South East Europe Drug Policy Network Meeting

The international drug control structures, the UN drug control conventions and drug policy in Austria

9th – 10th March 2012, Vienna, Austria

On Friday 9th and Saturday 10th March 2012, the South East Europe Drug Policy Network (SEE Network) held its annual meeting in Vienna, Austria. The programme of the meeting focused on the international drug control structures and the UN drug control conventions, the Austrian drug policy with special reference to young people who use drugs, and the work plan of the SEE Network for the coming year.

On Friday 9th, the participants met with the Austrian Federal Drug Coordinator to discuss the Austrian drug policy, and visited the Association Dialog, an NGO providing services to people who use drugs, people dependent on drugs, their relatives and families in Vienna. Special attention was given to the provision of drug dependence treatment among young people. The same day, the SEE Network met with representatives from the United Nations Office on Drugs and Crime (UNODC) working on South East Europe and the Civil Society Unit, followed by a visit of the Vienna International Centre where several UN bodies (including the UNODC) have established their headquarters. On Saturday 10th, Martin Jelsma, the Drugs and Democracy Programme Coordinator of the Transnational Institute made a presentation on the UN drug control conventions. The last session of this meeting consisted in a discussion about the future activities of the SEE Network.

1. An overview of the Austrian drug policy

Presentation from Dr. Franz Pietsch, Austrian Federal Drug Coordinator

1.1 Drug use and drug-related harms

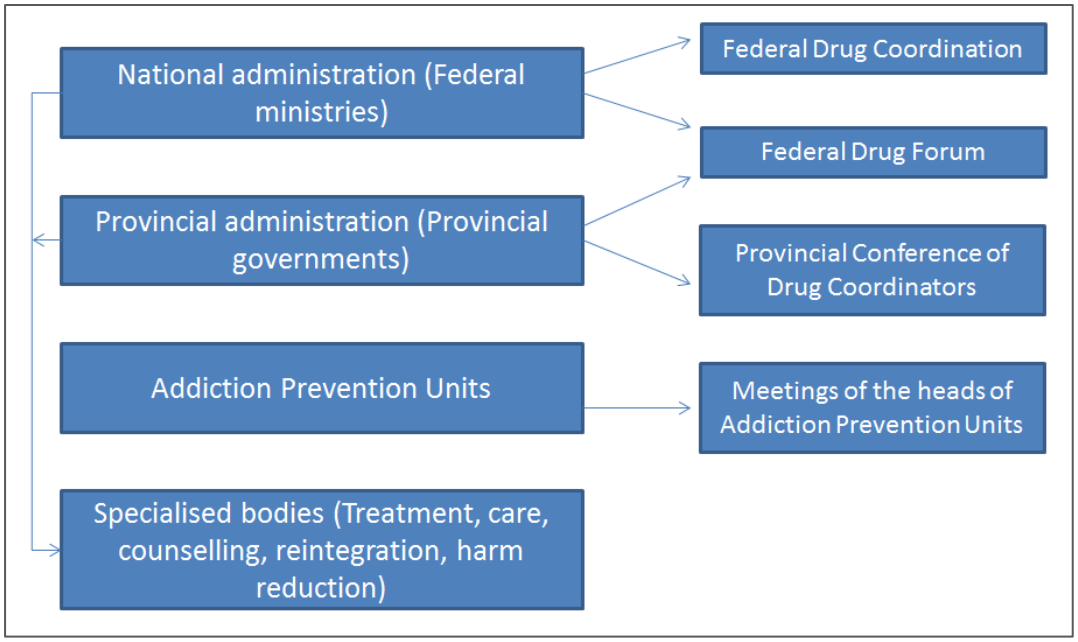
Cannabis is a major problem in Austria. 50 to 60% of Austrians reported having used cannabis at least once in their lifetime. This prevalence is at 30 to 40% among young people. Amphetamine use is currently increasing.

Today, as in other parts of Europe, legal highs have started to pose important problems in Austria. The government adopted new regulations and organised these substances in groups of substances.

The objective is not to criminalise users but to regulate the consumption of these substances through the control of distribution channels.

Up to 36% of people who use drugs are infected with hepatitis B virus, and between 38 and 73% of them live with hepatitis C. On the contrary, Austria reports a low HIV prevalence among people who use drugs – 0 to 5%.

1.2 Structure and organisation of the Austrian drug policy



The Austrian Federal Drug Coordination – The Austrian Federal Drug Coordination (FDC) was established by a decision of the Council of Ministers in 1997. It has exclusive federal competences and tasks are centralised within Federal authorities. Dr. Pietsch is the chair of the FDC.

The FDC has special competences in two core Ministries, the Ministry of Interior and the Ministry of Justice, but also in other ministries, including the Ministry of Education and the Ministry of Foreign Affairs.

The FDC is tasked with the preparation of all ministerial work and it ensures adequate and coherent Austrian representation in Federal and international bodies. The FDC also coordinates the work of Federal provinces and the exchange of information between Federal province authorities and between the authorities and NGOs working in the field. Close cooperation with NGOs and all other stakeholders involved in the field is crucial for the work of the FDC. Finally, the FDC is responsible for media and public relations.

The Austrian Federal Drug Forum – The Forum was established to fulfil the coordination tasks at the Federal and provincial level. IT is composed of the Chair of the FDC, other involved ministries, the drugs coordinators of the 9 Austrian provinces, and experts from the field (including scientists, field workers and NGOs).

The Forum constitutes an advisory board to the FDC. It is tasked with tackling questions related to drug policy, promoting cooperation in the field of drug prevention, exchanging information and drafting recommendations.

The Provincial administration – The Provincial administration is composed of provincial government. A large amount of money is coming from the provinces and it is therefore important that provinces have a say in the Federal drug policy. However, decisions are taken at the Federal level.

Committee on Quality and Safety for Substitution Treatment – In December 2006, a Committee on Quality and Safety for Substitution Treatment was established to advise the Ministry of Health on substitution issues on the basis of the revised Narcotic Substance Decree 2009. Substitution treatment is one of the key aspects of the Austrian drug policy, and the government was asked to take a better position on the prevention of abuse of medication used for substitution treatment. The amendment to the Narcotic Substance Decree in 2009 aimed to optimise the coordination between the Federal and Provincial levels of government. The Committee is chaired by a scientist to give space to scientific evidence rather than politics (this is why this committee is not chaired by the Federal Drug Coordinator).

Two additional types of bodies intervene in the Austrian drug policy – Addiction Prevention Units and Specialised Bodies (see graph on p. 2).

1.3 The international and national legal framework

At the international level – Austria is a signatory party to the three UN drug conventions – the 1961 UN Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

During the UNGASS special meeting in 1998, governments reiterated the need to make efforts to strengthen services to people who use drugs and toughen measures to combat drug trafficking. The 2009 Political Declaration and Action Plan adopted in 2009 did not have a specific reference to harm reduction as the term was highly controversial. However, those working in the field do know that harm reduction is indeed necessary.

At the national level – Drug policy is the exclusive competence of the Federal government, although decisions are taken in consultation with the Provinces.

In 2008, the Narcotics Substance Act was amended to allow for the use of cannabis for medical purposes, and establish a data registry on narcotic drugs. From then on, every person who uses drugs is registered in Austria when accessing drug dependence treatment services, or when they are reported by a court or the police. Although most of the information is confidential, the drug using status of the person can be given to certain entities, such as the military.

In 2010, the Substance Decree was adopted to provide training standards for physicians. This decree was adopted after controversial discussions on the fact that doctors needed more training to ensure that substitution drugs were not diverted to illicit use.

1.4 Substitution treatment in Austria

Drug dependence in Austria is considered as a disease and should therefore be tackled through treatment rather than punishment. The most commonly used substitution drugs are morphine and buprenorphine.

For 2 ½ years, a working group worked on the issue of substitution treatment. In March 2007, the results were released and led to the adoption of the following framework:

- Restrictions were established on the right to dispense substitution drugs
- Public health officers' position was strengthened
- Maintenance treatment is supervised through an online system so that information is available for each person undergoing treatment to avoid that individuals ask several general practitioners for substitution treatment.

An evaluation report was released in 2009 on the effects of the amendment and led to further amendments. The report found that:

- The substance of choice remains slow released substitution (in 67% of cases)
- The additional training for general practitioners had to be shortened. There is still a special education for those who take care of clients in treatment facilities, but others have a shorter training.
- General practitioners will now report to the authorities on the provision of substitution drugs.
- Public access to the registrar of substitution practitioners is now restricted.

1.5 Remaining challenges

In Austria, drug use or possession of drugs for personal use remains criminalised. One exception to the rule is cannabis – when a person is caught for cannabis smoking for the first time, the trial is closed automatically. The level of penalty (fine or prison sentence) does not depend on the types of drugs seized but on quantities seized. As a result, a large proportion of the prison population in Austria is composed of people who use drugs. In the Metz prison, for example, 60% of the population is imprisoned for drug use. In addition, up to 40% of those people that had never taken drugs before going to prison start using drugs while being incarcerated. From a health point of view, the criminalisation of people who use drugs is not effective. However, decriminalisation remains controversial in Austria. In addition, decriminalisation would involve a change in the country's constitution.

Remaining challenges are the need for improving networking and the exchange of information on drugs issues, cooperation and the development of regional and local solutions, and improving the involvement of NGOs.

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2. The UNODC Civil Society Unit and the UNODC regional unit for Eastern and South Eastern Europe

The meeting involved the representatives of the SEE Network, the UNODC Civil Society Team, the UNODC Regional Desk for East and South East Europe, the UNODC HIV/AIDS Section covering Eastern Europe, Central Asia and South East Europe, and the UNODC Prevention, Treatment and Rehabilitation Team.

The meeting started with a welcome speech by the head of the Civil Society Unit, Mrs. Mirella Dummar Frahi, who helped to organise the meeting at the UNODC. This was followed by a short introduction of the participants and a presentation of the SEE Network, its composition, its aims and objectives. Thanasis Apostolou thanked the Civil Society Unit and in particular Ms. Amanda Kratochvil for their support and expressed his appreciation for the presence of the UNODC representatives at the meeting. He explained that a few members of the SEE Network would participate in the 55th Session of the Commission on Narcotic Drugs (CND), which would take place between 12th and 16th March 2012. This would give them an opportunity to learn more about the functioning of the international drug control framework and the CND in the field of civil society involvement (both in terms of support and funding) and on themes related to harm reduction.

2.1 The UNODC presence in South East Europe

The UNODC representatives explained that they highly valued the work of civil society, this would be shown in more detail during the CND. What is now necessary is to look at how interactions can be increased at the country level between civil society organisations and UNODC.

Ms. Ekaterina Kolykhalova Executive Officer at the Office of the Director General/Office of the Executive Director, explained that UNODC has a small presence in South East Europe. Its headquarters were in Bulgaria, but operations have recently been moved and managed from Vienna, Austria. The UNODC now has an office in Serbia, Albania and the Former Yugoslav Republic of Macedonia (FYR-Macedonia). In South East Europe, UNODC is active in the fields of drug prevention, treatment and rehabilitation and HIV prevention, primarily in Serbia, Albania and Montenegro. More specifically, in Albania and Serbia, the UNODC is implementing key drug dependence treatment programmes in collaboration with the World Health Organisation. In the FYR-Macedonia, the UNODC works to increase availability and coverage of HIV prevention, treatment and care. In Bosnia-Herzegovina, the UNODC had initiated a project on drug law enforcement, but it terminated. For 2012-2015, the UNODC is developing a work plan to become more active in Albania, Bosnia-Herzegovina, the FYR-Macedonia, Montenegro and Serbia. The work plan will be finalised in the coming months.

Ms. Elizabeth Saenz, Project Coordinator of the Prevention, Treatment and Rehabilitation Unit, and Ms. Zhannat Kosmukhamedova, Expert HIV/AIDS Section, referred to the work of their units and pointed out that NGOs based in countries where the UNODC has a presence were encouraged to contact the UNODC country offices in order to identify areas of collaboration. At times, the UNODC also subcontracts work to NGOs for specific projects or for the promotion of campaigns. For example, the UNODC involved the Eurasian Harm Reduction Network (UNODC) in a project on HIV prevention work in prisons. EHRN was responsible for convening a technical working group to discuss and develop activities on the issue. In Serbia, the UNODC developed an evidence-based

drug prevention programme focusing on family skills building, and provided some funding for NGO participation in the programme. These projects do not always involve funding but mainly collaborative work. Indeed, the UNODC is not a financial organisation and therefore does not provide funds to governments or NGOs. It rather provides technical assistance to member states and sometimes implements programmes directly at country level, or involve external expertise. In that particular case, the UNODC can offer small grants to institutions and civil society organisations for specific projects.

2.2 UNODC, national governments and civil society in South East Europe

Several members of the SEE Network raised concerns about the visibility of UNODC's work in their own countries and the impact the UNODC's work had on national government policy. It was felt that the UNODC should involve national government officials more in its work, and that it should engage in stronger partnership with NGOs. In response to these concerns, UNDOC explained that they constantly sought to work in collaboration with national governments. It is the case, for example, for the drug dependence treatment programmes that were developed in Albania and Serbia. However, the UNODC needs to receive a formal request from a country to initiate a project, and it needs financial resources. In addition, although the UNODC welcomes the participation of NGOs, UNODC representatives made it clear that it was up to government officials to decide the level of involvement that NGOs should have in each country.

2.3 The HIV situation and harm reduction in South East Europe

The representative from the Romanian Harm Reduction Network (RHRN) also raised concerns about the worrying HIV situation in the country and the fact that the UNODC shut down a very successful programme it was implementing. The UNODC responded by explaining that it was also concerned about the situation, not only in Romania, but also in the Russian Federation and three additional Balkan countries and that it would seek to address the situation. Regarding the similar trends occurring in Greece, the UNODC HIV/AIDS Section covering Eastern Europe, Central Asia and South East Europe does not have a mandate to intervene in the country as it is part of the mandate of the European Union team of UNODC. However, an umbrella organisation will be created so that the two teams can collaborate on the HIV issue.

The representative from Association Margina then turned to the issue of funding following the Global Fund budget cuts and the severe impact this can have on South East Europe in the field of harm reduction. Both representatives from Association Margina and the Romanian Harm Reduction Network enquired whether the UNODC would be willing to support advocacy actions on drug policy and harm reduction, developed by civil society organisations towards national governments. The UNODC did confirm that they already support harm reduction in the region. For instance, the Romanian example of provision of harm reduction services in prisons is promoted as an example of best practice in the region. However, until governments take over these projects and fund them with state budgets, the UNODC cannot intervene. What the UNODC can do is help governments restructure their work and priorities in a way that supports HIV prevention. The UNODC is not here to substitute national governments. Its role is to provide guidance and recommendations on human rights, health, law enforcement, etc. One way in which the UNODC has had an effective impact was through collaborative work with law enforcement agencies. In the Russian Federation, for example, the UNODC worked with street level police to encourage closer collaboration between the police

and harm reduction service providers so that people who use drugs could be referred to the services they need. The UNODC also provides HIV training for law enforcement agencies. However, there are major challenges remaining (i.e. some resistance from some individuals or groups to work with the UNODC on certain issues, barriers linked to language, etc.) to achieve a truly balanced approach in drug policy between demand and supply reduction.

An HIV coordinator will soon be taking office in the UNODC office in Serbia. This person will be responsible for all of the countries in the region and it is hoped that this new position will be able to respond to at least some of the major concerns expressed during the meeting.

The meeting was concluded with a description of the various events that would be taking place at the CND the following week and that would be of interest for SEE Network participants.

3. Visiting the Vienna International Centre

The Vienna International Centre (VIC) is the building where the UN has established its offices in Vienna, Austria, in the 1970s. The headquarters of both the International Atomic Energy Agency (IAEA) and the UNODC are located in the VIC. The UN headquarters in Vienna focus on technical issues.

The VIC was designed by an Austrian Architect and was built between 1973 and 1979. The VIC was built as Y-shaped office towers of various sizes which offer a panoramic view to each employee as well as access to natural sunlight. The VIC is also the safest building Austria, being both bullet but also explosion proof. The building also offers a special room with increased security for VIP guests. The VIC is also one of the largest buildings in Europe, being able to accommodate 3,000 individuals at all times. The VIC hosts an average of 2,000 conferences per year. The Austrian Centre, which can be accessed from the VIC through a catwalk, provides an additional venue to hold conferences if necessary. This is now rarely used as a new hall was built in the VIC.

4,500 individuals work at the VIC, and an additional 1,500 work there 'indirectly', in banks, travel agencies, medical centres, language schools, post office, etc. A third of all employees are Austrian. The VIC therefore provides an important financial resource for the Austrian government in terms of employment and 'business tourism' (hotels, restaurants, etc.).

The VIC's conference rooms are used for a number of events, including the CND. The walls of the rooms are movable so as to adapt to the number of participants at each event. The UN has six official languages (English, Spanish, French, Russian, Chinese and Arabic), and the CND is translated simultaneously into each of these languages. Interpreters are only allowed to work three hours a day to ensure that they are efficient and do not make any 'interpretation' mistakes as those can have a considerable impact at UN meetings. The script of each meeting is also made available within 24 hours so as to correct any potential mistakes made during translation.

The UN works with over 1,000 NGOs which have observatory status (but do not have the right to vote).

The UNODC focuses on organised crime, corruption, human trafficking and slavery, money laundering, justice and prison reform, and terrorism prevention. The organisation focuses on traditional drugs such as cocaine, coca, cannabis and opium. It also supports alternative development programmes. In Europe, the UNODC is starting to work on new drugs. It has a research laboratory in Vienna to detect the ingredients used in new substances.

SEE Network participants also had the opportunity to learn more about:

- The IAEA: the IAEA focuses on electricity, weapons and medicines, that is, any peaceful use of atomic energy. The IAE is the oldest and biggest UN organisation, created in 1951, including 153 member states, and 2,000 staff members.
- The UN Industrial Development Organisation (UNIDO): it is also one of the oldest UN organisations, involving 700 staff members.
- The Preparatory Commission for the Comprehensive Nuclear-Test-Ban Treaty Organisation (CTBTO) includes 156 countries but the USA, China, Indonesia, Israel, Iran, Egypt, India, Pakistan and North Korea are not signatory parties to the treaty. The CTBTO is responsible for monitoring data on nuclear bombs, but the monitoring devise can also be used to monitor natural disasters such as tsunamis.
- The UN space programmes, including the moon rock.

4. Visiting the Association DIALOG

Presentation from Dr. Gerhard Rechberger, Medical doctor at ISG

4.1 Association Dialog's services

Dialog is a non-profit association founded in 1979 with the objective of providing free-of-charge, voluntary and confidential counselling care and treatment services for people who use drugs, people dependent on drugs and their relatives, in the City of Vienna. The organisation is funded by the Government of the City of Vienna (70% of its budget), the Ministry of Health, the Ministry of Family, the Ministry of Justice, and a company which works on drug prevention.

Dialog has adopted a non-ideological approach to drug dependence treatment and offers both abstinence-based and opioid substitution forms of treatment. The organisation also provides care and support based on the principle of harm reduction.

Dialog benefits from a multi-disciplinary professional team of 85 employees, including social workers, psychologists, general practitioners and psychiatrists (some specialised on children and teenagers).

Vienna has the highest number of people dependent on drugs in Austria, and therefore 60 to 80% of treatment services are available there. The target group of the organisation is people who use psychoactive drugs (this does not include alcohol), people who are dependent on drugs (mainly cocaine users, cannabis users, and a small group of people dependent on alcohol), relatives of people who use drugs, and people who are interested in drug dependence. This also includes sex workers who use drugs.

The services offered include individual psychosocial counselling, social work, clinical psychological diagnostic and treatment, coaching, psychotherapy, debt counselling, legal counselling and vocational training courses. Medical services are mainly based on residential substitution treatment, but it is possible to undergo out-patient detoxification, psychiatric treatment, medical counselling and treatment for co-occurring diseases. Indeed, drug dependence treatment usually establishes a stable therapeutic setting which can be used to identify co-morbidities. Dialog does not run NSPs as these services are provided by other entities (outreach workers, pharmacies providing free syringes in exchange for used ones). These NSP programmes are funded by the City of Vienna.

Four days a week, four hours a day, Dialog offers a special psychosocial counselling and care service for adults, and the same service is available for teenagers for three days a week, three hours a day.

Dialog runs four treatment centres in Vienna, each of which have a focus on specific services – training courses, treatment of people dependent on cocaine, services in detention centres for people with drug dependence and psychiatric disorders, and young people.

The out-patient treatment centre of Dialog provides treatment, counselling and care for people who use drugs in the Southern districts of Vienna, as well as low-threshold psychological care. In Vienna, at the beginning of an OST programme, patients get long-term prescriptions (for 1 to 4 weeks). The patients have to be registered so that they do not receive medication from two different general practitioners. The substitution medication is taken under supervision in pharmacies every day. If the patient is stable, then he/she can take the medicines home for a few days. 20 to 25% of patients are under methadone, 25% are under buprenorphine, while the rest are under polamidone or morphine. In Dialog, most patients are under polamidone.

Usually, patients have to give one urine test before starting substitution treatment, and then undergo a urine test once a month although it depends on the stability of the patients, and whether they are socially integrated or not. Drug testing is not a priority for Dialog as the patients trust the organisation and tell the staff if they have used drugs or not.

Dialog believes that it is highly important to involve the relatives of the patient in the treatment. For many patients, their family is in crisis, some of their family members need counselling and care, some have psychiatric and drug use disorders. Families also need information about the diagnosis and treatment programme that their relative is involved in. Families can also motivate the patient to continue treatment.

4.2 Drug dependence treatment among young people

There is no minimum age for involving patients in OST. When it relates to young people, abstinence is one of the objectives of treatment. In general, when there is a short duration of drug dependence, an intensive form of abstinence-based treatment can enable the patient to become fully abstinent, while OST might lead to chronic dependence.

There are many young people in Vienna who start using drugs early on. Usually, they have suffered from bad relationships with their parents, have been exposed or have experienced, high levels of violence, have a member of their family who has drug use problems, psychiatric disorders or severe

somatic disorders. In that case, it will be hard for the young person to become abstinent and the objective will be to stabilise him/her.

There is an intensive assessment system when young people enter OST. Since young people talk little about themselves, additional information is provided by parents, the youth welfare when relevant, and other sources of information. They undergo two urine controls a week.

When the patient is very young, they are usually referred to a residence-based treatment. Before the age of 14, it is necessary to have the authorisation of the parents and to get them involved in the programme. This involvement is important for the success of the treatment. The age of parent authorisation is different in Bulgaria, for example, where parental consent is necessary for people younger than 16. This creates many problems in the country as many young users are street children who do not have parents or have no relation with them. As a result, young users do not have access to voluntary testing and counselling or treatment although they are frequently sharing syringes and are at high risk of HIV and hepatitis infection.

Usually, teenagers are not put on long-term morphine treatment as there are risks that they will sell morphine on the black market. Dialog prefers to offer slow-release morphine. The quality of life under morphine is much better than under other products, although it might be difficult to reduce the dosage if the person wishes to become abstinent. Suboxone is rarely used because of its side effects (burning sensation and cancelling contraception for women).

Young people under treatment are given very low doses at the start, about half of what is given to adults. Dialog staff members see young patients every day to assess the effects of the treatment, whether the doses need to be increased or decreased and whether the patients is suffering any side effects.

There is a very high overdose risk among young people. Between 2004 and 2009, 17 to 40% of drug-related deaths among people aged 15 to 19 were related to overdose. This is mainly due to a combination of high-risk drug use and impulsivity, lack of knowledge about the substances they consume, and a low tolerance for these substances.

When providing care for young people, it is necessary to follow up with them if they miss their treatment to avoid any risky behaviours. It is also very important to provide gender-sensitive care in order to tackle any trauma, and to develop a healthy sexual identity. The counselling and care should also be flexible, much of the counselling is done in the waiting areas, when clients go for a walk or over the phone.

4.3 Dialog's clients

Dialog welcomes 4,801 people who use drugs, 585 relatives and 198 young people.

The older groups of users had an onset age of 17 to 23 for drug use, with a seven year time between start of use of cannabis and start of use of heroin. For the younger generations, the time of consumption for cannabis and switch to heroin is only two years. The patterns of consumption change rapidly among young people.

The clients at Dialog constitute a heterogeneous group. Some are users with a poly-toxic pattern, some are opiate users experiencing social relationships and are more likely to become abstinent, some have psychiatric disorders and use drugs as self-medication, some have multiple-substance dependence. This last group constitutes the majority of clients at Dialog. They never use the same substances for a long period of time and change substances frequently. Usually, it is difficult to detect dependence to one particular substance, but the user cannot live without taking any drug. These users are much more at risk of overdose.

With the appearance of legal highs, Dialog has seen the appearance of more severe effects on the health of people who use drugs, including sleeplessness, psychotic disorders, pains, and massive craving after two or three weeks of use. There is also a rapid increase in the dosage and frequency they use and therefore higher rates of injection for those that inject them. Some heroin users have switched to using legal highs, and when they see the consequences these have on their health, they switch back to opioids.

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5. The future of the international drug conventions

Presentation by Martin Jelsma, Transnational Institute (TNI)

We have recently started paying more attention to the analysis of the three UN drug conventions – the 1961 UN Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Drugs and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Indeed, this year we are commemorating 100 years of the international drug control system, and it is an opportunity to look back and look at how the system developed.

The 1961 Single Convention, adopted 50 years ago, constitutes the core of the current UN drug control system. Two papers were drafted by IDPC and TNI – *The UN drug control conventions: The limits of latitude* and *Towards revision of the UN drug control conventions: The logic and dilemmas of like-minded groups* (both available on the IDPC website: www.idpc.net). The papers analyse what is legally allowed under the drug conventions, existing tensions, policy developments that would require questioning the conventions, and what possibilities would be available to reform the conventions.

5.1 History of the UN drug control regime

When it was first developed 100 years ago, the main concern for the drug control system was opium. At the time, a range of medicines based on opium was circulated through an uncontrolled free market. There was therefore no illegal production – all of the opium produced was used for medical, traditional and recreational purposes. Coca was produced and consumed the same way.

The first Opium Convention adopted in 1912 sought to limit the international trade of these products. There was no intent to criminalise the use of opium, but instead to start regulating the opium market and put controls in place internationally. The system developed next with the 1925 Geneva

Convention, when cannabis was included in the international treaty mechanism. At the time, the system included three main plants, coca, opium and cannabis, as well as all of the products that derived from these plants. The objective was to limit the market to medical uses. In terms of regulation at the national level, drug control was left for countries to decide.

The next major change in the international drug control system was the adoption of the 1961 Single Convention, the first drug convention adopted after World War II within the UN system, which replaced all other conventions. The 1961 Convention expanded controls to the domestic sphere for the production, cultivation and consumption of controlled drugs.

The 1961 Convention came about with the realisation that if the non-medical use of controlled drugs was to be controlled, it was necessary to cut down the production itself. Limiting the international trade only was then considered insufficient to bring down the scale of the market. It was also necessary to end the widespread legal markets of traditional use in all drug producing countries. The burden was therefore placed on those producing countries to abolish the huge markets of products in their natural form that were controlled under the 1961 Convention. In order to facilitate the process, an exemption was established under the convention, with a period of 15 years of cannabis and of 25 years for the coca leaf to achieve full eradication of these markets.

Ten years later, the next step in the development of the international drug control system was the adoption of the 1971 Convention. This convention has an odd history and it takes some thinking to understand what truly happened in 1971. The origins of the convention came from the realisation that there were much more drugs in the market than the ones that had been included in the 1961 Convention. In the 1960s, psychedelics, mushrooms and amphetamines became more popular and had, to some extent, similar properties to opium, coca and cannabis. The logic would have been to include them in a similar drug control system. Negotiations started to add these drugs into the schedules that had been established with the 1961 Convention. However, the big difference this time was that the majority of these drugs were produced in developed countries. These countries and industries did not wish that these drugs be placed under the strict rules of control of the 1961 Convention. This led to the decision of creating a separate international instrument. Negotiators had to go as far as to create category for these new substances, “psychotropic drugs”, in order to justify the drafting of the new convention. In terms of control, the 1971 Convention creates a very strict level of control for a small group of substances which is similar to that created by the 1961 Convention, but most substances are put under a much lighter level of control.

With these two conventions, the objective was to avoid the diversion of controlled drugs to non-medical purposes. In fact, during those decades, a large increase in illicit production was observed, which the system was not able to stop. This led to the adoption of a third convention in 1988 to oblige countries to establish as criminal offences a range of activities around the production, trading and possession of controlled drugs. This is the convention that went furthest in interfering in the domestic sphere to harmonise the strict rules of criminalisation.

5.2 The war on drugs, de-escalation and cracks in the consensus

This third treaty marks the beginning of the “war on drugs”. In the 1980s, the military started to get involved in drug control in Latin America. The United States (USA) introduced a certification mechanism, according to which it would cut off funds and impose sanctions on any country that

would not collaborate sufficiently in its war on drugs. The exemptions to cannabis and coca set up in the 1961 Convention also came to an end (respectively in 1979 and 1989).

The consequences of the war on drugs started to be visible and documented. These included human rights violations, the spraying of chemicals in Colombia, an increase in poverty with opium bans being established in Afghanistan and Burma, etc. The escalation in the 1980s and 1990s also led to insufficient availability of essential medicines for medical and scientific use, which the conventions had been set to ensure. This led to dramatic and sometimes absurd situations, such as in Afghanistan, which produces 92% of the world opium production, but where hospitals do not have access to morphine for patients.

At the same time, we have started to witness a “de-escalation” process in Europe, with the development of harm reduction programmes. The expansion of the HIV epidemic was one of the factors that led to de-escalation, along with increasing concerns about the other negative consequences of the war on drugs. As a result, countries started to decriminalise the possession of controlled drugs for personal use in order to decrease the rate of HIV infections, as well as the number of people being incarcerated for possession of small amounts of drugs. Globally, the amount of people incarcerated had doubled and even tripled within a 15 to 20 year period, and the driving force behind this mass incarceration was the war on drugs.

Today, we witness some cracks in the consensus that has been in place for decades – the “de-escalation” has gone too far and we are now at a breaking point where many acknowledge the negative consequences linked with the implementation of the conventions. Attempts to repair the damage caused by this implementation are reaching the limits of legality. The first real challenge to the conventions themselves has now taken place, with a number of countries turning to the legal regulation of cannabis, and with Bolivia now challenging the international control on coca. As a result, Bolivia has now withdrawn from the 1961 Convention and is planning on re-acceding it with a reservation on coca use in its traditional form. This was a way for Bolivia to respond to tensions between its obligations under the drug control conventions and its obligations under the 2007 United Nations Declaration on the Rights of Indigenous Peoples. The major difficulty is that there is no clear mechanism at the UN level that would enable member states to negotiate and balance these types of inconsistencies. The matter goes back instead to the INB, which monitors the compliance of countries to drug convention obligations. The issue with this is that the INCB only looks at the drug conventions and does not take a wider view on additional international obligations focusing, for example, on human rights.

5.3 Access to essential medicines for pain relief

In 1961, the USA put a lot of pressure on the UN so that only a few countries would be able to keep producing controlled substances for medical use. Originally, seven countries could grow opium. The argument was that other countries would only be able to import opium from these traditional producers. However, no agreement was found on the issue. It was finally agreed that every country would have the right to start producing controlled medicines for their own domestic market. If a country wishes to grow more than what is necessary for its domestic market, it needs to ask permission to the INCB. The INCB is the UN body responsible for collecting from each UN country the estimated amount of controlled drugs they require for medical purposes. The INCB keeps track of the amounts produced and stocks that countries have in place.

Australia, Spain and France are major producers for legal use. The FYR-Macedonia, the UK and the Netherlands are also producers of controlled drugs for legal purposes. Afghanistan, however, is not. It would have been a logical step for the country to produce opium, at least for its domestic medical use. However, they fear pressure from the international community which might accuse the country of over-producing and loosening controls over opium production. The decision for Afghanistan not to produce opium for medical purposes is to keep their image of being strong against drugs, even if they have to sacrifice the availability of essential medicines for the local population.

5.4 New trends in drug consumption patterns

Many questions are being asked about the effectiveness of the current drug control system. The introduction of the conventions only led to the diversion of controlled substances from legal and pharmaceutical production into the illicit drug market. There is currently an increase in illicit production of pharmaceuticals, as well as a leakage of pharmaceutical substances into the illicit market. Some of the strong opiates that are being made for the licit production become very popular as their effects are similar to those of heroin. As such, when the quality of heroin tends to drop, users switch to these pharmaceutical drugs.

5.5 Conclusion

Understanding the international drug control framework is crucial for questioning national drug policies in our day-to-day work. It is necessary to fight against a system that is inefficient and harmful and discuss possibilities for change, and which strategy for drug policy reform. In certain countries, there is a structure that enables scientists to feed into the debate around drug policy, question the position of the INCB and the conventions and promote a human rights-based approach to drug policy. Germany, for instance, developed drug consumption rooms despite criticisms from the INCB. Power structures can therefore be challenged through such national-level (or local) policies.

For more information, please contact mjelsma@tni.org.

6. The South East Europe Network – Evaluation and next steps

6.1 Structure of the SEE Network

One SEE Network member raised an issue about miscommunication on the agreed points from the previous meeting of the SEE Network regarding the structure and way of functioning of the Network. Diogenis, which co-organised the previous meeting of the Network in Thessaloniki referred to the report of the meeting (available here: http://idpc.net/sites/default/files/library/idpc-report-see-network-meeting-thessaloniki-march-2011.pdf). The main decisions taken at the Thessaloniki meeting were as follows:

- The SEE Network will, for the moment, not be formalised and officially registered as a legal entity.
- The SEE Network will be led by Diogenis

- The SEE Network will have an advisory board composed of members of the Working Group and will act as the managing body of the Network. The members of the advisory board are: Andrej Kastelic (SEEAnet, Slovenia), Elena Yankova (Initiative for Health Foundation, Bulgaria), Genci Mucollari (Aksion Plus, Albania), Tijana Pavicevic (Juventas, Montenegro) and Thanasis Apostolou (Diogenis, Greece).
- The Vision, Mission and Policy Principles were agreed upon and were distributed to the members of the SEE Network members for comments before being finalised. The information is available on the Diogenis website: http://www.diogenis.info/index.php?menu_id=c59092ce-820c-11e0-822c-1c0ce76237ea&language=en

The documents will be sent around again with the report of this meeting.

Regarding the Advisory Board, it was decided in Vienna that the Board would not be composed of only five individuals, but of one representative from each country of the SEE Network (11 members). The Board will be responsible for the implementation of the work plan.

ACTION: Diogenis will follow up with the members of the SEE Network so that members nominate one person per country to be part of the Advisory Board.

ACTION: IDPC will design short Terms of Reference for the Advisory Board to the SEE Network members for their approval. These will include the following information:

- The Advisory Board will be composed of a representative from each country of the SEE Network.
- The Advisory Board will meet once a year.
- The Advisory Board will propose a yearly action plan to the rest of the Network.
- The Advisory Board will be responsible for the monitoring and implementation of agreed activities.
- The Advisory Board members will be responsible for the communication between the Board and the rest of the Network from their own country.
- The Advisory Board members will be required to consult with the SEE Network members from their own country before attending meetings.

6.2 Membership

The members of the SEE Network were asked to identify NGOs in their own country that would be interested in becoming members of the Network. One issue raised by this requirement was whether the Network should incorporate local NGOs which are part of national networks.

In Serbia, NGO Veza declared that they could ask a few local organisations as to whether they would be interested in becoming members of the Network, but also felt that they could create a national network that could then feed into the SEE Network. Association Prevent warned that there were only few NGOs working in the field of harm reduction in Serbia.

In Bulgaria, Dose of Love could be an interesting NGO for the SEE Network. The Initiative for Health Foundation will approach this organisation, as well as a movement of individuals working on

drug policy reform (including professionals, activists, journalists, harm reduction service providers, etc.).

In Romania, all of the NGOs that work in harm reduction are already part of the Romanian Harm Reduction Network.

6.3 Communication/information sharing

It was agreed that the SEE Network would continue to meet once a year, but that more communication was needed throughout the year.

A Google Group was created in December to ensure wide dissemination of information among the SEE Network. The name of the Google Group is: seendp@googlegroups.com. It seems that SEE Network Members have not all been subscribed to this Group.

ACTION: IDPC will check who is subscribed to the Group and may need to create a new Google Group to ensure that all are subscribed. We will be in touch with the SEE Network on this.

It was agreed in Vienna that a quarterly newsletter would be prepared by Diogenis, which members of the SEE Network would feed into, focusing on the following topics:

- Criminal justice
- Social and health programmes
- Human rights
- Events of interest

In order to make the process more efficient, the idea will be to focus on 3 countries every three months to ensure that the information provided is as comprehensive as possible.

ACTION: IDPC to suggest a model for the newsletter and a rolling mechanism for the countries for each newsletter for the year 2012-2013. Diogenis to start the newsletter process for a first newsletter to be created in May 2012. Each newsletter will be posted on the Diogenis website.

It was also agreed that each member of the SEE Network would create a link to the website of Diogenis on their own website to improve the visibility of the Network.

6.4 Publications

The members of the SEE Network were requested to propose themes for potential IDPC briefing papers for the year 2012-2013. Those that have been proposed so far include:

- New drug law in Greece – the factors that play a decisive role in terms of drug law reform
- The impact of budget cuts within the Global Fund in South East Europe
- Cannabis policy in Albania.

ACTION: SEE Network members should get in touch with the IDPC Secretariat (mnougier@idpc.net) if they wish IDPC to coordinate the drafting of briefing papers relevant to South East Europe.

6.5 Advocacy

It was felt that we needed to be more strategic about the organisation of advocacy work at the national level, with support from the SEE Network, IDPC and Diogenis. This could, for example, translate into the drafting of a letter as an advocacy tool, signed by other NGOs at the national, regional and/or international level to give more weight to an advocacy action conducted by one member of the SEE Network. It is also necessary to prioritise advocacy actions in order to be strategic and maximise impacts.

ACTIONS: The members of the SEE Network should think of which activities from the SEE Network could help support their advocacy actions at the national level.

6.6 Upcoming events of interest

17-19 May: 6th Regional Conference on HIV and AIDS in Sarajevo, Bosnia and Herzegovina, focusing on the treatment of co-infections and innovative approaches to prevent HIV. More information: http://idpc.net/events/sixth-regional-conference-on-hiv-aids.

21-23 June: Conference of the SEEA Net in Tirana, Albania, on juveniles, the treatment people with co-morbidity, workshop on treatment, panel discussions and posters.

Next meeting of the SEE Network: It was decided that the SEE Network would meet again at the end of the year or early next year. Several countries were named as potential locations for the meeting: Bosnia and Herzegovina, Albania, Romania, Serbia and Bulgaria. It was agreed that the format of the meetings would remain the same – a mixture of discussions with policy makers and field visits, and a discussion on the SEE Network activities. Some SEE Network members announced their interest in visiting NSP and drug dependence treatment facilities. In order to give more visibility to the SEE Network and our meetings, it was also decided that we would seek to approach a government body to co-host our meetings. This would also increase the possibility of civil society engagement with policy makers at the local or national level in a given country.

6.7 Funding opportunities

The European Commission (EC) has published a call for applications to fund networking activities for four-year projects covering the EU, the Western Balkans and Turkey. The thematic should be on human rights and social inclusion. The deadline for application is 13th April. The minimal grant amount is EUR 500,000 over four years, and there is a requirement for co-financing of 20%.

This funding opportunity was considered as highly relevant to the SEE Network activities. IDPC and Diogenis will not be able to lead on the management of the grant. The grant could be an interesting opportunity to build the capacity of one (or several) organisations from the SEE region. IDPC will provide support to review the draft of the proposal and seek to strengthen it. Each member of the SEE Network will need to feed into the application to ensure that the proposal includes all of the countries from the Network.

Aksion Plus was considered as a good partner to bring forward the proposal on the Network although this should be confirmed by Genci Mucollari. Other possibilities included the Romanian Harm Reduction Network and the Healthy Options Project Skopje. Aksion Plus will come back with

a confirmation on whether they are able to lead on the proposal in the coming days. They have experience in terms of EC funding as are finishing a project on national networking.[1]

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[1] Since the writing of this report, Aksion Plus submitted a proposal for funding to the European Commission 'Partnership programmes for civil society organisations' programme, on behalf of the SEE Network. Partners to the grant include: Association of citizens 'Viktorija', Healthy Options Project Skopje, Juventas youth Cultural Center, Association Margina, NGO Veza, Association Terra, Association Diogenis Drug Policy Dialogue in South East Europe, IDPC, Association Prevent, Initiative for Health Foundation and Romanian Harm Reduction Network.