



IDPC DRUG POLICY GUIDE

3RD EDITION



IDPC DRUG POLICY GUIDE

3RD EDITION

Acknowledgements

IDPC would like to thank the following authors for drafting chapters of the 3rd Edition of the IDPC Drug Policy Guide:

- Andrea Huber (Policy Director, Penal Reform International)
- Benoit Gomis (Independent international security analyst, Associate Fellow at Chatham House, and Research Associate at Simon Fraser University)
- Christopher Hallam (Research Officer, IDPC)
- Coletta Youngers (Consultant, IDPC & Washington Office on Latin America)
- Diana Guzmán (Associate investigator, DeJusticia, Associate Professor at Colombian National University and PhD candidate at Stanford University)
- Diederik Lohman (Associate Director, Health and Human Rights Division, Human Rights Watch)
- Gloria Lai (Senior Policy Officer, IDPC)
- Jamie Bridge (Senior Policy and Operations Manager, IDPC)
- Marie Nougier (Senior Research and Communications Officer, IDPC)
- Mike Trace (Chair of the Board, IDPC)
- Steve Rolles (Senior Policy Analyst, Transform Drug Policy Foundation)

We are also grateful for the valuable inputs and contributions of the following reviewers:

- Ann Fordham (IDPC)
- Christopher Hallam (IDPC)
- Constanza Sánchez Áviles (International Center for Ethnobotanical Education, Research & Service)
- Corina Giacomello (INACIPE; Equis: Justice for Women, Mexico)
- Damon Barrett (Essex University, International Centre on Human Rights and Drug Policy)
- Daniel Wolfe (International Harm Reduction Development Program, Open Society Foundations)
- Danny Kushlick (Transform Drug Policy Foundation)
- Dave Bewley Taylor (IDPC, Swansea University,

Global Drug Policy Observatory)

- Dave Borden (StoptheDrugWar.org)
- Eric Gutierrez (Christian Aid)
- Fabienne Hariga (United Nations Office on Drugs and Crime)
- George McBride (Beckley Foundation)
- Gloria Lai (IDPC)
- Graham Bartlett (former Chief Superintendent of the Sussex Police)
- Gregor Burkhardt (European Monitoring Centre for Drugs and Drug Addiction)
- Ines Gimenez
- Jamie Bridge (IDPC)
- Javier Sagredo (United Nations Development Program)
- Jean-Felix Savary (Groupement Romand d'Etudes en Addictologie)
- Juan Fernandez Ochoa (IDPC)
- Katherine Pettus (International Association for Hospice and Palliative Care)
- Luciana Pol (Centro de Estudios Legales y Sociales)
- Marcus Keane (Ana Liffey Drug Project)
- Maria Phelan (Harm Reduction International)
- Marie Nougier (IDPC)
- Martin Jelsma (Transnational Institute)
- Matt Southwell (Partner Coast peer-led technical support cooperative)
- Mike Trace (IDPC)
- Natasha Horsfield (Health Poverty Action)
- Niamh Eastwood (Release)
- Pien Metaal (Transnational Institute)
- Raquel Peyraube (International Center for Ethnobotanical Education, Research & Service)
- Rebecca Schleifer (United Nations Development Program)
- Ricardo Soberón (Centro de Investigación Drogas y Derechos Humanos)
- Ricky Gunawan (Community Legal Aid Institute, LBH Masyarakat)
- Tom Blickman (Transnational Institute)
- Willem Scholten (Independent consultant)

Table of contents

Acknowledgements	
Abbreviations	2
Foreword by Kofi Annan	3
Introduction from IDPC's Executive Director and Chair of the Board	4
Chapter 1: Policy principles	5
• Principle 1: Drug policies should be developed through an objective assessment of priorities and evidence	6
• Principle 2: Drug policies should focus on reducing the harmful consequences of illicit drug use and markets, rather than on reducing their scale	8
• Principle 3: Drug policies should be undertaken in full compliance with international human rights law	10
• Principle 4: Drug policies should promote the social inclusion of marginalised groups, and not focus on punitive measures towards them	13
• Principle 5: Drug policies should be developed and implemented based on open and constructive relationships with civil society	15
Chapter 2: Health policies and programmes	20
2.1 Scheduling and classifying substances	22
2.2 Ensuring access to controlled substances for medical and scientific purposes	30
2.3 Drug prevention	34
2.4 Harm reduction	41
2.5 Drug dependence treatment	49
Chapter 3: Criminal justice	62
3.1 Decriminalisation of people who use	64
3.2 Regulated drug markets	72
3.3 Proportionality of sentencing for drug offences	77
3.4 Alternatives to incarceration	83
3.5 Modernising drug law enforcement	90
3.6 Health-based policies in prison and closed settings	97
Chapter 4: Development, community strengthening and social inclusion	118
4.1 A development-oriented approach to drug control	120
4.2 Promoting sustainable livelihoods	127
4.3 Rights of indigenous groups	134
Glossary	144

Abbreviations

ACMD	Advisory Council for the Misuse of Drugs (UK)
ATS	Amphetamine-Type Stimulant
BUZA	Dutch Ministry of Internal Affairs
CAHR	Community Action on Harm Reduction
CAM	Co-ordination Centre for the Assessment and Monitoring New Drugs (Netherlands)
CCDU	Compulsory centre for drug users
CND	Commission on Narcotic Drugs
COIP	Comprehensive Organic Criminal Code (Ecuador)
DMT	<i>N,N</i> -Dimethyltryptamine
EC	European Commission
ECDD	Expert Committee on Drug Dependence of the World Health Organisation
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENACO	National Coca Enterprise (Peru)
EU	European Union
HIV	Human Immunodeficiency Virus
IDPC	International Drug Policy Consortium
INCB	International Narcotics Control Board
INEGI	National Institute for Statistics and Geography (Mexico)
INPUD	International Network of People who Use Drugs
LEAD	Law Enforcement Assisted Diversion (USA)
LSD	Lysergic acid diethylamide
MDMA	3,4-methylenedioxy-methamphetamine
NGO	Non-Governmental Organisation
NPS	New Psychoactive Substance
NSP	Needle and Syringe Programme
NYNGOC	New York NGO Committee on Drugs
OHCHR	Office of the United Nations High Commissioner for Human Rights
ONDCP	Office of National Drug Control Policy (USA)
OST	Opioid Substitution Therapy
SDGs	Sustainable Development Goals
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
UPP	Police Pacification Unit (Brazil)
USA	United States of America
USAID	United States Agency for International Development
VNGOC	Vienna NGO Committee on Drugs
WHA	World Health Assembly
WHO	World Health Organisation

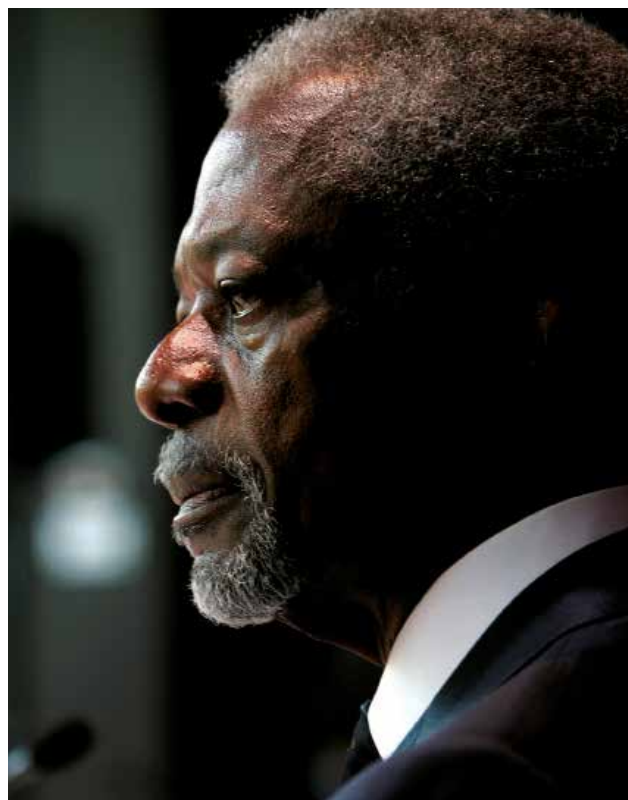
Foreword

I believe that drugs have destroyed many lives, but bad government policies have destroyed many more. A criminal record for a young person for a minor drug offence can be a far greater threat to their wellbeing than occasional drug use. What the United Nations Office on Drugs and Crime has called 'unintended consequences' of our policies over the last 50 years include mass incarceration and the creation of a huge, international criminal black market that fuels violence, corruption and instability. Sadly, drug policy has never been an area where evidence and effectiveness have driven decisions. All too often it appears to be ideological arguments which prevail. However, the original intent of drug policy, according to the UN Convention on Narcotic Drugs, was to protect the 'health and welfare of mankind'. We need to refocus policy on this objective.

In 2011, the Global Commission on Drug Policy set out to break the taboo on debate of drug policy reform in mainstream politics. We concluded that the global 'war on drugs' has not succeeded. We need to accept that a drug-free world is an illusion and focus instead on ensuring they cause the least possible harm to the least possible number of people. This means making sure that fewer people die from drug overdoses, not that more small time offenders end up in jail where their drug problems become worse. The use of drugs is harmful and reducing those harms is a task for the public health system, not the courts.

We have argued that it is scientific evidence and a deep concern for health and human rights which must shape drug policy. It is time for a smarter, health-based approach to drug policy. This means ending the criminalisation and demonisation of people who use drugs and non-violent, low-level drug offenders. These people should be offered support, not punishment. We need a balanced system which emphasises public health, human rights and development as well as law enforcement.

At this moment in time, we are at a crossroads in how the world responds to the issues of drugs. The UN General Assembly Special Session on drugs in April 2016 is an important milestone on the journey towards a more humane and more effective approach. I congratulate the International Drug Policy Consortium on its tireless work to guide this journey, providing a collective voice and visibility for its civil society members and a wide range of partners – including the Kofi Annan Foundation in its work on drug policies in West Africa. The role of



Credit: Eric Lefevre

civil society in questioning, evaluating and influencing drug policies has grown immeasurably in recent years. Indeed, the Consortium is celebrating its 10th anniversary this year, and has become an established and valuable source of analysis and expertise on drug policies, and an asset for many government officials and policy makers around the world.

I therefore welcome the third edition of the International Drug Policy Consortium's Drug Policy Guide. This edition of the Drug Policy Guide is the culmination of a decade of analysis and experience in the field – a most comprehensive repository of best practice on drug policies which reflect the three pillars of the United Nations: peace and security; development; and rule of law and respect for human rights. The Drug Policy Guide represents the collective work of authors from around the world who bring together a wealth of evidence and experience into a concise and readable format for policy makers. This guide will be a valuable help as they approach the task of reviewing and modernising their drug policies and programmes.

Kofi Annan

Chairman and founder of the Kofi Annan Foundation

Introduction from IDPC's Executive Director and Chair of the Board

It brings us great pleasure to present the third edition of the IDPC Drug Policy Guide as the IDPC network celebrates its 10th anniversary. This edition is more comprehensive and forward looking than ever before, and embodies the breadth and diversity of the consortium, which has grown both geographically and in thematic diversity since IDPC's inception ten years ago.

This Guide brings together global evidence, best practice and experiences to provide expert analysis across the spectrum of drug policy. This analysis has been made possible through the contributions from many IDPC members – including networks of key affected populations – and is the only document of its kind to provide such a broad and comprehensive investigation of what works and what doesn't in drug control policies.

The need for constructive policy analysis and guidance that builds on evidence and experience is greater now than ever in a rapidly changing and reforming drug policy environment. It is an exciting time as the calls for the reorientation of drug policies to ensure alignment with human rights, public health, development and human security are stronger now than they have ever been, and progressive reforms have been implemented, or are being considered, in a number of countries around the world.

Yet, in too many cases, drug policies remain driven by ideology rather than science and evidence. Governments have tended to give too great an emphasis on reducing the illicit drug market through largely punitive and repressive measures, despite the lack of progress that has been achieved through this approach. The inconvenient truth is that drugs are more widely used, and are more easily available, as affordable and as potent now as they have ever been – it has proven impossible to significantly and sustainably impede illicit drug markets despite the billions of dollars invested towards this end. Furthermore, the serious collateral damage caused in pursuit of eradicating the global drug trade can no longer be justified. This collateral damage includes, but is not limited to, HIV and hepatitis epidemics among people who inject drugs; the mass incarceration of millions of people for minor, non-violent drug offences; the erosion of basic livelihoods of subsistence farmers growing crops destined for the illicit market; and in some parts of the world widespread violence and insecurity fuelled by a “mano dura” government response to drug cartels.

Governments have a responsibility to develop policies and programmes that represent the most effective use of public funds to protect the health and welfare of their citizens, and to ensure that policy responses

do not exacerbate social and economic vulnerability or result in violations of human rights. It is therefore time to modernise our responses to the contemporary and rapidly diversifying global drug market.

The evidence shows that drug-related harms can be effectively managed through more balanced and humane policies that prioritise public health and human rights. This requires revisiting national drug control laws and policies – a process which this Guide is intended to support – as well as shifting narratives around drugs, and making the international drug control system fit for purpose.

In each section, we provide recommendations and further reading intended to help a wide audience of policy makers and civil society partners to promote effective, balanced and humane drug policies at the national, regional and international levels.

Each chapter of the Guide introduces a specific policy challenge or principle, and presents advice and recommendations:

- Chapter 1 describes the five core policy principles to which all IDPC members agree as the basis for our collective advocacy work
- Chapter 2 outlines the key issues related to public health – from scheduling and access to essential medicines, to drug prevention, harm reduction and treatment services.
- Chapter 3 offers guidance on the criminal justice system – including alternatives to incarceration, proportionate sentencing, regulated markets and decriminalisation, as well as policies in prisons.
- Chapter 4 finally turns to development, alternative livelihoods and the rights of indigenous groups.

Through its global network of members and experts, IDPC can also provide policy makers with specialist advice and support for local contexts – including written materials, presentations, dialogues with policy makers, study tours, and capacity building. For more information, please contact us at contact@idpc.net. We look forward to your feedback about the Guide, and are committed to continuing to update, refine and improve this document.



Ann Fordham



Mike Trace



Chapter 1:

Policy principles

IDPC promotes five core policy principles for the design and implementation of national and international drug policy, which will be analysed in detail in this first chapter. All guidance and recommendations proposed in the IDPC Drug Policy Guide were developed on the basis of these principles:

- **Policy principle 1:** Drug policies should be developed through an objective assessment of priorities and evidence
- **Policy principle 2:** Drug policies should focus on reducing the harmful consequences of illicit drug use and markets, rather than on reducing their scale
- **Policy principle 3:** Drug policies should be undertaken in full compliance with international human rights law
- **Policy principle 4:** Drug policies should promote the social inclusion of marginalised groups, and not focus on punitive measures towards them
- **Policy principle 5:** Drug policies should be developed and implemented based on open and constructive relationships with civil society.

Policy principle 1:

Drug policies should be developed through an objective assessment of priorities and evidence

The complexity of factors that affect the levels and patterns of drug production, supply and use in any particular territory means that governments need to take a comprehensive approach to developing effective and balanced drug policy responses. The process for policy making at the national level should include the following components:

Researching the problem

There is a severe lack of data around levels and patterns of drug production, trafficking and use across the world. In order to develop an informed drug policy, it is necessary to collect as much data as possible on the illicit drug market through wide consultation. This should include government officials, but also experts, academia, NGOs and those people most directly affected by drug policy (such as people who use drugs and subsistence farmers).

Identification of high-level objectives

The pursuit of a drug-free world or nation is unrealistic and counter-productive: no country has even come close to achieving this objective. However, a policy focus on eradication and elimination of illicit drug markets leads to widespread negative consequences, collateral damage, human rights violations and public health harms. Given that drug markets are not inherently dangerous or harmful, the objectives of drug policies should flow from an assessment of which consequences of drug markets and use are most harmful to society in a specific context. An assessment of the main drug-related harms, and therefore the selection of priorities for action, should be done with the participation of civil society and affected communities, in particular representatives of people who use drugs and subsistence farmers.

Selection of the activities that the government will pursue and support to meet these objectives

There is growing evidence to guide policy makers in developing policies and programmes that are most effective in achieving the outcome objectives described above. For example, the availability of

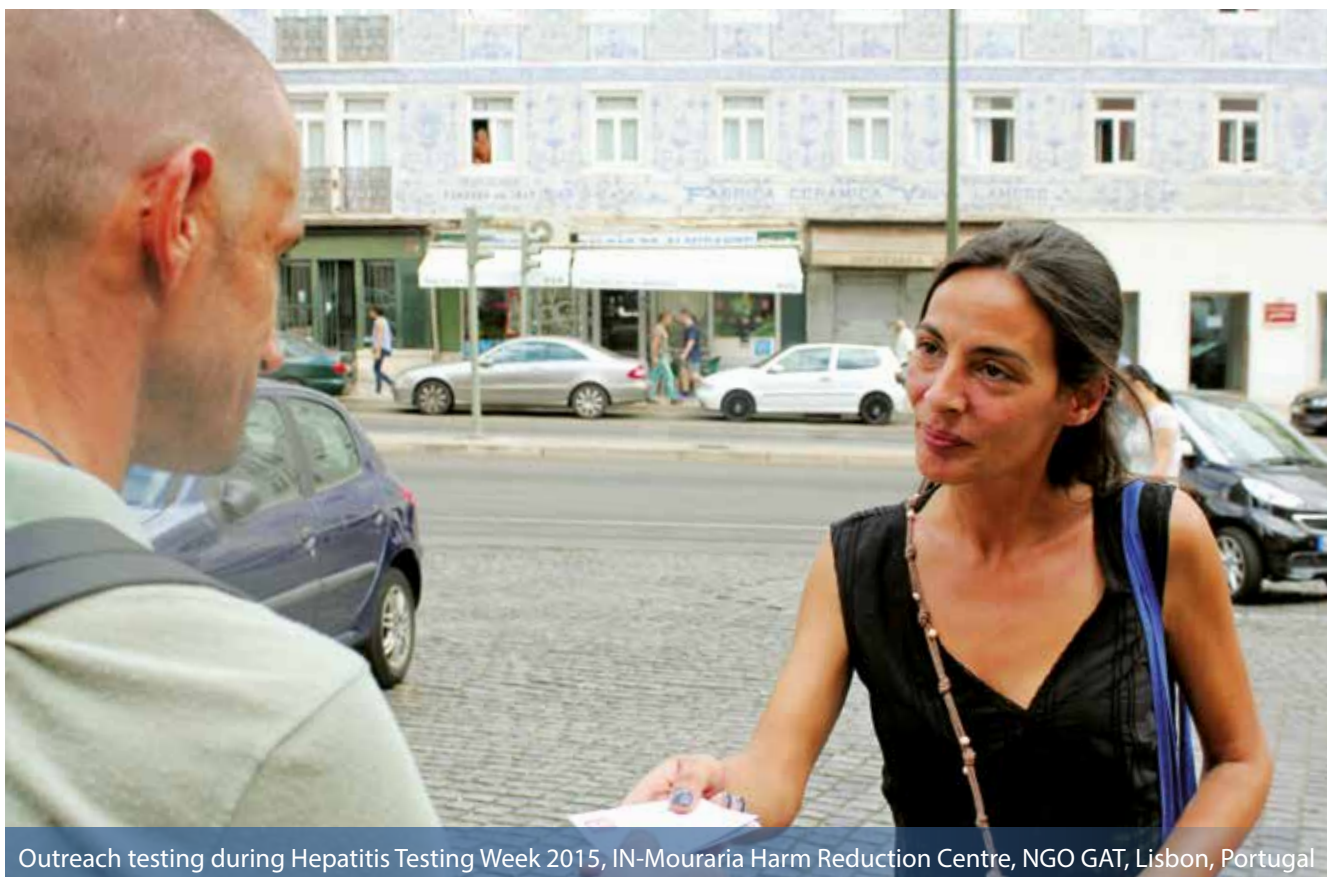
a range of evidence-based drug treatment programmes can reduce dependence and property crime (see Chapter 2.5),¹ while needle and syringe programmes have reduced HIV and hepatitis C infections (see Chapter 2.4).² Although the range and extent of activities will inevitably be constrained by available resources, the provision of effective measures will lead to greater savings by reducing the financial costs associated with health and social problems and crime – and will achieve better health and social outcomes.³

Clarification of the role of departments or agencies responsible for these activities, and coordination mechanisms between them

A society's drug problems cannot be solved by one government department or agency alone. A comprehensive and integrated strategy requires cooperation and coordination between many government bodies, including the departments of health, social affairs, justice, education and foreign affairs. Successful programme delivery should take place in partnership with local authorities, community and faith groups, civil society organisations, and affected communities such as people who use drugs and subsistence farmers.

Allocation of resources to support these activities

National drug strategies differ significantly in terms of the resources allocated to drug control and its different components. Furthermore, expenditures on areas such as general healthcare, education, criminal justice and law enforcement may be hard to ascertain, and their impact on achieving drug strategy objectives may not be explicitly evaluated. Policy makers need to take account of the 'proactive' amount spent on funding drug policy measures (i.e. law enforcement activities, prevention programmes, harm reduction and drug dependence treatment services), and the consequent savings that could be made on 'reactive' expenditure (i.e. in responding to drug-related crime, loss of economic activity, treatment for HIV and other blood-borne diseases, etc.). In most settings, the largest share



Outreach testing during Hepatitis Testing Week 2015, IN-Mouraria Harm Reduction Centre, NGO GAT, Lisbon, Portugal

of available funds is provided to law enforcement agencies – with tens of billions of dollars estimated to be spent globally on enforcement-led policies each year.⁴ Other sectors, such as public health, often receive far less attention – leading to a global funding crisis for evidence-based harm reduction services.⁵ Yet shifting just a fraction of the drug law enforcement expenditure towards public health would have huge impact on drug-related harm.⁶

Articulation of the scope and timescale of the strategy

Learning from drug policy successes and failures requires that strong mechanisms be established to assess the impact of drug strategies. This involves setting goals and timescales, and committing to carrying out objective and structured reviews on a regular basis (e.g. every five years). Although some countries have created comprehensive national drug strategies that include clear objectives, very few have reviewed their strategy in a systematic, objective and transparent manner. The absence of scientific evaluations can lead to the continuation of ineffective policy measures, and missed oppor-

tunities to introduce more effective approaches. Since no country has managed to fully resolve the problems associated with illicit drug markets and use, policy makers should continuously search for better policy responses, by referring to evidence and experience instead of being influenced by ideology, political interests or a reluctance to change.

Identification of adequate indicators to evaluate progress

The evaluation of drug policy achievements has tended to focus on indicators of process in implementing drug law enforcement strategies – that is, the number of arrests, seizures or punishments. These have not proven to be a good guide to the achievement of real reductions in drug-related health or social problems. Even the rise or fall in overall drug use does not in itself indicate whether health and social outcomes are being achieved. Depending on local contexts, these priority outcomes for a national drug strategy should be framed in terms of minimising health and social problems, and maximising social and economic development (see Policy principle 2 below for more details).

Policy principle 2:

Drug policies should focus on reducing the harmful consequences of illicit drug use and markets, rather than on reducing their scale

Governments have focused much of their drug control efforts on reducing the scale of drug markets through punitive means, believing that this would eventually reduce drug-related harms.⁷ At the time of the drafting of the UN drug conventions, these health and social objectives were assumed to be best achieved through stopping the illicit supply of drugs, and incarcerating people who use, produce or supply drugs. These attempts have been unsuccessful: despite all the political and financial investment in repressive policies over the last 50 years, internationally controlled substances are more available and more widely used than ever before.⁸ Theoretically, reductions in the scale of drug markets could lead to a reduction in harms, but in practice the opposite has generally occurred. For example, successful operations against a dealing network can increase violence as competing gangs fight over the vacant 'turf';⁹ and an action against a particular substance can lead people to switch to substances that may be more harmful.¹⁰

Government data also show that there is very little correlation between the numbers of arrests, seizures or crops eradicated, and the price and purity of drugs on the street.¹¹ The correlation is even more absent for outcomes that matter to people and communities – such as better public health, increased security, and community well-being. Simply

pursuing the long-term objective of a 'drug-free society' is not a sustainable policy and has led to the misdirection of attention and resources towards ineffective programmes, while the health and social programmes that have been proven to reduce drug-related harms are starved of resources and political support.

In consumer markets, the mass arrest of people who use drugs does not decrease drug use, but does cause or exacerbate health and social problems. Criteria such as the number of arrests, or of clampdowns on particular drugs or dealing networks, are therefore of little relevance to the achievement of the desired outcomes. Policies should aim instead to reduce drug-related crime, improve community safety, and reduce drug-related health problems such as overdoses, HIV and hepatitis C infections.

Similarly, crop eradication campaigns in producing countries do not stop the flow of drugs into consumer markets, but do lead to significant social, economic, health and environmental problems in the communities where crops destined for the illicit drug market are cultivated. The process measures applied in the field of supply reduction – the size of areas of crops eradicated, and levels of drug production – are also poor indicators of achievement. As these eradication programmes have ebbed and flowed in their local



Credit: Adam Schaffer, WOLA

Field of coca crops fumigated in Guaviare, Colombia

Box 1 What success looks like: Outcome indicators for national drug strategies

When understanding the effectiveness of different drug strategies and programmes, it is important to be clear from the outset on the objectives that the policy is designed to achieve. Drug policy is best viewed as a contributor to wider social goals under the headings of health, development and security. Governments are encouraged to articulate a set of objectives and outcome indicators that are appropriate to their particular circumstances, but a general guide to possible domains would include:

- **Health** – A reduction in the number of deaths from overdose; a reduction in drug-related HIV or hepatitis infections; a reduction in the number of citizens experiencing drug dependence; and better management of pain relief and palliative care through improved access to essential medicines.
- **Human rights** – The elimination of the imposition of the death penalty for drug offences; the closure of compulsory centres for people who use drugs; improved access to justice for victims of human rights abuses linked to drug law enforcement operations; improved access to gender- and youth-sensitive health and social services.

- **Development** – Strengthened governance and legitimate authorities; the development of licit economies; relief of poverty in areas of concentrated drug production, trafficking or retail sale – via rural and urban development strategies that encompass access to education, employment, land, social support, improved infrastructure and better access to licit markets, etc.
- **Security** – A reduction in drug market-related violence; a reduction in the power and reach of organised crime; a reduction in corruption and money laundering; a reduction in internal displacements related to supply reduction measures; a reduction in the numbers and proportion of people imprisoned for minor, non-violent drug offences; a reduction in property and violent crimes associated with drug dependence – with a focus of law enforcement efforts on the most harmful aspects of the illicit drug market, rather than on low-level and non-violent dealers, people who use drugs and vulnerable farming communities.

Any drug control strategy or programme should be explicitly evaluated on the extent to which they achieve (or contribute to) these outcomes.

impact, the overall market for the drugs produced remains largely unaffected, as the areas and methods of production improve and move around in response to law enforcement action.

People involved in the lowest levels of the trafficking chain have also borne the greatest costs of prohibitionist policies. These policies have led to mass incarceration and have exacerbated poverty and social exclusion – disproportionately affecting women involved in the illicit market as drug mules,¹² as well as for youth and ethnic minorities (see Chapter 3.4 for more details).¹³

In this context, policies should aim to reduce violence by targeting the most violent and damaging aspects of illicit drug markets instead of focusing on those at the lowest levels of the drug chain. Drug policies should also seek to improve the social and economic development of vulnerable and marginalised communities.

The concept of harm reduction – best defined as a set of policies, programmes and practices that aim

primarily to reduce the harms of drug use without necessarily reducing drug consumption itself¹⁴ – has been shown to be effective in improving health and social outcomes for people who use drugs, and should be applied to all aspects of drug policy. Policy makers should be explicit in articulating the specific harms that they are aiming to reduce; should design and provide resources for policies and programmes that have a reasonable evidence base for reducing these harms; and should evaluate them to ensure that they deliver the desired outcomes.¹⁵

This requires moving away from law enforcement process measures (such as arrests and seizures) to indicators of actual harm – such as levels of violent crime and corruption associated with drug trafficking, social and economic development indicators for communities in drug cultivation areas, and improvements in health and social-economic welfare.

Policy principle 3:

Drug policies should be undertaken in full compliance with international human rights law

Drug control bodies and governments are bound by the overarching obligations created under articles 55 and 56 of the 1945 UN Charter, which promote universal respect for, and observance of, human rights and fundamental freedoms.¹⁶ Human rights stem from the dignity and worth of the individual.¹⁷ They are universal, interdependent, interrelated, indivisible and inalienable,¹⁸ which means that they cannot be taken away from a person because they might be growing, transporting, dealing or using internationally controlled drugs, or living with HIV. As the UN High Commissioner for Human Rights, Navanethem Pillay proclaimed in 2009: ‘individuals who use drugs do not forfeit their human rights.’¹⁹

Human rights are not only a statement of principle – states also have binding obligations under international law to respect, protect and fulfil them.²⁰ This means that governments should not violate the human rights of their citizens (including people who are using and/or growing drugs) nor allow others to do so. They should also adopt appropriate legislative, constitutional, budgetary and other measures to fully protect and realise the human rights of all their citizens.

And yet, governments and law enforcement authorities have paid insufficient attention to fundamental rights and freedoms in the design and implementation of national drug policies (see Table 1 below). UN human rights agencies have continuously raised concerns on the human rights abuses that continue to proliferate under the auspices of drug policy.²¹ In 2015, the Office of the High Commissioner for Human Rights published a report which offers a solid analysis of the negative effects of drug control on the fulfilment of human rights.²² Moreover, the Human Rights Council hosted a panel discussion on the human rights impact of the world drug problem at its 30th Regular Session, to highlight key areas of concern and opportunities for reform.²³ Both are significant steps towards addressing the human rights violations that are taking place in the name of drug policy.

There is little doubt that human rights are now recognised as an issue that can no longer be ignored in any consideration of drug control policies. A paradigm shift is needed, whereby human rights law is recognised as a core element of the legal framework for drug policy.²⁴



Credit: Sven Torfinn/Panos, Open Society Foundations

A palliative care nurse and paralegal from Nyeri Hospice provide legal services and pain medicines to a cancer patient in Nyeri, Kenya

Table 1. Violations of human rights in the name of drug control

Human right	International human rights convention	Violations in the name of drug control
Right to life	<ul style="list-style-type: none"> Article 4 of the Universal Declaration of Human Rights, 1948 Article 6 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> Use of the death penalty for drug offences²⁵ Extra-judicial killings by law enforcement agencies²⁶
Right to the highest attainable standard of physical and mental health	<ul style="list-style-type: none"> Constitution of the World Health Organisation, 1946 Article 25 of the Universal Declaration of Human Rights, 1948 Article 12 of the International Covenant on Economic, Social and Cultural Rights, 1966 	<ul style="list-style-type: none"> Restricted access to essential medicines, including those for pain relief²⁷ Restricted access to humane and evidence-based drug dependence treatment, including opioid substitution therapy²⁸ Restricted access to harm reduction services that would prevent overdoses and the transmission of blood-borne infections such as HIV and hepatitis C²⁹
Right not to be subjected to arbitrary arrest and detention	<ul style="list-style-type: none"> Article 9 of the Universal Declaration of Human Rights, 1948 Article 9 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> Targeting of people who use drugs by law enforcement officers to meet arrest quotas³⁰ Arbitrary detention of people who use drugs³¹ Police harassment and sexual abuse of people who use drugs³²
Right to a fair trial	<ul style="list-style-type: none"> Article 10 of the Universal Declaration of Human Rights, 1948 Article 6 of the European Convention of Human Rights, 1950 	<ul style="list-style-type: none"> Denial of parole, pardon, amnesty or alternatives to incarceration for people convicted of a drug crime³³ Use of pre-trial detention, mandatory sentencing and disproportionate penalties against people involved in minor drug offences³⁴ Referral to compulsory centres for drug users without due process or trial³⁵
Right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment	<ul style="list-style-type: none"> Article 5 of the Universal Declaration of Human Rights, 1948 Article 7 of the International Covenant on Civil and Political Rights, 1966 Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1975 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984 	<ul style="list-style-type: none"> Abuses in compulsory centres for drug users³⁶ Use of corporal punishment for drug offenders, including caning, flogging, lashing and whipping³⁷

Continued overleaf

Right not to be held in slavery	<ul style="list-style-type: none"> Article 4 of the Universal Declaration of Human Rights, 1948 Article 8 of the International Covenant on Civil and Political Rights, 1966 	<ul style="list-style-type: none"> Use of forced labour in the name of drug treatment³⁸
Social and economic rights	<ul style="list-style-type: none"> Article 22 (and next) of the Universal Declaration of Human Rights, 1948 Articles 6 and 7 (and next) of the International Covenant on Economic, Social and Cultural Rights, 1966 Convention concerning Indigenous and Tribal Peoples in Independent Countries, 1989 	<ul style="list-style-type: none"> Implementation of forced crop eradication campaigns, leaving many farmers with no means of subsistence³⁹ Destruction of land, food crops and water supplies due to aerial spraying⁴⁰ Denial of the right of indigenous groups to use controlled substances for traditional and religious purposes⁴¹
Right to be free from discrimination	<ul style="list-style-type: none"> Article 7 of the Universal Declaration of Human Rights, 1948 Article 26 of the International Covenant on Civil and Political Rights, 1966 International Convention on the Elimination of All Forms of Racial Discrimination, 1965 Convention on the Elimination of All Forms of Discrimination Against Women, 1979 	<ul style="list-style-type: none"> Discriminatory application of drug control laws, notably towards minority ethnic groups,⁴² indigenous people, young people and women⁴³
Right to privacy⁴⁴	<ul style="list-style-type: none"> Article 12 of the Universal Declaration on Human Rights, 1948 	<ul style="list-style-type: none"> Practice of stopping and inspecting people, including school children, suspected of carrying drugs⁴⁵ Forced urine testing⁴⁶ Practice of including people who use drugs in official government registries⁴⁷ Sharing of confidential medical information of a person caught for drug use or undergoing drug dependence treatment with the police⁴⁸
Right to be protected from illicit drug use	<ul style="list-style-type: none"> Article 33 of the UN Convention on the Rights of the Child, 1989 	<ul style="list-style-type: none"> Denial of harm reduction services targeted at young people⁴⁹ Use of ineffective and stigmatising drug prevention measures⁵⁰

Policy principle 4:

Drug policies should promote the social inclusion of marginalised groups, and not focus on punitive measures towards them

The prevalence of drug use among different social groups varies from country to country. Nonetheless, a trend seems to persist in all societies – drug-related harms remain strongly concentrated among the most marginalised groups. This is unsurprising, as evidence shows that harsh living conditions and the associated trauma are major factors contributing to drug dependence.⁵¹ Similarly, the cultivation of crops destined for the illicit drug market is concentrated in the poorest areas of the world,⁵² while people engaging in micro-trafficking are also generally from poor and socially marginalised backgrounds.⁵³ Large-scale drug trafficking operations are also more likely to target underdeveloped nations and regions with weaker governance and capacity.⁵⁴

While governments and the international community may be focused on improving the living conditions of marginalised groups and integrating them more strongly into the social and economic mainstream, many aspects of national drug control policies have the opposite effect:

- The widespread stigmatisation of drug use (and, by extension, people who use drugs) marginalises individuals and entire communities
- The widespread criminalisation of drug use means that people (especially young people) caught using, or in possession of, drugs are often left with criminal records which can lead to their exclusion from education or employment – increasing their vulnerability to health, social and economic problems
- Programmes that focus on arrests and harsh criminal sanctions for people who use drugs and subsistence farmers have little deterrent effect, and only serve to increase exposure to health risks, criminality and violence
- Drug law enforcement activities and abuses can deter people who use drugs from accessing the health and social programmes that have been designed to help them
- Forced crop eradication programmes undermine

the basic livelihoods of subsistence farmers who grow crops destined for the illicit market, and drives them deeper into poverty

- Harsh criminal sanctions imposed on drug mules and micro-traffickers – in particular women – have exacerbated their poverty and vulnerability, hindering their access to licit employment and social services.

Social marginalisation can be minimised by reducing the reliance on widespread arrest and harsh punishments for people involved in low-level drug offences, and adopting policies and programmes that challenge the marginalisation and stigmatisation of vulnerable groups. In order to address these issues, many countries are now leaning towards less punitive drug policies such as: **decriminalisation** (the offence is no longer punished by a criminal sanction); **depenalisation** (criminal penalties for drug offences are reduced); **alternatives to incarceration**; and reviews of laws and sentencing guidelines to ensure **more proportionate penalties**. Others are considering **regulated markets** for some substances. More information on these policy options can be found in Chapter 3. The objective is to reduce the securitisation of drug control to move towards policies based on health, human rights and development (see Chapters 2 and 4 for more details). For example:

- Drug laws and enforcement strategies should avoid measures that worsen the social marginalisation of people engaged at the lower levels of the drug trade – including people who use drugs, subsistence farmers involved in the production of crops destined for the illicit drug market, and micro-traffickers
- Drug dependence treatment programmes should be evidence-based and focused on facilitating an individual's self-determined goals for recovery, and on supporting their social inclusion within their communities
- Harm reduction programmes should be adopted, supported, adequately funded and scaled-up –

and should be enshrined in an enabling policy environment

- Law enforcement measures against low-level offenders should rely on alternatives to incarceration and the provision of services to address the root causes of involvement in the drug trade. This is particularly important for offenders with children and other dependents
- Drug strategies in drug cultivation areas should focus on properly sequenced rural development approaches

- Representatives of the groups most affected by drug policies have a right to be involved in the design and implementation of drug policies and programmes that concern them. This is to ensure that these policies are informed, effective and do not lead to unintended negative consequences (see Chapter 1.5).⁵⁵

Credit: UNODC



Alternative livelihoods in Lao People's Democratic Republic

Policy principle 5:

Drug policies should be developed and implemented based on open and constructive relationships with civil society

For the purposes of this Guide, the term ‘civil society’ encompasses the people and communities most affected by drug policy (such as people who use drugs, people living with HIV, growers of crops destined for the illicit drug market, indigenous people, young people and women), harm reduction service providers, NGOs, faith-based organisations, academics working on drug policy, etc.

Across most areas of social policy, it is widely recognised that the participation of affected people and communities is critical for an effective and sustainable response. In the HIV sector, for example, the need to meaningfully engage people living with the virus was acknowledged at an early stage as a core component of any efforts to tackle the epidemic. In these arenas, affected populations – and civil society more broadly – perform essential functions in the conceptualisation, researching, design, implementation and evaluation of policies and programmes at all levels, as well as in ensuring the transparency, good governance and accountability of governmental and intergovernmental agencies.

In the field of drug policy, civil society organisations play an increasingly important role in analysing drug-related issues and in delivering and evaluating programmes and services. Because of their knowledge and understanding of drug markets and drug-using communities, as well as their ability to reach out to the most marginalised groups of society, civil society constitutes an invaluable source of information and expertise for policy makers. This is particularly true for organisations representing people who use drugs and subsistence farmers involved in illicit crop production. However, political sensitivities around drugs have often led policy makers to disregard or avoid the (sometimes very challenging) perspectives of civil society, or to view civil society participation as a problem itself.⁵⁶

Increasingly, the UN drug control system has started to recognise the added value that civil society organisations have brought to the drug policy debate. For example, in 2008, a structured mechanism was

created for civil society engagement in the review of drug policies 10 years after the UN General Assembly Special Session (UNGASS) on drugs in 1998 (which was held under the banner: ‘A drug-free world – we can do it!’). The ‘Beyond 2008’ initiative – an initiative of the Vienna NGO Committee on Drugs (VNGOC) in association with the New York NGO Committee on Drugs (NYNGOC) – saw civil society representatives from around the world come together to discuss the issues and agree on a declaration.⁵⁷

A similar initiative was coordinated in the lead up to the 2016 UNGASS on drugs, with the creation of a Civil Society Task Force, which includes civil society representatives from every region of the world, as well as representatives of the key affected populations.⁵⁸ Meanwhile, civil society participation has significantly improved over time at the annual sessions of the UN Commission on Narcotic Drugs (CND) in Vienna – with NGOs being invited onto some government delegations, greater coor-

Box 1 Extract from INPUD Consensus statement on drug use under prohibition⁵⁹

Right 10: People who use drugs have the right to assemble, associate, and form organisations

- Demand 20: People who use drugs must be respected as experts on their own lives and lived experiences.
- Demand 21: Participation of people who use drugs in debate and policy formulation must be meaningful, not tokenistic.
- Demand 22: The wellbeing and health of people who use drugs and their communities must be considered first and foremost in the formulation of laws and policies related to drug use.

dination amongst civil society, and increasing opportunities to present in, and access, the debates that take place.

The involvement of the International Network of People who Use Drugs (INPUD) and other regional and national networks of people who use drugs has been instrumental in promoting humane and evidence-based drug policy in these international forums, as well as at the national level.⁶⁰ Networks of people who use drugs are essential for the elaboration of effective and humane harm reduction and treatment policies. Meaningful participation in harm reduction, treatment and wider healthcare services is a key quality assurance measure and safeguard. Peer outreach and support has been instrumental in reaching out to marginalised communities of people who use drugs with targeted and accurate harm reduction messages and life-saving services.

Associations of illicit crop growers have also emerged, and several declarations have been drafted to map out the concerns related to drug policies in cultivation areas and to offer recommendations on alternative policies.⁶¹ Discussions between policy makers and subsistence farmers have taken place, for instance, in countries such as Bolivia and Colombia, ensuring that policies targeted at cultivation areas address the issues which local communities are facing, and do not cause additional harm (see Chapter 4.2 for more details).⁶²

The positive involvement of civil society in drug policy debates is highly beneficial for policy makers to:

- set objectives and priorities, and formulate better-informed policies based on practical advice and experience
- facilitate communication between policy makers and key civil society stakeholders, ensuring that people and communities are involved in planning interventions that will affect them
- establish mutually beneficial partnerships with civil society organisations to undertake joint programming and/or act as programme implementers to reach out to the most vulnerable and marginalised groups
- create a vibrant network of civil society organisations that can continue to support effective

Box 2 Extract from the Political declaration of the Global Forum of Producers of Crops Declared Illicit⁶³

Concerning social organization and relations with the state

- Producers' associations/organizations of plants declared to be illicit are, in some regions, strong but in others incipient, in-existent or prohibited by the State.
- In many countries, relationships with government authorities are conflictive because the authorities do not comply with signed agreements.
- Geo-political influence by world powers creates negative relationships between producers and their governments.
- Producers' organizations should be recognized, should take part in debates and decision making at all levels, with their own governments, donors and the UN.
- International organizations and governments should recognize and respect that each country has a different reality and that this should be taken into account when proposing policies.

policy and programme design, implementation, monitoring and evaluation.

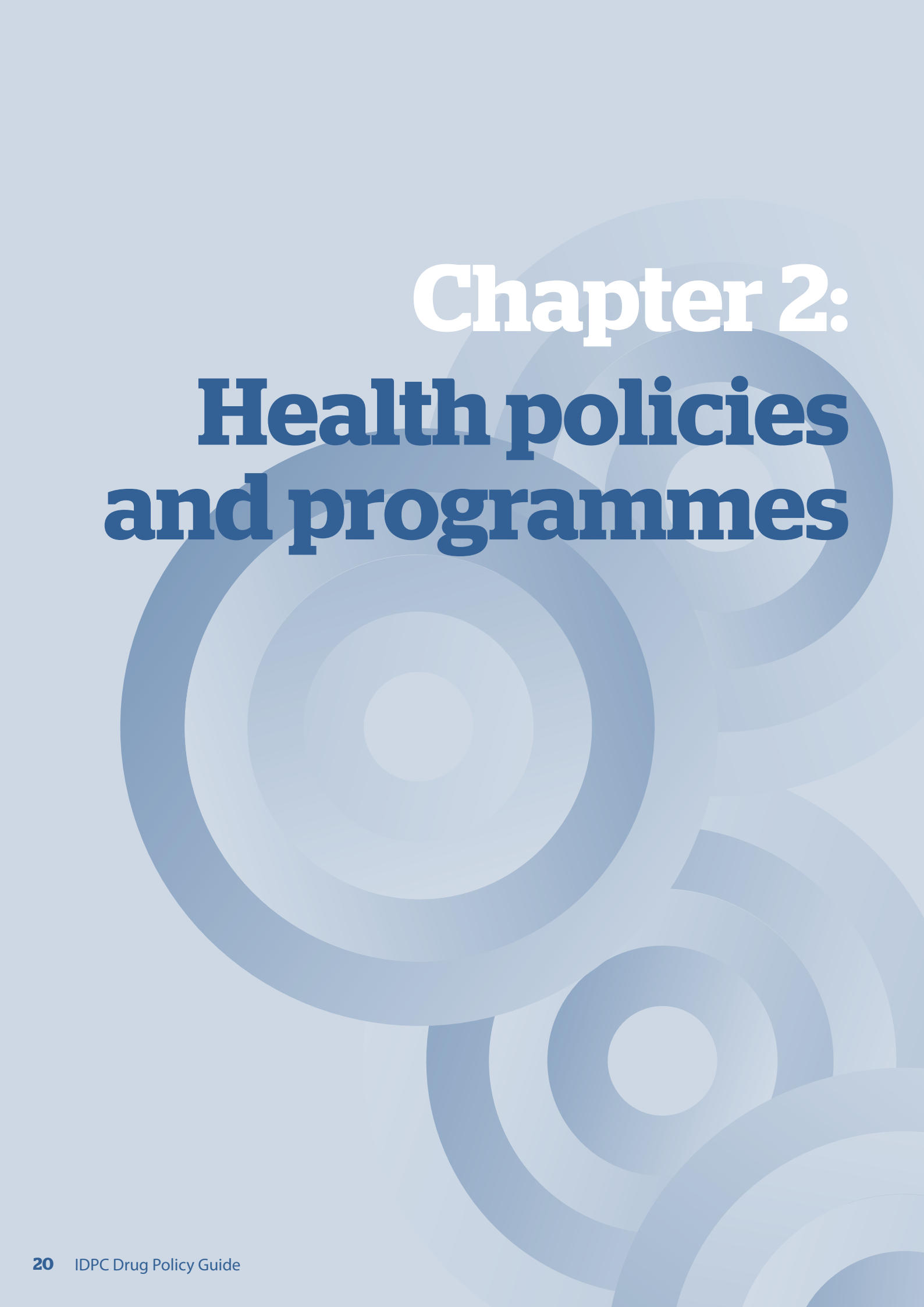
Respectful, strategic, constructive, transparent and accountable lines of communication should therefore be created between governments and civil society representatives, in order to ensure meaningful exchanges of information and perspectives. However, conditions for a truly open, respectful and meaningful dialogue with those most directly affected by drug policy will only be created if governments remove criminal sanctions for people who use drugs and subsistence farmers engaged in illicit crop production.⁶⁴

Chapter 1 - endnotes

1. Gossop, M. (2005), Drug misuse treatment and reductions in crime: findings from the National Treatment Outcome Research Study (NTSOR) (London: National Treatment Agency for Substance Misuse), <http://www.addictionservicesguide.com/articles/NTORS.PDF>; Hughes, C.E. & Stevens, A. (2010), 'What can we learn from the Portuguese decriminalization of illicit drugs?', *The British Journal of Criminology*, 50(6): 999–1022; Rajkumar, A.S. & French, M.T. (1997), 'Drug abuse, crime costs and the economic benefits of treatment', *Journal of Quantitative Criminology*, 13(3): 291–323, <http://www.springerlink.com/content/bg6247650485q36v/>
2. Global Commission on Drug Policy (June 2012), The war on drugs and HIV/AIDS – How the criminalization of drug use fuels the global pandemic, http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf; Global Commission on Drug Policy (May 2013), The negative impact of the war on drugs on public health: The hidden hepatitis C epidemic, http://www.globalcommissionondrugs.org/hepatitis/gcdp_hepatitis_english.pdf
3. Harm Reduction International (2011), Harm reduction: A low cost, high-impact set of interventions, http://www.ihra.net/files/2012/10/02/HRI_HR_resourcing2.pdf
4. Count the Costs (2013), The war on drugs: Wasting billions and undermining economies, <http://www.countthecosts.org/sites/default/files/Economics-briefing.pdf>
5. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), The funding crisis for harm reduction, <http://idpc.net/publications/2014/07/the-funding-crisis-for-harm-reduction>
6. Harm Reduction International, Spending where it matters, <http://www.ihra.net/spending-where-it-matters>
7. Preambles of the 1961, 1971 and 1988 UN Drug Conventions
8. See, for example, drug use prevalence data in: United Nations Office on Drugs and Crime (2015), UNODC World Drug Report 2015, <http://www.unodc.org/wdr2015/>
9. Felbab-Brown, V. (February 2013), Focused deterrence, selective targeting, drug trafficking and organised crime: Concepts and practicalities (London: International Drug Policy Consortium), https://dl.dropboxusercontent.com/u/64663568/library/MDLE-report-2_Focused-deterrence.pdf
10. European Monitoring Centre for Drugs and Drug Addiction (June 2015), New psychoactive substances in Europe: Innovative legal responses, <http://www.emcdda.europa.eu/publications/2015/innovative-laws>; Wodak, A. (August 2014), 'New psychoactive substances: reducing the harm caused by untested drugs and an unregulated market', *The Medical Journal of Australia*, 201(6): 310–311, <https://www.mja.com.au/journal/2014/201/6/new-psychoactive-substances-reducing-harm-caused-untested-drugs-and-unregulated>
11. Werb, D. et al (2013), 'The temporal relationship between drug supply indicators: An audit of international government surveillance systems', *British Medical Journal*, 3: e003077, <http://bmjopen.bmj.com/content/3/9/e003077.full>
12. Today, women constitute the fastest growing population worldwide, and this is mainly driven by drug control policies. See: Penal Reform International (2015), Global Prison Trends 2015 – Special focus: Drugs and imprisonment, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
13. In several countries, including the USA and the UK, ethnic minorities are being incarcerated for drug offences at a much higher rate than their white counterparts. See: Eastwood, N., Shiner, M. & Bear, M. (2014), The numbers in black and white: Ethnic disparities in the policing and prosecution of drug offences in England and Wales (London: Release), <http://www.release.org.uk/node/286/>; American Civil Liberties Union (June 2013), The war on marijuana in black and white: Billions of dollars wasted on racially biased arrests, <https://www.aclu.org/report/war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white-report>
14. Harm Reduction International (2010), What is harm reduction? A position statement from the International Harm Reduction Association, http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf
15. For a broader discussion on applying harm reduction to the supply side, see: Transnational Institute & Washington Office on Latin America (2011), Expert workshop on supply-oriented harm reduction, May 10, 2011, http://www.wola.org/commentary/wolatni_expert_workshop_on_supply_oriented_harm_reduction
16. According to article 103 of the UN Charter, the obligations contained in the Charter prevail upon every international agreement, including the three drug conventions
17. 1948 Universal Declaration of Human Rights
18. World Conference on Human Rights (12 July 1993), Vienna Declaration and Programme of Action (A/CONF.157/23), para. 1
19. United Nations Press Release (10 March 2009), 'High Commissioner calls for focus on human rights and harm reduction in international drug policy', http://www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf
20. Office of the High Commissioner for Human Rights website, International human rights law, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx>
21. See, for instance: Nowak, M. (February 2010), Report of the Special Rapporteur on torture and cruel, inhuman or degrading treatment or punishment, A/HRC/13/39/Add.5 (United Nations General Assembly), http://www2.ohchr.org/english/bodies/hrcouncil/docs/13session/A.HRC.13.39.Add.5_en.pdf; Grover, A. (August 2010), Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/65/255 (United Nations General Assembly), http://ap.ohchr.org/documents/alldocs.aspx?doc_id=17520
22. Office United Nations High Commissioner for Human Rights (September 2015), Study on the impact of the world drug problem on the enjoyment of human rights, A/HRC/30/65, <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx>
23. Office of the High Commissioner for Human Rights (28 September 2015), Human Rights Council holds panel discussion on the impacts of the world drug problem on the enjoyment of human rights, <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16515&LangID=E>; Fordham, A. (5 October 2015), 'Parallel universes collide: Drug control and human rights at the UN', *Huff Post Blog*, http://www.huffingtonpost.co.uk/ann-fordham/drug-control-human-rights_b_8237456.html
24. Barrett, D. & Nowak, M. (2009), 'The United Nations and drug policy: Towards a human rights-based approach'. In Constantinides, A. & Zaikos N., eds., *The diversity of international law: Essays in honour of Professor Kalliopi K. Koufa* (Leiden: Brill/Martinus Nijhoff), pp. 449–477, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1461445
25. At least 33 countries and territories retain the death penalty for drug offences within their legislation. See: Harm Reduction International (October 2015), The death penalty for drug offences: Global overview 2015, <http://www.ihra.net/the-death-penalty-doesnt-stop-drug-crimes>; Gallahue, P. (2015), *Drugs and the death penalty* (New York: Open Society Foundations), <https://www.opensocietyfoundations.org/reports/drugs-and-death-penalty>
26. See, for example: Centro de Estudios Legales y Sociales (2015), The impact of drug policy on human rights – The experience in the Americas, <http://www.cels.org.ar/common/drug%20policy%20impact%20in%20the%20americas.pdf>; Amnesty International (October 2012), Known abusers, but victims ignored: Torture and ill-treatment in Mexico, <http://www.amnestyusa.org/research/reports/known-abusers-but-victims-ignored-torture-and-ill-treatment-in-mexico>
27. The WHO estimates that approximately 80% of the world's population has either no or insufficient access to treatment for moderate or severe pain. See: World Health Organisation, Access to Controlled Medications Programme (2007), Improving access to medications controlled under international drug conventions, http://www.who.int/medicines/areas/quality_safety/access_to_controlled_medications_brnote_english.pdf; See also: Hallam, C. (January 2015), *The international drug control regime and access to controlled medicines* (International Drug Policy Consortium &

- Transnational Institute), <http://idpc.net/publications/2015/01/the-international-drug-control-regime-and-access-to-controlled-medicines>; Global Commission on Drug Policy (October 2015), *The negative impact of drug control on public health: The global crisis of avoidable pain*, <http://www.globalcommissionondrugs.org/reports/>.
28. Mendez, J.E. (1 February 2013), Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/22/53 (Human Rights Council), p. 13, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
 29. 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', *The Lancet*, 375(9719): 1014-1028, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60232-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60232-2/abstract)
 30. See, for example: Lai, G. (July 2013), 'Towards more proportionate sentencing laws in Thailand', IDPC Blog, <http://idpc.net/blog/2013/07/towards-more-proportionate-sentencing-laws-in-thailand>
 31. See, for example: Human Rights Watch (October 2011), Somsanga's secrets – Arbitrary detention, physical abuse and suicide inside a Lao drug detention center, <https://www.hrw.org/report/2011/10/11/somsangas-secrets/arbitrary-detention-physical-abuse-and-suicide-inside-lao-drug>
 32. Eurasian Harm Reduction Network (December 2013), Human rights of women who use drugs breached by law enforcement officials in Eurasia, <http://idpc.net/alerts/2013/12/human-rights-of-women-who-use-drugs-breached-by-law-enforcement-officials-in-eurasia>
 33. Harm Reduction International & Penal Reform International (May 2015), Submission: Impact of the world drug problem on the enjoyment of human rights, http://www.ohchr.org/Documents/HRBodies/HRCouncil/DrugProblem/PenalReformInternational_HarmReductionInternational.pdf
 34. See, for example, in Latin America: Colectivo de Estudios Drogas y Derechos (November 2015), The incarceration of women for drug offenses, http://www.drogasyderecho.org/publicaciones/pub-priv/luciana_i.pdf
 35. Center for Human Rights and Humanitarian Law, Anti-Torture Initiative (2013), Torture in healthcare settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report, <https://www.opensocietyfoundations.org/voices/extreme-abuse-name-drug-treatment>; Kamarulzaman, A. & McBrayer, J.L. (2015), 'Compulsory drug detention centers in East and Southeast Asia', *International Journal of Drug Policy*, 26(1): S33-S37, [http://www.ijdp.org/article/S0955-3959\(14\)00335-1/abstract](http://www.ijdp.org/article/S0955-3959(14)00335-1/abstract); Human Rights Watch (July 2012), Torture in the name of treatment: Human rights abuses in Vietnam, China, Cambodia and Lao PDR, <https://www.hrw.org/report/2012/07/24/torture-name-treatment/human-rights-abuses-vietnam-china-cambodia-and-lao-pdr>
 36. Ibid
 37. Harm Reduction International (2011), Inflicting harm: Judicial corporal punishment for drug and alcohol offences in selected countries, <http://www.ihra.net/contents/1211>
 38. Human Rights Watch (January 2010), 'Where darkness knows no limits' – incarceration, ill-treatment, and forced labor as drug rehabilitation in China, <https://www.hrw.org/report/2010/01/07/where-darkness-knows-no-limits/incarceration-ill-treatment-and-forced-labor-drug>
 39. Mansfield, D. (2011), Assessing supply-side policy and practice: Eradication and alternative development (Geneva: Global Commission on Drug Policy), http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Com_David_Mansfield.pdf
 40. See, for example: Isacson, A. (29 April 2015), Even if glyphosate were safe, fumigation in Colombia would be a bad policy. Here's why, (Washington Office on Latin America), <http://www.wola.org/commentary/even-if-glyphosate-were-safe-fumigation-in-colombia-would-be-a-bad-policy-heres-why>; see also: Guyton, K.Z., et al (May 2015), 'Carcinogenicity of tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate', *The Lancet*, 16(5): 490-491, [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(15\)70134-8/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(15)70134-8/fulltext)
 41. The chewing of the coca leaf and traditional use of cannabis and opium are prohibited under the UN drug conventions
 42. See, for example: Eastwood, N., Shiner, M. & Bear, M. (2014), The numbers in black and white: Ethnic disparities in the policing and prosecution of drug offences in England and Wales (London: Release), <http://www.release.org.uk/node/286/>; American Civil Liberties Union (June 2013), The war on marijuana in black and white: Billions of dollars wasted on racially biased arrests, <https://www.aclu.org/report/war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white-report>, Drug Policy Alliance (February 2014), The drug war, mass incarceration and race, <http://www.drugpolicy.org/resource/drug-war-mass-incarceration-and-race>
 43. United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People Who Use Drugs (August 2014), Women who inject drugs and HIV: Addressing specific needs, http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
 44. For more information about the right to privacy, see: International Network of People Who Use Drugs (October 2015), Consensus statement on drug use under prohibition – Human rights, health and the law, http://www.inpud.net/consensus_statement_2015.pdf
 45. Hallam, C. (April 2010), IDPC Briefing Paper – Jar wars: The question of schools-based drug testing (London: International Drug Policy Consortium), http://idpc.net/sites/default/files/library/Schools%20Briefing%20paper%202010%20FINAL_0.pdf
 46. See, for example: Drug Reporter (3 October 2015), Republic of Georgia cuts back its street drug testing program, <http://drog-reporter.hu/en/node/2760>; see also: Lai, G. (August 2015), 'Asia: Advocating for humane and effective drug policies', *International Journal on Human Rights*, 21, <http://sur.conectas.org/en/issue-21/asia-advocating-humane-effective-drug-policies/>
 47. See, for instance, in China: Zhang, S.X. & Chin, K. (2015), A people's war: China's struggle to contain its illicit drug problem (Brookings Institute), <http://www.brookings.edu/~media/Research/Files/Papers/2015/04/global-drug-policy/A-Peoples-War-final.pdf?la=en>
 48. For example in Central Asia: Eurasian Harm Reduction Network (2010), Opioid substitution therapy in Central Asia: Towards diverse and effective treatment options for drug dependence, <http://www.harm-reduction.org/library/opioid-substitution-therapy-central-asia-towards-diverse-and-effective-treatment-options>; and in Greece: Papamalis, F. (2013), Petition: Greek economic recession from the public health perspective: The social cost, <http://idpc.net/alerts/2013/02/petition-greek-economic-recession-from-the-public-health-perspective-the-social-cost>
 49. International Harm Reduction Association & Youth RISE (2009) Drugs, harm reduction and the UN Convention on the rights of the child: Common themes and universal rights, <http://www.ihra.net/child-rights>; Harm Reduction International (December 2013), Injecting drug use among under-18s, http://www.ihra.net/files/2014/08/06/injecting_among_under_18s_snapshot_WEB.pdf
 50. For example: US Government Accountability Office (January 2003), Youth illicit drug use prevention: DARE long-term evaluations and federal efforts to identify effective programs, <http://www.gao.gov/products/GAO-03-172R>. For more information, also see Chapter 2.3 of this Guide
 51. See, for example: Moore, G., Gerditz, M. & Manias, E. (2007), 'Homelessness, health status and emergency department use: An integrated review of the literature', *Australasian Emergency Nursing Journal*, 10(4): 178–185, <http://www.sciencedirect.com/science/article/pii/S1574626707001097>; Breslau, N. (2002), 'Epidemiologic studies of trauma, posttraumatic stress disorder and other psychiatric disorders', *The Canadian Journal of Psychiatry*, 47(10): 923–929, <http://www.ncbi.nlm.nih.gov/pubmed/12553127>
 52. United Nations Development Program (June 2015), Addressing the development dimensions of drug policy, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>; Health

- Poverty Action & International Drug Policy Consortium (November 2015), Drug policy and the sustainable development goals, <http://idpc.net/publications/2015/11/drug-policy-and-the-sustainable-development-goals>
53. See, for example: Washington Office on Latin America (May 2015), Women, drug policies, and incarceration in the Americas, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas
 54. See, for example: West Africa Commission on Drugs (June 2014), Not just in transit – Drugs, the state and society in West Africa, <http://www.wacommissionondrugs.org/report/>
 55. International Network of People Who Use Drugs (October 2015), INPUD consensus statement on drug use under prohibition – Human rights, health, and the law, <http://www.inpud.net/en/news/consensus-statement>; Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance & Open Society Institute (2008), 'Nothing about us without us' - Greater meaningful involvement of people who use illegal drugs: A public health, ethical and human rights imperative, http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/nothingaboutus_20080603/Int%20Nothing%20About%20Us%20%28May%202008%29.pdf
 56. See, for example: International Harm Reduction Association (2009), Civil society: The silenced partners? Civil society engagement with the UN Commission on Narcotic Drugs, <http://www.ihra.net/contents/248>
 57. Beyond 2008 (2009), Beyond 2008 declaration, https://www.unodc.org/documents/NGO/B2008_Declaration_and_Resolutions_English.pdf
 58. For more information about the Civil Society Task Force, see: <http://www.unodc.org/unodc/en/ngos/DCN13-civil-society-engagements-in-ungass-2016-preparatory-process.html>
 59. International Network of People Who Use Drugs (October 2015), INPUD consensus statement on drug use under prohibition – Human rights, health, and the law, <http://www.inpud.net/en/news/consensus-statement>
 60. For more information: International Network of People Who Use Drugs (October 2015), INPUD consensus statement on drug use under prohibition – Human rights, health, and the law, <http://www.inpud.net/en/news/consensus-statement>; Open Society Institute, International HIV/AIDS Alliance & Canadian HIV/AIDS Legal Network (2008), 'Nothing about us without us': Greater, meaningful involvement of people who use illicit drugs: A public health, ethical, and human rights imperative, <https://www.opensocietyfoundations.org/sites/default/files/Int%2520Nothing%2520About%2520Us%2520%2528May%25202008%2529.pdf>
 61. See, for instance: Foro Mundial de Productores de Cultivos Declarados Ilícitos (2009), Political declaration, http://idpc.net/sites/default/files/library/Political_Declaration_FMPCDI.EN.pdf; Statement of 3rd Myanmar opium farmer forum, 12 September 2015, https://dl.dropboxusercontent.com/u/64663568/library/statement_of_3rd_myanmar_opium_farmer_forum_english_final.pdf
 62. In Bolivia, subsistence farmers are involved as key strategic partners in coca reduction strategies. See: Farthing, L.C. & Ledebur, K. (July 2015), Habeas coca: Bolivia's community coca control (Open Society Foundations), <http://www.opensocietyfoundations.org/reports/habeas-coca-bolivia-s-community-coca-control>. In Colombia, coca farmers have also been heavily engaged in the peace talks between the Colombian government and the FARC. See: Observatorio de Cultivos Declarados Ilícitos (August 2015), Vicios Penales en Colombia: Cultivadores de coca, amapola y marihuana, en la hora de su despenalización, <http://www.indepaz.org.co/vicios-penales/>. In Myanmar, opium farmers came together in September 2015 to inform the review process of the national drug law. See: Statement of 3rd Myanmar Opium Farmer Forum, <https://www.tni.org/en/article/statement-of-3rd-myanmar-opium-farmer-forum>
 63. Foro Mundial de Productores de Cultivos Declarados Ilícitos (2009), Political declaration, http://idpc.net/sites/default/files/library/Political_Declaration_FMPCDI.EN.pdf
 64. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance & Open Society Institute (2008), 'Nothing about us without us' – Greater meaningful involvement of people who use illegal drugs: A public health, ethical and human rights imperative, http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/nothingaboutus_20080603/Int%20Nothing%20About%20Us%20%28May%202008%29.pdf



Chapter 2:

Health policies and programmes

Chapter overview

The Preambles of the 1961 and the 1971 UN drug conventions establish, as the primary objective of the treaties, the need to protect the health and welfare of mankind.¹ The right to health is also protected in a number of international human rights instruments. Protecting health should therefore be at the centre of any national drug policy. The UN drug control treaties also impose a dual obligation on member states: that of prohibiting the production, sale and use of internationally controlled substances for recreational purposes on the one hand, while ensuring their access for medical and scientific purposes on the other. In practice however, the focus has been placed on reducing the scale of the illicit drug market through prohibition-led drug policy, with far less attention paid to the need to ensure the availability of controlled substances for medical and scientific purposes.

Scheduling is at the heart of any drug control policy. It is the mechanism through which policy makers place controlled substances in diverse schedules according to their level of harm and potential for medical and scientific usages. However, scheduling has posed many political, technical and ideological issues. **Chapter 2.1** will review available practices and evidence on scheduling – with a specific focus on cannabis, khat, ketamine and new psychoactive substances – in an attempt to provide guidance on how best to overcome the main challenges of scheduling.

The scheduling of controlled substances has a significant impact on whether a substance will be made available for medical and scientific purposes – one of the two core objectives of the UN drug control system. However, as **Chapter**

2.2 highlights, 5.5 billion people currently live in countries with limited or no access to controlled medicines. The chapter provides a set of practical recommendations on how to remove the legislative, technical and ideological barriers that are currently hindering access to controlled medicines for medical usage.

Chapter 2 then turns to the health policies and programmes targeting people who use drugs. Drug use may lead to a number of preventable health consequences, including the transmission of infections such as hepatitis B and C and HIV, overdose deaths, and an exacerbation of existing psychiatric or physical illnesses. It is therefore essential that a comprehensive health approach is developed to address drug use and dependence.

Chapter 2.3 offers guidelines on how to develop effective and evidence-based drug prevention programmes, focusing on identifying objectives, methods and settings, on the basis of the international quality standards on drug prevention that have so far been developed.

Chapter 2.4 reviews international evidence on harm reduction and provides a list of principles and interventions that should be developed to address the health, social and economic harms associated with drug use.

Finally, **Chapter 2.5** turns to drug dependence treatment, offering guidance on how to develop and implement a comprehensive menu of effective, voluntary and evidence-based drug dependence treatment programmes – with detailed recommendations on treatment referrals, methods, settings and associated social support services.

2.1

Scheduling and classifying substances

Key recommendations

- International drug control bodies and national-level policy makers should attain the proper degree of balance between restriction of harm and the medical usefulness of a substance when making a scheduling decision
- The UN drug control regime should urgently review its scheduling processes to ensure that these reflect the latest evidence and the needs of the contemporary drug response. An expert group should be assigned this task, and the resulting advice should be passed on to governments to assist them in re-designing their national scheduling processes
- The role of scientific reviews – conducted by the WHO's ECDD – should be strengthened and protected as part of international scheduling processes at the UN level, including mandatory periodic reviews of currently controlled substances (including cannabis) to reflect any emerging evidence and make the necessary adjustments to the policy response
- Where they do not already exist, policy makers should establish national advisory committees composed of scientific and social scientific experts to recommend appropriate classifications for substances proposed for control
- Policy makers should be bound by the recommendations of their advisory committees. If governments reject the advice of their expert committees, the grounds for doing so should be systemically and transparently articulated, and must be based upon evidence
- The unique problems presented by NPS should be embraced as an opportunity for better scheduling approaches based on evidence. For example, the approach originally adopted by New Zealand should be re-established and its results monitored and studied to examine the potential of replicating it elsewhere.

Introduction

Although a complex technical issue, scheduling is at the heart of drug control. Both international law as embodied in the UN drug control conventions and national legislation systems include hierarchical classifications based on the degree of risk and the level of medical usefulness associated with controlled substances.

These hierarchies are often known as *schedules*, and their objective is to assign appropriate levels of control to a given set of substances. They are intended to apply the tightest control measures to those substances considered the most dangerous. Similarly, substances believed to carry the lowest levels of risk are assigned to the least restrictive schedule. The medical utility of drugs is also

factored into the decision to assign a substance to the appropriate schedule in drug laws and policies. Whether these classifications are appropriate in practice is, however, a matter of considerable dispute – often the scheduling is based on unexamined cultural beliefs or historical accidents instead of scientific evidence.²

The mandate for scientifically reviewing substances proposed for international control lies with the World Health Organisation (WHO), while at the national level many countries have set up specialised agencies to advise their governments on the appropriate schedules for substances. It is of great importance that the principle of scientific review is maintained, which should be independent of governments, and that its assessment of



Ketamine

substances proposed for control is carried out on a scientific basis. However, governments are often unwilling to take the advice of their own advisory bodies, fearing public reactions to scientific recommendations on drug control or holding ideological positions on substances that run counter to scientific advice.

Scheduling has recently become a more complex issue due to the emergence of large numbers of new psychoactive substances (NPS). These substances have generated a sense of panic among many governments. The proliferation of these new substances – and the dynamic ways in which they are produced and brought to market through the internet and social networking – have led to the conclusion that the customary processes of scheduling involving detailed scientific reviews are too slow and unwieldy to meet the control requirements of this novel situation.

Legislative/policy issues involved

Evidence-based hierarchies of harm

Attempts should be made to base scheduling on both hierarchies of harm, and a balance between those harms and medical usage. Figure 1 below represents an alternative pattern of scheduling derived from the work of Professor David Nutt in the UK.³ It compares an 'independent expert assessment of harm' with the current classification within the international drug

control system administered by the UN. It is notable that the two lists vary widely; cannabis, for example, is included in the most dangerous drugs (and with no medical value) within the UN system, while Nutt's system places it in the low risk category. A similar dissonance applies to LSD and ecstasy.

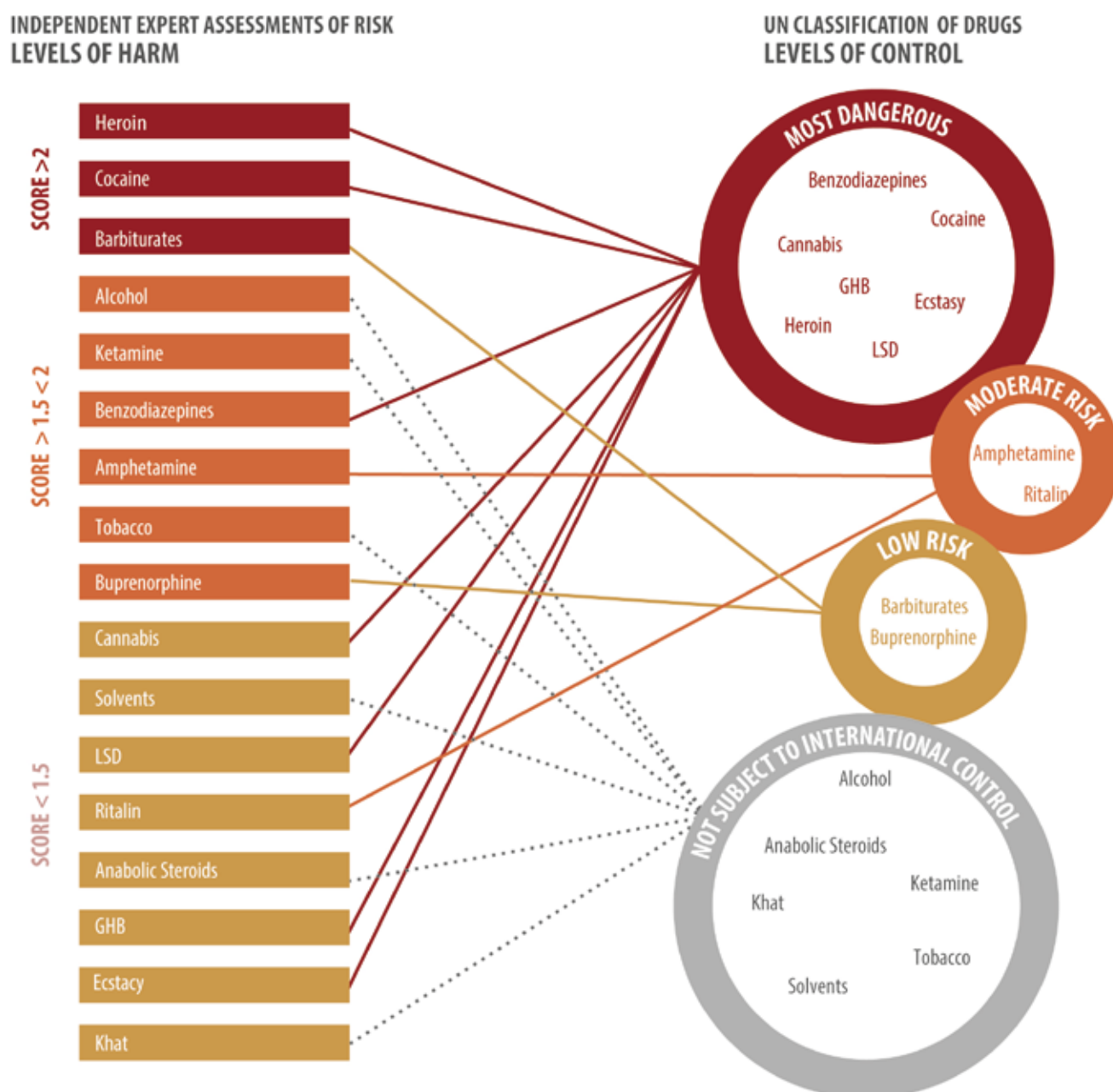
In general, the UN system classifies many more substances as 'most dangerous', which is arguably a result of cultural and historical factors at work during the early and mid-20th century, during which period colonial judgements and values, as well as xenophobia and racism, tended to prevail.

In 2007, the Nutt classification placed ketamine very close to the most dangerous drugs in its scale,⁴ whereas, for the moment, the substance is not scheduled in the UN system. Proposals to schedule it are being debated, as will be discussed below – but even if these efforts are successful, ketamine will be classified as a low-risk substance because of its high medical value. This demonstrates the difficulty of assigning scientific schedules to psychoactive substances through an objective and evidence-based assessment of both harms and medical benefits. The best practice at the moment involves recommendations made by expert committees of scientists to advise governments based on available evidence, and for governments to base policy decisions on these recommendations.

Assessing the medical usage of substances

The campaign against the non-medical consumption of controlled substances, which was waged

Figure 1. Classification of drugs: Levels of control vs. levels of harm⁵



through much of the 20th century, has resulted in a bias against the supply of controlled substances for medical purposes, demonstrating once more the imbalance within the international system and in many countries' domestic policy contexts.

At the 58th Session of the Commission on Narcotic Drugs (CND) in March 2015, it was proposed that ketamine be controlled under schedule IV of the 1971 UN Convention on Psychotropic Substances.⁶ This move was motivated by the expansion in the recreational use of ketamine, particularly in China and South East Asia, and increases in associated harms such as ketamine bladder syndrome, and patterns of dependence that had not previously been seen among populations using the substance for recreational purposes. A campaign by medical and clinical professionals, drug policy NGOs and some

governments was initiated to resist the proposal to schedule ketamine, because the substance is a vital anaesthetic in both human and animal medicine, particularly in rural districts of low and middle income countries. The restriction on ketamine stemming from international control would probably not adversely affect wealthy countries, but developing states would lack the economic, administrative and technical resources necessary to meet the requirements of international drug control – even if the substance were included in the least restrictive schedule IV of the 1971 Convention.⁷ For these developing countries, it would be much cheaper and simpler to effectively ban the substance altogether. Valium and Phenobarbital represent equivalent cases, and are extremely difficult to obtain in rural Asia and Africa, despite being classified under schedule IV of the 1971 Convention.

Box 1 The UK and the Dutch approaches to khat

In the Netherlands, a risk assessment was undertaken in 2007 by the Co-ordination Centre for the Assessment and Monitoring New Drugs (CAM), the official government advisory body for such matters, which concluded that 'khat poses little risk to the health of the individual user, and it presents no appreciable risk to Dutch society as a whole. There is therefore no reason to prohibit its use in the Netherlands'. According to the CAM, a ban would stigmatise the Somali community, without any prospects of a significant reduction in demand. Discouraging use through education was considered sufficient to increase the awareness to the potential negative social consequences and adverse health effects of excessive use.⁸

Another report was requested, from the Trimbos Institute, to look into the social impact of khat in the Somali migrant community, stories of public nuisance in some cities around the khat trade and the international context, since the Netherlands had also become an important hub for European imports and Scandinavian countries that had banned khat started to complain.

In January 2012, the Dutch government sent the Trimbos study to the parliament with the announcement that it had decided to put khat on List II, despite neither the Trimbos report nor the CAM making such a recommendation.⁹ Under the Dutch Opium Law, List II contains drugs

with 'an acceptable degree of addictiveness or physical harm', such as cannabis. This allows for prosecutorial discretion when it comes to use and possession, but it does make the importation and domestic trade of khat illegal and subject to active law enforcement.

In the case of the UK, where khat is estimated to be used by around 90,000 people from the Somali and Yemeni communities, the ACMD concluded in January 2013 'that the evidence of harms associated with the use of khat is insufficient to justify control and it would be inappropriate and disproportionate to classify khat under the Misuse of Drugs Act 1971'.¹⁰ However, UK Home Secretary Theresa May decided six months later to ban it, saying the risks posed might have been underestimated.¹¹

In November 2013, the Home Affairs Committee found that the ban on khat was not based on any evidence of medical or social harm and must be stopped before it becomes law. The parliamentarians concluded that the potential negative effects, both on the diaspora communities in the UK, and on the growers who cultivate it in Africa, outweighed any possible benefits of the ban. The Home Secretary continued to justify the ban by stating that most European Union (EU) countries had already banned khat so there was a danger of the UK becoming a regional hub for illegal onward trafficking to those countries.¹² The ban took effect on 24th June 2014.¹³

At the 2015 CND, the proposal to schedule ketamine was deferred owing to the controversy over its effect on the availability of this important anaesthetic. However, the proposal is likely to return at the next CND session. The WHO, which has the mandate to recommend on scheduling within the international regime, has critically reviewed the substance four times and found that it does not need to come under international control. Furthermore, the WHO has stated that the scheduling of ketamine would constitute a 'public health crisis'.¹⁴ The WHO position recognised that there are far more effective ways than scheduling to address the harms associated with ketamine use while avoiding restrictions in access for this vital anaesthetic substance.¹⁵

The controversy of the scheduling status of ketamine, which is on the WHO's Model List Of Essential Medicines,¹⁶ goes beyond the particular substance. If the UN drug control system is to meet its

retorical claims to be a more health- and human rights-focused regime, it needs to demonstrate its new orientation by shifting the balance toward medical applications in the field of scheduling, as well as listening to the advice of its expert committee. Individual countries should take similar steps to assign proper importance to the medical and therapeutic capacities of substances proposed for scheduling.

Implementation issues involved

Conflicts between expert groups assembled to provide guidance on the classification of substances on the one hand and those making the political decisions on the other have arisen both at national levels and in the international, UN-administered system. The following case studies, on cannabis, khat

and new psychoactive substances (NPS), illustrate these frictions. A similar case on the coca leaf is discussed in Chapter 4.3.

Scheduling controversies around cannabis

This has been particularly the case for discussions around the scheduling of cannabis. For example, the UK's Misuse of Drugs Act 1971 established the Advisory Council for the Misuse of Drugs (ACMD) – an independent expert scientific group which advises the government on scheduling matters.¹⁷ In 2007, when cannabis had been re-scheduled as a 'Class C' drug (the least harmful category) under the 2001 Misuse of Drugs Regulation, the government requested the ACMD to review this classification based on reports of severe mental health effects from high-strength 'skunk' preparations of the substance. The government wished to return cannabis to its earlier 'Class B' classification, but after extensive review the ACMD recommended that the drug remain in 'Class C'.¹⁸ Nevertheless, in 2008, cannabis was re-scheduled as a 'Class B' substance.

Then, in February 2009, the UK government once more rejected an ACMD recommendation, this time that ecstasy be downgraded from 'Class A' to 'Class B'. The government's justification for this decision at the time was: 'It is our view that the system should be based on evidence, but it should also be based on the considered view of those responsible for policy making, and should take into consideration the impact that changes in classification are likely to have on the use of, and harms caused by drugs and the impact that that has on the criminal justice system. That is why it will remain the case that our advisers will advise us, and we will decide'.¹⁹

The UK government is legally entitled to reject the ACMD recommendations, as the statutory framework only requires conscientious consultation by the government with the ACMD on classification decisions, not that its recommendations be followed. However, relations between the government and the ACMD, and parts of the scientific community more generally, became further strained following the sacking of the ACMD Chair, Professor David Nutt, over his views on the relative safety of ecstasy and cannabis compared to alcohol and tobacco.²⁰ The Home Secretary wrote to the Professor explaining that, 'it is important that the government's messages on drugs are clear and as an advisor you do nothing to undermine public understanding of them'.²¹ A total of six members of the ACMD resigned over the sacking and the issues it raised. Later in 2010, the UK government once again discarded the ACMD recommendations when it announced its ban on mephedrone.

Scheduling controversies around khat

Khat – a plant with leaves that are chewed for their mild stimulant properties – is not subject to international control at present. The Advisory Committee on the Traffic in Opium and Other Dangerous Drugs of the League of Nations first discussed khat in 1933, and the substance has appeared on the international agenda repeatedly since then. Several studies, including by the UN Narcotics Laboratory, subsequently identified a number of phenylalkylamine alkaloids as the major psychoactive compounds in the khat plant: cathinone and cathine (norpseudoephedrine), and to a lesser degree norephedrine. Cathinone is unstable and undergoes decomposition rapidly after harvesting and during drying of

Credit: Creative Commons Eestl



Khat leaves

Box 2 The European Union's approach to NPS

In Europe, the first formal action to respond to the growing problem of NPS was the creation, in 2005, of the EU 'Early Warning System' and structures that went with it. Through this, EU member states could register new substances of concern. Their risks were then assessed by the EU institutions (principally the European Monitoring Centre on Drugs and Drug Addiction, EMCDDA), and a decision made on whether or not to recommend the substance for control measures. In practice, this process was only fully used in a small number of substances.²² Furthermore, in most cases it took a long time and considerable resources to produce a recommendation. This naturally led to concerns about how the process could respond to the growing number of substances coming onto the market. As a result, the European Commission (EC or Commission) initiated a process to evaluate the existing early warning mechanism. At the beginning of 2010, amidst the emergence of mephedrone and the reports of deaths associated with its use – particularly in the UK and Ireland – the Commission started the preparatory work.

In July 2011, the EC published its assessment,²³ concluding that there were three major shortcomings when it came to submitting NPS to Europe-wide control measures. First, the existing system was unable to tackle the large increase in the number of NPS on the market because it addresses substances one by one, through a lengthy process. Second, it was seen to be overly reactive since substances brought under control measures were quickly replaced with new ones with similar effects, often through small modifications of their chemical composition. And third, it lacked a range of effective options for control measures that would allow for rapid and targeted action. Driven by these conclusions, and coinciding with discussions of the issue in the Informal Council on Justice and Home Affairs, the Commission engaged in a consultation process to propose to EU member states a mechanism to replace a system that was deemed 'no longer fit for purpose'.²⁴

The Commission's proposal aims to speed up the 'Union's ability to fight'²⁵ NPS by providing for:

- **A quicker procedure:** It currently takes a minimum of two years to ban a substance in

the EU. Under the new structure, the EU will be able to act within 10 months. In some cases, the procedure would be shorter since it will also be possible to withdraw a substance immediately from the market for a year. This measure is intended to ensure that the substance is no longer available to customers while a full risk assessment is being conducted. The current system does not allow temporary measures, with proposals to restrict substances having to wait for a full risk assessment.

- **A more proportionate system:** It is intended that the new system will allow for a graduated approach where substances posing a moderate risk will be subject to consumer market restrictions and substances posing high risk to full market restrictions. Only the most harmful substances posing severe risks to consumers' health will be submitted to criminal law provisions. This is a significant departure from the current system since it only provides for binary options – taking no action at EU level or imposing full market restrictions and criminal sanctions. This lack of options means that at present, the Union does not take action in relation to some harmful substances.²⁶ It is hoped that the new system will allow the EU to tackle more cases and deal with them more proportionately, by tailoring its response to risks involved and taking into account legitimate commercial and industrial uses.²⁷

The proposal now needs to be adopted by the European Parliament and by EU member states in the EU Council in order to become law. This may not be a straightforward process since it is becoming clear that, as is often the case within the EU, there is no universal agreement on the issue.²⁸ Beyond this, it remains likely that EU institutions and national governments will continue to lag behind drug designers and the changing nature of the NPS market.²⁹ Moreover, introducing the concept of proportionality and the option of regulating – rather than prohibiting – NPS within the new system raises interesting questions about the relative harm of organic substances, such as cannabis, that are currently under the strictest controls within the UN-based international scheduling framework.

Box 3 New Zealand's Psychoactive Substances Act

On the other side of the planet, New Zealand was faced with a flood of NPS that lay beyond the scope of existing drug control legislation.³⁰ New Zealand passed what appeared to be the ground-breaking Psychoactive Substances Bill in July 2013.³¹ The resultant Act set up a legal framework for the testing, manufacture, sale and regulation of previously uncontrolled psychoactive products, placing the responsibility on manufacturers to prove a product poses a 'low risk' before it can be sold. To this end, it established a Psychoactive Substances Regulatory Authority within the Ministry of Health, responsible for ensuring that products met appropriate safety standards before they could be distributed in New Zealand.

Underpinned by a belief in pragmatism, evidence and the protection of health, the Act acknowledged the demand for psychoactive substances and consequently focused on attempting to ensure that this was met in a low-risk manner. Unlike earlier legislation, it provided alternatives to a criminal justice approach and sought to protect the health of the user 'without undue emphasis on illegality and punishment'.³² As such, offences within the Act predominantly focused upon illegal manufacture and/or supply. It also contained an inbuilt five-year review mechanism to allow for aspects of the legislation to be revisited if it was felt that they were not operating as intended. Furthermore, while the legislation removed the onus of proof regarding the level of risk away from the government and placed it with manufacturers, authorities re-

tained oversight by being able to quickly remove a product from the market. It was the intention that the legislative framework would also incentivise manufacturers to make low-risk products rather than constantly seeking to circumvent the law by producing chemical variants of unknown harm potential. Approved products would only be available in certain outlets, would come with health warnings and be subject to restricted advertising at the point of sale only.

Under the Act, 41 of the lowest-risk substances were assigned temporary approval; however, in April 2014, the government suspended these approvals. According to Health Minister Peter Dunne, this sudden reversal in policy was prompted by increased reports of harmful side-effects of the substances in question. The terms of the Act were subsequently amended, bringing to an end the interim or provisional product approvals that had enabled certain substances to be sold prior to full testing. All interim licences to retail NPS have been revoked, and it is now illegal to supply and possess the products.

The reversal in New Zealand's policy was driven by fears of an underground economy and mass drug use and an attempt to prevent harm through the application of controls. Ironically, the Act probably represented the best available method of regulating the market, and its amendment – which is effectively an abandonment of its principles – means that in reality the state has little, if any, control over the market, which has, after a promising start, reverted into the hands of criminals.

the plant material. This is the main reason why fresh khat leaves are preferred by chewers. Dried leaves, which contain much lower levels of cathinone, are more often used to make tea, known as Abyssinian or Arabian tea.

Cathinone and cathine are alkaloids with similar effects on the central nervous system to those of amphetamine, though less potent. In the early 1980s, all amphetamine-type stimulants (ATS) have been placed as a group under international control. Cathinone and cathine were, based on a 1985 recommendation of the WHO Expert Committee on Drug Dependence (ECDD), added to the list of controlled substances of the 1971 UN Convention

on Psychotropic Substances, respectively to Schedules I and III.³³ Norephedrine was subsequently included in the list of precursors controlled under the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, as it was often used in the illicit manufacture of amphetamines.

The WHO ECDD concluded in 2006 on the basis of a critical review of khat that scheduling of the plant itself was not required: 'The Committee reviewed the data on khat and determined that the potential for abuse and dependence is low. The level of abuse and threat to public health is not significant enough to warrant international control. Therefore, the Committee did not recommend the scheduling

of khat. The Committee recognized that social and some health problems result from the excessive use of khat and suggested that national educational campaigns should be adopted to discourage use that may lead to these adverse consequences.³⁴

Scheduling controversies around new psychoactive substances

By December 2014, the United Nations Office on Drugs and Crime (UNODC) had received notice of 541 different NPS, compared to just 126 in 2009. This proliferating class of drugs has resulted in panic among many national governments, and put immense strain on the traditional methods of review and classification that take place prior to scheduling. NPS can be developed extremely rapidly, and are often marketed via the internet and social networks. Once one substance is scheduled, chemical variations of it can often be produced and marketed which are not covered under the scheduling decision, and therefore circumvent the law. It is problematic – and often impossible – for governments and law enforcement agencies to keep up. A number of new approaches have therefore been attempted, in particular at EU level (see Box 2) and in New Zealand (see Box 3).

Key resources



Cannabis at a Colorado dispensary

- European Monitoring Centre on Drugs and Drug Addiction (2015), *Legal approaches to controlling new psychoactive substances*, <http://www.emcdda.europa.eu/topics/pods/controlling-new-psychoactive-substances>
- Hallam, C. Bewley-Taylor, D. & Jelsma, M. (2014), *Scheduling in the international drug control system* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2014/06/scheduling-in-the-international-drug-control-system>
- Scholten, W. (2014), *Factsheet on the proposal to discuss international scheduling of ketamine at the 58th CND*, <http://idpc.net/publications/2015/01/fact-sheet-on-the-proposal-to-discuss-international-scheduling-of-ketamine-at-the-58th-cnd>
- McCullough, Wood, J. & Zorn, R. (September 2013), *New Zealand's psychoactive substances legislation* (London: International Drug Policy Consortium & New Zealand Drug Foundation), <http://idpc.net/publications/2013/09/idpc-briefing-paper-new-zealand-s-psychoactive-substances-legislation>

Ensuring access to controlled substances for medical and scientific purposes

Key recommendations

- National drug control regulations should be reviewed using WHO's 2011 guidance³⁵ to ensure that they do not needlessly interfere with the availability and accessibility of controlled medicines, especially opioid analgesics
- The adequacy of annual estimates for medical and scientific needs of controlled substances should be reviewed in accordance with the INCB and WHO's Guide on estimating requirements for substances under international control,³⁶ and estimates should be adjusted as needed
- Adequate training for current healthcare workers should be provided on the use of controlled medicines, and incorporated into undergraduate and graduate curricula for all relevant healthcare workers
- National health strategies should be reviewed, including for cancer, non-communicable diseases and HIV, to ensure that they adequately address the need for palliative care
- More scientific research should be encouraged, conducted and funded on the medical value of cannabis and psychedelics.³⁷

Introduction

Some substances controlled under the international drug control treaties are routinely used in healthcare in diverse fields of medicine, such as anaesthesia, drug dependence, maternal health, mental health, neurology, pain management and palliative care. For example, the World Health Organisation (WHO) has included 12 medicines that contain internationally controlled substances in its Model List of Essential Medicines: buprenorphine, codeine, di-

azepam, ephedrine, ergometrine, hydromorphone, lorazepam, midazolam, methadone, morphine, oxycodone and phenobarbital.³⁸ These represent the 'minimum medicine needs for a basic healthcare system' and 'the most efficacious, safe and cost-effective medicines'.³⁹ A number of countries also apply similar national controls to other essential medicines outside of those proscribed by international law – such as ketamine⁴⁰ (see Chapter 2.1 for more details).

Although ensuring the adequate availability of controlled substances for medical and scientific purposes is one of the fundamental aims of the UN drug conventions, the UN system and UN member states have so far failed at fulfilling this objective. The WHO estimates that 5.5 billion people live in countries with low or non-existent access to controlled medicines, and that tens of millions of people in these countries experience moderate to severe pain without access to treatment every year, including 5.5 million people with terminal cancer and a million people with late-stage HIV/AIDS.⁴¹

The international drug control regime also interferes with scientific research into potential medical uses of controlled substances. An increasing body of evidence suggests that substances such as cannabis and cannabinoids, heroin, ketamine, ketobemidone, LSD and MDMA, have medical uses in the treatment of a variety of conditions, including pain, multiple sclerosis, drug dependence, glaucoma, depression, post-traumatic stress disorder, and Parkinson's disease.⁴² Yet, the fact that these substances are listed in schedules that recognise no medical or scientific use in the drug control treaties creates significant regulatory and financial obstacles to further research and the development of new medications.⁴³

Legislative/policy issues involved

The 1961 Single Convention on Narcotic Drugs and the 1971 UN Convention on Psychotropic Substances articulate a dual obligation for states with respect



Dr. Gloria Dominquez Castillejos, pain clinic director, speaks with a patient in Hospital Doctor Angel Leano in Guadalajara, Mexico

to controlled substances and their medical use: countries must ensure their availability for medical and scientific use, and prevent their use and diversion for other uses (i.e. recreational and non-medical use).⁴⁴ The Single Convention formulates four basic requirements for national regulations of opioid analgesics, which are in the strictest schedule for substances with medical uses:

- Individuals dispensing the medication must be licensed, either by virtue of their professional license or through a special licensing procedure
- Only authorised institutions or people may handle and transfer these medications
- The medications can only be dispensed to a patient upon a medical prescription
- Records on the movement of these medications are kept for no less than two years.⁴⁵

The 1971 Convention contains similar provisions for psychotropic substances. However, both the 1961 and the 1971 conventions explicitly open the door for countries to adopt measures of control stricter or more severe than those provided by the drug control treaties, including a special prescription form for controlled medications, if they deem it necessary.⁴⁶ In contrast, specific operative paragraphs requiring states parties to ensure access to controlled medicines are conspicuously absent.

Many countries have adopted regulations around controlled substances that go far beyond the requirements of the 1961 Convention or the 1971 Convention. Often, these regulations directly interfere with medical practice and make controlled medicines inaccessible for patients. Common barriers in national legislation include:

- requirements for special prescription forms
- limitations on the number of days a prescription can cover

- limitations on which healthcare workers can prescribe controlled substances
- requirements for additional licenses for hospitals, pharmacists and healthcare workers
- additional record keeping or reporting requirements
- limitations on the daily doses that can be prescribed.

Furthermore, the laws on controlled substances of some countries impose harsh criminal punishments for healthcare workers, sometimes even for unintentional errors in handling them.

The WHO,⁴⁷ the International Narcotics Control Board (INCB),⁴⁸ the Commission on Narcotic Drugs (CND),⁴⁹ the United Nations Office on Drugs and Crime (UNODC),⁵⁰ and the World Health Assembly (WHA)⁵¹ have repeatedly called on UN member states to review their regulations on controlled substances to ensure they do not needlessly interfere with medical use. The WHO has also published guidance for countries on reviewing their national policies on controlled substances.⁵²

Implementation issues involved

Regulatory barriers are not the sole reason why the availability of controlled medicines, especially opioid analgesics, is so limited in much of the world. Few governments have put in place effective supply and distribution systems for these medications; they have no relevant health policies or guidelines for practitioners; they do not ensure that healthcare workers get instructions on the use of controlled medicines as part of their training; and they do not make sufficient efforts to ensure that they are affordable.⁵³ Myths about controlled medicines among both healthcare workers and the public, as

Box 1 Mexico reviews its prescribing and dispensing system for opioid analgesics

On 15 June 2015, Mexico introduced a new system for prescribing and dispensing opioid analgesics in response to concerns that the old system was so cumbersome that it deprived people with advanced illnesses of access to essential pain medicines. The new system allows physicians to download special prescriptions from a secure website with bar codes required for prescribing opioid pain relievers. It also introduces electronic record keeping for pharmacies.⁵⁴

Before June 2015, physicians had to travel in person to state capitals to obtain the bar-code stickers that Mexican law requires for prescriptions of opioid analgesics. This highly time-consuming requirement discouraged many physicians from prescribing these medicines. Moreover, pharmacies had to record all transactions involving these medicines in multiple log books, posing a significant bureaucratic burden. A 2014 Human Rights Watch report found that Mexico's regulations were so burdensome that the vast majority of doctors, especially those living outside state capitals, simply did not prescribe these medications and that very few pharmacies kept them in stock.⁵⁵

Apart from simplifying the prescription of opioid analgesics, the electronic system also improved

government oversight of their use. Previously, pharmacies were unable to scan the bar-code stickers on prescriptions for opioid analgesics to authenticate them because they were not linked to a central system. Thus, the requirement for bar codes, which was intended to allow close monitoring of prescribing and dispensing opioid analgesics, did not actually help prevent their misuse, but did create a major barrier to legitimate medical use.

Under the new system, pharmacies will be able to authenticate prescription forms using the bar code, and scripts will be automatically cancelled once they have been scanned. The new system for prescribing opioid analgesics is one of a series of measures by the Mexican government to improve access to palliative and end-of-life care. Pain treatment is an important component of this kind of healthcare.

In December 2014, the Ministry of Health issued guidelines to its healthcare system to put into effect provisions on end-of-life care as outlined in Mexico's 2009 health law and created a department to advance palliative care. In January 2015, the government adopted an inter-agency agreement on palliative care, which made it mandatory and instructed medical schools to include it in their curricula.



Doña Remedios and her daughter, Orlanda Hernandez Ramirez, 44, take a very early morning journey to receive palliative care at the National Cancer Institute in Mexico City, 2014

Credit: Ed Kashi/VII / Human Rights Watch

Box 2 Kenya's improved access to opioid analgesics

Kenya has made significant progress in improving access to opioid analgesics in the last five years, with morphine consumption jumping more than three-fold over that period. In 2010, access to opioid analgesics was very limited and available in just a few Kenyan hospitals. According to a 2010 Human Rights Watch report, Kenya recognised oral morphine as an essential medicine but its central pharmaceutical supplier – the Kenya Medical Supplies Agency, which procures essential medicines for public hospitals – did not purchase or stock oral morphine. Hospitals therefore had to negotiate individually with pharmaceutical companies to obtain the medication. Moreover, the government levied an import tax on morphine powder pushing up the price.⁵⁶ As Kenya's drug law prescribed heavy prison sentences for illicit possession of morphine and provided no detailed guidelines on lawful possession for healthcare workers and patients, many healthcare providers viewed morphine as a dangerous substance rather than as an essential medicine for pain.

Since 2010, Kenya has taken significant steps toward improving access to opioid analgesics. It has integrated palliative care into the public health system, developed clinical guidelines, and introduced multiple training curricula that include the use of opioid analgesics. In 2013, the Kenya Medical Supplies Agency began to procure morphine centrally for public hospitals, and the government removed the tax on morphine powder. As a result, 43 public hospitals offered palliative care by late 2014, and all had a steady supply of morphine.⁵⁷

well as often unfounded fears of diversion for illicit purposes, are key factors blocking improved access to controlled medicines.

In the case of pain management and palliative care, these factors combine to create a vicious cycle of under-treatment in many countries. Because pain treatment and palliative care are not policy priorities, healthcare workers do not receive the necessary training to assess the medicines necessary to treat moderate to severe pain. This leads to widespread under-treatment and to low demand for opioid analgesics. Similarly, the complex procurement

and prescription regulations, as well as the threat of harsh punishment mentioned above, discourage pharmacies and hospitals from stocking these medicines, and healthcare workers from prescribing them, again resulting in low demand. This, in turn, reinforces the low priority given to pain management and palliative care. This low prioritisation is not a function of low prevalence of pain, but of the invisibility of its sufferers.

To break out of this vicious cycle, governments and the international community should:

- take a multipronged approach that focuses on eliminating regulatory barriers and criminal sanctions for legitimate medical uses of controlled medicines
- develop health policies, such as national strategies on cancer or on non-communicable diseases, that identify palliative care as an objective, and integrate such services into the healthcare system
- overcome gaps in training on the use of controlled medicines for healthcare workers
- take action to ensure an adequate supply and distribution system.

Key resources

- Duthey, B. & Scholten, W. (2014), 'Adequacy of opioid analgesic consumption at country, global and regional level in 2010, its relation to development level and changes compared to 2006', *Journal of Pain and Symptom Management*, **47**(2): 283-97, doi:10.1016/j.jpainsymman.2013.03.015
- Global Commission on Drug Policy (October 2015), *The negative impact of drug control on public health: The global crisis of avoidable pain*, <http://www.globalcommissionondrugs.org/reports/>
- Hallam, C. (December 2014), *The international drug control regime and access to controlled medicines* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2015/01/the-international-drug-control-regime-and-access-to-controlled-medicines>
- International Narcotics Control Board & World Health Organisation (2012), *Estimating requirements for substances under international control*, https://www.incb.org/documents/Narcotic-Drugs/Guidelines/estimating_requirements/NAR_Guide_on_Estimating_EN_Ebook.pdf
- World Health Organisation (2011), *Ensuring balance in national policies on controlled substances*, http://apps.who.int/iris/bitstream/am/10665/44519/1/9789241564175_eng.pdf

Key recommendations

- Drug prevention programmes should be based on available evidence of effectiveness and cost-effectiveness, and be in line with international minimum quality standards
- Drug prevention should be considered as an integral part of – and never as a substitute for – a comprehensive health-centred approach towards drug use and dependence, alongside harm reduction, drug dependence treatment, care and support
- The objectives of drug prevention should be realistic and based on an honest assessment of local realities and available resources
- Drug prevention should focus on minimising the risk factors and strengthening the protective factors in the lives of targeted individuals and/or groups
- Drug prevention must take care to avoid increasing the social stigma and marginalisation of people who use drugs
- Drug prevention programmes should be subjected to short- and long-term scientific evaluations of processes and outcomes to measure the effectiveness and impact of the interventions, and should include mechanisms to adapt the programmes to new patterns of use and realities on the ground.

Introduction

Drug prevention can be defined as any activity, campaign, programme or policy aimed at preventing, delaying or reducing drug use and/or its negative consequences – either in the general population or within targeted sub-populations.

A myriad of interventions have so far been developed in the field of drug prevention. In many countries, such interventions have been guided by the

principle of deterrence – the belief that people will not use drugs if they are told about the negative effects of use and the harsh penalties they risk by using them. However, despite a consistent allocation of substantial government resources towards these interventions, available evidence indicates that the rates of drug use among young people remain high,⁵⁸ and are largely unaffected by the prevention approaches tried so far.

The failure of these interventions (often taking the form of mass media campaigns) can be explained by the fact that they do not have a resonance with young people's lived experiences, might increase normative beliefs (i.e. that drug use is normal and widespread), and that they do not target the factors that mostly impact on people's decisions around drug use – fashion and perception of social norms, peer pressure or peer selection, emotional well-being, social and community equality, etc.⁵⁹

Investing in evidence-based drug prevention not only reduces the individual, family and community harms associated with illicit drug use, but it can also greatly reduce costs to society. A growing body of evidence over the last 20 years demonstrates that well-designed and targeted prevention efforts can lead to significant savings.⁶⁰

The key challenge for policy makers is therefore to develop and implement drug prevention programmes that are based on the available evidence of effectiveness and cost-effectiveness, that respond to local needs and contexts, and that are relevant and meaningful to the population(s) being targeted.

Legislative/policy issues involved

Setting realistic objectives for prevention interventions

The first challenge for policy makers is to establish clear objectives for what prevention interventions are seeking to achieve. A common misconception is that effective drug prevention need only consist of informing – generally warning – young people about the dangers associated with drug use. Prevention is

'protective factors'. These can include greater psychological and emotional well-being, greater personal and social competence, a stronger attachment to caring families, accessible economic opportunities, and schools and communities that are well resourced and organised.⁶³

Some of the factors that make people vulnerable (or, in contrast, more resistant) to initiating drug use or experiencing problematic use differ according to age – with risk and protective factors evolving through infancy, childhood and early adolescence (e.g. family ties, peer pressure, etc.). At later stages of the age continuum, schools, workplaces, entertainment venues and the media may all contribute to make individuals more or likely to use drugs and engage in risky behaviours. Most importantly, there is a dynamic interaction of vulnerability factors at the personal (biological and psychological) and environmental (family, society, school, etc.) levels.

A significant reduction in the overall level of drug use in society is unlikely to be achieved through a prevention intervention alone. However, evidence shows that some prevention interventions have achieved positive results in delaying the onset of drug use and strengthening individuals' ability to avoid drug problems.

- ## Choosing the right prevention method

There are four broad categories of prevention interventions,⁶⁴ some of which have proven more suitable than others in certain situations or for a specific group of people:



1. Universal prevention – i.e. intervening with populations. This is the broadest approach to prevention, targeting the general public without any prior screening for their risk of drug use. These interventions therefore assume that all members of the population are at equal risk of initiating use. Universal prevention interventions should target skills development and interaction with peers and social life, and can be implemented in schools, communities or workplaces. Available evidence shows that mass media campaigns are costly, and have not been effective at reducing levels of use, while often accentuating the already high levels of stigma experienced by people who use drugs.⁶⁴ Nevertheless, some well-designed and well-funded universal prevention programmes targeting school children and using an interactive, skills-building approach have had some impact on levels of drug use (see Box 1).

2. Selective prevention – i.e. intervening with (vulnerable) groups. These interventions target specific sub-populations whose risk of starting using drugs or experiencing drug dependence is significantly higher than average. Often, this higher vulnerability to drug use stems from social exclusion (e.g. young offenders, school drop-outs, marginalised ethnic minorities, etc.) or from certain social contexts (youth in party settings). Selective prevention interventions therefore usually target the social risk factors (such as living conditions and social environment) that make this specific group more vulnerable to drug use. Available evidence shows that selective prevention interventions using multi-component, peer-led and interactive programmes focusing on teaching social and coping skills have showed a slight positive effect in delaying drug use initiation, as well as improving cognitive capabilities and self-worth (see Box 2).⁶⁵

3. Indicated prevention – i.e. intervening with (vulnerable) individuals. These programmes target high-risk individuals who are identified as being at greater risk of experiencing problems with drug use. Criteria for such risks might be mental illness, social failure, antisocial behaviour, hyperactivity and impulsivity. The aim of indicated prevention is not necessarily to prevent initiation of drug use, but rather to prevent the development of dependence. In this regard, prevention interventions are most effective when they seek to address those issues other than drug use by focusing on the social context and behavioural development of the targeted individual.⁶⁶

Box 1 Universal prevention at school: The Unplugged programme

Unplugged is a school-based drug prevention programme which was developed Europe-wide and has been subject to a number of evaluations. The objective of the programme was to reduce the prevalence of use of illicit substances, alcohol and tobacco among youth, delay initiation and stop transition towards problematic use. The programme is based on a comprehensive social influence and interactive approach that includes training and the strengthening of social and coping skills. It consists of 12 one-hour long sessions delivered weekly by school teachers. The teachers were provided with a detailed handbook to guide them in the organisation of the sessions, including practical suggestions for communication, listening skills and promoting dialogue with the pupils. Teacher training was a crucial component of Unplugged to ensure a high-quality implementation of the programme.⁶⁷

The programme was evaluated between 2004 and 2007 in Austria, Belgium, Germany, Greece, Italy, Spain and Sweden, involving 143 schools and 7,079 pupils. The evaluation showed that Unplugged had reduced cannabis use – an effect which was prolonged over an 18-months follow-up period. Following the evaluation, Unplugged was reviewed and a second phase of the project included a revised teacher handbook, as well as re-designed cards to be used in the interactive sessions with the pupils.⁶⁸

4. Environmental prevention – i.e. intervening with societies and systems. These interventions and strategies are aimed at altering the immediate cultural, social, physical and economic environments in which people make their choices about drug use. This perspective takes into account the fact that individuals do not become involved with drugs solely on the basis of personal characteristics, but rather that they are also influenced by a complex set of factors in their environment, what is expected or accepted in the communities in which they live, national legal contexts and the price, quality and availabil-

Box 2 Selective prevention programme among vulnerable families in Portugal: ‘Searching family treasure’⁶⁹

Searching family treasure was launched in 2004 in Portugal to reduce the family risk factors and increase family protective factors related to illicit drug use. The programme targeted vulnerable families with children aged 6 to 12 years old, and aimed to prevent drug use, but also delinquency, violence and mental health problems. It was composed of parent sessions, child sessions and family sessions. The objectives of the programme included:

- decreasing parental use of harsh or inadequate discipline
- improving parent/child relationships with better parenting skills
- increasing parental supervision and monitoring
- increasing family communication quality, strengths and resilience
- decreasing children’s hyperactivity or inattention, emotional symptoms and peer problems
- increasing children’s social behaviour.⁷⁰

The programme was organised around a family treasure hunt through which families learned and discovered their strengths and trained in parenting skills and children’s life skills – using

attractive materials and activities including skills trainings, group discussions, role-play, comic books, games, storytelling, etc.⁷¹

About 192 professionals were trained since 2004 and about 15 training programmes were implemented in Portugal, as well as one in Spain.⁷² An evaluation of the programme by the participants themselves showed that 57% of the children benefited/benefited greatly from the programme, and most parents reported implementing the skills gained in the programme back home. The families considered that the programme had improved their relationship with their children, increased their abidance to family rules, and reduced inattention problems. All parents reported being satisfied (37.5%), or very satisfied (65.5%), with the programme. In terms of impacts on substance use, while 91% of the participants consumed alcohol four or more times a week before the programme, upon its completion 62.5% of the parents reported total abstinence, 25% used alcohol once a month and only 12.5% consumed alcohol more than twice a month. Meanwhile, the perception of risks associated with illicit drug use largely increased among the children involved in the programme, and parents reported low levels of use for all substances among their children.⁷³

ity of drugs. Environment prevention strategies notably include taxation, advertising bans, as well as restricting availability in specific settings via retailer licencing, restricting retailers’ opening hours, etc. These have been largely applied for alcohol and tobacco – where governments have the opportunity to implement regulatory policies to effectively shape and structure the legal market. Similar policies are currently being established in regulated cannabis markets in Uruguay and some US states.⁷⁴

Enshrining prevention in broader health policies

Drug prevention is just one of the fundamental components of a health-centred drug policy, alongside harm reduction (see Chapter 2.4) and drug dependence treatment (see Chapter 2.5). In this respect, an effective drug prevention system should be:

- Embedded in – and never be a substitute for – a comprehensive and health-centred system of

drug control focused on providing treatment and care for people who use drugs, and on preventing the health and social consequences of drug use (e.g. HIV/AIDS, hepatitis C, overdoses, marginalisation, etc.)

- Based on an understanding that not all drug use is problematic
- Based on the understanding of drug dependence as a complex health condition with a mix of biological, psychological and social causes
- Based on evidence of effectiveness and cost-effectiveness
- Mandated and supported at the national level by appropriate regulations and public health strategies: including national standards, training for practitioners, and requirements for schools, workplaces and health and social agencies to implement relevant prevention interventions.

Box 3 The European drug prevention quality standards⁷⁵

The EMCDDA proposes a number of stages and components to ensure that drug prevention programmes are effective and of good quality.

These are exposed below:

1. Cross-cutting considerations:

- Sustainability and funding
- Communication and stakeholder involvement
- Staff development
- Ethical programme

2. Needs assessment:

- Knowing drug-related policy and legislation
- Assessing drug use and community needs
- Describing the need and justifying the intervention
- Understanding the target population

3. Resource assessment:

- Assessing the target population and community resources
- Assessing internal capacities

4. Programme formulation:

- Define the target population
- Use a theoretical model
- Define aims, goals and objectives
- Define the setting
- Refer to evidence of effectiveness
- Determine the timeline

5. Intervention design:

- Design should respond to quality and effectiveness
- Option of selecting an existing intervention
- Tailor the intervention to the target population
- Plan final evaluations

6. Management and mobilisation of resources:

- Plan the programme
- Plan financial requirements
- Set up the team
- Recruit and retain participants
- Prepare the programme materials
- Provide a project description

7. Delivery and monitoring:

- Option of conducting a pilot intervention
- Implementing the intervention
- Monitoring the implementation
- Adjusting the implementation

8. Final evaluations:

- Option of conducting an outcome evaluation
- Option of conducting a process evaluation

9. Dissemination and improvement:

- Deciding whether the programme should be sustained
- Disseminating information about the programme
- Producing a final report

Implementation issues involved

A series of minimum quality standards have been developed in the field of drug prevention, which can be useful to consider when designing and implementing a drug prevention programme (see Box 3).⁷⁶

Among these quality standards, policy makers should consider several specific issues which are exposed below.⁷⁷

Conducting a needs assessment of drug use and community needs

This is the first step to undergo for an effective prevention intervention, in order to gain a thorough understanding of the needs, local contexts and tar-

get populations or groups, and assessing how best to address them. This entails assessing drug use patterns among the general population and specific groups, using quantitative and qualitative data and studies. This data should be used to prioritise evidence-based programmes and carefully adapt prevention interventions when necessary to respond to new patterns of use and new socio-economic and cultural contexts. Risk and protective factors should be carefully studied, as well as other relevant issues, such as social marginalisation and inequalities. According to the EMCDDA, 'A good understanding of the target population and its realities is a prerequisite for effective, cost-effective and ethical drug prevention.'⁷⁸



People injecting heroin in Herat, Afghanistan

Some examples of quality standards:

- The main needs of the population are described, and if possible, quantified
- The organisation is aware of existing and recent drug prevention programmes
- The programme complements other health promotion or drug prevention programmes locally, regionally, and/or nationally
- The target population's culture and perspectives on drug use are included in the needs assessment.

Conducting a resource assessment

Depending on their design and scale, prevention programmes can be very cheap or extremely expensive. It is therefore important to conduct an assessment to gain a better understanding of what can realistically be achieved within available resources (including staff and financial resources), and what the type and scope of the programme should be. In resource-poor settings, it is important to avoid rushing into eye-catching campaigns that show immediate action, but have little short- or long-term impact (such as mass media campaigns). In addition, the success or failure of a prevention programme largely depends on whether the target group and other relevant stakeholders are willing and able to take part in, or support, the programme and its implementation.

Some examples of quality standards:

- Sources of opposition to, and support of, the programme are considered
- The ability of the target population to participate in, or support, the programme is assessed
- Internal resources and capacities (i.e. human resources, organisational, technological, financial resources) are assessed.

Evaluating the effectiveness and cost-effectiveness of prevention interventions

Any drug prevention programme should include a scientific monitoring and outcome evaluation component to assess whether the prevention interventions being evaluated have achieved the desired outcome, and are evidence-based. In some cases, governments may choose to test the intervention first with a pilot project, which can help identify the practical issues and weaknesses of the project's implementation. Once sufficient evidence is available around the impacts of the project, it can then be implemented on a broader scale after, if necessary, having been adapted to respond to any issues arising out of the pilot phase. While being carried out, the programme should be regularly monitored to help identify any need for modification. Outcomes and results should be carefully analysed on a regular basis to ensure that the programme is of high quality. The implementation of the programme should remain flexible to ensure that it can be adjusted in

line with the findings of the monitoring process. If such modifications are made, they should be well documented and evaluated to help understand their impact on the programme.

Some examples of quality standards:

- The intervention is implemented with high quality and an orientation towards participants
- The implementation of the intervention is adequately documented and adjusted if necessary
- Outcome and process data are collected frequently and reviewed frequently and systematically
- The conclusions of the evaluation indicate if and what elements of the programme need to be modified to complete the programme successfully
- Adjustments to the programme are well-justified and reasons for adjustments are documented.

Key resources

- European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
- Hawks, D., Scott, K., & McBride, M. (2002), *Prevention of psychoactive substance use: A selected review of what works in the area of prevention* (Geneva: World Health Organisation)
- United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, <http://www.unodc.org/unodc/en/prevention/prevention-standards.html>
- World Health Organisation, *Prevention publications*, http://www.who.int/substance_abuse/publications/prevention/en/

2.4

Harm Reduction

Key recommendations

- Harm reduction approaches and principles should be integrated across all areas of drug policy, and all services that work with people who use drugs – including across the health, social and security sectors
- The UN-endorsed package of harm reduction interventions should be expanded to address harms other than HIV, and delivered to scale and in a way that is acceptable and accessible for people who use drugs
- Governments and international donors should ensure sufficient funding to deliver the optimal harm reduction response. Funds should be diverted from punitive drug law enforcement practices and into harm reduction, where the returns on investments will be greater
- Legal impediments to harm reduction and other health services (including an over-reliance on incarceration and repressive drug policies) should be removed. Law enforcement practices undermining harm reduction services should be addressed and rectified
- Harm reduction should be delivered in a way that empowers communities and people who use drugs, and also meaningfully engages them in programme design, delivery and evaluation
- Harm reduction programmes should ensure that they are gender-sensitive and accessible and relevant for young people who use drugs. This may require the creation of specialist services or programmes for women, young people and other specific groups
- Harm reduction services must be made available in prisons and other closed settings, as well as in the community.

Introduction

Harm reduction has emerged as an evidence-based, highly effective and cost-effective response to drugs around the world in the last 30 years. This approach currently sits alongside other pillars of drug policy – such as demand reduction and supply reduction – and is distinct from these in that the primary focus is on reducing harms, even if this does not result in a reduction in the prevalence of drug use or the scale of the illicit drug market. Harm reduction is a pragmatic response to drug use that accepts that while abstinence may be a worthy goal, it may not be appropriate or desirable for some individuals.

Harm reduction has been best defined by Harm Reduction International as ‘policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.’⁷⁹ In some contexts, this approach is referred to as ‘harm minimisation’ or ‘risk reduction’.

Harm reduction applies to all types of substances and drug use. Historically, it has been overwhelmingly associated with interventions aimed to reduce the health harms associated with the injection of opioids. This has resulted in a lack of attention for harm reduction interventions targeting other types of drugs and use – in particular stimulant use. As patterns of drug use and routes of administration are changing rapidly, there is an urgent need to redress this situation.

Harm reduction can most usefully be conceived as a set of principles rather than a list of interventions (see Box 1). It is both a public health and human rights concept, but also one that focuses on public safety and security: the harms to be targeted may include overdose, infections, over-incarceration, police violence, stigmatisation, marginalisation or harassment, to name just a few – while harm reduction should also seek to empower and engage people who use drugs in the formation, delivery and evaluation of policies and programmes.

Box 1 The principles of harm reduction⁸⁰

- Harm reduction is targeted at risks and harms
- Harm reduction is evidence-based and cost effective
- Harm reduction is incremental, acknowledging the significance of any positive change that individuals make in their lives
- Harm reduction is rooted in dignity and compassion, and consequently rejects discrimination, stereotyping and stigmatisation
- Harm reduction acknowledges the universality and interdependence of human rights
- Harm reduction challenges policies and practices that maximise harm – including criminalisation
- Harm reduction values transparency, accountability and participation.

Around the world, an estimated 246 million people use internationally controlled substances.⁸¹ Of the 8.5 to 21.5 million people who inject drugs, around 13.5% are living with HIV – far exceeding the prevalence in the general population.⁸² While a minority of people who use drugs develop dependence, most experience heightened risks as a result of criminalisation and marginalisation. An estimated 52% of people who inject drugs are living with hepatitis C, and there are thought to be nearly 200,000 drug-related deaths each year – primarily by overdose.⁸³ A growing body of research also points to the harms associated with non-injecting drug use, in particular the snorting and smoking of cocaine and its derivatives. In Latin America, there is increasing evidence that such use is associated with increased vulnerability to HIV and hepatitis C, as well as lung infections.⁸⁴ However, more data is required on the issue.

Legislative/policy issues involved

Available data and statistics clearly demonstrate the need for services and interventions which aim to protect the health and well-being of people who use drugs, prevent infections and prolong life, as well as policies to remove barriers to accessing health or justice.

The concept of harm reduction has been highly politicised in drug policy debates, with a large number of countries strongly in favour, some countries strongly against, and others preferring to refer to individual interventions rather than a harm reduction approach per se. Yet harm reduction is now widely endorsed and recommended by the UN General Assembly, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organisation (WHO), the United Nations Office on Drugs and Crime (UNODC), the Human Rights Council, the Global Fund, and many others.⁸⁵ It is also endorsed in national policy documents in 91 countries, and such high-level endorsement (often through national HIV/AIDS policies) can be important for ensuring the funding and scale-up of these services.⁸⁶

Globally, the coverage of harm reduction services for people who inject drugs remains woefully inadequate: for example, just two needles are distributed per person who injects drugs per month, and only 8% of people who inject opioids had access to opioid substitution therapy (OST).⁸⁷ In many settings, this is a consequence of a lack of political will to scale-up and endorse harm reduction programmes, and a global funding crisis for this approach.⁸⁸ As highlighted above, people who use stimulants have even more limited access to harm reduction services that respond to their specific needs.

In some settings, the coverage of harm reduction is actively undermined by laws or law enforcement practice. For example, the delivery of needle and syringe programmes (which provide sterile injecting equipment to people who use drugs to prevent blood-borne virus transmission through the re-use of unsterile items) face severe barriers in countries where the possession of needles and syringes is deemed as evidence of drug use, or outlawed in its own right. Similarly, OST using methadone, buprenorphine or other medicines is prohibited in some countries.⁸⁹ The WHO has therefore clearly stated that 'Countries should work toward developing policies and laws that decriminalize the use of clean needles and syringes (and that permit NSPs) and that legalize OST for people who are opioid-dependent'.⁹⁰ Similar legislative reforms may also be required for other harm reduction interventions – including drug consumption rooms/safer injecting facilities, and pill or drug checking services. A wide range of UN agencies have now called for the decriminalisation of drug use in order to support harm reduction responses (see Chapter 3.1).

In many countries, harm reduction workers (especially peer and outreach workers) are also targeted by law enforcement for 'promoting' or 'facilitating' drug

Box 2 The Community Action on Harm Reduction (CAHR) Project

The CAHR project is an example of how harm reduction principles can be incorporated into a comprehensive programme. Funded by the Dutch Ministry of Internal Affairs (BUZA), via the International HIV/AIDS Alliance, the five-year project sought to expand access to harm reduction services for people who inject drugs in China, India, Indonesia, Kenya and Malaysia. The project was unique in its approach to develop and expand services to people who inject drugs by supporting grassroots community initiatives, building pragmatic partnerships with local stakeholders, and supporting international and national advocacy efforts to address the policy and structural barriers to programme sustainability.

By mid-2014, the project had reached 65,000 people who inject drugs and 240,000 further beneficiaries (such as sexual partners and family members). More than 13,000 people across the five countries have received voluntary HIV testing and counselling, 40,000 have benefited from psycho-social support, legal support, housing and/or income generation services, and 47,000 have been reached by sexual rights and health services. Furthermore, 90% of people who inject

drugs reported the use of sterile injecting equipment the last time they injected.⁹¹

The CAHR project also places a strong emphasis on building the local capacity of community-based organisations and sharing knowledge and experiences in order to introduce or improve essential harm reduction interventions. In Kenya, for example, the project was instrumental in starting needle and syringe programmes (NSPs) and OST – despite major challenges from police crackdowns and some religious and community leaders.

CAHR also has a strong policy agenda that is defined by the pragmatic objective of developing effective HIV and drug use services based on available evidence. Experiences of the project on the ground are captured to influence policy debates both at the national and international level. Finally, CAHR objectives include the full and meaningful participation of people who use drugs in policy and programme design and a strong commitment to protecting and promoting human rights – for example, the project enabled the establishment of the Kenyan Network of People who Use Drugs.⁹²

use. Wherever possible, it is important that harm reduction services are delivered with the agreement, understanding and collaboration of law enforcement agencies to prevent such issues – whether this is negotiated at the local level, or formalised in national policy guidelines and protocols.⁹³ Similarly, if law enforcement officers target harm reduction services to find and arrest people who use drugs, these services will not be used by their clients and the potential health benefits will be lost.

Implementation issues involved

In 2009, the WHO, the UNODC and UNAIDS articulated a ‘comprehensive package’ of nine interventions to address HIV among people who inject drugs (see the first nine interventions listed below). These interventions collectively ‘have the greatest impact on HIV prevention and treatment’ and a ‘wealth of scientific evidence supporting [their] efficacy’.⁹⁴

It has been widely acknowledged that this list of interventions is not exhaustive. We therefore propose a number of additional evidence-based interventions (interventions 10 to 21 below) – although even this list is not comprehensive as harm reduction is forced to evolve to respond to new patterns of use and harms.

This list is predominantly focused on people who inject drugs and on HIV. However, in an effort to respond to the urgent need to elaborate better harm reduction responses for non-opioid and non-injecting drug use (for instance cocaine and ATS use,⁹⁵ as well as the non-medical use of some pharmaceutical medications), we propose a set of harm reduction interventions specifically targeted at stimulant use (interventions 19 to 21).

1. Needle and syringe programmes: The supply of sterile injecting equipment (including needles and syringes, but also filters, spoons, cleaning swabs and sterile water) to reduce the spread of infections.⁹⁶ Clients are also encouraged to return

their used equipment to allow for their safe disposal, and should be provided with information and education on safer injecting techniques. NSPs have a very strong evidence base in terms of reducing HIV transmission, risk behaviours such as syringe sharing, and helping to signpost individuals into drug treatment where required.⁹⁷

2. OST and other drug dependence treatment:

WHO Essential Medicines such as methadone or buprenorphine can be used to substitute street opioids such as heroin – either in the long term (referred to as ‘maintenance’ therapy) or the shorter term. Some countries also prescribe pharmaceutical heroin (diacetylmorphine) for this purpose, particularly to patients who have not responded to the other medicines available. This heavily-researched intervention has been proven to reduce injecting, reduce criminality, support adherence to HIV,⁹⁸ hepatitis C and tuberculosis⁹⁹ treatment, and improve overall health and well-being.¹⁰⁰ For more information, see Chapter 2.5.

3. HIV testing and counselling: This is targeted specifically at people who use drugs – but always on a voluntary and confidential basis, and ideally tied to efforts to connect newly diagnosed individuals to accessible care and treatment services.

4. Antiretroviral therapy: People who use drugs should have the same access to HIV treatment, following the same recommendations as for all adults.¹⁰¹ In practice, they are often discriminated against or perceived as likely to fail on treatment – yet when treatment is provided in a supportive environment, people who use drugs have similar outcomes to everyone else.¹⁰²⁻¹⁰³

5. Prevention and treatment of sexually transmitted infections: For people who use drugs and their sexual partners, particularly because such infections – especially those that cause genital lesions – may increase the risk of HIV transmission.

6. Condom distribution: Targeted at people who use drugs and their sexual partners.

7. Targeted information, education and communication: Including safer injecting advice (also known as ‘behaviour change communication’). It is important to provide credible information on the effects and harms associated with different substances, as well as objective information about different routes of drug administration. Information, education and communication should be up-to-date and adapt to changing patterns of drug use and purchase – for example, the trend in some countries towards online drug sales provides opportunities for the provision of harm reduction advice through online forums and customer reviews.

8. Vaccination, diagnosis and treatment of viral hepatitis: The vaccine for hepatitis B is highly effective and should be made available to all people at risk, including people who use drugs, prisoners and harm reduction workers. There have been major advances in treatment for hepatitis C, which is a curable disease regardless of a person’s drug use.¹⁰⁴

9. Prevention, diagnosis and treatment of tuberculosis: People who use drugs are at heightened risk of tuberculosis (and multi-drug-resistant tuberculosis) for a range of reasons – from frequent incarceration to the

Credit: Pham Hoai Thanh



A peer educator collecting used needles in Vietnam

Box 3 Overdose programmes in New York City

After years of increasing overdose mortality and the deaths of many friends and clients, three community-based harm reduction programmes launched New York City's first overdose prevention programmes in 2004, including naloxone distribution to people who use opioids. The three groups covered a geographically diverse section of the city, included one harm reduction programme for young people, and quickly moved from an initially small-scale, periodic service to one that expanded to street-based training and saturated communities with information and tools to prevent and reverse overdoses. In mid-2006, following an evaluation of the first projects, the New York City government picked up the costs of the programme – contributing enough funding to support overdose programmes at all of the city's harm reduction organisations and to hire a full-time medical director for the programme. In the two years that followed, overdose mortality dropped by a further 27% across the city.¹⁰⁵

compromised immune systems associated with HIV infections.

10. Basic health services, including overdose prevention and management:¹⁰⁶

Overdose is a common experience for many people who use drugs, and a leading cause of death among people who inject drugs. Harm reduction programmes include the provision of naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Box 3). Services may also focus on resuscitation techniques, and advice on how to prevent overdose in the first place. Additionally, medical amnesties and 'good Samaritan' laws in many countries help to protect people who respond to overdoses from potential liability, increasing the likelihood of life-saving interventions.

11. Services for people who are drug dependent or using drugs in prison or detention:

The whole suite of harm reduction services should be made available in prisons and other closed settings, just as in the community. Yet only eight countries have NSPs in prison (compared to 90



Quai 9, Geneva's drug consumption room, Switzerland

Credit: Studio KO & Association Première Ligne



Crack pipe vending machine in Vancouver, Canada

Credit: PHS Community Services Society & Open Society Foundations

countries with community programmes), and only 43 countries provide OST in prison settings (compared to 80 countries with community programmes). For more information, please refer to Chapter 3.6.

12. Advocacy: This is identified by UNAIDS as one of the 'critical enablers' for an effective HIV response, and covers a wide range of interventions promoting and protecting the health and human rights of people who use drugs, and other affected populations. A key part of this is advocacy for drug policy reform and for harm reduction services.¹⁰⁷ Efforts to reduce the stigma associated with drug use are also crucial to remove key barriers faced by people who use drugs (see Box 4).

13. Psychosocial support: In order to meet the needs of people who use drugs, services should also be able to provide – or help clients to access – mental health, social and financial services where they are required. Psychiatric disorders such as depression, stress and post-traumatic stress disorder are more prevalent among drug using populations.¹⁰⁸ New York's Lower East Side Harm Re-

Box 4 Support Don't Punish: A global show of force for harm reduction and policy reform

The 'Support. Don't Punish' campaign¹⁰⁹ is a global advocacy initiative calling for greater investments in the harm reduction response, and for the reform of ineffective drug policies. First conceived as part of the CAHR project (see Box 2), the campaign comprises independent branding, an interactive website featuring open-access resources, social media presence,¹¹⁰ an Interactive Photo Project where more than 7,000 supporters around the world have taken part,¹¹¹ and a 'Global Day of Action'. For the latter, advocacy efforts are focused on 26 June – the United

Nations Day Against Drug Abuse and Illicit Trafficking – with the aim of reclaiming the media, the public narrative and the political discourse on this high-profile day. On 26 June 2015, activists in 160 cities around the world organised a wide variety of local actions – all using the 'Support. Don't Punish' branding and messaging to raise awareness of the campaign issues, in particular allocating more funding for harm reduction, scaling up services, and removing political and legislative barriers to ensure better access.¹¹²



Credit: Collectif Urgence Toxida

Global Day of Action in Mauritius, 26th June 2015

duction Centre, for example, established a team of mental health professionals to support clients living with mental health issues, as well as housing services, legal support, and case management to coordinate health and social services.¹¹³

14. Access to justice/legal services: As an almost universally criminalised population, people who use drugs often find themselves in confrontation with the criminal justice system. They may also be subject to human rights abuses, police abuse, mistrial and harassment. It is important, therefore, that they have access to legal support. For example, Release is a UK charity focused on drug laws and human rights, which provides a free helpline for people who use drugs to access confidential expert legal advice and support.¹¹⁴

15. Children and youth programmes: Although many young people use drugs, most services are designed for adults and may not even be legally allowed to provide people under the age of 18 with services such as NSPs. Many other

barriers exist that prevent young people from accessing harm reduction services, including parental consent in some countries. Yet many successful youth-oriented harm reduction programmes exist. For example, Vancouver's Crystal Clear harm reduction project provides peer outreach, support and leadership development, harm reduction education and health services, to support young people who use methamphetamine.¹¹⁵

16. Livelihood development/economic strengthening: This includes education, training and financial support for people to access employment, and micro-financing programmes to support people in generating legitimate incomes.

17. Drug consumption rooms/safer injecting facilities:¹¹⁶ These supervised facilities allow people to bring their pre-purchased drugs to be injected, smoked and/or snorted in a sterile, safe environment. The presence of medically trained staff ensures that overdoses and oth-

er health problems can be addressed quickly and effectively. As of 2015, there were 86 drug consumption rooms across seven European countries,¹¹⁷ plus additional services in Sydney, Australia and Vancouver, Canada. Despite many years of operation, and millions of injections overseen, there has never been a fatal overdose in these supervised facilities. The effects extend beyond the facilities themselves: deaths in the neighbourhood around Insite, Vancouver's injection facility, dropped by 35% in the year after it opened.¹¹⁸ In Switzerland, drug consumption rooms have also drastically reduced levels of disturbance in the surrounding public areas.

18. Gender-sensitive services: Women who use drugs often face greater stigma, discrimination and risks than men, and their needs may differ significantly. For example, gender-sensitive harm reduction services are those which provide, or make alternative arrangements for childcare, the prevention of mother-to-child HIV transmission, family counselling and support, programmes to reduce gender-based violence, sex work services, female condoms, and women-only spaces and/or times.¹¹⁹

19. Drug checking: In response to the harms associated with stimulant use and the emergence of a diverse array of NPS, drug checking has

Box 5 The Braços Abertos Programme in Sao Paulo

The 'Braços Abertos' (Open Arms) programme aims to address the significant health, social and security problems in Cracolândia, a large open crack scene in Sao Paulo, Brazil. Launched in 2013, it is targeted at homeless people who use crack in the area. It provides housing in hotels contracted by the government, and offers access to health-care, employment, clothing and one meal a day – without requiring abstinence from crack use. It is an example of a 'Housing First' approach – the objective being to support people with their drug problems by providing stable housing, hence enabling people to reduce a variety of harms associated with life on the street.¹²⁰

The 'Braços Abertos' programme required coordination across several municipal departments (health, culture, education, social welfare, environment, labour and human rights), as well as close partnerships with civil society groups. It seeks to strengthen social networks and encourage the participation and support of society. Since its creation, the programme has empowered participants to return to their families, gain formal employment or adhere to health treatments – and the Brazilian government has announced plans to scale up the approach in 21 cities.¹²¹



Participants of the Braços Abertos programme

Credit: João Luiz/SECOM

emerged to help people know what they are consuming, and avoid using unknown and potentially dangerous adulterants. This service also assists emergency medical staff and public health agencies in identifying trends in illicit drug markets to better tailor their harm reduction and treatment response. Organisations such as DanceSafe in North America provide drug checking services directly at electronic music events, with the cooperation of local public health departments.¹²²

20. Distribution of smoking paraphernalia: Crack use continues to be associated with various health problems, including blisters, sores, cuts on the lips and gums, as well as HIV and hepatitis C infections. Harm reduction groups in Canada have recently promoted the distribution of sterile crack smoking paraphernalia which include glass pipes (which are heat-resistant and shatterproof), mouthpieces, filters, alcohol swabs, screens and push sticks.¹²³

21. Social support services: Other relevant harm reduction services include housing, shelter and employment services (see Box 5).

Key resources

- European Monitoring Centres for Drugs and Drug Addiction (2010), *Harm reduction: Evidence, impacts and challenges*, <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>
- Harm Reduction International (2013), *When sex work and drug use overlap: Considerations for policy and practice*, http://www.ihra.net/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf
- Harm Reduction International (2014), *The global state of harm reduction 2014*, <http://www.ihra.net/contents/1524>
- Harm Reduction International (2015), *A global review of the harm reduction response to amphetamines: A 2015 update*, http://www.ihra.net/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf
- Harm Reduction International, the International HIV/AIDS Alliance, Save the Children & Youth RISE (2015), *Step by step: Preparing for work with children and young people who inject drugs*, <http://www.ihra.net/contents/1660>
- International HIV/AIDS Alliance (2010), *Good practice guide: HIV and drug use*, http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf
- United Nations Office on Drugs and Crime & World Health Organisation (2013), *Opioid overdose: Preventing and reducing opioid overdose mortality*, <https://www.unodc.org/docs/treatment/overdose.pdf>
- United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People Who Use Drugs (2014), *Women who inject drugs and HIV: Addressing specific needs*, http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
- World Health Organisation (July 2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
- World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2012), *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 Revision*, <http://www.who.int/hiv/topics/idu/en/index.html>

2.5

Drug dependence treatment

Key recommendations

- The primary objective of treatment systems for drug dependence should be to enable individuals to enhance autonomy and live fulfilling lifestyles
- Although abstinence may be a worthy goal, it may not be achievable or appropriate for some individuals, who should be given the right to remain under substitution therapy should they wish to do so, and as long as they deem it to be necessary
- Policy makers should make a long-term investment in treatment, in order to adequately respond to drug dependence and reduce its associated health and social costs
- Investments in drug dependence treatment should demonstrate a systemic approach rather than a w of isolated interventions: it should identify those most in need of treatment; offer a balanced menu of evidence-based services; and develop smooth mechanisms for individuals to move between different elements as their circumstances change
- Approaches that breach human rights standards (such as the compulsory detention of people who use drugs) should not be implemented. Not only are these unethical, they are also highly unlikely to achieve the desired aims and are not cost-effective
- More research should be conducted on the treatment of stimulant dependence
- It is necessary to constantly review and evaluate national treatment systems to make sure that they are operating effectively and in accordance to global evidence. Services can be made more effective and responsive if they include the meaningful involvement of clients in their design and delivery.

Introduction

There is an increasing trend to view drug dependence in health terms rather than as a criminal and/or moral problem. Recent estimates suggest that in 2013, approximately 246 million adults used controlled drugs for non-medical purposes (range 162 to 329 million).¹²⁴ Of this total, just one in ten (approximately 27 million adults), were estimated to be dependent on drugs.¹²⁵

Evidence-based drug dependence treatment has proved effective in managing drug dependence, reducing drug-related harms and minimising social and crime costs. Available data demonstrate that opioid substitution therapy (OST) improves retention in treatment and reduces illicit opioid use,¹²⁶ thereby reducing the incidence of injecting, and consequently exposure to blood-borne viruses such as HIV and hepatitis C.¹²⁷ However, only one in six people dependent on drugs has access to evidence-based drug treatment.¹²⁸ In view of this situation, access to OST should be scaled up to address the unmet need that currently exists worldwide.

The range of drugs available is itself increasing, and a model effective for one (for example opioids) may not be effective for another (for example crack, methamphetamines, etc.). There is therefore an urgent need to give more prominence and attention to substitution treatment options for other substances, in particular stimulants. Indeed, pilot studies on the treatment of methamphetamine dependence using dexamphetamine, as well as on the use of cannabis to reduce crack dependence, have shown promising results.

There is a clear economic case for expanding investments in drug dependence treatment, as investments can lead to large-scale savings in health, social and crime costs.¹²⁹ A 2010 study by the UK Home Office estimated that for every £1 (US\$1.40) spent on drug dependence treatment, society benefits to the tune of £2.50 (US\$3.60).¹³⁰ Research in the USA has estimated that the benefit return for methadone maintenance treatment is around four times



A nurse measures out methadone at Ar Rahman mosque in Kuala Lumpur, Malaysia

the treatment cost.¹³¹ Indeed, according to the National Institute on Drug Abuse, 'The average cost for 1 full year of methadone maintenance treatment is approximately \$4,700, whereas 1 full year of imprisonment costs approximately \$18,400 per person',¹³² concluding that 'Research has demonstrated that methadone maintenance treatment is beneficial to society, cost effective and pays for itself in basic economic terms'.¹³³

The impact of drug use on individuals depends on the complex interaction between the pharmacological properties of the substance used, the attributes and attitudes of the person who uses drugs, and the environment in which consumption takes place. Treatment interventions need to consider each of these factors and how they interact. In all societies, the prevalence of drug dependence has been largely concentrated among marginalised groups, where rates of emotional trauma, poverty and social exclusion are highest.¹³⁴ Given the many factors that drive

drug dependence, no single approach to treatment is likely to produce positive outcomes across society. Therefore, policy makers should work towards a treatment system that encompasses a range of models that are closely integrated and mutually reinforcing – and that takes into account the choice and preferences of the person accessing treatment. The impact of the legal and physical environment means that effective treatment interventions should offer both medications and psychosocial services, while taking into account the impact of the social and cultural setting in which they do so. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

Legislative/policy issues involved

International obligations

The obligation on UN member states to provide drug treatment to their citizens is embedded in the international drug control conventions. Under Article 38 of the 1961 Single Convention on Narcotic Drugs, and article 20 of the 1971 Convention on Psychotropic Substances, signatory states are required to take practical measures for 'the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved'.¹³⁵

Moreover, the right to treatment is included in the more general obligations relating to the right to the enjoyment of the highest attainable standard of physical and mental health ('the right to health'). The right to health was first articulated in the Constitution of the World Health Organisation in 1946, and mentioned in the Universal Declaration of Human Rights two years later.¹³⁶ These are foundational documents in the UN system, and the inclusion within them of the right to health demonstrates the importance with which the concept is endowed in international law. The preambles to the UN drug control conventions reinforce these principles; the first words of the 1961 Convention and the 1971 Convention express member states' concern 'with the health and welfare of mankind'.¹³⁷ And, as the former High Commissioner for Human Rights stated: 'Individuals who use drugs do not forfeit their human rights'.¹³⁸

Ensuring access to essential medicines for OST

Both methadone and buprenorphine are included in the WHO Model List of Essential Medicines.¹³⁹ According to human rights treaties within which the right to health is protected, such as the International Covenant

Box 1 Heroin-assisted treatment (HAT) - the UK example

An estimated 5% of opioid users in substitution treatment do not respond well to treatment with methadone. They are often among the most marginalised of people who use drugs and may experience a range of severe health and psychosocial problems. This may result in high costs in terms of welfare and engagement with the criminal justice system.

In the UK, there is a history of prescribing injectable heroin to people dependent on opioids. However, in the 1960s and 1970s, this practice became politically controversial, mainly because people collected take-away doses from pharmacies, with very little supervision. It is probable that this prescribing fed an illicit market. By the mid- to late-1970s, the prescribing of heroin ceased almost entirely. Nonetheless, there continued to be an unmet therapeutic need among a highly vulnerable section of people dependent on drugs, who did not progress with methadone and tended to purchase and use illicit supplies of heroin in addition to, or instead of, their methadone doses.

In recent years, a new and politically more acceptable regime of HAT was developed in Europe, especially in Switzerland.¹⁴¹ The UK began

scientific trials of this method, in which clients received doses of injectable heroin in special clinical facilities, under controlled conditions, with close supervision and support from medical staff in a clean and secure setting.¹⁴²

Many of these clients found it to be a life-changing experience, and saw significant improvement in their health and social well-being, alongside large reductions in illicit drug use and associated criminal activity. The trials involved the clients in peer support and research assistant capacities. The researchers found that HAT enabled a hard-to-reach and hard-to-treat population to access healthcare and support services, as well as meeting political and public order objectives and the requirements of clinical safety.¹⁴³

A recent systematic review and meta-analysis of randomised controlled trials with HAT has been carried out by some of the researchers involved in these trials. Those reviewed were carried out in Canada, Germany, the Netherlands, Spain, Switzerland and the UK. The research concluded that 'heroin-prescribing, as a part of highly regulated regimen, is a feasible and effective treatment for a particularly difficult-to-treat group of heroin-dependent patients'.¹⁴⁴

on Economic, Social and Cultural Rights, the medicines that signatory states are obliged to make available must be 'scientifically and medically appropriate'.¹⁴⁰

In countries such as the Netherlands, the UK and Switzerland, governments have developed successful treatment programmes providing a large range of options, including substitution with methadone and buprenorphine, but also with morphine and heroin (see Box 1). It is essential that drug laws and policies be reviewed to ensure adequate access to these substances for OST.

In some countries, however, people who use drugs have lost their fundamental right to health. In Russia, Turkmenistan and Uzbekistan, for instance, the use of methadone is prohibited by law. This is despite the fact that the United Nations Office on Drugs and Crime (UNODC) estimates that 2.29% of the adult population of Russia are injecting drugs. A third of the global total of people who inject drugs living with HIV reside in Russia.¹⁴⁵ The proportion of Russian AIDS cases linked to injecting drug use is estimated at 65%, while around 35% of people who inject

drugs are living with HIV.¹⁴⁶ The country is subject to epidemic levels of both injecting drug use and HIV, yet the availability of the treatment with the most extensive evidence base, OST, is blocked by the Russian government. In other countries where methadone is available, buprenorphine remains illegal, as is the case in Mauritius – leaving limited treatment options for people dependent on opioids.

Ending compulsory detention

In many countries, treatment systems for drug dependence are non-existent or under-developed, or pursue models inconsistent with human rights standards and global evidence of effectiveness. Research, experience and international human rights instruments indicate that certain treatment practices should not be implemented. Some governments, for example, have introduced treatment regimes that rely on coercion, ill-treatment, denial of medical care, or forced labour.¹⁴⁷

In China and South East Asia, including in Vietnam, Cambodia, Malaysia, Thailand and Lao People's Democratic Republic, the use of compulsory centres

for drug users (CCDUs) as a mode of rehabilitation is a widely accepted and common practice.¹⁴⁸ The use of compulsory detention is also found in Latin America and Central Asia.

CCDUs are generally run by the police or military rather than health authorities, and people caught using drugs are forced to stay in such facilities, frequently without due legal process or judicial oversight, sometimes for several years. They are denied scientific, evidence-based drug treatment, and can be subjected to forced labour, which is either unpaid or paid well below minimum wage levels, as well as a range of punishment such as physical, psychological and sexual abuse, and solitary confinement. General medical healthcare is often non-existent, and diseases such as HIV and tuberculosis are widespread among detainees.

CCDUs are also very costly and ineffective. Relapse rates are very high (in Vietnam, for example, from 80% to 97%)¹⁴⁹ and detainees face challenges with social reintegration largely due to the stigmatisation associated with being detained for using drugs. Although certain governments in the region have recently introduced new drug laws that have modified the status of people who use drugs from 'criminals' to 'patients', such as China's 2008 Anti-Drug Law and Thailand's 2002 Narcotic Addict Rehabilitation Act, the humanitarian rhetoric of these legal texts is unrepresentative of the reality of life in the compulsory centres, which impose cruel and dangerous

punishments under the guise of treatment.¹⁵⁰ These conditions violate scientific and medical standards, as well as international human rights law.

In 2012, a joint statement supported by 12 UN agencies called for the closure of compulsory detention centres on the grounds that they violate human rights and threaten the health of detainees.¹⁵¹ The UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have since run a series of consultations on compulsory centres. The third consultation took place in September 2015, and was attended by drug control, health and finance officials from Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand and Vietnam. These countries agreed to sign up to a 'roadmap' toward evidence-based support services for people who use drugs.¹⁵²

Nonetheless, there is a clear need to accelerate national-level transitions to voluntary, community-based drug dependence treatment and support services, which require corresponding reforms to drug laws and policies in order to remove incarceration and other punitive responses for people who use drugs. Although the process may be a slow one, the UN and civil society stakeholders have worked hard to develop guidance and recommendations on the way forward, and elements of community-based treatment have already been established in Cambodia, China, Indonesia, Malaysia, Thailand and Vietnam.¹⁵³



Credit: 2011 Private, Human Rights Watch

A guard keeps an eye on the detainees of a Vietnamese compulsory detention centre before they head to their working morning session

Box 2 A community-based treatment model in Indonesia

Rumah Singga PEKA (PEKA) is a local civil society organisation based in Bogor, Indonesia, offering treatment options for people who inject drugs. The overall objective of PEKA is to improve the quality of life of people who use drugs. As such, it relies heavily on client-centred approaches to deliver tailored health services that adequately meet the needs of people who use drugs. Access to treatment is voluntary and people can withdraw from the programme at any time. Treatment includes both in-patient and community-based options. Clients can choose between an intensive two-months programme (involving detoxification, peer counselling, psychosocial support, life-skills training, relapse prevention and social and vocational activities) or a non-intensive four-months programme (involving counselling, life-skills training, relapse prevention and social and vocational activities).

Clients have the option of entering OST (with both methadone and suboxone), primary and reproductive healthcare, HIV counselling and testing, ART, testing and treatment for hepatitis C, tuberculosis and STIs. To do so, PEKA has established a comprehensive network of hospitals, community health centres, health laboratories and private psychiatrists to facilitate effective health referrals for clients. Sterile injecting equipment is available for all clients. Finally, PEKA mobilises people who use drugs to participate in advocacy interventions and campaigns.

In 2013, PEKA reached a total of 786 people using drugs. Among those, 95 received inpatient treatment, and 691 were reached via community outreach, 670 were referred to HIV counselling and testing, and 13 to OST. In 2014, an additional 250 inmates received training and education sessions in four prisons.¹⁵⁴

Implementation issues involved

The complexity of drug dependence is such that the response, setting and intensity of treatment need to be tailored to each person. It is therefore essential that a comprehensive menu of services is made available to suit the differing characteristics, needs, preferences and circumstances of each person

wishing to access treatment. Moreover, treatment programmes should be thoroughly integrated with prevention and harm reduction services, and have effective linkage(s) with criminal justice, public health and social welfare services.

Entering a treatment programme

There are a number of potential routes through which a person can approach treatment services without falling into the trap of coercive treatment models or compulsory detention:

- Self-referral – Sufficient information should be available for people to be aware of the range of treatment services available
- Identification through general health and social service structures – Existing healthcare and social services will often be in an excellent position to recognise symptoms of drug dependence and encourage the person to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role, provided they have sufficient training on drugs and drug dependence
- Identification through specialist drug advice centres or street outreach services – These services can offer food, temporary housing, low-threshold harm reduction services, and mechanisms to refer people to drug treatment programmes on a voluntary basis
- Identification through the criminal justice system – Through the illicit nature of their drug use, and the need to fund it, people dependent on drugs may come into contact with the criminal justice system. A range of referral schemes can be established to offer people dependent on drugs who have committed low-level offences opportunities to attend a treatment programme (see Chapter 3.4 for more information).

Treatment methods

Multiple methods of evidence-based treatment should be available, ranging from substitution therapy to psychosocial support and abstinence-oriented approaches, so that those seeking treatment may select the most appropriate form for themselves. When the treatment method chosen is substitution therapy, it is essential that medical staff providing the treatment be adequately trained, and that the dosage of the substitution drug is adequate for the needs of the client.

As the range of substances being used is expanding – and the demand for treatment for stimulant dependence is increasing – governments and

scientists are now playing catch-up to develop effective systems of treatment for methamphetamines (see Box 3), crack (see Box 4), and new psychoactive substances (NPS). Some countries have established extensive treatment systems over many decades, while others are just starting to develop experience and understanding of this policy area. However, all countries have some way to go to achieve a sufficiently integrated range of treatment services for drug dependence that makes effective use of available resources to maximise health and social gains.

Treatment success and recovery should not be understood only as abstinence from drug use. Recovery encompasses any positive step or change that leads to the improvement of the person's health, well-being and overall quality of life. This is particularly true for people under substitution therapy,¹⁵⁵ but also for people who have learned to control their drug use in order to minimise the health and social harms associated with it (for example, see Box 4).¹⁵⁶ Recovery is therefore incremental, and it is up to each individual to decide what their goal towards recovery will be within their treatment programme.

Treatment setting

As well as offering a variety of evidence-based interventions, an effective treatment system should also deliver interventions in a range of environments. Treatment can be community-based (such as regular attendance at a clinic where clients receive prescribed medications, psychosocial support and counselling, etc.), residential, or delivered in other health services such as drop-in centres or harm reduction facilities. It is difficult to be prescriptive about which should receive the greatest emphasis, as this will vary according to the particular needs of the person, available resources, and the availability of trained medical professionals – for maximum coverage, a combination of all of these settings constitutes the best option. Community settings tend to be less costly in resource-constrained environment, and may be more appropriate where there is strong social, family and community support for the person dependent on drugs. However, it can sometimes be better for the client to be treated away from their home area when these supports are absent. Such decisions should be made on an individual basis, by the client and therapist working in partnership, as part of a care plan. The chain of care should be thoroughly integrated – as clients may wish to move across all three of these settings during their treatment programme, according to their needs.

Box 3 Treatment for amphetamine-type stimulants

Methamphetamine and other ATS are the second most widely used drugs globally, after cannabis.¹⁵⁷ These stimulants can be associated with considerable levels of health harms, including psychological problems and medical complications, many of which can be severe in the case of heavily dependent use.¹⁵⁸ Current treatment for ATS use is predominantly behavioural, with cognitive behavioural therapy amongst the most frequently given treatments.

Substitution therapies are not widely available to people who use ATS, as the evidence base remains nascent.¹⁵⁹ Many prescribed psychostimulant substances have been proposed and utilised, including modafinil and dexamphetamine. In addition, dopamine agonists, anticonvulsants, antidepressants and antipsychotics have been used in trials of treatments for amphetamine. In Melbourne, Australia, dexamphetamine was prescribed in a supervised setting to a group of long-term ATS injectors. They reported that dexamphetamine reduced their drug cravings, and alleviated the symptoms of withdrawal. Approximately half became abstinent, according to self-report (although no urine analysis was carried out to confirm the abstinent status).¹⁶⁰

However, it is highly unlikely that a single substitute will be found suitable for treatment of the diverse range of ATS on the market. With ATS now a global commodity with prolific individual and social harms, it is important for researchers, pharmaceutical manufacturers and governments to cooperate in the urgent identification of new substitution treatments for ATS and other substances, such as cocaine.

Effective aftercare support

Many people dependent on drugs are economically vulnerable and socially excluded, mainly because of the high stigma and discrimination resulting from the criminalisation of drug use (see Chapter 3.1). A crucial objective of treatment is to improve people's engagement in society. This means raising levels of education, facilitating access to employment and housing, and offering other social support. A key element of this process is the strengthening of so-

Box 4 Evidence for crack dependence treatment: The case for medical cannabis

In Brazil, the use of crack is associated with a number of health and social harms, including marginalisation, violence, increased vulnerability to HIV, or involvement in petty crime and sex work. The lack of adequate harm reduction and treatment measures offered by the government has led people using crack to develop their own strategies for minimising these harms, in particular cravings and psychosis. Such measures have included combining crack use with cannabis.¹⁶¹

A 2015 qualitative study using interviews among 27 Brazilian people combining cannabis and crack consumption showed that this technique reduced craving for crack, improved people's sleep and appetite, and 'protected' them from the violence often associated with crack culture in the country – therefore improving their overall quality of life.¹⁶² A 1999 study among 25 young men dependent on crack in Brazil showed similar results – 68% of those involved in the study stopped using crack and reported that cannabis use had reduced craving symptoms.¹⁶³

The local government in Bogota, Colombia introduced a similar initiative in 2013 in an effort to assess whether cannabis use could alleviate the harms associated with crack use.²²⁹ Uruguay is also considering the use of medicinal cannabis for people dependent on cocaine and pasta base.¹⁶⁵

cial and community ties. The engagement of people who use drugs – current and former – in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services.

The goal of drug treatment should be, if possible, to assist a person dependent on drugs to achieve a high level of health and well-being. In this context, it is necessary to recognise that some people may find it impossible or undesirable to attain abstinence. However, this needs not preclude the main objective of treatment, that of helping clients to live happily and productively. Indeed, many people who are dependent on opioids are perfectly able to successfully achieve this while remaining on OST.

Key resources

- Council of the European Union (September 2015), *Council conclusions on the implementation of the EU Action Plan on Drugs 2013-2016 regarding minimum quality standards in drug demand reduction in the European Union*, <http://www.emcdda.europa.eu/news/2015/eu-minimum-quality-standards>
- Tanguay, P., Stoicescu, C. & Cook, C. (October 2015), *Community-based drug treatment models for people who use drugs*, http://www.ihra.net/files/2015/10/19/Community_based_drug_treatment_models_for_people_who_use_drugs.pdf
- United Nations Office on Drugs and Crime (2012), *TREATNET Quality standards for drug dependence treatment and care services*, https://www.unodc.org/docs/treatment/treatnet_quality_standards.pdf
- United Nations Office on Drugs and Crime & World Health Organisation (2008), *Principles of drug dependence treatment*, http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf
- World Health Organisation (2001), *Management of substance dependence review series – Systematic review of treatment for amphetamine-related disorders*, http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.5.pdf
- World Health Organisation (2009), *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*, http://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf
- World Health Organisation (2011), *Therapeutic interventions for users of Amphetamine Type Stimulants (ATS)*, WHO Briefs on ATS number 4, <http://www.idpc.net/sites/default/files/library/WHO-technical-brief-ATS-4.pdf>
- World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2004), *WHO/UNODC/UNAIDS Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

Chapter 2 - endnotes

1. Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, <http://www.unodc.org/unodc/en/treaties/single-convention.html> & UN Convention on Psychotropic Drugs of 1971, <https://www.unodc.org/unodc/en/treaties/psychotropics.html>
2. Hallam, C. Bewley-Taylor, D. & Jelsma, M. (2014), *Scheduling in the international drug control system* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2014/06/scheduling-in-the-international-drug-control-system>
3. Nutt, D. King, L.A., Saulsbury, W. & Blackmore, C. (2007), 'Development of a rational scale to assess the harm of drugs of potential misuse', *The Lancet*, **369**(9566): 1047-1053, <http://www.thelancet.com/journals/lancet/article/PIIS0140673607604644/abstract>. This research was reviewed in 2010, see: Nutt, D., King, L.A. & Phillips, L.D. (November 2010), 'Drug harms in the UK: A multicriteria decision analysis', *The Lancet*, **376**(9752): 1558-1565, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961462-6/fulltext#article_upsell. However, even the scientific methodology and ranking proposed by Nutt et al has been questioned, highlighting the complexity of capturing the level of harms related to drug using behaviours and environments, the personal and social risks of particular groups of people who use drugs, and the broader socio-cultural context in which drug use takes place. See: Rolles, S. & Measham, F. (July 2011), 'Questioning the method and utility of ranking drug harms in drug policy', *International Journal of Drug Policy*, **22**(4): 243-246, [http://www.ijdp.org/article/S0955-3959\(11\)00058-2/abstract](http://www.ijdp.org/article/S0955-3959(11)00058-2/abstract)
4. The revised 2010 ranking of harm places ketamine lower in the scale of harms, after alcohol, heroin, crack, methamphetamine, tobacco, cannabis and GHB. See: Nutt, D., King, L.A. & Phillips, L.D. (November 2010), 'Drug harms in the UK: A multicriteria decision analysis', *The Lancet*, **376**(9752): 1558-1565, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2961462-6/fulltext#article_upsell
5. Figure taken from: West Africa Commission on Drugs (2014), *Not just in transit: An independent report of the West Africa Commission on Drugs*, <http://www.wacommissionondrugs.org/report/>
6. Commission on Narcotic Drugs (16 December 2014), *Changes in the scope of control of substances, Note by the Secretariat*, E/CN.7/2015/7, <http://www.un.org/Docs/journal/asp/ws.asp?m=E/CN.7/2015/7>
7. Scholten, W. (2014), *Factsheet on the proposal to discuss international scheduling of ketamine at the 58th CND*, <http://idpc.net/publications/2015/01/fact-sheet-on-the-proposal-to-discuss-international-scheduling-of-ketamine-at-the-58th-cnd>
8. Co-ordination Centre for the Assessment and Monitoring New Drugs (November 2007), *Riscoschatting qat 2007* (Coördinatiepunt Assessment en Monitoring nieuwe drugs), http://www.rivm.nl/bibliotheek/digitaaldepot/CAM_qat_riscoschattingsrapport_2007.pdf
9. De Jonge, M. & Van der Veen, C. (2011), *Qatgebruik onder Somaliërs in Nederland* (Utrecht: Trimbos Instituut)
10. Advisory Council on the Misuse of Drugs (January 2013), *Khat: A review of its potential harms to the individual and communities in the UK*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144120/report-2013.pdf
11. BBC News (3 July 2013), *Herbal stimulant khat to be banned*, <http://www.bbc.com/news/uk-23163017>
12. Travis, A. (29 November 2013), 'MPs urge Theresa May to reverse qat ban', *The Guardian*, <http://www.theguardian.com/politics/2013/nov/29/mps-urge-theresa-may-reverse-qat-ban>
13. UK Home Office (2014), *Khat fact sheet for England & Wales*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341917/Khat_leaflet_A4_v12_2.pdf
14. World Health Organisation (2012), *WHO Expert Committee on Drug Dependence – Thirty-fifth Report*, WHO Technical Report Series 973, http://apps.who.int/iris/bitstream/10665/77747/1/WHO_trs_973_eng.pdf?ua=1
15. Durjava, L. & Southwell, M. (29 September 2013), 'Ketamine: Living in dreams, managing the realities', *Open Democracy*, <https://www.opendemocracy.net/lana-durjava-mat-southwell/ketamine-living-in-dreams-managing-realities>
16. World Health Organisation (April 2015), *WHO Model list of essential medicines, 19th list*, http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1
17. Advisory Council on the Misuse of Drugs, UK government, <https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs>
18. Advisory Council on the Misuse of Drugs (2008), *Cannabis: Classification and public health* (London: Home Office), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/119174/acmd-cannabis-report-2008.pdf
19. House of Commons Hansard Debates for 9th February 2009, Column 1094, <http://www.publications.parliament.uk/pa/cm200809/cmhansrd/cm090209/debtext/90209-0001.htm>
20. David Nutt (2009), *Estimating drug harms – A risky business?* (London: Centre for Crime and Justice Studies), <http://www.crimeandjustice.org.uk/publications/estimating-drug-harms-risky-business>
21. Mark Easton (2009), 'Nutt gets the sack', *BBC Blog*, http://www.bbc.co.uk/blogs/thereporters/markeaston/2009/10/nutt_gets_the_sack.html
22. BZP in 2007 and mephedrone in 2010
23. European Commission (11 July 2011), *Report from the Commission on the assessment of the functioning of Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances*, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0430:FIN:en:PDF>; European Commission (11 July 2011), *Commission Staff Working Paper on the assessment of the functioning of Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances*, *Accompanying the Document Report from the Commission on the assessment of the functioning of Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances*, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=SEC:2011:0912:FIN:en:PDF>
24. See: Europa Press releases database (17 September 2013), *European Commission takes decisive action against legal highs*, http://europa.eu/rapid/press-release_IP-13-837_en.htm
25. Ibid
26. Ibid
27. Ibid
28. For example, in January 2014, the UK announced that it would opt out of the proposed system ostensibly because it strongly disputes the EU claim that 20% of 'legal highs' have 'legitimate commercial and industrial uses'. See: Travis, A. (13 January 2014), 'Legal highs: UK to opt out of new EU regulation regime', *The Guardian*, <http://www.theguardian.com/world/2014/jan/13/legal-highs-uk-opt-out-eu-regulation-regime>
29. Vasconi, C. (September 2013), *Expert Seminar – Where next for Europe on drug policy reform? IDPC-TNI-SICAD, Lisbon, Portugal, 20th to 21st June 2013*, p. 15, http://www.tni.org/sites/www.tni.org/files/download/expert_seminar_in_lisbon_final.pdf
30. See: McCullough, Wood, J. & Zorn, R. (September 2013), *New Zealand's psychoactive substances legislation* (London: International Drug Policy Consortium & New Zealand Drug Foundation), <http://idpc.net/publications/2013/09/idpc-briefing-paper-new-zealand-s-psychoactive-substances-legislation>; New Zealand Drug Foundation (2013), *Briefing and submission guide on the Psychoactive Substances Bill*, https://www.drugfoundation.org.nz/sites/default/files/NZ%20Drug%20Foundation%20-%20Psychoactive%20Substances%20Bill%20submission%20guide_0.pdf
31. <http://www.legislation.govt.nz/act/public/2013/0053/latest/DLM5042921.html?src=qs>
32. See: McCullough, Wood, J. & Zorn, R. (September 2013), *New Zealand's psychoactive substances legislation* (London: International Drug Policy Consortium & New Zealand Drug Foundation), p. 7,

<http://idpc.net/publications/2013/09/idpc-briefing-paper-new-zealand-s-psychoactive-substances-legislation>

33. World Health Organisation (1985), *WHO Expert Committee on Drug Dependence: Twenty-Second Report*, TRS 729, http://apps.who.int/iris/bitstream/10665/39635/1/WHO_TRS_729.pdf
34. World Health Organisation (2006), *Assessment of khat (Catha edulis Forsk)*, WHO Expert Committee on Drug Dependence, 34th ECDD 2006/4.4, http://www.who.int/medicines/areas/quality_safety/4.4KhatCritReview.pdf
35. See: World Health Organisation (2011), *Ensuring balance in national policies on controlled substances*, http://apps.who.int/iris/bitstream/10665/44519/1/9789241564175_eng.pdf
36. See: International Narcotics Control Board & World Health Organisation (2012), *Estimating requirements for substances under international control*, https://www.incb.org/documents/Narcotic-Drugs/Guidelines/estimating_requirements/NAR_Guide_on_Estimating_EN_Ebook.pdf
37. Nutt, D. (27 January 2015), 'Illegal drugs laws: Clearing a 50-year-old obstacle to research', *PLOS Biology*, **13**(1): e1002047. doi:10.1371/journal.pbio.1002047, <http://journals.plos.org/plos-biology/article?id=10.1371/journal.pbio.1002047>
38. World Health Organisation (April 2015), *WHO Model list of essential medicines, 19th list*, http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1
39. Ibid
40. See: World Health Organisation (April 2015), *WHO Model list of essential medicines, 19th list*, http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1; World Health Organisation (April 2015), *WHO model list of essential medicines for children, 5th list*, http://www.who.int/entity/medicines/publications/essentialmedicines/EMLc_2015_FINAL_amended_AUG2015.pdf?ua=1
41. World Health Organisation (April 2012), *Briefing note – Access to controlled medications programme: Improving access to medications controlled under international drug conventions*, http://www.who.int/medicines/areas/quality_safety/ACMP_BrNote_Genrl_EN_Apr2012.pdf?ua=1
42. Global Commission on Drug Policy (October 2015), *The negative impact of drug control on public health: The global crisis of avoidable pain*, p. 22, <http://www.globalcommissionondrugs.org/reports/>
43. Ibid
44. International Narcotics Control Board (2011), *Report of the International Narcotics Control Board on the availability of internationally controlled drugs: Ensuring adequate access for medical and scientific purposes*, http://www.incb.org/documents/Publications/AnnualReports/AR2010/Supplement-AR10_availability_English.pdf; International Narcotics Control Board (1995), *Availability of opiates for medical needs: Report of the International Narcotics Control Board for 1995*, p. 1, <https://dl.dropboxusercontent.com/u/64663568/library/incb-availability-of-opiates-for-medical-purposes-1995.pdf>
45. 1961 Single Convention on Narcotic Drugs, articles 30(1)(b)(i), 30(1)(b)(ii), 30(2)(b)(i) and 34(b)
46. See: article 39 of the 1961 Single Convention on Narcotic Drugs and article 23 of the 1971 Convention on Psychotropic Substances
47. World Health Organisation (2011), *Ensuring balance in national policies on controlled substances*, http://apps.who.int/iris/bitstream/10665/44519/1/9789241564175_eng.pdf
48. International Narcotics Control Board (2015), *INCB Annual Report for 2014*, https://www.incb.org/documents/Publications/AnnualReports/AR2014/English/AR_2014.pdf; International Narcotics Control Board (2011), *Report of the International Narcotics Control Board on the availability of internationally controlled drugs: Ensuring adequate access for medical and scientific purposes*, http://www.incb.org/documents/Publications/AnnualReports/AR2010/Supplement-AR10_availability_English.pdf
49. General Assembly (30 March 2010), *Resolution adopted by the General Assembly on 18 December 2009 – 64/182. International cooperation against the world drug problem*, A/RES/64/192, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/RES/64/182>; Commission on Narcotic Drugs (2010), *CND Resolution 53/4: Promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse*, https://www.unodc.org/documents/commissions/CND/Drug_Resolutions/2010-2019/2010/CND_Res-53-4.pdf
50. United Nations Office on Drugs and Crime (2011), *Ensuring availability of controlled medications for the relief of pain and preventing diversion and abuse*, https://www.unodc.org/docs/treatment/Pain/Ensuring_availability_of_controlled_medications_FINAL_15_March_CND_version.pdf
51. World Health Assembly (2014), *Strengthening of palliative care as a component of comprehensive care throughout the life course*, WHA67.19, http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R19-en.pdf
52. World Health Organisation (2011), *Ensuring balance in national policies on controlled substances*, http://apps.who.int/iris/bitstream/10665/44519/1/9789241564175_eng.pdf
53. Human Rights Watch (June 2015), *Mexico: Breakthrough for pain treatment modernized system for prescribing strong medicines*, <https://www.hrw.org/news/2015/06/15/mexico-breakthrough-pain-treatment>
54. Human Rights Watch (October 2014), *Care when there is no cure – Ensuring the right to palliative care in Mexico*, <https://www.hrw.org/report/2014/10/28/care-when-there-no-cure/ensuring-right-palliative-care-mexico>
55. Human Rights Watch (September 2010), *Needless pain government failure to provide palliative care for children in Kenya*, <https://www.hrw.org/report/2010/09/09/needless-pain/government-failure-provide-palliative-care-children-kenya>
56. Communication with Dr. Zipporah Ali, Executive Director of the Kenya Hospice and Palliative Care Association, September 2015
57. The 2015 UNODC World Drug Report acknowledges that the global prevalence of drug use has overall remained stable. See: United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, p. 11, <http://www.unodc.org/wdr2015/>
58. See, for instance: Werb, D., Mills, E.J., DeBeck, K., Montaner, J.S.G. & Wood, E. (2011), 'The effectiveness of anti-illicit-drug public-service announcements: A systematic review and meta-analysis', *Journal of Epidemiology & Community Health*, **65**(10): 834-840, <http://www.ncbi.nlm.nih.gov/pubmed/21558482>
59. United Nations Office on Drugs and Crime, *Prevention*, <http://www.unodc.org/unodc/en/prevention/>; Canadian Centre on Substance Abuse (2013), *A case for investing in youth substance abuse prevention*, <http://www.ccsa.ca/Resource%20Library/2012-ccsa-Investing-in-youth-substance-abuse-prevention-en.pdf>; Miller, T., & Hendrie, D. (2009), *Substance abuse prevention dollars and cents: A cost-benefit analysis* (Center for Substance Abuse Prevention), <http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf>; Lee, S., Drake, E., Pennucci, A., Miller, M. & Anderson, L. (2012), *Return on investment: Evidence-based options to improve statewide outcomes* (Olympia: Washington State Institute for Public Policy)
60. US Government Accountability Office (January 2003), *Youth illicit drug use prevention: DARE long-term evaluations and federal efforts to identify effective programs*, <http://www.gao.gov/products/GAO-03-172R>; Rosenbaum, D.P. & Hanson, G.S. (1998), 'Assessing the effects of school-based drug education: A six year multilevel analysis of Project DARE', *Journal of Research in Crime and Delinquency*, **35**(4): 381, <http://jrc.sagepub.com/content/35/4/381.abstract>; Lynam, D.R., et al. (1999), 'Project DARE: No effects at 10-year follow-up', *Journal of Consulting and Clinical Psychology*, **67**(4): 590, <http://barkingduck.net/ehayes/essays/ccp674590.html>. A similar campaign in the UK entitled 'Heroin Screws You Up', aimed to show the adverse impacts of heroin on physical appearance, was also counter-productive and led to increases in heroin use in the country. See: Hinkley, K. (21 October 2014), '5 ridiculous anti-drugs posters', *TalkingDrugs*, <http://www.talkingdrugs.org/5-anti-drugs-campaigns>
61. European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
62. United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, <https://www.unodc.org/unodc/en/prevention/prevention-standards.html>

63. See: <http://www.emcdda.europa.eu/topics/prevention>
64. Hawks, D., Scott, K., & McBride, M. (2002), *Prevention of psychoactive substance use: A selected review of what works in the area of prevention* (Geneva: World Health Organisation); Orwin, R., et al. (2004), *Evaluation of the national youth anti-drug media campaign: 2004 report of findings* (Washington DC: National Institute on Drug Abuse), <http://archives.drugabuse.gov/initiatives/westat/#reports>
65. Hawks, D., Scott, K., & McBride, M. (2002), *Prevention of psychoactive substance use: A selected review of what works in the area of prevention* (Geneva: World Health Organisation); European Monitoring Centre on Drugs and Drug Addiction, *EMCDDA best practice in drug interventions*, <http://www.emcdda.europa.eu/best-practice#view-start>
66. Babor, T., et al. (2010), *Drug policy and the public good* (Oxford: Oxford University Press); See, also the impacts of the Coping Power Programme in the Netherlands: http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=NL0801, or that of the 'EmPeCemos' (Emotions, Thoughts and Feelings for a healthy development) programme in Spain: http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=ES_03
67. More information about Unplugged, as well as the tools, activities and various projects, can be found on the EU-Dap website: www.eudap.net
68. See, for instance: Van der Kreeft, P. et al (2009), 'Unplugged': A new European school programme against substance abuse', *Drugs: education, prevention and policy*, **16** (2): 167-181; Faggiano, F. et al (2010), 'The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial', *Drug and Alcohol Dependence*, **108**: 56-64
69. European Monitoring Centre on Drugs and Drug Addiction, *Searching family treasure summary*, http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=5136&tab=overview
70. European Monitoring Centre on Drugs and Drug Addiction, *Searching family treasure – Executive summary*, http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=5136
71. European Monitoring Centre on Drugs and Drug Addiction, *Searching family treasure summary*, http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=5136&tab=overview
72. Ibid
73. Instituto da Droga e da Toxicodependência (2012), *Prevenção das toxicodependências em Grupos Vulneráveis – Catálogo de Boas Práticas*, <http://www.sicad.pt/PT/Intervencao/PrevencaoMais/Documents/Cat%C3%A1logo de Boas Pr%C3%A1ticas 2012.pdf>
74. Room, R. (2006), *The effectiveness and impact of environmental strategies of prevention: Lessons from legal psychoactive substances, and their applicability to illicit drugs*, http://www.emcdda.europa.eu/attachements.cfm/att_44273_EN_History%20and%20concepts%20of%20environmental%20strategies%20-%20Robin%20Room.pdf
75. European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
76. See: United Nations Office on Drugs and Crime (2013), *International standards on drug use prevention*, <http://www.unodc.org/unodc/en/prevention/prevention-standards.html>; European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
77. These key points and examples of quality standards presented below are drawn from: European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
78. European Monitoring Centre on Drugs and Drug Addiction (2011), *European drug prevention quality standards*, <http://www.emcdda.europa.eu/publications/manuals/prevention-standards>
79. Harm Reduction International (2010), *What is harm reduction?* A position statement from the International Harm Reduction Association, <http://www.ihra.net/what-is-harm-reduction>
80. Ibid
81. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
82. Ibid
83. Ibid
84. Harm Reduction International (2015), *A global review of the harm reduction response to amphetamines: A 2015 update*, http://www.ihra.net/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf
85. See, for example: <http://bookofauthorities.info/>
86. Harm Reduction International (2014), *The global state of harm reduction 2014*, <http://www.ihra.net/contents/1524>
87. 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', *The Lancet*, **375**(9719): 1014-1028, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60232-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60232-2/abstract)
88. Harm Reduction International, International Drug Policy Consortium & International HIV/AIDS Alliance (2014), *The funding crisis for harm reduction*, www.ihra.net/files/2014/09/22/Funding_report_2014.pdf
89. Most notably Russia, where more than one-third of people who inject drugs are living with HIV. See: Global Commission on Drug Policy (2011), *War on drugs*, http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf
90. World Health Organisation (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
91. Shaw, G. (2014), *Independent evaluation: Community Action on Harm Reduction (CAHR)*, <http://www.cahrproject.org/resource/independent-evaluation-cahr/>
92. For more information, visit the CAHR website: www.cahrproject.org
93. International Conference on Drug Policy and Policing (2013), *Frankfurt principles on drug law enforcement*, <https://www.openso-cietyfoundations.org/briefing-papers/frankfurt-principles>
94. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2009), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, <http://www.who.int/hiv/pub/idu/targetsetting/en/>. This document has since been updated in 2012: http://www.who.int/hiv/pub/idu/targets_universal_access/en/
95. Harm Reduction International (2015), *A global review of the harm reduction response to amphetamines: A 2015 update*, http://www.ihra.net/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf
96. United Nations Office on Drugs and Crime & World Health Organisation (2013), *Opioid overdose: Preventing and reducing opioid overdose mortality*, <https://www.unodc.org/docs/treatment/overdose.pdf>
97. World Health Organisation (2004), *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, <http://www.who.int/hiv/pub/idu/e4a-needle/en/>
98. Roux, P., et al. (2009), 'Retention in opioid substitution treatment: A major predictor of long-term virological success for HIV-infected injection drug users receiving antiretroviral treatment', *Clinical Infectious Diseases*, **49**(9): 1433–1440, <http://cid.oxfordjournals.org/content/49/9/1433.full>
99. Deiss, R.G., Rodwell, T.C. & Garfein, R.S. (2009), 'Tuberculosis and illicit drug use: Review and update', *Clinical Infectious Diseases*, **48**(1): 72–82, <http://www.ncbi.nlm.nih.gov/pubmed/19046064>
100. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2004), *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

101. World Health Organisation (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
102. Wolfe, D., Carrier, M.P. & Shepard, D. (2010), 'Treatment and care for injecting drug users with HIV infection: A review of barriers and ways forward', *The Lancet*, **376**(9738): 355–366, [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(10\)60832-X.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(10)60832-X.pdf)
103. Wolfe, D. & Cohen, J. (2010), 'Human rights and HIV prevention, treatment, and care for people who inject drugs: Key principles and research needs', *Journal of Acquired Immune Deficiency Syndromes*, **55**(S1): S56–S62, <http://www.ncbi.nlm.nih.gov/pubmed/21045602>
104. Hellard, M., Sacks-Davis, R. & Gold, J. (2009), 'Hepatitis C treatment for injection drug users: A review of the available evidence', *Clinical Infectious Diseases*, **49**(4): 561–573, <http://www.ncbi.nlm.nih.gov/pubmed/19589081>
105. New York City Department of Health and Mental Hygiene (2010), 'Illicit drug use in New York City', *NYC Vital Signs*, **9**(1), <http://www.nyc.gov/html/doh/downloads/pdf/survey/survey-2009drugod.pdf>
106. Interventions 10 to 16 were elaborated as part of a broader package of interventions that also include the 9 UN interventions in: International HIV/AIDS Alliance (2010), *Good practice guide: HIV and drug use*, http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf
107. International Drug Policy Consortium & Eurasian Harm Reduction Network (2014), *Drug policy training toolkit: Facilitation guide*, <http://idpc.net/policy-advocacy/training-toolkit>
108. Kessler, R.C., et al. (1994), 'Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey', *Archives of General Psychiatry*, **51**: 8-19; Regier, D.A., et al. (1990), 'Comorbidity of mental disorders with alcohol and other drug abuse', *Journal of the American Medical Association*, **264**: 2511-2518, <http://jama.ama-assn.org/content/264/19/2511.abstract>
109. For more information, visit the Support. Don't Punish campaign website: <http://supportdontpunish.org/>
110. For example: <https://www.facebook.com/supportdontpunish> and <https://twitter.com/sdpccampaign>
111. For more information, visit: <http://supportdontpunish.org/photo-project>
112. For more information, visit: <http://supportdontpunish.org/day-of-action-2015/>
113. See: <http://www.leshrc.org/>
114. See the Release website at: www.release.org.uk
115. Vancouver Coastal Health (2006), *Crystal Clear: A practical guide for working with peers and youth*, http://www.vancouveragreement.ca/wp-content/uploads/2006_Crystal-Clear-A-Practical-Guide.pdf
116. IDPC also recommends interventions 17 to 21 as part of a comprehensive harm reduction approach – this list is not exhaustive. For more recommendations on harm reduction targeting people who use amphetamines, see: Harm Reduction International (2015), *A global review of the harm reduction response to amphetamines: A 2015 update*, http://www.ihra.net/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf
117. European Monitoring Centre for Drugs and Drug Addiction (2015), *Drug consumption rooms: An overview of provision and evidence*, <http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms>
118. Marshall, B.D.L., Milloy, M.J., Wood, E., Montaner, J.S.G. & Kerr, T. (2011), 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', *The Lancet*, **377**(9775): 1429-1437, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)62353-7/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62353-7/abstract)
119. United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People who Use Drugs (2014), *Women who inject drugs and HIV: Addressing specific needs*, www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
120. See: Croisier, J. (2 December 2014), 'Braços Abertos in Sao Paulo, what can we learn from the Housing First model?', *IDPC Blog*, <http://idpc.net/blog/2014/12/braços-abertos-in-sao-paulo-what-can-we-learn-from-the-housing-first-model>
121. Prefeitura da Cidade de Sao Paulo (2015), *Alcohol and drug policy within the city of Sao Paulo*, presentation delivered at the International Harm Reduction Conference in Kuala Lumpur, Malaysia, October 2015
122. For more information, see: <https://dancesafe.org/drug-checking/>
123. See, for instance: National Post (30 December 2011), *Vancouver health body begins free crack pipe program for addicts*, <http://news.nationalpost.com/news/canada/vancouver-health-body-begins-free-crack-pipe-program-for-addicts>; for best practice guidelines on safer crack smoking equipment distribution, see: Strike, C, Gohil, H. & Watson T.M. (2014), *Safer crack cocaine smoking equipment distribution: Comprehensive best practice guidelines* (Canada's source for HIV and hepatitis C information), <http://www.catie.ca/en/pif/fall-2014/safer-crack-cocaine-smoking-equipment-distribution-comprehensive-best-practice-guideli>
124. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
125. Ibid
126. National Institute for Health and Clinical Excellence (2007), *Methadone and buprenorphine in the management of opioid dependence* (London: NICE), <https://www.nice.org.uk/guidance/ta114>
127. MacArthur, G.J., et al (October 2012), 'Opiate substitution treatment and HIV transmission in people who inject drugs: Systematic review and meta-analysis', *British Medical Journal*, **345**: e5945, <http://www.bmj.com/content/345/bmj.e5945>
128. Ibid; As observed by the UNODC, many people dependent on drugs 'who would be motivated to treatment but do not find accessible well equipped treatment facilities in their neighbourhood are de facto condemned to remain in a condition of dependence and to perpetuate their dependence in social exclusion'. See: United Nations Office on Drugs and Crime (2009), *Reducing the adverse health and social consequences of drug abuse: A comprehensive approach*, <https://www.unodc.org/documents/prevention/Reducing-adverse-consequences-drug-abuse.pdf>
129. Godfrey, C., Stewart, D. & Gossop, M. (2004), 'Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)', *Addiction*, **99**(6): 697–707, <http://cat.inist.fr/?a-Modele=afficheN&cpsidt=15796344>
130. National Treatment Agency for Substance Misuse (2010), *A long-term study of the outcomes of drug users leaving treatment*, http://www.nta.nhs.uk/uploads/outcomes_of_drug_users_leaving_treatment2010.pdf
131. Stimson, G. et al (2010), *Three cents a day is not enough* (London: Harm Reduction International), http://idpc.net/sites/default/files/library/IHRA_3CentsReport.pdf
132. National Institute on Drug Abuse (2007), *Cost effectiveness of drug treatment*, <https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>
133. National Institute on Drug Abuse (2006), *International program, methadone research web guide*
134. Botvin, G., Schinke, J. & Steven, P. (1997), *The etiology and prevention of drug abuse among minority youth*, (New York: Haworth Press); Beauvais, F. & LaBoueff, S. (1985), 'Drug and alcohol abuse intervention in American Indian communities', *Substance Use & Misuse*, **20**(1): 139–171, <http://informahealthcare.com/doi/abs/10.3109/10826088509074831>; Davis, R.B. (1994), 'Drug and alcohol use in the former Soviet Union: selected factors and future considerations', *Substance Use & Misuse*, **29**(3): 303–323, <http://informahealthcare.com/doi/abs/10.3109/10826089409047383>
135. The texts of the 3 UN drug control treaties are available here: <https://www.unodc.org/unodc/en/commissions/CND/conventions.html>

136. Office of the United Nations High Commissioner for Human Rights & World Health Organisation (2008), *The right to health: Fact sheet No. 31* (Geneva: United Nations), <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>
137. 1961 Single Convention on Narcotic Drugs, <http://www.unodc.org/unodc/en/treaties/single-convention.html> & UN Convention on Psychotropic Drugs of 1971, <https://www.unodc.org/unodc/en/treaties/psychotropics.html>
138. Office of the High Commissioner for Human Rights (2009), *Press release: High Commissioner calls for focus on human rights and harm reduction in international drug policy* (Geneva: Human Rights Council), http://www.ohchr.org/documents/Press/HC_human_rights_and_harm_reduction_drug_policy.pdf
139. World Health Organisation (April 2015), *WHO model list of essential medicines, 19th list*, http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amended_AUG2015.pdf?ua=1
140. Human Rights Watch (2007), *Rehabilitation required: Russia's human rights obligation to provide evidence-based drug dependence treatment*, <https://www.hrw.org/report/2007/11/07/rehabilitation-required/russias-human-rights-obligation-provide-evidence-based>
141. Hallam, C. (2010), *IDPC Briefing Paper – Heroin-assisted treatment: The state of play* (London: International Drug Policy Consortium), <http://idpc.net/publications/2010/07/idpc-briefing-heroin-assisted-treatment>
142. Strang J., et al (2010), 'Supervised injectable heroin or injectable methadone versus optimised oral methadone as treatment for chronic heroin addicts in England after persistent failure in orthodox treatment (RIOTT): A randomised trial', *The Lancet*, **375**(9729): 1885–1895, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60349-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60349-2/abstract)
143. Ibid
144. Strang, J., et al (July 2015), 'Heroin on trial: Systematic review and meta-analysis of randomised trials of diamorphine-prescribing as treatment for refractory heroin addiction', *The British Journal of Psychiatry*, **207**(1): 5-14, <http://bjp.rcpsych.org/content/207/1/5>
145. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
146. Holt, E. (2010), 'World report: Russian injected drug use soars in the face of political inertia', *The Lancet*, **376**(9734): 13-14, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61041-0/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61041-0/fulltext)
147. World Health Organisation Western Pacific Region (2009), *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: An application of selected human rights principles*, http://www.who.int/hiv/pub/idu/assess_treatment_users_asia/en/; Pearshouse R. (2009), *Compulsory drug treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)* (Toronto: 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/>; 'Harm Reduction 2009: IHRA's 20th International Conference' in Bangkok (21 April 2009): Session on 'Compulsory drug dependence treatment centres: Costs, rights and evidence (supported by the UNODC and the International Harm Reduction Development Program of the Open Society Institute)', <http://www.ihra.net/contents/128>
148. International Harm Reduction Development Programme (2011), *Treated with cruelty: Abuses in the name of drug rehabilitation* (New York: Open Society Foundations), http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/treated-with-cruelty-20110624/treatedwithcruelty.pdf
149. Human Rights Watch (2011), *The rehab archipelago: Forced labour and other abuses in drug detention centres in Southern Vietnam*, <http://www.hrw.org/sites/default/files/reports/vietnam-0911ToPost.pdf>
150. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
- Human Rights Watch (2010), *Where darkness knows no limits: Incarceration, ill-treatment and forced labour as drug rehabilitation in China*, <http://www.hrw.org/reports/2010/01/07/where-darkness-knows-no-limits-0>
151. See: United Nations Office of the High Commissioner for Human Rights, International Labor Organization, United Nations Development Program, UNESCO, United Nations Population Fund, United Nations High Commissioner for Refugees, UNICEF, United Nations Office on Drugs and Crime, UN Women, World Food Programme, World Health Organisation & Joint United Nations Programme on HIV/AIDS (March 2012), *Joint statement: Compulsory drug detention and rehabilitation centres*, https://dl.dropboxusercontent.com/u/64663568/alerts/Joint-Statement_Compulsory-drug-detention-and-rehabilitation-centres.pdf
152. United Nations Programme on HIV/AIDS (23 September 2015), *Press release: New Roadmap to voluntary community-based services for people who use drugs in Asia*, <http://unaids-ap.org/2015/09/23/press-release-new-roadmap-to-voluntary-community-based-services-for-people-who-use-drugs-in-asia/>
153. Tanguay, P., et al (2015), 'Facilitating a transition from compulsory detention of people who use drugs towards voluntary community-based drug dependence treatment and support services in Asia' *Harm Reduction Journal*, **12**:31, <http://www.harmreductionjournal.com/content/12/1/31>; Tanguay, P., Stoicescu, C. & Cook, C. (October 2015), *Community-based drug treatment models for people who use drugs*, http://www.ihra.net/files/2015/10/19/Community_based_drug_treatment_models_for_people_who_use_drugs.pdf
154. Case study drawn from: Tanguay, P., Stoicescu, C. & Cook, C. (October 2015), *Community-based drug treatment models for people who use drugs*, http://www.ihra.net/files/2015/10/19/Community_based_drug_treatment_models_for_people_who_use_drugs.pdf
155. National Treatment Agency for Substance Misuse (2012), *Medications in recovery – Re-orientating drug dependence treatment*, <http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf>
156. Patterson, K. (10 June 2015), 'A new definition of recovery: Beyond abstinence', *Addiction.com*, <https://www.addiction.com/10687/a-new-definition-of-recovery-beyond-abstinence/>
157. United Nations Office on Drugs and Crime (2011), *Amphetamines and Ecstasy: 2011 Global ATS Report*, https://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf
158. Shearer, J., Sherman, J., Wodak, A. & Van Beek, I. (2002), 'Substitution therapy for amphetamine users', *Drug and Alcohol Review*, **21**: 179-185, <http://www.undrugcontrol.info/en/issues/safer-crack-use/item/4535-substitution-therapy-for-amphetamine-users>
159. Srisurapanont, M., Jarusuraisin, N. & Kittirattanaipaboon, P. (2008), 'Treatment for amphetamine dependence and Abuse', *Database of Systematic Reviews*, Issue 3, <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003022.pub2/epdf>
161. Shearer, J., Sherman, J., Wodak, A. & Van Beek, I. (2002), 'Substitution therapy for amphetamine users', *Drug and Alcohol Review*, **21**: 179-185, <http://www.undrugcontrol.info/en/issues/safer-crack-use/item/4535-substitution-therapy-for-amphetamine-users>
162. Goncalves, J.R. & Nappo, S.A. (July 2015), 'Factors that lead to the use of crack cocaine in combination with marijuana in Brazil: A qualitative study', *BMC Public Health*, **15**: 706, <http://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-015-2063-0#CR14>; Ribeiro, L.A., Sanchez, Z.M. & Nappo, S.A. (2010), 'Surviving crack: A qualitative study of the strategies and tactics developed by Brazilian users to deal with the risks associated', *BMC Public Health*, **10**: 671, <http://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-10-671>
163. Goncalves, J.R. & Nappo, S.A. (July 2015), 'Factors that lead to the use of crack cocaine in combination with marijuana in Brazil: A qualitative study', *BMC Public Health*, **15**: 706, <http://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-015-2063-0#CR14>
164. Labigalini, E., Rodrigues, L.R. & Da Silveira, D.X. (1999), 'Therapeutic use of cannabis by crack addicts in Brazil', *Journal of Psychoactive*

- Drugs*, **31**(4): 451-455, http://druglawreform.info/images/stories/documents/Therapeutic_Cannabis_Crack_Brazil.pdf
165. BBC Mundo (25 March 2013), *Bogotá quiere de aliada a la marihuana*, http://www.bbc.com/mundo/noticias/2013/03/130322_colombia_marihuana_combate_adicciones_bogota_aw.shtml#reports
166. Red Iberoamericana de ONGs que trabajan en drogodependencias (9 December 2015), *Hospital de Uruguay impulsa tratar a adictos a pasta base con marihuana*, <http://www.riod.org/noticia.php?idn=1660>



Chapter 3:

Criminal justice

Chapter overview

Drug control has traditionally focused on imposing criminal sanctions against all people involved in the illicit drug market, with the hope that harsh criminal sanctions would deter people from entering the drug trade. As a result, governments have introduced severe and disproportionate criminal penalties for drug-related offences, ranging from incarceration to the death penalty.¹

Recent estimates from the United Nations Office on Drugs and Crime show that one in five people currently in prison have been condemned for a drug possession or trafficking offence – with around 80% for possession alone.² Nevertheless, global drug use prevalence remains high³ and this policy has created more harms than the substances they are meant to put under control. To respond to this situation, some countries have decided to decriminalise drug use. Although this policy presents certain challenges, it has been instrumental in reducing the incarceration of people who use drugs, as well as the stigma and discrimination that they face. Decriminalisation is also critical towards improving people's access to life-saving harm reduction, drug dependence treatment and other health and social services. This will be explained in further detail in **Chapter 3.1**.

Others have moved further, towards the legal regulation of certain substances – including cannabis, coca and some new psychoactive substances (NPS). These reforms are in conflict with the UN drug control treaties, which currently do not allow legal markets for the recreational use of internationally controlled substances. Despite these clear tensions with the global drug control regime, the need to protect the health of people who use drugs, to increase citizen security and to reduce social exclusion has been at the forefront of this approach. **Chapter 3.2** offers an overview of the different regulatory regimes that could be established, drawing lessons from experiences for cannabis, coca, NPS, alcohol and tobacco.

An effective criminal justice system relies on the principle of proportionality – whereby sentences imposed for an offence should be measured in accordance to the harms caused by the offender's actions. Today, most people incarcerated for drug offences are in prison for lengthy periods of time, generally for low-level, non-violent drug crimes. Some are on death row as a minority of countries worldwide retain the death penalty for drug offences. Disproportionate punishment has not led to a reduction in the scale of the illicit market, but has resulted in significant prison overcrowding, and related negative consequences. While **Chapter 3.3** defines the concept of proportionality in more detail and offers guidance on how to implement it across the spectrum of drug offences, **Chapter 3.4** provides recommendations for the design and implementation of alternatives to incarceration for non-violent offenders – an essential policy option to reduce prison overcrowding and focus resources on those most harmful and violent offenders operating in the illicit drug market.

The effectiveness of the criminal justice system is very much dependent upon effective law enforcement. **Chapter 3.5** analyses the failures of an overly prohibitive approach to tackle the illicit drug market, and offers guidance for a review and modernisation of current drug law enforcement efforts, focusing on prioritising a reduction in violence, money laundering and corruption, fulfilling wider social objectives, promoting community policing, increasing partnerships between the police and health and social authorities, and so on.

The last chapter of this section, **Chapter 3.6**, focuses on best practice for delivering health services in prison, in an attempt to reduce the health harms related to the continued incarceration of large numbers of people who use drugs. The chapter offers guidance and best practice on how best to deliver harm reduction, treatment and other healthcare services to prisoners.

3.1

Decriminalisation of people who use drugs

Key recommendations

- Drug laws, policies and practices should be reviewed to remove criminal penalties for drug use, possession of drugs for personal use, possession of drug use paraphernalia and cultivation and purchase for personal use
- The gold standard of decriminalisation is the removal of all punishment for drug use, and the provision of voluntary health and social services, including harm reduction responses and evidence-based drug dependence treatment programmes. If an administrative sanction is imposed for drug use, it should be applied as part of a framework encouraging access to health and social services, and not lead to net-widening
- Differentiating between personal use and intent to supply should be done via *indicative* quantity thresholds, as well as an assessment of *all evidence available* on a case-by-case basis. Even if people are found in possession of quantities above the threshold, mechanisms should be in place to identify whether possession is for personal use or intent to supply
- Trainings, sensitisation and guidance should be offered to police, prosecutors and judges on drug use, harm reduction, treatment and decriminalisation
- Decriminalisation measures should be accompanied by investments in health and social programmes to ensure maximum health outcomes

Introduction

The criminalisation of people who use drugs across the world has had severe impacts on their health and well-being and increased their exposure to health risks and criminal groups. Fear of incarceration drives people who use drugs away from the life-saving health and harm reduction services they need, increasing their vulnerability to blood-borne diseases such as HIV and hepatitis C, and the risk of overdose deaths. At the same time, the criminalisation of possession of drug use paraphernalia such as sterile needles and syringes and crack pipes has further undermined harm reduction efforts to curb HIV and hepatitis epidemics.⁴

Police crackdowns, compulsory urine testing, drug user registration in official government records, or compulsory detention deter people from accessing health and social services.⁵ Drug law enforcement actions against people who use drugs, as well as social disapproval of drug use have exacerbated marginalisation and stigmatisation – breaking up family and community ties, and undermining access to employment and education.

People with a criminal record for drug offences can be excluded from accessing social welfare and scholarships, and can even be denied the right to vote (as is the case in the USA). Minority groups – in particular ethnic minorities – are especially affected as they are often the primary targets of law-enforcement interventions. In some areas of the world, the implementation of drug laws by the police has become a form of social control.⁶

Because of the devastating effects of overly repressive approaches to drug control, criminalisation has come under increasing scrutiny. A number of international agencies have now explicitly called for the removal of criminal sanctions against people who use drugs, including the Joint United Nations Programme on HIV/AIDS (UNAIDS),⁷ the World Health Organisation (WHO),⁸ the United Nations Development Program (UNDP),⁹ the Office of the High Commissioner on Human Rights (OHCHR),¹⁰ UN Women¹¹ and the Organization of American States (OAS),¹² among others.¹³

Box 1 What is decriminalisation?

Decriminalisation entails the removal of criminal penalties for selected activities. In the context of drug use, the following activities would no longer constitute a criminal offence or be subject to criminal penalties:

- Drug use
- Possession of drugs for personal use
- Cultivation and purchase of controlled plants for personal use
- Possession of drug use paraphernalia.

The overarching objective of decriminalisation is to end the punishment and stigmatisation of people who use drugs. After drug use has been decriminalised, governments may respond to drug use and associated activities with a variety of approaches, such as referrals to health and social services. Crucially, when implemented under a harm reduction-oriented approach, decriminalisation can provide a supporting and enabling legal framework within which health interventions can be voluntarily accessed without fear of stigma, arrest and detention.¹⁴ The gold standard of decriminalisation is therefore an approach where drug use, cultivation, pur-

chase, possession for personal use and possession of use paraphernalia is no longer punished, and where people are able to access healthcare, harm reduction and treatment services. In practice, some governments have chosen to impose administrative sanctions against people who use drugs. In that case, such sanctions should not result in more severe punishment than those imposed under criminalisation – this will be discussed in more detail below.

Decriminalisation differs from legalisation, which is a process by which all drug-related behaviours (use, possession, cultivation, trade, etc.) become legal activities. Within this process, governments may choose to adopt administrative laws and policies to regulate drug cultivation, distribution and use, including limitations on availability and access – this process is known as legal regulation (see Chapter 3.2). Decriminalisation should also be distinguished from depenalisation, a process by which criminal penalties are reduced or removed altogether for select behaviours that remain offences punishable by criminal law (see Chapter 3.3 on proportionality for more details).

At the national level, several countries have adopted innovative decriminalisation models.¹⁵

Legislative/policy issues involved

Decriminalising drug use and possession for personal use

Over 40 countries and jurisdictions around the world have enacted some form of decriminalisation for certain drug offences.¹⁶ Decriminalisation processes can be classified in two types – *de jure* and *de facto*. In the first type, the removal of criminal sanctions takes place through a legislative process – via the repeal of criminal legislation, the creation of civil law, or a constitutional court decision leading to legislative review. In a *de facto* model, although drug use remains a criminal offence in a country's legislation, in practice people are no longer prosecuted (for example in the Netherlands). Decriminalisation can focus on a specific substance (usually cannabis), several or all substances (as is the case in Portugal).

While decriminalisation through law reform may take several years to achieve, *de facto* decriminalisation can be implemented relatively rapidly through pragmatic policy adjustments. However, a *de facto* decriminalisation policy can also be more easily reversed, for example when there is a change in political leadership.

Decriminalisation works best when implemented in conjunction with the development, funding and scale up of a wide array of harm reduction and evidence-based drug dependence treatment services. In that case, people who use drugs are able to access these services without fear of arrest or punishment, stigma or discrimination.

In many instances, countries that have decriminalised drug use have chosen to adopt administrative sanctions for drug use activities, including community service orders, fines and suspension of licences. It is essential that these administrative sanctions do not result in greater harm than criminalisation (for example, the use of compulsory detention centres, registration of people who use



Silent march to end stop and search and racial profiling in the USA

drugs in government records, the imposition of high fines resulting in lengthy prison sentences if unpaid, etc.).

Decriminalising cultivation for personal use

Some decriminalisation models encompass the cultivation of substances for personal use to ensure that people who use drugs do not have to resort to the criminal market to access their substance of choice. For example, in several countries, cannabis social clubs were born out of efforts by people using cannabis to move away from the black market and ensure good quality products.¹⁷

In Belgium, Spain and Uruguay for example, cannabis social clubs enable people to grow their own plants as part of a cooperative, and only in quantities sufficient for the needs of the club members (these quantities are established by the members themselves). Cultivation and distribution are limited to club members, and cannabis can be consumed on the club's premises or taken away. Membership is prohibited for people under the age of 18. Most clubs limit the number of members. For example, Uruguay established the limit at 45 members, while the Federation of Cannabis Associations in Catalonia set a limit of 655 members – although a series of Supreme Court decisions in Spain have recently

set some stricter limits to the number of members for social clubs (in its latest decision, the Supreme Court ruled that a club containing 290 members was unacceptable).¹⁸

Many of the clubs have been instrumental in encouraging responsible consumption among their members, offering guidance and information about usage. This model has both protected people from the black market for cannabis, and often helped avoid a profit-driven model, while remaining within the constraints set out in the UN drug control conventions.^{19, 20}

Implementation issues involved

Following decriminalisation, policy makers have the choice to establish a wide array of responses to drug use activities, and models worldwide have varied greatly.²¹ Some of them have proven to be ineffective or to have exacerbated harms for people who use drugs. Available evidence shows that a successful model should focus on investing in harm reduction and drug dependence treatment services. Below are a set of considerations that should be taken into account when moving towards a decriminalisation model for drug use.

Box 2 The Portuguese referral model to health services

In July 2001, Portugal adopted Law 30/2000 which decriminalised the possession of all internationally controlled drugs for personal use. Under the new legal regime, drug trafficking is still prosecuted as a criminal offence, but the possession of quantities of drugs for up to 10 days of use has become an administrative offence. The law also introduced a system of referral to Commissions for the Dissuasion of Drug Addiction (*Comissões para a Dissuasão da Toxicodependência*). When a person found in possession of drugs is arrested, the police refer them to these regional panels, consisting of three professionals – a social worker, a legal adviser and a medical professional – supported by a team of technical experts.

The Commissions use targeted responses to reduce drug use and encourage people dependent on drugs to enter treatment. To that end, they can impose sanctions such as community service, fines, suspension of professional licences and bans on attending designated places, but also recommend harm reduction, treatment or education programmes, as well as offer social support for those in need.

Between 2002 and 2009, the Dissuasion Commissions facilitated approximately 6,000 administrative processes a year. As Figure 1 below shows, in 2009, most cases (68%) resulted in suspensions of proceedings for people who were not dependent on drugs (i.e. no further action was taken). As 14% of the cases resulted in punitive sanctions (10% were sanctions such as licence suspension or restrictions on movement and 4% were fines).²¹ 15% of the cases were provisionally suspended with an agreement that the individual would undergo treatment. Approximately 76% of cases involved cannabis, 11% involved heroin, 6% involved cocaine and the remaining cases involved multiple drugs.²³

Crucially, the decision to decriminalise drug use was accompanied by significant investments in health interventions, including harm reduction measures (with a new legal basis in the form of Decree-law 183/2001) and drug dependence treatment programmes. As a direct result of decriminalisation, prison overcrowding significantly dropped, with the proportion of drug offenders sentenced to imprisonment dropping

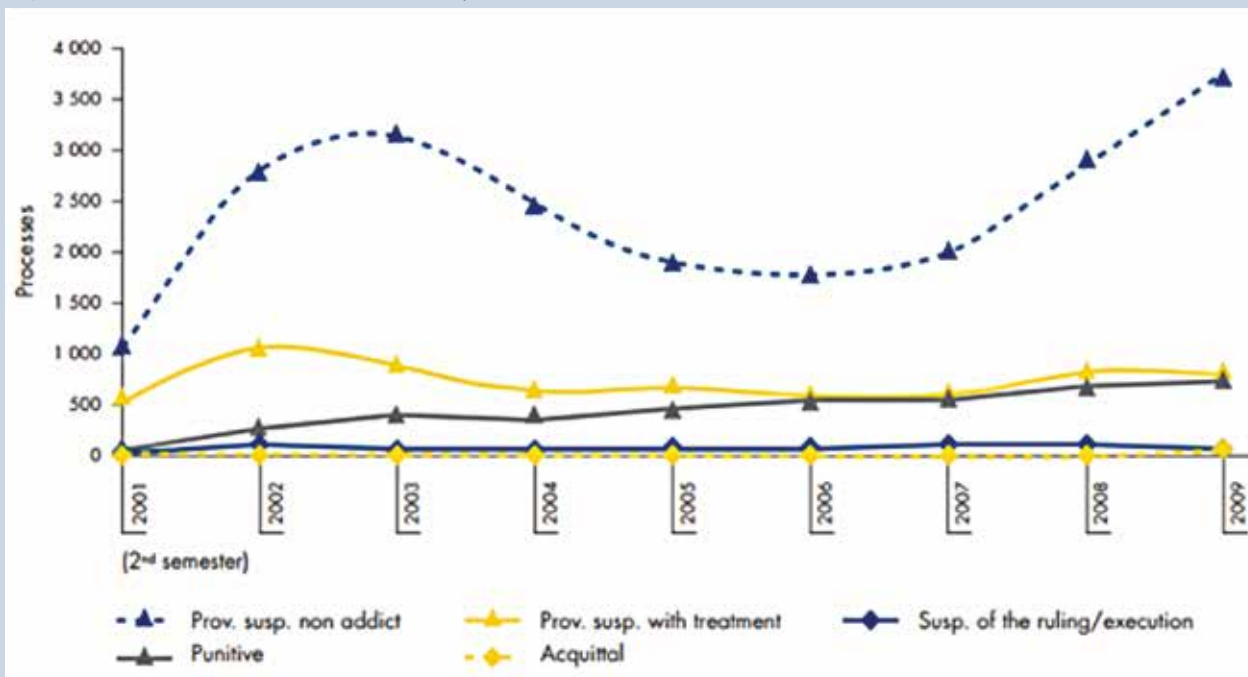


Credit: Pedro A. Pina

Outreach testing: 'European HIV Testing Week' in Mouraria Harm Reduction Centre, NGO GAT, Lisbon, Portugal

Continued overleaf

Figure 1. Application of sanctions by the Dissuasion Commissions, 2001 to 2009²⁴



to 28% in 2005 from a peak of 44% in 1999 – taking some of the pressure off the criminal justice system.²⁵ In the area of health, the number of people using drugs newly diagnosed with HIV decreased from 907 new cases in 2000²⁶ to 79 in 2012.²⁷ A similar downward trend was observed for new cases of hepatitis B and C,²⁸ while the number of drug overdose deaths in Portugal is the second lowest in the European

Union.²⁹ The number of people receiving voluntary drug dependence treatment increased by more than 60% between 1998 and 2008. Over 70% of those seeking treatment received OST.³⁰ The Portuguese decriminalisation model has therefore been highly successful in offering harm reduction and voluntary treatment services to people who use drugs, with very positive health outcomes.

Differentiating between use and intent to supply

This is one of the main challenges of implementing an effective decriminalisation model. A number of countries have developed quantity thresholds to determine whether drug possession is for personal use or for intent to supply to others. While these thresholds can be useful, they have sometimes proven to be problematic. In some circumstances, for example in Mexico and Russia, the thresholds were set so low that they resulted in more people who use drugs being sent to prison for what was identified as being a ‘trafficking’ offence (for example, Mexico set out quantity thresholds at 0.5g of cocaine, 0.05g of heroin and one ecstasy tablet³¹). To be effective, quantity thresholds should adequately reflect market realities – taking into account patterns of use, the quantity of drugs a person is likely use in a day, and patterns of purchasing.

Other countries opted not to adopt thresholds and not to define what would be the ‘reasonable amounts’ or ‘small quantities’ allowed. They focused instead

on other considerations to be taken into account as evidence, on a case-by-case basis – for example, possession of several mobile phones, drugs divided into different packets, money, firearms, or history of drug dependency, etc. This approach, however, also presents disadvantages, including the risk of abuses and corruption from the police or judges.

In order to benefit from the objectivity provided by thresholds, while also considering other factors, decriminalisation should combine indicative quantity thresholds with discretionary powers for the police, prosecutor or judge to decide on a case-by-case basis according to all available evidence at hand.³² For example, a long history of drug use and referrals to health and harm reduction services may be considered as evidence that a person caught with a large amount of drugs was still intending them for personal use, and not for commercial purposes.

Authority responsible for determining personal use

In order to reduce unnecessary burdens on the criminal justice system and to avoid the risk of pre-trial detention,³³ it is preferable to leave the

role of determining whether possession is for personal use or intent to supply to the discretion of the police, ensuring that people are diverted away from the criminal justice system as early as possible. However, such an approach does present some risks of corruption and abuses from the police, including harassment, racial discrimination, the imposition of excessive fines, etc.

There is also a risk of ‘net-widening’, the unintended effect of increasing the number of people in contact with the criminal justice system as a result of expanded police powers and facilitated procedures that make it easier for the police to stop people for drug possession. This has been observed in Switzerland after cannabis possession became an administrative offence punishable with a fine, and in some parts of Australia.³⁴ In this context, although drug use is decriminalised, people who use drugs continue to be punished with a fine, and the failure to pay it may result in opening criminal proceedings. As policy makers establish a decriminalisation policy, they should keep in mind that the overarching objective is to *reduce* the number of people being punished for drug use, and of those suffering from the consequences of criminal sanctions.

These implementation issues can be addressed through solid prosecutorial guidance, including a tight oversight and scrutiny of police behaviour, in particular guidance on how to assess the quantity

thresholds (for example, on whether to take into account dry weight or wet weight), on how to exercise police discretion, or on charging standards. This will also require police training on drugs and harm reduction, to increase awareness of the need to support a health and social approach towards drug use. Engaging representatives of people who use drugs in the process of designing, managing and evaluating decriminalisation models is also useful to help build trust between communities and the police.³⁵

Identifying appropriate responses

Here again, there is significant variance around the globe. Some countries, such as the Netherlands (see Box 4) and Belgium, do not impose any sanction on people caught in illicit possession of drugs for personal use. This approach presents significant benefits, not least the cost savings to the criminal justice system, and the fact that the person does not undergo any punishment – while allowing for a health and social response for those who need it. Indeed, in countries where people caught in possession of drugs are given a choice between an administrative fine, a criminal sanction or treatment (as is the case in Chile, Armenia, Poland or Paraguay), the person will often decide to undergo a treatment programme even if they are not dependent on drugs – creating an unnecessary burden on the health system and on public funding.



Blue pills in the hand of a person who uses drugs in India, 2011

Credit: Private

Box 3 Establishing quantity thresholds in the Czech Republic

The first drug law of the Czech Republic, adopted in 1993 after the fall of the Soviet Union, did not impose criminal penalties for drug use or possession for personal use. Five years later, as drug markets became more visible, the Czech Republic revised its drug laws to criminalise the possession of 'greater than small' amounts of drugs – without defining what quantities this would entail.³⁶ People caught using drugs, however, were not criminalised.³⁷ The government invested in a large-scale research project to evaluate the impact of the new law. The study concluded that the 1998 law had not managed to significantly curb drug use, while each person kept in prison for drug possession cost the government €30,000 a year.³⁸

The study resulted in the adoption of a new drug law in 2009, leading to significant debates to define which amounts of drugs should be characterised as 'greater than small'. A government decree established quantities below which possession would not result in criminal penalties but in a misdemeanour, subject to the imposition of a fine. The government study was instrumental in providing practical information around patterns of drug use and drug markets in an effort to establish adequate thresholds. For instance, noting

that patterns of usage varied between people using different drugs, the authors of the study concluded that it would be wise to distinguish between types of drugs in law and policy making.³⁹ An attempt was made to reflect the study's findings in the law, with a higher threshold being established for cannabis than for other drugs – Government Decree No. 467/2009 established maximum quantities of 15g for cannabis, 1.5g for heroin and 1g for cocaine.⁴⁰

In 2013, the directive was abolished by a ruling of the Constitutional Court which asserted that 'only a law, not a government regulation, could define what a criminal offence is'. The Czech Supreme court then set stricter thresholds – allowing 1.5g of methamphetamine, 1.5g of heroin, 1g of cocaine, 10g of cannabis and 5 units of ecstasy.⁴¹ These quantities are significantly lower than what is allowed in parts of Australia or Spain (in Spain, the thresholds are set at 7.5g for cocaine and 200g for cannabis). Nonetheless, the Czech example shows an attempt to establish quantity thresholds that reflect the realities of the drug market so as to meaningfully reduce the number of people sent to the criminal justice system for simple possession.

If countries decide to impose administrative fines as an alternative to criminal sanctions, as is the case in a large number of countries and jurisdictions, they should be mindful not to impose fines that are so high as to lead to prosecution and/or incarceration for failure to pay. Other forms of civil penalties, such as seizure of passport or driving licence, should be avoided as these can have a disproportionately negative impact on a person's life and sometimes their ability to work.

When referral mechanisms are in place to encourage people to enter voluntary treatment programmes, these should offer a variety of treatment options, including OST. Failure to meet the conditions of the treatment programme should not result in the imposition of a criminal sanction. Portugal, for instance, has adopted an incremental response to drug use. On the first instance, people caught for drug use will see the process suspended, but an administrative sanction may be imposed if they are caught again within

a six-month period. However, Portugal also offers a wide range of health and social services to people brought to its Dissuasion Commissions (see Box 2), including referrals to harm reduction and treatment programmes. In the Portuguese case, treatment is never coercive and people who fail to adhere or comply will not be imposed a criminal sanction.⁴²

In East and South East Asia, countries such as China and Vietnam have revised their drug laws to remove criminal sanctions for people who use drugs, but have instead adopted an administrative system whereby to people caught for drug use are ordered to enter compulsory drug detention centres for periods of a few months up to two years. Such a practice should be avoided as these compulsory detention centres constitute harsh punishment, do not include any form of evidence-based treatment or rehabilitation, and result in a range of human rights abuses (see Chapter 2.5 for more details).⁴³

Box 4 The Dutch cannabis decriminalisation model

In 1976, the Netherlands enacted a new law to differentiate between ‘soft’ drugs – judged to pose ‘acceptable’ risks to consumers and society (i.e. cannabis) – and ‘hard’ drugs associated with greater risks. This ‘separation of markets’ allowed the State to adopt a more lenient approach to cannabis sale, possession and use through *de facto* decriminalisation. Although cannabis sale and possession for personal use remain offences, the Dutch Ministry of Justice chose to apply a ‘policy of tolerance’ that translates into the non-enforcement of the law in certain instances. For example, possession of less than 5g of cannabis is no longer a target for law enforcement interventions. Since the 1980s, the sale and purchase of small quantities of cannabis has also been permitted in licensed ‘coffee shops’ within strict limitations. Initially implemented in Amsterdam, Rotterdam and Utrecht, by the end of the 1990s, coffee shops could be found in almost every large or mid-sized city in the country.⁴⁴

The establishment of cannabis coffee shops has not led to an explosion in drug use in the Netherlands – with prevalence rates remaining broadly in line with the European average.⁴⁵ However, this policy had a significant impact on reducing stigma, as well as arrests and convictions for illicit drug use and possession, which remain very low in the Netherlands.⁴⁶

The 30 years of experience of this policy have also shown that the coffee shop model has suc-

cessfully enabled people who use cannabis to avoid exposure to ‘hard drug’ scenes and markets. Heroin and cocaine use in the Netherlands is reportedly lower than the European average,⁴⁷ and HIV prevalence among people who use drugs remains low⁴⁸ – the country having also established a series of harm reduction services including needle and syringe programmes (NSPs), opioid substitution therapy (OST), heroin-assisted treatment and safe injection rooms early on.⁴⁹

Nevertheless, this model also presents some difficulties, not least the paradox around the fact that although the sale and possession of cannabis are tolerated, supply to the coffee shops (the so-called ‘backdoor’) continues to be criminalised, and is therefore increasingly controlled by criminal groups and networks. Today, a great majority of the Dutch population is in favour of the full legal regulation of the cannabis market ‘from seed to sale’, in an effort to end reliance on the black market.⁵⁰ And while the government is trying to restrict any activity that would facilitate cultivation by criminalising preparatory acts (such as grow shops),⁵¹ local authorities are increasingly in favour of regulating the backdoor through a new Cannabis Act. A recent report by the VNG – the Dutch local authorities’ platform – called on the government to allow regulated cannabis production by introducing licences for growers⁵² (see Chapter 3.2 for more details on legal regulation).

Key resources

- Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe, Version 2*, <http://www.release.org.uk/publications/policy-papers>
- Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
- International Drug Policy Consortium (2015), *Comparing models of decriminalization, an e-tool by IDPC*, <http://decrim.idpc.net/>
- Rolles, S. & Eastwood, N. (2015), ‘Chapter 3.4: Drug decriminalisation policies in practice: A global summary’, In: Harm Reduction International (2012), *The global state of harm reduction: Towards an integrated response*, http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf

3.2

Regulated drug markets

Key recommendations

- The responsible legal regulation of drug markets can reduce harms associated with the illicit drug trade and offer improved outcomes on a range of health, community safety and financial indicators – this policy option should therefore be actively and publicly debated and explored
- Policy makers exploring options for regulation should consider establishing a national expert advisory group to design policy and legal frameworks tailored to meet local needs and priorities. This panel should include expertise from public health, law enforcement, drug policy reform, evaluation and monitoring, alcohol and tobacco regulation, prevention, treatment and harm reduction, as well as representation of people who use drugs and subsistence farmers of crops destined for the illicit drug market
- Reforms should be phased-in cautiously, using solid and well-funded evaluation and monitoring of impacts built into any legislation and process of change, along with a willingness to adapt approaches on the basis of emerging evidence
- Particular care should be taken to mitigate risks of over-commercialisation, with public health and community safety remaining the guiding influence for policy design, rather than private profit. Non-commercial models should be considered as viable options, whilst commercial models should mitigate risks of over-commercialisation by learning from the successes and failures of different approaches to alcohol and tobacco control
- Policy makers should encourage, and meaningfully engage in, debates at high-level regional and UN forums around reforming the global drug control system to accommodate demands for greater flexibility to experiment with regulation models, either independently or alongside any ongoing domestic reform processes
- Policy makers should encourage the UN to convene an independent expert group to consider the issues raised by legal regulation, implications for the existing treaty system and options for its modernisation and reform.⁵³

Introduction

The decriminalisation of drug use has increasingly been adopted as policy and practice around the world (see Chapter 3.1) – and has assumed a central position in UN agency advocacy and high-level debates. However, a parallel debate around the legal regulation of production, supply and consumption of certain internationally controlled substances has also developed rapidly in the past five years.

The legal regulation of cannabis has been at the forefront of this rapidly evolving debate – particularly since 2012, when cannabis was legalised for

non-medical use in the US states of Washington⁵⁴ and Colorado.⁵⁵ Soon after, Uruguay became the first UN member state to do the same by adopting Law No 19.172.⁵⁶ Since then, two more US states (Alaska⁵⁷ and Oregon⁵⁸) and the District of Columbia⁵⁹ have followed, and several more states are likely to do so in the next few years – in particular California. In 2015, Jamaica legalised cannabis for medical, industrial and religious purposes,⁶⁰ and the newly elected Canadian Government has also pledged to legalise cannabis⁶¹ – the first G7 country to do so.

Other developments around the world are also feeding into these ongoing discussions – including the system of legal regulation of the coca leaf in Bolivia, the New Zealand model of regulation for certain lower-risk new psychoactive substances (NSP) (see Box 3 in Chapter 2.1), and the ongoing development of maintenance prescribing to people dependent on heroin and other controlled substances (see Chapter 2.5 for more details).

The move from a theoretical legalisation debate to real world policy development means that the global consensus supporting an overly prohibitionist approach to drug control is now broken. With cannabis at least, a tipping point has been reached. It is therefore important for policy makers to consider the implications of this rapidly changing policy landscape, and the options for reform at domestic level.

Legislative/policy issues involved

There remains some confusion about what the ‘legalisation’ of controlled substances actually means. ‘Legalisation’ is the *process* by which an illegal product or activity becomes legal. In policy discussions, it is therefore more helpful to refer to the ‘legalisation and regulation’ or the ‘legal regulation’ of a controlled substance (or substances), as this provides a clearer description of the model being proposed and employed. A legalisation process allows for a

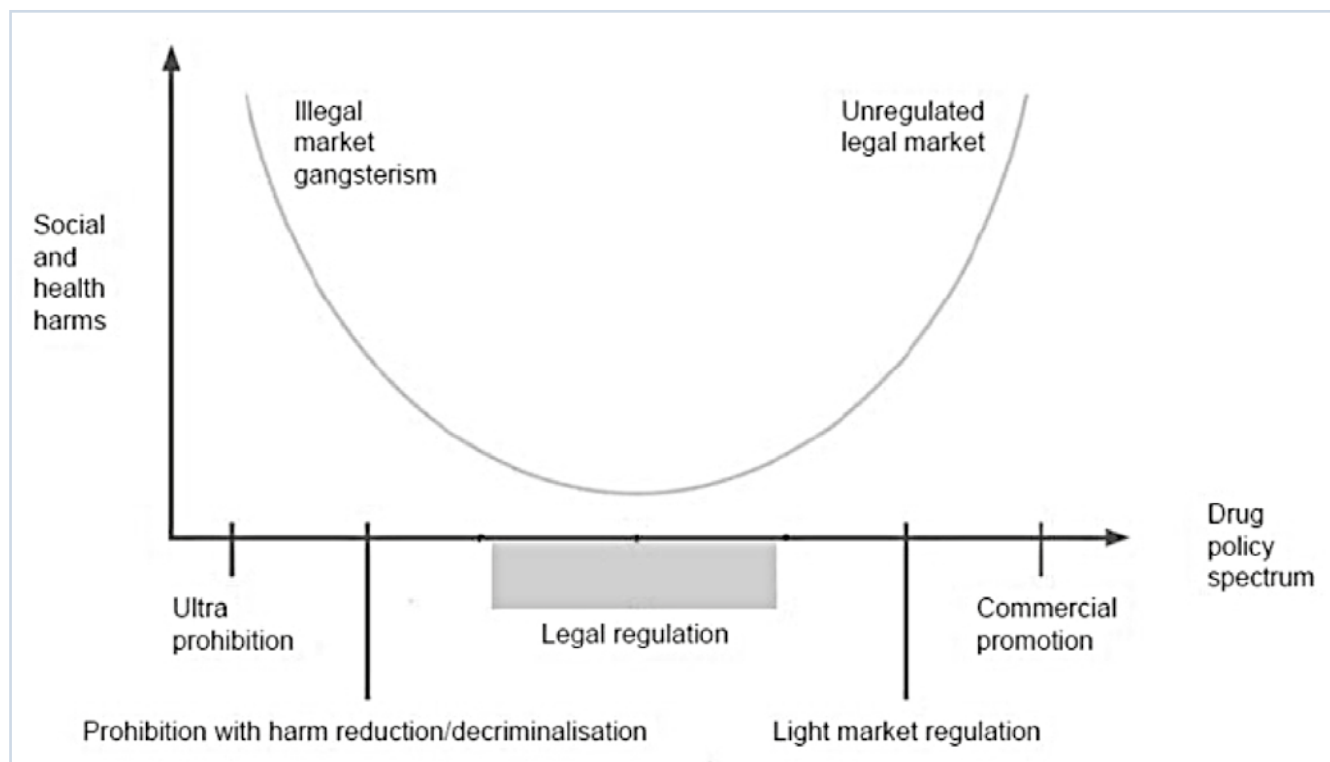
policy of legal regulation to be implemented. Under legal regulation, substances can be adequately controlled and the regulatory regime can be effectively implemented by government authorities – in an effort to remove the drug trade from the control of criminal groups.⁶²

The last decade has seen the first detailed proposals emerge that offer different options for how the legal regulation of drugs can take place.⁶³ These proposals have explored options for controls over:

- The drug products themselves (dose, preparation, price, and packaging)
- Licensing of drug product vendors (vetting and training requirements)
- The outlets from which the drug products are available (location, outlet density, appearance)
- Marketing (advertising, branding and promotions)
- Availability and access (age controls, licensed buyers, club membership schemes, rationing)
- Where, when and how drugs can be consumed.

There are a number of options for how different regulatory tools are applied to different substances or among different populations. Box 1 offers a summary of the various regulatory models that could be implemented, with the aim of managing drug markets in a way that minimises the health and social harms associated with both illicit drug use and drug markets.⁶⁴

Figure 1. Spectrum of drug policy options and their likely effects⁶⁵



Box 1 Five basic models for regulating drug availability

- Medical prescription model with optional supervised consumption facilities – for the most risky substances and behaviours (injected drugs, including heroin and cocaine, and more potent stimulants such as methamphetamine)
- Specialist pharmacist retail model – trained and licensed vendors, potentially combined with named/licensed user access and rationing of volume of sales for moderate-risk drugs such as amphetamine, powder cocaine, and ecstasy
- Licensed retailing – Including tiers of regulation appropriate to product risk and local needs; this could be used for lower-risk drugs and preparations such as cannabis, khat and kratom, or lower-strength stimulant-based drinks
- Licensed premises for sale and consumption – similar to licensed alcohol venues and cannabis ‘coffee shops’ in the Netherlands, these could potentially also be for smoking opium or drinking poppy tea. Additional tiers of licensing and onsite supervision could be introduced to cater for some types of psychedelic use, or the sale and use of certain stimulants at events and party settings
- Unlicensed sales – minimal regulation for the least risky products, such as caffeine drinks and coca tea.

Implementation issues involved

Reducing health, social and financial costs

The regulation of drug markets is not a ‘silver bullet’ solution to the problems associated with drug use and drug markets. In the short term, legal regulation can only seek to reduce some of the health, human rights, crime and security problems that stem from prohibition-led drug control efforts and those fuelled by the illicit drug market (see Box

2 on Uruguay, as well as Box 3 of Chapter 2.1 for an overview of the New Zealand experience with regards to NPS). However, legal regulation cannot tackle the underlying socio-economic drivers that may exacerbate drug problems within a community – such as poverty, inequality and social marginalisation. Nevertheless, by promoting a more pragmatic public health model and freeing up drug law enforcement resources for evidence-based health and social policy, regulatory models may very well create a more conducive environment for doing so.⁶⁶

Different social environments will require different approaches in response to the specific challenges policy makers face. The emerging range of regulatory options available to manage drug markets and use, through state and commercial institutions, now offer a credible option for policy makers if the harms facing their societies cannot be addressed within the current international drug control regime. Such reforms are likely to unfold in an ad-hoc basis for different substances, in different jurisdictions.

The costs of developing and implementing a new regulatory infrastructure should be considered, but would likely represent only a fraction of the ever-increasing resources currently directed into prohibition-led efforts to control illicit supply and demand. There is also an important potential for translating a proportion of existing criminal profits into legitimate tax revenue – as has happened with some of the US cannabis regulation models.⁶⁷

Learning from the challenges of regulatory models for alcohol and tobacco

There are legitimate concerns around the fact that over-commercialisation of legal drug markets could lead to increased use and related health harms, as business interests seek to expand their markets and maximise profits. Policy makers therefore have a responsibility to ensure that public health is prioritised at all times over commercial interests when designing any new regulatory model. This has certainly not been the case historically with alcohol and tobacco in most jurisdictions – with more responsible public health policy models only now being explored and implemented, after long-term resistance by powerful industry lobby groups. Policy makers have an opportunity and responsibility to ensure that lessons from the alcohol and tobacco markets are learnt, and built into any new drug regulatory model from the outset.

Credible and functioning options for non-commercial models of market regulation exist – including

Box 2 Uruguay's legal regulation of cannabis markets

In 2013, Uruguay became the first country to pass legislation to legalise and regulate cannabis for non-medical uses. The argument for a legally regulated market was made by the government on the basis that it would help to protect the health of people who use cannabis, as well as minimise risks to citizen security from the criminality associated with the illicit trade.⁶⁸

The Uruguayan model involves a greater level of government control than the more commercial models developed in the USA. Under the control of a newly established regulatory body (*Instituto de regulación y control del cannabis, IRCCA*), only production of specified herbal cannabis products by state-licensed growers is permitted. There is a complete ban on all forms of branding, marketing and advertising, and tax revenue will be used to fund new cannabis prevention and education campaigns.⁶⁹

Sales are permitted only via licensed pharmacies, to registered adult Uruguayan residents, and at prices set by the new regulatory body. The pharmacies are allowed to sell cannabis for therapeutic purposes on the basis of a medical prescription, and for non-medical use up to a maximum of 40g per registered adult per month. Citizens are allowed to grow up to six plants in their homes for their personal consumption, with a maximum harvest of 480g per year. They can also form cannabis clubs of 15 to 45 members allowed to cultivate up to 99 cannabis plants with an annual harvest proportional to the number of members and conforming to the established quantity for non-medical use.⁷⁰ So far, the implementation of the regulatory regime has remained slow, in particular the licencing of pharmacies for cannabis sale.

state monopolies (or partial monopolies), not-for-profit corporations, or not-for-profit cooperative 'social clubs', or the promotion of self-cultivation. If a commercial market is established, lessons from alcohol and tobacco regulation are particularly relevant. The blueprint provided by the UN Framework Convention on Tobacco Control,⁷¹ and World Health Organisation guidance on alcohol regulation⁷² provide useful evidence-based recommendations on how to mitigate such risks – for example through controls on sponsorship, advertising and branding (also see Box 2 on Uruguay's regulatory model for cannabis).

Addressing tensions with the UN drug control conventions

Moves towards legal regulation will require a review of the substantial institutional and political obstacles presented by the international drug control system. Specifically, the emerging trend towards exploring legal regulation for internationally controlled substances creates a clear tension with the three UN drug control conventions that unambiguously do not allow it.⁷³

Countries where regulatory regimes have so far been adopted have approached this problem in different ways:

- The USA has argued that state-level legalisation may be allowable under a 'flexible interpretation' of the treaties

- Uruguay has stated that its requirement to meet wider UN obligations to protect human rights, health and security take precedence over technical UN drug treaty commitments
- Bolivia has denounced the 1961 Convention and then re-accessed it with a reservation on the specific articles that prohibit the coca leaf
- Jamaica has regulated cannabis cultivation and use for religious purposes (see Chapter 4.3 for more details)
- New Zealand's NPS regulation framework is only available to substances not controlled under the UN drug conventions.

In reality, this area of drug policy reform is moving into uncharted waters with regards to the various, potentially conflicting treaty obligations – and there are multiple outstanding questions of international law that are only now beginning to be explored in the various high-level UN forums. Whilst precisely how or when these can be addressed satisfactorily remains unclear, the fact that multiple reforms are already underway clearly highlights the shortcomings of an outdated international framework that is unable to meet the needs of a growing number of member states. It therefore seems inevitable that a process of modernisation must take place to provide the flexibility for the evidence-based experimentation and innovation that is required.⁷⁴

Key resources

- Bewley-Taylor D., Jelsma M. & Blickman T. (March 2014), *The rise and decline of cannabis prohibition* (Transnational Institute & Global Drug Policy Observatory), https://www.tni.org/files/download/rise_and_decline_web.pdf
- Caulkins, J. et al (January 2015), *Considering marijuana legalisation: Insights for Vermont and other jurisdictions* (RAND Corporation), http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR864/RAND_RR864.pdf
- Farthing, L.C. & Ledebur, K. (July 2015), *Habeas coca: Bolivia's community coca control* (Open Society Foundations), <http://www.opensocietyfoundations.org/reports/habeas-coca-bolivia-s-community-coca-control>
- Franquero, O.P. & Bouso Saiz, J.C. (2015), *Innovation born of necessity: Pioneering drug policy in Catalonia* (New York: Open Society Foundations Global Drug Policy Program), <https://www.opensocietyfoundations.org/sites/default/files/innovation-born-necessity-pioneering-drug-policy-catalonia-20150428.pdf>
- Global Commission on Drug Policy (2014), *Taking control: Pathways to drug policies that work*, www.gcdpsummary2014.com/s/AF_global_comission_Ingles.pdf
- Rolles, S. & Murkin, G. (2013), *How to regulate cannabis: A practical guide* (Bristol: Transform Drug Policy Foundation), <http://www.tdpf.org.uk/resources/publications/how-regulate-cannabis-practical-guide>
- Rolles, S. (2009), *After the war on drugs: Blueprint for regulation* (Bristol: Transform Drug Policy Foundation), <http://www.tdpf.org.uk/resources/publications/after-war-drugs-blueprint-regulation>
- Transnational Institute (8 December 2015), *UNGASS 2016: Background memo on the proposal to establish an expert advisory group*, <https://www.tni.org/en/publication/ungass-2016-background-memo-on-the-proposal-to-establish-an-expert-advisory-group>



Credit: Jessamine Barley-Matthews, WOLA

Cannabis plant at a Colorado grow house

Proportionality of sentencing for drug offences

Key recommendations

- Existing sentencing frameworks for drug offences should be reviewed to ensure proportionality of sentencing, and address the consequences resulting from disproportionate sentencing such as prison overcrowding, and ineffective use of criminal justice resources
- A range of factors should be considered during sentencing to ensure that sentences are proportionate to the culpability and role of the offender, including the consideration of mitigating and aggravating factors, and the harms caused by the offence. In that regard, judges and prosecutors should adopt a gender perspective when imposing penalties and considering alternatives to incarceration
- Sentencing frameworks for drug offences should include sentencing options of no punishment at all (e.g. under decriminalisation of drug use and possession for use), or alternatives to conviction and imprisonment, for minor, non-violent offences
- Mandatory minimum penalties should be eliminated
- The death penalty should be abolished for drug offences, as an ineffective deterrent and a violation of international law.

Introduction

Disproportionate sentencing for drug offences is commonplace, as countries implement drug policies premised upon harsh punishment to deter the illicit supply and use of drugs. Non-violent drug offences involving small quantities of substances, e.g. low-level cultivation, dealing or smuggling, are often punished with harsher penalties than for other offences that cause far more harm, particu-

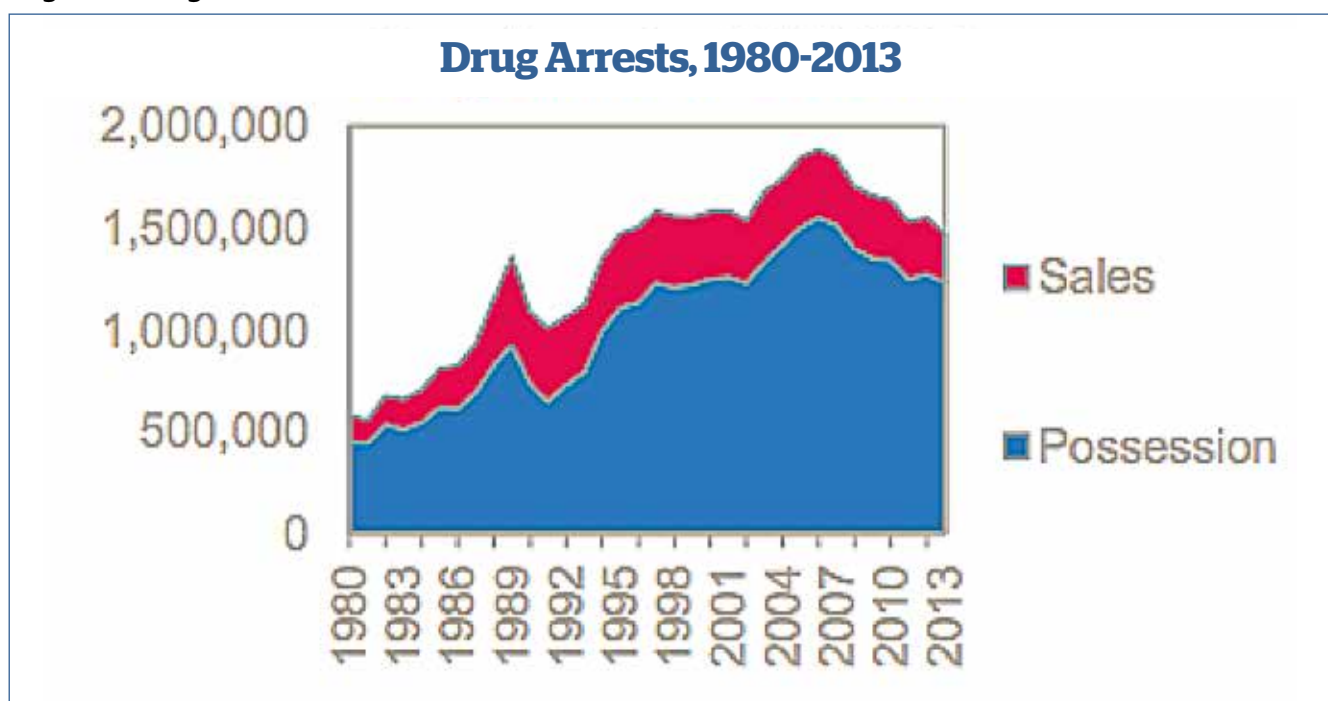
larly violent offences such as murder and rape.⁷⁵ Sentences are often determined solely on the basis of possession and the quantity of drugs involved, without taking into account other factors essential to assessing the extent of harm caused, the culpability and role of the individual (e.g. high, intermediate or low-level role in a drug supply transaction), and mitigating factors such as being a first-time offender, the sole care provider for dependants, and not being involved in violence or connected with organised criminal networks.⁷⁶

In the USA, where over half of the inmates in federal prisons are sentenced with drug offences, 80% of drug arrests made in 2013 were for possession only (see Figure 1).⁷⁷ In addition, the imposition of mandatory minimum penalties for drug offences in the USA restricts the exercise of prosecutorial and judicial discretion and excludes consideration of mitigating factors in individual cases, thereby increasing the likelihood of disproportionately severe sentencing.⁷⁸ In 2011, over 75% of the sentenced offences subject to a mandatory minimum penalty were for drug offences; in 2010, the average sentence imposed for people convicted of a drug offence subject to a mandatory minimum penalty was 11 years.⁷⁹ The high rates of imprisonment for drug offences in other regions of the world, especially of people who use drugs and women, further demonstrate the disproportionate nature of sentencing for drug offences (see Chapter 3.4).⁸⁰

Despite decades of excessively severe punishment for drug offences, there is no evidence of their effectiveness as a deterrent for the illicit use, cultivation, manufacturing and trafficking of drugs. In fact, successive global reports by the United Nations Office on Drugs and Crime (UNODC) contain data predominantly showing expanding and diversifying drug markets in all regions of the world.⁸² Drug policies imposing harsh punishment have not only failed in their objective of deterring drug-related activities, they have resulted in damaging outcomes for public health, human security, and development:

- **Public health** – prisons are a high-risk setting

Figure 1. Drug arrests in the USA, 1980 to 2013⁸¹



Credit: Drug Policy Alliance; Data from the Federal Bureau of Investigation, 'Uniform Crime Report'

for the transmission of illnesses such as HIV, viral hepatitis and tuberculosis. HIV infection rates tend to be higher in prisons than in the community as there is very poor coverage of harm reduction services for inmates who use drugs⁸³ (see Chapter 3.6)

- **Human security** – the majority of individuals sentenced with the most severe punishment for drug offences, including the death penalty, do not play a serious or high-level role in drug trafficking operations. They are often poor, vulnerable to exploitation, and engaged in low-level drug trafficking roles.⁸⁴ Their incarceration does not impact upon the scale of the illicit market as they are easily replaced by others. Consequently, significant criminal justice resources (including law enforcement, prosecutors, judges, detention centres and the prison system) are spent on arresting and incarcerating low-level offenders, while people engaged in high-level drug crimes are left largely free to continue their operations and recruitment of low-level actors. Disproportionate sentencing is therefore not only ineffective, it also results in the unbalanced investment of law enforcement and criminal justice resources on minor, low-level drug-related activities, thereby diverting them from targeting serious criminal activity, i.e. violence, corruption, organised crime and money laundering, which pose a greater threat to human security⁸⁵
- **Development** – Incarcerating farmers engaged in illicit cultivation for subsistence purposes and other low-level actors in the drug market merely ex-

acerbates the poverty and insecurity that are the root cause of their involvement in drug markets.⁸⁶

Legislative/policy issues involved

Defining the concept of proportionality

Proportionality is an internationally recognised legal principle, applicable to a government's response to activities that cause harm to others. It requires the severity of any punishment imposed to be measured in accordance with the harms caused by an offender's actions, and the culpability and circumstances of the offender. International human rights, crime prevention and criminal justice instruments contribute to setting standards of proportionality.⁸⁷ For example, article 29(2) of the Universal Declaration of Human Rights states that:

In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

The International Covenant on Civil and Political Rights protects many rights relevant to sentencing for drug offences, notably the rights to life, liberty, security of the person, and privacy. In interpreting the application of the Covenant, the Human Rights Committee has found that where a state implements measures to restrict a right protected under

the treaty, it 'must demonstrate their necessity and only take such measures as are proportionate to the pursuance of legitimate aims in order to ensure continuous and effective protection of Covenant rights'.⁸⁸ The Committee has further explained that measures to restrict rights protected under the Covenant must be the least intrusive measure required for achieving a legitimate aim.⁸⁹

A proportionate sentencing framework for drug offences should therefore primarily target people playing high-level roles in drug supply operations and causing the most harm to communities, such as violence and control over organised criminal activity. Sentencing frameworks should also aim to achieve improved outcomes for development, health, and human security, as well as protection of human rights.

Applying the legal principles of proportionality to sentencing for drug offences

International legal principles of proportionality are seldom applied to sentencing for drug offences, due to the politically driven development of the international drug control system over the past few decades favouring excessively severe measures in response to controlled substances. The UN drug control conventions contain language emphasising the gravity of the world drug problem,⁹⁰ thereby leading to the justification of imposing disproportionately severe sanctions for drug-related offences. For example, the preamble of the 1961 Convention asserts that 'addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind'.

However the stated objective of each of the UN drug conventions is to ensure the 'health and welfare of mankind', by restricting the non-medical use of controlled substances whilst ensuring their availability for medical purposes.⁹¹ Importantly, the conventions do not contain any requirement to criminalise drug use (see Chapter 3.1 for more details) and contain explicit provisions permitting alternatives to conviction or punishment for offences relating to personal use, including possession, purchase and cultivation, and for 'appropriate cases of a minor nature' not relating to personal use (see Chapter 3.4 for more details).⁹² In cases of a minor nature, states are encouraged to implement alternatives to conviction or punishment, such as education, rehabilitation or social reintegration, and where the offender is a person who uses drugs, 'treatment and aftercare'.⁹³ As a result, the conventions recognise the need to establish sentencing frameworks for drug offences that distinguish between:

- consumption and supply offences
- minor and serious offences, and
- different types of substances, in accordance with the potential health harms and therapeutic value of a particular substance.⁹⁴

The concept of proportionality of sentencing becomes essential when considering the application of the death penalty for drug offences. According to the UN Human Rights Committee, drug offences do not meet the threshold of 'most serious crimes' for which the death penalty may apply under Article 6 of the International Covenant on Civil and Political Rights, as they do not amount to intentional killing.⁹⁵ As a result, the imposition of death penalty sentences and executions for drug offences contravene international human rights law. The International Narcotics Control Board (INCB) has encouraged 'those States which retain and continue to impose the death penalty for drug-related offences to consider abolishing the death penalty for such offences'.⁹⁶ However as of 2015, 33 countries retain the death penalty for drug offences, and at least ten countries impose it as a mandatory sentence, with seven countries still actively executing people convicted of drug offences.⁹⁷

Implementation issues involved

A number of countries, as well as the European Union, now recognise the need to address disproportionate penalties and sentencing for drug offences. They have taken steps to ensure more proportionate outcomes, including the consideration of factors indicating the harms caused by an offence and the culpability of the offender, beyond possession alone or the amount of drugs involved.⁹⁸

A proportionate sentencing framework for drug offences should be proportionate within itself, and also in comparison with the sentences for other offences in a criminal justice system.

Systems of penalties are disproportionate in countries where violent offences attract less severe penalties than non-violent drug offences, such as the UK which imposes a 5-year imprisonment starting point for a rape conviction, and a 14-year imprisonment starting point for importing 10,000 ecstasy tablets for commercial gain.⁹⁹

Distinctions should be made between offences related to personal use, and those with intent to supply, to reflect the varying degrees of an offender's culpability and the harms caused to society by their offence.

Box 1 Ecuador puts proportionality at the heart of its criminal code

Ecuador has long been known for its severe punishments against drug traffickers – as well for the high rates of people incarcerated for drug offences in the country – mainly drug mules. Facing a prison crisis, Ecuador issued a pardon for all drug mules incarcerated in 2008.¹⁰⁰ Nevertheless, this one-time pardon did not stem the influx of people entering the criminal justice system, and the incarceration rate increased significantly between 2010 and 2014.¹⁰¹

In an effort to promote more proportionate sentences for drug offences, Ecuador enacted its Comprehensive Organic Criminal Code (COIP, Spanish acronym)¹⁰² in 2014, which re-asserted the decriminalisation of drug use (as per article 364 of Ecuador's Constitution¹⁰³) and introduced proportionate sentences for varying degrees of involvement in drug-related offences – with different penalties for those involved in the low levels of the trafficking chain, and those that have a leading role within the illicit market. COIP also created four categories of trafficking – from minor to large scale, with proportionate sentences in accordance to the quantity and type of substances being trafficked.¹⁰⁴

Following the adoption of COIP, more than 2,000 people were released from prison.¹⁰⁵ However, in September 2015, Ecuador revised the quantities established to differentiate between the levels of trafficking, by lowering them significantly – a political move which is likely to result in yet another increase in the prison population in the country.¹⁰⁶ Nevertheless, Ecuador's reform constitutes an interesting example of how to introduce more proportionate sentencing for drug offences.

- Personal use of drugs, and related possession, cultivation and purchase: alternatives to criminalisation and punishment should be implemented, along with referrals to harm reduction and health options such as evidence-based drug treatment (see Chapter 3.1)
- User-dealer offences, where a person who uses drugs engages in dealing for the primary purpose

of sustaining his or her own drug use: alternatives to conviction, incarceration and punishment should be implemented, along with referrals to harm reduction and drug dependence treatment, in order to address the root causes of the offence (see Chapter 3.4)

- Supply-related offences, including dealing and trafficking (see below).

Distinctions should be made between the different roles and motivations of people involved in supply offences.

- People engaged in subsistence-driven cultivation: those involved in illicit cultivation are mostly subsistence farmers in situation of high vulnerability who grow poppy, coca or cannabis as cash crops in order to buy food, clothes, and access to health and education. They should not be criminalised. Instead, a development-oriented approach should be implemented to offer them opportunities for viable and sustainable livelihoods (see Chapter 4.2)
- Dealers engaged in the small-scale sale of controlled substances within a network of friends, and who obtain limited financial gains – these individuals should be offered alternatives to incarceration to ensure that criminal justice systems and prisons are not overloaded with minor, non-violent cases¹⁰⁷ (see Chapter 3.4)
- Drug couriers or 'mules' are individuals engaged in trafficking offences, usually in the transportation of controlled substances.¹⁰⁸ They usually come from extremely vulnerable social backgrounds, they put their health at serious risk in return for very low pay, and are often coerced or exploited into carrying drugs.¹⁰⁹ For these offenders, severe penalties should not be imposed and alternatives to incarceration should be offered – in particular for women in charge of children or dependents¹¹⁰ (see Chapter 3.4)
- Serious or organised criminals making large-scale profit, and playing a high-level role in a production or trafficking operation, or organised crime network, often using violence and corruption. These individuals should be imposed more severe penalties – keeping in mind the principle of proportionality across the spectrum of criminal offences, as described above.

Mitigating factors should be considered to determine whether a sentence should be reduced.

- The socio-economic circumstances of an offender: disproportionately criminalising people from vulnerable and poor communities exacerbates

Box 2 Costa Rica adopts more proportionate drug laws

In Costa Rica, many activities related to drug production and commercial supply were considered a serious offence punishable with a minimum of eight years of imprisonment. As a result by 2012, 65% of the 780 women incarcerated in the Buen Pastor Institutional Centre were held for drug offences. Of these women, 23.5% (120) were convicted of smuggling drugs into prison, as first-time offenders. Most of them were heads of household, living in poverty and responsible for one or more children whose personal development was seriously affected as a result of the enforced separation from their primary caregiver.

Acknowledging the need for a proportionate and gender-sensitive approach to its sentencing framework for drug offences, Costa Rica amended its drug law (article 77 of Law 8204) in 2013. The penalty for bringing drugs into prisons was reduced from an 8-20 years' imprisonment term to 3-8 years' imprisonment. The sentencing option of alternatives to imprisonment was also introduced, for women who met the following criteria (see Box 3 in Chapter 3.4 for more details):

- living in a situation of poverty
- head of household, in a situation of vulnerability
- responsible for the care of minors, elderly people or people with any kind of disability or dependence
- an elderly person in a situation of vulnerability.

Following the reform, 159 women were released from prison. Costa Rica is now considering expanding its reform to other drug offences. Costa Rica's reform is particularly interesting for Latin America – where prison overcrowding is commonplace, and where a great majority of women are incarcerated for minor, non-violent drug offences.¹¹¹ The reform is also consistent with international standards on the rights and welfare of women, such as the United Nations Rules for the treatment of women prisoners and non-custodial measures for women offenders (also known as the Bangkok Rules). Rule 61 in particular calls for the consideration of mitigating factors including first time offence, low-level crime and caretaking responsibilities.¹¹²



Buen Pastor prison for women in San Jose, Costa Rica

Credit: Jessamine Bartley-Matthews, WOLA

their depressed socio-economic circumstances, prevent them from finding employment post-incarceration, and can have devastating consequences for their dependent children or other family members¹¹³

- The caretaking responsibilities of an offender, especially women who are often the primary caregiver for children and other dependants such as elderly parents or people living with disabilities¹¹⁴
- The motivation for financial gain of the offender: several drug-related activities are not motivated by significant financial gain, as is the case for drug mules
- If it is a first-time offence
- No involvement with organised crime or violence.

Aggravating factors should be considered to determine whether a sentence needs to be enhanced.

- Motivation for significant financial gain
- Involvement of minors
- Involvement in violent activities, corruption and/or money laundering
- Involvement in organised crime.

Key resources

- European Commission (2009), *Report from the Commission on the implementation Framework Decision 2004/757/JHA laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking* (Brussels), COM(2009)69 final [SEC (2009)1661]
- Harris, G. (2011), *Conviction by numbers: Threshold quantities for drug policy* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/sites/default/files/library/Threshold-quantities-for-drug-policy.pdf>
- Lai, G. (2012), *Drugs, crime and punishment: Proportionality of sentencing for drug offences* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/publications/2012/06/drugs-crime-and-punishment-proportionality-of-sentencing-for-drug-offences>
- United Nations Office on Drugs and Crime (2013), *UNODC Handbook on strategies to reduce overcrowding in prisons*, Criminal Justice Handbook Series, https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf
- Washington Office on Latin America, International Drug Policy Consortium, DeJusticia, Inter-American Commission on Women (2016), *Women, drug policy and incarceration: A policymaker's guide for adopting, reviewing and implementing reforms related to women incarcerated for drug offenses*, <http://www.wola.org/commentary/women-drug-policies-and-incarceration-in-the-americas>

3.4

Alternatives to incarceration

Key recommendations

- Drug use should be considered as a health issue. Harm reduction and evidence-based treatment should be available and prioritised for people who use drugs, as well as people involved in low-level drug offences who are found to be dependent on drugs
- Incarceration should only be used as a last resort, and only for high-level, violent drug offenders
- Diversion mechanisms at arrest, prosecution and sentencing should be developed to help ensure that cases of low-level drug offenders do not overload and incapacitate criminal justice systems
- Legislative and practical barriers to the implementation of alternatives to incarceration for drug offenders should be removed¹¹⁵
- Social and community support networks should be established, including educational and employment programmes, housing, health services, etc. in order to address the socio-economic factors that led people to engage in the illicit drug trade in the first place
- Alternatives to incarceration should be tailored to address the specific needs and vulnerabilities of women
- Countries implementing or considering measures to increase diversion need to carefully review the evidence and options before choosing the best process/model for their circumstances.

Introduction

As a result of the punitive approaches that have prevailed in international and national drug control regimes, rates of incarceration have steadily increased since the 1970s. The steepest rise has been

in the USA.¹¹⁶ In Latin America, the rate of people incarcerated for drug offences has grown at a faster rate than the overall prison population.¹¹⁷ Rises have also taken place throughout Europe, Asia, Africa, and Oceania.¹¹⁸ Currently, although there are large differences between individual countries and between regions,¹¹⁹ persons convicted for drug offences (drug possession and drug trafficking) make up 21 per cent of the sentenced prison population worldwide.¹²⁰

The high rates of imprisonment for drug-related offences have contributed to prison overcrowding, exacerbating serious concerns about prison conditions. According to the Working Group on Arbitrary Detention, overcrowding 'can call into question compliance with article 10 of the International Covenant on Civil and Political Rights, which guarantees that everyone in detention shall be treated with humanity and respect for their dignity'.¹²¹

Both mass incarceration for drug offences and prison overcrowding disproportionately affect the most vulnerable groups in society, in particular ethnic minorities. In Europe, for example, most prisoners are from poor communities, and the proportion of immigrants and ethnic minorities is increasing.¹²² Similarly, in the USA '5 times as many Whites are using drugs as African Americans, yet African Americans are sent to prison for drug offenses at 10 times the rate of Whites'.¹²³ In producing countries, incarcerated coca growers and small producers usually belong to the most marginalised sectors of society.

Drug offences have played an important role in the significant increase in the female prison population. Over 90% of prison inmates are male; however, over time 'the total number of female prisoners (who constitute 5-8 per cent of the prison population) grew by 26 per cent between 2004 and 2012 — an increase far higher than that recorded for men (11 per cent)'.¹²⁴ A significant percentage of this increase is associated with drug offences¹²⁵ — generally of a minor, non-violent nature.¹²⁶ For example, 'in Argentina, Brazil, and Costa Rica, well over 60 percent of each country's female prison population is incarcerated for drug-related crimes'.¹²⁷ In Europe, drug of-



Prison for women in Bogotá, Colombia

fences account for about 28% of incarcerated women, with the highest percentages in Tajikistan (70%) and Latvia (68%), and the lowest in Poland (3.1%).¹²⁸ Thailand has the world's sixth largest prison population, and the world's highest rate of imprisonment of women – in 2015, it was reported that 70% of the men and 80% of the women imprisoned were held for drug offences, mostly for possession and consumption offences. In addition, the number of arrests for drug use alone increased from 51,566 in 2003 to 209,366 by 2013, accounting for 92% of all drug-related arrests in 2013 for Thailand.¹²⁹

The imprisonment of mothers and caregivers can have crushing effects on their children, families, and communities.¹³⁰ Infants and young children with an incarcerated parent become victims of the punitive approach to drugs.¹³¹ In many countries around the world, some children live with their mothers in prison, generating complex situations for prison institutions.¹³²

A paradigm shift is urgently needed, in order to address this situation. Here again, it is important to recall that most prison inmates are incarcerated for drug offences of a minor, non-violent nature. For example, in the Federal District and in the state of Mexico, about 75% of the prisoners are detained for possession of small amounts of drugs; and in Colombia, over 98% of the prisoners incarcerated for drug offences 'would not have had – or it was unlikely that it could be proved that they had – an important role in drug trafficking networks.'¹³³

In this context, comprehensive and contextualised alternatives to arrest, sentencing and incarceration should be designed and implemented. Alternatives to incarceration provide more effective and less costly ways to reduce drug-related crime, while also promoting the health and social inclusion of low-level drug offenders by addressing some of the root causes of their involvement in the illicit market.

Empirical evidence suggests that alternatives yield better cost-effectiveness than incarceration. For example, drug dependence treatment programmes operating outside of prisons yield up to US\$8.87 for every dollar invested, while drug treatment in prison yields a return on investment of US\$1.91-US\$2.69 for every dollar invested.¹³⁴ Similarly, studies conducted in England and Wales suggest that alternatives including both residential treatment and supervised release are more cost-effective than incarceration and are more effective at reducing recidivism.¹³⁵ Finally, alternatives to incarceration can reduce the stigma and discrimination experienced by people sentenced to prison, and are instrumental in helping states to meet their international human rights obligations.

Legislative/policy issues involved

The UN drug conventions include explicit provisions allowing alternatives to conviction or punishment for offences relating to personal use, including pos-

Box 1 The Law Enforcement Assisted Diversion (LEAD) programme in Seattle¹³⁶

LEAD is a police diversion programme, launched in October 2011 in Seattle, USA. It targets people arrested for minor drug offences and sex work who meet the eligibility criteria: i.e. individuals identified as suffering from 'substance use disorders'.

The programme offers significant discretion to police officers, based on the assumption that they know the community best – LEAD therefore places a strong emphasis on community policing and strengthening community ties with the law enforcement authority. Thus, when the police officer stops a person, he/she has the power to decide whether or not to divert them into the programme. As the referral authority, police officers therefore have the ability to divert people to adequate services without conducting an actual arrest.

If the person is diverted into the programme, he/she is connected to a case manager who will decide the type of monitoring arrangement the person will be subjected to, which usually includes a set of services tailored to the individual's needs. The programme generally involves community-based treatment and support ser-

vices, guided by harm reduction principles. If the individual complies with the programme and its assessments, he/she is not charged and consequently does not get a criminal record. It is also important to note that the programme has no formal or punitive sanctions for 'non-compliance', and a person can re-enter the programme if they fail on the first instance and are caught by the police for a similar offence. Indeed, the reason why the programme was initiated in the first place was for the police to find better ways to deal with the same individuals going in and out of the criminal justice system.¹³⁷

The programme was originally designed as a pilot project, funded by private foundations. LEAD is now funded by the city of Seattle. The first evaluations of LEAD's effectiveness were published in early 2015. Available data reported reductions in law enforcement costs, as well as increased effectiveness of the programme to reduce recidivism when compared to the traditional criminal justice system. The evaluation concluded that, 'People in LEAD were 60% less likely than people in the control group to be arrested within the first 6 months of the evaluation.'¹³⁸



LEAD caseworker Tim Candela, right, attends a LEAD meeting at the SPD West Precinct in Seattle in August 2014

Credit: Mike Kane, The Huffington Post

session, purchase, cultivation and production, and for 'appropriate cases of a minor nature' not relating to personal use¹³⁹ – for which states are encouraged to implement alternatives to conviction or punishment, such as education, rehabilitation or social reintegration, and where the offender is found to be dependent on drugs, 'treatment and aftercare'.¹⁴⁰

Alternatives to incarceration for drug offences can be defined as any measure intended to: a) limit the use of imprisonment as a punishment; b) reduce the pressure on countries' criminal justice systems, particularly on prisons; and c) decrease the time of actual deprivation of liberty for individuals who have committed drug-related offences. The ultimate objective of alternatives to incarceration is to ensure that prison is used as a last resort.

Alternatives to incarceration should be available for all non-violent drug offenders, such as low-level couriers and dealers, as well as drug dependent individuals who have committed economic/acquisitive offences – that is, for those who currently constitute the majority of the prison population today. Alternatives to incarceration for these individuals would ensure that more effective responses and resources are tailored towards large-scale, violent drug traffickers and high-level criminals.

People who use drugs should not be subject to incarceration, and a process of **decriminalisation** should be adopted for drug use, possession of drugs for personal use, the possession of drug use paraphernalia and the cultivation and purchase of substances for personal use (see Chapter 3.1). Small-scale farmers involved in illicit crop cultivation should also be decriminalised (see Chapter 4.2). This ensures that people who use drugs and subsistence farmers do not end up in prison, and that the health and social dimensions of these activities are addressed within an enabling political environment.

Other alternatives can be grouped into three main categories: a) **diversion at arrest and pre-prosecution stages**; b) **diversion at prosecution**; and c) **alternatives at sentencing and post-sentencing**.

Diversion at arrest and pre-prosecution stages

There are a number of mechanisms at the arrest or pre-prosecution stages that can be used to avoid incarceration. These may involve referrals to an administrative monitoring system, to evidence-based drug dependence treatment where required, or other non-punitive measures such as educational programmes.¹⁴¹ In this case, such mechanisms usually rely on police officers as the key personnel making decisions on whether to divert a person into criminal

prosecution or to an alternative mechanism. Several countries have established such diversion systems which may vary greatly, but which usually apply to both people caught for low-level dealing and people arrested for offences motivated by drug dependence.

Diversion at arrest and pre-prosecution stages have two main advantages when they are compared to other forms of diversion. Firstly, they reduce pre-trial detention, which has led to a serious human rights crisis in several countries around the world.¹³² Secondly, they prevent people from having to undergo a lengthy and difficult criminal procedure, thereby reducing criminal justice overload and incarceration rates, as well as associated costs. The sooner the person is diverted away from the justice system, the better.

Diversion at prosecution

In this diversion system, prosecutors are the key decision makers that determine whether the person arrested should appear before a court or be referred to an alternative such as drug dependence treatment, or other health and social services. The Scottish diversion system, for instance, allows prosecutors to divert people into social support interventions (see Box 2).

Sentencing and post-sentencing alternatives

These alternatives include both diversion through the criminal proceedings and mechanisms to reduce

Box 2 The Scottish diversion system

In Scotland, Procurators Fiscals (equivalent of prosecutors) are responsible for identifying which of those accused of having committed a minor crime and who do not represent a significant risk to the public, should be diverted into social support interventions. Such interventions involve individual and/or group sessions as well as referrals to harm reduction and voluntary drug dependence treatment services, aiming to address a range of issues such as offending behaviours, alcohol and drug use, social skills, education, employment and training. An evaluation of the scheme highlighted the advantages of addressing the needs of drug offenders in a community-based setting, which were shown to be more cost-effective and more likely to result in lower rates of reoffending.¹⁴³

Box 3 Costa Rica's Restorative Justice Project

In parallel with its 2013 legislative reform (presented in Box 2 of Chapter 3.3), Costa Rica has adopted a Restorative Justice Project. The project includes several measures aiming to reduce the prison population. It created a drug treatment court adapted to the Costa Rican legal system – where drug use is decriminalised. Targeted populations include low-level and first-time offenders, who have committed an offence related to their drug dependence. An interdisciplinary and specialised group of restorative justice (composed of physicians, psychologists and social workers, among others) tailors their response to the needs of the beneficiary, focusing on residential or outpatient treatment.

Furthermore, Costa Rica has developed alternatives to incarceration with a gender perspective. The 2013 legislative reform enables women accused of introducing drugs in prison and who are living in conditions of poverty, are heads of household living in conditions of vulnerability, or have custody of minor children, older adults or persons with some form of disability, to be granted the benefit of home arrest, supervised release, residence in a halfway house, or electronic monitoring.¹⁴⁴

Most interestingly, Costa Rica is currently developing an institutional network of health and social services to assist former female offenders to reintegrate into society. The network offers psychological support, help to find employment, social services, childcare, etc. in an effort to address the underlying causes of involvement in the drug trade, as well as to reduce recidivism.¹⁴⁵

the length of incarceration. In these cases, judges decide whether to initiate the referral process – and when.

Diversion mechanisms can be initiated at the moment when a person has entered the criminal justice system, for example through a suspension of criminal proceedings under judicial supervision. The diverted person must comply with certain conditions such as treatment for drug dependence and/or a series of social interventions, including

education and community work. Drug courts and community courts are common examples of such diversion mechanisms.¹⁴⁶

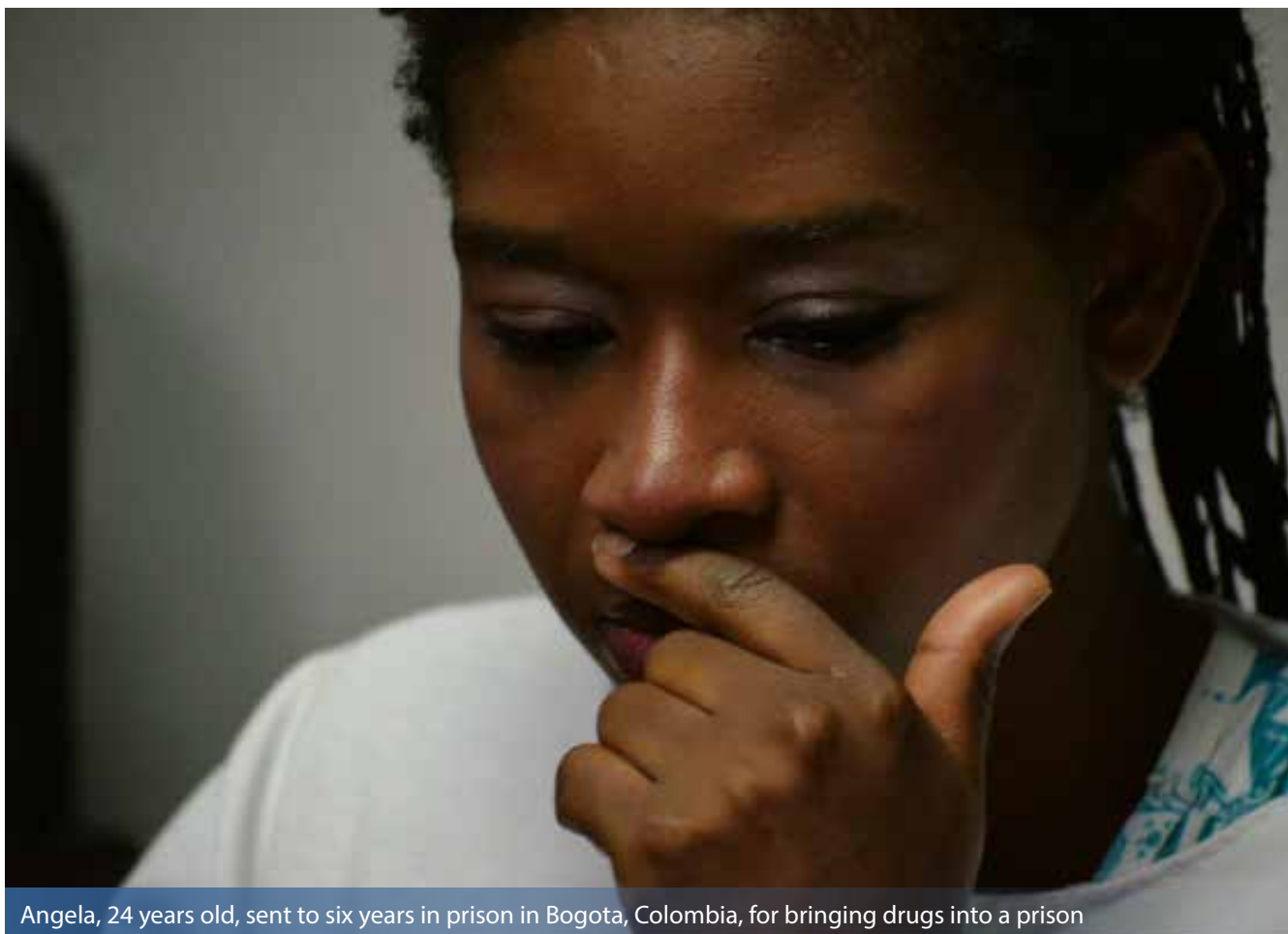
The drug court model has been widely implemented in the USA and in several Latin American countries – however, severe criticisms have emerged around this model, which should therefore be approached with caution.¹⁴⁷ One of the main criticisms of the drug court model is that it continues to address drug dependence through the lens of the criminal justice, instead of a health and social issue. Drug courts were also heavily criticised for:

- The fact that, in some regions of the world, drug courts focus on simple drug use, instead of people dependent on drugs who have committed other offences
- Pushing people who are not necessarily dependent on drugs to accept treatment instead of going to prison – leading to an ineffective use of available resources
- The absence of health professionals for the determination of whether the person is dependent or not
- The fact that the person has to admit culpability to access the treatment programme
- The practice of imposing sanctions for people failing to complete their treatment programme – these sanctions are sometimes more severe than if the person had gone through the traditional criminal justice system.¹⁴⁸

A person may also be diverted away from incarceration after he/she has been convicted, through mechanisms that substitute or reduce the prison sentence. These include probation programmes, conditional sentencing, clemency, etc.¹⁴⁹ Although such diversion schemes have a more limited impact on reducing criminal justice overload – since drug offenders will have already gone through the criminal justice system – it does impact both on prison overcrowding, as well as on people's ability to reintegrate in society. These diversion mechanisms can also help reduce the harms caused by the incarceration of people in charge of children, elderly and people with disabilities.

Implementation issues involved

A set of guiding principles should underpin the design and implementation of alternatives to incarceration:



Angela, 24 years old, sent to six years in prison in Bogota, Colombia, for bringing drugs into a prison

Adopting a human rights approach

Alternatives to incarceration have to meet international human rights standards. Compliance with the rights to health, life and the prohibition of torture is a central purpose of promoting alternatives.¹⁵⁰ Therefore, any alternative involving ill treatment, including compulsory detention centres, should not be implemented.

Using incarceration and punishment as a last resort

The objective of alternatives to incarceration is to reduce the overall use of prison. However, care should also be taken to ensure that alternatives to incarceration do not lead to an increase in the overall volume of sanctions and punishments (e.g. the so-called ‘net-widening effect’ described in Chapter 3.1).¹⁵¹

Approaching drug use as a health issue

The harms associated with drug control should not outweigh the harms of the substances themselves. A change in focus is therefore needed where drug use is dealt with as a health and social issue, instead of a criminal one – and is therefore decriminalised (see Chapter 3.1). As explained above, the UN drug conventions¹⁵² and several international human rights instruments¹⁵³ support this approach.

Avoiding coercive treatment

Not all people who use drugs require treatment. As explained in Chapter 2.5, only about one in 10 people who use drugs experience problems with their drug use and as a result may require treatment. When an offender is dependent on drugs, he/she should be offered appropriate and evidence-based treatment as an alternative to incarceration. When the offender uses drugs but is not dependent, alternatives such as referrals to harm reduction services should be available.

Adopting a gender perspective

This entails dealing with both the vulnerabilities of women and their children and the effects that incarceration may have on their lives. It also means that more research should be conducted on the scale of women’s involvement in the drug trade, the number of women incarcerated for drug offences, which offences they are incarcerated for, data on their situation (age, education, employment history, whether they have children, etc.), and who has benefited from alternatives to incarceration. Diversion mechanisms should also be based on a gender perspective to ensure that alternatives are effective at addressing the specific needs of women and children.¹⁵⁴

Promoting proportionate penalties for drug offences

Drug offences should reflect the seriousness of the crime and the likely impact of punishment on the overall illicit drug market. Alternatives to incarceration are but one component of a proportionate regime (see Chapter 3.3 for more details).

Developing a wide range of health and social services

The successful implementation of alternatives to incarceration depends on the accessibility and quality of health and social services such as healthcare services, including harm reduction and treatment, as well as social interventions. Networks of services, agencies and NGOs working together to address health and/or social and/or economic issues that the offender is facing are essential to develop the institutional support necessary to prevent recidivism and promote social reintegration.

Key resources

- European Monitoring Centre for Drugs and Drug Addiction (2015), *Alternatives to punishment for drug using offenders*, <https://dl.dropboxusercontent.com/u/64663568/library/EMCDDA-alternatives-to-punishment-for-drug-using-offenders-2015.pdf>
- Giacomello, C. (2013) *Women, drug offenses and penitentiary systems in Latin America* (London: International Drug Policy Consortium), https://www.unodc.org/documents/congress//background-information/NGO/IDPC/IDPC-Briefing-Paper_Women-in-Latin-America_ENGLISH.pdf
- Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
- Transnational Institute & Washington Office on Latin America (December 2010), *Systems overload: Drug laws and prisons in Latin America*, http://www.wola.org/publications/systems_overload_drug_laws_and_prisons_in_latin_america_0
- United Nations Office on Drugs and Crime (2007), *UNODC handbook of basic principles and promising practices on alternatives to imprisonment*, http://www.unodc.org/pdf/criminal_justice/07-80478_ebook.pdf
- Washington Office on Latin America, International Drug Policy Consortium, DeJusticia, Inter-American Commission on Women (2016), *Women, drug policy and incarceration: A policymaker's guide for adopting, reviewing and implementing reforms related to women incarcerated for drug offenses*, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas

Key recommendations

- Illicit drug markets cannot be fully eradicated, but can be managed in a way to reduce the most harmful effects of the drug trade. Drug law enforcement should therefore focus on wider social objectives instead of merely trying to reduce the size of the black market
- A new and more comprehensive approach should focus on tackling organised crime more broadly, notably corruption and money laundering, as well as other types of smuggling (tobacco, alcohol, weapons, etc.) and criminal activities (extortion, kidnapping, etc.)
- With this in mind, cross-government approaches should be established – police authorities should partner with justice, health, education, welfare services, youth ministries, as well as civil society organisations and representatives of affected communities
- Efforts should be strengthened on arms control, through disarmament initiatives and initiatives against arms trafficking to help mitigate the harmful effects of the drug trade, given the overwhelming scientific evidence that fewer guns leads to less violence, deaths, and crime
- New metrics and indicators of drug law enforcement performance – focused on social outcomes rather than interdiction process indicators – should be developed and independently evaluated.

Introduction

The UN drug conventions are based on the ‘belief that that there [is] a simple linear relationship between the scale of the drug market and the level of harm to human health and welfare (i.e., the smaller

the market, the fewer the harms)’.¹⁵⁵ Partly as a result of that, national drug policies have largely focused on the overall objective of decreasing the size of the illicit drug market, with the ultimate goal a ‘drug-free world’.¹⁵⁶ In this context, crop eradication (including through aerial spraying with glyphosate), drug seizures, and arrests have been seen as positive steps towards this goal, and therefore often used as indicators of policy success.

This approach has proved largely ineffective and harmful. Globally, the average price of controlled substances has decreased while their purity has increased.¹⁵⁷ Meanwhile, drug policies have not managed to cut down overall illicit drug consumption worldwide,¹⁵⁸ while people have switched from one substance to another, partly in response to changes in price and availability. Illicit drug production has also remained high. Afghanistan, which produces an estimated 90% of the world’s opium, has had record-high cultivation levels in recent years.¹⁵⁹ Successes in curbing production in some countries have often shifted production to nearby areas, including from China to the Golden Triangle, from Thailand to Myanmar, from Turkey, Iran and Pakistan to Afghanistan,¹⁶⁰ and more recently between Bolivia/Peru and Colombia.¹⁶¹

Drug law enforcement practices have had numerous negative impacts that have outweighed their benefits. First, law enforcement crackdowns on certain drug trafficking routes have led to the emergence of other routes. For instance, until the 1990s, the Caribbean was the primary transit route for cocaine planes, often stopping for refuelling en route to Florida. When US law enforcement stepped up, the Pacific, Central America and Mexico became increasingly used instead, while more cocaine was directed to the European market by air and sea. Officials from Europol and the United Nations Office on Drugs and Crime (UNODC) also noted that more recent law enforcement efforts in the Netherlands, including a total controls policy on flights from specific Latin American countries in the early 2000s, may have led traffickers to use different routes, notably through West Africa, a transit area increasingly af-

fectured by the transatlantic cocaine trade.¹⁶² As long as there is demand and profit to be made, traffickers have shown great adaptability and sophistication in their tactics as well. In particular, the vast profits to be gained from illicit drug markets have constituted important economic incentives for criminal organisations' continued involvement in the drug trade.

Second, national drug policies focused on reducing the size of the drug market have led to more violence and instability. Retail drug markets are not inherently violent; there are a number of more important factors in levels of violence, including 'demographic factors, such as the age of criminal capos and the geographic concentration of minority groups, levels of poverty, the balance of power in the criminal market as well as the capacity of policing agencies and their choice of strategies.'¹⁶³ A 2011 study found that 'gun violence and high homicide rates may be an inevitable consequence of drug prohibition and that disrupting drug markets can paradoxically increase violence.'¹⁶⁴ Examples of drug law enforcement contributing to more violence include Colombia between the mid-1980s and the mid-1990s;¹⁶⁵ Mexico, whose homicide rate nearly tripled between 2007 and 2012;¹⁶⁶ and Brazil, where police officers killed over 11,000 people between 2008 and 2013.¹⁶⁷

Militarised interventions have proven to be even more problematic. In Mexico, as part of the military crackdown carried out under President Felipe Calderón (2006-2012), over 70,000 people died in drug-related killings, and more than 26,000 disappeared. Between 2007 and 2010, kidnapping increased by 188%, extortion by 100%, and aggravated

robbery by 42%.¹⁶⁸ While changes in the balance of powers between the six main 'drug cartels' as well as an increased availability of weapons from the USA constituted other important factors in the increased violence in the country, the military response certainly aggravated the situation on the ground. The Mexican government's military gains against the 'drug cartels' La Familia Michoacana and Los Zetas led to the emergence of a new and highly violent group, Los Caballeros Templarios (Knights Templar). Meanwhile, Los Zetas were not defeated but merely displaced to new areas, including Monterrey, Nuevo León and further south near the border with Guatemala.¹⁶⁹

High-level targeting (also called leadership removal or decapitation) against organised crime groups has proved even less effective in reducing violence than in the case of terrorist organisations. Notably, studies have demonstrated that 'leadership removals are generally followed by increases in drug-related murders',¹⁷⁰ and that the 'competitive structure of the illicit drug market in Mexico has created the paradoxical result that state crackdowns increase incentives for [drug trafficking organisations] to fight turf wars by reducing the costs of fighting against the decapitated [drug trafficking organisation]'.¹⁷¹ Interestingly, arresting leaders can result in less violence than killing them,¹⁷² and the short-term reduction of violence is even more robust when a mid-level leader, instead of a high-level one, is arrested.¹⁷³

Third, in a context of budgetary pressures, a disproportionate law enforcement focus on drug interdiction has created opportunity costs, diverting crucial law enforcement resources away from prevention



Seized cannabis being destroyed in Ivory Coast

Credit: Issouf Sanogo, AFP

and investigation. Because of this, murders, kidnappings, sexual violence, and corruption, have arguably been neglected. Mexico's National Institute for Statistics and Geography estimated that in 2013 almost 94% of crimes were not investigated.¹⁷⁴ Similarly, at least 600,000 murders have gone unsolved in the USA since the 1960s.¹⁷⁵ In Colombia, 95% of the 3,000 cases of assassination of trade union members of the past 30 years remain unprosecuted.¹⁷⁶ In Guatemala, impunity for perpetrators of rape and domestic violence stood at approximately 98% in 2012.¹⁷⁷

Fourth, *mano dura* (or 'tough on crime') policing has been a key factor in overcrowding prisons. Incarcerating low-level drug offenders has proved most controversial, damaging their economic and social prospects in the long-term, and making their participation in drug dealing and other types of crime more likely following their release. Former prisoners face low career prospects, and effective rehabilitation and reintegration programmes remain rare in many countries (see Chapters 3.4 and 3.6).

Fifth, *mano dura* approaches have contributed to the emergence of oversimplifying the links between drug trafficking and terrorism, as reflected in the term 'narcoterrorism', often used to describe situations in countries such as Afghanistan, Mali, Mexico, and Peru. The term is problematic in that it suggests a 'symbiotic relationship' between drug traffickers and terrorists, rarely confirmed in practice. The term oversimplifies an extremely complex situation and diverts attention from other important issues, such as corruption, state abuses, arms trafficking, human trafficking and other types of organised crime and violence. Overestimating the importance of the drug trade in funding terrorism, and of the use of terrorist tactics by drug traffickers, may lead to disproportionate and counterproductive policies.¹⁷⁸

Lastly, heavy-handed drug law enforcement has caused massive human rights violations, such as illegal detention, forced treatment and forced labour, physical and sexual abuse, as well as the moral and social stigmatisation of low-level drug offenders, including subsistence farmers¹⁷⁹ (see Policy principle 3).

Legislative/policy issues involved

In order to address those limitations, drug law enforcement needs to be refocused and modernised to target those most harmful aspects of the illicit drug market.

Box 1 Social programmes in Boston and Chicago

In the mid-1990s, the Boston police put in place one of the first applications of the concept of community-based deterrence. Operation Ceasefire prioritised its efforts on the most violent gangs in the city, and involved local community leaders. A coalition of religious groups held forums for gang members, police officers, church ministers, and social services staff to discuss relevant issues, and to give an opportunity for offenders to receive education and training in exchange for leaving the gangs.¹⁸⁰ Studies found that Operation Ceasefire 'was associated with statistically significant reductions in all time series, including a 63% decrease in the monthly number of youth homicides in Boston, a 32-percent decrease in the monthly number of citywide shots-fired calls, a 25% decrease in the monthly number of citywide all-age gun assault incidents, and a 44% decrease in the monthly number of District B-2 youth gun assault incidents.'¹⁸¹

Similar initiatives in High Point, North Carolina and Santa Tecla, El Salvador have proved effective as well.¹⁸² More recently, interventions carried out in parts of South Side and West Side, Chicago aiming at improving the outcomes of low-income youth by teaching them to be less automatic in their behaviour, showed promising results. Cognitive behaviour therapy was used to help youth to overcome their difficulties by changing their thinking, behaviour, and emotional responses.¹⁸³ In a series of randomised controlled trials, a programme called Becoming a Man developed by Youth Guidance showed that 'participation improved schooling outcomes and reduced violent-crime arrests by 44%' and 'reduced overall arrests by 31%'.¹⁸⁴

Prioritising violence reduction

National drug policies have largely placed priority on reducing the size of the drug market at all costs. Instead, policing designed to proactively shape the drug markets towards more benign, less violent forms, is a more realistic and effective way to mitigate the harms caused by the drug trade, as demonstrated by effective programmes put in place in Bos-

Box 2 Police support to health services: Switzerland, Vancouver, Australia and the UK

In the early 1990s, Switzerland reformed its drug policy around a 'Four Pillars' approach (prevention, treatment, harm reduction and law enforcement), endorsed by the Federal Council in 1994. Police authorities, initially reticent, came to accept the shift in perspective from public order to public health. They were made equal partners with public health officials as the new drug policy was developed and implemented. A cross-government drug committee helped improve communication and coordination between services towards a common strategy. The new drug policy and the introduction of harm reduction programmes contributed to a significant drop in the number of HIV deaths among people who use drugs from the early 1990s to 1998.¹⁸⁵

Based on the Swiss model, a similar drug strategy emerged in the early 2000s in Vancouver, Canada. The strategy has centred on harm reduction, including measures such as condom distribution,

needle exchange, and North America's first safe injection site, opened in 2003. Despite political difficulties, police authorities have supported Insite in practice, and diverted people using heroin to the site.¹⁸⁶ 'Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced – open drug dealing is discouraged, while drug users are encouraged to access needed services', the Ministry of Health of British Columbia noted.¹⁸⁷ Since 2003, numbers of overdose deaths and new HIV infections among people who inject drugs went down to the lowest on record, and treatment levels have increased considerably.¹⁸⁸

Measures put in place in Australia in the early 1990s offer another relevant example of beneficial cooperation between law enforcement and health services at the national and local levels, including through harm reduction courses for the police, greater use of police discretion, direct involvement in harm reduction efforts, and the creation of a Drug Programs Co-ordination Unit 'responsible for fostering a harm reduction approach to drug law enforcement by both generalist and specialist police'.¹⁸⁹

A similar multi-disciplinary approach emerged in the mid-1990s in the UK, involving drug law enforcement cooperation with community policing, health and social authorities, and the justice system. Drug Action Teams were created, and tasked with identifying problems, coordinating the local response and reporting back to relevant national public health authorities. This led to more harm reduction trainings for the police, increased awareness of their role and responsibilities, and greater cooperation between services.¹⁹⁰ In 2013, an Independent Commission on Drugs convened by the Safe in the City Partnership also highlighted the benefits of collaboration between police, council, health services and community organisations in Brighton & Hove.¹⁹¹

Credit: Skeptic North



Front door of Insite in Vancouver, Canada

ton and Chicago (see Box 1). Stronger actions on the number of weapons in circulation and against arms trafficking are key in that regard.

Focusing on wider social objectives

A focus on improving the socio-economic circumstances of populations affected by the drug trade would go a long way in addressing some of the root

causes of the problem, while mitigating the unintended, yet entirely foreseeable negative consequences of *mano dura* policing. Recent experiences in Seattle provide a relevant case study (see Box 1 in Chapter 3.4).

Promoting community policing

Community policing concentrating on crime prevention should be inclusive and welcome participa-

tion and input from the local population, civil society organisations and affected communities. Lessons can be learnt from the experience of the Police Pacification Units (UPPs), launched in Rio de Janeiro, Brazil in 2008. In particular, the UPPs' objective to deliver social services and new infrastructure to boost social and economic development in the *favelas* could be useful elsewhere. However, the UPPs have also been criticised because of the militarisation of some of the *favelas'* communities, leading to tight police controls, arbitrary searches and harassment. Others have raised concerns about the capacity of the UPPs to truly tackle drug-related violence – in fact, out of the 1,000 *favelas* of Rio de Janeiro, only 17 have been pacified so far, often leading organised criminal groups to move to neighbouring *favelas* to resume their activities.¹⁹² The UPPs' mixed results demonstrate the need for sustained efforts in the long term, accompanied by measures such as those designed to reduce economic and social inequalities, improve work conditions, and decrease school dropout rates.

Building partnerships with health and social authorities

As part of this new approach, police authorities should work in close cooperation with health authorities, to divert people dependent on drugs towards treatment and other harm reduction services available. In particular, the successful experiences of Switzerland and Vancouver, with police notably informing and directing people who inject drugs towards supervised injection sites, are worth building upon (see Box 2). In addition, partnering with social organisations focusing on rehabilitation and reintegration, through welfare support, career counselling, cognitive behaviour therapy, or social skills training, is likely to have a stronger positive impact than punitive measures for low-level drug offenders.

Tackling corruption and money laundering

Going after the main enablers of the drug trade and organised crime are key dimensions of an effective drug law enforcement approach. Ultimately, corruption is a leading factor behind violence and organised crime. A concerted effort at the local, regional, national and international levels, and support from civil society on the matter, are essential, and could learn from previous experiences in Georgia, Croatia and Sierra Leone (see Box 3). Preventing criminals from easily spending, investing and hiding proceeds from the drug trade is another crucial element of the law enforcement response.¹⁹³

Box 3 Anti-corruption initiatives in Georgia, Croatia and Sierra Leone

A World Bank report highlighted a number of measures behind achievements in Georgia: 'exercising strong political will; establishing credibility early; launching a frontal assault; attracting new staff; limiting the state's role; adopting unconventional methods; coordinating closely; tailoring international experience to local conditions; harnessing technology; and using communications strategically'.¹⁹⁴

In Croatia, the government created the Bureau for the Suppression of Corruption and Organised Crime, a specialised prosecution service. After early struggles, the Bureau now holds a conviction rate higher than 95%, and has successfully prosecuted a former prime minister, a former vice president, a former top-level general, and other high-level officials. Strengthened legislation, popular support, media scrutiny, and the perspective of European Union membership have been considered as key factors behind this progress.¹⁹⁵

A 2013 report on Sierra Leone pointed out that effective anti-corruption efforts may include the creation of institutions specifically dedicated to tackling corruption, the development of oversight processes led by civil society, parliamentary committees or the judiciary, a focus on education, accountability and transparency, especially regarding asset disclosure and political party financing, and engagement with the private sector (learning for instance from the South African Initiative – Business Against Crime South Africa).¹⁹⁶

Building up investigation capacity and strengthening the criminal justice system

Much of the foreign aid and national investments in drug law enforcement have targeted screening and interdiction capabilities. While some of these are needed, an important tool has often been neglected: the authorities' capacity to investigate and prosecute drug cases and their associated networks. This not only requires tackling corruption amongst government, police, and the judiciary, but also a renewed focus on education, training, more system-

atic and comprehensive data gathering processes, personnel, budgets, and international cooperation.

Mid-level targeting

Targeting low-level, non-violent drug offenders has led to a dramatic increase in prison populations, and negative socio-economic effects in the long term. 'Kingpin' strategies to remove top leaders often make little impact on the work of their organisations, and may lead to cycles of violence for succession. Instead, investigating and arresting mid-level leaders are likely to have a stronger impact on violence reduction and the drug trafficking organisations themselves.

Implementation issues involved

Reforming drug law enforcement is an arduous task, affected by a number of factors. These include:

- **Sunk cost fallacy**, or 'the idea that a company or organization is more likely to continue with a project if they have already invested a lot of money, time, or effort in it, even when continuing is not the best thing to do'.¹⁹⁷ In other words, we have invested so much money, time and effort in the current drug law enforcement approach, that reforming it is seen by many as a waste, or giving up, while related bureaucracies are now embedded in our law enforcement budgets and infrastructures.
- **A third-rail issue**: Although the debate has significantly evolved in recent years in several countries, a reform of drug law enforcement strategies remains a politically controversial topic. Many politicians remain unwilling to champion more liberal policies by fear of being labelled as 'soft on drugs' or 'weak on crime'.
- **Counter-narcotics aid**: Foreign assistance and training has also disseminated and perpetuated outdated and inadequate drug law enforcement approaches across the world.¹⁹⁸

There is thus a clear need to work with law enforcement officials, politicians, the media and the greater public to explain that the current approach is not only largely ineffective but also harmful, and explain the merits of the new approach and the scientific evidence behind it.

Crucially, change will only occur if the objectives and performance indicators to incentivise effective practice are amended (see Box 4). These should no longer focus on the number of seizures, arrests,

Box 4 Examples of new drug law enforcement performance indicators

Indicators of drug markets that focus more on the outcomes of law enforcement operations:

- Have law enforcement operations reduced the availability of a particular substance to young people (measured by the level of use or ease of access)?
- Have law enforcement operations affected the price or purity of drugs at the retail level? If so, has this had positive or negative effects on the drug market and people who use drugs?

Indicators measuring drug-related crime:

- Have the profits, power and reach of organised crime groups been reduced?
- Has the violence associated with drug markets been reduced?
- Has the level of crime committed by people to support, or as a consequence of, their drug use been reduced?

Indicators measuring the law enforcement contribution to health and social programmes:

- How many people dependent on drugs have law enforcement agencies referred to drug dependence treatment services?
- How many people have achieved a sustained period of stability as a result of treatment?
- Has the number of overdose deaths been reduced?
- Has the prevalence of HIV and hepatitis among people who use drugs declined?

Indicators evaluating the environment and patterns of drug use and dependence:

- How did law enforcement activities impact affected communities' socio-economic environment and people's feelings of safety and security?
- Have patterns of drug use and dependence changed as a result of law enforcement actions?

crops eradicated, or extraditions (*processes*), but rather on evidence of fewer harms associated with the drug trade, and an improved quality of life (*outcomes*), independently evaluated.¹⁹⁹

Key resources

- Brookings Institution (2015), *Improving global drug policy: Comparative perspectives and UNGASS 2016*, <http://www.brookings.edu/research/papers/2015/04/global-drug-policy>
- International Drug Policy Consortium, International Institute for Strategic Studies & Chatham House (2012-2013), *Modernising Drug Law Enforcement publication series*, <http://idpc.net/policy-advocacy/special-projects/modernising-drug-law-enforcement>
- Organization of American States (2013), *Report on the drug problem in the Americas*, http://www.oas.org/en/media_center/press_release.asp?sCodigo=E-194/13
- Werb, D. Rowell, G., Guyatt, G., Kerr, T. & Montaner, J. (2011), 'Effects of drug market violence: A systematic review', *International Journal of Drug Policy*, **22**(2): 87-94, [http://www.ijdp.org/article/S0955-3959\(11\)00022-3/abstract](http://www.ijdp.org/article/S0955-3959(11)00022-3/abstract)
- West Africa Commission on Drugs (2014), *Not just in transit: An independent report of the West Africa Commission on Drugs*, <http://www.wacommissionondrugs.org/report/>

3.6

Health-based policies in prisons and other closed settings

Key recommendations

- Governments should consider bringing prison health under the control of the Ministry of Health rather than ministries of justice, interior or corrections
- An understanding of the level and nature of drug use and drug dependence among prisoners is needed to design appropriate policies and programmes; and services should be designed, implemented and evaluated with the meaningful involvement of people who use drugs
- A range of interventions and programmes should be developed and properly resourced in custodial settings, including treatment and harm reduction services. These programmes should be gender sensitive, and be stringently evaluated and adapted if necessary
- NSPs in prisons are needed to avoid the risks related to sharing injection equipment. The introduction of NSPs should be carefully prepared, including providing information and training for prison staff. The mode of delivery of needles, syringes and other equipment (for example, by hand or dispensing machine) should be chosen in accordance with the environment of the prison and the needs of its population²⁰⁰
- Additional harm reduction programmes – such as information and education programmes, naloxone distribution, HIV testing and counselling, ART, crack pipe distribution, etc. – should also be provided
- A person's participation in drug treatment programmes should not be used as a reason to discriminate against them
- Effective links with community-based services should be established to ensure continuity of care so that the benefits of treatment started before or during imprisonment are retained.

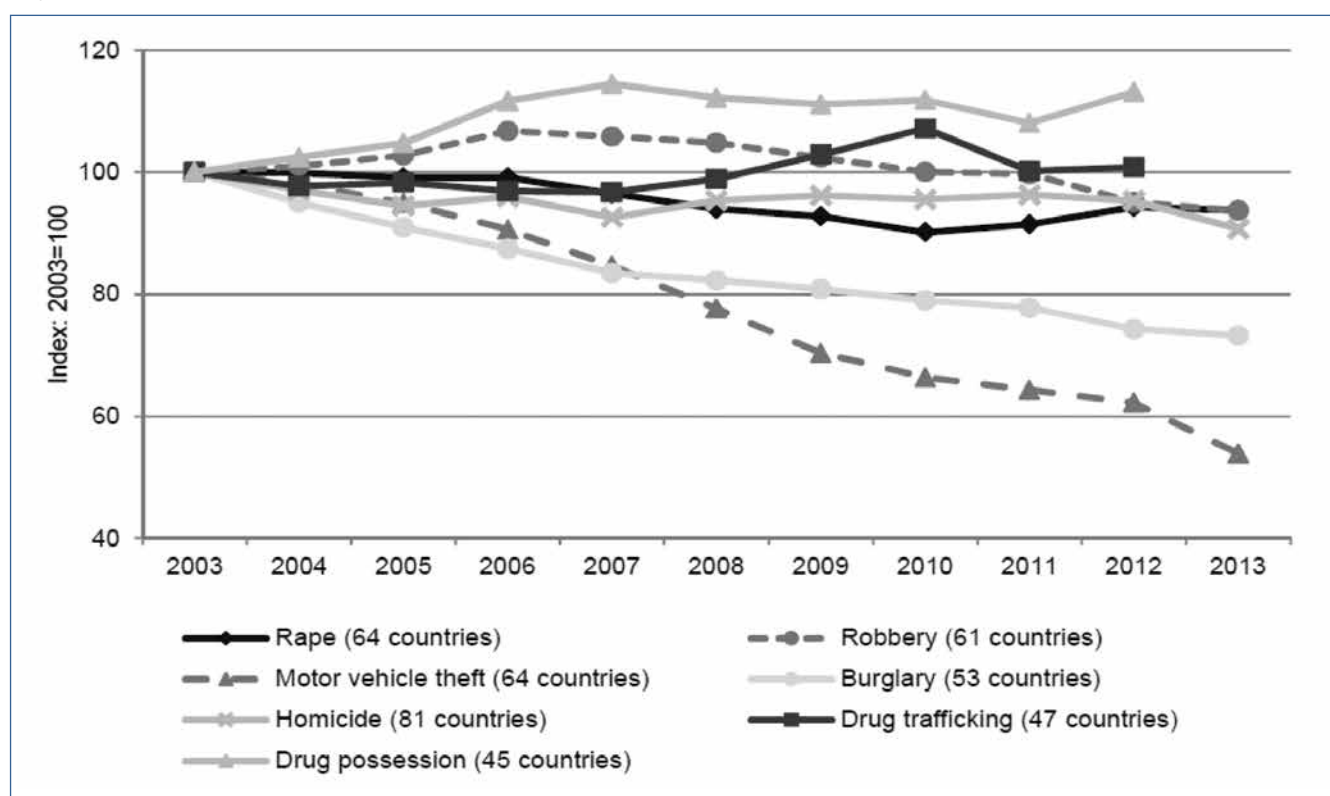
Introduction

The best estimate of the current world prison population is 10.2 million, a figure excluding at least 650,000 persons reported to be in pre-trial or 'administrative' detention in China and 15,000 in North Korea.²⁰¹ The number of people imprisoned for drug-related offences has been growing in the past few decades irrespective of imprisonment for offences such as theft, robbery and fraud committed to raise money to fund drug purchases. As already mentioned in previous chapters of the Guide, the global increase in drug-related crime is driven mainly by a rising number of offences related to drug possession – with offences related to drug possession currently comprising 83% of total global drug-related offences. Criminal offences relating to drug trafficking, however, have remained relatively stable over time (see figure 1),²⁰² and the vast majority of traffickers in prison are low-level offenders.²⁰³

The proportion of drug-related offences among female prisoners is typically higher than for their male counterparts.²⁰⁴ This trend has been attributed to the greater ease with which low-level crimes can be prosecuted,²⁰⁵ as well as gender disparities in the enforcement of drug laws and policies.²⁰⁶ Overall, however, the vast majority of prisoners the world over are adult men, although the number of women prisoners is increasing at a much faster rate than for men.²⁰⁷

In most countries, prisoners are drawn from the poorest and most marginalised strata of society, with low education, high unemployment rates, and histories of physical or sexual abuse, broken homes and relationships.²⁰⁸ Many prisoners may have used alcohol and/or controlled substances as a coping mechanism, including to 'escape' childhood abuse and violence. In prison, drugs are widely available, and are often used to escape the misery, brutality, lack of privacy, anxiety and chronic insecurity that frequently characterise life within these institutions. Boredom and lack of constructive activities in prison can also increase the likelihood of drug use.²⁰⁹

Figure 1. Global trends of selected crimes, 2003 to 2013²¹⁰



Although data are difficult to obtain and compare, studies indicate that approximately 50% of prisoners in the European Union, and more than 80% in the USA, have a history of drug use, and that this number is increasing.²¹¹ Estimates show that approximately one in three people detained have used drugs at least once while in prison,²¹² with the prevalence of drug use varying considerably from country to country. There is also evidence that many prisoners initiate injecting drugs for the first time in prison.²¹³ While the number of people who inject drugs in the community is only 0.26% of people aged 15-64, the rate is considerably higher in prison. For example, a study found that 23% of prisoners in Australia had injected drugs at some point in prison, as had 39% of male prisoners in Bangkok, Thailand.²¹⁴

While the rate of infections in prisons within and across countries varies considerably, the prevalence of HIV, sexually transmitted infections (STIs), hepatitis B and C as well as tuberculosis is much higher in prison populations as compared to the general population. HIV prevalence has been found to be 50 times higher in some prison settings than in the general population.²¹⁵ In Europe, the World Health Organisation (WHO) estimated that one in four detainees (an estimated 2.2 million people) are living with hepatitis C, compared to one in every 50 in the broader community.²¹⁶ Similarly, the prevalence of tuberculosis is 'multiple times higher' in prisons than it is in the general population.²¹⁷ While statistics are hard to come

by, in European prisons it was found in 2006 that tuberculosis infection was 17 times more likely in prisons than in the general population, and up to 81 times more likely in Eastern Europe.²¹⁸

The sharing of needles and syringes is a major factor for the spread of blood-borne diseases in prison, driven by the lack of availability of sterile equipment via harm reduction services and by fear of detection of drug use. Statistics show that a high number of prisoners who inject drugs share needles and other injecting equipment: for example, 56% in Pakistan, 66% in Russia, 70-90% in Australia, 78% in Thailand and 83-92% in Greece.²¹⁹ Other factors for the transmission of infections are rape and sexual violence as well as consensual unprotected sex. Where the use of drugs is particularly stigmatised, those at the bottom of the prison's informal hierarchy are most prone to being victims of such assaults.²²⁰

Based on these data, it is clear that prisons are an inadequate place to deal with drug use and dependence; rather, such settings result in additional health risks, even more so when facilities are overcrowded and under-resourced. There are therefore a number of reasons why an effective prison policy is essential, notwithstanding the need for broader drug policy reforms that seek to divert low-level drug offenders away from prisons in the first place (see Chapters 3.1 to 3.4):

- **Public health:** Prisons constitute an unsuitable

place for dealing with drug use and dependence,²²¹ but rather incubate health problems such as blood-borne viruses and overdose. Such health problems are not sealed away, they impact on the rest of the community as prison staff, service providers and visitors enter and exit the institutional setting, and prisoners are ultimately released. Consequently, effective healthcare in prison is in the vital interest of society.

- **Human rights obligations:** International human rights obligations include the right to the highest attainable standard of physical and mental health,²²² and prisoners retain their human rights while detained. Governments bear a particular responsibility towards those they deprive of their liberty.
- **Improve drug treatment and prevent recidivism:** Effective treatment for drug dependence in prisons – including opioid substitution therapy (OST) – improves health outcomes and can help to prevent a return to crime after release.²²³ Without treatment and a continuum of care, evidence shows a high rate of overdoses, relapse to drug use and recidivism among people who use drugs after they are released from prison.²²⁴
- **Economics:** Responding to drug-related crime, overdose and blood-borne infections can be very expensive, in particular for illnesses such as HIV that are chronic and may require life-long treatment. There is therefore a powerful economic case to be made for harm reduction and evidence-based drug treatment measures in prisons, as well as in community settings.

Legislative/policy issues involved

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is enshrined in article 12 of *International Covenant on Economic, Social and Cultural Rights*²²⁵ and reflected in Principle 9 of the Basic principles for the treatment of prisoners.²²⁶ The right to health cannot be curtailed because a person is caught using drugs or ends up in prison.²²⁷

States bear a particular duty of care for those detained, as prisoners have no alternative but to rely on prison authorities to promote and protect their health.²²⁸ The Special Rapporteur on torture has held that states ‘must provide adequate medical care, which is a minimum and indispensable material requirement for ensuring the humane treatment of persons in its custody’, and that ‘omissions on the part of the authorities can amount to ill-treatment and even torture’.²²⁹

People in custody are entitled to the same standard of healthcare found outside of prisons, including with regard to prevention, harm reduction and antiretroviral therapy (ART).²³⁰ The Special Rapporteur on the right to health has clarified that the right to health is violated if harm reduction and evidence-based treatment programmes are available to the general public, but not to people in detention.²³¹

The most comprehensive guidance on healthcare in prisons is enshrined in the revised UN Standard minimum rules for the treatment of prisoners, also known as the Mandela Rules (Rules 24 to 35).²³² The



Bandung prison, Indonesia

Credit: International HIV/AIDS Alliance



Prison medical facility in Kazakhstan

revised Rules clarify that the provision of healthcare for prisoners is a state responsibility, free of charge and without discrimination on the grounds of their legal status (Rule 24).²³³ The same standards apply in prison as they do in the community (based on the principle of equivalence of care), and healthcare services in prison should be organised 'in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence' (Rule 24). The revised Rules also call for 'particular attention to prisoners with special healthcare needs or with health issues that hamper their rehabilitation' (Rule 25). The role of healthcare personnel is to evaluate, promote, protect and improve the physical and mental health of prisoners, through 'an interdisciplinary team with sufficient qualified personnel acting in full clinical independence' (Rule 25, see also the Dual Loyalty Guidelines,²³⁴ the Declaration of Tokyo of the World Medical Association²³⁵ and the UN Rules for the treatment of women prisoners – the 'Bangkok Rules'²³⁶).

Healthcare staff in prisons are subject to the same ethical and professional standards as for patients in the community, including adherence to prisoners' autonomy with regard to their own health, informed consent in the doctor-patient relationship, and confidentiality of medical information – unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others (Rule 32, see also General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights²³⁷). Information is a precondition for prisoners to be able to give their informed consent to

medical interventions. As the Special Rapporteur on the right to health emphasized, 'informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision'.²³⁸

Professional healthcare requires the maintenance of medical files. However, the confidentiality of such information is reflected in Mandela Rule 26, including the prisoners' access to it and the duty to transfer medical files to another facility along with the prisoner.

The lack of gender-sensitive provisions relating to healthcare provision in prison settings has been

Box 1 Principles for the provision of healthcare in prison²³⁹

- State responsibility
- Without discrimination
- Equivalence of healthcare
- Clinical independence
- Same ethical principles as in the community
- Medical screening upon admission
- Drug dependence treatment
- Mental healthcare
- Continuity of care

acknowledged and rectified by the adoption of the Bangkok Rules.²⁴⁰

While the Mandela Rules and the Bangkok Rules do not constitute legally-binding treaties, they carry the weight of unanimously adopted standards at the international level. At the regional level, provisions on healthcare in prisons have been incorporated in the European prison rules²⁴¹ and the Principles and best practices on the protection of persons deprived of liberty in the Americas.²⁴²

The WHO and the UNODC have been at the forefront of developing guidance relating to prisoner healthcare and the treatment of drug dependencies (see Key Resources below). The WHO guidelines²⁴³ on controlled substances have been endorsed by the International Narcotics Control Board (INCB), who also advised in 2007 that, 'Governments have a responsibility to (...) provide adequate services for drug offenders (whether in treatment services or in prison)'.²⁴⁴

Implementation issues involved

Prison authorities have usually focused on preventing drug use in prison through stringent security measures and drug-testing programmes, while dedicating little attention and resources to the provision of healthcare, drug dependence treatment and harm reduction programmes. Countries who focus on mandatory drug testing²⁴⁵ argue that this measure deters prisoners from using drugs in prison and allows them to identify individuals for treatment. However, the practice has shown a number of problems, including the diversion of financial and staff resources away from evidence-based treatment and prevention services, a negative effect on the prison regime²⁴⁶ and the risk of prisoners switching to more harmful drugs because these are not being tested for or are harder to detect (e.g. prisoners may switch to the use of heroin or new psychoactive substances rather than cannabis, as the latter can be detected in the body for a longer period of time).²⁴⁷

Implementing a comprehensive package of services in prison

A comprehensive package recommended by the UNODC, the International Labor Organization (ILO), the United Nations Development Program (UNDP), the WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) for HIV prevention, treatment and care in prisons and other closed settings comprises 15 key interventions (see Box 2).²⁴⁸

Box 2 The UN comprehensive package of interventions in prison²⁴⁹

The comprehensive package consists of 15 interventions that are essential for effective HIV prevention and treatment in closed settings. While each of these interventions alone is useful in addressing HIV in prisons, they have the greatest impact when delivered as a whole. Although by no means truly 'comprehensive', this package is a useful start to address HIV in closed settings.

1. Information, education and communication
2. Condom programmes
3. Prevention of sexual violence
4. Drug dependence treatment, including OST
5. Needle and syringe programmes (NSPs)
6. Prevention of transmission through medical or dental services
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. Prevention, diagnosis and treatment of tuberculosis
12. Prevention of mother-to-child transmission of HIV
13. Prevention and treatment of STIs
14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards

A combination of measures that address drug use, drug dependence and related health risks in prison includes:

Education and information – As prisoners typically come from the most marginalised groups of society and may have had limited access to healthcare before admission to prison, they are less likely to be aware of health and infection risks. However, the



Buen Pastor prison in Bogotá, Colombia

spread of infectious diseases can only be prevented if prisoners are given information about means of protection and prevention in a diction that is appropriate to their language skills and education. Health education has also shown to improve adherence to treatment and rises in cure rates.²⁵⁰ Some prison administrations have used educational videos or lectures to deliver health education, leading to higher levels of awareness. Information material should be developed in consultation with prisoners and prison staff, as it 'makes the information more sensitive and appropriate to the prison context, increases the sense of ownership among prisoners and contributes to the continuity of the programme.'²⁵¹

Drug dependence treatment – With a large number of people dependent on drugs held in custody at any one time, prisons can be an effective setting for a range of evidence-based treatment programmes (for more information on treatment, refer to Chapter 2.5). OST – in particular with methadone and buprenorphine – has proven to be feasible and beneficial in a wide range of prison settings for people dependent on opioids. Yet only 43 countries provided OST in prison settings in 2014.²⁵² OST has proven to lower rates of heroin use, reduce drug injection, reduce the sharing of injecting equipment, lower rates of fatal overdose (especially post-release), increase adherence to ART, and lower re-incarceration rates.²⁵³ For example, a review of 21 studies on OST in prisons found that it provided an effective way to get people into treatment programmes, reduce risk behaviours, and lower overdose risks upon release. It also found that, where liaison with community-based programmes existed, the prison programmes ensured longer-term ben-

efits²⁵⁴ (see also the Madrid Recommendations²⁵⁵). Drug dependence treatment programmes showed additional positive effects on institutional behaviour and reduced violence.²⁵⁶ As in the community, however, more attention should be given to substitution treatment options for stimulant dependence (see Chapter 2.5 for more detail).

Several studies have also acknowledged that other forms of treatment, such as psychosocial therapy, are effective at reducing drug dependence in prisons.²⁵⁷ Structured therapeutic programmes have been shown to move a proportion of prisoners away from drug dependence, with resulting reductions in crime and health problems. Prison authorities should aim to make available a full range of evidence-based treatment programmes, based on the following principles:

- Screening procedures need to be in place to identify those in need of treatment, while respecting the principle of informed consent²⁵⁸
- As long as the treatment programmes provided are voluntary, humane and of good quality, prisoners will be likely to participate
- Programmes should be organised so that prisoners are able to move between services throughout their time in prison, according to their needs and when they choose to do so
- Compliance and success rates of treatment for drug dependence in prisons can be improved by linking treatment progress to prisoner incentives, such as consideration for early release
- Careful attention needs to be paid to continuity of treatment upon admission and post release

- Treatment success and recovery should not be understood solely as abstinence from drug use. Individuals should be encouraged to identify and strive towards their own recovery, which may or may not require abstinence but will always include progressive steps to improve their health and well-being (see Chapter 2.5).

Needle and syringe programmes – While there has been great reluctance to introduce NSPs in prison settings, programmes involving the distribution of sterile injecting equipment to people who inject drugs have been effective at preventing HIV and hepatitis infection. Fears included the possibility that prisoners would use needles as weapons against staff or other prisoners, that discarded needles would present an infection risk, and that the availability of sterile needles and syringes would increase the prevalence of drug injecting in prisons. However, these concerns have not materialised in practice and the outcomes of such programmes have been very positive in reducing the sharing of injecting equipment.²⁵⁹ Yet, in 2014, only 8 countries provided NSPs in prisons (three less than in 2012), compared to 90 countries where such programmes were available in the community.²⁶⁰ The UNODC, the WHO and UNAIDS recommend that both NSPs and OST be accessible in prisons.²⁶¹

Access to measures for safer sex – A number of countries provide free access to condoms in prison settings, including in Western Europe, parts of Eastern Europe and Central Asia, as well as Australia, Canada, Indonesia, the Islamic Republic of Iran,²⁶² South Africa and the USA.²⁶³ Research in a Los Angeles county prison found that condom distribution prevented a quarter of HIV transmissions among sexually active inmates, and that the averted future medical costs far exceeded the programme costs.²⁶⁴ No security problems or other negative consequences have been reported, and evidence shows that the provision of condoms has not led to an increase in security issues, sexual activity or drug use.²⁶⁵ Further measures have also included providing information, education and communication programmes for prisoners and prison staff on STIs, consisting of voluntary counselling and testing for prisoners or measures to prevent rape, sexual violence and coercion.

Vaccination programmes – Effective vaccinations exist to protect people against hepatitis B, and incarceration does provide an opportunity to encourage people to take up these vaccinations. However, vaccination schemes should remain voluntary.²⁶⁶ The UK, for example, established an 'opt-out' testing programme for hepatitis B in prisons, whereby all prisoners are offered the chance to

Box 3 Moldova's harm reduction programme in prison

In Moldova, OST for prisoners dependent on drugs was introduced in 2005, and recipients are provided with methadone each day in the prison pharmacy after signing a register. There is also an NSP in prison.²⁶⁷ Research documented a decline in overdoses²⁶⁸ and a positive impact of the treatment on the health and general well-being of prisoners.²⁶⁹ Initial challenges with the programme have been addressed, for example by providing staff with specific health and safety information including the type and scope of risks to staff.²⁷⁰ Concerns about methadone being used to bribe medical personnel or prisoners have been successfully addressed by administering the methadone under strict supervision, as well as by self-regulation by the participants of the programme.

As of 2009, more than two-thirds of adult sentenced prisoners had access to harm reduction services in Moldovan prisons and the results have been wholly positive. HIV and hepatitis C incidence have decreased, there has not been any recorded case of needles being used as weapons against prison staff or fellow prisoners, and drug use has not increased.²⁷¹

be tested for infection, and recommended that all prisoners be vaccinated against hepatitis B.²⁷² Most prison administrations that have targeted hepatitis A and B vaccination programmes at drug-using prisoners report high levels of engagement and compliance.

Establishing responsibility / prison management

It is now widely recognised that prison health services should be integrated into public national health policies and systems.²⁷³ It is also increasingly acknowledged that this can be done most effectively, and that continuity of care is best achieved, when the responsibility for prison healthcare is assumed by the Ministry of Health.²⁷⁴ Healthcare staff employed by prison services may not be sufficiently in touch with clinical and professional developments in the wider society, may lack independence, or may not be trusted by inmates.²⁷⁵ Countries such as Italy,

Norway, France, England and Wales and most parts of New South Wales in Australia have already taken this step, with broadly positive results.²⁷⁶

Ensuring gender sensitivity

Drug dependence has been consistently found to be over-represented in female prison populations, compared to the general population.²⁷⁷ This is linked to the background of these women, including the high rates of domestic and sexual violence they may have experienced prior to arrest and detention.²⁷⁸

HIV and other sexually-transmitted and blood-borne diseases are also more prevalent among female prisoners than their male counterparts,²⁷⁹ due to the combination of gender inequality, stigma and women's higher vulnerability to contracting STIs, limited access to information and inadequate health services.²⁸⁰ This background as well as physiological differences result in greater and different healthcare needs, and mean that drug dependence treatment and other measures need to be gender-sensitive in order to be effective. Treatment programmes need to take into account prior victimisation, diverse cultural backgrounds, any history of abuse or domestic violence, mental health problems common among female prisoners and the special needs of pregnant women and women with children. However, many prison systems discriminate against women when it comes to drug treatment and harm reduction programmes – i.e. by only providing them in male prisons.²⁸¹ Where these programmes exist, they are often not tailored to women.²⁸²

Rule 6 of the Bangkok Rules²⁸³ recommends that the health screening of female prisoners shall include 'the existence of drug dependency' and 'the presence of sexually transmitted diseases or blood-borne diseases'. Depending on risk factors, female prisoners should also be offered voluntary testing for HIV and other blood-borne diseases, with pre- and post-test counselling.

Gendered differences in drug use and dependence and related complications are acknowledged by Bangkok Rule 15, which highlights the need for 'specialised treatment programmes designed for women substance abusers'. The UN Committee on the Elimination of Discrimination against Women has also recommended that states provide gender-sensitive and evidence-based drug treatment services as well as harm reduction programmes for women in detention.²⁸⁴

With regard to HIV, Bangkok Rule 14 recommends programmes that are 'responsive to the specific needs of women, including prevention of mother-to-

Box 4 Spain's harm reduction programme in prison reduces HIV and hepatitis C infections

In the late 1990s, the rate of HIV infection among prisoners who injected drugs in Spain was reported to be around 30% – one of the highest in Europe. The country therefore launched a prevention and control programme for communicable diseases in prison, mirrored in the community. A comprehensive harm reduction approach was adopted based on voluntary testing, confidentiality, free distribution of condoms, OST, NSPs, health-related education, prisoners' training as health mediators, and parole for terminally-ill prisoners.²⁸⁵

The impact was significant. Spain has reported that HIV prevalence among prisoners fell from 22.4% in 1995 to 6.3% in 2011,²⁸⁶ and in one particular prison in the Ourense region, a 10-year review of the NSP found that between 1999 and 2009 the prevalence of HIV infection decreased from 21% in 1999 to 8.5% in 2009, and hepatitis C prevalence from 40% to 26.1%.²⁸⁷

child transmission', encouraging 'the development of initiatives on HIV prevention, treatment and care, such as peer-based education'. Further measures should include gender-sensitive support groups, drug education, and psychosocial programmes.

Preventing overdoses

Overdose is a common experience for many people who use drugs, in particular opioids, and is a leading cause of death among people who inject drugs. The period immediately following release from prison poses a significant risk of (fatal) overdose.²⁸⁸ This is because former prisoners may resume similar doses as prior to detention, when their body can no longer cope with these doses due to reduced tolerance following abstinence, reduced use or the use of other drugs while in prison.²⁸⁹ For instance, a UK study showed that male prisoners were 29 times, and female prisoners 69 times more likely to die from an overdose during the week following their release compared to the general population.²⁹⁰ In another study of Washington state prisons, former prisoners were found to be 129 times more likely to die from a drug overdose in the first two weeks after release than their counterparts in the general population.²⁹¹

Because of this elevated risk, prison services should seek to provide training and information on overdose prevention and emergency responses – both for people who use drugs and for prison staff. Upon release and/or while in prisons, people who use opioids should also be provided with naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Chapter 2.4 for more details).

Addressing post-release issues

Upon transferral to or release from prison, continuity of drug-related programmes, in particular OST, is essential to ensure that people who stopped using drugs do not relapse into drug use or suffer from an overdose, that a former inmate does not suffer from opioid withdrawal, and that those on ART or other forms of medication do not develop resistance to such medications if their treatment is suddenly interrupted.

As set out by the UNODC, UNAIDS and the WHO, 'In order to ensure that the benefits of treatment (...) started before or during imprisonment are not lost, as well as to prevent the development of resistance to medications, provision must be made to (...) continue these treatments without interruption.'²⁹² This continuity of care is best achieved when community services can provide support to a prisoner in custody and after release and accompany his/her re-entry into the community.²⁹³ Several studies have suggested that aftercare is needed to optimise the effects of in-prison treatment for drug dependence on reducing drug re-offending.²⁹⁴ Continuity of care also requires that medical files follow the prisoner to the relevant public health service upon release (see Rule 26 of the Mandela Rules).

Key resources

- Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
- United Nations Office on Drugs and Crime (2004), *Drug abuse treatment toolkit, substance abuse treatment and care for women: Case studies and lessons learned*, http://www.unodc.org/docs/treatment/Case_Studies_E.pdf
- United Nations Office on Drugs and Crime (2014), *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (Advance Copy), <https://www.unodc.org/>

Box 5 Lichtenberg women's prison in Berlin, Germany

At admission to Lichtenberg prison, each woman is provided with a harm reduction kit, which includes a plastic case with ascorbic acid (to be used in the preparation of drugs for injection), alcohol wipes, vein cream, and a 'dummy' needle for use in the sterile needle dispensing machine (which requires a used syringe to be deposited before a sterile one is dispensed).²⁹⁵ These dispensing machines allow prisoners to obtain sterile syringes anonymously.²⁹⁶ Syringes stored properly in plastic cases provided are permitted by the prison. However, any prisoner found with an improperly stored or hidden needle or in possession of more than one needle is subject to sanctions.²⁹⁷ A review in 2013 found that there had been no increase in drug use or injecting drug use, and needle sharing had been strongly reduced.²⁹⁸

The prison also provides a holistic approach to drug dependence. There is a 'drug addiction unit' which is divided into a basic unit and the so-called 'motivated' and 'substituted' units. Usually drug dependent women move into the basic unit at admission. During the 'orientation' phase, they are encouraged to address their drug use. Women can apply to move into the 'motivated' unit – which is divided into two flats: one for women who are in the OST programme, and one for women who are abstinent from drugs (where all women have to participate in urine testing to prove their abstinence).

[documents/hiv-aids/publications/Prisons and other closed settings/ADV COPY NSP PRISON AUG 2014.pdf](https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf)

- United Nations Office on Drugs and Crime (2014), *Handbook on women and imprisonment, 2nd edition with reference to the United Nations Rules for the treatment of women prisoners and non-custodial measures for women offenders (The Bangkok Rules)*, https://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf
- United Nations Office on Drugs and Crime, International Labor Organization & United Nations

- Development Program (2012), *Policy Brief: HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, www.unodc.org/documents/hiv-aids/V0855768.pdf
- United Nations Office on Drugs and Crime, World Health Organisation & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention – A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, <http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf>
 - World Health Organisation (2009), *Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings*, http://www.who.int/hiv/topics/idu/prisons/clinical_guidelines_close_setting_wpro.pdf
 - World Health Organisation (2014), *Health interventions for prisoners – Update of the literature since 2007*, http://apps.who.int/iris/bitstream/10665/128116/1/WHO_HIV_2014.12_eng.pdf?ua=1
 - World Health Organisation Regional Office for Europe & United Nations Office on Drugs and Crime (2013), *Good governance for prison health in the 21st century: A policy brief on the organization of prison health*, https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf
 - World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for action technical papers – Interventions to address HIV in prisons: Drug dependence treatments*, http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf
 - World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS, *Drug dependence treatment: Interventions for drug users in prisons*, https://www.unodc.org/docs/treatment/111_PRISON.pdf

Chapter 3 – endnotes

1. In many countries, drug use continues to be criminalised – even though the UN drug conventions offer considerable flexibility by allowing social and health measures to be used in addition to, or instead of, criminal penalties for people who use drugs and offenders found to be dependent on drugs
2. Commission on Crime Prevention and Criminal Justice (2014), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2014/5, https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf
3. In its 2015 World Drug Report, UNODC declared: ‘illicit drug use has in fact remained stable’. See: United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
4. Global Commission on Drug Policy (June 2012), *The war on drugs and HIV/AIDS: How the criminalization of drug use fuels the global pandemic*, http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf; Global Commission on Drug Policy (May 2013), *The negative impact of the war on drugs on public health: The hidden hepatitis C epidemic*, http://www.globalcommissionondrugs.org/hepatitis/gcdp_hepatitis_english.pdf; Count The Costs (April 2013), *The war on drugs: Threatening public health, spreading disease and death*, <http://www.countthecosts.org/sites/default/files/Health-briefing.pdf>
5. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
6. For more information, see: Eastwood, N., Shiner, M. & Bear, M. (2014), *The numbers in black and white: Ethnic disparities in the policing and prosecution of drug offences in England and Wales* (London: Release), <http://www.release.org.uk/node/286/>; American Civil Liberties Union (June 2013), *The war on marijuana in black and white: Billions of dollars wasted on racially biased arrests*, <https://www.aclu.org/report/war-marijuana-black-and-white?redirect=criminal-law-reform/war-marijuana-black-and-white-report>; Drug Policy Alliance (February 2014), *The drug war, mass incarceration and race*, <http://www.drugpolicy.org/resource/drug-war-mass-incarceration-and-race>
7. Joint United Nations Programme on HIV/AIDS (2015), *The gap report*, http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report
8. World Health Organisation (2014), *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
9. United Nations Development Program (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>
10. Office of the High Commissioner on Human Rights (2015), *Study on the impact of the world drug problem on the enjoyment of human rights*, A/HRC/30/65, http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx
11. UN Women (2015), *A gender perspective on the impact of drug use, the drug trade, and drug control regimes*, https://www.unodc.org/documents/ungass2016/Contributions/UN/Gender_and_Drugs_-_UN_Women_Policy_Brief.pdf
12. Organization of American States (2013), *The drug problem in the Americas*, http://www.oas.org/documents/eng/press/Introduction_and_Analytical_Report.pdf
13. Transform Drug Policy Foundation (17 August 2015), *All these experts and agencies say: Don't treat drug users as criminals. It's time politicians listened*, <http://www.tdpf.org.uk/blog/all-these-experts-and-agencies-say-dont-treat-drug-users-criminals-its-time-politicians>
14. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
15. See: International Drug Policy Consortium (2015), *Comparing models of decriminalization, an e-tool by IDPC*, <http://decrim.idpc.net/>; Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe*, Version 2, <http://www.release.org.uk/publications/policy-papers>
16. See: International Drug Policy Consortium (2015), *Comparing models of decriminalization, an e-tool by IDPC*, <http://decrim.idpc.net/>; Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe*, Version 2, <http://www.release.org.uk/publications/policy-papers>
17. Open Society Foundations (March 2015), *Innovation born out of necessity: Pioneering drug policy in Catalonia*, <http://www.opensocietyfoundations.org/reports/innovation-born-necessity-pioneering-drug-policy-catalonia>
18. Blickman, T. (30 December 2015), ‘Harsh sentences against the Pannagh cannabis club’, *Transnational Institute*, <http://undrugcontrol.info/en/newsroom/latest-news/item/6688-harsh-sentences-against-the-pannagh-cannabis-club>
19. Transform Drug Policy Foundation (January 2015), *Cannabis social clubs in Spain: Legalisation without commercialisation*, <http://www.tdpf.org.uk/resources/publications/cannabis-social-clubs-spain-legalisation-without-commercialisation>
20. The treaty requirements do not differentiate between possession and cultivation for personal use. It is on this basis that first in Spain, and then in other countries, cannabis social clubs started engaging in collective cultivation for personal use. For more details, see: Bewley-Taylor D., Jelsma M. & Blickman T. (March 2014), *The rise and decline of cannabis prohibition* (Transnational Institute & Global Drug Policy Observatory), https://www.tni.org/files/download/rise-and-decline_web.pdf
21. See: International Drug Policy Consortium (2015), *Comparing models of decriminalization, an e-tool by IDPC*, <http://decrim.idpc.net/>; Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe*, Version 2, <http://www.release.org.uk/publications/policy-papers>
22. European Monitoring Centre on Drugs and Drug Addiction (2011), *Drug policy profiles – Portugal*, p. 17, http://www.emcdda.europa.eu/attachements.cfm/att_137215_EN_PolicyProfile_Portugal_WEB_Final.pdf
23. Ibid
24. Taken from: European Monitoring Centre on Drugs and Drug Addiction (2011), *Drug policy profiles – Portugal*, http://www.emcdda.europa.eu/attachements.cfm/att_137215_EN_PolicyProfile_Portugal_WEB_Final.pdf
25. Aebi, M.F. & Delgrande, M. (2009), *Council of Europe annual penal statistics, Space I, Survey 2007* (Strasbourg: Council of Europe), http://www.coe.int/t/dghl/standardsetting/prisons/SPACEI/PC-CP_2009_%2001Rapport%20SPACE%20I_2007_090505_fi-nal_rev.pdf
26. Ibid
27. Institute for Drugs and Drug Addiction (May 2014), *2013 National Report to the EMCDDA: ‘Portugal’ – New developments, trends and in-depth information on selected issues*, p. 84, <http://www.emcdda.europa.eu/html.cfm/index228487EN.html>; Domsławski, A. (June 2011), *Drug policy in Portugal: The benefits of decriminalising drug use*, <http://idpc.net/publications/2011/08/drug-policy-in-portugal-the-benefits-of-decriminalising-drug-use>
28. European Monitoring Centre on Drugs and Drug Addiction, *Portugal country overview*, <http://www.emcdda.europa.eu/countries/portugal>; Transform Drug Policy Foundation (June 2014), *Drug decriminalisation in Portugal: Setting the record straight*, <http://www.tdpf.org.uk/blog/drug-decriminalisation-portugal-setting-record-straight>
29. Ingraham, C. (5 June 2015), ‘Why hardly anyone dies from a drug overdose in Portugal’, *The Washington Post*, <https://www.washingtonpost.com/news/wnk/wp/2015/06/05/why-hardly-anyone-dies-from-a-drug-overdose-in-portugal/>
30. Drug Policy Alliance (February 2014), *Drug decriminalization in Portugal: A health-centered approach*, <http://www.drugpolicy.org/resource/drug-decriminalization-portugal-health-centered-approach>

31. See article 478 in: Diario Oficial de la Federación (20 August 2009), *Decreto por el que se reforman, adicionan y derogan diversas disposiciones de la Ley General de Salud, del Código Penal Federal y del Código Federal de Procedimientos Penales*, http://dof.gob.mx/nota_detalle.php?codigo=5106093&fecha=20/08/2009
32. For a full discussion, see: Harris, G. (2011), *Report of TNI-EMCDDA expert seminar on threshold quantities* (Transnational Institute & European Monitoring Centre for Drugs and Drug Addiction), <http://idpc.net/sites/default/files/library/thresholds-expert-seminar.pdf>; Harris, G. (2011), *Conviction by numbers: Threshold quantities for drug policy* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/sites/default/files/library/Threshold-quantities-for-drug-policy.pdf>
33. In many countries, people can await their trial for a drug offence for months, sometimes years. In Mexico, 40% of people incarcerated are currently awaiting their trial. In Bolivia, this percentage rises to an alarming 74%. For more information, see: Washington Office on Latin America (December 2010), *Systems overload: Drug laws and prisons in Latin America*, http://www.wola.org/publications/systems_overload_drug_laws_and_prisons_in_latin_america_0
34. Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe, Version 2*, <http://www.release.org.uk/publications/policy-papers>
35. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
36. Transnational Institute & Diogenis (February 2013), *Informal drug policy dialogue report*, Warsaw, Poland, 14th to 16th February 2013, <http://idpc.net/publications/2013/08/report-of-tni-diogenis-informal-drug-policy-dialogue-2013-warsaw>; Csete, J. (February 2012), *A balancing act: Policymaking on illicit drugs in the Czech Republic* (New York: Open Society Foundations), <http://www.soros.org/reports/balancing-act-policymaking-illicit-drugs-czech-republic>
37. European Monitoring Centre for Drugs and Drug Addiction (2002), *Drugs in focus: Drug users and the law in the EU – A balance between punishment and treatment*, www.emcdda.europa.eu/attachements.cfm/att_10077_EN_pb02_en.pdf
38. Záborský, T., Mravčík, V., Gajdosikova, H. & Miovský, M. (2001), *PAD: Impact analysis project of new drugs legislation (summary final report)* (Prague: Office of the Czech Government, Secretariat of the National Drug Commission)
39. Sevchenko, M. (28 November 2010), 'Prague: The new Amsterdam?', *Global Post*, <http://www.globalpost.com/dispatch/czech-republic/101127/marijuana-laws>
40. Csete, J. (February 2012), *A balancing act: Policymaking on illicit drugs in the Czech Republic* (New York: Open Society Foundations), <http://www.soros.org/reports/balancing-act-policymaking-illicit-drugs-czech-republic>
41. Filipkova, T. (28 September 2015), *Cannabis policy in the Czech Republic* (Transnational Institute), <https://www.tni.org/en/article/cannabis-policy-in-the-czech-republic>
42. Drug Policy Alliance (February 2014), *Drug decriminalization in Portugal: A health-centered approach*, <http://www.drugpolicy.org/resource/drug-decriminalization-portugal-health-centered-approach>
43. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), <http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation>
44. Based on: Open Society Foundations (July 2013), *Coffee shops and compromise: Separated illicit drug markets in the Netherlands*, <http://www.opensocietyfoundations.org/reports/coffee-shops-and-compromise-separated-illicit-drug-markets-netherlands>
45. See: European Monitoring Centre on Drugs and Drug Addiction, *Prevalence maps – Prevalence of drug use in Europe*, <http://www.emcdda.europa.eu/countries/prevalence-maps>
46. European Monitoring Centre on Drugs and Drug Addiction (2011), *Annual report 2011: The state of the drugs problem in Europe*, <http://www.emcdda.europa.eu/publications/annual-report/2011>
47. Poel, A. Van der Doekhie, J., Verdurmen, J., Wouters, M., Korf, D. & Van Laar, M. (2010), *Feestmeter 2008–2009. Uitgaan en middelengebruik onder bezoekers van party's en clubs* (Utrecht: Trimbos Instituut)
48. European Monitoring Centre on Drugs and Drug Addiction (2012), *Country overview: Netherlands*, <http://www.emcdda.europa.eu/publications/country-overviews/nl>; National Drug Monitor (2012), *Jaarbericht 2011* (Utrecht: Trimbos-instituut)
49. Schatz, E., Schiffer, K., & Kools, J.P. (January 2011), *IDPC Briefing Paper – The Dutch treatment and social support system for drug users: Recent developments and the example of Amsterdam* (London: International Drug Policy Consortium), <http://idpc.net/publications/2011/01/idpc-paper-dutch-drug-treatment-programme>
50. The most recent opinion poll in June 2015 showed support for regulated production reaching 70% of the Dutch population, with strong majority support across voters for all main parties. For an overview of public opinion polls on cannabis in the Netherlands, see: http://druglawreform.info/images/stories/documents/Cannabis_opinion_polls_in_the_Netherlands_June_2015.pdf
51. Helping people grow marijuana is about to become a crime, *Dutch News*, 23 February 2015; <http://www.dutchnews.nl/news/archives/2015/02/helping-people-grow-marijuana-is-about-to-become-a-crime/>
52. Summary and conclusions, in: Meesters, M. (2015), *Het failliet van het gedogen: Op weg naar de cannabiswet*, Vereniging Nederlandse Gemeenten (VNG), https://vng.nl/files/vng/rapport_werkgroep_cannabisbeleid_engels.pdf
53. Ibid
54. State of Washington, Initiative Measure No. 502, <http://sos.wa.gov/assets/elections/initiatives/i502.pdf>
55. State of Colorado, Amendment 64: Use and regulation of marijuana, <http://www.fcgov.com/mmj/pdf/amendment64.pdf>
56. Law No 19.172: Marijuana and its derivatives – Control and regulation of the status of importation, production, purchase, storage, marketing and distribution, http://druglawreform.info/images/stories/Uruguay_Marijuana_Law_-_ENG.docx
57. State of Alaska, Ballot Measure No. 2 – 12PSUM: An act to tax and regulate the production, sale and use of marijuana, <https://www.elections.alaska.gov/doc/bml/BM2-13PSUM-ballot-language.pdf>
58. State of Oregon, Measure 91, <http://www.oregon.gov/olcc/marijuana/documents/measure91.pdf>
59. District of Columbia Ballot Initiative 71, <http://dcjmj.org/ballot-initiative/>
60. Ministry of Justice of Jamaica (2015), *Fact sheet prepared by the Ministry of Justice on the Dangerous Drugs (Amendment) Act 2015*, http://moj.gov.jm/sites/default/files/Dangerous%20Drugs%20Amendment%20Act%202015%20Fact%20Sheet_0.pdf
61. See, for instance: The Guardian (4 December 2015), *Canada's new Liberal government repeats promise to legalize marijuana*, <http://www.theguardian.com/world/2015/dec/04/canada-new-liberal-government-legalize-marijuana>
62. Global commission on Drug Policy (2014), *Taking Control: Pathways to Drug Policies that Work*, www.gcdpsummary2014.com/s/AF_global_comission_ingles.pdf
63. King County Bar Association Drug Policy Project (2005), *Effective drug control: Toward a new legal Framework. State-level intervention as a workable alternative to the 'war on drugs'* (Seattle: King County Bar Association), www.kcba.org/druglaw/pdf/EffectiveDrugControl.pdf; Health Officers Council of British Columbia (2005), *A public health approach to drug control* (Victoria: Health Officers Council of British Columbia), www.cfdp.ca/bchoc.pdf; Rolles, S. (2009), *After the war on drugs: Blueprint for regulation* (Bristol: Transform Drug Policy Foundation), <http://www.tdpf.org.uk/resources/publications/after-war-drugs-blueprint-regulation>
64. For a comprehensive discussion on the regulatory models described here and in Box 1, see: Rolles, S. (2009), *After the war on drugs: Blueprint for regulation* (Bristol: Transform Drug Policy Foundation), <http://www.tdpf.org.uk/resources/publications/after-war-drugs-blueprint-regulation>; also see: Caulkins, J. et al (January 2015), *Considering marijuana legalisation: Insights for Vermont and other jurisdictions* (RAND Corporation), <http://www.rand.org>

- org/content/dam/rand/pubs/research_reports/RR800/RR864/RAND_RR864.pdf
65. Taken from: Transform Drug Policy Foundation, *Concerns about legal regulation*, <http://www.tdpf.org.uk/resources/concerns-about-legal-regulation>
 66. Transform Drug Policy Foundation & Mexico Unido Contra la Delincuencia (2014), *Ending the war on drugs: How to win the global drug policy debate*, <http://www.tdpf.org.uk/resources/publications/ending-war-drugs-how-win-global-drug-policy-debate>
 67. Transform Drug Policy Foundation (2015), *Cannabis regulation in Colorado: Early evidence defies the critics*, <http://www.tdpf.org.uk/resources/publications/cannabis-regulation-colorado-early-evidence-defies-critics>; Drug Policy Alliance (2015), *Marijuana legalization in Colorado after one year of retail sales and two years of decriminalization*, https://www.drugpolicy.org/sites/default/files/Colorado_Marijuana_Legalization_One_Year_Status_Report.pdf; for information on the potential of tax revenues in other jurisdictions, see: Bryan, M.L., Del Bono, E. & Pudney, S. (14 September 2013), *Licensing and regulation of the cannabis market in England and Wales: Towards a cost-benefit analysis* (Institute for Social & Economic Research), <https://www.iser.essex.ac.uk/research/publications/521860>
 68. Global Commission on Drug Policy (2014), *Taking control: Pathways to drug policies that work*, www.gcdpsummary2014.com/s/AF_global_comission_Ingles.pdf
 69. Ibid
 70. Law No 19.172: Marijuana and its derivatives – Control and regulation of the status of importation, production, purchase, storage, marketing and distribution, http://druglawreform.info/images/stories/Uruguay_Marijuana_Law_-_ENG.docx; see also: Bewley-Taylor D., Jelsma T. & Blickman T. (March 2014), *The rise and decline of cannabis prohibition* (Transnational Institute & Global Drug Policy Observatory), https://www.tni.org/files/download/rise_and_decline_web.pdf
 71. See: http://www.who.int/fctc/text_download/en/
 72. See: http://www.who.int/substance_abuse/publications/alcohol/en/
 73. Global Drug Policy Observatory, International Centre on Human Rights and Drug Policy, Transnational Institute & Washington Office on Latin America (2014), *International law and drug policy reform – Report of a GDPO/ICHRDP/TNI/WOLA expert seminar, Washington, D.C., 17-18 October 2014*, <https://www.tni.org/en/publication/international-law-and-drug-policy-reform>
 74. IDPC, alongside a number of NGOs and UN member states are calling for the establishment of an expert advisory group to review the tensions existing between the UN drug conventions and reforms on the ground. For more information about the proposal, see: Transnational Institute (8 December 2015), *UNGASS 2016: Background memo on the proposal to establish an expert advisory group*, <https://www.tni.org/en/publication/ungass-2016-background-memo-on-the-proposal-to-establish-an-expert-advisory-group>
 75. Guzman, D., et al (2012), *Addicted to punishment: Disproportionality of drug laws in Latin America*, <http://www.dejusticia.org/#/actividad/1391>
 76. Harris, G. (2011), *Conviction by numbers: Threshold quantities for drug policy* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/sites/default/files/library/Threshold-quantities-for-drug-policy.pdf>
 77. U.S. Department of Justice (2014), *Crime in the United States 2013*; Drug Policy Alliance (2015), *The drug war, mass incarceration, and race: Fact sheet*, http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf
 78. United Nations Office on Drugs and Crime (2013), *UNODC Handbook on strategies to reduce overcrowding in prisons*, pp. 48-49, https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf
 79. United States Sentencing Commission (2011), *Mandatory minimum penalties: Quick facts*, http://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Quick_Facts_Mandatory_Minimum_Penalties.pdf
 80. Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, p. 3, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
 81. Figure taken from: Drug Policy Alliance (2015), *The drug war, mass incarceration, and race: Fact sheet*, http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_June2015.pdf
 82. See, for example, the UNODC World Drug Reports for 2012 and 2015
 83. United Nations Office on Drugs and Crime (2013), *Handbook on strategies to reduce overcrowding in prisons*, https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf
 84. Gallahue, P., et al (2012), *The death penalty for drug offences: Global overview 2012 - Tipping the scales for abolition*, (London: International Harm Reduction Association), pp. 21-22, http://www.ihra.net/files/2012/11/27/HRI_-_2012_Death_Penalty_Report_-_FINAL.pdf
 85. International Centre for Prison Studies (2010), *Current situation of prison overcrowding*
 86. Jelsma, T. & Kramer, T. (March 2012), *Tackle Burma's drugs problem* (Transnational Institute), <https://www.tni.org/en/article/tackle-burmas-drugs-problem>
 87. International Narcotics Control Board (2007), *Report of the International Narcotics Control Board for 2007*, p. 2, http://www.incb.org/documents/Publications/AnnualReports/Thematic_chapters/English/AR_2007_E_Chapter_1.pdf; Penal Reform International (2015), *Global Prison Trends 2015*, p. 10, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>; UK Sentencing Council (2012), *Drug offences – Definitive guideline*, p. 4, http://www.sentencingcouncil.org.uk/wp-content/uploads/Drug_Offences_Definitive_Guideline_final_web1.pdf
 88. Human Rights Committee (2004), *General comment No 31 on the nature of the general legal obligation imposed on state parties to the Covenant*, CCPR/C/21/Rev.1/Add.13, [http://www.ohchr.org/EN/Issues/Education/Training/Compilation/Pages/c/GeneralCommentNo31TheNatureoftheGeneralLegalObligationImposedonStatesPartiestotheCovenant\(2004\).aspx](http://www.ohchr.org/EN/Issues/Education/Training/Compilation/Pages/c/GeneralCommentNo31TheNatureoftheGeneralLegalObligationImposedonStatesPartiestotheCovenant(2004).aspx)
 89. Human Rights Committee (1999), *General comment No 27 on freedom of movement (Article 12)*, CCPR/C/21/Rev.1/Add.9, <http://www.refworld.org/docid/45139c394.html>
 90. 1961 UN Single Convention on Narcotic Drugs, 1971 UN Convention on Psychotropic Drugs & 1988 UN Convention against Illicit Traffic on Narcotic Drugs and Psychotropic Substances
 91. Preambles to the 1961 UN Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic Substances, and 1988 Convention against Illicit Traffic of Narcotic Drugs and Psychotropic Substances
 92. 1988 Convention against Illicit Traffic of Narcotic Drugs and Psychotropic Substances, Article 3(4)(b),(c) and (d); Bewley-Taylor, D. & Jelsma, M. (March 2012), *The UN drug control conventions – The limits of latitude*, (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude>
 93. 1988 UN Convention against Illicit Traffic on Narcotic Drugs and Psychotropic Substances, article 3(4)(c)
 94. Hallam, C. Bewley-Taylor, D. & Jelsma, M. (2014), *Scheduling in the international drug control system* (International Drug Policy Consortium & Transnational Institute), <http://idpc.net/publications/2014/06/scheduling-in-the-international-drug-control-system>
 95. United Nations High Commissioner for Human Rights (September 2015), *Study on the impact of the world drug problem on the enjoyment of human rights*, A/HRC/30/65, para. 38, <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx>
 96. International Narcotics Control Board (2015), *Report of the International Narcotics Control Board for 2014*, p. iii, <http://www.incb.org/incb/en/publications/annual-reports/annual-report-2014>

- [html](#); see also: United Nations Office on Drugs and Crime (2014), *Contribution of the Executive Director of the United Nations Office on Drugs and Crime to the high-level review of the implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, to be conducted by the Commission on Narcotic Drugs in 2014*, para. 52(c), https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_57/_UNODC-ED-2014-1/_UNODC-ED-2014-1_V1388514_E.pdf
97. Gallahue, P. & Lines, R. (2015), *The death penalty for drug offences: Global overview 2015* (London: Harm Reduction International Report), p. 6, https://dl.dropboxusercontent.com/u/64663568/library/DeathPenaltyDrugs_Report_2015.pdf
 98. Harris, G. (2011), *Conviction by numbers: Threshold quantities for drug policy* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/sites/default/files/library/Threshold-quantities-for-drug-policy.pdf>
 99. UK Sentencing Council (2012), *Drug offences definitive guideline*, [http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Definitive_Guideline_final_\(web\).pdf](http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Definitive_Guideline_final_(web).pdf)
 100. Metaal, P. (February 2009), *Pardon for mules in Ecuador, a sound proposal* (Transnational Institute & Washington Office on Latin America), http://www.wola.org/publications/pardon_for_mules_in_ecuador
 101. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
 102. http://www.justicia.gob.ec/wp-content/uploads/2014/05/c%C3%B3digo_org%C3%A1nico_integral_penal_-_coip_ed._sdn-mjdhc.pdf
 103. http://www.asambleanacional.gov.ec/documentos/constitucion_de_bolsillo.pdf
 104. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
 105. Tegel, S. (6 October 2014), 'Ecuador is freeing thousands of convicted drug mules', *The Global Post*, <http://www.globalpost.com/dispatch/news/regions/americas/141003/ecuador-releases-drug-mules-victims>
 106. Paladines, J. (October 2015), 'Duros contra los débiles y débiles contra los duros' – *La lección no aprendida*, https://dl.dropboxusercontent.com/u/64663568/library/ECUADOR%20Art%C3%ADculo%20final_oct%202015%281%29.pdf
 107. European Commission (2009), *Report from the Commission on the implementation Framework Decision 2004/757/JHA laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking* (Brussels), COM(2009)69 final [SEC (2009)1661]
 108. European Monitoring Centre for Drugs and Drug Addiction (2012), *A definition of 'drug mules' for use in a European context*, <http://www.emcdda.europa.eu/publications/thematic-papers/drug-mules>
 109. See, for instance: Inter-American Commission on Women (April 2014), *Women and drugs in the Americas*, <http://idpc.net/publications/2014/04/women-and-drugs-in-the-americas>
 110. Washington Office on Latin America, International Drug Policy Consortium, DeJusticia, Inter-American Commission on Women (2016), *Women, drug policy and incarceration: A policymaker's guide for adopting, reviewing and implementing reforms related to women incarcerated for drug offenses*, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas
 111. See, for instance: Inter-American Commission on Women (April 2014), *Women and drugs in the Americas*, <http://idpc.net/publications/2014/04/women-and-drugs-in-the-americas>
 112. Cortés, E. (2013), 'Drug law reform in Costa Rica benefits vulnerable women and their families', *IDPC Blog*, <http://idpc.net/blog/2013/08/drug-law-reform-in-costa-rica-benefits-vulnerable-women-and-their-families>
 113. Giacomello, G. (2013), *IDPC Briefing Paper – Women, drug offenses and penitentiary systems in Latin America* (London: International Drug Policy Consortium), <http://idpc.net/publications/2013/11/idpc-briefing-paper-women-drug-offenses-and-penitentiary-systems-in-latin-america>
 114. ECOSOC Resolution 2010/16, *United Nations Rules for the Treatment of Women Prisoners and Non-custodial measures for Women Offenders* (the Bangkok Rules), Rules 58 and 61, <https://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>
 115. In certain countries, such as in Mexico, drug offences are considered to be 'serious crimes' and drug offenders are therefore not eligible for alternatives to incarceration
 116. Federal Bureau of Prisons (September, 2015), *Inmates statistics*, http://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp
 117. Colectivo de Estudios, Drogas y Derechos (2015), *Curbing addiction to punishment: Alternatives to incarceration for drug offenses*, p. 6, http://www.drogasyderecho.org/publicaciones/pub-priv-sergio_i.pdf
 118. Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
 119. 'Prisoners convicted for drug offences account for 21 per cent of all sentenced prisoners in the Americas, 35 per cent in Asia and 13 per cent in Europe'; see: Commission on Crime Prevention and Criminal Justice (2014), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2014/5, https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf
 120. *ibid*, p. 21
 121. Human Rights Council (2015), *Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General*, A/HRC/30/65, p. 45, http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_AEV.docx
 122. European Monitoring Centre for Drugs and Drug Addiction (2012), *Prisons and drugs in Europe: The problem and responses*, p. 7, http://www.emcdda.europa.eu/attachements.cfm/att_191812_EN_TDSI12002ENC.pdf
 123. National Association for the Advancement of Colored People (2015), *Criminal justice fact sheet*, <http://www.naacp.org/pages/criminal-justice-fact-sheet>
 124. Commission on Crime Prevention and Criminal Justice (2014), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2014/5, https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf
 125. Giacomello, C. (2013) *Women, drug offenses and penitentiary systems in Latin America*, <https://www.unodc.org/documents/congress/background-information/NGO/IDPC/IDPC-Briefing-Paper-Women-in-Latin-America-ENGLISH.pdf>
 126. United Nations Development Program (2015), *Perspectives on the development dimensions of drug control policy*, p. 9, https://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf
 127. Washington Office on Latin America (2015), *Women, drug policies, and incarceration in the Americas*, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas
 128. Iakobishvili, E. (2012), *Cause for alarm: The incarceration of women for drug offences in Europe and Central Asia, and the need for legislative and sentencing reform*, www.ihra.net/contents/1188
 129. Kittayarak, K. (June 2015), *TIJ Quarterly: Thailand Institute of Justice's Newsletter*, Issue 1, pp. 10-11, <http://www.tijthailand.org/useruploads/files/aw-eng-web.pdf>; Macdonald, V. & Nacapew, S. (2013), *IDPC Briefing Paper – Drug control and harm reduction in Thailand* (London: International Drug Policy Consortium), <http://idpc.net/publications/2013/11/idpc-briefing-paper-drug-control-and-harm-reduction-in-thailand>
 130. United Nations Development Program (2015), *Perspectives on the development dimensions of drug control policy*, p. 9, https://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf

131. Washington Office on Latin America (2015), *The invisible victims of Latin America's incarceration crisis*, http://www.wola.org/commentary/the_invisible_victims_of_latin_americas_incarceration_crisis
132. In Ecuador, for example, researchers have documented a dire lack of institutional adjustments to meet the special needs of mothers and infants in prison; see: Fleetwood, J. & Torres, A. (2011), 'Mothers and children of the drug war: A view from a women's prison in Quito, Ecuador'. In: Barrett, D. (ed.), *Children of the drug war* (New York, International Debate Education Association), [http://www.ihra.net/files/2011/08/08/Children_of_the_Drug_War\[1\].pdf](http://www.ihra.net/files/2011/08/08/Children_of_the_Drug_War[1].pdf)
133. Transnational Institute & Washington Office on Latin America (December 2010), *Systems overload: Drug laws and prisons in Latin America*, http://www.wola.org/publications/systems_overload_drug_laws_and_prisons_in_latin_america_0
134. McVay, D. (2004), *Treatment or incarceration: National and state findings on the efficacy and cost savings of drug treatment versus imprisonment* (Justice Policy Institute), <http://www.justicepolicy.org/research/2023>
135. Matrix Knowledge Group (2007), *The economic case for and against prison*, <http://www.optimityadvisors.com/sites/default/files/research-papers/10-economic-case-for-and-against-prison.pdf>
136. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, p. 24, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>; Beckett, K (2014) *Seattle's Law Enforcement Assisted Diversion Program: Lessons learned from the first two years* (Washington: University of Washington), <http://www.seattle.gov/council/Harrell/attachments/process%20evaluation%20final%203-31-14.pdf>
137. Ibid
138. Evaluation of the LEAD Program (2015), <http://leadkingcounty.org/lead-evaluation/>
139. 1988 Convention against Illicit Traffic of Narcotic Drugs and Psychotropic Substances, Article (3)(4)(b),(c) and (d); Bewley-Taylor, D. & Jelsma, M. (March 2012), *The UN drug control conventions – The limits of latitude* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude>
140. 1988 UN Convention against Illicit Traffic on Narcotic Drugs and Psychotropic Substances, article 3(4)(c)
141. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, p. 24, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
142. Open Society Foundations (2014) *Why the overuse of pretrial detention is an overlooked human rights crisis*, <https://www.opensocietyfoundations.org/voices/why-overuse-pretrial-detention-overlooked-human-rights-crisis>
143. Malloch, M. & McIvor, G. (2013), 'Criminal justice responses to drug related crime in Scotland', *International Journal of Drug Policy*, 24: 69-77, http://findings.org.uk/PHP/dl.php?file=Malloch_M_3.txt
144. Ibid
145. See, for example: Eurosocal (13 January 2015), *Una segunda oportunidad para las cenicistas*, <http://eurosocal-ii.eu/es/entre-vistaarticulo/una-segunda-oportunidad-para-las-cenicistas>
146. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, pp. 27-30, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
147. Guzmán, D. (2012), *Drug courts: Scope and challenges of an alternative to incarceration* (International Drug Policy Consortium & DeJusticia), <http://idpc.net/publications/2012/07/idpc-briefing-paper-drug-courts>
148. Guzmán, D. (2012), *Drug courts: Scope and challenges of an alternative to incarceration* (International Drug Policy Consortium & DeJusticia), <http://idpc.net/publications/2012/07/idpc-briefing-paper-drug-courts>; Washington Office on Latin America, International Drug Policy Consortium, DeJusticia, Inter-American Commission on Women (2016), *Women, drug policy and incarceration: A policymaker's guide for adopting, reviewing and implementing reforms related to women incarcerated for drug offenses*, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas
149. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
150. Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, <http://www.cicad.oas.org/apps/Document.aspx?id=3203>
151. United Nations Office on Drugs and Crime (2006), *Custodial and non-custodial measures: Alternatives to incarceration – Criminal justice assessment toolkit*, https://www.unodc.org/documents/justice-and-prison-reform/cjat_eng/3_Alternatives_Incarceration.pdf
152. See articles 36b and 38 of the 1961 Convention, and article 14(4) of the 1988 Convention
153. See, for example, the UN standard Minimum Rules for Non-custodial Measures (the Tokyo Rules); Human Rights Council (2015), *Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General*, A/HRC/30/65, p. 45, http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_AEV.docx
154. Washington Office on Latin America, International Drug Policy Consortium, DeJusticia, Inter-American Commission on Women (2016), *Women, drug policy and incarceration: A policymaker's guide for adopting, reviewing and implementing reforms related to women incarcerated for drug offenses*, http://www.wola.org/commentary/women_drug_policies_and_incarceration_in_the_americas
155. Trace, M. (2011), *Drug policy – Lessons learnt, and options for the future* (Rio de Janeiro: Global Commission on Drug Policy), http://www.globalcommissionondrugs.org/wp-content/themes/gcdp/v1/pdf/Global_Com_Mike_Trace.pdf; also see article 14(4) the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which notes: 'The Parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic'
156. 'A drug-free world, we can do it!' was the slogan of the 1998 United Nations General Assembly Special Session on the World Drug Problem: <http://www.un.org/ga/20special/>
157. In the USA, 'the average inflation-adjusted and purity-adjusted prices of heroin, cocaine and marijuana decreased by 81%, 80% and 86%, respectively, between 1990 and 2007, whereas average purity increased by 60%, 11% and 161%, respectively'. In Europe 'during the same period the average inflation-adjusted price of opiates and cocaine decreased by 74% and 51%, respectively'. See: International Centre for Science in Drug Policy (2013), *New research shows war on drugs has failed to reduce supply and access to illegal drugs internationally*, http://www.icsdp.org/bmj0_2014
158. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
159. United Nations Office on Drugs and Crime (2014), *Afghanistan opium survey: Cultivation and production*, <http://www.unodc.org/documents/crop-monitoring/Afghanistan/Afghan-opium-survey-2014.pdf> See, for instance, 'Figure 1: Opium cultivation in Afghanistan, 1994-2014 (Hectares)', p.12
160. United Nations Office on Drugs and Crime (2008), *UNODC World Drug report 2008*, p. 216, https://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf
161. Rouse, S.M. & Arce M. (2006), 'The drug laden balloon: US military assistance and coca production in the central Andes', *Social Science Quarterly*, 87(3): 540-57, <http://onlinelibrary.wiley.com/doi/10.1111/j.1540-6237.2006.00395.x/abstract>; United Nations Office on Drugs and Crime (2015), *UNODC crop monitoring*, <https://www.unodc.org/unodc/en/crop-monitoring/>
162. United Nations Office on Drugs and Crime (2007), *Cocaine trafficking in Western Africa*, p. 6, <http://www.unodc.org/documents/data-and-analysis/Cocaine-trafficking-Africa-en.pdf>; European Monitoring Centre for Drugs and Drug Addiction (2013), *EU drug markets report: A strategic analysis*, p. 45, <https://www.europol.europa.eu/sites/default/files/publications/att-194336-entd3112366enc-final2.pdf>; see also: West Africa Commission on Drugs (2014), *Not just in transit: An independent report of the West*

Africa Commission on Drugs, <http://www.wacommissionondrugs.org/report/>

163. Felbab-Brown points to the differences in levels of drug-related violence between Japan, Europe, or the USA on the one hand, and Latin America on the other hand. See: Felbab-Brown, V. (2012), 'Organized crime won't fade away', *The World Today*, <https://www.chathamhouse.org/publications/twt/archive/view/185139>
164. Werb, D., Rowell, G., Guyatt, G., Kerr, T. & Montaner, J. (2011), 'Effects of drug market violence: A systematic review', *International Journal of Drug Policy*, **22**(2): 87-94, [http://www.ijdp.org/article/S0955-3959\(11\)00022-3/abstract](http://www.ijdp.org/article/S0955-3959(11)00022-3/abstract)
165. See, for instance: Gillin, J. (14 January 2015), 'Understanding Colombia's armed conflict: The role of drugs', *Colombia Reports*, <http://colombiareports.com/understanding-colombian-conflict-drugs/>
166. United Nations Office on Drugs and Crime (2013), *UNODC homicide statistics*, <http://www.unodc.org/gsh/en/data.html>
167. Fórum Brasileiro de Segurança Pública (2014), *Anuário brasileiro de segurança pública* (São Paulo), <http://www.forumseguranca.org.br/produtos/anuario-brasileiro-de-seguranca-publica/8o-anuario-brasileiro-de-seguranca-publica>
168. México Evalúa (2011), *El gasto en seguridad: Observaciones de la ASF a la gestión y uso de recursos*, <http://mexicoevalua.org/2011/06/el-gasto-en-seguridad-observaciones-de-la-asf-a-la-gestion-y-uso-de-recursos/>
169. Felbab-Brown, V. (2013), *Focused deterrence, selective targeting, drug trafficking and organized crime: Concepts and practicalities – Modernising drug law enforcement report 2* (London: International Drug Policy Consortium), p. 7, <http://www.brookings.edu/~media/research/files/reports/2013/03/drug-law-enforcement-felbabbrown/drug-law-enforcement-felbabbrown.pdf>
170. Dickenson, M. (2014), 'The impact of leadership removal on Mexican drug trafficking organizations', *Journal of Quantitative Criminology*, **30**(4): 651-676, <http://link.springer.com/article/10.1007%252Fs10940-014-9218-5>
171. Stanford University (2015), *The dynamics of violence in Mexico's drug war*, Freeman Spogli Institute for International Studies (Stanford: Stanford University), <http://fsi.stanford.edu/research/the-dynamics-of-violence-in-mexicos-drug-war>
172. Dickenson, M. (2014), 'The impact of leadership removal on Mexican drug trafficking organizations', *Journal of Quantitative Criminology*, **30**(4): 651-676, <http://link.springer.com/article/10.1007%252Fs10940-014-9218-5>
173. Phillips, B.J. (2015), 'How does leadership decapitation affect violence? The case of drug trafficking organizations in Mexico', *Journal of Politics*, **77**(2): 324-336, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2294822
174. Cawley, M. (2014), 'Mexico victims' survey highlights under-reporting of crime', *Insight Crime*, <http://www.insightcrime.org/news-briefs/mexico-victimization-survey-highlights-reporting-gap>
175. NPR (2015), 'Open cases: Why one-third of murders in America go unsolved', <http://www.npr.org/2015/03/30/395069137/open-cases-why-one-third-of-murders-in-america-go-unresolved>
176. Amnesty International (2015), *Colombia – Impunity*, <http://www.amnestyusa.org/our-work/countries/americas/colombia/impunity>
177. U.S. Department of State (2012), *Guatemala – Country reports on human rights practices for 2012*, (Washington DC: U.S. Department of State), <http://www.state.gov/documents/organization/204664.pdf>
178. Gomis, B. (2015), *Demystifying 'narcoterrorism'* (Swansea: Global Drug Policy Observatory), <http://www.swansea.ac.uk/media/Demystifying%20narcoterrorism%20FINAL.pdf>
179. See, for instance: Human Rights Watch (2013), *UN report highlights abuse as 'drug treatment'*, <https://www.hrw.org/news/2013/03/03/un-report-highlights-abuse-drug-treatment>
180. US Department of Justice (2001), *Reducing gun violence: The Boston Gun Project's Operation Ceasefire*, Research report (Washington DC: US Department of Justice), <https://www.ncjrs.gov/pdffiles1/nij/188741.pdf>
181. US Department of Justice (2001), *Reducing gun violence: The Boston Gun Project's Operation Ceasefire*, Research report (Washington DC: US Department of Justice), p. 58, <https://www.ncjrs.gov/pdffiles1/nij/188741.pdf>
182. Organization of American States (2013), *Scenarios for the Drug Problem in the Americas*, p.31, http://www.oas.org/documents/eng/press/Scenarios_Report.PDF
183. Beck Institute for Cognitive Behavior Therapy (2015), *Cognitive behavior therapy* (Bala Cynwyd, PA: Beck Institute), <http://www.beckinstituteblog.org/cognitive-behavioral-therapy/>
184. Heller, S.B., Shah, A.K., Guryan, J., Ludwig, J., Mullainathan, S. & Pollock, H.A. (2015), 'Thinking, fast and slow? Some field experiments to reduce crime and dropout in Chicago', *NBER Working Paper*, <http://www.nber.org/papers/w21178>
185. Csete, J. (2010), *From the mountaintops: What the world can learn from drug policy change in Switzerland*, (New York: Open Society Foundations), <http://www.opensocietyfoundations.org/reports/mountaintops>
186. Geddes, J. (2010), 'RCMP and the truth about safe injection sites', *MacLean's*, <http://www.macleans.ca/news/canada/injecting-truth/>; Bailey, I. (2013), 'Vancouver police urge drug addicts to use Insite following deaths', *Globe and Mail*, <http://www.theglobeandmail.com/news/british-columbia/vancouver-police-warn-drug-addicts-to-use-insite/article14366192/>
187. British Columbia Ministry of Health (2005), *Harm reduction: A British Columbia community guide*, (Victoria), p. 6, <http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf>
188. British Columbia Centre for Excellence in HIV/AIDS (BCCE) (2013), *Drug situation in Vancouver* (Vancouver: Urban Health Research Initiative), http://www.cfenet.ubc.ca/sites/default/files/uploads/news/releases/war_on_drugs_failing_to_limit_drug_use.pdf
189. Forell, S. & Price, L. (1997), *Using harm reduction policing within drug law enforcement in the NSW police services, Australia*, <http://www.drugtext.org/Crime-police-trafficking/using-harm-reduction-policies-within-drug-law-enforcement-in-the-nsw-police-service-australia.html>
190. Hughes, R., Lart, R. & Higate, P. (eds) (2006), *Drugs: Policy and politics* (Maidenhead: Open University Press), p. 103
191. Safe in the city (2013), *Independent drugs commission for Brighton & Hove: Report & recommendations*, <http://www.safeinthecity.info/independent-drugs-commission>
192. Stevens, A. (March 2013), *Applying harm reduction principles to the policing of retail drug markets – Modernising drug law enforcement report 3* (London: International Drug Policy Consortium), https://dl.dropboxusercontent.com/u/64663568/library/MDLE-report_3_applying-harm-reduction-to-policing-of-retail-markets.pdf
193. Levi, M. (September 2013), *Drug law enforcement and financial investigation strategies – Modernising drug law enforcement report 5* (London: International Drug Policy Consortium), <https://dl.dropboxusercontent.com/u/64663568/library/MDLE-5-drug-law-enforcement-financial-investigation-strategies.pdf>
194. World Bank (2012), *Fighting corruption in public services: Chronicling Georgia's reforms*, Directions in Development: Public Sector Governance: 6649, <http://documents.worldbank.org/curated/en/2012/02/16187217/fighting-corruption-public-services-chronicling-georgias-reforms>
195. Kuris, G. (2013), *Cleaning house: Croatia mops up high-level corruption, 2005-2012*, Innovation for Successful Societies, Princeton University (Princeton: ISS), <http://successfultsocieties.princeton.edu/publications/cleaning-house-croatia-mops-high-level-corruption-2005-2012>
196. Walker, S. & Burchert, E. (2013), *Getting smart and scaling up: The impact of organized crime on governance in developing countries. A Desk study of Sierra Leone* (Center on International Cooperation, New York University), p. 187, http://cic.nyu.edu/sites/default/files/kavanagh_crime_developing_countries_sierra_leone_study.pdf
197. Cambridge Dictionaries (2015), *Sunk cost fallacy*, <http://dictionary.cambridge.org/dictionary/english/sunk-cost-fallacy>
198. See, for instance: Comolli, V. & Hofmann, C. (2013), *Drugs markets, security and foreign aid – Modernising Drug Law Enforcement Report*

- 6 (London: International Drug Policy Consortium), <https://dl.dropboxusercontent.com/u/64663568/library/MDLE-6-Drug-markets-security-and-foreign-aid.pdf>
199. Garzón Vergara, J.C. (2014), *Fixing a broken system: Modernizing drug law enforcement in Latin America* (Transnational Institute & International Drug Policy Consortium), <https://www.tni.org/en/briefing/fixing-broken-system>
 200. World Health Organisation, Joint United Nations Programme on HIV/AIDS & United Nations Office on Drugs and Crime (2007), *Guide to starting and managing needle and syringe programmes*, <https://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf>
 201. Walmsley, R. (2013), *World prison population list (tenth edition)* (London: International Centre for Prison Studies), http://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_10.pdf
 202. The global total is based on data from 53 countries; see: Report of the Secretary-General (19 January 2015), *State of crime and criminal justice worldwide*, A/CONF.222/4, p. 23
 203. Commission on Crime Prevention and Criminal Justice (2013), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2013/9, https://www.unodc.org/documents/data-and-analysis/statistics/crime/World_Crime_Trends_2013.pdf
 204. Commission on Crime Prevention and Criminal Justice (2014), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2014/5, para. 29, https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf; for background on women's drug dependence issues and a compilation of statistics, see: Penal Reform International (2015), *Women in criminal justice systems and the added value of the UN Bangkok Rules*, pp. 6-8, <http://www.penalreform.org/resource/women-in-the-criminal-justice-system-the-added/>
 205. Ibid, p. 15; Research in Argentina, for example showed that women's primary role in drug trafficking is that of a mule (transporting drugs, often by swallowing them or introducing them into their body cavities), which makes them typically easy targets for drug enforcement authorities, even though it does little to disrupt drug trafficking networks. See: Cornell Law School, Avon Global Center for Women and Justice, Defensoria General de la Nación en Argentina, University of Chicago. Law School. International Human Rights Clinic (2013), *Women in prison in Argentina: Causes, conditions, and consequences*, p. 15, with reference also to a report from the Office of the Human Rights Ombudsman in Buenos Aires
 206. Manjoo, R. (21 August 2013), *Report to the UN General Assembly by Special Rapporteur on violence against women, its causes and consequences*, Rashida Manjoo, *Pathways to, conditions and consequences of incarceration for women*, A/68/340, para. 26, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/68/340>
 207. Walmsley, R. (23 September 2015), *The world prison brief (Institute for Criminal Policy Research)*, <http://blogs.bbk.ac.uk/research/2014/11/28/the-world-prison-brief-database-of-global-imprisonment-levels/>
 208. See, for example: Sepúlveda Carmona, M. (4 August 2011), *UN Special Rapporteur on extreme poverty and human rights*, A/66/265, p. 12, <http://www.ohchr.org/Documents/Issues/EPoverty/A.66.265.pdf>
 209. Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, p. 4, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>
 210. Taken from: United Nations Survey of Crime Trends and Operations of Criminal Justice Systems. Note: The global total is based on data from 53 countries; see: Report of the Secretary-General (19 January 2015), *State of crime and criminal justice worldwide*, A/CONF.222/4, p. 5
 211. Dolan, K., Merghati Khoei, E., Brentari, C. & Stevens, A. (June 2007), *Prisons and drugs: A global review of incarceration drug use and drug services* (The Beckley Foundation Drug Policy Programme), p. 1, http://www.beckleyfoundation.org/pdf/Beckley_RPT12_Prison_Drugs_EN.pdf
 212. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, Chapter 1, p. 4, referencing several studies, <http://www.unodc.org/wdr2015/>
 213. Jürgens, R., et al (2011), 'HIV and incarceration: prisons and detention'. *Journal of the International AIDS Society*, **14**:26, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3123257/>
 214. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, Chapter 1, p. 4, <http://www.unodc.org/wdr2015/>
 215. United Nations Office on Drugs and Crime, *Publications related to HIV in prison settings*, https://www.unodc.org/unodc/en/hiv-aids/new/publications_prisons.html
 216. Larney, S., et al (2013), 'Incidence and prevalence of Hepatitis C in prisons and other closed settings: Results of a systematic review and meta-analysis', *Journal of Hepatology*, **58**(4). Cited in: Sanders, G. (2015), 'Preventing infectious diseases in prisons: A public health and human rights imperative', *Penal Reform International blog*, www.penalreform.org/blog
 217. World Health Organisation (2013), *Global tuberculosis report 2013*, Table 3.3, p. 33, http://apps.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf
 218. World Health Organisation Regional Office for Europe, United Nations Office on Drugs and Crime, International Committee of the Red Cross, Pompidou Group, Council of Europe & Schweizerische Eidgenossenschaft (2014), *Prisons and health*, p. 56
 219. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, p. 4, <http://www.unodc.org/wdr2015/>; referencing Dolan, K., et al (2015), 'People who inject drugs in prison: HIV prevalence, transmission and prevention', *International Journal of Drug Policy*, **26**: S12-S15, [http://www.ijdp.org/article/S0955-3959\(14\)00293-X/references](http://www.ijdp.org/article/S0955-3959(14)00293-X/references)
 220. See, for example: Report on the human rights of persons deprived of liberty in the Americas (2011), para. 566; National Aids Trust (UK) (2003), *Factsheet – HIV-related stigma and discrimination: Prisoners*
 221. United Nations Office on Drugs and Crime (2009), *From coercion to cohesion – Treating drug dependence through health care, not punishment*, Discussion paper, https://www.unodc.org/docs/treatment/Coercion_Ebook.pdf
 222. See, in particular the International Covenant on Economic, Social and Cultural Rights
 223. World Health Organisation Regional Office for Europe, United Nations Office on Drugs and Crime, International Committee of the Red Cross, Pompidou Group, Council of Europe & Schweizerische Eidgenossenschaft (2004), *Prisons and health*, p. 116; see also evidence from: Prisoner Crime Reduction Survey in background tables supporting Ministry of Justice (2010), *Compendium of reoffending statistics and analysis* (London: Ministry of Justice), <https://www.gov.uk/government/statistics/compendium-of-reoffending-statistics-and-analysis-2010>
 224. Penal Reform International (2015), *Global Prison Trends 2015 – Special focus: Drugs and imprisonment*, <http://www.penalreform.org/wp-content/uploads/2015/04/PRI-Prisons-global-trends-report-LR.pdf>; United Nations Office on Drugs and Crime (2009), *From coercion to cohesion – Treating drug dependence through health care, not punishment*, Discussion paper, https://www.unodc.org/docs/treatment/Coercion_Ebook.pdf
 225. United Nations Treaty Series (1976), **993**, p. 3; see also: UN Committee on Economic, Social and Cultural Rights (11 August 2000), *General comment No. 14: The right to the highest attainable standard of health*, E/C.12/2000/4, paragraphs 12(a)-(d), <http://www.un.org/Docs/journal/asp/ws.asp?m=E/C.12/2000/4>
 226. See: Principle 1(4) of the United Nations Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care, G.A. res. 46/119 1991 and Rule 54 of the Bangkok Rules
 227. Special Rapporteur on the right to health (6 August 2010), *Report submitted by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/65/255, para. 8, http://ap.ohchr.org/documents/alldocs.aspx?doc_id=17520
 228. World Health Organisation Regional Office for Europe & United Nations Office on Drugs and Crime (2013), *Good governance for*

prison health in the 21st century: A policy brief on the organization of prison health, p. 5, https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf

229. UN Special Rapporteur on Torture (9 August 2013), *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/68/295, para. 50, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/68/295>
230. United Nations High Commissioner for Human Rights (September 2015), *Study on the impact of the world drug problem on the enjoyment of human rights*, A/HRC/30/65, para. 21, <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx>
231. Special Rapporteur on the right to health (6 August 2010), *Report submitted by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/65/255, para. 60, http://ap.ohchr.org/documents/alldocs.aspx?doc_id=17520
232. Based on a 2010 General Assembly Resolution, a process of review of the UN Standard Minimum Rules for the Treatment of Prisoners (initially adopted by the UN General Assembly in 1955) has resulted in the revision of nine areas, including the incorporation of a number of key safeguards on healthcare into this international standard. The revised Standard Minimum Rules for the Treatment of Prisoners (known as the Mandela Rules) were adopted by the UN Crime Commission in May 2015 and Subsequently the Third Committee of the UN General Assembly on 5 November 2015, A/C.3/70/L.3, www.un.org/ga/search/view_doc.asp?symbol=A/C.3/70/L.3
233. See also: Principle 24 of the *UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, adopted by the UN General Assembly on 9 December 1988, A/RES/43/173; World Health Organisation (24 October 2003), *Moscow declaration on prison health as part of public health*, <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health>
234. Guidelines for prison, detention and other custodial settings of the working group on dual loyalties, para. 12: 'The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference'
235. WMA Declaration of Tokyo – Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment, adopted in 1975 and revised 2005, para. 5: 'A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible', <http://www.wma.net/en/30publications/10policies/c18/>
236. ECOSOC Resolution 2010/16, *United Nations Rules for the Treatment of Women Prisoners and Non-custodial measures for Women Offenders* (the Bangkok Rules), <https://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>
237. UN Committee on Economic, Social and Cultural Rights (11 August 2000), *General comment No. 14: The right to the highest attainable standard of health*, E/C.12/2000/4, para. 8, <http://www.un.org/Docs/journal/asp/ws.asp?m=E/C.12/2000/4>
238. Anand Grover (10 August 2009), *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/64/272, para. 9, <http://www.un.org/Docs/journal/asp/ws.asp?m=A/64/272>; also quoted in: Mendez, J.E. (1 February 2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/HRC/22/53, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
239. These principles were developed by Penal Reform International
240. <https://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>
241. European Prison Rules, adopted by the Council of Europe and revised in 2006, Part III – Health, Rules 40 et seq, <https://wcd.coe.int/ViewDoc.jsp?id=955747>
242. The Convention on the Elimination of All Forms of Racial Discrimination of 1965 (Article 5(e) (iv)) and the Convention on the Elimination of All Forms of Discrimination against Women of 1979 (Articles Article 11.1 (f) and 12) as well as the Convention on the Rights of the Child of 1989 also recognise the right to health
243. World Health Organisation (2011), *Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines*, http://www.who.int/medicines/areas/quality_safety/guide_nocp_sanend/en/index.html
244. International Narcotics Control Drugs (2007), *INCB Annual Report for 2007*, <http://www.incb.org/incb/annual-report-2007.html>
245. For example, mandatory drug testing in prisons is now carried out in most EU Member States. See: European Monitoring Centre on Drugs and Drug Addiction (2012), *Prisons and drugs in Europe – The problem and responses*, p. 15, <http://www.emcdda.europa.eu/publications/selected-issues/prison>
246. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS, *Drug dependence treatment: Interventions for drug users in prisons*, p. 23, https://www.unodc.org/docs/treatment/111_PRISON.pdf
247. See: United Nations Office on Drugs and Crime, World Health Organisation & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention – A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, <http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf>; Singleton, N. (September 2008), 'Policy forum: The role of drug testing in the criminal justice system', *Drugs and Alcohol Today*, 8(3): 4-8, <http://www.ukdpc.org.uk/wp-content/uploads/Article%20-%20The%20role%20of%20drug%20testing%20in%20the%20criminal%20justice%20system.pdf>
248. United Nations Office on Drugs and Crime, International Labor Organization & United Nations Development Program (2012), *Policy brief: HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, www.unodc.org/documents/hiv-aids/V0855768.pdf
249. Ibid
250. World Health Organisation Regional Office for Europe, United Nations Office on Drugs and Crime, International Committee of the Red Cross, Pompidou Group, Council of Europe & Schweizerische Eidgenossenschaft (2014), *Prisons and health*, p. 1, 45 & 49
251. Ibid, p. 70
252. Harm Reduction International (2014), *The global state of harm reduction 2014*, <http://www.ihra.net/contents/1524>
253. United Nations Office on Drugs and Crime (2014), *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (Advance Copy), p. 13, https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf; also see: Stover, H. & Kastelic, A. (2014), *Drug treatment and harm reduction in prisons*; World Health Organisation Regional Office for Europe, United Nations Office on Drugs and Crime, International Committee of the Red Cross, Pompidou Group, Council of Europe & Schweizerische Eidgenossenschaft (2014), *Prisons and health*, p. 119
254. Hedrich, D., et al (2012), *The effectiveness of opioid maintenance treatment in prison settings: A systematic review*
255. World Health Organisation (2010), *The Madrid Recommendation: Health protection in prisons as an essential part of public health*, https://www.unodc.org/documents/hiv-aids/publications/The_madrid_recommendation.pdf
256. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for action technical papers – Interventions to address HIV in prisons: Drug dependence treatments*, http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf
257. Moreno Jimenez, M.P. (2000), 'Psychosocial interventions with drug addicts in prison. Description and results of a programme', *Psychology in Spain*, 4(1): 64–74, <http://www.psychologyinspain.com/content/full/2000/6.htm>; Council of Europe & Pompidou Group (2013), *Mental health and addictions in prisons*, <https://www.coe.int/T/DG3/Pompidou/Source/Activities/Prisons/2014/>

- [MentalHealth-2013-dlv.pdf](#); European Monitoring Centre for Drugs and Drug Addiction (2003), *Annual report 2003: The state of the drugs problem in the European Union and Norway*, <http://www.emcdda.europa.eu/publications/annual-report/2003>
258. A medical screening upon admission and thereafter as necessary is prescribed in Rule 30 of the revised Mandela Rules, by a physician or other qualified health-care professionals, paying 'particular attention' to a number of issues listed, including the identification of withdrawal symptoms resulting from the use of drugs, medication or alcohol; and undertaking all appropriate individualised measures or treatment
 259. World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for action technical papers – Interventions to address HIV in prisons: Needle and syringe programmes and decontamination strategies* (Geneva: World Health Organisation), <http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20NSP.pdf>; Harm Reduction Coalition (January 2007), *Syringe exchange in prisons: The international experience*, <http://harmreduction.org/wp-content/uploads/2012/01/harmreductionprisonbrief.pdf>
 260. Harm Reduction International (2014), *The global state of harm reduction 2014*, pp. 11 & 18, <http://www.ihra.net/contents/1524>
 261. United Nations Office on Drugs and Crime (2014), *A handbook for starting and managing needle and syringe programmes in prisons and other closed settings* (Advance Copy), p. 13, https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/ADV_COPY_NSP_PRISON_AUG_2014.pdf; World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for action technical papers – Interventions to address HIV in prisons: Drug dependence treatments*, http://www.unodc.org/documents/hiv-aids/EVIDENCE%20FOR%20ACTION%202007%20drug_treatment.pdf
 262. In conjugal visiting rooms only
 263. United Nations Office on Drugs and Crime, World Health Organisation & Joint United Nations Programme for HIV/AIDS (2008), *HIV and AIDS in places of detention – A toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, <http://www.unodc.org/documents/hiv-aids/HIV-toolkit-Dec08.pdf>
 264. Leibowitz, A.A., et al (4 May 2012), 'Condom distribution in jail to prevent HIV infection, Aids and behaviour', **17**(8): 2695–2702, Cited in: HIV Law Project, *Condoms in prisons: Safe, effective and essential, factsheet*, <http://hivlawproject.org/wp-content/uploads/2014/11/condoms-in-prison-fact-sheet-FINAL.pdf>
 265. World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2007), *Evidence for action technical papers: Effectiveness of Interventions to Manage HIV in Prisons – Provision of condoms and other measures to decrease sexual transmission*, p. 7, http://www.who.int/hiv/idu/Prisons_condoms.pdf
 266. Todts, S. (2014), *Infectious diseases in prison*; World Health Organisation Regional Office for Europe, United Nations Office on Drugs and Crime, International Committee of the Red Cross, Pompidou Group, Council of Europe & Schweizerische Eidgenossenschaft (2004), *Prisons and health*, p. 53
 267. Kazatchkine, M. (2 May 2014), 'Is Moldova leading the world on harm reduction in prisons?', *Huff Post Blog*, http://www.huffingtonpost.com/michel-d-kazatchkine/is-moldova-leading-the-world_4731043.html
 268. Ibid
 269. Hoover, J. (July 2009), *Harm reduction in prison: The Moldova model* (New York: Open Society Institute Public Health Program), p. 52, <https://www.opensocietyfoundations.org/reports/harm-reduction-prison-moldova-model>
 270. Ibid, p. 46
 271. Ibid, pp. 11 & 52–54
 272. Public Health England, *Frequently asked questions (FAQs) to support opt-out BBV testing policy*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365192/BBVs_Frequently_Asked_Questions.pdf; see also: Chapter 18, *Hepatitis B vaccination in the Green book: Immunisation against infectious disease*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263311/Green_Book_Chapter_18_v2_0.pdf
 273. World Health Organisation Regional Office for Europe & United Nations Office on Drugs and Crime (2013), *Good governance for prison health in the 21st century: A policy brief on the organization of prison health*, p. 17, https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/Good-governance-for-prison-health-in-the-21st-century.pdf
 274. Ibid, pp. vi & 17
 275. Weissner P. & Stuijke R. (2010), *Discussion paper: Does it matter which government ministry is responsible for health in prison?* (Brussels: European AIDS Treatment Group), <http://www.eatg.org/eatg/Global-HIV-News/World-Policy/Discussion-paper-Does-it-matter-which-ministry-is-responsible-for-health-in-prison>
 276. Hayton P., Gatherer A. & Fraser A. (2010), *Prisoner or patient: Does it matter which government ministry is responsible for the health of prisoners?* (Copenhagen: World Health Organisation Regional Office for Europe), <http://www.euro.who.int/en/health-topics/health-determinants/pages/news/news/2010/11/from-prison-health-to-public-health/patient-or-prisoner-does-it-matter-which-government-ministry-is-responsible-for-the-health-of-prisoners>
 277. Moloney, K.P., van den Bergh, B.J. & Moller, L.F. (2009), 'Women in prison: The central issues of gender characteristics and trauma history', *Public Health*, **123**(6): 426–430
 278. Penal Reform International (2015), *Women in criminal justice systems and the added value of the UN Bangkok Rules*, pp. 5–6, <http://www.penalreform.org/resource/women-in-the-criminal-justice-system-the-added/>; Special Rapporteur on violence against women (21 August 2013), *Pathways to, conditions and consequences of incarceration for women*, A/68/340, <http://www.ohchr.org/Documents/Issues/Women/A-68-340.pdf>; United Nations Office on Drugs and Crime (2014), *Handbook for prison managers and policymakers on women and imprisonment*, 2nd edition, pp. 8–10, https://www.unodc.org/documents/justice-and-prison-reform/women_and_imprisonment_-_2nd_edition.pdf
 279. United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2008), *Women and HIV in prison settings*, p. 2, https://www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf
 280. A 2010 report from Indonesia, for example, found that HIV prevalence was over five times higher in female (6%) than in male respondents (1%). See: Department of Corrections Ministry of Justice and Human Rights (2010), *HIV and syphilis prevalence and risk behavior study among prisoners in prisons and detention centres in Indonesia*. Jakarta, https://www.unodc.org/documents/hiv-aids/HSPBS_2010_final-English.pdf; Joint United Nations Programme on HIV and AIDS (2015), 'Chapter 3: Prisoners', *The gap report*, p. 3, http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report; Blogg, S., Utomo, B., Silitonga, N., Hidayati, D. & Sattler G. (2014), *Indonesian national inmate bio-behavioural survey for HIV and syphilis prevalence and risk behaviours in prison and detention centres* (New York: Sage Publications), <http://sgo.sagepub.com/content/4/1/2158244013518924>
 281. Harm Reduction International (2014), *The global state of harm reduction 2014*, pp. 11 and 18, <http://www.ihra.net/contents/1524>. For example, Mauritius is among those countries providing substance dependence treatment in male prisons only
 282. Penal Reform International (2015), *Women in criminal justice systems and the added value of the UN Bangkok Rules*, p. 10, <http://www.penalreform.org/resource/women-in-the-criminal-justice-system-the-added/>; United Nations Office on Drugs and Crime, UN Women, World Health Organisation & International Network of People Who Use Drugs (2014), *Women who inject drugs and HIV: Addressing specific needs*, pp. 2, 6, http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
 283. ECOSOC Resolution 2010/16, *United Nations Rules for the Treatment of Women Prisoners and Non-custodial measures for Women Offenders* (the Bangkok Rules), <https://www.un.org/en/ecosoc/docs/2010/res%202010-16.pdf>

284. UN Committee on the Elimination of Discrimination against Women (24 July 2014), *Concluding observations on the combined fourth and fifth periodic reports of Georgia*, CEDAW/GEO/CO/4-5, para. 31(e), http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/GEO/CO/4-5&Lang=En
285. Information from: CND Blog (18 March 2014), *Side event: Harm reduction in prisons*, Speaker: Jose Manuel Arroyo, Deputy Director of prison health care in Spain, Ministry of Interior, <http://cndblog.org/2014/03/side-event-harm-reduction-in-prisons/>
286. European Centre for Disease Prevention and Control (2012), *Thematic report: Prisoners – Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2012 Progress Report*, p. 4, quoting source as GARP reporting 2012: Epidemiological surveillance in prisons, <http://ecdc.europa.eu/en/publications/Publications/dublin-declaration-monitoring-report-prisoners-october-2013.pdf>
287. Ferrer-Castro, V., et al (March-June 2012), 'Evaluation of needle exchange program at Peireiro de Aguilar prison (Ourense, Spain): Ten years of experience', *Revista Espanola de Sanidad Penitenciaria*, 14(1), http://scielo.isciii.es/pdf/sanipe/v14n1/en_02_original1.pdf
288. World Health Organisation Regional Office for Europe (2014), *Preventing overdose deaths in criminal justice systems*, http://www.euro.who.int/_data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf
289. United Nations Office on Drugs and Crime & World Health Organisation (2013), *Discussion paper 2013: Opioid overdose: Preventing and reducing opioid overdose mortality*, p. 6
290. Montanari, L., et al. (2014), *Drug use and related consequences among prison populations in European countries*; World Health Organisation Regional Office for Europe (2014), *Prisons and health*, p. 110
291. Fazel, S. & Baillargeon, J. (12 March 2011), 'Review: the health of prisoners', *The Lancet*, 377(9769): 956-965, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)61053-7/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)61053-7/abstract)
292. United Nations Office on Drugs and Crime, International Labor Organization & United Nations Development Program (2012), *Policy brief: HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions*, p. 5, www.unodc.org/documents/hiv-aids/V0855768.pdf
293. Hariga, F. (2014), 'HIV and other bloodborne viruses in prisons', In: World Health Organisation Regional Office for Europe, *Prisons and health*, p. 53; United Nations Office on Drugs and Crime & World Health Organisation (2013), *Discussion paper 2013: Opioid overdose: Preventing and reducing opioid overdose mortality*
294. Bullock, T. (2003), 'Key findings from the literature on the effectiveness of drug treatment in prison', In: Ramsay, M. (ed.), *Prisoners' drug use and treatment: Seven research studies. Home Office Research Study 267* (London: Home Office)
295. Connections Project, *Good practice in preventing drug misuse and related infections in criminal justice systems in Europe*, <http://www.ohrn.nhs.uk/resource/policy/GuidelinesdrugsHIVEUCJS.pdf>
296. European Monitoring Centre on Drugs and Drug Addiction (2012), *Prisons and drugs in Europe: The problem and responses*, p. 25, http://www.emcdda.europa.eu/attachements.cfm/att_191812_EN_TDSI12002ENC.pdf
297. Connections Project, *Good practice in preventing drug misuse and related infections in criminal justice systems in Europe*, <http://www.ohrn.nhs.uk/resource/policy/GuidelinesdrugsHIVEUCJS.pdf>
298. Gesundheit Österreich & Sogeti (April 2013), *Report on the current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries*, p. 29, http://ec.europa.eu/justice/anti-drugs/files/drug-dependence-systematic-review_en.pdf





Chapter 4: **Drugs, development and the rights of indigenous groups**

Chapter overview

There are clear links between development and illicit drug production, trafficking and consumption. Generally, drug control efforts have focused on drug law enforcement and prohibition in an effort to reduce the scale of the illicit drug market. Today, however, the drug trade is worth hundreds of billions of US dollars a year and affects all aspects of the world economy and the lives of vulnerable groups – while production, trafficking and drug dependence continue to be largely concentrated among some of the poorest and most marginalised communities across the world.

Efforts have been made to move towards a development-oriented approach to drug control at international level, with attempts to link up UN drug control debates with the Sustainable Development Goals. At national level, this has sometimes translated into policies seeking to improve governance, increase security, protect health, provide sustainable livelihoods and develop new goals and indicators to evaluate the success of drug policy. These issues will be explored in **Chapter 4.1**.

Chapter 4.2 will further analyse the key aspects and challenges of providing sustainable liveli-

hoods in rural areas affected by illicit crop cultivation. The concept of sustainable livelihoods has evolved over time to encompass a broader development approach underpinned by the following considerations: the need to decriminalise farmers engaged in illicit crop cultivation and engage them as key partners in development programmes, the need to ensure proper sequencing in reducing illicit crop cultivation, to prioritise small-scale rural development and to integrate programmes into broader development plans, and the necessity of promoting good governance and the rule of law.

Finally, **Chapter 4.3** considers the need to protect the rights of indigenous groups, in particular their ancestral, traditional, cultural and religious right to grow and use internationally controlled plants. This chapter offers an overview of the jurisprudence, legislative exceptions, constitutional rules and legal regulatory regimes that have been established across the world to protect traditional uses of psychoactive plants for indigenous groups – and which may serve as guidance for policy makers as they seek to advance the human rights of indigenous people.

A development-oriented approach to drug control

Key recommendations

- A thorough review of drug laws and policies should be conducted in the context of the SDGs to ensure that drug control addresses the underlying social and economic drivers of engagement in the drug trade. This should include an analysis of how drug policies affect the capacity of communities, territories and countries to reach the SDG targets
- Drug policies should no longer aim at reducing the overall scale of the drug market but aspire to reduce the harms associated with these markets – including insecurity, corruption, violence, health harms, etc.
- Drug laws and policies should be reviewed to ensure access to essential medicines, as well as to harm reduction and treatment services
- Policies and practices in illicit crop cultivation areas should be revised to move away from forced eradication towards a long-term development approach focused on sustainable livelihoods
- Criminal sanctions should be removed for people who use drugs and small-scale farmers engaged in illicit crop cultivation, and proportionality of sentencing should be ensured for all drug offences
- A gender-sensitive approach to drug control should be adopted to address the specific vulnerabilities of women engaged in the drug trade
- Mechanisms to protect and promote human rights, as well as end impunity for human rights abuses, should be established and strengthened
- A new set of development-oriented metrics and indicators should be adopted to measure the success of drug control based on human development.

Introduction

Until recently, the connection between drugs, drug policy and development has been largely ignored by both development agencies and UN drug control bodies. Yet, the relationship between drug control and development goals is undeniable, albeit a complex and multifaceted one. The sheer scale of the illicit drug market – estimated at between US\$449 to US\$674 billion a year, using the World Bank ranking table for 2014¹ – can affect many aspects of the world economy, such as shaping the creation of jobs, determining access to land and markets, swaying trends in banking, driving cross-border financial flows, affecting public services, as well as influencing political decisions.²

Today, millions of people survive because of the illicit drug trade – a context that development agencies and drugs agencies alike can no longer afford to ignore. In some areas of the world, such as in Afghanistan, Mali or Colombia, the division between licit and illicit economies has become blurred, with organised criminals providing the jobs, investment, stability and security that the state is unable to provide, while drug lords get elected onto local and national governments.³ This can significantly impact upon the credibility and long-term stability of states, the provision of security and the creation of a strong licit economy.

Development-sensitive drug policies have generally been limited to alternative development programmes, while most drug control strategies have focused on law enforcement efforts that have tended to exacerbate poverty and marginalisation, and impede sustainable development.

In drug cultivation areas, crop eradication campaigns have led to the destruction of farmers' only means of subsistence, as well as of legal crops cultivated near coca and opium poppy fields. The use of chemical spraying has had a severe impact on the health of affected communities, as well as on the environment and fragile ecosystems, affecting food security, contaminating water supplies and causing



Ethnic Wa children in an opium field, Myanmar

long-term degradation of land and further deforestation to plant new crops.⁴ Affected farmers, their families and sometimes entire communities are often left with no other choice but to move to more remote areas, where access to schools, employment and other health and social services may be unavailable – leading conflict and supply reduction efforts to spread to other territories and communities. Indigenous and ethnic communities are particularly affected by these policies.

Even when alternative development programmes have been established, they have focused on crop reduction rather than sustainable development as a primary goal, and as a result have failed to offer long-term investments, or to ensure local ownership, access to markets and infrastructure, or the meaningful engagement of farmers and indigenous groups as partners in development.⁵

Drug trafficking hubs usually emerge in fragile, conflict-affected and under-developed regions, where governance is weak, and organised crime groups are in a position to corrupt, influence or elude state institutions. In these areas, drug traffickers are in a position of power, offering the basic health, security and social services the local population needs, including employment in the illicit economy in exchange for free lodgings, transportation, information and a form of local cooperation that protects traffickers from law enforcement actions. In such contexts, the illicit drug trade is strongly woven into the very

fabric of communities.⁶ A law enforcement-oriented approach that disregards this situation often ends up fuelling more violence (for example, in Mexico and Brazil), corruption, prison overcrowding, and exacerbating the poverty and social marginalisation of vulnerable communities.

Women are particularly vulnerable to engaging in illicit drug activities due to the gender inequality that continues to mark societies across the world, as well as gender discrimination in access to education and employment.⁷ Their incarceration for lengthy periods of time for minor, non-violent drug offences (often as drug mules or micro-traffickers) has a significant impact on their lives, but also on that of their children and other dependents who are then left in a situation of dire poverty – with no other choice but to go to prison with their mother or to end up in the street.⁸

Drug use is a global phenomenon, yet drug-related harms are often concentrated in poor and marginalised areas, where access to harm reduction and drug dependence treatment services may be limited. The criminalisation of people who use drugs has led to significant stigma and discrimination, as well as widespread human rights abuses. Women who use drugs suffer an additional level of stigma in many regions of the world as they are seen as contravening the 'natural' roles of women in society as mothers and caretakers.⁹ They also face heightened levels of violence. Tough drug law enforcement practices



A client speaking with a healthcare professional at an NSP at the Humanitarian Action Fund's mobile clinic in St. Petersburg, Russia, where the government remains strongly opposed to harm reduction

deter people from accessing the harm reduction, treatment and other healthcare that they need, affecting their health and well-being, but also leading to significant preventable health and social costs.

Legislative/policy issues involved

A development-oriented approach to drug control requires moving beyond a drug law enforcement-focused approach, with the objective of addressing the root causes of engagement in the illicit drug trade, such as poverty, inequality and weak governance. Although there are no simple solutions, below are some suggestions on how to address some of these underlying issues.

Improving governance

Strengthening democratic governance and accountability, legislative oversight, transparency of public accounts, improving public spending on health and social services, promoting participatory processes for citizens (including for communities affected by drug policies),¹⁰ and building the capacities of local authorities to deliver basic services are important steps towards reducing corruption and infiltration of government institutions by organised crime.¹¹

Such policies should eventually aim at reinforcing the rule of law, improving citizen security, and ensuring adequate access to justice.¹² The latter should include revising the laws and policies which have led

to the mass incarceration of people who use drugs, subsistence farmers and low-level, non-violent drug offenders, to ensure proportionality of sentencing and promote alternatives to imprisonment (see Chapters 3.3 and 3.4 for more information). Improving governance also entails putting an end to impunity by building solid mechanisms to ensure that victims of human rights abuses resulting from drug control have adequate access to justice.

Initiatives resulting in higher levels of employment and income, more equitable access to land and other resources, and better protection against economic crises can also build resilience among vulnerable communities to limit their involvement in illicit activities.¹³

Sometimes, however, improving governance in the short term may only be guaranteed by granting organised criminals and traffickers concessions and compromises in order to reduce levels of violence and public disorder – this is sometimes the only way to strengthen governance mechanisms in the longer term.¹⁴

Improving security

Development is simply impossible in a context of violence and insecurity. This is particularly the case in zones affected by, or coming out of, armed conflicts. In some instances, drug law enforcement efforts – especially where the military gets involved as a repressive tool against drug cultivators and traffickers – have tended to exacerbate insecurity and drug market-related violence. In areas where



Nor Yungas (Bolivia) coca leaf farmer sweeps up freshly picked leaves for taking to the legal market after being sun-dried on a slate patio, called a kachi in Aymara

state presence is only seen as a repressive machinery against the local population, the government can lose credibility in the face of organised crime groups which are often better able to provide safety and protection to the communities within which they operate. Improving human security in areas strongly affected by illicit drug production and trafficking should therefore be a top priority of a development-centred approach to drug control.¹⁵

Evidence clearly indicates that illicit drug markets are not inherently violent.¹⁶ A number of strategies have led to a decrease in drug-related violence – a modernised drug law enforcement strategy can help shape the illicit markets in a way that is the least harmful for the local population, and most beneficial for supporting development efforts (see Chapter 3.5 for more details).

Protecting health

Lack of access to health services can seriously hamper people's ability to access education and employment, and therefore to participate in a country's economy. The spread of infections such as HIV and hepatitis can also create a significant burden on a country's healthcare system and economy. Ensuring adequate access to harm reduction and evidence-based drug dependence treatment programmes is therefore an important component of a development-oriented approach to drug control (for more information, see Chapters 2.5 and 2.6). This also implies the removal of legislative and political barriers to accessing harm reduction and treatment

services – in particular the criminalisation of people who use drugs (see Chapter 3.1).

Providing sustainable livelihoods

There is ample evidence to show the severe impacts of forced eradication campaigns on local populations. Laws and regulations should be urgently reviewed to ensure adequate access to natural resources and to a fair and equitable distribution of benefits arising from the sustainable use of biodiversity by local communities, including indigenous groups.

Fumigation campaigns should be immediately halted considering the lack of success achieved so far in reducing the scale of crops cultivated and the long-term impact of the use of chemicals on lands and communities, the displacement of affected groups as a result of the campaigns, and the deforestation of new areas (sometimes natural parks or other protected lands) to re-grow crops destined for the illicit drug market.

Finally, it is essential to recognise that in drug cultivation areas, people are currently only able to survive, not because they are targeted by development programmes, but because they have become part of the illicit drug economy. Alternative development programmes should be enshrined in a comprehensive development policy which includes protecting the environment, developing strong infrastructure and adequate access to legal markets, and engaging local communities as equal partners (see Chapter 4.2 for more information).

Box 1 A drug policy enshrined in the Sustainable Development Goals¹⁷

In September 2015, governments met in New York to adopt the Sustainable Development Goals (SDGs).¹⁸ These goals replace the Millennium Development Goals, which came to an end in 2015. The SDGs set out 17 ambitious goals that will frame the development agenda until 2030. Although internationally controlled substances are only mentioned once within these goals – as Target 3.5 to ‘Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol’ – there is ample room to link drug control policies with the SDG targets.¹⁹ However, there are a number of contradictions between the targets established by the SDGs and current drug policies.²⁰ The SDGs cannot be achieved unless drug control policies and strategies are subjected to thorough review:

Goal 1: ‘End poverty in all its forms everywhere’: Ending poverty will only be achieved if governments address the underlying social and economic factors that lead people to engage in the drug trade, instead of exacerbating cycles of poverty and marginalisation by destroying crops and incarcerating large segments of society for low-level and non-violent drug offences.

Goal 2: ‘End hunger, achieve food security and improved nutrition and promote sustainable agriculture’: Sustainable agriculture and food security will only be achieved when alternative development programmes are fully enshrined within a comprehensive and long-term development strategy in areas of concentrated illicit crop production, involving small-scale farmers and indigenous groups as equal partners in the design and implementation of these policies.

Goal 3: ‘Ensure healthy lives and promote well-being for all at all ages’: Ensuring ‘healthy lives and promoting the well-being for all at all ages’ will only be achieved when drug laws and policies are revised to ensure adequate and affordable access to internationally controlled substances, such as morphine for pain relief and palliative care. Similarly, universal health coverage will only be achieved if people who use drugs are able to access the harm reduction, treatment and other health services they need without fear of arrest or discrimination.

Goal 5: ‘Achieve gender equality and empower all women and girls’: Gender equality will only



Credit: CAFOD

be achieved if governments recognise the many factors of vulnerability that push women to engage in the drug trade.

Goal 15: ‘Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss’: Halting land degradation will only be achieved if governments permanently put an end to aerial and manual fumigation campaigns. Protecting the homes of the indigenous population will not be achieved unless governments establish strong laws that protect the rights of indigenous groups to grow and use plants such as coca and opium for traditional and ancestral purposes.

Goal 16: ‘Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective,

accountable and inclusive institutions at all levels’: The provision of access to justice for all and the building of effective, accountable institutions will only be achieved when impunity for human rights violations related to drug law enforcement (such as extra-judicial killings, disappearances, etc.) comes to an end.

Goal 17: ‘Strengthen the means of implementation and revitalize the global partnership for sustainable development’: A global partnership for development will only be achieved when affected communities – including people who use drugs and small-scale farmers engaged in illicit crop production – are considered by governments as equal partners in the design and implementation of drug laws and policies at all levels of government. This goal underscores the necessity to remove criminal penalties for people who use drugs and small-scale farmers.

Implementation issues involved

One of the main issues to consider for the implementation of a development-oriented approach to drug control is how success will be measured and evaluated. Traditionally, metrics and indicators used to measure success in drug control focused on *process* indicators such as numbers of seizures, hectares of illicit crops eradicated, numbers of people arrested and/or incarcerated. These indicators have done little to measure the real impact of drug control on development outcomes.

We propose the development of a new set of metrics and indicators that can truly measure the full spectrum of drug-related health issues, as well as the impact of drug policy on human rights, security and development. These could include:

- **Goals** that address the root causes of engagement in illicit drug production, distribution and consumption – for example:²¹
 - Reducing poverty
 - Improving food security and access to licit markets
 - Addressing land tenure issues
 - Improving security
 - Increasing gender equality
 - Reducing corruption and impunity
 - Improving community well-being via better

access to healthcare, education and employment, etc.

- **Indicators** based on the Human Development index²² – which offers a useful set of tools that could be adapted on drug control. New indicators could include:²³
 - % of people living above the poverty line in communities affected by the drug trade
 - % of people having access to land tenure in areas vulnerable to, or affected by, the drug trade
 - % of people having access to stable housing in communities affected by the drug trade
 - % of people having access to primary, secondary and higher education
 - % of people working in the licit economy
 - Number of people having access to healthcare information and services – including harm reduction and drug dependence treatment
 - Number of women who use drugs accessing harm reduction and drug dependence treatment services
 - Number of deaths by drug overdose
 - Incidence of HIV, hepatitis, tuberculosis among people who use drugs – and % of infection among people who use drugs compared to the general population
 - % of people suffering from moderate to severe

pain who have access to pain relief

- % of victims of human rights abuses initiating judicial proceedings against their perpetrators
- Number of people (disaggregated by gender) incarcerated for drug offences – and % of inmates (disaggregated by gender) condemned for drug offences within the overall prison population
- % of drug offenders who benefited from alternatives to incarceration and/or punishment
- Reduction in levels violence and corruption in areas affected by production and trafficking
- Reduction in the number of people displaced from their land due to crop eradication activities and other drug law enforcement efforts
- Mechanism(s) established for the participation of affected communities in policy making and implementation.

Key resources

- Gutierrez, E. (2015), *Drugs and illicit practices: Assessing their impact on development and governance* (Christian Aid), <http://www.christianaid.org.uk/Images/Drugs-and-illicit-practices-Eric-Gutierrez-Oct-2015.pdf>
- Health Poverty Action & International Drug Policy

Consortium (November 2015), *Drug policy and the sustainable development goals*, <http://idpc.net/publications/2015/11/drug-policy-and-the-sustainable-development-goals>

- Martin, C. (February 2015), *Casualties of war: How the war on drugs is harming the world's poorest*, <http://idpc.net/publications/2015/02/casualties-of-war-how-the-war-on-drugs-is-harming-the-world-s-poorest>
- Melis, M. & Nougier, M. (October 2010), *IDPC Briefing Paper - Drug policy and development: How action against illicit drugs impacts on the Millennium Development Goals* (London: International Drug Policy Consortium), <http://idpc.net/publications/2010/10/idpc-briefing-drugs-and-development>
- United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>

4.2

Promoting sustainable livelihoods

Key recommendations

- Decades of experience in promoting alternative development show that reducing the cultivation of coca and opium poppy crops is a long-term problem that needs a long-term solution, involving broader nation-building and development goals. Government strategies need to be based on promoting economic growth and providing basic services; democratic institution building and the rule of law; respect for human rights; and improved security in the impoverished rural areas where coca and poppy cultivation flourishes
- Forced eradication of crops deviated to illicit markets should be replaced by alternative livelihoods efforts, which should be mainstreamed into local, regional and national development plans and carried out in close collaboration with the intended beneficiaries
- The cultivation of crops destined for the illicit drug market should not be criminalised; and farmers should be involved as partners in promoting rural development
- Local communities should be involved in the design, implementation, monitoring and evaluation of development efforts. This includes community leadership, and the involvement of local organisations such as producer groups and the farmers themselves. Government officials can play a key role in mobilising, coordinating and supporting community participation
- Governments should advance towards regulatory models for coca, opium poppy and cannabis cultivation, respecting traditional and licit uses of such crops and allowing for small-scale and industrialised transformation into products for licit use
- Governments should protect biological, cultural and intellectual property rights with regards to the plants, seeds and other derivatives of the communities where these crops are traditionally cultivated and used
- Results should not be measured in terms of hectares of crops eradicated. Rather, alternative livelihoods programmes should be evaluated using human development and socio-economic indicators that measure the well-being of society.²⁴

Introduction

The Latin American countries of Colombia, Peru and Bolivia are the primary source of coca, the raw material for cocaine.²⁵ From 2002-2010, Colombia led the region in coca cultivation, though in recent years, Peru has emerged as the global leader in hectares of coca under cultivation. In 2013, the most recent year for which there is reliable data, the United Nations Office on Drugs and Crime (UNODC) reported that Colombia had 48,000 hectares to Peru's 49,800. Bolivia, meanwhile, has seen consistent reductions in recent years, dropping from 30,900 hectares in 2009 to 20,400 in 2014, likely due to its innovative

'social control' model, which prioritises cooperative coca reduction and sustainable development over forced eradication. The country has set a target of 20,000 hectares under cultivation to leave a supply of coca leaf for traditional and other licit uses.

Cultivation of the opium poppy, the raw material for opium and heroin, has shifted over time. The Golden Triangle of Thailand, Lao People's Democratic Republic, and Myanmar once produced more than 70% of the world's opium, most of which was refined into heroin. Since 1998, dramatic decreases in opium cultivation have taken place in the Golden Triangle; cultivation is now concentrated in what is



Opium poppy field in Afghanistan

known as the Golden Crescent, the poppy-growing areas in and around Afghanistan. According to the UNODC,²⁶ in 2014 Afghanistan had 224,000 hectares of poppy under cultivation, followed by Myanmar with 57,600. As Afghanistan increased cultivation by over 100% since 1999, alternative livelihoods programmes in South East Asia contributed to important gains. Thailand has effectively eliminated its small poppy crops, and Lao People's Democratic Republic has seen considerable reductions as well, with 6,200 hectares in 2014. Myanmar saw marked reductions from a peak of 128,642 hectares in 2000 to 24,000 in 2006, but has recently seen a rise in cultivation.

Supply reduction efforts have typically been measured according to the areas of crops cultivated, the amounts of cocaine and opium produced, and the number of hectares eradicated. These figures, however, are not without controversy. While the UN data on cultivation tends to be the most accurate, the US Office of National Drug Control Policy (ONDCP) also publishes its own annual cultivation estimates.²⁷ The ONDCP figures are far more opaque, and are published without any explanation of methodology. Their findings are particularly questionable in their divergence from the UNODC figures in Bolivia, where the ONDCP has retroactively changed estimates from years prior.²⁸ Some of their post-facto adjustments include changing potential cocaine production estimates, again without any explanation for methodology. In Colombia, the ONDCP brought forward its regular release date for coca cultivation estimates to point to an increase in cultivation, at a time when the country debated ending the harmful practice of aerial spraying.²⁹ It is also important to point out that as crop yields and pro-

duction techniques have improved, less cultivation is needed, rendering eradication indicators increasingly irrelevant.

Efforts to reduce the cultivation of crops destined for the illicit drug market have been a cornerstone of the supply-side approach to drug control and are closely aligned with national and public security objectives. They have mainly consisted of forced crop eradication campaigns, which rely on manual eradication or aerial spraying and are conducted without the consent of the growers.

Decades of evidence show that, while this approach may achieve short-term reductions in cultivation of crops such as coca or opium poppy, in the medium- to long-term farmers, lacking other viable sources of cash income, are forced to replant. As a result, cultivation can be spread to new areas. In addition, crop eradication campaigns are associated with violence, conflict, and displacement, as well as a number of health, environmental and socio-economic harms.³⁰

In short, forced eradication has pushed some of the world's poorest people deeper into poverty and is counter-productive. Even when conducted hand-in-hand with alternative development programmes, eradication campaigns undermine cooperation with the local community, which in turn compromises the effectiveness of the development agenda. In other words, it causes distrust between donors, state agencies and recipient communities, and undermines the very development efforts needed to wean subsistence farmers off the cultivation of crops destined for the illicit drug market. The criminalisation of cultivation and hence of small farmers is tantamount to the criminalisation of poverty.

Legislative/policy issues involved

The cultivation of crops that are used to produce internationally controlled substances tends to take place in very remote and extremely poor regions of the world where there is often little or no effective state presence. It also tends to be in areas where conflict and violence are rampant. The fundamental drivers of such cultivation are poverty and insecurity: farmers living in extreme poverty see cultivation of opium poppy, coca or cannabis as a means of providing some income to complement subsistence-level agriculture. Simply put, it is a way for basic needs to be met. The United Nations Development Program (UNDP) points out that: 'Conditions of scarcity, displacement, state neglect, economic and geographic isolation and livelihoods insecurity, including in situations of conflict, increase the vulnerability of peasants and poor farmers to engaging in drug crop production.'³¹

In recognition of this, several decades ago policy makers began incorporating 'crop substitution' programmes into drug control efforts, usually carried out hand-in-hand with forced eradication. However, little attention was paid to the problems that led farmers to resort to cultivation in the first place, such as lack of roads and transportation infrastructure, lack of access to credit and markets, etc. This led to the development of the concept of 'alternative development', a more integrated approach. That, in turn, subsequently evolved towards the principle of 'alternative livelihoods', which focuses on improving the overall quality of life in these rural areas. Today these efforts

are referred to by many terms such as 'development in a drugs environment', 'development-oriented drug control' or even 'food security'. These efforts seek to promote equitable economic development in the rural areas used for illicit crop cultivation.

This approach recognises that farmers will only be able to reduce their dependence on income from coca and poppy crops if they are provided with alternative livelihoods through long-term multi-sectorial development. It is designed to improve the overall quality of life of farmers, including: ensuring food security and access to land; improved access to healthcare, education and housing; the development of infrastructure and other public services; and both on-farm and off-farm income generation.³² Such programmes are no longer purely focused on reducing the production of crops destined for the illicit drug market, but are incorporated, or mainstreamed, into comprehensive strategies for rural development and economic growth. Specifically, they call for embedding strategies for reducing coca and opium poppy crops in local, regional and national development initiatives.

Implementation issues involved

This broader concept of alternative development is now widely recognised and is enshrined in the UN International principles on alternative development.³³ However, not all countries implement these policies in the same way; indeed, many, such as Peru and Colombia, continue to prioritise forced



Field of coca crops fumigated in Guaviare, Colombia

Credit: Adam Schaffer, WOLA

eradication. In a major setback for small-scale farmers, in 2015 the Peruvian government implemented a legal reform that criminalises growers who replant following forced eradication with three to eight years in prison.

The following reforms should be put into place to ensure that alternative development achieves its desired outcomes of reducing cultivation of such crops while improving the livelihoods of vulnerable farmers.

Decriminalising crop cultivation

The criminalisation of subsistence farmers involved in the cultivation of crops destined for the illicit drug market has caused significant harm, often impacting on entire communities. Although some claim that the decriminalisation of these farmers is contrary to the international drug control treaties, their continued punishment constitutes a breach of international human rights law and a significant barrier to development. In 2012, the Colombian parliament initiated discussions on a bill that aimed to decriminalise the cultivation of crops destined for the illicit drug market.³⁴ Although this bill is on hold, discussions have continued and constitute a key challenge in the peace discussions between the Colombian government and the Revolutionary Armed Forces of Colombia (FARC). In the framework of the peace process, cultivators of crops destined for the illicit drug market have proposed the creation of an organisation to support the creation of a mechanism to regulate the cultivation of such crops.³⁵

Ensuring proper sequencing

In order to avoid the replanting described above, viable, sustainable livelihoods must be in place prior to significant crop reductions. Once economic development has taken root and alternative sources of income are in place, governments and international donor agencies can work with local communities to encourage the gradual elimination of crops used to produce internationally controlled substances. Crop reductions should always be voluntary and conducted in collaboration with the local community. Both Thailand (see Box 1) and Bolivia (see Box 3) provide examples of how a focus on economic development and proper sequencing has led to steady reductions in the cultivation of opium poppy and coca crops, respectively.

Including farmers as key partners in development programmes

Alternative livelihoods programmes require that small-scale farmers should no longer be considered as criminals but should instead be viewed as key

Box 1 The Thai alternative livelihoods model³⁶

Beginning in 1969, the Thai government sought to integrate highland communities into national life and therefore carried out sustained economic development activities over a 30-year period. Over time, it became clear that agricultural alternatives alone were insufficient. As a result, increasing emphasis was placed on providing social services such as healthcare services and schools, as well as infrastructure development such as roads, electricity and water supplies. Alternative livelihoods programmes were integrated into local, regional and national development plans. This led to steady improvement in farmers' quality of life, and increased opportunities for off-farm employment. A focus on local community participation emerged over time.

The Thai experience points to the importance of proper sequencing. Efforts for crop reduction only started in 1984, after about 15 years of sustained economic development. While some forced eradication did take place initially, the adoption of proper sequencing allowed farmers to reduce poppy cultivation gradually, as other sources of income developed, avoiding the problem of re-planting that inevitably frustrates crop eradication efforts. Although the entire process took about 30 years, the results of the Thai strategy have proved sustainable; however, on the negative side, there has been an increase in methamphetamine use and production in the region since the 1990s.³⁷

The Thai experience also underscores the importance of local institution building and community involvement in the design, implementation, monitoring and evaluation of development efforts. Local know-how became the basis for problem solving, and local leadership was fully integrated into project implementation.

stakeholders in the design and implementation of the development programmes that affect them (see Box 2).³⁸ The involvement of farmers is necessary, both because local farmers have a better knowledge and understanding of the local geographical conditions, and in order to protect the rights and cultural



Nutritionist Maria Eugenia Tenorio displaying her recipes using coca "flour" (finely ground leaves) at the 2004 Coca y Soberania Fair in El Alto, Bolivia

traditions of local communities (see Chapter 4.3). As evident in the Thai experience, community buy-in and involvement is also a key factor in ensuring project success and continuity (see Box 1).

Prioritising small-scale rural development

Decades of neo-liberal and pro-urban economic development models, free-trade agreements and government efforts to promote agro-business have proven to be seriously detrimental to the world's rural poor. Rural development efforts should prioritise promoting sustainable production on small farms, advance land reform, promote crop diversification, and encourage the development of domestic processing industries, and regulate imports and exports in order to protect vulnerable populations and resources.³⁹ They should also respect the rights, customs and farming practices of indigenous peoples.

Promote good governance and the rule of law

Nation building and promoting good governance and the rule of law are also essential components of an alternative livelihoods approach. These are particularly necessary to foster the legitimacy and credibility of the government in areas where state presence is often limited to security and/or eradication forces. A growing body of academic literature now points to the absence of violent conflict as a pre-condition for sustainable development and drug control efforts (see Chapter 4.1 for more details).⁴⁴

Integrating alternative development into local, regional and national development plans

Alternative livelihoods goals should be integrated at all levels and should in particular incorporate those involved in rural development, including multilateral and international development agencies, relevant government ministries, regional and local officials, and community and civil society organisations. Some donor agencies refer to this as

Box 2 Farmers' involvement in decision making processes

The participation of subsistence farmers in the elaboration and implementation of drug policies and development programmes in illicit crop cultivation areas remains a major challenge, as in most areas of the world this group remains heavily criminalised. However, attempts have been made across the world to improve farmers' participation in the decision making processes that affect them.

In Bolivia, for example, subsistence farmers are now involved as key strategic partners by the government in coca reduction strategies, as part of an approach based on social control (see Box 3).⁴⁰ Similarly, in Colombia coca farmers have been heavily engaged in the peace talks between the Colombian government and the FARC, and a bill is currently being discussed to decriminalise the cultivation of crops destined for the illicit drug market.⁴¹

In South Asia, community participation has been a major factor of success for the Thai alternative development programme (see Box 1). In Myanmar, however, opium farmers continue to be excluded, criminalised and harassed by the police and military. In September 2015, opium farmers and representatives from the Kayah State, Shan State, Kachin State and Chin State, came together in Upper Myanmar to adopt a statement highlighting the issues they face and calling for reform.⁴²

At global level, the International Forum of Producers of Crops Declared Illicit (FMPCDI in Spanish) adopted a political declaration calling for farmers to be able to 'take part in debates, decision making at all levels, with their own governments, donors and the UN'.⁴³

'mainstreaming counternarcotics into development programs'.⁴⁷

Using human development indicators

To date, most crop eradication and alternative development projects have primarily evaluated their success by reductions in the cultivation of crops destined for the illicit drug market. However, in an evaluation report to the Commission on Narcotic Drugs (CND) in 2008, the UNODC stated that, 'there is little proof that the eradications reduce illicit cultivation

Box 3 The Bolivian economic development model⁴⁵

Upon taking office in 2006, President Evo Morales extended a cooperative coca reduction programme, which had been in place since October 2004. The policy allows each registered coca grower to cultivate one *cato* of coca, which is 1,600 square meters or about one-third the size of a football field. Any coca grown beyond that is subject to elimination. The government has put into place a sophisticated coca monitoring system that includes land titling, a biometric registry of growers authorised to grow the *cato*, periodic measurements of coca fields, and implementation of a sophisticated database, SIS-COCA. Local coca grower unions work with government officials to ensure compliance with the *cato* agreement, a policy known as ‘cooperative coca reduction’.

Allowing limited coca cultivation – and thereby ensuring a steady flow of cash income – has allowed farmers to risk investing in other economic income generating activities. At the same time, the Morales administration has invested

in transportation infrastructure (including an international airport), education and health-care, improving the overall quality of life of local residents. The government is also investing in productive enterprises, such as fisheries and agricultural products such as pineapples.

To date, this approach has produced positive results and the possibility of long-term reductions in coca cultivation, while virtually eliminating the violence and social conflict associated with the forced coca eradication campaigns pursued by previous governments. For the fourth consecutive year, the UNODC reported a decline in coca cultivation in Bolivia; the country has achieved a 34% net reduction in coca cultivation between 2010 and 2014.⁴⁶ Bolivia now lags far behind Peru and Colombia in its supply of the coca leaf.

The Bolivia model shows that it is possible to regulate cultivation, improve people’s living standards, and promote traditional and licit uses of the coca leaf, while seeking to prevent the deviation of coca to the illicit market.



Aymara women collectively harvest the coca leaf in Bolivia's Nor Yungas province

Credit: Caroline S. Conzelmann

in the long term as the crops move somewhere else', adding that, 'alternative development must be evaluated through indicators of development and not technically as a function of illicit production statistics'.⁴⁸ Improved indicators include measuring improvements in education, health, employment, income generation and the like (see Chapter 4.1 for more details on development indicators).

Key resources

- *Background paper for the International workshop and conference on alternative development* (2011), http://icad2011-2012.org/wp-content/uploads/Background_Paper_ICAD2011-2012.pdf
- Buxton, J. (2015), *Drugs and development: The great disconnect* (Swansea: Global Drug Policy Observatory, Swansea University), <http://www.swansea.ac.uk/media/The%20Great%20Disconnect.pdf>
- Kramer, T., Jelsma, M. & Blickman, T. (2009), *Withdrawal symptoms in the golden triangle: A drugs market in disarray* (Amsterdam: Transnational Institute), <http://www.tni.org/report/withdrawal-symptoms-golden-triangle-4>
- Mansfield, D. (2006), *Development in a drugs environment: A strategic approach to 'alternative development'* (Eschborn: Deutsche Gesellschaft für Technische Zusammenarbeit)
- Renard, R.D. (2001), *Opium reduction in Thailand 1970 – 2000, a thirty year journey* (Chiang Mai: Silk-worm Books)
- *Report – Workshop portion of the International Workshop and Conference on Alternative Development ICAD, Chiang Rai and Chiang Mai Provinces, Thailand, 6–11 November 2011*, https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_55/E-CN7-2012-CRP3_V1251320_E.pdf
- United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
- Youngers, C.A. & Ledebur, K. (2015), *Building on progress: Bolivia consolidates achievements in reducing coca and looks to reform decades-old drug law* (Washington Office on Latin America & Andean Information Network), <http://www.wola.org/sites/default/files/Drug%20Policy/WOLA-AIN%20Bolivia.FINAL.pdf>
- Youngers, C.A. & Walsh, J.M. (2009), *Development first: A more humane and promising approach to reducing cultivation of crops for illicit markets* (Washington DC: The Washington Office on Latin America), http://www.wola.org/sites/default/files/downloadable/Drug%20Policy/2010/WOLA_RPT_Development_web_FNL.pdf

Key recommendations

- Governments should repair the discrepancies between the UN drug conventions and international human rights agreements, to ensure that the rights of indigenous peoples are upheld and fully protected
- Indigenous communities should be meaningfully involved in the design and implementation of any policies and regulations that affect them
- Governments should set up data collection mechanisms to review the impact of drug policies and in particular drug law enforcement strategies on indigenous groups, and review any harmful drug law, policy or practice
- The historical, cultural and traditional character and potential benefits of plants controlled at the national and international level should be recognised
- Where the use of psychoactive substances is part of people's traditional and religious practices, the right to cultivate, trade and use such plants for these purposes should be allowed and protected
- Aerial fumigation campaigns should be immediately stopped as they cause significant harm on the health of farmers and indigenous communities, and on the environment. Any crop reduction or alternative development programme should be undertaken in full collaboration and partnership with affected communities, and take specific care to protect the rights of indigenous people, including access to and use of their lands and natural resources in a way that is respectful of their culture and traditions.

Introduction

The 1989 International Labor Organization's Convention concerning Indigenous and Tribal Peoples in Independent Countries⁴⁹ defines indigenous people as those who, 'on account of their descent from the populations which inhabited the country at the time of conquest, colonisation, or the establishment of present state boundaries and who, irrespective of their legal status, retain some, or all, of their own social, economic, cultural and political institutions'; or 'tribal peoples in independent countries whose social, cultural and economic conditions distinguish them from other sections of the national community, and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations'.

In practical terms, this means that in addition to the universal human rights recognised in international conventions (see Policy principle 2), indigenous people enjoy specific rights that protect their identity, culture, traditions, habitat, language and access to ancestral lands. These rights are enshrined in the 2007 UN Declaration on the Rights of Indigenous Peoples⁵⁰ which notably recognises indigenous peoples' right to self-determination and autonomy; to maintain, protect and develop cultural manifestations of the past, present and future, as well as their cultural heritage, traditional knowledge and manifestations of their science, technology and culture (articles 11 and 31); to maintain their traditional medicines and healing practices (article 24); to participate in decision making in matters that would affect their rights (article 18); and to the conservation and protection of the environment and the productive capacity of their lands or territories and resources (article 29).

For generations, people worldwide have used psychoactive plants such as coca, cannabis, opium, kratom (*Mitragyna speciosa*), khat (*Catha edulis*), peyote (*Lophophora williamsii*), chamico (*Datura ferox*), San Pedro (*Echinopsis pachanoi*), *Salvia Divinorum* and ayahuasca or yahé (*Banisteriopsis caapi*), among many others, for traditional, cultural and religious purposes. In the Andean region and Amazon basin,



Morning mist in a Yungas coca field outside of Coroico, Bolivia

for example, the coca leaf has a wide application in social, religious, spiritual and medical areas for indigenous people, and is also used by the general population. Similarly in India, cannabis and opium have been bound to faith and mysticism in Hindu and Islamic traditions for centuries, and are enshrined in countless cultural practices. In Jamaica, cannabis has played a central part in the religious ceremonies of the Rastafarian community (see Box 1). Other plants, such as khat in Eastern Africa and kratom in South East Asia, have also been used for traditional and social purposes for centuries. Some of these substances have also been employed medicinally, especially for the treatment of rheumatism, migraine, malaria, cholera and other gastrointestinal complaints, to reduce pain from opioid withdrawal symptoms, and to facilitate births and surgery.⁵¹ These plants can also provide food grain, oil seed or fibre for manufacturing products.

However, and despite the significant advances in international human rights law to protect traditional and medicinal practices of indigenous populations, those involved in the cultivation and use of plants destined for the illicit drug market have been criminalised, marginalised and discriminated against by harsh drug laws and policies.

Regions where crops destined for the illicit drug market thrive are usually characterised by extreme poverty, state abandonment, limited infrastructure, restricted access to basic services, and often conflicts. Instead of addressing these underlying issues, governments have tended to focus on forced crop eradication campaigns. In the Andean region, for instance, these campaigns have caused wide-

spread damage to the health, habitat and traditions of coca-growing indigenous communities⁵² – and only serve to remove vulnerable communities' only means of subsistence in a context of market-driven crop prices, where many licit crop alternatives are not profitable enough to ensure survival, hence exacerbating their poverty.⁵³

In some countries, violent clashes have erupted between armed groups fighting for control of the drug trade and between those armed groups and drug law enforcement agencies, placing local affected communities in the crossfire. Forced eradication campaigns have exacerbated the harms caused by armed conflict, impacting particularly on indigenous groups. For instance, Plan Colombia launched in 1999 has not only had disastrous consequences on the lives, health, environment and economy of indigenous people and farmers, but has also put them in the crossfire between government forces, insurgent groups and paramilitaries fighting to control the territory. The plan did not achieve an overall reduction in cocaine production in Colombia, but has led instead to a serious humanitarian crisis, contributing heavily to the displacement of 3.6 to 5.2 million people⁵⁴ and increased levels of poverty and insecurity. Colombia's constitutional court estimated that at least 27 indigenous groups were at risk of disappearing as a result of armed conflict.⁵⁵

In locations where alternative development programmes have been implemented, no local knowledge, know-how or cultural traditions have been contemplated or considered, and indigenous groups have been excluded from these programmes. Furthermore, land grabbing processes and macroeco-

nomic 'development' projects such as monoculture, hydroelectric dams, open mining and petrol and gas exploitation in ancestral territories affect indigenous people's access to medicinal plants which are often grown within the native biodiversity of their territory⁵⁶ – jeopardising indigenous people's access to health, cultural and spiritual practices. It is essential that these programmes are developed in collaboration with affected populations after a careful assessment of the local cultivation possibilities and market access, and with full respect for the rights and traditions of indigenous people (see Chapter 4.2).

Legislative/policy issues involved

The 1961 Single Convention on Narcotic Drugs has classified three psychoactive plants – cannabis, coca and opium poppy – as subject to controls that limit their production, distribution, trade and use to medical and scientific purposes. The premise behind this policy is that it would be impossible to achieve a significant reduction in the illicit production of internationally controlled substances so long as large-scale local consumption of raw materials for these drugs continued. This led to pressure on producing countries to end traditional usage of these plants. Opium poppy, cannabis and coca were placed under the same strict levels of control as extracted and concentrated alkaloids such as heroin and cocaine, under Schedule I of the 1961 Convention – with a deadline of 15 years for the abolition of opium smoking, and 25 years for coca leaf chewing and cannabis use (article 49, para. 2).⁵⁷

The 1971 UN Convention on Psychotropic Substances does not control any plant, but does impose controls on several of the active ingredients of some plants. This is the case for mescaline, contained in peyote and the San Pedro cactus; for psilocybin and psilocin, responsible for the stimulating effect of khat; for DMT, the psychedelic compound in ayahuasca; and for THC, the psychoactive constituent of cannabis, among others.⁵⁸ This level of control creates confusion for substances such as khat, peyote or ayahuasca, since some of their psychoactive compounds are internationally controlled, but the plants themselves remain outside the remit of the conventions. As for cannabis, the plant species itself (cannabis and cannabis resin) is included in Schedule I of the 1961 Convention, but THC is scheduled in the 1971 Convention – also leading to inconsistencies for drug control.

Article 32, para. 4 of the 1971 Convention states that: 'A State on whose territory there are plants growing wild which contain psychotropic substances from among those in Schedule I and which are traditionally used by certain small, clearly determined groups in magical or religious rites, may, at the time of signature, ratification or accession, make reservations concerning these plants'⁵⁹ – thereby allowing member states to make a reservation to allow the traditional use of some plants in delimited geographic locations, during ceremonies or rituals. These provisions are important as they have been used in some countries to legitimise the use of ayahuasca, for example in Brazil, Peru, Colombia, or among the 'Ceu do Montreal' Church members in Canada,⁶⁹ as will be further discussed below.



Ayahuasca brewing

Credit: Creative Commons Paul Hessel

Box 1 The right of Rastafarians to use cannabis in Jamaica

Cannabis (known in Jamaica as ganja) is regarded as sacred by members of Jamaica's Rastafarian community. The plant was first introduced in Jamaica in the 19th century, originating from India, and quickly gained popularity as a recreative and medicinal herb. Its use spread among poor communities in the 1930s with the founding of the Rastafarian religion, a spiritual movement based on the Old Testament and Pan-Africanism.⁶⁰ Of all the herbs, cannabis occupies a special, spiritual place in the Rastafari celebrations. First and foremost is its place in the ceremonial rituals held five or six times a year, known as a nyabingi, or 'binghi'. But for Rastafarians, the herb is part of a way of life. The plant is often smoked, but can also be drunk or eaten. Knowledge about Rastafarian culture and traditions – drawn directly from testimonies among the Rastafarian community – was collated in a report by the National Commission on Ganja published in 2001, in which the Commission recommended the decriminalisation of the plant.⁶¹ As a community, the Rastafari have been advocating for cannabis legalisation, or at the very least for a removal of its criminal status, for over half a century.

It was not until April 2015, however, that the Jamaican government adopted the Dangerous

Drug (Amendment) Act, amending Section 7(c) of para. 6. This reform constitutes a positive attempt at protecting the religious and cultural rights of the Rastafarian community. The amendment authorises cannabis sacramental use by any person aged above 18 adhering to the Rastafarian faith, or to a Rastafarian organisation. Members of the Rastafarian community can also apply for authorisation to cultivate cannabis for religious purposes as a sacrament in adherence to the Rastafarian faith. Finally, they can apply for an event to be declared exempt from cannabis prohibition rules, as long as the event is primarily organised for the purpose of the celebration of the Rastafarian faith.⁶²

The amendment is broader in scope, also decriminalising the possession of up to 2 ounces (56g) of cannabis, as well as possession for medical and therapeutic purposes as recommended or prescribed by a registered medical doctor or health practitioner. However, the Rastafarian community benefits from broader rights in terms of cultivation and use than the broader community, demonstrating a clear attempt at protecting the cultural and ancient traditions of this community.



Rastafari Rootzfest 2015 in Jamaica

Credit: Creative Commons Beverly Xuen Thompson

Box 2 Bolivia, coca leaf chewing and the protection of indigenous culture



Credit: Ali Margeaux Pfenninger

Aymara yatiri (shaman) performing a coca leaf reading on the summit of Mt. Uchumachi near Coroico, Bolivia on the winter solstice or Aymara New Year

Coca has been sacred to the indigenous peoples of the Andean region for thousands of years. In Bolivia, the Quechua and Aymara peoples make up the majority of the rural population, and use of the coca leaf is widespread among them. The practice is associated with social and cultural solidarity, economic activity and work, medicinal factors (such as adding nutrients to the diet and providing protection against altitude sickness or stomach pains), and spirituality, restoring the balance between natural and spiritual realms.⁶³ For those involved in coca cultivation, this activity often constitutes their only means of subsistence.

The first Western attempts at prohibiting coca came with colonisation in the 16th century, when the Catholic church became aware of the plant's role in native religious ritual. An agreement with coca was achieved, however, recognising the plant as a means of first necessity – this agreement lasted until the 20th century. Following World War II, the UN led a drive for 'modernisation', which identified the practice of coca chewing as being primitive and outmoded. A report of the ECOSOC Coca Leaf Inquiry Commission published in 1950, supported the assumption that coca chewing was a harmful habit, a form of 'drug addiction' and a degenerative moral agent causing malnutrition.⁶⁴ This report resulted in the scheduling of the coca leaf in the same schedule as for cocaine and heroin in the 1961 Single Convention on Narcotic Drugs (Schedule I) and a provision for the abolition of coca chewing within 25 years. Since then, the report has been criticised for being biased, scientifically flawed, culturally insensitive and even racist. A 1995 study by the World Health Organisation

(WHO) concluded that the 'use of coca leaves appears to have no negative health effects and has positive therapeutic, sacred and social functions for indigenous Andean populations'.⁶⁵ This study, however, was never made public.

The international prohibition of the coca leaf demonstrates a clear misunderstanding of indigenous customs and traditions. Andean and Amazonian coca consumers often feel ignored, insulted and humiliated by the call by the international community and the UN to abolish what they consider to be a healthy ancestral tradition.

In order to repair this historical error, Bolivia made an attempt at amending the 1961 Convention to remove the obligation to ban coca leaf chewing – an initiative that was blocked by a coalition led by the USA. As a response, in June 2011, Bolivia withdrew from the 1961 Convention, announcing its intention to re-accede with a reservation to align its treaty obligations with its constitution.⁶⁶ Bolivia re-acceded the Convention on 10 January 2013, its reservation stating that: 'The Plurinational State of Bolivia reserves the right to allow in its territory: traditional coca leaf chewing; the consumption and use of the coca leaf in its natural state for cultural and medicinal purposes; its use in infusions; and also the cultivation, trade and possession of the coca leaf to the extent necessary for these licit purposes'.⁶⁷ Since then, Bolivia has developed an innovative community control approach to coca production, with a strong focus on partnership working with coca producing communities to ensure that subsistence farmers are not affected by a sudden and forced removal of their means of subsistence (see Chapter 4.2).⁶⁸

Another condition for the traditional use of internationally controlled plants was stipulated in article 14, para. 2 of the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which provides that drug policies should ‘respect fundamental human rights’ and ‘take due account of traditional licit uses, where there is historical evidence of such use’. However, this clearly contradicts the obligations included in articles 14.1 and 25 of the 1988 Convention, which state that the treaty’s provisions should not derogate from any obligations under the previous drug control treaties, including the 1961 obligation to abolish any traditional uses of coca, opium and cannabis.⁷⁰ This lack of clarity around traditional uses of these plants has enabled governments to place strict control mechanisms on cannabis, coca and opium, but also on traditional psychoactive plants that have not been classified by the UN, such as khat and kratom. In order to ensure that the rights of indigenous groups are adequately protected, there should be an explicit recognition of the traditional use of internationally controlled substances – and the UN drug control conventions should be revised to accommodate this obligation.

Implementation issues involved

Indigenous rights protected in courts

In exceptional cases, jurisprudence has recognised the rights of indigenous people to use internationally controlled plants to protect their traditional cultural and religious rights. This was the case, for instance, in Italy where a drug conviction was reversed on appeal on the grounds that the lower court had not considered the religious rights of a Rastafarian defendant to use cannabis.⁷¹ Similarly, in March 2015, the Oral Tribunal of Arica in Chile recognised the right to use the coca leaf for cultural purposes.⁷²

Legal exceptions to protect indigenous rights

Some governments have revised their drug laws and policies – often as a result of favourable court decisions – in order to include provisions within their national legal systems to allow the traditional use of certain psychoactive plants, under specific circumstances.

This is the case for example in Canada, where Section 56 of the Canadian Controlled Drugs and Substances Act stipulates that: ‘The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class

Box 3 Khat: The dangers of prohibition

Khat has been used for hundreds – if not thousands – of years in the highlands of Eastern Africa and Southern Arabia. Traditionally, khat has been chewed communally, after work or on social occasions, in public spaces or dedicated rooms in private houses. Global khat markets have been driven by demand from diaspora populations settling in Europe, particularly from Somalia. So far, there has been little cross-over from migrants to the mainstream European population – khat use remains concentrated among Eastern African migrant communities who consume khat in commercial establishments, and communal centres where social and community bonds remain strong. This enables consumers to control the quality of the khat they use and to perpetuate cultural and social traditions among their community.

A number of studies have demonstrated that the potential for dependence associated with khat, and the physical and mental health risks related to khat use, remain very low.⁷³ Evidence also suggests that prohibiting khat use can lead to a number of negative consequences, including expanding the isolation and vulnerability of immigrant populations, and impacting negatively on livelihoods and economic development in producer countries.⁷⁴

For instance, the recent prohibition of khat in the UK – adopted against the expert advice of the scientific community⁷⁵ (see Chapter 2.1) – is likely to generate an important illicit criminal market, and may alienate certain ethnic minorities in the country.⁷⁶ Beyond the UK itself, the ban had devastating impacts on khat producing areas in Africa, in particular in Kenya.⁷⁷

thereof from the application of all or any of the provisions of the Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.⁷⁸ Although this exemption is rarely applied to protect indigenous rights, an exception was made for the import and use of ayahuasca by the Ceu do Montreal followers a small group of religious leaders using ayashuasca (which they call Daime) for traditional purposes.⁷⁹

A similar rule exists in Section 1307.31 of the US Code of Federal Regulations with regards to peyote – a small, spineless cactus containing the psychoactive alkaloid mescaline (controlled under the 1971 Convention), which is used by members of the Native American Church during religious ceremonies. The rule states that: ‘The listing of peyote as a controlled substance in Schedule I does not apply to the nondrug use of peyote in bona fide religious ceremonies of the Native American Church’. As for Canada, this provision is limited in scope, but it effectively enables Native Americans to perpetuate their religious traditions and rituals by using peyote without fear of prosecution.

Peru, Colombia and Argentina also have domestic legal exemptions for a coca leaf market. Indeed, Peru has always maintained an internal legal coca market under the state monopoly of the National Coca Enterprise, ENACO.⁸⁰ Peru has also recognised the traditional use of ayahuasca as part of its cultural heritage.⁸¹ Colombia introduced specific exemptions for coca in indigenous territories.⁸² As for Argentina, in 1989 it introduced the following provision in Article 15 of its Criminal Law, N23.737: ‘The possession and consumption of the coca leaf in its natural state, destined for the practice of “coqueo” or chewing, or its use as an infusion, will not be considered as possession or consumption of narcotics’.⁸³

The latest country to date to have adopted an exception to its drug law is Jamaica, with regards to the right of Rastafarians to use cannabis in their religious ceremonies (see Box 1).

Constitutional protections of indigenous rights

Bolivia is no doubt the country that has gone furthest in seeking to protect the rights of indigenous groups to produce and use coca for traditional purposes. In 2009, Bolivia adopted a new constitution, in which it recognised the traditional use of the coca leaf as a cultural heritage,⁸⁴ therefore ensuring that the right of Bolivian indigenous communities and all its citizens to chew coca is protected (see Box 2).

Regulating plants not placed under international control

As mentioned above, some plants containing psychoactive substances are not included in the UN

drug control conventions, therefore placing no obligations on governments to schedule them – but some did nonetheless. This is the case, for instance, for kratom, khat and ayahuasca. Kratom is currently prohibited under national laws in several Asian countries (including Thailand, Australia or Myanmar), while the national legal status for khat varies considerably from country to country. As for ayahuasca, there are three broad legal statuses for the plant: 1- countries in which there is a legal vacuum, and where the plant’s status might be decided by court decision and jurisprudence; 2- countries where the plant is specifically prohibited (as is the case in France); and 3- countries that allow and sometimes regulate certain uses of ayahuasca, while other uses remain outside the remit of the law (for example in Peru).⁸⁵

Key resources

- Foro Mundial de Productores de Cultivos Declarados Ilicitos (2009), *Political declaration*, http://idpc.net/sites/default/files/library/Political_Declaration_FMPCDI.EN.pdf
- International Drug Policy Consortium (2011), *IDPC Advocacy Note – Correcting a historical error: IDPC calls on countries to abstain from submitting objections to the Bolivian proposal to remove the ban on the chewing of the coca leaf*, <http://idpc.net/publications/2011/01/idpc-advocacy-note-bolivia-proposal-coca-leaf>
- United Nations (27 June 1989), *ILO Convention concerning Indigenous and Tribal Peoples in Independent Countries*, <http://www.un-documents.net/c169.htm>
- United Nations (March 2008), *United Nations Declaration on the Rights of Indigenous Peoples*, http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
- United Nations Development Programme (March 2015), *Perspectives on the development dimensions of drug control policy*, http://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf

Chapter 4 – endnotes

1. Gutierrez, E. (2015), *Drugs and illicit practices: Assessing their impact on development and governance* (Christian Aid), <http://www.christianaid.org.uk/Images/Drugs-and-illicit-practices-Eric-Gutierrez-Oct-2015.pdf>
2. Ibid
3. Ibid
4. See, for instance, a recent WHO study that highlighted evidence that herbicide glyphosate – a common chemical used for crop eradication campaigns – may cause significant health harms, including cancer: World Health Organisation, International Agency for Research on Cancer (20 March 2015), *IARC monographs volume 112: Evaluation of five organophosphate insecticides and herbicides*, <http://www.iarc.fr/en/media-centre/iarcnews/pdf/Monograph-Volume112.pdf>
5. Youngers, C. & Walsh, J. (2009), *Development first: A more humane and promising approach to reducing cultivation of crops for illicit markets* (Washington DC: Washington Office on Latin America), http://www.wola.org/publications/development_first_a_more_humane_and_promising_approach_to_reducing_cultivation_of_crops
6. Gutierrez, E. (2015), *Drugs and illicit practices: Assessing their impact on development and governance* (Christian Aid), <http://www.christianaid.org.uk/Images/Drugs-and-illicit-practices-Eric-Gutierrez-Oct-2015.pdf>
7. United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
8. See, for instance: Giacomello, C. (November 2013), *IDPC Briefing Paper - Women, drug offences and penitentiary systems in Latin America*, <http://idpc.net/publications/2013/11/idpc-briefing-paper-women-drug-offences-and-penitentiary-systems-in-lat-in-america>; UN Women (July 2014), *A gender perspective on the impact of drug use, the drug trade and drug control regimes*, http://www.unodc.org/documents/ungass2016/Contributions/UN/Gender_and_Drugs_-_UN_Women_Policy_Brief.pdf
9. Kensy, J., Stengel, G., Nougier, M. & Birgin, R. (November 2012), *IDPC Briefing Paper – Drug policy and women: Addressing the negative consequences of harmful drug control*, <http://idpc.net/publications/2012/11/drug-policy-and-women-addressing-the-negative-consequences-of-harmful-drug-control>
10. United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
11. United Nations Development Program (2013), *Informe regional de desarrollo humano 2013-2014, seguridad ciudadana con rostro humano: Diagnostico y propuestas para América Latina*, <http://www.latinamerica.undp.org/content/dam/rblac/img/IDH/IDH-AL%20Informe%20completo.pdf>
12. United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
13. Ibid
14. For example, in Tajikistan where security and stability could only be reached by collaborating with the criminal groups that exercised control over certain parts of the country. See: Gutierrez, E. (2015), *Drugs and illicit practices: Assessing their impact on development and governance* (Christian Aid), <http://www.christianaid.org.uk/Images/Drugs-and-illicit-practices-Eric-Gutierrez-Oct-2015.pdf>
15. Gutierrez, E. (2015), *Drugs and illicit practices: Assessing their impact on development and governance* (Christian Aid), <http://www.christianaid.org.uk/Images/Drugs-and-illicit-practices-Eric-Gutierrez-Oct-2015.pdf>
16. Wilson, L. & Stevens, A. (2008), *Understanding drug markets and how to influence them*, Beckley Report 14 (Oxford: Beckley Foundation Drug Policy Programme), http://www.beckleyfoundation.org/pdf/report_14.pdf
17. Health Poverty Action & International Drug Policy Consortium (November 2015), *Drug policy and the sustainable development goals*, <http://idpc.net/publications/2015/11/drug-policy-and-the-sustainable-development-goals>; Tinasti, K., Bem, P., Grover, A., Kazatchkine, M. & Dreifuss, R. (19 September 2015), 'SDGs will not be achieved without drug policy reform', *The Lancet*, **386**(9999): 1132, <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2815%2900198-1/fulltext>
18. <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>
19. Health Poverty Action & International Drug Policy Consortium (November 2015), *Drug policy and the sustainable development goals*, <http://idpc.net/publications/2015/11/drug-policy-and-the-sustainable-development-goals>
20. For an analysis of contradictions between the SDGs and current drug policies, see: United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, pp. 36-37, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
21. United Nations Development Program (June 2015), *Addressing the development dimensions of drug policy*, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
22. <http://hdr.undp.org/en/content/human-development-index-hdi>
23. For a more thorough discussion on indicators, see: Bewley-Taylor, D. (2016), *The 2016 United Nations General Assembly Special Session on the World Drug Problem: An opportunity to move towards metrics that measure outcomes that really matter*, Working Paper No. 1 (UK: Global Drug Policy Observatory & Swansea University)
24. UNODC refers to 'a mix of impact indicators [that] include measuring improvements in education, health, employment, the environment, gender-related issues, institution-building, and governmental capacity'. See: *UNODC's Executive Director's Report on the action plan on international cooperation on the eradication of illicit drug crops and on alternative development*, presented at the 51st session of the Commission on Narcotic Drugs in March 2008, E/CN.7/2008/2/Add.2, 17 December 2007, p. 20
25. United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, <http://www.unodc.org/wdr2015/>
26. Ibid
27. Office of National Drug Control Policy, *Coca in the Andes* (Washington DC: White House), <https://www.whitehouse.gov/ondcp/targeting-cocaine-at-the-source>
28. Youngers, C.A. & Ledebur, K. (2015), *Building on progress: Bolivia consolidates achievements in reducing coca and looks to reform decades-old drug law* (Washington Office on Latin America & Andean Information Network), <http://www.wola.org/sites/default/files/Drug%20Policy/WOLA-AIN%20Bolivia.FINAL.pdf>
29. Gomez, S. (2015), 'Coca se dispara en Colombia, dice informe de la Casa Blanca', *El Tiempo*, <http://www.eltiempo.com/mundo/ee-uu-y-canada/fumigacion-de-cultivos-ilicitos-con-glifosato-gobierno-le-explica-a-estados-unidos/15686595>
30. For additional information, see: Youngers, C.A. & Rosin, E. (2005), *Drugs and democracy in Latin America: The impact of U.S. policy* (Boulder, Colorado: Lynne Rienner Publishers, Inc.); Gaviria Uribe, A. & Mejía, L. (2011), *Políticas antidroga en Colombia: Éxitos, fracasos y extravíos* (Bogotá: Universidad de los Andes)
31. United Nations Development Programme (June 2015), *Addressing the development dimensions of drug policy*, p. 14, <http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/addressing-the-development-dimensions-of-drug-policy.html>
32. *Background paper for the International workshop and conference on alternative development* (2011), http://icad2011-2012.org/wp-content/uploads/Background_Paper_ICAD2011-2012.pdf
33. Youngers, C. (9 November 2012), *UN international guiding principles on alternative development* (Washington DC: Washington Office on Latin America), http://www.wola.org/commentary/un_international_guiding_principles_on_alternative_development

34. Colombian Congress (28 October 2015), *Bill 183/2012 'Despenalización Cultivo'*, http://www.camara.gov.co/portal2011/proceso-y-tramite-legislativo/proyectos-de-ley?option=com_proyectosdeley&view=ver_proyectedeley&idpry=745
35. See: <http://druglawreform.info/es/informacion-por-pais/america-latina/colombia/item/245-colombia>
36. Youngers, C.A. & Walsh, J.M. (2009), *Development first: A more humane and promising approach to reducing cultivation of crops for illicit markets* (Washington D.C.: Washington Office on Latin America), http://www.wola.org/sites/default/files/downloadable/Drug%20Policy/2010/WOLA_RPT_Development_web_FNL.pdf; Renard, R.D. (2001), *Opium reduction in Thailand 1970 – 2000, a thirty year journey* (Chiang Mai: Silkworm Books)
37. Advisory Council on the Misuse of Drugs (2005), *Methylamphetamine review* (UK), <https://www.gov.uk/government/publications/methylamphetamine-review-2005>
38. EU Presidency Paper (2008), *Key points identified by EU experts to be included in the conclusion of the open-ended intergovernmental expert working group on international cooperation on the eradication of illicit drug and on alternative development*, presented to the open-ended intergovernmental working group on international cooperation on the eradication of illicit drug crops and on alternative development (2-4 July 2008)
39. See: Farthing, L.C. & Ledebur, K. (July 2015), *Habeas coca: Bolivia's community coca control* (Open Society Foundations), <http://www.opensocietyfoundations.org/reports/habeas-coca-bolivia-s-community-coca-control>
40. See: Observatorio de Cultivos Declarados Ilícitos (August 2015), *Vicios Penales en Colombia: Cultivadores de coca, amapola y marihuana, en la hora de su despenalización*, <http://www.indepaz.org.co/vicios-penales/>
41. See: Statement of 3rd Myanmar Opium Farmer Forum, <https://www.tni.org/en/article/statement-of-3rd-myanmar-opium-farmer-forum>
42. Foro Mundial de Productores de Cultivos Declarados Ilícitos (2009), *Political declaration*, http://idpc.net/sites/default/files/library/Political_Declaration_FMPCDI.EN.pdf
43. Youngers, C.A. & Walsh, J.M. (2009), *Development first: A more humane and promising approach to reducing cultivation of crops for illicit markets* (Washington DC: Washington Office on Latin America), p. 30, http://www.wola.org/sites/default/files/downloadable/Drug%20Policy/2010/WOLA_RPT_Development_web_FNL.pdf
44. *The role of alternative development in drug control and development cooperation*, International Conference, 7–12 January 2002, Feldafing (Munich), Germany, http://www.unodc.org/pdf/Alternative%20Development/RoleAD_DrugControl_Development.pdf; Youngers, C. & Walsh, J. (2010), *Development first – a more humane and promising approach to reducing cultivation of crops for illicit markets* (Washington DC: Washington Office on Latin America), http://www.wola.org/sites/default/files/downloadable/Drug%20Policy/2010/WOLA_RPT_Development_web_FNL.pdf; Aktionsprogramm Drogen und Entwicklung Drugs and Development Programme & Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, *Drugs and conflict – Discussion paper by the GTZ Drugs and Development Programme* (Eschborn: Deutsche Gesellschaft für Technische Zusammenarbeit), <http://www.gtz.de/de/dokumente/en-drugs-conflict.pdf>
45. European Union, Food and Agriculture Organization, GIZ & United Nations Office on Drugs and Crime (2008), *Complementary drug-related data and expertise to support the global assessment by Member States of the implementation of the declaration and measures adopted by the General Assembly at its twentieth special session*, presented at the 51st session of the Commission on Narcotic Drugs in March 2008, E/CN.7/2008/CPR.11, 27 February 2008, p. 7
46. United Nations Office on Drugs and Crime Executive Director (2008), *Fifth report of the Executive Director on the world drug problem, Action Plan on International Cooperation on the Eradication of Illicit Drug Crops and of Alternative Development*, E/CN.7/2008/2/Add.2 (Vienna: United Nations Office on Drugs and Crime); For more information, see: *Background paper for the International workshop and conference on alternative development* (2011), http://icad2011-2012.org/wp-content/uploads/Background_Paper_ICAD2011-2012.pdf
47. Excerpts from: Youngers, C.A. & Ledebur, K. (2015), *Building on progress: Bolivia consolidates achievements in reducing coca and looks to reform decades-old drug law* (Washington Office on Latin America & Andean Information Network), <http://www.wola.org/sites/default/files/Drug%20Policy/WOLA-AIN%20Bolivia.FINAL.pdf>
48. Estado Plurinacional de Bolivia, *Monitoreo de Cultivos de Coca 2014*, http://www.unodc.org/documents/bolivia/Informe_Monitoreo_Coca_2014/Bolivia_Informe_Monitoreo_Coca_2014.pdf
49. United Nations (27 June 1989), *ILO Convention concerning Indigenous and Tribal Peoples in Independent Countries*, <http://www.un-documents.net/c169.htm>
50. See: United Nations (March 2008), *United Nations Declaration on the Rights of Indigenous Peoples*, http://www.un.org/esa/socdev/unpfi/documents/DRIPS_en.pdf; Four countries – the USA, Canada, Australia and New Zealand – initially voted against the declaration in 2007, but all four revised their position, since the Obama administration announced its support for it in December 2010. Although this declaration is not legally binding under international law, it represents an important step forward in the recognition of indigenous rights and provides governments with a comprehensive code of good practice
51. Kalant, H. (2001), 'Medicinal use of cannabis: history and current status', *Pain, Research and Management*, **6**(2): 80-91, <http://www.ncbi.nlm.nih.gov/pubmed/11854770>; Touw, M. (1981), 'The religious and medicinal uses of cannabis in China, India and Tibet', *Journal of Psychoactive Drugs*, **13**(1): 23-34, <https://www.cnsproductions.com/pdf/Touw.pdf>; Chopra, R.N., Chopra, I.C., Handa, K.L. & Kapur L.D. (1958), *Chopra's indigenous drugs of India* (Calcutta: UNDhur and Sons Private Ltd; Martin, R.T. (1970), 'The role of coca in the history, religion, and medicine of South American Indians', *Economic Botany*, **24**(4): 422–438; Weil, A.T. (1981), 'The therapeutic value of coca in contemporary medicine', *Journal of Ethnopharmacology*, **3**(2-3): 367-376, <http://www.sciencedirect.com/science/article/pii/0378874181900647>; Tanguay, P. (2011), *Kratom in Thailand: Decriminalisation and community control?* (Transnational Institute & International Drug Policy Consortium), <http://idpc.net/sites/default/files/library/kratom-in-thailand.pdf>
52. See, for example: Isacson, A. (29 April 2015), *Even if glyphosate were safe, fumigation in Colombia would be a bad policy. Here's why*, (Washington D.C.: Washington Office on Latin America), http://www.wola.org/commentary/even_if_glyphosate_were_safe_fumigation_in_colombia_would_be_a_bad_policy_heres_why; see also: Guyton, K.Z., et al (May 2015), 'Carcinogenicity of tetrachlorvinphos, parathion, malathion, diazinon, and glyphosate', *The Lancet*, **16**(5): 490-491, [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(15\)70134-8/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(15)70134-8/fulltext)
53. United Nations Development Program (March 2015), *Perspectives on the development dimensions of drug control policy*, http://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf; Center for Legal and Social Studies, Conectas Direitos Humanos, Corporacion Humanas Centro Regional de Derechos Humanos y Justicia de Genero (2015), *Contributions to the OHCHR for the preparation of the study mandated by resolution A/HRC/28/L.22 of the Human Rights Council on the impact of the world drug problem and the enjoyment of human rights*, <http://www.ohchr.org/Documents/HRBodies/HR-Council/DrugProblem/CELS.pdf>
54. Although the government estimates that 3.6 million people were displaced as a result of Plan Colombia, the independent Observatory on Human Rights and Displacement (CODHES) estimated the figure to be as high as 5.2 million people
55. See: United Nations (2008), *Struggle for survival: Colombia's indigenous people face threat of extinction*, <http://www.un.org/en/events/tenstories/08/colombia.shtml>
56. United Nations Development Program (2011), *Protecting biodiversity in production landscapes – A guide to working with agribusiness supply chains towards conserving biodiversity*, http://www.undp.org/content/undp/en/home/librarypage/environment-energy/ecosystems_and_biodiversity/biodiversity_agribusiness_supply_chains.html
57. Bewley-Taylor, D. & Jelsma, M. (2011), *Fifty years of the 1961 Single Convention on Narcotic Drugs: A reinterpretation* (Amsterdam:

- Transnational Institute), <http://www.idpc.net/sites/default/files/library/fifty-years-of-1961-single-convention.pdf>
58. Sanchez, C. & Bouso, J.C. (December 2015), *Ayahuasca: From the Amazon to the Global Village* (International Center for Ethnobotanical Education, Research & Service & Transnational Institute), <http://news.iceers.org/2015/12/ayahuasca-from-the-amazon-to-the-global-village-new-iceers-tni-report/>
 59. https://www.unodc.org/pdf/convention_1971_en.pdf
 60. For more information, see: NcFaddem, D. (16 September 2014), 'Jamaica's Rastas ready for ganja decriminalization', *The Jamaica Observer*, http://www.jamaicaobserver.com/news/Jamaica-s-Rastas-ready-for-ganja-decriminalisation_17546818
 61. National Commission on Ganja (7 August 2001), *A report of the National Commission on Ganja to Rt. Hon. P.J. Patterson, Q.C., M.P. Prime Minister of Jamaica*, <http://www.cannabis-med.org/science/Jamaica.htm>
 62. Fact sheet prepared by the Ministry of Justice on the Dangerous Drugs (Amendment) Act 2015, http://www.moj.gov.jm/sites/default/files/Dangerous%20Drugs%20Amendment%20Act%202015%20Fact%20Sheet_0.pdf; Jamaican Parliament (2015), http://www.japarlament.gov.jm/attachments/339_The%20Dangerous%20Drug%20bill%202015.pdf
 63. Spedding, A. (2004), 'Coca Use in Bolivia: a tradition of thousands of years'. In: Coomber, R. & South, N., eds. (2004), *Drug use and cultural contexts 'beyond the West'* (London: Free Association Books)
 64. Economic and Social Council (May 1950), *Report of the Commission of Enquiry on the Coca Leaf*, <https://www.tni.org/en/issues/unscheduling-the-coca-leaf/item/995-report-of-the-commission-of-enquiry-on-the-coca-leaf>
 65. World Health Organisation & United Nations Interregional Crime and Justice Research Institute (1995), *Cocaine project, briefing kit*, <http://www.undrugcontrol.info/images/stories/documents/who-briefing-kit.pdf>; See also: Duke, J.A., Aulik, D. & Plowman, T. (1975), 'Nutritional value of coca', *Botanic Museum Leaflets Harvard University*, **24**(6): 113–118
 66. International Drug Policy Consortium (2011), *IDPC Advocacy Note – Correcting a historical error: IDPC calls on countries to abstain from submitting objections to the Bolivian proposal to remove the ban on the chewing of the coca leaf*, <http://idpc.net/publications/2011/01/idpc-advocacy-note-bolivia-proposal-coca-leaf/>; C.N.829.2011.TREATIES-28 (Depositary Notification), *Bolivia (Plurinational State of): communication, 10 January 2012* (New York: United Nations), <http://treaties.un.org/doc/Publication/CN/2011/CN.829.2011-Eng.pdf>
 67. See: <http://druglawreform.info/images/stories/documents/bolivia-reaccession-reservation.pdf>; Transnational Institute (14 January 2013), *UN accepts "coca leaf chewing" in Bolivia*, <https://www.tni.org/en/inthemedial/un-accepts-coca-leaf-chewing-bolivia>
 68. Farthing, L.C. & Ledebur, K. (July 2015), *Habeas coca: Bolivia's community coca control* (Open Society Foundations), <http://www.opensocietyfoundations.org/reports/habeas-coca-bolivia-s-community-coca-control>
 69. Sanchez, C. & Bouso, J.C. (December 2015), *Ayahuasca: From the Amazon to the Global Village* (International Center for Ethnobotanical Education, Research & Service & Transnational Institute), <http://news.iceers.org/2015/12/ayahuasca-from-the-amazon-to-the-global-village-new-iceers-tni-report/>
 70. Jelsma, M. (2011), *Lifting the ban on coca chewing. Bolivia's proposal to amend the 1961 Single Convention* (Amsterdam: Transnational Institute), <http://www.idpc.net/sites/default/files/library/lifting-the-ban-on-coca.pdf>
 71. Supreme Court of Italy (2012), Judgement No. 14876; see also: United Nations High Commissioner for Human Rights (September 2015), *Study on the impact of the world drug problem on the enjoyment of human rights*, A/HRC/30/65, <http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Pages/ListReports.aspx>
 72. Tapia Mendez, D. (12 March 2015), 'Fallo histórico en Arica reconoce uso cultural de la hoja de coca en Chile', *El Morro Cotudo*, <http://www.elmorrocotudo.cl/noticia/sociedad/fallo-historico-en-arica-reconoce-uso-cultural-de-la-hoja-de-coca-en-chile>
 73. World Health Organisation (2006), *Assessment of khat (Catha edulis Forsk.)*, WHO Expert Committee on Drug Dependence, 34th ECDD 2006/4.4, http://www.who.int/medicines/areas/quality_safety/4.4KhatCritReview.pdf; Advisory Council on the Misuse of Drugs (2005), *Khat (Qat): Assessment of risk to the individual and communities in the UK*; Fitzgerald, J. (2009), *Khat: A literature review* (Melbourne: Louise Lawrence Pty Ltd), http://www.ceh.org.au/downloads/Khat_Report_FINAL.pdf; Pennings, E.J.M., Opperhuizen A. & Van Amsterdam, J.G.C. (2008), 'Risk assessment of khat use in the Netherlands. A review based on adverse health effects, prevalence, criminal involvement and public order', *Regulatory Toxicology and Pharmacology*, **52**: 199–207
 74. Klein, A., Metaal, P. & Jelsma, M. (2012), *Chewing over khat prohibition: The globalisation of control and regulation of an ancient stimulant* (Amsterdam: Transnational Institute), <https://www.tni.org/files/download/dlr17.pdf>
 75. Advisory Council on the Misuse of Drugs (January 2013), *Khat report 2013*, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144120/report-2013.pdf
 76. Global Drug Policy Observatory (January 2014), *The UK khat ban: Likely adverse consequences*, <https://dl.dropboxusercontent.com/u/64663568/library/GDPO-situation-analysis-khat.pdf>
 77. The Guardian (26 June 2015), *How Britain's khat ban devastated an entire Kenyan town*, <http://www.theguardian.com/world/2015/jun/26/khat-uk-ban-kenyan-farmers-poverty>; Anastasio, M. (21 May 2014), 'The knock-on effect: UK khat ban and its implications for Kenya', *Talking Drugs*, <http://www.talkingdrugs.org/the-knock-on-effect-uk-khat-ban-and-its-implications-for-kenya>
 78. Department of Justice Canada (2007), *Controlled Drugs and Substance Act*, <http://laws-lois.justice.gc.ca/eng/acts/C-38.8/>
 79. Tupper, K.W. (2011), 'Ayahuasca in Canada: cultural phenomenon and policy issue'. In: Labate, B.C. & Jungaberle, H., eds, *The internationalization of ayahuasca* (Zurich: Lit Verlag)
 80. See: <http://www.enaco.com.pe/>
 81. Declaración Patrimonio Cultural de la nación a los conocimientos y usos tradicionales del Ayahuasca practicados por comunidades nativas amazónicas, Resolución Directoral Nacional, N° 836/INC. Lima, 24 June 2008, <http://www.bialabate.net/news/peru-declara-la-ayahuasca-patrimonio-cultural>; see also: Sanchez, C. & Bouso, J.C. (December 2015), *Ayahuasca: From the Amazon to the Global Village* (International Center for Ethnobotanical Education, Research & Service & Transnational Institute), <http://news.iceers.org/2015/12/ayahuasca-from-the-amazon-to-the-global-village-new-iceers-tni-report/>
 82. See: Sentencia C-882/11, Reforma constitucional introducida al artículo 49 de la constitución política – No requería la realización de consulta previa a las comunidades indígenas, <http://www.cor-teconstitucional.gov.co/relatoria/2011/C-882-11.htm>
 83. Abduca, R. & Metaal, P. (June 2013), *Working towards a legal coca market: The case of coca leaf chewing in Argentina* (Amsterdam: Transnational Institute), <https://dl.dropboxusercontent.com/u/64663568/library/TNI-Working-towards-a-legal-coca-market.pdf>
 84. Article 384: 'The State protects coca in its original and ancestral form as a cultural patrimony, a renewable biodiversity resource in Bolivia, and a social cohesion factor; in its natural state, it is not considered as a psychoactive substance. Its revalorisation, production, commercialisation and industrialisation will be governed by the law' (unofficial translation)
 85. See: <http://www.iceers.org/more-about-ayahuasca.php?lang=en#VfmdnBFVhBc> and <http://www.iceers.org/legal-defense.php?lang=en#VjeiX7fhCUJ>; see also: Sanchez, C. & Bouso, J.C. (December 2015), *Ayahuasca: From the Amazon to the Global Village* (International Center for Ethnobotanical Education, Research & Service & Transnational Institute), <http://news.iceers.org/2015/12/ayahuasca-from-the-amazon-to-the-global-village-new-iceers-tni-report/>

Glossary

Abstinence	State of refraining from using drugs.
Alternative livelihoods	Also known under the concepts of ‘development in a drugs environment’, development-oriented drug control’ or ‘food security’, alternative livelihoods programmes aim to promote equitable economic development in the rural areas where crops used in the production of internationally controlled substances are cultivated. The objective is to improve the overall quality of life in these rural areas.
Controlled substance	A psychoactive substance, the production, sale, possession and use of which is restricted to those authorised by the international drug control regime. This term is preferred to ‘illicit drug’ or ‘illicit substance’ as it is not the drug itself that is illicit, but its production, sale, possession or consumption in particular circumstances in a given jurisdiction. ‘Illicit drug market’, a more exact term, refers to the production, distribution, sale and use of any substance outside legally sanctioned channels.
Decriminalisation	<p>The decriminalisation of drug use refers to the removal of criminal penalties for drug use, and for the possession of drugs, possession of drug use equipment, as well as the cultivation and purchase of drugs for the purpose of personal consumption. Decriminalisation may involve the removal of all penalties. Alternatively, while civil or administrative (as opposed to criminal) penalties may be imposed following decriminalisation, they should be less punitive than those imposed under criminalisation, and lead to increased voluntary access to evidence- and human rights-based harm reduction, health and social services.</p> <p>Under <i>de jure</i> decriminalisation, criminal penalties for selected activities are formally removed through legal reforms.</p> <p>Under <i>de facto</i> decriminalisation, the selected activity remains a criminal offence but, in practice, the criminal penalties are not applied.</p>
Demand reduction	A general term used to describe policies or programmes directed at reducing the demand for internationally controlled substances. It particularly refers to prevention, educational, treatment and rehabilitation strategies, as opposed to law enforcement strategies that aim to interdict the production and distribution of drugs.
Depenalisation	Depenalisation is the reduction in severity of penalties for a criminal offence. Depenalisation may involve reducing the maximum and/or minimum lengths of sentences, or amounts of fines, for certain drug offences, or replacing imprisonment with alternative sentencing options for minor offences.
Diversion / alternatives to incarceration	Diversion refers to measures that provide alternatives to criminal sanctions or incarceration for people who are arrested for minor, non-violent drug offences. Diversion measures can be implemented through policies, programmes and practices that aim to refer people to social and health interventions such as harm reduction and drug dependence treatment, rather than subject them to criminal justice processes involving arrest, detention, prosecution, judicial sentencing and imprisonment. Diversion measures can be conducted by police (before or after arrest), prosecutors, or judges (prior to, at the time of, or after sentencing).
Drug control/drug policy	The regulation, by a system of laws and agencies, of the production, distribution, sale and use of specific controlled substances locally, nationally or internationally.

Drug dependence	<p>Drug dependence remains a contested concept. The World Health Organisation defines it as a ‘chronic, relapsing medical condition with a physiological and genetic basis’. However, some drug user activists have rejected terms describing drug dependence as a medical condition as this approach seems to define drug use as an illness – whereas the UN reports that only about 10% of those who use drugs have problems related to their drug use. This is often referred to as ‘pathologising’ drug use. Policy makers and practitioners interacting with groups and networks of people who use drugs should be aware that some activists may be uncomfortable with language or models that promote such a definition.</p> <p>For the purposes of this Guide, drug dependence refers to a range of behaviours that include a strong desire to use drugs, the difficulty in controlling consumption, and the continued use of the substance despite physical, mental and social problems associated with drug use. It is often characterised by increased tolerance over time, and withdrawal symptoms if substance use is abruptly stopped.</p>
Drug dependence treatment	<p>Drug dependence treatment describes a range of interventions – both medical and psychosocial – that support people who have a problem with their drug use to stabilise or recover control over their consumption, or seek abstinence. The complexity of drug dependence is such that the response, setting and intensity of treatment need to be tailored to each person. A comprehensive menu of services should therefore be made available to suit the differing characteristics, needs, preferences and circumstances of each person wishing to access treatment. The objective of treatment is to enable an individual to live a healthy and socially constructive lifestyle.</p>
Drug testing	<p>The analysis of body fluids (such as blood, urine or saliva), hair or other tissue for the presence of one or more psychoactive substances. Drug testing is employed to monitor abstinence from drug use in individuals pursuing drug rehabilitation programmes, to monitor surreptitious drug use among patients on maintenance therapy, and where employment is conditional on abstinence from such substances. Drug testing is not an effective method to deter drug use and has led to a number of negative consequences, such as users moving to more harmful substances to avoid detection.</p>
Drug use	<p>Self-administration of a psychoactive substance.</p>
Harm reduction	<p>Policies, programmes and practices that seek to reduce physical, psychological and social problems associated with drug use without necessarily stopping that use. Some people are unable or unwilling to cease their drug use, yet still require healthcare and other interventions to optimise their health and well-being. Harm reduction is, consequently, a pragmatic set of responses directed toward these objectives, rather than an ideology that seeks to stop drug use as its fundamental priority. The best known harm reductions interventions are Needle and Syringe Exchange (NSPs), Opioid Substitution Therapy (OST), Drug Consumption Rooms, etc., measures which embody a pragmatic approach toward the reality of drug use.</p>
Heroin-assisted treatment	<p>Heroin-assisted treatment (HAT) is a therapeutic option that has been added to the range of OST in a growing number of countries in the past two decades, as its evidence base has grown more extensive and secure. It involves the provision of diamorphine to patients, usually those who have not gained benefit from more traditional OST employing methadone or buprenorphine. Diamorphine doses are given under clinical supervision in a safe and clean medical setting, and the medication elements are combined with intensive psychosocial support mechanisms. HAT is currently provided with positive outcomes in Switzerland, Germany, the UK, Denmark, Spain, Canada and the Netherlands.</p>

Injecting drug use	<p>Injectations may be intramuscular (into a muscle), subcutaneous (under the skin), intravenous (into a vein), etc.</p>
Legal regulation	<p>Legal regulation refers to a model whereby the cultivation, manufacture, transportation and sale of selected drugs are governed by a legal regulatory regime. This regime can include regulations on price, potency, packaging, production, transit, availability, marketing and/or use – all of which are enforced by state agencies.</p>
Legalisation	<p>Legalisation is a process by which all drug-related behaviours (use, possession, cultivation, production, trade, etc.) become legal activities. Within this process, governments may choose to adopt administrative laws and policies to regulate drug production, distribution and use, limiting availability and access – this process is known as ‘legal regulation’.</p>
New psychoactive substance	<p>Also known as ‘legal high’ – a substance with psychoactive properties (capable of altering mood and/or perception), whose production, distribution, possession and consumption is not subject to international drug control.</p>
Proportionality of sentencing	<p>Proportionality is an internationally recognised legal principle, applicable to a government’s response to activities that cause harm to others. It requires the severity of any punishment imposed to be measured in accordance with the harms caused by an offender’s actions, and the culpability and circumstances of the offender. International human rights, crime prevention and criminal justice instruments contribute to setting standards of proportionality. It represents the legislative equivalent of the popular belief that ‘the punishment should fit the crime’.</p>
Recidivism	<p>The tendency to repeat an offence and/or to keep on returning to prison.</p>
Recovery	<p>Recovery encompasses any positive step or change that leads to the improvement of a person’s health, well-being and overall quality of life. It should therefore not be limited to, understood solely as, abstinence from drug use. Recovery is incremental, and it is up to each individual to decide what their goal towards recovery will be (e.g. controlled usage of substances, substitution therapy, etc.).</p>
Rehabilitation	<p>The process by which an individual dependent on drugs achieves an optimal state of health, psychological functioning and social well-being. Rehabilitation follows the initial phase of treatment (which may involve detoxification, medical and psychiatric treatment). It encompasses a variety of approaches, including group therapy, specific behaviour therapies to prevent relapse, involvement with a mutual help group, residence in a therapeutic community or halfway house, vocational training, and work experience. It can also include long-term OST.</p>
Scheduling	<p>The international drug control system assigns drugs to a particular set of controls termed ‘schedules’. The objective is to place a given drug within an appropriate set of controls according to its level of harms and medical utility. The act or process of assigning the ‘narcotic’ or ‘psychotropic’ substances (as the treaties describe them) to its place within the control regime is known as ‘scheduling’. The more dangerous the drug, the tighter the controls – at least in theory. The WHO recommends on what the appropriate schedule is (if any), while the CND makes the final decision. WHO recommends on scientific and medical grounds, while CND takes into account social, economic and other factors. National legal systems include systems of classification based on the international one, sometimes using alternative terminology to represent their schedules.</p>

Supply reduction

Policies or programmes aiming to reduce and eventually eliminate the production and distribution of drugs. Historically, the international drug control system has been focused on supply-side strategies based on crop eradication, interdiction by law enforcement, etc. Evidence demonstrates that these strategies have been unsuccessful in curbing the global drug market. Some countries have now turned to an approach based on alternative livelihoods.

UN drug conventions/ treaties

International treaties concerned with the control of production, distribution, possession and use of psychoactive drugs. The first international treaty dealing with controlled substances was the Hague Convention of 1912: its provisions and those of succeeding agreements were consolidated in the 1961 Single Convention on Narcotic Drugs (amended by a 1972 protocol). To this have been added the 1971 UN Convention on Psychotropic Substances and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Funded, in part, by Open Society Foundations and the Robert Carr Fund



The IDPC Drug Policy Guide brings together global evidence, best practice and experiences to provide expert analysis across the spectrum of drug policy (including public health, criminal justice and development). In each chapter, IDPC offers recommendations and further reading in an effort to promote effective, balanced and humane drug policies at the national, regional and international levels.

The International Drug Policy Consortium (IDPC) is a global network of NGOs that promotes objective and open debate on the effectiveness,

direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harms. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates. IDPC offers specialist advice through the dissemination of written materials, presentations at conferences, meetings with key policy makers and study tours. IDPC also provides capacity building and advocacy training for civil society organisations.

Report design by Mathew Birch
email: mathew@mathewbirch.com

Cover artwork by Rudy Tun-Sánchez
email: rudo.tun@gmail.com

© International Drug Policy Consortium Publication 2016

Tel: +44 (0) 20 7324 2974
Fax: +44 (0) 20 7324 2977
Email: contact@idpc.net
Website: www.idpc.net