimated 69% of all people who used drugs reported having ever used cannabis and 35% reported having ever used kratom. An estimated 9% of all people who have used drugs in their lifetime have used opiates (about 4% used heroin and 5% opium).<sup>1118</sup>

A *Bangkok Post* poll conducted in 2012 revealed that 88% of respondents felt that drugs represented the most serious problem affecting Thailand.<sup>1119</sup> Indeed, the Deputy Secretary General of ONCB noted in 2008, that “the drug problem is one of the highest priority issues on the Royal Thai Government’s agenda.”<sup>1120</sup> Table 46 below shows the ranking of illicit drugs in order of perceived importance based on prevalence surveys conducted every two years,<sup>1121</sup> which clearly shows that methamphetamine pills have remained a constant priority for the period 2006-2012.

**Table 46: Ranking of illicit drugs by order of level of concern, 2006-2012**<sup>1122</sup>

Drug type	2006	2007	2008	2009	2010	2011	2012
Crystal methamphetamine	3	3	8	7	7	3	2
Methamphetamine pills	1	1	3	1	1	1	1
Ecstasy	6	6	7	9	9	8	8
Ketamine	3	6	9	-	-	9	9
Cannabis herb	2	2	1	2	2	2	3
Heroin	8	5	6	5	5	7	7
Inhalants	4	3	4	3	3	5	5
Kratom	10	4	2	6	6	4	4
Opium	9	9	5	4	4	6	6

Also in 2012, the results of an independent evaluation of the national response to

<sup>1115</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1116</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1117</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1118</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1119</sup> 30 June 2012. “Poll: Drugs Thais’ biggest concern” in *Bangkok Post*, online at: <http://www.bangkokpost.com/news/local/300382/page-2/>; poll results, available in Thai, available online at: <http://www.nidapoll.nida.ac.th/main/index.php/en/2012-08-06-13-57-45/226-poll16-55>.

<sup>1120</sup> Jinawat, P. 2008. “Thailand’s Experiences of Sustainable Alternative Development and Opium Reduction” in *Sustaining Opium Reduction in Southeast Asia: Sharing Experiences on Alternative Development and Beyond*, 125-132. UNODC. ([https://www.unodc.org/documents/alternative-development/UNODC\\_Layout.pdf](https://www.unodc.org/documents/alternative-development/UNODC_Layout.pdf))

<sup>1121</sup> United Nations Office on Drugs and Crime. 2011. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/Asia\\_and\\_the\\_Pacific\\_2011\\_Regional\\_ATS\\_Report.pdf](https://www.unodc.org/documents/scientific/Asia_and_the_Pacific_2011_Regional_ATS_Report.pdf))

<sup>1122</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf)); United Nations Office on Drugs and Crime. 2011. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/Asia\\_and\\_the\\_Pacific\\_2011\\_Regional\\_ATS\\_Report.pdf](https://www.unodc.org/documents/scientific/Asia_and_the_Pacific_2011_Regional_ATS_Report.pdf))



HIV among key populations covered by Global Fund-supported programs identified a number of critical barriers undermining the implementation of comprehensive health services to prevent HIV among PWID. Specifically, the evaluation identified the absence of legal and policy instruments to support implementation of harm reduction; the continued implementation of war on drugs approaches; mass incarceration of PWUD; limited willingness of government officials to work and coordinate with CSO or on harm reduction; and frequent police harassment of PWUD, all of which were considered serious impediments to the achievements evidence-based public health objectives as well as project-specific goals.<sup>1123</sup>

In February 2013, the Law Reform Commission of Thailand approved the establishment of a multi-sectoral Narcotics Law Reform Sub-Committee to review existing drugs laws and propose amendments that would modernize Thailand's drug control approach.<sup>1124</sup> Specifically, the revisions were intended to make punishments for drug-related offences more proportional.<sup>1125</sup> For example, Thailand's harsh drug laws punish methamphetamine violations nearly 10 times more severely than heroin violations, while both drugs are scheduled in the same category.<sup>1126</sup> In August that year, Thailand's Minister of Justice announced that his office was considering decriminalizing kratom.<sup>1127</sup> Later that year, in order to address prison overcrowding largely driven by drug-related arrests, Thailand's Minister of Justice announced the allocation of THB 30 billion (USD 92 million) to build 42 new prisons nationwide.<sup>1128</sup>

On 1 October 2013, the *Order of National Command Centre for Combating Drugs' No. 1/2557: Guidelines for Harm Reduction among Injection Drug Users* came into force and a formal announcement was made by the Kingdom's Deputy Prime Minister on 19 October 2013 fully endorsing the first *National Harm Reduction Policy*. The policy was officially finalized on 7 February 2014 and publicly launched on 17 March 2014 at a meeting co-hosted by ONCB and CSO. The national harm reduction policy was designed to achieve five objectives:

1. To support PWID to access health services by strengthening care and support strategies;
2. To reduce the burden of blood-borne infections among PWID;
3. To assist PWID to access and enter voluntary drug rehabilitation services aimed at reduction and eventual cessation of drug use;
4. To reduce drug-related harms amongst PWID, their communities and society as a whole;
5. To create an enabling service delivery environment that facilitates access to

<sup>1123</sup> Burns, K. et al. 2012. *Evaluation of HIV programmes among female sex workers, people who inject drugs, and men who have sex with men*. Institute for Population and Social Research, Mahidol University.

<sup>1124</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1125</sup> Fernquest, J. 10 October 2016. "New drug laws: Make punishment fit the crime" in *Bangkok Post*, online at: <http://www.bangkokpost.com/learning/advanced/1107000/new-drug-laws-make-punishment-fit-the-crime>.

<sup>1126</sup> Paungasawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

<sup>1127</sup> Tanguay, P. & Vasconi C. 2013. "Kratom decriminalisation in Thailand" in *IDPC Blog*, online at: <http://idpc.net/blog/2013/09/kratom-decriminalisation-in-thailand>.

<sup>1128</sup> 17 October 2013. "Thai Justice Ministry Eyes New Prisons" in *The Nation*. (<http://www.nationmultimedia.com/news/national/aec/30217262>)

and delivery of harm reduction services.<sup>1129</sup>

ONCB was assigned overall responsibility for implementation of the policy while the Sub-Committee on Strategic Planning for Overcoming Drug Abusers/Addicts Problem was established as mandated by the policy to prepare implementation guidelines and to oversee all relevant operations that flow from the guidelines. In addition, provincial Command Centers for Combating Drugs in 19 pilot provinces (aligned with the geographical scope of the CHAMPION-IDU project) were meant to operationalize guidelines at community level, supported by a provincial harm reduction task force as a channel for policy advocacy and troubleshooting.

The *National Harm Reduction Policy* specified that comprehensive harm reduction services should be piloted in 19 provinces, targeting highly vulnerable people who were dependent on illicit drugs and had been unable to achieve abstinence. The services were designed to prevent the harms associated with drug use, including transmission of blood-borne infections, as well as potential harms to their families, communities and the wider Thai society.<sup>1130</sup> The policy acknowledged that dependence or “addiction” is as a brain disease and offered a clear distinction between users, abusers, dependents, and highly vulnerable dependents.<sup>1131</sup>

In early 2015, a new project – the Stop TB and AIDS through RTTR (STAR) – was established to continue delivery of HIV prevention services amongst PWID in 12 provinces. However, Global Fund financial support for HIV prevention amongst PWID was reduced by approximately 50% compared to the 2009-2014 period, the number of service delivery sites was reduced by approximately 50%, fewer CSO have been involved in the delivery of harm reduction services amongst PWID,<sup>1132</sup> and serious concerns have been raised over the transition process by the STAR project implementers<sup>1133</sup> and key stakeholders related to the Global Fund.<sup>1134</sup> That same year, revised PWID population size estimates were approved by MOH, concluding on a new figure of 71,000 PWID,<sup>1135</sup> and the *National Harm Reduction Policy* expired quietly in October 2015.<sup>1136</sup>

By then, the Minister of Justice had made public statements acknowledging that efforts designed to eradicate all drugs were counterproductive and associated

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<sup>1129</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1130</sup> Government of Thailand. 2010. *Draft national harm reduction policy – Unofficial translation*.

<sup>1131</sup> Government of Thailand. 2010. *Draft national harm reduction policy – Unofficial translation*.

<sup>1132</sup> Open Society Foundations. 2015. *Ready, Willing, and Able? Challenges Faced by Countries Losing Global Fund Support*. (<https://www.opensocietyfoundations.org/sites/default/files/ready-willing-and-able-20160403.pdf>)

<sup>1133</sup> Likhitpreechakul, P. 17 February 2016. “Amid the good news a ticking time bomb for Aids in Thailand” in *The Nation*, online at: <http://www.nationmultimedia.com/news/opinion/aec/30279445>;

<sup>1134</sup> Oberth, G. 3 February 2016. “Thailand’s transition triggers concerns for some, but others are more confident” in *Global Fund Observer*, 280. ([http://www.aidspace.org/gfo\\_article/thailand's-transition-triggers-concerns-some-others-are-more-confident](http://www.aidspace.org/gfo_article/thailand's-transition-triggers-concerns-some-others-are-more-confident))

<sup>1135</sup> National AIDS Management Centre. 2015. *National consensus meeting: size estimation on PWID, September 2015; minutes from AIDS epidemic model meeting*.

<sup>1136</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

with systemic police corruption and prison overcrowding.<sup>1137</sup> At the UNGASS on the World Drug Problem in April 2016, Minister Koomchaya stated:

*We do not agree with legalization of illicit drugs and decriminalization for serious offences. At the same time, drug users should receive treatment and rehabilitation, not incarceration. Promote Bangkok rules for incarceration of female prisoners. Illicit trafficking of precursor chemicals is one of Thailand's priorities.*<sup>1138</sup>

Later that year, Thailand's Minister of Justice was making global headlines with what was perceived as a radical shift in drug control approaches. "The world has lost the war on drugs, not only Thailand," noted Minister Koomchaya in July 2016 in an interview with Reuters.<sup>1139</sup> Rescheduling methamphetamines and other ATS,<sup>1140</sup> decriminalization cannabis and kratom,<sup>1141</sup> and scaling-up evidence-based drug dependence treatment<sup>1142</sup> were some of the options that have been raised by the Minister and his team.

On 24 November 2016, the National Legislative Assembly unanimously approved amendments to the 1979 *Narcotics Act* that removed the assumption that all drug offenders have the intent to sell/distribute, that offered greater opportunities for judicial discretion, and that slightly reduced the severity of the most severe punishments reserved for drug offenders.<sup>1143</sup> At the end of 2016, announcements were made that as of 1 January 2017, hemp – previously criminalized and scheduled in category V – would be decriminalized in 15 districts in six provinces in the northern region.<sup>1144</sup>

In February 2017, MOJ issued an official order approving national harm reduction implementation guidelines for a three-year period. The guidelines include provisions for comprehensive service delivery in 38 provinces, specifically targeting PWID.<sup>1145</sup>

### **Implementation of the national drug control strategy**

While Thailand's drug control policies have addressed supply reduction (law enforcement targeting production and trafficking), demand reduction (law enforcement targeting users and dealers, treatment and rehabilitation), and potential demand reduction (prevention among non-users) at least since

<sup>1137</sup> Fawthrop, T. 8 August 2015. "Drug-free ASEAN by 2015?" in *The Diplomat*, online at: <http://thediplomat.com/2015/08/drug-free-aseanby-2015/>.

<sup>1138</sup> Koomchaya, P. 20 April 2016. *Statement by H. E. Paiboon Koomchaya Minister of Justice of Thailand at the Thirteenth Special Session of the United Nations General Assembly on the World Drug Problem*. New York City, United States. (<http://statements.unmeetings.org/media/2/7657420/thailand.pdf>)

<sup>1139</sup> Marshall, A. R. C. and Slodkowski, A. 10 September 2016. "Bullets trump rehab as Asia quickens 'failing' war on drugs" in Reuters, online at: <http://www.reuters.com/article/us-asia-drugs-idUSKCN11H01K>.

<sup>1140</sup> Lefevre, A. S. 18 July 2016. "Soaring prison population prompts Thailand to re-think 'lost' drug war" in *Reuter*. (<http://www.reuters.com/article/us-drugs-thailand-prisons-idUSKCN0ZX01J>)

<sup>1141</sup> Charuvastra, T. 30 August 2016. "Regime moves to ease drug laws starting with meth, marijuana," in *KhaoSod*, online at: <http://www.khaosodenglish.com/news/crimecourtsalamity/2016/08/30/regime-moves-ease-drug-laws-starting-meth-marijuana/>.

<sup>1142</sup> Lefevre, A. S. 18 July 2016. "Soaring prison population prompts Thailand to re-think 'lost' drug war" in *Reuter*. (<http://www.reuters.com/article/us-drugs-thailand-prisons-idUSKCN0ZX01J>)

<sup>1143</sup> iLaw. 2 December 2016. ผ่านแล้ว! กฎหมายยาเสพติดใหม่ เปิดช่องคนขายไม่ถูกประหาร เพิ่มโอกาสให้ผู้ต้องหาพิสูจน์ความบริสุทธิ์, online at: <https://ilaw.or.th/node/4352>.

<sup>1144</sup> 29 December 2016. "Thailand's Narcotics Control Board Legalizes Growing Hemp" in *LovePattaya*, online at: <http://lovepattaya-thailand.com/thailands-narcotics-control-board-legalizes-growing-hemp>.

<sup>1145</sup> Ministry of Justice. 2017. คำสั่งที่ 2/2560 เรื่อง แนวทางการดำเนินงานลดอันตรายจากยาเสพติด.

2002,<sup>1146</sup> an analysis of the implementation of drug control policies in Thailand will continue to assess interventions and their impact based the Swiss *Four Pillars* model, which has included prevention, harm reduction, treatment and law enforcement strategies and interventions to address national drug issues.

### *Prevention*

Limited information was available on drug prevention activities in Thailand or their impact. As noted above, the responsibility for primary prevention activities was entrusted to MOJ since 2002. Prevention activities in Thailand were designed with the objective of preventing people from initiating drug consumption.<sup>1147</sup> Prevention activities have relied on different approaches: education and sensitization; increasing "immunity" to drugs; and drug testing. Specifically, prevention interventions have relied on education in schools and sensitization through public awareness campaigns; on "immunizing" communities by reducing exposure to drugs through after-school and youth leadership programs; and on conducting urine testing campaigns in- and out-of-schools, in the workplace and in the community.<sup>1148</sup> A number of prevention programs have been implemented across Thailand, including a program designed to provide support to family networks, drug-free school programs, drug-free workplace programs, life skills learning programs, anti-drug counseling programs, as well as training of trainers for youth recreational activities.<sup>1149</sup> The 2011 *Kingdom's Unity for Victory over Drugs Strategy* further identified three behaviors to be prevented, all of which should be integrated at community levels: initiation of drug use, exposure to risk factors, and recidivism and relapse.<sup>1150</sup>

Reports indicate that students aged 15-18 have been primary targets for drug prevention interventions and school-based programs have been the most commonly implemented across Thailand.<sup>1151</sup> In 2008, programs focused on building capacity of teachers to implement drug prevention programs and contribute to early identification of drug problems in schools.<sup>1152</sup> In addition, a total of 17,318 grade 6 students graduated from the Drug Abuse Resistance Education (DARE) program in which specially trained uniformed police officers work as teachers in schools.<sup>1153</sup> By 2013, prevention targets had shifted to focus on students, aiming to "immunize" 1.5 million primary school students from grade 5 and 6, and to deploy drug use surveillance programs in 11,490 schools.<sup>1154</sup>

Workplace programs have also been prioritized, including sensitization campaigns and especially urine testing to control the labor force in an effort to

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<sup>1146</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1147</sup> Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1148</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*; Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1149</sup> Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1150</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*.

<sup>1151</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*; Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1152</sup> Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1153</sup> Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1154</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*.

achieve a drug-free workplace. Interventions have included the development of workplace drug control guidelines, development of a database of drug use and drug use prevention in the workplace, sensitization campaigns and distribution of education materials, as well as an accreditation system to encourage compliance with national drug-free workplace guidelines.<sup>1155</sup> For example, in 2013, a total of 3,006 firms screened employees for drug use and referred those who were identified as using drugs to treatment (over a target of 2,000 firms); a total of 3,479 firms were employing people recovering from drug use; a total of 5,555 firms implemented drug control activities to screen their employees (with 1,587 firms implementing such activities with foreign employees); and a total of 2,666 firms met national drug control standards for a drug-free workplace.<sup>1156</sup>

Recognizing that out-of-school youth are highly vulnerable, recent efforts have focused on targeting youngsters associated and affiliated with known criminal elements and the nightlife entertainment industry. While the intent has been to transform vulnerable youth into empowered youth who can resist the appeal of illicit drugs, the interventions implemented under this banner have largely been limited to urine testing designed to apprehend users and coerce them into accepting "voluntary" treatment. For example, the 2013 ONCB *Annual Report* provided the following results: 67,029 vulnerable youths were put on probation; 38,450 vulnerable youths were referred to behavior modification programs; 24,415 families participated in family strengthen activities; 19,247 out-of-school youths accessed vocational skills training; and 42,805 youths volunteered to enroll in drug treatment programs.<sup>1157</sup> Additional interventions to reach out-of-school youth included capacity development programs for religious leaders. For example, in 2013, a total of 560 Buddhist monks from seven provinces were trained to deliver drug prevention education sessions.<sup>1158</sup> CSO have also been implementing a range of drug prevention and drug education programs across Thailand.<sup>1159</sup>

Little is known about the impact of drug prevention activities in Thailand. No evaluation has been performed and limited studies have assessed the impact of such interventions. Despite the lack of evidence supporting the effectiveness of drug prevention interventions in Thailand, a total of USD 334,766,667 was earmarked for drug prevention activities and allocated to MOH in order to support implementation in 2015.<sup>1160</sup>

### *Harm reduction*

Since 2002, significant efforts have been made to deploy a national harm reduction policy, with government engagement starting in 2009.<sup>1161</sup> However, it

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<sup>1155</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*; Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1156</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*.

<sup>1157</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*.

<sup>1158</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*.

<sup>1159</sup> Office of the Narcotics Control Board. 2013. *Thailand Narcotics Control Annual Report 2013*; Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1160</sup> Government of Thailand. 2015. *Thailand's Budget in Brief Fiscal Year 2015*. ([http://www.bb.go.th/budget\\_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf](http://www.bb.go.th/budget_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf))

<sup>1161</sup> Tanguay, P. and Ngammee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)



wasn't until 2014 that the first national harm reduction policy was formally approved and deployed in Thailand.<sup>1162</sup> As noted earlier, the policy remained in effect for approximately 12 months before expiring.<sup>1163</sup> In February 2017, national harm reduction implementation guidelines were approved.<sup>1164</sup> CSO have been at the forefront of the advocacy movement to encourage the government to endorse harm reduction since 2002 when TDN was first established.<sup>1165</sup> Despite those efforts, the Thai government as well as the population at large have systematically resisted if not opposed the deployment of harm reduction policies and strategies that would facilitate access to and delivery of health services to those who use drugs but are unable or unwilling to stop.<sup>1166</sup>

Responsibility for implementation the 2014 *National Harm Reduction Policy* was delegated to ONCB, an organ of the criminal justice system. The ONCB was staffed by people trained in law enforcement approaches who had little or no medical or public health experience in regards to reducing drug-related harms. Comparatively, the 2010 draft harm reduction policy was meant to be overseen jointly by the National AIDS Prevention and Alleviation Committee, under MOH, in collaboration with ONCB.

The 2014 policy endorsed the delivery of a comprehensive package of interventions, aligned with UNAIDS, UNODC and WHO recommendations,<sup>1167</sup> in order to prevent HIV amongst PWID in Thailand. Specifically, the 2014 policy endorsed the deployment of OST and distribution of sterile equipment, although the latter was not endorsed or included in the 2010 draft policy and the legal ambiguity highlighted by the Council of State in 2011 remains unresolved in the legal and policy instruments that are currently in place. Even though the 2017 implementation guidelines include needles and syringes, there are no formal plans in place to scale-up this intervention through government agencies.

As in European countries, injecting drug use became increasingly popular and common in the 1960s as high-grade heroin was introduced on the Thai market, marking a shift from opium smoking. With injecting drug use came the rapid spread of HIV in the late 1980s (HIV prevalence amongst PWID rose from 0% to 49% between 1987 and 1988)<sup>1168</sup>, and by the mid-1990s, amphetamines and

<sup>1162</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1163</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>1164</sup> Ministry of Justice. 2017. คำสั่งที่ 2/2560 เรื่อง แนวทางการดำเนินงานลดอันตรายจากยาเสพติด.

<sup>1165</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand: Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned))

<sup>1166</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand: Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned)); Kaplan, K., & Tanguay, P. 2013. "One Step Forward, Two Steps Back: Consequences of Thailand's Failure to Adopt Evidence-based Drug Policy" in *Drug Law Reform in East and Southeast Asia*. Lexington Books; Megaloudi, F. et al. 31 July 2012. "Thailand: Ambivalent about needle exchanges" in *IRIN*. (<http://www.irinnews.org/report/95984/THAILAND-Ambivalent-about-needle-exchanges>).

<sup>1167</sup> World Health Organization. 2014. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. (<http://www.who.int/hiv/pub/guidelines/keypopulations/en/>); Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime, and World Health Organization. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. ([http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf))

<sup>1168</sup> AIDS Data Hub for Asia Pacific. 2009. *Thailand at a glance: country profile*, online at: [http://www.aidsdatahub.org/files/country\\_reviews/thailand\\_country\\_review.pdf](http://www.aidsdatahub.org/files/country_reviews/thailand_country_review.pdf); Phoolcharoen, W. et al. 1998. *Thailand: lessons*

methamphetamines had become the most commonly used drugs in Thailand. By 2010, data showed that approximately a third of PWUD were injecting of ATS.<sup>1169</sup> Later reports also indicate that patterns of drug use in Thailand have changed, where approximately 50% of CHAMPION-IDU clients in the Bangkok Metropolitan Area reported injecting ATS and pharmaceuticals in 2014, compared to 70% who were injecting heroin in 2009 in the same region.<sup>1170</sup>

Population size estimates show a rapid rise in the number of people who used heroin in the 1970s and 1980s, which dropped in the mid-1990s and early 2000s as a result of, amongst other factors, the increasing popularity of ATS and repressive law enforcement crackdowns. From 2010 onwards, the number of injectors has been on the rise again as injecting of ATS became increasingly popular. By 2011, UNODC was reporting injecting as the second most common mode of administration for crystal methamphetamine and the third preferred mode of administration among amphetamine users in Thailand.<sup>1171</sup> *Table 47* below summarizes population size estimates in Thailand from 1972 to 2015. In addition to official estimates, recent reports indicate that up to 5% of men who have sex with men in the ASEAN region are also injecting drugs, mostly ATS.<sup>1172</sup> For Thailand, this could represent an additional 28,000 PWID that are currently not captured through regular surveys.<sup>1173</sup>

***Table 47: Evolution in the PWID/problematic drug user population size, 1972-2015***

<b>Year</b>	<b>Estimated number of problematic drug users</b>	<b>Estimated number of PWID</b>
<b>1972</b>	130	
<b>1974</b>	953	
<b>1984</b>	39,974	
<b>1980-1995</b>		160,000
<b>2001</b>		70,000
<b>2002</b>		57,000
<b>2004</b>		38,380
<b>2010-2014</b>		40,300
<b>2015</b>		71,000

Harm reduction services in Thailand have focused exclusively on meeting the needs of PWID (as opposed to all people who use drugs) given donor restrictions that have prioritized HIV prevention. All such services, with the exception of OST, have been delivered virtually exclusively by CSO. This implied that harm reduction services have essentially not been integrated in the national health

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from a strong national response to HIV/AIDS. AIDS Division, Communicable Disease Control Department, Ministry of Public Health.

<sup>1169</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1170</sup> Tanguay, P. and Ngammee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1171</sup> United Nations Office on Drugs and Crime. 2011. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/Asia\\_and\\_the\\_Pacific\\_2011\\_Regional\\_ATS\\_Report.pdf](https://www.unodc.org/documents/scientific/Asia_and_the_Pacific_2011_Regional_ATS_Report.pdf))

<sup>1172</sup> World Health Organization. 2010. *HIV/AIDS among men who have sex with men and transgender populations in South-East Asia: The current situation and national responses*. ([http://apps.searo.who.int/PDS\\_DOCS/B4568.pdf?ua=1](http://apps.searo.who.int/PDS_DOCS/B4568.pdf?ua=1))

<sup>1173</sup> World Health Organization. 2010. *HIV/AIDS among men who have sex with men and transgender populations in South-East Asia: The current situation and national responses*. ([http://apps.searo.who.int/PDS\\_DOCS/B4568.pdf?ua=1](http://apps.searo.who.int/PDS_DOCS/B4568.pdf?ua=1))

system,<sup>1174</sup> and their implementation has not been coordinated with national authorities. This has resulted in clients having to visit multiple sites and deal with multiple people and agencies in order to access a comprehensive package of services.<sup>1175</sup> It also implies that CSO delivering harm reduction services have been at constant risk, both legally and economically, thereby undermining the fundamental sustainability of the national response.<sup>1176</sup>

Distribution of sterile injecting equipment to prevent HIV started in 1992 in northern Thailand, with leftover sterile needles and syringes from a vaccination program.<sup>1177</sup> Despite 25 years of implementation, coverage has remained extremely low by international standards, primarily due to ambiguities related to the legality of distributing injecting equipment that persist today, as well as political resistance, despite significant advocacy efforts implemented over more than a decade. In 2010, fewer than one needle and/or syringe was being distributed to each PWID each year.<sup>1178</sup> By 2012, coverage had risen to 12 needles and/or syringes per PWID per year,<sup>1179</sup> further up to 14 needles and/or syringes per PWID per year by 2016.<sup>1180</sup> Again, this is well below the recommended coverage of 200 needles and/or syringes per PWID per year, as indicated by UN agencies.<sup>1181</sup>

All sterile injecting equipment distribution services have been operated exclusively by CSO and have been available only through community outreach or through DIC. Financial support for such services has been mobilized from the Global Fund and to a lesser extent from other international donors and development partners. Thai government agencies have not engaged or supported distribution of sterile injecting equipment in Thailand. The number of sites from which clients could have access to sterile needles and/or syringes remained equal to or below 10 until 2009 when the CHAMPION-IDU project scaled-up services across 14 provinces, further up to 38 sites by the end of

<sup>1174</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1175</sup> Burns, K. et al. 2012. *Evaluation of HIV programmes among female sex workers, people who inject drugs, and men who have sex with men*. Institute for Population and Social Research, Mahidol University; Tyndall, M. 2010. *Harm Reduction Policies and Interventions for Injecting Drug Users in Thailand*. World Bank. (<http://documents.worldbank.org/curated/en/678211468310529526/pdf/646420Revised00ion0for0IDUs00final0.pdf>)

<sup>1176</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand: Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned)); Tanguay, P. and Ngammee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>);

<sup>1177</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1178</sup> Mathers, B. M. et al. 2010. "HIV prevention, treatment and care services for people who inject drugs: A systematic review of global, regional and national coverage" in *The Lancet*, 375(9719): 1014-1028, (<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960232-2/abstract>)

<sup>1179</sup> Joint United Nations Programme on HIV and AIDS. 2013. *Global Report: UNAIDS report on the global AIDS epidemic 2013*. ([http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS\\_Global\\_Report\\_2013\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf))

<sup>1180</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>1181</sup> Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime, and World Health Organization. 2012. *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*. ([http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf))

2014,<sup>1182</sup> but back down to 14 sites by 2016, after Global Fund support had been substantially reduced by approximately 50%.<sup>1183</sup>

CSO workers and their clients have faced important obstacles and challenges when delivering and accessing harm reduction services in Thailand. Studies have shown that workers and clients have been frequently harassed by law enforcement, that law enforcement representatives have regularly resorted to physical, psychological and sexual abuse,<sup>1184</sup> that law enforcement have planted drugs,<sup>1185</sup> extorted bribes,<sup>1186</sup> coerced confessions,<sup>1187</sup> and demanded urine samples without consent,<sup>1188</sup> in public spaces with no expectation of privacy.<sup>1189</sup> Between 2009 and 2014, an average of two to three harm reduction project workers were arrested every month by police.<sup>1190</sup> The limited protections and safeguards that were deployed to ensure the safety and security of harm reduction project workers and clients have unfortunately been eliminated in 2015 during the transition from the CHAMPION-IDU to the STAR project, leaving workers and clients especially vulnerable.<sup>1191</sup>

OST with methadone was initiated for detoxification purposes in 1979 and for long-term maintenance in 2000.<sup>1192</sup> The Queen Mother Institute for Treatment of Drug Abuse (also known as the Thanyarak Institute) has been mandated to oversee implementation of methadone services all over the country. The Thanyarak Institute has thus been issuing national guidelines that apply to all providers with the exception of those in the Bangkok Metropolitan area, which have been overseen and guided by the Bangkok Metropolitan Administration. Enrollment in methadone programs is reportedly free of charge given that the cost of the service has been covered by the national health insurance scheme,<sup>1193</sup> although clients continue to report being charged for operating costs.<sup>1194</sup>

<sup>1182</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International.

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>1183</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf))

<sup>1184</sup> Hayashi, K. et al. 2013. "Reports of police beating and associated harms among people who inject drugs in Bangkok, Thailand: A serial cross-sectional study" in *BMC Public Health*, 13:733. (<http://www.biomedcentral.com/1471-2458/13/733>)

<sup>1185</sup> Fairbairn, N. et al. 2009. "Reports of evidence planting by police among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 9: 24. (<https://www.ncbi.nlm.nih.gov/pubmed/19811653>)

<sup>1186</sup> Fairbairn, N. et al. 2009. "Reports of evidence planting by police among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 9: 24. (<https://www.ncbi.nlm.nih.gov/pubmed/19811653>)

<sup>1187</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1188</sup> J. Suwansaksri, V. and Wiwanitkit. 2003. "Urine Amphetamine Screening, Informed Consent Is Useful Or Useless?" in *The Internet Journal of Toxicology*, 2:1. (<http://print.ispub.com/api/0/ispub-article/6150>)

<sup>1189</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1190</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1191</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1192</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1193</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1194</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)



No drug other than methadone - such as buprenorphine - has been approved for use in the context of substitution in Thailand, although pilots have assessed the feasibility of buprenorphine and suboxone for substitution.<sup>1195</sup> Methadone clinics have been concentrated in the Bangkok Metropolitan Area, where 18 of the Kingdom's 111 clinics are located.<sup>1196</sup> Approximately 10% of government hospitals currently offer OST services. In addition to government operated clinics, a number of private sector health providers have offered methadone, taking the number of outlets to 147 for the period of 2010 to 2016.<sup>1197</sup> In 2012, CSO started a community-based methadone substitution project in the hilltops near Chiang Rai operated by recovering PWUD with supervision from the Chiang Rai provincial hospital.<sup>1198</sup>

Coverage with OST has remained very low: in 2013, reports show that only 7% of PWID were enrolled in OST,<sup>1199</sup> rising to 8.4% (or 5,956 PWID) in 2016.<sup>1200</sup> PWID have reported having to fail detoxification with methadone three times before being allowed to enroll in OST programs and, once enrolled, receiving decreasing doses of methadone for between 45-90 days. Drop-out rates have been high, given that clients have also reported methadone doses that are generally too low to prevent cravings and withdrawals, that costs have been too high, that clinics have been located too far away from clients' homes, that there have been few opportunities to access take-home doses, that stigma and discrimination has been commonly experienced in clinics,<sup>1201</sup> and that police have often harassed clients near or at methadone clinics.<sup>1202</sup>

In 2010, the Thai AIDS Treatment Action Group (TTAG), a Thai CSO, initiated the first community-based overdose prevention project using naloxone.<sup>1203</sup> In 2013, the overdose prevention project was integrated in the CHAMPION-IDU project, extending the reach of the intervention to 19 provinces.<sup>1204</sup> However, the Thai Food and Drug Administration has classified naloxone as a 'dangerous drug'

<sup>1195</sup> Tyndall, M. 2010. *Harm Reduction Policies and Interventions for Injecting Drug Users in Thailand*. World Bank. (<http://documents.worldbank.org/curated/en/678211468310529526/pdf/646420Revised00ion0for0IDUs00final0.pdf>)

<sup>1196</sup> Ngamdee, V. 2015. *Community-based Methadone Maintenance Therapy: An Evidence-based Report on Effective Treatment for Opioid Substance Users in Santikhiri Village, Thailand*. PSI Thailand. (<http://www.psi.org/wp-content/uploads/2015/07/Small-Santikhiri-Community-Methadone-Best-Practice-Report.pdf>)

<sup>1197</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International. ([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf)); Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International. ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf)).

<sup>1198</sup> Ngamdee, V. 2015. *Community-based Methadone Maintenance Therapy: An Evidence-based Report on Effective Treatment for Opioid Substance Users in Santikhiri Village, Thailand*. PSI Thailand. (<http://www.psi.org/wp-content/uploads/2015/07/Small-Santikhiri-Community-Methadone-Best-Practice-Report.pdf>)

<sup>1199</sup> Bergenstrom, A. et al. 3 July 2013. "Overview of epidemiology of injection drug use and HIV in Asia," presentation at the 7th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, Kuala Lumpur, Malaysia.

<sup>1200</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>1201</sup> MacDonald, V. and Nacape, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1202</sup> Hayashi, K. et al. 2013. "Experiences with Policing among People Who Inject Drugs in Bangkok, Thailand: A Qualitative Study" in *PLOS Medicine*, 10(12). (<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001570>)

<sup>1203</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1204</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)



which can only be administered by a medical professional, thereby limiting use of naloxone in community settings.<sup>1205</sup> Data on drug-related mortality was rare in Thailand given that "overdose" has not been accepted as a valid cause of death by authorities.<sup>1206</sup>

Harm reduction services have been generally unavailable in prisons and detention centers, although small-scale methadone projects have been facilitated by CSO in a handful of prisons.<sup>1207</sup> Distribution of sterile injecting equipment in closed settings has been strictly prohibited. Supervised drug consumption facilities, heroin-assisted therapy, and specific harm reduction interventions for ATS users are not available in Thailand.

The impact of harm reduction services is not easy to assess in Thailand since such services were never formally approved, integrated or supported by national government agencies. Assessments and evaluations have been generally limited to project-specific assessments related to HIV and public health considerations providing limited insights into the overall performance of the drug control apparatus. That said, the impact of harm reduction services in Thailand can be assessed by analyzing HIV, viral hepatitis and overdoses prevalence rates as well as investments in harm reduction.

In 2016, HIV prevalence amongst PWID was recorded at 21%,<sup>1208</sup> compared to a general population prevalence of 1.1% in 2015.<sup>1209</sup> HIV prevalence among PWID peaked in 1987-1988 at 49%,<sup>1210</sup> hovered between 30% and 50% from 1989 to 2006,<sup>1211</sup> was recorded between 20% and 56% in 2008,<sup>1212</sup> at 42.5% in 2010,<sup>1213</sup> down to 21.9% in 2012,<sup>1214</sup> up to 25.2% in 2014,<sup>1215</sup> and finally down to 21% as of 2016.<sup>1216</sup> While HIV prevalence amongst PWID has dropped significantly, prevalence rates have remained high. Meanwhile, Thailand has been recognized globally as a leader in provision of ART medication to people living with HIV,

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<sup>1205</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1206</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1207</sup> Tanguay, P. and Ngammee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1208</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>1209</sup> World Health Organization. 2015. *Country fact sheet: HIV/AIDS in Thailand*. (<http://www.searo.who.int/entity/hiv/data/tha-fs-2015.pdf?ua=1>)

<sup>1210</sup> AIDS Data Hub for Asia Pacific. 2009. *Thailand at a glance: country profile*, online at: [http://www.aidsdatahub.org/files/country\\_reviews/thailand\\_country\\_review.pdf](http://www.aidsdatahub.org/files/country_reviews/thailand_country_review.pdf); Phoolcharoen, W. et al. 1998. *Thailand: lessons from a strong national response to HIV/AIDS*. AIDS Division, Communicable Disease Control Department, Ministry of Public Health.

<sup>1211</sup> Razak, M.H. et al. 2003. "HIV Prevalence and risks among IDUs in northern Thailand: Need for comprehensive HIV prevention programs" in *J Acquir Immune Defic Syndr*, 33(2): 259-66.

<sup>1212</sup> Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International. (<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

<sup>1213</sup> Cook, C. (ed). 2010. *The Global State of Harm Reduction: Key issues for broadening the response*. Harm Reduction International. ([https://www.hri.global/files/2010/06/29/GlobalState2010\\_Web.pdf](https://www.hri.global/files/2010/06/29/GlobalState2010_Web.pdf))

<sup>1214</sup> Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International ([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf))

<sup>1215</sup> Stone, K. (ed). 2014. *The Global State of Harm Reduction 2014*. Harm Reduction International. (<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>)

<sup>1216</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

scaling up coverage from 8% in 2002 to 72% in 2011.<sup>1217</sup> However, coverage amongst PWID living with HIV has been estimated at only 2%,<sup>1218</sup> pointing to significant obstacles and critical obstacles in the national health care system.

In 2012, IBBS results indicated that 10% of new HIV infections were identified amongst PWID.<sup>1219</sup> Assessments of risk behaviors amongst PWID have shown that 95.3% reported the use of sterile injecting equipment the last time they injected in 2016.<sup>1220</sup> However, an independent academic study performed in Bangkok in 2015 found that 30% of PWID had borrowed non-sterile injecting equipment in the past six months, and that 65% reported multiple borrowing events.<sup>1221</sup> Another academic study performed in 2015 found that 78% of incarcerated PWID were sharing injecting equipment in Thailand.<sup>1222</sup> In addition, reports have shown that 61.3% of PWID who received an HIV test in the past 12 months know their results, and that 51.2% had used a condom during last risky sex.<sup>1223</sup>

HCV prevalence amongst PWID has remained extremely high - at around 90% - since 2008.<sup>1224</sup> HIV-HCV co-infection amongst PWID is also extremely high, ranging between 60% and 90%.<sup>1225</sup> In 2014, exclusion criteria preventing people actively using illicit drugs from enrolling in HCV treatment were removed, though uptake amongst PWID living with HCV has not improved since the policy changes, pointing again to significant issues within the national health care system.

A study conducted in 2010 showed that approximately 30% of PWID in Bangkok had experienced non-fatal overdose, mainly associated with heroin, while 68% had witnessed an overdose.<sup>1226</sup> IBBS data from 2010, summarized in *Figure 28*, shows that between 10% and 32.6% of PWID across Thailand have experienced at least one overdose. Project reports corroborate these findings, adding that 27% of PWID had suffered at least one opioid overdose in their lifetime (compared to 8% in the past 12 months), with an average of two overdoses

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<sup>1217</sup> Himakalasa, W. et al. 2013. "Access to antiretroviral therapy among HIV/AIDS patients in Chiang Mai province, Thailand," in *HIV/AIDS (Auckl)*, 5: 205–213. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3754485/>)

<sup>1218</sup> Bergenstrom, A. et al. 3 July 2013. "Overview of epidemiology of injection drug use and HIV in Asia," presentation at the 7th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, Kuala Lumpur, Malaysia.

<sup>1219</sup> Bureau of Epidemiology. Unpublished. 2012 Integrated biological and behavioral survey.

<sup>1220</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>1221</sup> Voon, P. et al. 2015. "High prevalence of syringe lending among HIV-positive people who inject drugs in Bangkok, Thailand" in *Harm Reduction Journal*, 12:16. (<https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-015-0050-5>)

<sup>1222</sup> Dolan, K. et al. 2015. "People who inject drugs in prison: HIV prevalence, transmission and prevention" in *International Journal of Drug Policy*, 26: S12-S15. (<https://www.ncbi.nlm.nih.gov/pubmed/25727258>)

<sup>1223</sup> Joint United Nations Program on HIV/AIDS. 2016. *Do No Harm: Health, Human Rights and People Who Use Drugs*. (<http://www.unaids.org/en/resources/documents/2016/do-no-harm>)

<sup>1224</sup> Stone, K. (ed). 2016. *The Global State of Harm Reduction*. Harm Reduction International.

([https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf)); Stone, K. (ed). 2014. *The Global State of Harm Reduction*

(<https://www.hri.global/files/2015/02/16/GSHR2014.pdf>); Stoicescu, C. (ed). 2012. *The Global State of Harm Reduction*. Harm Reduction International

([http://www.ihra.net/files/2012/09/04/GlobalState2012\\_CoverIntro.pdf](http://www.ihra.net/files/2012/09/04/GlobalState2012_CoverIntro.pdf)); Cook, C., and Kanaef, N. (eds). 2008. *The Global State of Harm Reduction: Mapping the response to drug-related HIV and hepatitis C epidemics*. Harm Reduction International.

(<https://www.hri.global/files/2010/06/16/GSHRFullReport1.pdf>)

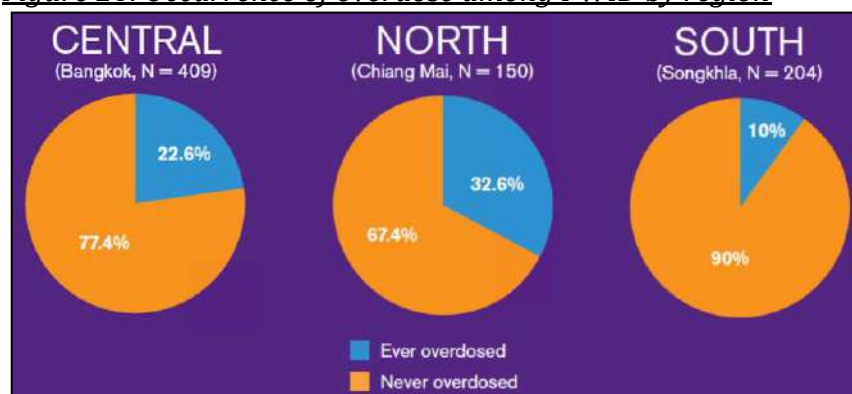
<sup>1225</sup> Metheny, N. 2010. *Illuminating a Hidden Epidemic: The Public Health Crisis of HIV/HCV Co-infection Among Injecting Drug Users (IDU) in Thailand*. Thai AIDS Treatment Action Group.

(<http://dl.dropboxusercontent.com/u/566349360/library/Thai%20HIVHCV%20Policy%20Brief.pdf>)

<sup>1226</sup> Milloy, M. J. et al. 2010. "Overdose experiences among injection drug users in Bangkok, Thailand" in *Harm Reduction Journal*, 7: 9. (<http://link.springer.com/article/10.1186%2F1477-7517-7-9-page-1>)

witnessed in the lifetime of each respondent.<sup>1227</sup> When asked to qualify the type of assistance they received after an overdose, PWID noted that they were verbally coaxed to wake up (64%), hit or slapped (57%), injected with saline (24%), injected with naloxone (22%), placed in the recovery position (20%), given cardiopulmonary resuscitation (18%), and given mouth-to-mouth (14%).<sup>1228</sup>

*Figure 28: Occurrence of overdose among PWID by region* <sup>1229</sup>



Between 2013 and 2014, the CHAMPION-IDU project trained a total of 148 staff, volunteers and clients, and at least 26 vials of naloxone were used by project workers to reverse 21 recorded cases of opioid overdose. In all 21 cases, the overdose was reversed and a life was potentially saved.<sup>1230</sup>

Investments in harm reduction have been limited in Thailand. The first significant investment was provided by the Global Fund in the context of HIV prevention amongst PWID,<sup>1231</sup> channeled through the "HIV Prevention, Care and Support for Injecting Drug Users" (CASIDU) project which operated for three years from 2004 to 2007 with a total budget of USD 1,236,108.<sup>1232</sup> In 2008, the University of British Columbia's Center for Excellence in HIV, Chulalongkorn University and TTAG initiated a community-based peer-led research project amongst PWID that led to the publication of over 20 peer-reviewed scientific journal articles as well as dozens of presentations delivered in international forums on issues related to injecting drug use and HIV in Thailand.<sup>1233</sup> Between 2008 and 2012, the Mitsampan Harm Reduction Center project received a total of USD 230,187.40 from the University of British Columbia's Center for Excellence in HIV to support harm reduction service delivery as well as research activities.<sup>1234</sup> From 2009 to 2014, the Global Fund invested \$16,281,978 to

<sup>1227</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1228</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1229</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1230</sup> Tanguay, P. 2014. *Servicing communities with opioid overdose prevention (SCOOP): Lessons learned from Thailand*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-SCOOP-Report.pdf>)

<sup>1231</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand---lessons-not-learned))

<sup>1232</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2017. "THA-304-G06-H: Preventing HIV/AIDS and Increasing Care and Support for Injection Drug Users in Thailand" online at: <http://www.theglobalfund.org/en/portfolio/country/grant/?k=71ca87d7-aa1f-49fc-9a59-84aba8f6c428&grant=THA-304-G06-H>.

<sup>1233</sup> For details, visit [www.cfenet.ubc.ca/research/mitsampan](http://www.cfenet.ubc.ca/research/mitsampan).

<sup>1234</sup> Personal communication with Dr. Kanna Hayashi, St. Paul's Hospital Chair in Substance Use Research, Assistant Professor

support HIV prevention amongst PWID channeled through the CHAMPION-IDU project.<sup>1235</sup> The national budget allocated to cover operational costs of methadone programs was estimated at THB 43,778,823 (USD 1,348,971) for the period 2013-2015.<sup>1236</sup> In 2015-2016, the Global Fund continued to support harm reduction although expenditure for harm reduction services dropped significantly to a total of USD 2,363,971 for a 24-month period.<sup>1237</sup> Over the years, additional investments were made to support harm reduction through small grants that are not tracked here due to the low amounts and the sparse numbers of such grants.

Table 48 below summarizes the value of the average annual investments made by each project between 2003 and 2016, based on actual expenditure, including the investment per PWID per year, based on population size estimates presented earlier. While investments have waxed and waned over the years, it is clear that those investments have always been vastly insufficient to meet the needs of even a minority of clients and provide a safe environment for workers and clients alike.

*Table 48: Project-based expenditure supporting harm reduction services, 2003-2016*

	War on drugs (2003-2004)	CASIDU (2004-2007)	MSHRC-BCCE (2008-2012)	CHAMPION-IDU (2009-2014)	National methadone programs (2013-2015)	STAR (2015-2016)
Total invested in harm reduction per year (USD)	\$0	\$412,036	\$46,037	\$2,960,360	\$449,657	\$1,181,986
PWID population size estimate	38,380	38,380	38,380 (2008-2009) 40,300 (2010-2012)	40,300	40,300 (2013-2014) 71,000 (2015)	71,000
Annual average project investment in harm reduction per PWID per year (USD)	\$0	\$11	\$1	\$73	\$10	\$17

at the Faculty of Health Sciences, Simon Fraser University, and Research Scientist for the Urban Health Research Initiative at the British Columbia Centre for Excellence in HIV/AIDS at the University of British Columbia. 15 November 2016. Currency conversions from THB to CAD calculated at FX rate of CAD1=THB30; historical rates for CAD-USD conversion generated by <https://www.oanda.com/currency/average>.

<sup>1235</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2017. "THA-H-PSI: Comprehensive HIV Prevention Among MARPs by Promoting Integrated Outreach and Networking (CHAMPION)" online at: <http://www.theglobalfund.org/en/portfolio/country/grant/?k=e34bf65d-906a-4bd9-8ca3-11fbd6baba3f&grant=THA-H-PSI>; The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2017. "THA-809-G11-H Comprehensive HIV prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-3)" online at: <http://www.theglobalfund.org/en/portfolio/country/grant/?k=811e8af7-b717-4f1d-adb0-c60c87af9f34&grant=THA-809-G11-H>; an additional USD 860,726 was invested by the Global Fund through MOH's Department of Disease Control, as part of "THA-809-G10-H: Comprehensive HIV Prevention among MARPs by Promoting Integrated Outreach and Networking (CHAMPION-1)" worth a total of USD 15,071,273.

<sup>1236</sup> It should be assumed that the national government allocated funds to support implementation of methadone therapy before 2013. However, data was only available for 2013-2015 from: 15 August 2015. "สิทธิบัตรของเมทาโดน 8 ปีช่วยผู้ติดยาหมิ่นคน" in RYT9, online at: <http://www.ryt9.com/s/tpd/2485779>.

<sup>1237</sup> Personal communication with Monsuda Chansiri, Program Officer, Program Quality Department, at Raks Thai Foundation, 14 February 2017.

The CHAMPION-IDU project represents the single most important investment in harm reduction in Thailand since the discovery of HIV in 1984, and the Global Fund has covered the vast majority of the investments to prevent HIV amongst PWID since 2004, by providing a total of USD 17,518,086 of the recorded USD 21,975,793 invested since 2004, or 80% of the total recorded investments. However, Global Fund investments in harm reduction between 2004 and 2014 represent a mere 6% of its total contribution to prevent HIV in Thailand during the same period.<sup>1238</sup> Meanwhile, a cost-effectiveness analysis revealed that HIV prevention interventions amongst PWID were disproportionately expensive compared to interventions costs targeting other vulnerable populations (see Table 49).

*Table 49: Unit cost of HIV prevention service uptake among key populations*<sup>1239</sup>

Target group	Total cost (USD)	Number of persons reached		Total cost per person reached (USD)	
		Target	Actual	Cost per target (USD)	Actual cost (USD)
Female sex workers	\$3,868,457	30,473	32,100	\$127	\$121
Men who have sex with men	\$2,983,071	37,671	42,298	\$79	\$71
People who inject drugs	\$3,328,979	4,388	3,934	\$759	\$846
Prisoners	\$1,049,238	7,875	6,942	\$133	\$151

Despite data limitations detailed extensively in the CHAMPION-IDU report,<sup>1240</sup> the disparity between HIV prevention intervention costs amongst PWID and other key populations has been interpreted by Thai CSO as the result of the absence of an enabling legal and policy environment, the lack of integration of harm reduction in national health systems, and the cost of criminalization of people who use and inject drugs.<sup>1241</sup> Essentially, overcoming the structural barriers and obstacles created by the criminalization of people who use and inject drugs seems to have artificially inflated the cost of such public health interventions.

### *Treatment*

In 2004, Thailand's Minister of Justice defined the objectives of the national treatment strategy: "First, there should be no new drug addicts; second, all existing drug addicts are under a proper treatment, rehabilitation, or continuing

<sup>1238</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1239</sup> Teerawattananon, Y. et al. 2013. "Health technology assessments as a mechanism for increased value for money: recommendations to the Global Fund," in *Globalization and Health*, 9:35. (<https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-9-35>); currency conversion rate based on annual historical results for the year 2013 from <https://www.oanda.com/currency/average>.

<sup>1240</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)

<sup>1241</sup> Tanguay, P. and Ngamdee, V. 2015. *CHAMPION-IDU: Innovations, best practices and lessons learned: Implementation of the national response to HIV among people who inject drugs in Thailand 2009-2014*. PSI Thailand. (<https://www.psi.org/wp-content/uploads/2015/07/Small-CHAMPION-IDU-INNOVATIONS-BEST-PRACTICE-AND-LESSONS-LEARNED.pdf>)



care program; and third, communities are empowered to protect themselves against drugs."<sup>1242</sup> The 2002 *Narcotic Addict Rehabilitation Act* has not defined the objectives of the treatment apparatus but has emphasized that the "rehabilitation centre shall be an institution for treatment under the Penal Code" and that the "rehabilitation centre shall be a unit of the Department of Probation of Ministry of Justice."<sup>1243</sup> In practice, the drug treatment apparatus aims to achieve "abstinence at any cost,"<sup>1244</sup> though limited medical resources have been allocated to achieve this objective. For example, out of 45,312 people enrolled in community-based drug treatment services in 2001, only 318 (0.7%) of clients were enrolled in evidence-based programs compared to 19,801 (43.7%) who received 'orientation', 22,738 (50.2%) who were enrolled in religious group therapy, 2,447 (0.5%) who were enrolled in morality-based programs, and 8 (0.02%) who were ordained as Buddhist monks as part of treatment.<sup>1245</sup>

Thailand's drug treatment apparatus has been divided into three arms: the voluntary arm, coordinated by MOH; the correctional system managed by DOC and the compulsory system, overseen by the Department of Probation.<sup>1246</sup> The majority of Thailand's drug treatment options have little medical relevance: outside counseling - delivered through the therapeutic community model - so-called treatment programs include religious therapy, vocational training, relapse prevention, electronic monitoring, and restorative justice,<sup>1247</sup> although the Matrix model<sup>1248</sup> has often been deployed for non-correctional, non-custodial treatment interventions.<sup>1249</sup> Custodial treatment programs have generally required four-month residential treatment based on the therapeutic community model that have emphasized group psychotherapy and practical activities in a highly structured residential environment, as well as an additional two-month re-entry program.<sup>1250</sup>

Similarly, compulsory treatment has also relied on a six-month residential program using a modified therapeutic community model that has involved group

<sup>1242</sup> Thepkanjana, P. 28 June 2004. Keynote address by H.E. Mr Phongthep Thepkanjana, Minister of Justice of Thailand at the observance of the United Nations "International Day Against Drug Abuse and Illicit Trafficking" in Bangkok, Thailand. ([http://www.unodc.un.or.th/interday/2004/HE\\_Phongthep\\_keynote.pdf](http://www.unodc.un.or.th/interday/2004/HE_Phongthep_keynote.pdf)).

<sup>1243</sup> Government of Thailand. 2002. *Narcotic Addict Rehabilitation Act*. ([http://thailaws.com/law/t\\_laws/tlaw0149\\_2.pdf](http://thailaws.com/law/t_laws/tlaw0149_2.pdf))

<sup>1244</sup> Tyndall, M. 2010. *Harm Reduction Policies and Interventions for Injecting Drug Users in Thailand*. World Bank. (<http://documents.worldbank.org/curated/en/678211468310529526/pdf/646420Revised00ion0for0IDUs00final0.pdf>)

<sup>1245</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1246</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1247</sup> Rittirat, S. 2015. "Overview of the community-based treatment system of Thailand," in *Annual Report for 2014 and Resource Material Series No. 96*. ([http://www.unafei.or.jp/english/pdf/RS\\_No96/No.96\\_00All.pdf](http://www.unafei.or.jp/english/pdf/RS_No96/No.96_00All.pdf))

<sup>1248</sup> The Matrix program is an out-patient treatment program for stimulant use and dependence developed by the Matrix Institute on Addictions, based in the U.S.<sup>57</sup> Often, the program is structured in sessions that take place approximately two hours a day, two or three times a week, over four months. The intervention consists of individual sessions and group sessions that cover relapse prevention, education on drugs, social support as well as individual counseling and drug education for family members. Patients are regularly monitored for drug use by urine testing. This four-month period is followed by a two-month "re-entry" period. (from Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>))

<sup>1249</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1250</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

work, work therapy, vocational training and physical education, where the patient have had no influence on the structure and nature of the treatment program.<sup>1251</sup> The number of compulsory centers for PWUD has increased rapidly since the approval of the 2002 *Narcotic Addict Rehabilitation Act*: from 35 in 2004, to 49 in 2005, to 84 in 2008,<sup>1252</sup> to 91 in 2012.<sup>1253</sup> As of February 2012, a total of 1,278 drug treatment and rehabilitation facilities were operating across Thailand – 1,008 were voluntary centers (both residential/in-patient and out-patient services, community- and school-based programs); 91 were compulsory residential centres (16 ‘strict’ detention centres and 75 ‘non-strict’ detention centres) and 179 were correctional centres.<sup>1254</sup>

It is worth pointing out that the detention and coercive treatment of people who use illicit drugs is currently the dominant approach in Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Vietnam. A committee of experts from the Asian region has pointed out that compulsory treatment is ineffective, unsafe for clients, and costly while the majority of such centers have insufficient capacity to deliver services that align with minimum international standards of evidence-based practice.<sup>1255</sup> Evidence from Thailand has identified significant abuses perpetrated in the name of treatment, including denial of medications or treatments to alleviate the symptoms of withdrawal, shackling of patients to prevent escape, physical discipline including military-style drills, and punishments, including physical abuse, for those who relapse.<sup>1256</sup> Research from Thailand has also shown that detention in drug treatment centers was associated with reduced access to health care as well as reduced health-seeking behaviors.<sup>1257</sup>

PWUD have reported significant stigma and discrimination in health care settings, including drug treatment facilities: research among health service providers has indicated that a significant but slowly diminishing proportion consider PWID to be the “lowest immoral group” due to their illicit behaviors.<sup>1258</sup> While health service providers generally failed to recognize their behaviors as

<sup>1251</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1252</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1253</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1254</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1255</sup> Tanguay, P., Kamarulzaman, A., Aramrattana, A., Wodak, A., Thomson, N., Ali, R., Vumbaca, G., Lai, G., Chabungbam, A. 2015. *Discussion paper: Transition from compulsory centres for drug users to voluntary community-based treatment and services*. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion\\_Paper\\_on\\_Transition\\_from\\_CCD\\_Us\\_Edited\\_Final4\\_04Sept15.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion_Paper_on_Transition_from_CCD_Us_Edited_Final4_04Sept15.pdf))

<sup>1256</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1257</sup> Kerr, T., et al. 2014. “The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand” in *International Journal of Drug Policy*, 25(1): 171-4. (<http://www.sciencedirect.com/science/article/pii/S0955395913000911>)

<sup>1258</sup> Churcher, S. 2013. “Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: a review of recent literature,” in *WHO South-East Asia Journal of Public Health*, 2:1. ([http://www.searo.who.int/publications/journals/seajph/seajphv2n1\\_p12.pdf?ua=1](http://www.searo.who.int/publications/journals/seajph/seajphv2n1_p12.pdf?ua=1))

stigmatizing, PWID have systematically reported, through official national mechanisms and through low-threshold project-specific channels, significant concerns in regards to fear of disclosure, patient confidentiality, and overall lack of trust in health service providers.<sup>1259</sup>

Except for small local pilots, OST is currently not available in correctional or compulsory centers for PWUD in Thailand.<sup>1260</sup> *Table 50* below provides an overview of the number of people registered in drug treatment across all three arms for a 12-month period between 2011 and 2012. That year, national targets were set to enroll at least 400,000 people into drug treatment.<sup>1261</sup>

*Table 50: Number of people registered by type of treatment centre, 1 October 2011 to 30 September 2012*<sup>1262</sup>

Treatment system	Number of people registered
<b>Voluntary</b>	
Community-based therapy	213,552
Therapy under Measure 315 (an ONCB initiative in the Bangkok area to help reach the national target, e.g. door-to-door urine testing)	6164
School/university student camps	7,439
Psychosocial support in schools	17,219
Residential treatment centre	147,819
Total voluntary	392,163
<b>Compulsory</b>	148,026
<b>Correctional</b>	19,857
<b>TOTAL</b>	<b>560,046</b>

Between 2004 and 2012, more than 80% of people who enrolled in drug treatment sought assistance related to the consumption of methamphetamines.<sup>1263</sup> In 2014, methamphetamine users remained the largest group of consumers of drug treatment services in Thailand.<sup>1264</sup> In response to the popularity of methamphetamines, the Thai government developed the Matrix program, a specialized treatment model for stimulant users.<sup>1265</sup> *Table 51* provides an overview of the main drugs of concern for people being admitted to drug treatment for the period 2008 to 2012.

<sup>1259</sup> Churcher, S. 2013. "Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: a review of recent literature," in *WHO South-East Asia Journal of Public Health*, 2:1.

([http://www.searo.who.int/publications/journals/seajph/seajphv2n1\\_p12.pdf?ua=1](http://www.searo.who.int/publications/journals/seajph/seajphv2n1_p12.pdf?ua=1))

<sup>1260</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1261</sup> Csete, J. et al. 2011. "Compulsory drug detention centre experiences among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 11:12. (<http://bmcinthealthhumanrights.biomedcentral.com/articles/10.1186/1472-698X-11-12>)

<sup>1262</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>); based on National Command Center for Combating Drugs. 12 September 2012. *Press Release: National success in sending 500,000 drug users and addicts to drug treatment*. ([www.nccd.go.th/index.php?mod=news&id=292](http://www.nccd.go.th/index.php?mod=news&id=292))

<sup>1263</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf)); United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))

<sup>1264</sup> United Nations on Drugs and Crime. 2016. *World Drug Report*. ([https://www.unodc.org/documents/scientific/WORLD\\_DRUG\\_REPORT\\_2016\\_web.pdf](https://www.unodc.org/documents/scientific/WORLD_DRUG_REPORT_2016_web.pdf))

<sup>1265</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))

*Table 51: Drug treatment admissions in Thailand by drug type, 2008-2012* <sup>1266</sup>

Drug type	2008	2009	2010	2011	2012
Methamphetamine pills	79,977	101,971	113,430	158,316	245,920
Crystalline methamphetamine	582	930	2,353	6,728	16,503
'Ecstasy'	237	333	209	172	263
Cannabis	6,155	8,736	7,471	7,136	14,279
Cocaine	17	19	18	15	27
Cough medicine	36	76	45	81	●
Heroin	1,107	1,374	1,414	2,115	2,559
Inhalants	3,911	6,495	4,709	3,535	4,288
Ketamine	9	12	12	13	18
Kratom*	1,067	2,030	2,357	2,835	11,593
Opium	2,019	2,081	1,910	2,601	2,846
<b>Total</b>	<b>95,117</b>	<b>124,057</b>	<b>133,928</b>	<b>183,547</b>	<b>298,296</b>

● = Not reported. \*Includes users of kratom in leaf and liquid form

In 2015, an estimated USD 208 (THB 6,500) was invested per patient by the government to cover the cost of compulsory and correctional drug treatment for up to 15,000 individuals for one year,<sup>1267</sup> representing fewer than 10% of the number of individuals sent to compulsory and correctional treatment in 2012. This represents a total allocation of USD 3,120,000; however, based on the actual number of compulsory and correctional drug treatment enrollments, the investment then represents USD 0.05 per patient per year, an amount insufficient to provide even the most basic care and support services under any circumstances. In contrast, if the same amount had been invested per person for the actual number of individuals enrolled in treatment that year, the total budget would skyrocket to USD 62,045,568, or almost twenty times more.

### *Law enforcement*

Law enforcement related activities have been central to Thai drug control efforts. Implementing such activities has mobilized a range of stakeholders and institutions, including the police who investigate and arrest lawbreakers, the courts that decide on appropriate sentencing, and prisons that detain individuals. The 2009 *Five Fences Strategy* explicitly defined the objectives of law enforcement interventions, seeking "to suppress drug traffickers and/or drug networks" with a special focus on border control.<sup>1268</sup>

Thailand is well known globally for the rigor of its drug policies and the severity of its criminal sanctions against drug law offenders. Police officers and officials have played a central role in the implementation of drug control strategies and activities in Thailand starting in the 1960s and sustained through to the present. Thailand's national drug control efforts have prioritized responses from law enforcement and the criminal justice system.<sup>1269</sup> This has translated into

<sup>1266</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1267</sup> Office of the Narcotics Control Board. 2017. แผนปฏิบัติการและแก้ไขปัญหายาเสพติด ปี ๒๕๖๐. (<http://www.nccb.go.th/upload/news/60.pdf>)

<sup>1268</sup> Government of Thailand. 2009. *National Narcotics Control Policy* (SEP) *Five Fences Strategy 2009-2010*.

<sup>1269</sup> Kaplan, K., & Tanguay, P. 2013. "One Step Forward, Two Steps Back: Consequences of Thailand's Failure to Adopt Evidence-based Drug Policy" in *Drug Law Reform in East and Southeast Asia*. Lexington Books.



significant and sustained numbers of police contacts with suspected drug offenders, increasing volumes of seizures, significant and sustained numbers of drug-related court cases, and increasing numbers of individuals incarcerated for drug-related crimes.

For Thai law enforcement agencies, drug-related activities have represented a significant proportion of the workload. Based on available estimates summarized in *Table 52*, more than three-quarters of all arrests have been related to drug-related offences for the period 1996 to 2000, except in 1997 when the proportion dropped to a quarter of all arrests that year. Already in 1983, sources reported that drug-related arrests were the third most frequent across all crimes committed that year.<sup>1270</sup>

*Table 52: Number of reported arrests in Thailand, 1996-2000*<sup>1271</sup>

	1996	1997	1998	1999	2000
<b>Crimes against the person</b>	18,711	19,109	20,717	21,481	22,099
<b>Property crimes</b>	25,581	29,763	37,726	34,779	35,377
<b>Drug-related crimes</b>	178,994	18,866	243,661	253,461	275,551
<b>Prostitution</b>	6,085	4,961	6,853	10,272	11,591
<b>Cheating and fraud</b>	2,335	2,233	2,825	2,777	3,099
<b>TOTAL</b>	<b>231,706</b>	<b>74,932</b>	<b>311,782</b>	<b>322,770</b>	<b>347,717</b>
<b>Proportion of drug-related crimes</b>	<b>77.3%</b>	<b>25.2%</b>	<b>78.2%</b>	<b>78.5%</b>	<b>79.2%</b>

By the early 2000s, the number of drug-related arrests had dropped: 60,722 drug-related arrests were made in 2004; 73,684 drug-related arrests in 2005; 90,845 drug-related arrests in 2006; 106,333 drug-related arrests in 2007; and 146,170 drug related arrests in 2008.<sup>1272</sup> *Table 53* below shows that the number of drug-related arrests has been increasing steadily and has remained consistently high. However, the proportion of drug-related arrests dropped significantly based on data from 2015 (data from unpublished Royal Thai Police reports indicate that 39.35% of all arrests were related to drugs in 2015). *Table 53* also shows that methamphetamine pills, crystal methamphetamine and cannabis herb have been linked to the vast majority of all drug-related arrests during the 2008-2012 period. *Figure 28* also confirms that the vast majority of drug-related arrests have been related to ATS.

*Table 53: Drug-related arrests in Thailand, 2008-2012*<sup>1273</sup>

<sup>1270</sup> LePoer, B. L. (ed). 1987. *Thailand: A Country Study*. GPO for the Library of Congress. (<http://countrystudies.us/thailand/>)

<sup>1271</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

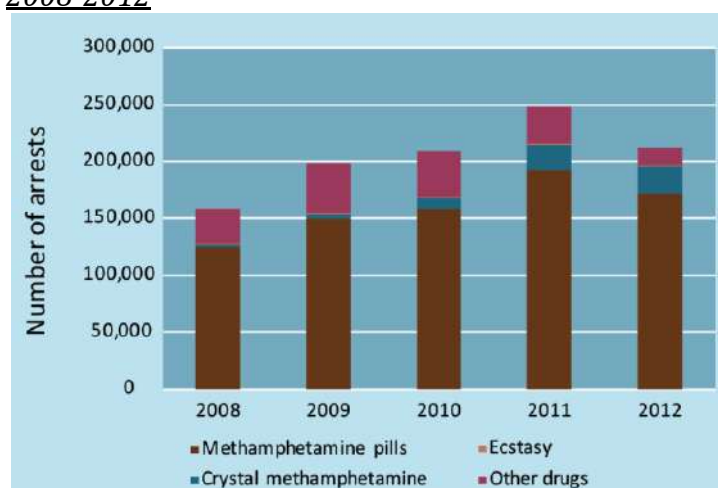
<sup>1272</sup> Office of the Narcotics Control Board. 2008. *Thailand Narcotics Control Annual Report 2008*.

<sup>1273</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))



Drug type	2008	2009	2010	2011	2012
Methamphetamine pills	124,800	149,441	157,683	191,956	171,272
Crystalline methamphetamine	2,395	4,488	10,463	22,823	24,469
'Ecstasy'	592	496	217	187	153
Cannabis herb	13,155	18,579	15,257	13,721	11,630
Cannabis resin	13	21	24	16	7
Cocaine	109	125	96	82	77
Codeine	82	119	6	8	•
Heroin	481	856	838	1,115	966
Inhalants	6,361	6,528	4,952	3,420	2,071
Ketamine	206	266	204	177	170
Kratom	7,920	14,378	16,276	13,134	•
Opium (raw and prepared)	907	1,003	843	738	557
Others	850	1,487	1,485	419	•
<b>Total</b>	<b>157,871</b>	<b>197,787</b>	<b>208,344</b>	<b>247,796</b>	<b>211,372</b>

*Figure 28: ATS arrests as a proportion of the total drug-related arrests in Thailand, 2008-2012*<sup>1274</sup>

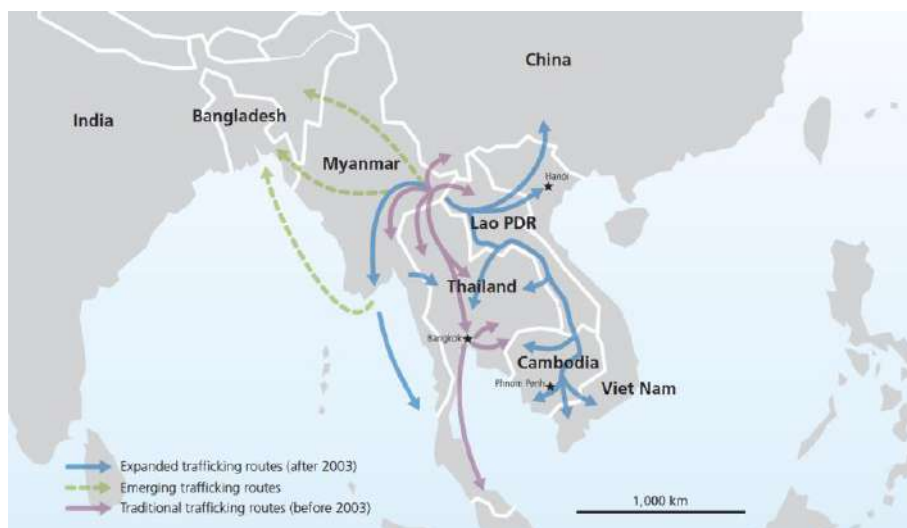


Thai law enforcement agencies have also been very active in seizing illicit drugs and dismantling production sites. The Kingdom's strategic geographical position in Southeast Asia has led to the development of significant trafficking routes into Thailand, as illustrated in *Figure 29* below. While trafficking of opium and heroin were characteristic of the 1960s through to the mid-1990s, since then, illicit drug production and trafficking have overwhelmingly focused on ATS rather than opiates.

*Figure 29: Primary methamphetamine trafficking routes in the Greater Mekong Subregion*<sup>1275</sup>

<sup>1274</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs - Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1275</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))



Large shares of the global methamphetamine market are located in Thailand and China. Globally the highest quantities of methamphetamines reported seized were in Mexico, followed by the United States, China, Thailand and then Iran.<sup>1276</sup> Figures 30 to 32 below show the proportion of the Thai methamphetamine market over the years, with global and regional comparisons.

Figure 30: Countries reporting the highest methamphetamine seizures, 2010-2012  
1277

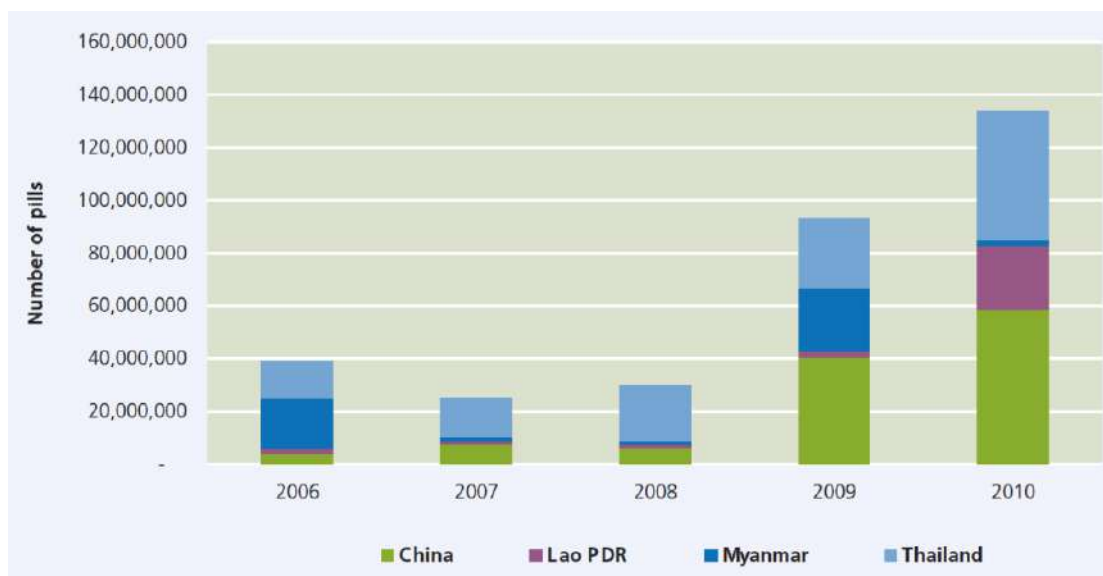


Figure 31: Combined methamphetamine pill seizures in China, Lao People's Democratic Republic, Myanmar and Thailand<sup>1278</sup>

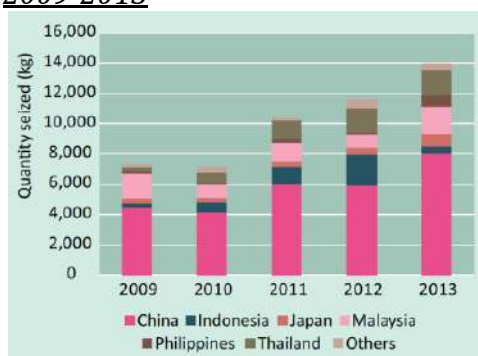
<sup>1276</sup> United Nations on Drugs and Crime. 2014. *World Drug Report*.  
([https://www.unodc.org/documents/wdr2014/World\\_Drug\\_Report\\_2014\\_web.pdf](https://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf))

<sup>1277</sup> United Nations on Drugs and Crime. 2014. *World Drug Report*.  
([https://www.unodc.org/documents/wdr2014/World\\_Drug\\_Report\\_2014\\_web.pdf](https://www.unodc.org/documents/wdr2014/World_Drug_Report_2014_web.pdf))

<sup>1278</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*.  
([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))



*Figure 32: Crystal methamphetamine seizures reported in East and Southeast Asia, 2009-2013*<sup>1279</sup>



ATS production in Thailand has been limited to small-scale manufacture according to UNODC reports, although local production has been increasing.<sup>1280</sup> For example, between 2012 and 2013, a total of 11 methamphetamine laboratories were dismantled, most of which were found in locations close to Bangkok, including five home-based methamphetamine tablet-pressing laboratories.<sup>1281</sup> However, the majority of ATS pills found in Thailand were produced in Myanmar.<sup>1282</sup> Authorities reported 14 million methamphetamine pills and 47 kilos of crystal methamphetamine seized by law enforcement in 2007.<sup>1283</sup> Table 54 below shows that by 2012, over 95 million methamphetamine pills and over 1,500 kilos of crystal methamphetamine were seized. In 2013, over 1,700 kilos of crystal methamphetamine were seized by law enforcement in

<sup>1279</sup> United Nations Office on Drugs and Crime. 2015. *The Challenge of Synthetic Drugs in East and South-East Asia and Oceania 2015: Trends and Patterns of Amphetamine-type Stimulants and New Psychoactive Substances*. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS\\_2015\\_Report\\_web.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS_2015_Report_web.pdf))

<sup>1280</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))

<sup>1281</sup> United Nations Office on Drugs and Crime. 2015. *The Challenge of Synthetic Drugs in East and South-East Asia and Oceania 2015: Trends and Patterns of Amphetamine-type Stimulants and New Psychoactive Substances*. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS\\_2015\\_Report\\_web.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS_2015_Report_web.pdf))

<sup>1282</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))

<sup>1283</sup> United Nations Office on Drugs and Crime. 2011. *Amphetamines and ecstasy: 2011 Global ATS Assessment*. ([https://www.unodc.org/documents/ATS/ATS\\_Global\\_Assessment\\_2011.pdf](https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf))

Thailand.<sup>1284</sup>

*Table 54: Seizures of selected drugs in Thailand, 2008-2012*<sup>1285</sup>

Drug type	Quantity	2008	2009	2010	2011	2012
Methamphetamine pills	pills	20,023,705	24,638,320	48,793,951	49,365,700	95,268,000
Crystalline methamphetamine	kg	54.3	213.2	706.0	1,232.0	1,585.8
'Ecstasy'*	pills	49,833	61,089	16,647	21,115	4,809
Cannabis herb	kg	21,105.9	26,070.8	22,415.2	14,302.0	24,393.5
Cannabis resin	kg	29.9	10.2	55.4	72.5	18.2
Cocaine	kg	11.5	9.3	31.1	31.8	17.9
Codeine	kg	141.7	97.6	14.0	4.1	•
Heroin	kg	199.9	143.1	137.6	547.5	127.5
Inhalants	kg	165.8	165.4	133.0	100.2	69.0
Ketamine	kg	18.5	20.6	166.7	78.0	21.0
Kratom**	kg	15,675.6	29,917.8	44,206.2	32,913.6	28,978.4
Opium (raw and prepared)	kg	117.9	111.1	157.9	42.7	30.1

• = Not reported. \* 'Ecstasy' pill seizures converted into estimated kg equivalents at 1 pill = 250-300 mg. \*\* Combined seizures of kratom leaves and kratom liquid.

The number of drug-related arrests has been a key performance indicator for law enforcement agencies across Thailand,<sup>1286</sup> which suggests that success has been defined by reaching quantifiable targets in terms of numbers of drug-related arrests. In order to motivate law enforcement agencies, previous governments have deployed a range of incentives, including a system of reward and penalties. For example, during the 2003-2004 war on drugs,

*Police and other officials were offered cash incentives for arrests and seizures, while senior officials such as governors and police chiefs stood to lose their jobs if targets were not met. The Prime Minister said of the cash incentives that at three Baht [U.S.\$0.07] per methamphetamine tablet seized, a government official can become a millionaire by upholding the law, instead of begging for kickbacks from the scum of society.*<sup>1287</sup>

Thai law enforcement officers earn substantially less than compared to those employed in other professions. In an interview conducted in 2008, an anonymous Thai police officer revealed that the average annual salary on entry in the police was approximately THB 80,000 (USD ~2,700) plus additional financial benefits for danger and rank,<sup>1288</sup> as compared to a national average income of approximately THB 130,000 (USD ~4,400) in 2010.<sup>1289</sup> The combination of low salaries and financial incentives to support aggressive drug control campaigns have clearly been effective in mobilizing law enforcement agencies and personnel in targeting drug law offenders.

<sup>1284</sup> United Nations Office on Drugs and Crime. 2015. *The Challenge of Synthetic Drugs in East and South-East Asia and Oceania 2015: Trends and Patterns of Amphetamine-type Stimulants and New Psychoactive Substances*. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS\\_2015\\_Report\\_web.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/drugs/ATS_2015_Report_web.pdf))

<sup>1285</sup> United Nations Office on Drugs and Crime. 2013. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs in Asia and the Pacific*. ([https://www.unodc.org/documents/scientific/2013\\_Regional\\_ATS\\_Report\\_web.pdf](https://www.unodc.org/documents/scientific/2013_Regional_ATS_Report_web.pdf))

<sup>1286</sup> Godwin, J. 2016. *A public health approach to drug use in Asia: Principles and practices for decriminalization*. International Drug Policy Consortium. ([https://dl.dropboxusercontent.com/u/566349360/library/Drug-decriminalisation-in-Asia\\_ENGLISH-FINAL.pdf](https://dl.dropboxusercontent.com/u/566349360/library/Drug-decriminalisation-in-Asia_ENGLISH-FINAL.pdf))

<sup>1287</sup> Human Rights Watch. 2004. *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights*.

<sup>1288</sup> Cleary, S. 17 February 2008. *Interview with a Thai Policeman*.

<sup>1289</sup> Government of Thailand. 2001. Thailand National Household Economic Survey; see also 2010. "Thais' annual income to reach \$10,000" in Bangkok Post, 10 July 2010.

However, the incentive system has also opened the door to abuses of power perpetrated by Thai law enforcement officers and officials. As noted earlier, evidence shows that harassment,<sup>1290</sup> coercion,<sup>1291</sup> extortion,<sup>1292</sup> and drug planting,<sup>1293</sup> are not uncommon. Indeed, a recent *Bangkok Post* article quoted current Deputy Prime Minister Chalerm Yubamrung on the issue of police bribes: “[...] this is part of society, of tradition.”<sup>1294</sup>

After being arrested, an offender must appear before the court within 48 hours (within 24 hours for minors). Drug-related cases have been reviewed by court officials who determine whether the offender should be diverted to treatment, although criteria for doing so are not clear. A court order can then be issued, referring the offender to meet with NARC representatives.<sup>1295</sup> However, only a small proportion of drug offenders have been diverted in practice: an estimated 3% of cases were diverted in 2012,<sup>1296</sup> indicating that the majority of drug cases were addressed through the criminal justice system in Thailand.

Indeed, the number of drug-related cases addressed through the Thai courts has been on the rise. In 1983, a total of 28,992 convictions for drug-related offences were formalized by the court.<sup>1297</sup> By 2001, the number of drug-related cases prosecuted in court had risen to 256,032 (see *Table 55* below). According to the data presented in this sub-section, an estimated 86.7% of drug-related arrests led to criminal prosecution in the year 2000. That same year, 76.5% of convictions were related to drug cases.

*Table 55: Number of criminal cases prosecuted, 2000-2001*<sup>1298</sup>

Major Types of Cases	2000	2001
Offences of Bodily Harm	16,828	17,737
Offences of Theft	36,172	35,686
Offences of Cheating and Fraud	2,765	2,894
Narcotics	238,907	256,032
Controlling Firearms Act	17,451	18,519

Sentencing data in Thailand was scarce so little information on the outcomes of prosecution was available. The 1979 *Narcotics Act* calls for imprisonment for

<sup>1290</sup> Hayashi, K. et al. 2013. "Reports of police beating and associated harms among people who inject drugs in Bangkok, Thailand: A serial cross-sectional study" in *BMC Public Health*, 13:733. (<http://www.biomedcentral.com/1471-2458/13/733>)

<sup>1291</sup> Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1292</sup> Fairbairn, N. et al. 2009. "Reports of evidence planting by police among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 9: 24. (<https://www.ncbi.nlm.nih.gov/pubmed/19811653>)

<sup>1293</sup> Fairbairn, N. et al. 2009. "Reports of evidence planting by police among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 9: 24. (<https://www.ncbi.nlm.nih.gov/pubmed/19811653>)

<sup>1294</sup> 12 February 2013. "Chalerm: Police can ask for money" in *Bangkok Post*. (<http://www.bangkokpost.com/archive/chalerm-cops-can-ask-for-money/335525>)

<sup>1295</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1296</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1297</sup> LePoer, B. L. (ed). 1987. *Thailand: A Country Study*. GPO for the Library of Congress. (<http://countrystudies.us/thailand/>)

<sup>1298</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121st International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))



four years to life and a fine of THB 400,000 to THB 5 million, or the death penalty, for possession with intent to distribute of quantities equal to or below 20 grams of category I substances. Amounts greater than 20 grams were punishable by life imprisonment and a fine of THB 1-5 million, or the death penalty. Despite a lack of direct sentencing data and other limitations, anecdotal evidence from case studies and site visits have revealed some informative trends. For example, the case of Ms. Supatta Ruenrurung has become increasingly well known as an example of disproportional sentencing and overcriminalization of drugs. Ms. Ruenrurung was arrested by Thai police at the Thai-Lao border in possession of 1.5 pills of methamphetamine worth approximately USD 5; in 2010, Ms. Ruenrurung was sentenced to 25 years in prison and fined THB 1 million for her first criminal offence of possession with intent to distribute / trafficking.<sup>1299</sup>

In October 2016, the authors of this report also conducted interviews in two prisons, in Nakhon Phanom and in Udon Thani provinces, with a total of 24 drug offenders with an average of 32.6 years of age (see *Table 56* below). Collectively, the 24 prisoners were sentenced to a combined total of 825 years in prison (and four death penalties) as punishment for possession of a combined total of 138 tablets of amphetamines. This represents a six-year prison sentence for every pill confiscated, although the four death sentences have not not quantified in this calculation.

*Table 56: Demographic and sentencing details of prisoners interviewed*

No.	Gender	Nationality	Age at incarceration	Marital & family status	Criminal record	Number of pills	Incarceration sentence
1	Male	Thai	21	Single	No	0.5	Life imprisonment (50 years)
2	Male	Thai	20	Single	Yes (driving under the influence)	0.5	Life imprisonment (50 years)
3	Male	Thai	44	Divorced	Yes (stole a dog to eat it)	6	Life imprisonment (50 years)
4	Male	Thai	25	Single	No	4	Life imprisonment (50 years)
5	Male	Thai	31	Single	Yes (drug use)	5	Life imprisonment (50 years)
6	Male	Thai	27	Married, 1 child	No	4	Life imprisonment (50 years)

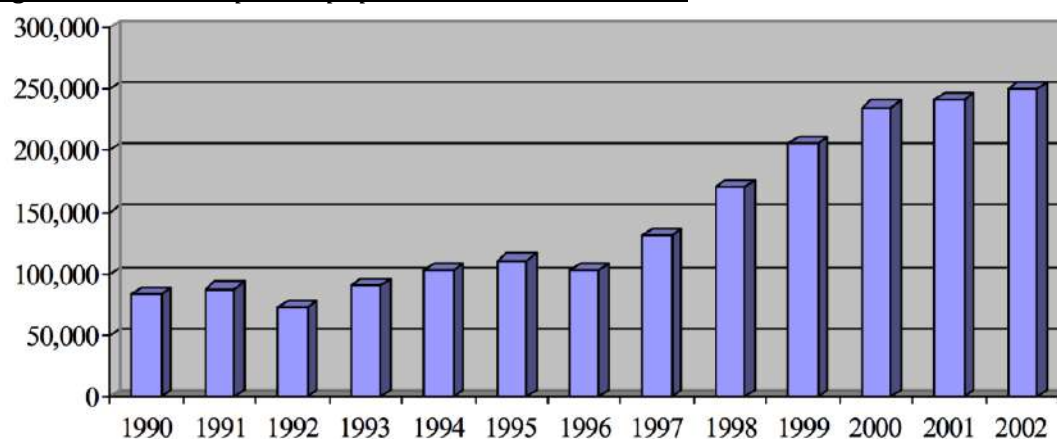
<sup>1299</sup> Paungsawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

7	Female	Thai	31	Single	No	1.5	Life imprisonment (50 years)
8	Female	Lao	55	Married	No	9	Life imprisonment (50 years)
9	Female	Lao	23	Single	No	14	Death sentence
10	Female	Lao	49	Divorced	No	10	Life imprisonment (50 years)
11	Female	Thai	31	Divorced	No	10	Life imprisonment (50 years)
12	Female	Thai	36	Married, pregnant at arrest	No	22 (jointly owned, in the same car at arrest)	Life imprisonment (50 years)
13	Male	Thai	40	Married	No		Life imprisonment (50 years)
14	Male	Thai	38	Single	No		Life imprisonment (50 years)
15	Female	Thai	48	Single	No	6	8 years
16	Female	Thai	38	Married	No	2	8 years
17	Female	Thai	23	Single	No	10	3 years
18	Female	Thai	42	Married	Yes (drug possession)	7	6 years
19	Male	Thai	30	Married, 2 children	No	0.5	Life imprisonment (50 years)
20	Male	Lao	28	Single	No	3	Life imprisonment (50 years)
21	Male	Thai	29	Married, wife pregnant at arrest	No	4	Life imprisonment (50 years)
22	Male	Lao	23	Single	No	5	Life imprisonment (50 years)
23	Male	Thai	26	Married	Yes (driving under the influence)	7	Life imprisonment (50 years)
24	Male	Thai	26	Married, 1 child	No	7	Life imprisonment (50 years)

In addition to anecdotal evidence, prison data has provided another informative

indicator of sentencing outcomes. The Thai prison system included 144 custodial institutions in 2012, which held a total prison population of 289,675, over a capacity of 217,000 (144.8% of capacity) in early 2017.<sup>1300</sup> *Figure 33* and *Table 57* below show a rapid increase in the size of the Thai prison population followed by a small dip in 2004-2006, and another significant increase from 2008 onwards. In 2002, an estimated 62% of people in Thai prisons were incarcerated for to drug-related crimes;<sup>1301</sup> in 2012, the proportion rose to 64%,<sup>1302</sup> and by 2016, the proportion had risen further to 73%.<sup>1303</sup> Thailand currently has the sixth largest prison population in the world and the country has the highest female incarceration rate in the world, where more than 80% of incarcerated women are drug law offenders.<sup>1304</sup> Data presented in *Table 58* also shows that the majority of incarcerated drug law offenders were overwhelmingly arrested for methamphetamines, and charged with disposal (distribution) and possession to dispose (possession with intent to distribute).

*Figure 33: Annual prison population size, 1990-2002* <sup>1305</sup>



*Table 57: Total prison population and prison population rate 2000-2016* <sup>1306</sup>

Year	Total prison population	Prison population rate
2000	223,406	357
2002	254,070	397
2004	167,142	256
2006	152,625	231

<sup>1300</sup> International Center for Prison Studies. 2016. *World Prison Brief - Thailand*. Online at: <http://www.prisonstudies.org/country/thailand>.

<sup>1301</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1302</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1303</sup> Paungasawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

<sup>1304</sup> Paungasawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

<sup>1305</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1306</sup> International Center for Prison Studies. 2016. *World Prison Brief - Thailand*. Online at: <http://www.prisonstudies.org/country/thailand>.

<b>2008</b>	185,082	280
<b>2010</b>	210,855	317
<b>2012</b>	234,895	351
<b>2014</b>	316,700	471
<b>2016</b>	304,090	450

*Table 58: Nature of offences for which people are imprisoned in Thailand, 2012* <sup>1307</sup>

	Number	%
<b>Total number of prisoners</b>	<b>143,846</b>	
Drug offences	92,077	64.01
	Number	% of drug offences
<b>Drug of use</b>		
Methamphetamine	74,336	80.73
Heroin	14,733	16.04
Cannabis	1,222	1.85
<b>Case type</b>		
Disposal	29,208	31.72
Possession to dispose	37,327	40.54
Import, export, production	899	0.98
Consumption	4,438	4.82
Possession	13,621	14.79
Consumption and possession	6,584	7.15

Since the 1990s, prison overcrowding has been a serious concern among government officials.<sup>1308</sup> Despite the introduction of measures such as the good times allowances, a parole system, a conditional release system, diversion to treatment, Royal Pardons and the construction of new prisons, those measures have done little to alleviate increasing prison overcrowding which has been largely driven by application of drug laws.<sup>1309</sup> However, in many cases, drug offenders have not been eligible for such privileges or for early release.<sup>1310</sup>

Again, limited health services have been available in Thai prisons and HIV transmission risks have been significantly higher compared those living in community settings. Reports have indicated that amongst PWID in northern Thailand who had never been to jail, HIV prevalence was recorded at 20%; among those who had been incarcerated but did not report injecting drugs while in jail, 38% were living with HIV after release; among those who reported injecting while incarcerated, HIV prevalence rose to 49%; an estimated 78% of injections in prisons are done with non-sterile equipment.<sup>1311</sup>

<sup>1307</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1308</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1309</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1310</sup> Kalyanasuta, K. and Suriyawong, A. 2002. "The criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf))

<sup>1311</sup> Pisani, E. and Brown, T. 2004. *AIDS in Asia: Face the Facts*. Monitoring the AIDS Pandemic. ([http://data.unaids.org/unaids/docs/map\\_aidsinasia\\_11jul04\\_en.pdf](http://data.unaids.org/unaids/docs/map_aidsinasia_11jul04_en.pdf))

Financial data regarding law enforcement budgets earmarked for drug control was scarce and have usually not been available to the public. Budgets for police, courts, prisons and parole have provided the financial resources necessary to implement all law enforcement-led drug control activities in Thailand. For example, the total Royal Thai Police budget for the fiscal year 2015 was THB 94,668,300,000 (USD 2,764,314,360)<sup>1312</sup> but, based on available data, it would be reasonable to assume that up 39.35% of the budget had been allocated for drug control, given that that proportion of arrests have been related to illicit drugs in 2015. Based on this assumption, the estimate for the Royal Thai Police budget allocated for drug control activities for 2015 would be approximately THB 37 billion (USD 1,241,732,535). A supplementary allocation specifically to support ONCB was also included in the 2015 budget, totaling THB 2,543,100,000 (USD 74,258,520).<sup>1313</sup>

Total operational budgets for Thai criminal courts were indicated at THB 29,804,200,000 (USD 870,282,640) for 2015.<sup>1314</sup> Again, based on data from the year 2015, it would be reasonable to assume that up to 39.35% of the criminal court's budget was invested in drug-related cases, given that figure represents the proportion of arrests for drug-related crimes in 2015, thus representing a budget allocation of THB 11,727,952,700 (USD 390,931,757). Alternatively, sources from within ONCB who wish to remain anonymous have indicated that THB 76,000 (USD 2,220) was allocated for each court case by MOJ for an average of 200,000 cases per year, leading to a total estimated budget of THB 15.2 billion (USD 443,840,000) per year.

The national budget for prison management was indicated at THB 10,878,200,000 (USD 317,643,440) for the year 2015.<sup>1315</sup> It would be reasonable again to assume that, since 73% of people were incarcerated for drug-related offences, a similar proportion of the budget would cover incarceration costs for drug-related crimes – or THB 7,941,086,000 (USD 231,879,711). However, the same anonymous source within ONCB indicated that THB 58 (USD 1.70) was invested per prisoner per day in Thailand. In 2015, the authorities used an estimated 190,200 drug-related prisoners as an assumption for budget calculations, leading to an estimated budget of THB 4,026,534,000 (USD 117,574,793). Finally, *Table* below shows budget allocations for the department of probation, highlighting a significant budget increase over time. Again, applying the same assumptions, that 73% of prisoners are incarcerated for drug crimes, we can estimate that in 2001, the probation department's budget for drug-related cases was THB 355,818,425 (USD 7,991,682).

***Table 59: Department of Probation annual budget, 1997-2001, 2011-2014*** <sup>1316</sup>

<sup>1312</sup> Ministry of Finance. 2015. *Thailand Budget in Brief FY2015*. ([http://www.bb.go.th/budget\\_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf](http://www.bb.go.th/budget_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf))

<sup>1313</sup> Ministry of Finance. 2015. *Thailand Budget in Brief FY2015*. ([http://www.bb.go.th/budget\\_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf](http://www.bb.go.th/budget_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf))

<sup>1314</sup> Ministry of Finance. 2015. *Thailand Budget in Brief FY2015*. ([http://www.bb.go.th/budget\\_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf](http://www.bb.go.th/budget_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf))

<sup>1315</sup> Ministry of Finance. 2015. *Thailand Budget in Brief FY2015*. ([http://www.bb.go.th/budget\\_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf](http://www.bb.go.th/budget_book/e-Book2558/PDF/Budget-in-Brief-2015.pdf))

<sup>1316</sup> Rittirat, S. 2015. "Overview of the community-based treatment system of Thailand," in *Annual Report for 2014 and Resource Material Series No. 96*. United Nations Asia and Far East Institute for the Prevention of Crime and the Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No96/No.96\\_00All.pdf](http://www.unafei.or.jp/english/pdf/RS_No96/No.96_00All.pdf)); Kalyanasuta, K. and Suriyawong, A. 2002. "The



Year	THB	USD
1997	279,180,300	9,310,663
1998	251,126,800	6,140,050
1999	237,888,800	6,285,022
2000	385,154,700	9,609,610
2001	487,422,500	10,947,509
2011	1,437,559,700	46,893,197
2012	1,451,262,700	46,512,970
2013	1,706,892,900	55,491,088
2014	1,824,690,900	56,072,751

The financial data presented above is summarized in *Table 60* below. In effect, using the most conservative estimates, close to USD 2 billion was invested to support law enforcement agencies and the criminal justice response to drug-related issues in Thailand in 2015.

*Table 60: Budgets for law enforcement drug control in 2014-2015*

	Estimate (USD)	
	Low	High
Royal Thai Police	1,241,732,535	1,241,732,535
Office of the Narcotics Control Board	74,258,520	74,258,520
Courts	390,931,757	443,840,000
Prisons	117,574,793	231,879,711
Probation	56,072,751	56,072,751
<b>Total</b>	<b>1,880,570,356</b>	<b>2,047,783,517</b>

### Concluding analysis

No independent evaluation has been performed to comprehensively assess the impact of all aspects of Thai drug policies, although specific interventions have been assessed and documented, and the data presented in this sub-section can be used to draw conclusions regarding the overall performance of national drug control efforts in Thailand. The modern Thai drug control apparatus was largely developed in the 1970s and subsequent reforms overwhelmingly expanded the scope of law enforcement's role in this sector. The 2002 *Narcotic Addict Rehabilitation Act* was the first genuine attempt to introduce balance between public security objectives and public health objectives in Thai drug control policies. Out of the 16 major policy changes covered in this report occurring in Thailand between 1936 and 2013 (see *Box 7* below), only four focused on public health objectives among which, one was never implemented (the 1991 *Drug Addict Rehabilitation Act*), one expired within a very short time (the 2013 *National Harm Reduction Policy*), another is rarely applied in practice (the 2002 *Narcotic Addict Rehabilitation Act*) and the last has just been approved (national harm reduction implementation guidelines).

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criminal justice system and community-based treatment of offenders in Thailand" in *121<sup>st</sup> International Training Course*, 61: 265-293, Tokyo, Japan. United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders. ([http://www.unafei.or.jp/english/pdf/RS\\_No61/No61\\_22PA\\_Suriyawong.pdf](http://www.unafei.or.jp/english/pdf/RS_No61/No61_22PA_Suriyawong.pdf)); historical rates for THB-USD conversion generated by <https://www.oanda.com/currency/average>.

Box 7: Relevant Thai legal and policy documents and milestones

- *Penitentiary Act* (1936)
  - *Ministerial Regulations* (1937)
  - *Kratom Act* (1943)
  - *Harmful Habit Forming Drugs Act* (1959)
  - *Psychotropic Substances Act* (1975)
  - *Narcotics Control Act* (1976)
  - *Narcotics Act* (1979)
  - *Drug Addict Rehabilitation Act* (1991)
  - *Narcotic Addict Rehabilitation Act* (2002)
  - *Three Minuses, Three Pluses and Three Focuses Strategy* (2008)
  - *Ninety Days Away from Drugs Operation Strategy* (2008)
  - *Clean and Seal Strategy* (2009)
  - *National Narcotics Control Policy on Five Fences Strategy* (2009)
  - *Kingdom's Unity for Victory over Drugs Strategy* (2011)
  - *Order of National Command Centre for Combating Drugs' No. 1/2557: Guidelines for Harm Reduction among Injection Drug Users* (2013)
  - *National harm reduction implementation guidelines* (2017)
- 

Motivation for drug policy change in Thailand has emerged in the past five years or so, driven by public concerns related to illicit drugs as well as government worries about prison overcrowding. Strong negative public opinions about drugs have been systematically fueled by political leaders emphasizing, and often exaggerating the risks and threats associated with illicit drugs, while the common media discourse has often been stigmatizing and discriminating against PWUD. Meanwhile, Thailand has often been singled out in the international media for its application of drug control policies. While efforts to balance Thai drug control policies are underway, the most recent amendment approved in late 2016 and deployed in early 2017 is likely to be insufficient to address public concerns or prison overcrowding. Meanwhile, previous efforts to reduce overcrowding in prisons have also not been sufficient to reduce the prison population, which has exceeded overall capacity for decades.

Thai drug control policies have also encompassed structural contradictions that have influenced practice on the ground. Perhaps the most striking contradiction is the conflict between the fundamental principles underpinning the 1979 *Narcotics Act* which criminalizes drug-related offences and compels severe penalties, and those underpinning the 2002 *Narcotic Addict Rehabilitation Act* which explicitly recognized the need to provide health services to people dependent on illicit drugs, acknowledging that PWUD are patients, not criminals. Both policy instruments have diverging objectives that have remained unreconciled since 2002. In addition, the Minister of Health is officially responsible for the implementation of drug policies that define criminal punishments and sanctions (1979 *Narcotics Act*) while legal authority to divert people to treatment - based on clinical criteria - is located with the Minister of Justice (2002 *Narcotic Addict Rehabilitation Act*). In a similar vein, compulsory treatment centers are also managed by agencies under MOJ's purview. Despite official documents, Thailand's MOJ has been and remains the lead national

agency responsible for the implementation of drug control efforts. Meanwhile, amendments to prison policies formally indicate that DOC is overseen by MOI while in practice, line oversight is provided by MOJ.<sup>1317</sup> In parallel, while national authorities have acknowledged the value of CSO participation in crop substitution programs in the context of drug control, extremely limited space has been available for CSO to engage in other aspects of drug control in Thailand.<sup>1318</sup>

Thai drug policy objectives have consistently sought to reduce trafficking as well as reduce the number of PWUD by focusing on three core intervention strategies: prevention, treatment and policing. In terms of achievements in preventing an increase in the number of PWUD, available data shows that there has been a steady continuous rise in the number of problematic drugs users, the number of PWID, and the number of people who have ever used drugs in Thailand.

In terms of treatment, the sole focus on abstinence as the ultimate goal has restricted performance and results. Evaluations and reviews of the Thai drug treatment apparatus have concluded that implementation of such services have not been conducive to even achieving abstinence, much less other public health objectives.<sup>1319</sup> While numbers of people who were enrolled in drug treatment programs is incredibly high,<sup>1320</sup> reports indicate that relapse has remained high,<sup>1321</sup> that motivation to access drug treatment has remained low,<sup>1322</sup> and that discrimination and abuse have been reportedly too common to go unaddressed.<sup>1323</sup> Compulsory detention in the name of treatment has been identified by UN agencies and experts from across Asia as ineffective, unsafe for clients, and costly, while the majority of such centers had insufficient capacity.<sup>1324</sup>

<sup>1317</sup> Atabay, T. and Owen, B. 2014. *Women Prisoners and the Implementation of the Bangkok Rules in Thailand*. Thailand Institute of Justice. ([http://www.tijthailand.org/useruploads/files/women\\_prisoners\\_and\\_the\\_implementation\\_of\\_the\\_bangkok\\_rules\\_in\\_thailand\\_tij.pdf](http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_thailand_tij.pdf))

<sup>1318</sup> Tanguay, P. 2015. *Civil Society and Harm Reduction in Thailand – Lessons Not Learned*. ([www.mei.edu/content/map/civil-society-and-harm-reduction-thailand—lessons-not-learned](http://www.mei.edu/content/map/civil-society-and-harm-reduction-thailand—lessons-not-learned))

<sup>1319</sup> Kerr, T., et al. 2014. "The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand" in *International Journal of Drug Policy*, 25(1): 171-4. (<http://www.sciencedirect.com/science/article/pii/S0955395913000911>); Csete, J. et al. 2011. "Compulsory drug detention centre experiences among a community-based sample of injection drug users in Bangkok, Thailand" in *BMC International Health and Human Rights*, 11:12. (<http://bmcinthealthhumanrights.biomedcentral.com/articles/10.1186/1472-698X-11-12>); Pearshouse, R. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. Canadian HIV/AIDS Legal Network. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

<sup>1320</sup> MacDonald, V. and Nacapew, S. 2013. *IDPC Briefing Paper: Drug control and harm reduction in Thailand*. International Drug Policy Consortium / PSI Thailand Foundation. (<https://dl.dropboxusercontent.com/u/566349360/library/IDPC-briefing-paper-Thailand-drug-policy-English.pdf>)

<sup>1321</sup> Thomson, N. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*. Open Society Foundations / Nossal Institute for Global Health. (<https://www.opensocietyfoundations.org/sites/default/files/Detention-as-Treatment-20100301.pdf>)

<sup>1322</sup> Kerr, T., et al. 2014. "The impact of compulsory drug detention exposure on the avoidance of healthcare among injection drug users in Thailand" in *International Journal of Drug Policy*, 25(1): 171-4. (<http://www.sciencedirect.com/science/article/pii/S0955395913000911>)

<sup>1323</sup> Churcher, S. 2013. "Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: a review of recent literature," in *WHO South-East Asia Journal of Public Health*, 2:1. ([http://www.searo.who.int/publications/journals/seajph/seajphv2n1\\_p12.pdf?ua=1](http://www.searo.who.int/publications/journals/seajph/seajphv2n1_p12.pdf?ua=1))

<sup>1324</sup> Tanguay, P., Kamarulzaman, A., Aramrattana, A., Wodak, A., Thomson, N., Ali, R., Vumbaca, G., Lai, G., Chabungbam, A. 2015. *Discussion paper: Transition from compulsory centres for drug users to voluntary community-based treatment and services*. ([https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion\\_Paper\\_on\\_Transition\\_from\\_CCD\\_Us\\_Edited\\_Final4\\_04Sept15.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2015/hiv/Discussion_Paper_on_Transition_from_CCD_Us_Edited_Final4_04Sept15.pdf))

Although not specifically an objective of Thai drug control policies, it is important to include in this analysis the impact of harm reduction in Thailand and its impact on public health. For example, HIV prevalence amongst PWID has remained high, between 49% in 1988 to 21% in 2016; HCV prevalence amongst PWID has remained at a steady 90% since 2008; and overdoses were a relatively common occurrence for PWID. In parallel, harm reduction programs to prevent such public health conditions have not been integrated in national health systems while official drug control activities have actively hampered implementation of such services.

In terms of reducing trafficking, Thai authorities have certainly achieved good results if quantities of illicit drugs seized and number of arrests made are performance indicators. Indeed, seizures in Thailand have been increasing and generating better results over time against these indicators, while the number of people arrested for drug crimes has also continued to rise. However, tracking drug control performance with such indicators says little about the impact on the illicit drug market - while seizures may have increased, data shows that the market has expanded more rapidly than law enforcement interventions have been able to keep up.<sup>1325</sup> Again, such interventions have exacerbated rather than alleviated prison overcrowding and popular concerns regarding illicit drugs.

In Thailand in 2015, between USD 2.3 billion were invested in to implement drug control activities. Furthermore, a little over 85% of those financial resources were invested in law enforcement responses compared to between 14%% invested in health responses. It is therefore not surprising that public health objectives - both in terms of abstinence and in terms of harm reduction - have not been achieved. Meanwhile, among health-related interventions, less than 1% of the funds have been invested towards harm reduction in a single year, whereas 98% of funds have been invested in prevention. Data summarized in *Table 61* also highlights that extremely small amounts of funds have been invested in harm reduction when compared to investments in other areas of drug control in Thailand.

*Table 61: Total annual budget and expenditure on drug control activities in Thailand*

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<sup>1325</sup> Hayashi et al. 2013. "Increasing availability of illicit drugs among people who inject drugs in Bangkok, Thailand" in *Drug Alcohol Depend.* 132(1-2): 251-6. (<https://www.ncbi.nlm.nih.gov/pubmed/23490451>)

	Estimated budget and expenditure in 2015 - LOW	Proportion of total investment in 2015	Estimated budget and expenditure in 2015 - HIGH	Proportion of total investment in 2015
Royal Thai Police	\$1,241,732,535	53.1%	\$1,241,732,535	52.0%
Office of the Narcotics Control Board	\$74,258,520	3.2%	\$74,258,520	3.1%
Courts	\$390,931,757	16.8%	\$443,840,000	18.6%
Prisons	\$231,879,711	9.9%	\$117,574,793	9.7%
Probation	\$56,072,751	2.4%	\$56,072,751	2.4%
<b>Sub-Total</b>	<b>\$1,994,875,274</b>	<b>85.5%</b>	<b>\$2,047,783,517</b>	<b>85.8%</b>
Compulsory and correctional treatment	\$3,120,000	0.1%	\$3,120,000	0.1%
Drug prevention	\$334,766,667	14.3%	\$334,766,667	14.0%
Harm reduction	\$1,631,643	0.07%	\$1,631,643	0.07%
Drug treatment	N/A	0.0%	N/A	0.0%
<b>Sub-total</b>	<b>\$339,518,310</b>	<b>14.5%</b>	<b>\$341,296,684</b>	<b>14.2%</b>
<b>TOTAL</b>	<b>\$2,334,393,584</b>	<b>100.0%</b>	<b>\$2,387,301,827</b>	<b>100%</b>

Despite the lack of evaluations showing positive results, as well as mounting evidence that Thai drug control policies have generated perverse negative results while failing to achieve their own objectives and continued massive investments in non-evidence-based approaches, a recent poll conducted by the *Bangkok Post* showed that 71.15% of respondents felt confident in the government's ability to solve the drug problem in Thailand.<sup>1326</sup> Despite significant problems with prison overcrowding, 75.37% of respondents agreed that drug laws must continue to be strictly enforced; despite having some of the most severe sentences in the world, 66.92% of respondents said drug offenders must be subject to drastic action; despite more than 50 years of law enforcement led drug control, 62.94% agreed that law enforcement-led anti-drug campaigns must continue to be carried out; and despite repeated calls for evidence-based decisions related to drug control, 62.05% agreed that morality must continue to be emphasized in drug control interventions.<sup>1327</sup>

<sup>1326</sup> Online Reporters. 5 February 2017. "Majority confident govt can solve drug problem: poll" in *Bangkok Post*, online at: <http://m.bangkokpost.com/news/general/1193136/majority-confident-govt-can-solve-drug-problem-poll?refer=http%3A%2F%2Fm.facebook.com>.

<sup>1327</sup> Online Reporters. 5 February 2017. "Majority confident govt can solve drug problem: poll" in *Bangkok Post*, online at: <http://m.bangkokpost.com/news/general/1193136/majority-confident-govt-can-solve-drug-problem-poll?refer=http%3A%2F%2Fm.facebook.com>.



## ANALYSIS: WHAT THAILAND CAN LEARN FROM EUROPE

Comparison of the results achieved by implementing national drug control activities across the five European countries reveals important similarities and differences that are instrumental for drug policy reforms, especially in the context of the development and implementation of decriminalization models and approaches. To set the stage, *Table 62* below provides an overview of the countries' overall population and resources. There are significant differences, especially when compared to Thailand – with a population of 67.7 million, Thailand is closest to Germany, but with a per capita GDP of USD 15,520 in 2015,<sup>1328</sup> Thailand is closer, yet well below Portugal's per capita GDP. In that respect, the scale and scope of Thailand's drug problem is significantly different compared to Europe given important differences in national population size, while available resources for drug control are likely to be much more limited in Thailand. However, *Table 62* also shows that Thailand spent more on drug control in 2015 than most European countries reviewed in this report except Germany and the Netherlands. However, when compared to investments in drug control as a proportion of national GDP for the same year as we have investment data, Thailand outranks both Germany and the Netherlands. Note however that data about investments in drug control for the Czech Republic and Portugal did not include budgets for law enforcement.

*Table 62: Country population and GDP information compared with national investments in drug control (USD)*

	<b>Czech Republic</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Portugal</b>	<b>Switzerland</b>	<b>Thailand</b>
<b>Population</b> (OECD 2013-2014)	10.5 million	80.9 million	16.8 million	10.5 million	8.1 million	68 million
<b>GDP per capita</b> (OECD 2015)	\$33,753	\$47,999	\$49,570	\$29,688	\$59,150	\$5,815
<b>Total investment in drug control</b>	\$20 million	\$6.5 billion	\$2.5 billion	\$100 million	\$980,000	\$2.3 billion
<b>Year</b>	2008	2006	2003	2010	2016	2015
<b>GDP in year of investment (OECD)</b>	\$288.53 billion	\$2,822.34 billion	\$546.82 billion	\$289.29 billion	\$517.65 billion (2015)	\$395.17 billion
<b>Proportion of drug control investments vs GDP</b>	0.0069%	0.21728%	0.45219%	0.03442%	0.00019%	0.59073%

### *Motivation for drug policy reform:*

The fundamental motivations for governments to reform drug policies have varied extensively, even within the five European countries analyzed in this report. Despite the differences, two major themes emerge from this review: on the one hand, a number of European countries were compelled to change drug control strategies given the negative public health consequences that were being

<sup>1328</sup> World Bank. 2015. *Gross national income per capita 2015, Atlas method and PPP*. <http://databank.worldbank.org/data/download/GNIPC.pdf>

exacerbated by criminal justice responses. The motivation to reform drug policies in Germany, Portugal and Switzerland was fueled by the rapid spread of HIV and viral hepatitis and by a significant burden of mortality associated with drug use. On the other hand, public perception of a growing drug problem and a challenge to the national self-image were important triggers for the Czech Republic, Portugal and Switzerland to initiate drug policy reforms.

In addition to public health and public perception, addressing growing visibility of public nuisance associated with drugs was also a driving factor in Germany and Switzerland, while a long history of authoritarian governments also stimulated change in drug control approaches in the Czech Republic and Portugal. In contrast, motivation to decriminalize drugs in the Netherlands came earlier than for other European nations, and was borne of a rational and pragmatic decision to reduce the reach of the black market and organized crime through a clear segregation of hard and soft drug markets. Meanwhile, it is worth highlighting that drugs have not been officially decriminalized in Switzerland, but significant reforms have been introduced in drug policies since the 1990s.

Thailand's motivation to reform drug control policies and approaches is a relatively recent phenomenon compared to reforms introduced in the European countries reviewed in this report. However, public perceptions of the national drug problem is very much akin to the triggers that motivated reforms in the Czech Republic, Portugal and Switzerland. While HIV and public health issues have been insufficient to motivate those reforms, prison overcrowding in Thailand has triggered greater interest in reforming drug policies.

*Decriminalization model and guiding principles:*

Except in Switzerland, where drugs have not officially been decriminalized, all four other European countries reviewed have relied on a combination of official quantity thresholds and law enforcement discretion to divert non-violent drug law offenders away from the criminal justice system. In the case of quantity thresholds, data collected and summarized in *Table 63* below shows that all four countries have decriminalized possession of small quantities of cannabis, although the thresholds vary significantly across countries: from 5 grams in the Netherlands to 25 grams in Portugal.

***Table 63: Drug decriminalization quantity thresholds***

<b>Drug type</b>	<b>Czech Republic</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Portugal</b>
Methamphetamine	1.5g	5g	N/A	N/A
Amphetamines	N/A	0.5g - 3g	N/A	1g
Heroin (diacetylmorphine)	1.5g	1g	N/A	1g
Cocaine	1g	0.5g - 3g	N/A	2g
Medicines containing buprenorphine	N/A	N/A	N/A	N/A
Medicines containing methadone	N/A	N/A	N/A	1g

Ecstasy	5 tablets or 0.4g powder or crystals	20 tablets	N/A	1g (MDMA)
LSD	5 paper tabs, tablets, capsules, or crystals	N/A	N/A	0.1g
Cannabis	10g	6g	5g	25g
Hashish	5g	N/A	???	5g
Psilocybin mushrooms	40 fruiting bodies	N/A	N/A	N/A

In addition to these formal guidelines, law enforcement agencies involved in drug control in the four European countries have also benefited from a significant level of discretionary power that has allowed those agencies to divert cases away from the criminal justice system. Police in all four countries have some measure of discretionary power although this is not officially recognized in legal documents in Germany. In parallel, Czech, Dutch and German prosecutors also have enjoyed the discretionary power to dismiss drug-related charges, suspend sentences and broker other arrangements without approval of the courts. Courts in the Czech Republic have also benefited from significant discretionary powers, while non-violent offenders arrested for possession have been directly diverted away from the courts towards the dissuasion commissions in Portugal.

In Thailand, thresholds have also been officially approved to facilitate diversion of people dependent on drugs to treatment services. However, in practice, diversion mechanisms have been underused and have ended up diverting people who use but are not dependent on drugs to costly treatment services that are not clinically required. Recent reforms introduced in Thailand's drug control laws have also provided greater opportunities for judicial discretion though it is currently unclear how these changes will impact process outcomes.

Overall drug control and specific efforts to divert non-violent drug offenders arrested for possession and/or consumption crimes have been firmly grounded on fundamental public health and human rights principles in all five European countries. Official policy documents specifically mention these principles and government representatives from the five countries under review have often promoted these guiding principles as the cornerstone of drug policy at the international level. This has often implied, in practice, that client-centered public health strategies and interventions have been prioritized over criminal justice interventions and the political compulsion to punish. In addition, drug control policies in all five European countries reviewed have been solidly grounded on evidence; studies, reports, assessments and evaluations were systematically performed and government agencies consistently integrated and followed expert recommendations from those evidence-based documents.

The Czech and Dutch drug control policies are explicitly guided by the *ultimum remedium* principle, where use of the criminal justice system is a means of last resort, further de-prioritizing criminal justice and law enforcement interventions

in the context of drug control. Implementation of German and Dutch drug control policies are also explicitly guided by the expediency principle – or the empowerment of officials to dismiss drug-related charges before those are brought to court, when such charges would generate little or no public good or added-value – on which prosecutorial discretion is grounded and formalized into law. Promoting of meaningful involvement of PWUD and CSO is an explicit guiding principle in both German (subsidiarity) and Swiss (participation) drug policy documents. Meanwhile, the Dutch drug control policies have remained grounded on the core principle of segregation of soft and hard drug markets.

In contrast, Thailand's drug control policies and strategies have rarely mentioned public health or human rights. While policy instruments and political leaders have repeatedly affirmed that PWUD should be treated as patients rather than criminals, evidence clearly shows that criminalization of drug offenders has been the mainstay of the national response since the 1960. Based on the information and data reviewed in this report, it is fair to say that Thailand's drug control efforts have been firmly grounded on principles of deterrence and prohibition, though those have never been explicitly mentioned in policy documents. Indeed, drug policies in Thailand have systematically emphasized morality over evidence. Stigma and discrimination against drug law offenders and people who are involved in the illicit drug market has been common, forcing many of them underground and restricting access to public health services. Limited transparency from drug control agencies across Thailand has limited participation and engagement of key stakeholders, especially from CSO, who have been eager and capacitated to support reforms to the Kingdom's drug control apparatus.

#### *Drug policymaking:*

In all five European countries reviewed, control over and leadership in decision-making related to drug policy development, implementation, coordination, monitoring and evaluation was shifted from justice ministries to the ministries of public health around the time of decriminalization. Again, this shift in the locus of control over drug control policymaking has been grounded on the formal principles described above and represents an official effort to practically initiate and sustain legislative and programmatic reforms needed to successfully implement decriminalization and achieve specific objectives. It is also worth noting that in all five European countries, drug policy reforms towards decriminalization have led to significant amount of legislative tinkering. The number of reforms, amendments, new laws and policies that were developed, proposed and approved is significant in that achieving effective decriminalization has required a willingness to change official laws and policies that impede or limit such results.

In Thailand, operational control over drug laws and policies has remained firmly entrenched in the criminal justice system even while official policy documents have empowered agencies within the MOH to play important leadership roles. Implementation of a number of drug laws and policies in Thailand, particularly those related to the promotion of health among people associated with illicit drugs, have been compromised by political and operational barriers. So while

there has been a comparable amount of legislative tinkering in Thailand as in the five European countries reviewed in this report (see *Table 64*), many of the reforms could be described as cosmetic given that those had virtually no effect. While reforms in Europe have largely focused on addressing health, reforms in Thailand have largely focused on expanding the role of the criminal justice system.

*Table 64: Number of major legislative and drug policy milestones*

	<b>Czech Republic</b>	<b>Germany</b>	<b>Netherlands</b>	<b>Portugal</b>	<b>Switzerland</b>	<b>Thailand</b>
<b>Number of reforms</b>	13	11	17	20	23	16

Specific individuals and organizations have played important leadership roles that paved the way for decriminalization and drug policy reforms. Especially in the Czech Republic and Switzerland, the leadership of key individuals – in both cases medical professionals affiliated with CSO – triggered important efforts that eventually led to drug policy reforms. In all countries reviewed save the Czech Republic, an official national network of PWUD, managed by PWUD, was established and currently contributes to drug policy development and implementation.

In all five European countries reviewed, implementation of decriminalization and associated drug policy reforms has implied the establishment of a number of new institutional structures. However, the nature of those new institutions and structures has been relatively different across all five countries. In the Czech Republic, in Germany and in Switzerland, a new government authority was created and mandated with overall drug policy development, implementation, coordination, monitoring and evaluation. In Portugal, the drug dissuasion commissions were established to substitute criminal justice courts in cases of possession of illicit drugs. In the Netherlands, the notorious coffeeshops were established as licit commercial dispensaries for soft drugs. The establishment of new structures and institutions has been particularly relevant given that, in the Czech Republic, the Netherlands and Portugal, this has been explicitly acknowledged as the result of the failure of previous institutions and structures to successfully address drug-related problems.

In addition to the new government structures and mechanisms, implementation of decriminalization models and associated drug policy reforms in all five European countries reviewed was consistently supported by CSO. Non-government agencies have played such an important role that governments in most of the five countries reviewed provide direct funding that allows CSO to engage effectively and meaningfully in drug control to complement and add value to the national response. Many government officials – from all five countries – have publicly acknowledged in global forums that the successes achieved by their national drug control efforts have been contingent on meaningful CSO involvement.



In contrast, politicians and law enforcement representatives have defended the war on drugs approach in Thailand, dominating discussions on drug policy issues. However, in recent years, a number of political, academic and civil society leaders have been advocating for reforms. Ex-Minister of Justice Paiboon Koomchaya, currently serving as an advisor to HRH King Vajiralongkorn on the Privy Council, recently opened the door for sweeping reforms within Thailand's drug control apparatus. HRH Princess Bajarakitiyhaba, recently appointed as the UN Goodwill Ambassador for the Rule of Law in Southeast Asia,<sup>1329</sup> is a leading advocate for drug policy reform, especially in the context of improving the Kingdom's prison system. While Thailand's national network of PWUD played a critical role in mobilizing support for a response to HIV among PWID, the network and its CSO partners have had limited opportunities to contribute to drug policy reform.

It also is worth noting that with the exception of Switzerland, all four other European countries reviewed report annually to EMCDDA, a regional drug surveillance agency established in 1993. The comprehensive data collected by EMCDDA across all relevant aspects of drug control provides opportunities for comparisons across the EU, and generates reliable up-to-date information about drugs and drug policy implementation. While the ASEAN Senior Officials on Drugs collect data related to drug control, data collection is specifically limited to law enforcement related activities - arrests, seizures, etc. - and data is not available to non-government, non-law enforcement agencies.

#### *Drug control policies:*

Drug control policies across the five European countries are now largely, if not directly based on the Swiss *Four Pillars* policy, providing an elegant and effective framework for balancing prevention, harm reduction, treatment and law enforcement strategies and interventions. The Swiss *Four Pillars* model was developed and formally deployed in 1991 and the Czech and German drug policies were rapidly modeled on the Swiss approach. In contrast, the Portuguese drug control strategy does not formally include law enforcement although law enforcement remains an important component in the context of drug control, especially at market level. Similarly, the Dutch policy is not explicitly grounded on the four pillars but the national drug control policy prioritizes strategies and interventions that belong to the four pillars listed above.

In all five countries, drug control policies' strategic pillars are targeted at clear population segments and behaviors to maximize impact and generate success. Based on the Swiss model and approach, *Table 65* below shows that prevention activities seek to reduce initiation among children and youth; that harm reduction is targeted at all PWUD in order to prevent negative consequences of drug use; that treatment activities seek to address dependence among those who are clinically dependent on drugs; and that law enforcement activities target organized crime outfits to reduce the overall drug market.

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<sup>1329</sup> The Nation. 8 February 2017. "Princess Bajrakitiyabha to be named UN Goodwill Ambassador" in *The Nation*, online at: <http://www.nationmultimedia.com/news/breakingnews/30305954>.

*Table 65: Segmentation of drug control strategies by pillar* <sup>1330</sup>

Pillar	Population segment	Target issue / behavior
Prevention	Children and young people	Initiation
Harm reduction	People who use and inject drugs	Adverse consequences of drug use
Treatment	People dependent on drugs and problem drug users	Drug dependence
Law enforcement	Producers, traffickers and dealers	Production, distribution and trafficking

In Thailand, drug control strategies have focused on prevention, treatment and law enforcement, with an emphasis on the latter. Even prevention and treatment strategies have been largely aligned with law enforcement objectives - to eliminate all drugs from the Kingdom - and many of the activities identified as prevention (urine testing) and treatment (compulsory detention) in ONCB's annual reports are in effect law enforcement activities. Though a new policy was recently approved in 2017, harm reduction interventions have yet to be officially integrated in national drug control systems and practices. Meanwhile, the criminal justice system has struggled to clearly differentiate between and define criteria to identify PWUD but are not dependent, people who are clinically dependent on drugs, people involved in petty distributing drugs to support their habit, and people who produce and traffic drugs as part of organized crime networks. In effect, fewer sentencing options for drug law offences have been available to criminal justice officials in Thailand compared to the European countries reviewed in this report.

While the *Four Pillars* model has provided an elegant framework to balance various drug control components across Europe, it is worth pointing out that despite limited data, evidence has shown that investments in law enforcement continue to represent 50% or more of the total expenditure related to drug policy. For example, an estimated 50% of the Swiss drug control budget was invested in law enforcement,<sup>1331</sup> compared to an estimated 65% to 70% in Germany.<sup>1332</sup> In that sense, a balanced approach to drug control in Europe has not implied a significant de-funding of law enforcement but rather a more equitable distribution of resources allocated for drug control strategies and activities.

Comparatively, investments in drug control in Thailand have been narrowly focused on law enforcement mechanisms, where almost 90% of all financial resources have been allocated to the police, the courts, prisons and probation. This represents a significant deviation from the data available from the

<sup>1330</sup> Reuter, P. and Schnoz, D. 2009. *Assessing drug problems and policies in Switzerland, 1998-2007*. Swiss Federal Office of Public Health.

(<http://www2.pr.gov/agencias/assmca/Documents/BibliotecaVirtual/Sustancias/Assessing%20Drug%20Problems%20and%20Policies%20in%20Switzerland.pdf>)

<sup>1331</sup> Federal Office of Public Health. 2000. *Swiss Drugs Policy*.

(<http://ponce.inter.edu/acad/facultad/jvillasr/La%20politica%20suiza%20respecto%20a%20las%20drogas2.pdf>)

<sup>1332</sup> European Monitoring Centre for Drugs and Drug Addiction. 2016. *Germany Country Overview*, online at: <http://www.emcdda.europa.eu/countries/germany>.

European countries reviewed in this report, indicating that Thailand's response to drugs may be out of balance.

*Prevention pillar:*

Across all five European countries, limited relevant information was available about the nature and results of drug prevention activities. Data from Germany and the Netherlands – where independent prevention monitoring systems have been established – includes information about the nature of activities, although again, limited information was available on the overall impact of prevention activities. Despite those limitations, it is clear that school-based prevention has been a mainstay across all five European countries analyzed. Data about the Netherlands has shown that school-based prevention programs need to be evidence-based in order to be effective, otherwise those efforts risk encouraging drug use instead. The Netherlands has also increasingly relied on targeted selective prevention interventions, mostly carried out by CSO in collaboration with government agencies. Virtually all countries have a drug-related telephone helpline and an increasing number of countries have setup online web- and smartphone-based platforms to support prevention interventions.

In Thailand, school-based interventions have also been a mainstay of the national drug policy although there was limited information on the content of those activities, while all prevention efforts have focused on achieving a drug-free life in a drug-free school. Immunization, another mainstay of Thailand's drug prevention strategy, has essentially reinforced stigma and discrimination against people involved with illicit drugs and has encouraged the exclusion of such individuals. Urine testing, also a core prevention strategy, has actually become a mechanism to coerce people into treatment facilities. There is limited information on the role of CSO in prevention activities in Thailand.

*Harm reduction pillar:*

All five European countries have officially integrated harm reduction strategies and implemented a comprehensive package of services aligned with UN recommendations and guidelines. Financial costs for such services have generally been covered by government budgets, most often allocated to CSO to reach clients, deliver services, and facilitate entry into drug treatment specifically and into the national health care system generally. Government support for harm reduction has also contributed to the development of important innovations in service delivery, where HAT, drug consumption rooms, and distribution of gelatin capsules for people who inject methamphetamine were introduced and scaled up given their effectiveness. In virtually every European country reviewed, early introduction of harm reduction interventions has contributed to reducing HIV and viral hepatitis transmission amongst PWID, to reducing the number of problem drugs users, to reducing overdoses, and to an overall improvement in health and social functioning of clients. In addition, harm reduction services have acted as a gateway that facilitates access to drug dependence treatment among clients who are ready and willing.

In stark contrast, the Thai government's longstanding resistance to harm reduction interventions has compromised the limited efforts to implement the

UN's recommended package of interventions: no one single service delivery outlet offers the comprehensive package of services, coverage amongst PWID is below 10% across virtually all harm reduction services, and both PWID population size as well as HIV and HCV rates have remained stable for more than a decade but have remained high. Harm reduction services have almost exclusively been provided by CSO that receive their funds exclusively from international donors.

#### *Treatment pillar:*

All five European countries have provided a wide range of treatment services to address the needs of clients. In all five European countries, services have been client-centered and aligned with the fundamental human rights of principles. In all European countries under review except Germany, abstinence is not an explicit objective of drug policy in general or treatment activities specifically – the objective is rather designed to empower clients to be able to manage their dependence in the short- to long-term. Both residential and outpatient treatment services are available, although all five European countries have increasingly relied on outpatient treatment services and de-prioritized and scaled-down inpatient treatment. Since drug policy reforms towards decriminalization were introduced, the number of people volunteering for drug dependence treatment has increased in all five countries. Compulsory drug treatment is an option in the Czech Republic and in the Netherlands, although such interventions are rarely implemented in practice, while there is evidence that compulsory detention in the name of treatment was implemented in the mid-1990s in Switzerland.

In Thailand, drug treatment has always been designed to achieve total abstinence, and relapse is often considered as a personal failure of the client, including by drug treatment professionals. Both in- and outpatient drug treatment services are available in Thailand although there has been a rapid expansion of inpatient facilities, both voluntary and compulsory, in the past 15 years. In the majority of treatment programs, patients have reported having little control over treatment plans and have been provided with few options to address drug-related issues. There have been no external evaluations of drug dependence treatment services in Thailand although reports indicate that relapse rates are high and that such services have been associated with human rights abuses, especially in compulsory settings.

#### *Law enforcement pillar:*

Even as the largest share of resources has continued to support law enforcement interventions after decriminalization, the five European countries reviewed have clearly prioritized prevention, harm reduction and treatment interventions, over interventions led by the criminal justice system which has explicitly been used as a measure of last resort in the Czech Republic and the Netherlands' national responses to drug issues. Interventions implemented under the national law enforcement pillars have been increasingly focused on drug production and trafficking as well as tackling organized crime across all European five countries, rather than on policing street-level consumption, possession and dealing. That said, Germany's drug control policy still incorporates strong elements of street-

level policing and has thus been qualified as the most repressive state among the five European countries reviewed.

In Europe, since decriminalization, the number of police contacts with drug law offenders has continued to increase, showing that law enforcement agencies continue to act as an important mechanism in addressing drug-related issues. However, while the number of police contacts with drug offenders has increased in the Czech Republic, Germany and Switzerland, the number of trafficking arrests has increased in all countries under review except for Germany, the number of people sentenced and incarcerated for drug-related offences has decreased in all five countries, the proportion of drug-related offenders in the overall prison population has decreased in all countries under review (save the Netherlands for which relevant data was not available), the overall prison population has dropped in Germany and the Netherlands, and the severity of punishments for possession/consumption offences has decreased in all countries. This could mean that law enforcement activities have been scaled-up since decriminalization but have been increasingly focused on controlling the drug market and tackling production and trafficking, rather than investing time and resources policing individual possession and consumption.

In Thailand, drug control has prioritized law enforcement activities, while a number of prevention and treatment activities have directly supported law enforcement objectives, rather than public health objectives. Again, the Thai criminal justice system has struggled to distinguish between recreational users, drug dependents, petty dealers and organized crime, and law enforcement have often been encouraged to focus on street-level policing through financial incentives and arrest quotas. While arrests, seizures and the number of drug law offenders have continued to rise, evidence shows that growth in the illicit drug market has outstripped the law enforcement response.

#### *Evaluations and results:*

Data indicates that all European countries under review except Germany have systematically evaluated the implementation of their national drug control policies. Results from both internal and independent external evaluations consistently indicate that drug policies have significantly contributed to achieving or have achieved their objectives and consistently generated significant benefits for PWUD, their families, their communities and the country as a whole. In the Czech Republic, the impact of the return to criminalization was documented and evaluated, showing clearly that criminalization had exacerbated drug-related problems rather than solving them. Additional service specific evaluations have shown that innovative services such as HAT and drug consumption rooms have generated significant health benefits and social value with virtually no negative unintended consequences.

In Thailand, a very limited number of evaluations have been performed to assess the impact of drug control activities; when evaluations have been performed, they have rarely been independently conducted or comprehensive in scope. Based on policy indicators such as number of individuals enrolled in treatment and the number of drug-related arrests, targets have been consistently met yet



policies systematically fail to achieve their ultimate objectives of eliminating all illicit drugs and achieving sustained abstinence from drug consumption. In parallel, policy decisions regarding drug control have systematically been grounded on morality, on popular appeal and on Thai exceptionalism, rather than on peer-reviewed scientific evidence.

The impact of decriminalization on drug use patterns in Europe seems to be limited. Evidence shows that after decriminalization, consumption rates – especially for cannabis – have tended to increase, but dropped again after a few years, below the level of other countries that have not decriminalized. Evidence reviewed shows that when there has been an increase in drug use patterns among certain age groups in countries that have decriminalized drugs, similar and comparable increases were detected in other countries across Europe where drug control has remained focused on prohibition led by law enforcement agencies. However, there was no evidence to show that either decriminalization or specific services such as HAT or distribution of needles and syringes have encouraged non-users to start consuming illicit drugs. In that sense, such patterns show that the severity of drug laws and the content of drug policies may have little impact on overall drug consumption patterns, and that such an indicator may not generate the evidence required to make sound decisions regarding drug control.

Data related to the financial investments in drug control for the five European countries reviewed was rather limited and no reliable conclusions can be made regarding the changes in investments prior to and after decriminalization. Available data shows that the cost of drug control has been significant. Important sums have been allocated each year to support implementation of the drug control policies and the interventions under each of the four pillars. As noted above, the largest share of funds continues to support law enforcement activities but national governments have also allocated significant amounts for prevention, harm reduction and treatment without relying on external donors. In addition, available data shows that specific services, particularly harm reduction services, have been especially cost-effective and have generated significant return-on-investment in the long-term. It is also worth highlighting that in the Netherlands, coffeeshops have generated up to EUR 400 million per years in tax benefits for the national government.

Meanwhile, Thailand has invested considerable sums of money in drug control activities that have failed to deliver expected results and have exacerbated public security as well as public health problems. Revising allocations for drug control activities in Thailand is therefore urgently required to support a balanced approach and align with evidence and international guidelines.

## CONCLUSION

During the 2016 UNGASS on the World Drug Problem, ex-Minister of Justice General Paiboon Koomchaya emphasized Thailand's opposition to legalization and decriminalization "for serious offences,"<sup>1333</sup> echoing support for ASEAN's position on drug-related issues. However, shortly after the UNGASS, General Koomchaya publicly admitted that the global war on drugs, as well as Thailand's had failed,<sup>1334</sup> contrasting sharply with ASEAN's preferred approach.

Prompted by increasing use of ATS and other party drugs, by long and especially punitive sentences for drug-related offences that have disproportionately affected women, as well as by overall soaring prison populations, General Koomchaya announced that his office was ready to consider all drug control options – including decriminalization – that respect and adhere to the international drug control conventions.<sup>1335</sup>

Thailand has often been singled out in the media and by human rights defenders for aggressive war on drugs campaigns. For example, the Global Commission on Drug Policies recently recognized that "aggressive law enforcement practices targeting drug users have also been proven to create barriers to HIV treatment," pointing to "devastating consequences" in Thailand, Russia and the United States.<sup>1336</sup> Human Rights Watch published damning reports of the 2003-2004 war on drugs that left over 2,000 people dead,<sup>1337</sup> while other agencies have documented a number of abuses carried out in compulsory drug detention centers.<sup>1338</sup> The recent call for decriminalization and drug policy reform is therefore a significant change in direction that could have profound impact for Thailand.

The experiences of the five European countries documented in this report can provide some support to the Thai government in planning the way forward for national drug policies. The lessons learned from the Czech Republic, from Germany, from the Netherlands, from Portugal and from Switzerland may provide Thailand with an opportunity to adapt some of the approaches, strategies and services to generate better results for Thai society as a whole. In considering the way forward, Thai officials could consider a number of options to align national drug control efforts on the European experience, without necessarily decriminalizing drugs, much like in Switzerland. The analysis of the

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<sup>1333</sup> Koomchaya, P. 20 April 2016. *Statement by H. E. General Paiboon Koomchaya Minister of Justice of Thailand at the Thirteenth Special Session of the United Nations General Assembly on the World Drug Problem*. New York City, United States. (<http://statements.unmeetings.org/media2/7657420/thailand.pdf>)

<sup>1334</sup> Lefevre, A. S. 18 July 2016. "Soaring prison population prompts Thailand to re-think 'lost' drug war" in *Reuter*. (<http://www.reuters.com/article/us-drugs-thailand-prisons-idUSKCN0ZX01J>)

<sup>1335</sup> Pakkawan, A. 19 November 2016. "Paiboon stands by delisting pot, krathom plan" in *Bangkok Post*. (<http://www.bangkokpost.com/news/general/1138965/paiboon-stands-by-delisting-pot-krathom-plan>)

<sup>1336</sup> Global Commission on Drug Policy. 2012. *The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic*. ([https://www.globalcommissionondrugs.org/wp-content/uploads/2012/03/GCDP\\_HIV-AIDS\\_2012\\_EN.pdf](https://www.globalcommissionondrugs.org/wp-content/uploads/2012/03/GCDP_HIV-AIDS_2012_EN.pdf))

<sup>1337</sup> Human Rights Watch. 2004. *Not Enough Graves: The War on Drugs, HIV/AIDS, and Violations of Human Rights*. (<https://www.hrw.org/reports/2004/thailand0704/thailand0704.pdf>)

<sup>1338</sup> Canadian HIV/AIDS Legal Network. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*. (<http://www.aidslaw.ca/site/compulsory-drug-treatment-in-thailand-observations-on-the-narcotic-addict-rehabilitation-act-b-e-2545-2002/?lang=en>)

European experience documented in this report has provided a number of policy options that could be implemented in Thailand.

Shifting control over drug control policies from MOJ to MOH has been an instrumental step in each of the five European countries reviewed in this report. In the countries reviewed, MOH has continued to work closely with MOJ to develop and implement drug control policies. In parallel, new institutions and structures were established in all five countries reviewed, often to coordinate drug control activities at the national level. In virtually all countries under review, CSO have been invited to play meaningful roles in drug control activities.

These would represent significant changes for Thailand whose drug control policy has been led and dominated by MOJ, where collaboration between MOH and MOJ in the context of drug control has been limited to delivering health services in closed settings, where challenging the traditional roles of key institutions has generated significant resistance, and where collaboration with CSO has been extremely limited and significantly tense. That said, the shift in control to MOH, the establishment of new national coordination entities and improved collaboration with CSO are all feasible and relatively simple steps that could considerably improve the results generated by the national drug policy activities.

Additional lessons learned from the European countries reviewed have shown that there is overwhelming consensus for drug control policies and activities to be guided and grounded on human rights and public health principles. Client-centered approaches that offer a comprehensive range of public health options have generated positive results in motivating PWUD to volunteer and enroll in drug dependence treatment, especially when their rights are protected and their health is prioritized. In addition, all five countries reviewed made their drug policy decisions based on evidence generated by national and international experts rather than based on moral ideals, history, tradition or popular support.

Integrating these principles in Thai drug control policies would greatly enhance opportunities for more effective and balanced responses to drug issues. Specifically, a growing body of evidence has underlined the negative consequences caused by prohibition and overly punitive drug control policies; mountains of evidence consistently show that harm reduction services are effective, cost-effective and safe; and evidence consistently shows that decriminalization has not lead to increased drug use, more crime or significant narcotourism. Integrating the lessons learned from the five European countries reviewed here as well as those found in the literature produced in the last decade alone represents a daunting challenge, yet investing in generating local evidence through studies and evaluations, and a willingness to be guided by the results of these processes would provide opportunities to address some of the challenges Thailand faces in regards to illicit drugs.

Modeling the national drug control on the Swiss *Four Pillars* policy is an option that would contribute to balancing the national response to illicit drugs in Thailand. Implementation of Thailand's national drug control policy has been

focused explicitly on law enforcement responses and criminal justice efforts in order to deter further drug law offences, and significant investments have been and continue to be made to support law enforcement's role in drug control. Prevention and rehabilitation are secondary objectives that have focused on maintaining and achieving abstinence; treatment is often compulsory and few treatment options have been available for patients. Harm reduction is not supported by the national government, virtually 100% of funding for harm reduction activities is sourced from international donors, and though recent policy changes have been made to support harm reduction, it remains unclear how the national government will support implementation of services.

Modeling the Thai drug control response on the Swiss *Four Pillars* would thus prove an important challenge. For example, drug prevention education and activities in schools would need to be shored with evidence and implemented to empower rather than to scare or deter. Comprehensive harm reduction services would need to be rapidly scaled up and practically and financially supported by national government agencies while new and additional interventions could be piloted and evaluated to better meet the specific needs in the Thai context. Treatment services would require extensive retooling of the workforce to integrate a new approach focused on meeting client needs by providing a range of treatment options ideally through outpatient mechanisms, rather than focusing on achieving abstinence and forcibly detaining PWUD in closed residential facilities in the name of treatment.

Adopting a drug control policy approach grounded on the *Four Pillars* model in Thailand would also imply a significant de-prioritization of law enforcement interventions, especially in the context of policing possession and consumption offences, where law enforcement would be ideally refocused on containing the drug market by targeting production and trafficking offenders while undermining organized crime. While overcriminalization of illicit drugs and disproportionate punishments have been common,<sup>1339</sup> such practices should rather become a measure of last resort when all other options have failed and drug-related sentences should be proportional to the potential harm to the individual and to society caused by the offence.

All the options presented so far do not involve any form of decriminalization, but rather a rebalancing of drug policy objectives and efforts. The four European countries reviewed that decriminalized drugs all relied on a combination of quantity thresholds and discretion as well as the segregation of soft and hard drugs markets. In this context, an American government report notes:

*Options for decriminalization include a diversity and common threads among these jurisdictions as to defining narcotics, distinguishing between "hard" and "soft" drugs, establishing special regulations concerning cannabis, refusing to prosecute personal use and/or possession of small quantities of drugs for personal use, giving law enforcement authorities the discretion not to prosecute minors and first-time offenders, applying alternative forms of punishment, and providing treatment opportunities.*<sup>1340</sup>

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<sup>1339</sup> Paungsawad, G. et al. 2016. "Bangkok 2016: From overly punitive to deeply human policies" in *Drugs and Alcohol Dependence*, 167: 233-234.

<sup>1340</sup> The Law Library of Congress. 2016. *Decriminalization of Narcotics*. (<https://www.loc.gov/law/help/decriminalization-of-narcotics/decriminalization-of-narcotics.pdf>)

These are all feasible options worth considering but implementation of full-fledged decriminalization approaches would be most effective if the options presented earlier were implemented, well integrated, and supported by both government and the general population. However, these are not required, and a radical shift away from criminalization approaches towards those focused on public health objectives is possible, as the experience in the Czech Republic has shown. That said, the recent introduction of additional opportunities for judicial discretion in the criminal justice system might contribute to reducing the growing prison population. Applying quantity thresholds for diversion would also reduce criminal justice bottlenecks created by overcriminalization of drug issues in Thailand and contribute to refocusing law enforcement efforts on targeting producers and traffickers while facilitating access to treatment and other health and social care services for PWUD. Implementation of the decriminalization options identified here, while possibly controversial for the general population and making for newsworthy media coverage, are in full compliance with the international drug control conventions, as proclaimed by the President of INCB in regards to Portugal in 2015.

The Thai government has a historic opportunity to provide valuable leadership across Southeast Asia as options for new approaches to drug control are being considered. The models, approaches, strategies, interventions and services presented in this report have been identified as valuable evidence-based options that could add significant value to Thailand's drug control efforts. While it is clear that the Thai context is considerably different from that of Europe, nonetheless the options identified in this report have generated significant positive results while virtually no major negative consequences have resulted from drug policy reforms towards decriminalization. Additional data and evidence is urgently required to further assess the potential impact of drug policy reforms presented here as well as other options proposed by other stakeholders in Thailand.



## RECOMMENDATIONS

Based on the findings of this comprehensive literature review, the following recommendations are made for consideration by the Thai government but also by other governments in the Southeast Asia region struggling to find alternatives to strict criminalization of illicit drugs. Governments should consider:

- Shifting control over drug control policymaking **from** health authorities while maintaining collaboration with public security authorities
- Establishing and building capacity of drug policy coordination institutions to oversee all aspects of drug policy
- Engaging meaningfully with civil society and non-government groups, including groups of PWUD
- Integrating and prioritizing human rights and public health principles in drug policies and practices
- Eliminating abstinence and elimination of illicit drugs as policy objectives
- Ensuring that drug policy decisions are grounded on solid evidence rather than tradition or morality
- Adapting national drug policies modeled on the Four Pillars approach with balanced investments to support all four pillars
- Funding, integrating and scaling up comprehensive harm reduction services
- Sensitizing the drug treatment workforce to adopt a new approach focused on meeting client needs and providing treatment options, ideally through outpatient mechanisms
- Closing all compulsory drug treatment facilities and investing in scaling up voluntary community-based treatment options
- Deprioritizing law enforcement interventions at street level for non-violent offenders and refocus efforts on controlling market
- Reducing and/or eliminating sentences for non-violent drug offenders caught for possession/consumption offences
- Developing and/or reinforcing mechanisms to support diversion, discretion, thresholds, and segregation of markets.