



A PUBLIC HEALTH APPROACH TO DRUG USE IN ASIA:

Principles and practices for decriminalisation

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Acronyms

ANPUD	Asian Network of People who Use Drugs
ASEAN	Association of South East Asian Nations
CCDU	Compulsory centres for drug users
CFP	Country Focal Point
IDPC	International Drug Policy Consortium
INCB	International Narcotics Control Board
LEAHN	Law Enforcement and HIV Network
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PCPI	Police Community Partnership Initiative (Cambodia)
SAARC	South Asia Association for Regional Cooperation
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

Methodology

This report was developed by a review of available evidence conducted in October-November 2015, consultations with stakeholders attending the 24th International Harm Reduction Conference, Kuala Lumpur, 18-21 October 2015 and two rounds of consultation amongst stakeholders on the first and final draft report in October 2015 and January 2016.



The project is funded by **The European Union**

Disclaimer: The contents of this publication are the sole responsibility of the author and do not necessarily reflect the opinion of the European Union.

This report was published as part of the 'Asia Action on Harm Reduction' project, managed by the International HIV/AIDS Alliance. This project, funded by the European Union in 2013-2015 enables community advocates in China, India, Malaysia, Indonesia, Cambodia and Vietnam to advocate for harm reduction.

Acknowledgements

This report was written by John Godwin, Consultant.

IDPC wishes to thank the Asian Network of People who Use Drugs and the International HIV/AIDS Alliance for supporting this report.

The following people reviewed drafts and/or provided comments and suggestions:

- Gloria Lai, Jamie Bridge, Ann Fordham, Marie Nougier, International Drug Policy Consortium
- Akihiko Sato, Kwansei Gakuin University (Japan)
- Alex Wodak, President, Australian Drug Law Reform Foundation (Australia)
- Anand Chabungbam, Jimmy Dorabjee, Asian Network of People who Use Drugs (Regional)
- Asmin Fransiska, Atma Jaya University (Indonesia)
- Atul Ambekar, All India Institute of Medical Sciences (India)
- Brianna Harrison, Vladanka Andreeva, UNAIDS RST (Thailand)
- Claudia Stoicescu, Rick Lines, Harm Reduction International (United Kingdom)
- Daniel Wolfe, Denise Tomasini, Naomi Burke Shyne, Matthew Wilson, Open Society Foundations
- Dave Burrows, APMGlobal Health (Australia)
- Edo Agustian Nasution, PKNI – Indonesian Drug Users Network (Indonesia)
- Ernestien Jensema, Transnational Institute (Netherlands)
- Goro Koto, Japan Advocacy Network for Drug Policy (Japan)
- Ma Inez Feria, NoBox Transitions Foundation (Philippines)
- Olga Golichenko, Susie McLean, Jet Riparip, International HIV/AIDS Alliance
- Kanna Hanayashi, University of British Columbia (Canada)
- Michael Cole, Consultant (Thailand)
- Nex Bengson, AKEI (Philippines)
- Niamh Eastwood, Release (United Kingdom)
- Oanh Khuat, Center for Supporting Community Development Initiatives (Vietnam)
- Pann Ei, Consultant (Myanmar)
- Pascal Tanguay, Consultant (Thailand)
- Rebecca Schleifer, Yale University Global Health Justice Partnership
- Ricky Gunawan, LBH Masyarakat (Indonesia)
- Risa Alexander, HIV Cooperation Programme in Indonesia (Indonesia)
- Simon Beddoe, India HIV/AIDS Alliance (India)
- Steve Rolles, Transform Drug Policy Foundation (United Kingdom)
- Taing, Korsang (Cambodia)
- Tripti Tandon, Lawyers Collective (India)

Foreword

In Asia, the use of drugs such as opium, cannabis, and kratom for medical, religious or cultural purposes has been a part of traditional practice for many centuries. Opium was used for medicinal purposes across Asia from Iran to Indonesia. Smoking opium with tobacco was common in ritualistic and social gatherings in China. Similarly, cannabis was widely used for medical, cultural and social purposes—in my home country India, cannabis was described as a ‘way of life’. In Thailand and Malaysia, kratom has been traditionally used for medicinal, cultural and other purposes.

Despite the findings of the Opium and Hemp Commissions in the late 19th century that the ‘mild and moderate use of these substances is not deleterious to health’, the major powers of the time pushed for their prohibition under the establishment of the international drug control system, now underpinned by the three UN Conventions of 1961, 1971 and 1988. The prejudice of the major powers against local practices in Asia was so much that the therapeutic benefits of cannabis were not acknowledged in modern medicine for a long time. It is ironic that countries in Europe and North America are now ‘rediscovering’ the medical uses of cannabis and even changing their laws to allow for the supply and use of medical cannabis, whereas our traditional medical practices are lost on our governments. Without doubt, drug prohibition is an ‘historical wrong’ which needs to be corrected in societies in Asia.

It is a travesty that in the 20th century, Asia became the region with the most repressive and punitive drug policies in the world. While other parts of the world are acknowledging the damage caused by enforcement-driven strategies and shifting towards health- and rights-based approaches to drug use, including in Africa, Latin America, North America and Europe, countries in Asia still insist on criminalisation and punishment as their primary response. The epidemics of HIV and hepatitis C, high rates of incarceration, deeply inadequate access to humane and effective drug treatment and harm reduction measures, extensive human rights

violations (including police abuse and harassment, arbitrary detention, forced urine testing, and forced labour and denial of healthcare in compulsory detention settings), and the use of the death penalty for drug offences – contrary to international human rights and constitutional norms – make an undeniably strong case for governments to change course. An open debate on drug policies that work in redressing these devastating consequences and in reducing the harms associated with drug use is desperately needed.

I welcome this report as a critical resource for policy makers in our region ready to confront the contemporary realities of drug use and the inability of criminalisation and punishment to effectively manage those realities. It provides a comprehensive outline of the principles and practices that underpin effective approaches to decriminalising the use of drugs and the possession and cultivation of drugs for personal use. I encourage policy makers to make full use of this report as a source of technical advice and recommendations for implementing health- and rights-based policy responses to drug use. In considering the most appropriate alternatives to criminalisation and punishment to apply in country and regional contexts, I urge policy makers to engage the most affected communities, that is people who use drugs. I urge you to take account of our region’s traditional approaches to drugs, in which prohibition, criminalisation and punishment were virtually strangers until only the past century.



Anand Grover

Senior Advocate, Supreme Court of India
Commissioner, Global Commission on Drug Policy
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Terminology

For the purposes of this report the following definitions apply.

Administrative or civil sanctions refer to penalties that do not result in a criminal conviction or punishment, or a criminal record. Examples include a warning, confiscation, and monetary fines (in small amounts). Administrative or civil sanctions are generally intended to be less punitive than criminal sanctions, however such sanctions imposed in some countries in Asia involve compulsory detention for people who use drugs.

Decriminalisation of drug use refers to the removal or non-enforcement of criminal penalties for drug use, and for the possession of drugs, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption. Decriminalisation may involve the removal of all penalties. Alternatively, civil or administrative penalties rather than criminal penalties may be imposed following decriminalisation. If so, these penalties 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.¹

Under **de jure decriminalisation**, criminal penalties for selected activities are formally removed through legal reforms.

Under **de facto decriminalisation**, the selected activities remain criminal offences but, in practice, the criminal penalties are not applied.

Diversion refers to measures that provide alternatives to criminal sanctions or incarceration for people who are arrested for drug use or drug-related offences, particularly minor, non-violent 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 treatment, rather than subjected to arrest, detention, prosecution, judicial sentencing and imprisonment. Diversion measures can be conducted by police (before or after arrest), prosecutors, or judges prior to or at the time of sentencing.² Such measures may be implemented in jurisdictions that have implemented *de jure* decriminalisation or *de facto* decriminalisation. They may also be implemented where drug use is not decriminalised, and apply specifically to people who use or are dependent on drugs, including where a minor, non-violent offence has been committed.

Drug dependence remains a contested concept. The World Health Organisation (WHO) defines it as a 'chronic, relapsing medical condition with a physiological and genetic basis.'³ However, some experts have rejected terms describing drug dependence as a medical condition as this can lead to people making the incorrect assumption that all drug use is an illness. The UN reports that only about 10% of people who use drugs have problems related to their drug use, and may need evidence-based, voluntary drug treatment.⁴

For the purpose of this report, 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.

Drug dependence treatment refers to 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 be available to suit the differing characteristics, needs, preferences and circumstances of each person wishing to access treatment. Treatment should be provided by medical staff, therapists or other appropriately trained professionals, the goal being the improvement of the health and social functioning of the person.⁵ The objective of treatment is to enable an individual to live a healthy and socially constructive lifestyle. It is important to contrast this definition of drug treatment with detention in a compulsory centre for people who use drugs (CCDU) – that is, when a person is sent to a locked facility without medical evaluation or informed consent, where the 'treatment' is generally not evidence-based, and emphasises instead physical or religious discipline or forced labour.⁶

Harm reduction refers to 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.⁷ Examples of this approach include needle and syringe programmes (NSPs) – which provide sterile injecting equipment to people who use drugs to reduce the risks of HIV and hepatitis transmission – and opioid substitution therapy (OST) – which replaces an illegal opioid drug (such as heroin) with a controlled substance under medical supervision (for example, methadone or buprenorphine). Measures such as NSPs and OST are part of the globally agreed package of interventions for HIV-related prevention, treatment and care amongst people who inject drugs, and have been repeatedly proven to help stabilise and reduce illicit drug use, improve health and quality of life, and reduce crime.⁸

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.

Legal regulation refers to a model whereby the cultivation, production, 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.

Chapter 1

Introduction

Summary of key messages

In this report, the International Drug Policy Consortium (IDPC) offers recommendations based on evidence and examples of good practice to inform a shift in policy responses to drug use in Asia away from criminalisation and punishment, and towards public health and harm reduction. It describes effective approaches to the decriminalisation of drug use. It also discusses approaches implemented in Asia that have proven ineffective, such as the detention of people who use drugs in compulsory centres as a form of 'rehabilitation'.

The following factors are highlighted to guide the development of policies that seek to achieve improved outcomes for health, security and human rights:

- Decriminalisation of drug use is permitted within the existing international drug control conventions. It can be achieved by the removal or non-enforcement of criminal penalties for drug consumption, and for the possession of drugs, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption.
- Decriminalisation is evidence-based, human rights-based and complies with the principles of harm reduction and social inclusion.
- In a decriminalisation model, administrative sanctions such as a minor fine, caution or referral to treatment and social services may be applied instead of criminal sanctions. However, this report proposes a best practice model of decriminalisation in which no sanctions whatsoever apply for drug consumption or use, possession of drugs, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption.
- Programming priorities for countries moving towards decriminalisation include:
 - Transitioning away from the detention of people who use drugs in compulsory centres to voluntary, community-based treatment, harm reduction and social services.
 - Introducing mechanisms for the diversion of people who use drugs away from the criminal justice system through programmes implemented by the police, prosecutors, courts, or health care workers. Police diversion for people arrested for drug use or low-level, non-violent drug offences may include a decision to take no further action, issue a caution or to provide

referral to social and/or health services. Police diversion is effective in contexts where the police are able to build trust with communities of people who use drugs. Prosecutors and judges can also implement diversion programmes, with courts offering diversion for people who use drugs arrested for more serious offences (rather than for drug use or possession for personal use, where it is recommended that diversion occurs at police or prosecutor stage).

Chapter 4 provides comprehensive recommendations and identifies practical considerations for governments seeking to implement decriminalisation. It highlights the need to mobilise public support for decriminalisation and the importance of engaging key stakeholders from across government and civil society including communities of people who use drugs, religious and community leaders, the legal and medical professions, and the media.

Objectives of the report

- To explain the principles underpinning the decriminalisation of drug use
- To provide recommendations for the design and implementation of decriminalisation models targeted at people who use drugs
- To offer guidance on diversion of people who use drugs away from the criminal justice system towards evidence-based health and social services, based on principles of public health and human rights
- To identify the roles of criminal justice, law enforcement, health, legal and social service agencies in implementing decriminalisation and referrals to health and social programmes.

This report is intended as a resource for policy makers, legislators, communities of people who use drugs and civil society organisations in Asia. The overall goal of the report is to offer guidance on steps that countries can undertake to develop drug policies that achieve better public health outcomes, by shifting away from the criminalisation and punishment of people who use drugs. It also describes legal and policy responses to drugs that are not effective, such as the detention of people who use drugs in compulsory centres for drug users (CCDUs), forced urine testing, compulsory registration and other punitive measures.

The report does not address the legalisation of the supply of drugs or systems for the legal regulation of drugs.⁹

Chapter 2

The decriminalisation of drug use

2.1 Background on decriminalisation

For the purpose of this report, decriminalisation is defined as the removal or non-enforcement of criminal penalties for selected activities. The decriminalisation of drug use refers to the removal or non-enforcement of criminal penalties for drug use, and for the possession of drugs, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption.

Decriminalisation may involve the removal of all penalties. Alternatively, civil or administrative penalties rather than criminal penalties may be imposed following decriminalisation. If so, these penalties 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.¹⁰

High-level support for decriminalisation

The United Nations (UN) Secretary General Ban Ki Moon has repeatedly supported the removal of criminal sanctions for people who use drugs. At the occasion of the 2015 International Day Against Drug Abuse and Illicit Trafficking, he called on UN member states to ‘consider alternatives to criminalization and incarceration of people who use drugs and focus criminal justice efforts to those involved in supply. We should increase the focus on public health, prevention, treatment and care, as well as on economic, social and cultural strategies’.¹¹

A number of UN agencies have also issued statements in favour of decriminalising drug use, including the Joint UN Programme on HIV/AIDS (UNAIDS),¹² the UN Development Programme (UNDP)¹³, the WHO¹⁴, the Office of the High Commissioner on Human Rights (OHCHR),¹⁵ and UN Women,¹⁶ as well as the UN Special Rapporteur on the right to health.¹⁷

Similarly, the Executive Director of the United Nations Office on Drugs and Crime (UNODC) stated in 2013 that people who use drugs should ‘not [be] treated as criminals’ and in 2015 UNODC’s Regional Representative for Southeast Asia and the Pacific called for a shift from a ‘sanction-oriented to a health-oriented approach to drug use and dependence’.¹⁸

The International Narcotics Control Board (INCB) has further emphasised the need for a non-punitive approach to drug use, and clarified the requirements of the UN drug conventions, when its President declared in 2015:

*The treaties do not require the incarceration of drug users, but rather provide for alternatives to conviction or punishment for those affected by drug abuse, including treatment, education, after-care, rehabilitation and social reintegration. That some countries have chosen incarceration rather than treatment has been a denial by governments of the flexibility that the treaties provide.*¹⁹

A series of international experts and high-profile individuals have also supported calls for decriminalisation, via a number

of declarations (for example, the 2010 Vienna Declaration, which called for the decriminalisation of drug use due to the mounting scientific evidence of harmful consequences of drug law enforcement, including human rights violations and the undermining of public health systems).²⁰ A landmark report by the Global Commission on Drug Policy, published in 2014, also recommended decriminalisation of drug use, and possession of drugs for personal use, along with the provision of harm reduction and treatment measures for people who are dependent on drugs.²¹

Decriminalisation permitted under international law

The three UN drug conventions that shape drug policy globally are:

- The Single Convention on Narcotic Drugs of 1954, as amended by the 1972 Protocol;²²
- The UN Convention on Psychotropic Substances of 1971;²³ and
- The UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.²⁴

There is a commonly held misconception among policy makers that these conventions require signatory states to criminalise drug use and possession for personal consumption. In fact, there is no specific obligation in the UN drug conventions to make drug use *per se* a criminal offence – the treaties do not oblige countries to impose any penalty (criminal or administrative) for drug use.²⁵ On the contrary, the preambles of these conventions place ‘health and welfare’ as overarching concerns – and as the INCB President recently confirmed, the conventions recognise that: ‘the drug issue is first and foremost a matter of public and individual health and welfare’.²⁶

The conventions also grant flexibility with respect to the legal response to the illicit possession of drugs for personal use. The 1988 Convention requires countries to establish possession of drugs for personal use as a criminal offence, subject to the caveat that countries can choose their legal framework for drug control, based on each country’s ‘constitutional principles and the basic concepts of its legal system’. This means that states can opt out of the requirement to criminalise possession for personal use if it would be unconstitutional (for example, based on human rights considerations) or otherwise contrary to their legal system. The 1988 Convention further states:

*The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence...measures for the treatment, education, after-care, rehabilitation or social reintegration of the offender.*²⁷

Decriminalising drug use and possession for personal use is therefore permitted by the international drug conventions. Further information on obligations under international law is available in **Annex 1**.

Growing support for shifting away from punishment – but not yet in Asia

At least 25 countries worldwide have adopted laws, policies or other measures to decriminalise drug use and possession of drugs for personal use. This includes countries in Europe, North America, Latin America, the Caribbean and Oceania.²⁸ Many of these countries have replaced criminal sanctions with referrals to health and social services or administrative penalties such as minor fines. Some countries have removed all penalties for possession of small quantities of drugs for personal use.²⁹

However, the national drug control policies and strategies established in Asia remain strongly oriented towards law enforcement and supply reduction, and continue to impose detention or imprisonment as sanctions for drug use or possession of drugs for personal use. The region retains the most severe penalties for drug offences, including the death penalty for drug trafficking which is imposed as a mandatory sentence in some countries.³⁰ Although many countries in Asia have introduced legal mechanisms to compel people arrested for drug use to attend treatment and ‘rehabilitation’ (including to CCDUs often labelled as ‘rehabilitation’ centres, **see section 2.6**), no country in the region has sought to remove all sanctions for drug use or possession of drugs for personal use. In addition, several countries conduct police raids to harass or arrest users,³¹ implement forced urine testing, and impose compulsory registration with security or law enforcement agencies for people who use drugs.³² Some countries also impose corporal punishment as a penalty for possession of drugs, even where possession is for personal use (e.g. caning or whipping in Brunei, Malaysia and Singapore).³³ In some countries, the possession of drug use equipment such as needles and syringes is also criminalised (e.g. Brunei, Singapore and the Philippines).³⁴

Policy makers in Asia have sought to justify these strict measures as necessary to eradicate the illicit drug trade – as called for in the 2009 *UN Political Declaration and Plan of Action on the World Drug Problem*.³⁵ In Southeast Asia, the eradication of supply and demand was also identified as key to achieving the commitment made in 1998 to achieving ‘a drug-free ASEAN by 2020’, with the deadline brought forward to 2015 in the year 2000.³⁶ The goal of eradicating all drugs has also been enshrined in the national drug policies of a number of countries in the region, for example Indonesia, Lao PDR and Myanmar.³⁷ More recently, policy makers in India and Sri Lanka have adopted similar language.³⁸

Evidence from countries in Asia and around the world demonstrates that governments have clearly failed to achieve drug-free goals.³⁹ The pursuit of such goals has led to disproportionate investment in law enforcement and criminal justice interventions, at the expense of public health, where the most severe impacts are borne by people who use drugs. In this context, it is critical that drug policies balance security, health and harm reduction, and do not rely on the criminalisation and punishment of people who use drugs.

Within Asia, some political and community leaders have now started to acknowledge the futility of pursuing the unrealistic goal of drug eradication. For example, Thailand’s Minister of Justice told an audience in 2015 that the eradication of all drugs was a counterproductive policy goal, associated with systemic police corruption and overcrowding of prisons with non-violent offenders.⁴⁰ At the 4th ASEAN Ministerial Meeting on Drugs (2015), Malaysia’s Deputy Prime Minister conceded that ASEAN had failed to meet the 2015 target for total drug eradication, which he described as ‘an illusion’.⁴¹

Nevertheless, although most governments in Asia may now recognise that drug use has a public health dimension, it is still primarily perceived as a public security issue. Hence, governments have been hesitant to take the decisive steps required to shift away from the criminalisation and punishment of people who use drugs. Further, there has been a lack of understanding of the nature of the legislative and policy reforms needed to establish a new health-oriented paradigm that guarantees voluntary access to evidence-based treatment and harm reduction services. As Asian countries are likely to face significant implementation challenges in transitioning from criminalisation to a more robust public health approach (including political pressure to retain a hard-line, zero-tolerance approach to drugs), public support for new policy directions will be critical. Efforts would be required to dispel fears that decriminalisation will lead to a rapid escalation of drug use and crime. This may require engaging the media to assist in educating the community about the harms caused by criminalisation, and the public health and security benefits of decriminalisation as demonstrated by global experience (see **Annex 2** for suggestions on practical steps to undertake in implementing decriminalisation).

The negative consequences of criminalising and punishing drug use in Asia

The criminalisation of people who use drugs in Asia and elsewhere around the world has failed to deter drug use – there is no evidence that increasing the ferocity of law enforcement or the severity of punishments results in meaningful reductions in the prevalence of drug use.⁴² Available data shows that countries that impose severe penalties for possession and consumption of drugs are no more likely to deter drug use than countries that impose less severe sanctions.⁴³

In addition to being ineffective, the criminalisation of people who use drugs across Asia has resulted in immense harms to individuals and societies.

Firstly, punitive legal frameworks have been premised on the notion that drug use represents a ‘social evil’ or a ‘moral failing’, contributing to the threat posed by drug markets to the ‘social fabric of nations’ and ‘stability of states’;⁴⁴ instead of being grounded on a scientific understanding about drugs, drug use and drug dependence.⁴⁵ This has contributed to high levels of stigma and discrimination associated with drug use – deterring people who use drugs from accessing essential health and social services such as harm reduction, treatment, as well as housing,

Table 1 HIV prevalence among people who inject drugs in Asia^{46*}

Country	Numbers of people who inject drugs (estimate)	Adult HIV prevalence amongst people who inject drugs (%)
Philippines	14,000	44.9
Indonesia	74,326	36.4
Pakistan	104,848	27.2
Cambodia	1,300	24.8
Myanmar	83,000	23.1
Thailand	40,300	19
Malaysia	170,000	16.6 (male)
Vietnam	271,506	10.5 (male)
India	177,000	7.2
Nepal	52,174	6.3 (male)
China	2,170,000	6
Afghanistan	36,000	4.4 (male)
Singapore	10,000 – 20,000	1.5
Bangladesh	23,800	1.1
Sri Lanka	423	0

* The HIV prevalence rates amongst people who inject drugs in some cities are significantly higher than national prevalence rates, for example, 56% in Jakarta (Indonesia), 18.3% in New Delhi (India), and 15.7% in Herat (Afghanistan). The HIV prevalence rates among people who inject drugs for Bhutan, Brunei, Japan, Lao PDR, and South Korea are not known.

education and employment, further exacerbating their social marginalisation.

Secondly the criminalisation of people who use drugs, as well as legal restrictions on distribution of needles and syringes and the provision of OST, have fuelled Asia's escalating HIV epidemics (see Table 1). In contexts where drug use is criminalised, people who use drugs are deterred from accessing the health services they may need, and are more likely to use drugs in unsafe environments. They may engage in hurried, higher-risk injecting practices including sharing of injecting equipment. This increases their vulnerability to HIV and other infections, overdoses and other injuries associated with unsafe injecting practices.

Most countries in Asia provide OST and/or NSPs, which are harm reduction interventions that play a critical role in the prevention of HIV and other blood-borne viruses (see **Figure 1**). However, the accessibility of people who inject drugs to these harm reduction interventions throughout the region is inadequate.⁴⁷

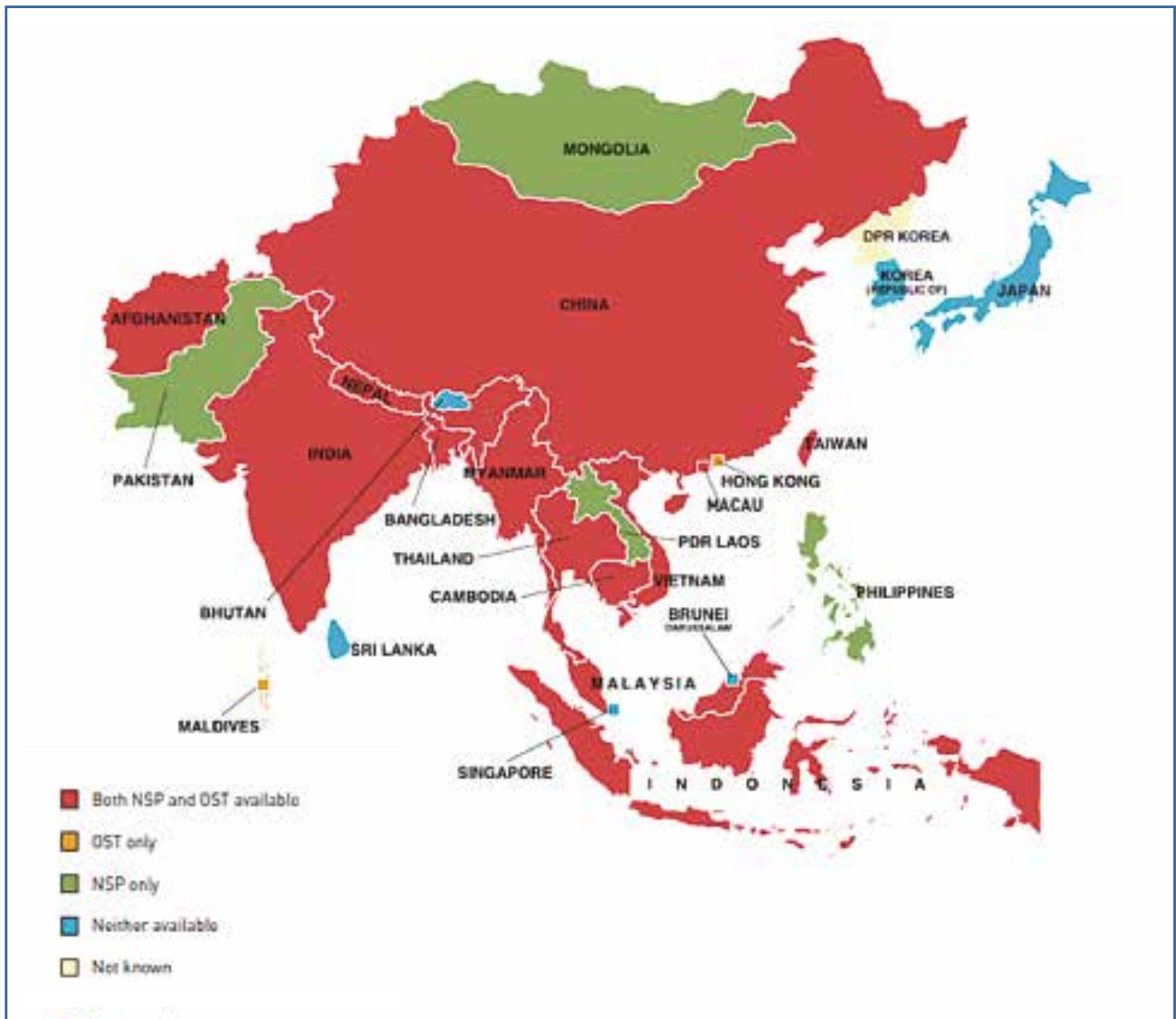
Thirdly, in criminalised contexts, abuses perpetrated by law enforcement personnel against people who use drugs are commonplace.⁴⁸ These abuses include extortion and entrapment, violence and harassment. Frequent police abuse drive people who use drugs away from life-saving health and social care services.⁴⁹

Furthermore, criminalising people who use drugs has increased prison populations, creating additional pressure on government budgets. In many countries, a large portion of the national prison population is comprised of people in pre-trial detention or imprisoned for drug use or minor drug-related offences. The proportion of the prison population held on drug-related offences is estimated at 60% in Indonesia,⁵⁰ 50% in the Philippines,⁵¹ 64% in Thailand⁵² and 70% in

Box 1 Vietnam: innovative policy for people who cultivate drugs for subsistence purposes

Vietnam provides an example of a flexible approach to policing drug cultivation. The cultivation of plants destined for the illicit drug market remains a criminal offence in the country. However, the cultivation of opium poppy has a long history among Vietnam's ethnic populations. Therefore, the law provides some leniency towards farmers. Criminal liability is only imposed on a person who has returned to cultivation after being the subject of several non-custodial measures, including education, financial and technical support for alternative cultivation, and the imposition of a fine or warning. A record of previous administrative sanctions is required before a farmer is convicted of a criminal offence, and faces imprisonment.⁵³

Figure 1 Map of availability of NSPs and OST in Asia⁵⁴



Myanmar.⁵⁵ In some cases, these high incarceration rates and the overcrowding that results is causing a crisis in criminal justice systems. Overcrowded prison facilities also provide a high-risk environment for the transmission of HIV, hepatitis C and tuberculosis, with public health implications for the entire community.⁵⁶

Finally, the criminalisation of people who use drugs has given rise to a range of adverse human security outcomes. Governments invest significant financial and human resources on policing, prosecuting and imprisoning low-level offenders, rather than focusing on high-level trafficking operations and organised crime. The removal of criminal penalties applying to people who use drugs would allow more resources to be invested in reducing the violence, corruption and money laundering associated with illicit drug supply.

Decriminalising other drug offences: cultivation for subsistence purposes

While the main focus of this report is the decriminalisation of people who use drugs, it should be noted that there

are also strong human rights arguments in favour of decriminalising other aspects of the illicit drug market.

For example, existing legal frameworks impose harsh punishment on small-scale subsistence farmers involved in the cultivation of crops destined for the illicit drug market. These individuals are generally involved in illicit crop cultivation in order to buy food, clothes and to access basic health and education. This is the case in Asia, where opium cultivation is strongly linked to poverty. In the 'Golden Triangle' region of Southeast Asia, most households involved in opium cultivation are impoverished subsistence farmers from ethnic minority populations living in remote mountain areas. They grow opium as a cash crop to solve food insecurity and to pay for health and education (opium is also used traditionally, as a medicine).⁵⁷ Criminalising subsistence farmers exacerbates their situation of poverty and vulnerability, without addressing the root causes of their involvement in the illicit market, or offering legal alternatives for their survival.

2.2 The key principles of decriminalisation

Different models of decriminalisation have been developed worldwide.⁵⁸ Decriminalisation approaches can achieve positive health, security and social outcomes if they are **evidence-based**, and grounded in the principles of **public health, harm reduction, human rights and social inclusion**.

Evidence-based

Drug policy should be based on the strongest evidence available. Governments should base their decisions on an objective assessment of the evidence of the impact of laws, policies and practices, by considering factors such as:

- the relative costs and cost-effectiveness of different approaches to drug control.
- the distinction between the needs of people dependent on drugs compared to those who use drugs occasionally or recreationally. The UNODC has reported that only about 10% of all people who use drugs experience drug dependence.⁵⁹ As a result, only a minority of people who use drugs may need, and benefit from, drug treatment.
- the need to offer a range of drug dependence treatment options, including detoxification, rehabilitation, psychological care and peer support. Evidence shows that treatment and care must be tailored to individual circumstances, and take account of the varying health and social impacts of different drugs, rather than imposing a 'one-size-fits-all' approach.⁶⁰ As explained in **section 2.6**, CCDUs do not constitute an evidence-based form of treatment and should therefore be phased out.

Public health and harm reduction

Harm reduction refers to '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.'⁶¹ It is an approach that benefits people who use drugs, their families and the community.

Decriminalisation should be seen as part of a harm reduction approach; key to creating an enabling environment for the provision of public health interventions for people who use drugs. In 2009, the WHO, the UNODC and UNAIDS recommended a comprehensive package of nine harm reduction interventions based on scientific evidence of efficacy in preventing the spread of HIV, in addition to reducing other harms associated with drug use.⁶² These nine interventions were re-affirmed by the WHO in its consolidated guidelines released in 2014, which further recommended the implementation of overdose prevention measures:⁶³

1. NSPs
2. OST and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections

6. Condom distribution
7. Targeted information, education and communication
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis.

The International HIV/AIDS Alliance has expanded this package to also include: basic health services (including overdose prevention and management); services for people who are drug dependent or using drugs in prison or detention; advocacy; psychosocial support; access to justice and legal services; children and youth programmes; and livelihood development or economic strengthening.⁶⁴ IDPC has also proposed a set of additional harm reduction interventions, including: drug checking services, the distribution of smoking paraphernalia, supervised drug consumption facilities, as well as social support services (which may include housing, shelter and employment services).⁶⁵ Additional measures specifically targeted at reducing the harms related to the use of amphetamine-type stimulants were recently developed by Harm Reduction International.⁶⁶

The health benefits of harm reduction include reductions in illness and deaths, by preventing the transmission of HIV and other blood-borne viruses, reducing overdose deaths and increasing access to healthcare services including drug treatment services. Harm reduction interventions such as NSPs and OST are proven to be cost-effective when scaled-up nationally, with significant savings generated to national health budgets (see, for example, the analysis of the return on investment of harm reduction programmes in Malaysia and China).⁶⁷

Box 2 Engaging people who use drugs in policy development

The Asian Network of People who Use Drugs (ANPUD) is a regional network that operates at grassroots level and has made strong calls for decriminalisation.⁶⁸ ANPUD has called on governments, UN and donor agencies to promote, facilitate and financially support the meaningful participation of people who use drugs and civil society groups in local, national, regional and global forums relating to drug policy.⁶⁹

Some countries in Asia also have national networks of people who use drugs (e.g. India, Indonesia, Myanmar and Nepal) that are linked to local self-help and advocacy groups of people who use (or previously used) drugs. These networks and organisations constitute an invaluable resource for governments seeking to implement voluntary and rights-based services for people who use drugs.

Human rights

Under international human rights law, UN member states are required to respect, protect and fulfil the right to health for all people, without discrimination – as guaranteed in a number of international legal instruments, in particular the *International Covenant on Economic, Social and Cultural Rights*.⁷⁰

The criminalisation of people who use drugs is in direct violation of the right to health. Fear of criminal penalties deters people who use drugs from using health services and treatment, and increases their vulnerability to violence, discrimination and serious health harms. The criminalisation of drug use also places people at risk of torture, forced labour and ill-treatment and infringes on human rights to autonomy, privacy, work, education and housing.⁷¹ These rights are all recognised under international law, including in the *International Covenant on Civil and Political Rights*.⁷²

Limitations on human rights may be justified, but only if they meet the criteria of 'legitimate purpose', 'proportionality', 'necessity', and 'non-discrimination'.⁷¹ While protecting health is a legitimate government purpose, the criminalisation of drug use has in fact exacerbated health harms for both people who use drugs and the wider community and therefore cannot be justified under the international human rights framework. Evidence shows that less intrusive and more humane and effective approaches than criminalisation could be implemented to reduce the harms associated with drug use, while upholding the right to health of people who use drugs – this includes the provision of harm reduction and social support, as well as evidence-based drug dependence treatment (see the above **principle on 'public health and harm reduction'**).

Social inclusion

Although drug use is a global phenomenon, drug-related harms and drug dependence are often concentrated among the poorest and most marginalised communities – as social exclusion, poverty and harsh living conditions can be major factors contributing to drug dependence.⁷⁴ The principle of social inclusion is therefore of fundamental importance.

Punitive drug laws and policies can contribute to social exclusion by stigmatising people who use drugs and restricting their ability to engage in social and economic

activities. Approaches that focus on arrest and criminal sanctions towards people who use drugs have little deterrent effect, and remove people from positive social influences while increasing their exposure to health risks and criminal groups. Police crackdowns can force people who use drugs to remain hidden, making it difficult for health and social programmes to reach them.⁷⁵ Similarly, media campaigns that demonise people who use drugs and policies that encourage neighbours to report people who use drugs to the police also drive people who use drugs underground. Finally, people with a criminal record for drug offences are often excluded from education or employment opportunities, and are thereby consigned to 'informal' or illegal sectors of the economy.

Decriminalisation can play a positive role in promoting social inclusion by reducing stigma and removing barriers to health services, education and employment. Drug policy should be designed to benefit vulnerable populations, particularly people who use and are dependent on drugs, rather than to alienate them or exacerbate their marginalisation. In implementing decriminalisation of drug use, groups that require special attention include people living with HIV, hepatitis and/or tuberculosis, as well as people with other specific mental and physical health needs, people with disabilities, adolescents, women (especially pregnant women), sex workers, migrants, asylum seekers and refugees, homeless people and other marginalised groups.⁷⁶ For example, women who use drugs report discrimination in a range of areas including in relation to their role as child-bearers and mothers, such as limited or contingent access to contraception or healthcare, coerced and forced abortion, and denial of access to children.⁷⁷

Transparency, accountability and the participation of people who use drugs in policy making processes are key to ensuring social inclusion. A wide range of stakeholders should be meaningfully involved in policy development and programme implementation, delivery and evaluation. The principle of social inclusion requires that people be involved in decisions that affect them. Civil society groups and community-based organisations can ensure policy decisions are well informed in relation to the realities of drug markets. Governments should therefore build open and constructive relationships with communities affected by drug policies, particularly networks of people who use drugs and civil society organisations, in the design and delivery of decriminalisation approaches.

2.3 Best practice experiences of decriminalisation around the world

This section describes country experiences in implementing decriminalisation that are consistent with the principles of public health, harm reduction, human rights and social inclusion. As will be described below, decriminalisation may apply to all drugs, or be limited to specific drugs. Decriminalisation can be achieved through either of two approaches:

- **de jure decriminalisation:** criminal penalties are formally removed from the law through legal reforms.
- **de facto decriminalisation:** criminal penalties remain in the law, but in practice the criminal penalties are not enforced or applied.

2.3.1 De jure decriminalisation

De jure decriminalisation requires the amendment or repeal of legislation to remove criminal penalties for:

- drug use
- possession and cultivation of drugs for personal use, and
- possession of drug use equipment (e.g. needles and syringes, and other drug use paraphernalia such as swabs, spoons, filters and water ampoules).

Under a *de jure* decriminalisation approach, civil or administrative (non-criminal) sanctions may be established, such as fines. Therefore, in addition to removing criminal penalties, legislation may also need to be developed that defines these new civil or administrative penalties. Alternatively, there could be no sanction at all for drug use and possession or cultivation for personal use, and instead referrals to treatment, health or social services on a voluntary basis.

Decriminalisation models with no sanctions

Uruguay has adopted a model of decriminalisation in which the law does not impose any sanctions (criminal or administrative) for drug use or possession of 'a reasonable quantity' of drugs for personal use.⁷⁸ However, criminal sanctions apply in the case of a person who *produces* drugs, even if the drug is produced for the person's own consumption.

Decriminalisation models with civil or administrative sanctions

In many models of *de jure* decriminalisation, the use or possession of drugs are treated as civil or administrative offences, rather than as criminal ones. Non-criminal sanctions in different jurisdictions include: fines, community service orders, cautions or formal warnings, mandatory treatment or counselling and education sessions, suspension of driver's or professional licences and mandatory drug testing.⁷⁹

Countries that consider drug use or possession of small quantities of drugs for personal use to be an administrative offence, rather than a criminal offence, include the Czech Republic, Portugal, Germany, Estonia, Spain and Switzerland. Some countries have reformed their drug laws to replace

criminal sanctions with administrative penalties for cannabis, but not other drugs (e.g. some Australian states).⁸⁰

This approach can be effective if the consequences of an administrative sanction are minor (such as small fines or drug confiscation, rather than detention). The imposition of administrative sanctions instead of criminal penalties can provide budgetary benefits by avoiding the expense of the criminal justice process, including pre-trial detention, court hearings and imprisonment. The fact that the individual does not receive a criminal record is also beneficial to future employment, education and housing prospects.

Nevertheless, where administrative penalties are applied, caution needs to be exercised to ensure that the penalties do not compound the social exclusion of people who use drugs. Some countries impose fines (including on-the-spot fines issued by the police) for possession of drugs for

Box 3 Comparing different models of decriminalisation

The models of decriminalisation implemented all over the world vary widely. IDPC has developed an e-tool, which maps out how these models work in practice, describing their legal framework, the role of the police, the judicial or administrative process, the applicable sanction (if any), and examples of countries to illustrate each model. The e-tool enables the comparison of various models of decriminalisation. It can be viewed at: <http://decrim.idpc.net>.

Box 4 Best practice approach to decriminalisation

A best practice model of decriminalisation is one in which the law is changed to remove *all* penalties (i.e. removal of all civil or administrative sanctions as well as criminal sanctions). It is one in which no sanctions whatsoever apply to people for drug use, possession or cultivation of drugs for personal use, or possession of drug use equipment. However, restrictions may apply to regulate such activities in limited circumstances such as drug use in public spaces.

To maximise public health outcomes, when decriminalisation is implemented governments should allocate resources to ensure that evidence-based health, harm reduction and support services are available and accessible to all people who use drugs.

This combination of legal reform and health measures represents best practice for an approach to decriminalisation that is evidence-based and consistent with principles of human rights, public health, harm reduction and social inclusion.

Table 2 International experiences in *de jure* decriminalisation

	Legal framework	Police authority	Judicial / administrative process	Sanctions for drug use	Country examples
Drug use or possession is not an offence	Possession or use is not a punishable offence; law distinguishes between personal use and intent to supply	The police do not have the authority to detain people as long as there is no indication of intent to supply	No further action in the absence of indication of intent to supply	Confiscation of drugs above amount that may reasonably be required for personal use	Uruguay
Police discretion	Possession is not a criminal act but it is an administrative offence	Police can determine the nature of the offence - if deemed to be possession only, on the spot sanction can be applied, if not referral to criminal justice system	No further action in the absence of indication of intent to supply	Confiscation; warning or fine	Spain, some Australian states (for cannabis only)
Administrative decision	Possession not a criminal act but it is an administrative offence	Police can detain people in possession of drugs and refer them to an administrative body; criminal justice proceedings only start if there is suspicion of intent to supply	Civil or administrative body determines the appropriate health or social intervention	Confiscation; warning or fine; referral to treatment; other administrative sanctions	Portugal, Czech Republic
Criminal justice decision	Possession not a criminal act but it is an administrative offence	Police can detain people in possession of drugs but have no authority to determine the nature of the offence. The case is referred by police to state prosecutors or to the judiciary	Judicial authorities (including state prosecutors) determine if the act falls within the legal parameters set for personal use	Confiscation; warning or fine; referral to treatment; other administrative sanctions	Germany, Estonia, Argentina (proposed)

personal use. If a system of fines is to be adopted, it should be set at a reasonable level and not result in imprisonment for non-payment. Other forms of civil penalties, such as confiscation of passports or suspension of driver's licences, should be avoided as they can have an unduly negative and disproportionate impact on a person's life, including employment opportunities.

De jure decriminalisation in Asia

Both China and Vietnam have removed criminal sanctions for drug use, but have replaced them with highly punitive administrative sanctions such as detention in CCDUs. In Lao PDR, possession of very small quantities of drugs has been decriminalised, but people who use drugs are directed to

Box 5 Portugal: Global good practice example in *de jure* decriminalisation

Portugal decriminalised the possession of small amounts of all drugs in 2001. The possession of less than 10 days' supply⁸¹ of drugs for personal use is an administrative violation, rather than a criminal offence. The first time an offender is detected, usually no action is taken. The person's name is recorded by the authorities and after six months their name is removed from the records. However, if the person is detected with drugs on a second occasion within the six-month period, the case is referred to a district-level commission comprising three people including health and social workers. The commission decides whether to refer the person to health services, impose an administrative sanction or take no further action.

Members of the commission focus on a health-centred approach to design individualised plans that address health and social needs including referral to treatment, harm reduction services and social services. The sanctions the panel may apply include requiring treatment for those who are found to be dependent on drugs, requiring regular reporting to the panel, mandating community service, suspending a driver's licence or other licences, or, as a last resort, issuing administrative fines. People who are dependent on drugs are encouraged to seek treatment, but are rarely sanctioned if they choose not to attend. The aim of the commissions is to encourage people who are drug dependent to enter or remain in a drug treatment programme voluntarily.⁸²

Evaluations of Portugal's model confirm positive health outcomes including a decrease in heroin use, an increase in the uptake of drug treatment services, and a decrease

in drug-related deaths and levels of HIV and hepatitis C. The annual number of new HIV cases reduced dramatically, from 1,016 in 2001 to 56 in 2012. Deaths related to drug use decreased from 80 in 2001, to 16 in 2012.⁸³

Decriminalisation has also reduced pressures on the criminal justice system.⁸⁴ There was a reduction in the number of people arrested and attending criminal courts for drug offences from over 14,000 in 2000, to around 5,500-6,000 per year after decriminalisation.⁸⁵ This approach also freed-up criminal justice resources to tackle high-level trafficking and organised crime. The proportion of people who committed offences under the influence of drugs or to fund drug use in the prison population declined from 44% in 1999, to just under 21% in 2012.⁸⁶

Portugal's approach is considered a successful model of decriminalisation because the government invested heavily in treatment, harm reduction and social reintegration programmes for people who use drugs as the legal changes were implemented. At the same time as funding for health and social services increased, people who use drugs became more willing to access health services because of the reduced stigma that resulted from decriminalisation.⁸⁷ Since decriminalisation, there has not been an increase in drug use; in fact, decreases in drug use have been reported among young people aged 15-24.⁸⁸ A study on the impact of decriminalisation on the price of drugs in Portugal found that prices of cocaine and heroin did not decrease following decriminalisation.⁸⁹ Therefore, decriminalising drug use has not led to an increase in the availability of drugs due to price reductions.

compulsory treatment and can be imprisoned for relapse. These do not represent models of decriminalisation that comply with principles of human rights, public health, harm reduction and social inclusion. The ineffectiveness of administrative detention in CCDUs as a deterrent and in treating drug use, and its associated harms, is discussed in **section 2.6**.

2.3.2 *De facto* decriminalisation

De facto decriminalisation achieves a similar outcome to *de jure* decriminalisation but is achieved through a policy decision not to enforce criminal laws that technically remain in force. Current models of *de facto* decriminalisation have the following characteristics:

- Drug use and/or possession for personal use is a criminal offence, but policy and police practice allows people who use drugs to avoid a criminal conviction and criminal penalties.
- Instead of a criminal conviction and criminal penalties, either:
 - no penalty applies; or
 - minor civil or administrative sanctions apply; and/or
 - the person is diverted to treatment, health and social services or counselling and education.

Whereas decriminalisation through law reform may take many years to achieve, *de facto* decriminalisation can be implemented relatively rapidly through pragmatic policy adjustments. However, as it is not backed by legislation, *de facto* decriminalisation can easily be reversed by a decision to apply the existing criminal law.

The Netherlands has a *de facto* approach to decriminalisation of cannabis use. It remains an offence to cultivate, supply and consume cannabis in the country, but as a matter of policy the government does not prosecute certain cannabis use and possession offences.

Some Australian states also apply a *de facto* decriminalisation approach to drug use through police diversion programmes. A system of cautions or diversion to treatment, education and counselling operate as an alternative to criminal conviction. Education may take the form of provision of written materials, telephone or face-to-face information, education and counselling sessions.

De facto decriminalisation in Asia

No country in Asia has fully implemented *de facto* decriminalisation of drug use or possession for personal use as national policy. Nonetheless, in some countries local arrangements operate at specific harm reduction sites at

Box 6 Traditional, religious and medicinal uses of drugs

Decriminalisation is being debated in some Asian countries in the context of substances that have been used for centuries in religious practices or as traditional medicines, including cannabis, opium and kratom.

Some legal frameworks do not criminalise traditional uses of certain drugs. For example, Cambodia's *Law on Drug Control* of 2011 provides that prosecutors have discretion to relinquish the offender from prosecution if the offence committed in connection with drugs involves a small quantity and is part of **customary consumption**. Consumption is deemed 'customary' if it does not result in drug dependence and if the person uses the substance as part of ancestral customs that have been practiced over a long period of time.⁹⁰

India does not criminalise drinks made from **cannabis leaves ('bhang')**, which are used in Hindu religious festivals.⁹¹ A consultation held in 2015 on decriminalisation of drug use in India recommended removing criminal sanctions for consumption of drugs with traditional uses:

*'Differentiation should be made between substances which have lesser addiction potential and have traditionally been used in the Indian society. Such substances include preparations of cannabis (ganja, sulpha, etc.) and some low potency opioids (doda, bhukki, afeem, etc).'*⁹²

Proposals for legalising the **medical use of cannabis** are under active consideration in India, where health-care workers are leading a campaign advocating for law reform so that cannabis can be used in the treatment of cancer and other illnesses; and the Philippines, where Congress is debating the *Compassionate Use of Medical Cannabis Act*.⁹³ Several countries in other regions have legalised cannabis for medical uses (e.g. Czech Republic, Israel and over 20 US states).

In Nepal and Bangladesh, the police tolerate the possession of **cannabis for religious uses** (but not commercial dealing) during certain festivals e.g. the Shivarati festival in Nepal.⁹⁴

Kratom is a plant indigenous to Southeast Asia which is used as an antidiarrheal, a cough suppressant, an antidiabetic, a deworming agent and wound poultice.⁹⁵ Kratom is a controlled substance in Thailand, Myanmar and Malaysia. In Myanmar and Thailand, the number of kratom related arrests more than doubled between 2007 and 2011.⁹⁶ In 2013, Thailand's Minister of Justice announced that his office was considering decriminalising kratom, however it remains a controlled substance. Thai civil society groups are continuing to advocate for the decriminalisation of kratom.⁹⁷

which police have agreed to either avoid arresting people who use drugs or to refer people to health services as an alternative to arrest and prosecution. Where an ongoing police commitment to avoid arrests is secured, this can in effect operate as a local version of *de facto* decriminalisation.

In the Philippines, for example, the possession of drugs and drug use equipment is criminalised. To enable a study on a pilot needle and syringe distribution programme, a specific village (Barangay Kamagayan) was designated by the local government in Cebu City as an area where no arrests for possession of drug injecting equipment would be carried out. However, the pilot study was halted in 2015 following opposition from a senator.⁹⁸

Similarly, in some localities in Cambodia, China, Thailand and Vietnam, mechanisms have been established to ensure that the police do not arrest people who use drugs, and instead refer them to health and harm reduction services (see **section 3.3** for more details).

These mechanisms and approaches could inform the development of national *de facto* decriminalisation models in the future. They represent positive steps towards a public health-based approach to drug use. However, as yet such examples of good practice are exceptional and limited to specific local jurisdictions.

In some countries in Asia, procedures have also been introduced to enable the diversion of some people who use drugs away from the criminal justice system and towards treatment and services (e.g. India and Thailand), even though possession of any quantity of drugs remains a criminal offence (see **section 3.3 and 3.5**).

However, in all these countries, the overall policy approach to drugs remains highly punitive, with drug use and/or possession and cultivation for personal use remaining criminalised. In addition, police harassment is still reported at many harm reduction programme sites across Asia, and political support for harm reduction programmes is often ambivalent. Policies that conflict with harm reduction remain in place in some countries, for example the offering of incentives that encourage police arrest of people who use drugs even in the vicinity of harm reduction sites by setting arrest quotas (in Vietnam and China), inclusion of drug arrests as a key performance indicator (in Malaysia⁹⁹ and Thailand), and compulsory reporting of drug use to authorities by family members, acquaintances or neighbours (in China and Indonesia).

There needs to be a significant reorientation of national drug policies and new investments in harm reduction, treatment, health and support services to provide the foundations for an effective model of decriminalisation that complies with the principles of human rights, public health, harm reduction and social inclusion.

Table 3 Types of *de facto* decriminalisation: Global experiences

	Legal framework	Police authority	Judicial / administrative process	Sanctions for drug use	Examples
No sanction	Possession is a criminal offence, but police and/or prosecution are given instructions not to intervene based on discretionary powers	Police do not have the authority to detain people as long as there is no indication of intent to supply	No further action in the absence of indication of intent to supply	Confiscation	The Netherlands (for cannabis)
Police diversion	Possession is a criminal offence but policy provides alternative sanctions to prison	Police can determine the nature of the offence and decide the sanction (or no sanction), or refer to a senior official for a specialist assessment at the police station	No further action in the absence of indication of intent to supply	Confiscation; warning or fine; other administrative sanctions. Referrals to treatment, harm reduction and social services are also offered	Some cities in the USA (Albany, Seattle, Santa Fe), some Australian states
Criminal justice diversion	Possession is a criminal offence but policy/legislation provides for alternative sanctions to prison	Police can arrest people in possession of drugs	Judicial authorities have the discretion to refer the individual to treatment or other non-criminal sanctions	Confiscation; warning or fine. Referrals to treatment, harm reduction and social services are also offered	Some states in Australia and the USA

2.4 Effective use of threshold quantities in decriminalisation models¹⁰⁰

Use of thresholds to decriminalise possession of small quantities

Many of the countries that have implemented decriminalisation have done so by establishing threshold quantities to differentiate possession of drugs for personal use from possession for trafficking or supply. A person found in possession of a quantity of drugs below the threshold is not subject to criminal penalties, but may be subject to administrative penalties or diverted to treatment, health services and education. Threshold quantities may be used in both *de facto* decriminalisation (where the thresholds may be established by government policies or police guidelines) and *de jure* decriminalisation models (where the thresholds are established by laws or regulations). Threshold quantities may be defined in relation to specific drugs. For example, Table 4 sets out the threshold quantities established in different countries for decriminalisation of possession of cannabis, which vary greatly, ranging from 3 grams in Belgium to 200 grams in Spain.

Some countries specify that no criminal penalties apply for the possession of a quantity sufficient for personal use for a given number of days, based on the average daily dose (see the examples of this approach in Spain and Portugal in Table 5 below).

Concerns with establishing threshold quantities

It should be noted that establishing thresholds is controversial and some countries prefer not to use them, referring instead to the broad term 'small quantity' in laws or guidelines. This allows discretion for prosecutors or judges to determine whether the quantity of drugs possessed was intended for personal use, taking into consideration all of the unique circumstances of the case in question – such as a long history of drug use and referrals to health and harm reduction services.

Threshold quantities can be helpful if they enable the police, prosecutors and courts to clearly distinguish drug use from low-level dealing and from higher-level engagement in the drug market to generate profit. However, arguments against the use of thresholds include the fact that the methods by which thresholds have been devised tend to be *ad hoc* and non-transparent – resulting in very different quantities set out in a variety of countries, as highlighted in Table 4 on the decriminalisation of cannabis possession. The amounts defined in law or police and/or prosecutorial guidance should be based on evidence of drug market realities, in order to minimise the number of people who use drugs who are prosecuted. This should include considerations on drug use patterns,

Table 4 Decriminalisation of possession of cannabis¹⁰¹

Country	Threshold quantity for decriminalisation of cannabis possession (grams)
Spain	200
Australia (varies by State / Territory)	
South Australia	100
Northern Territory	50
Australian Capital Territory	25
Portugal	25
Colombia	20
Czech Republic	15
Ecuador	10
Paraguay	10
Switzerland	10
Peru	8
Russian Federation	6
Mexico	5
Netherlands (<i>de facto</i>)	5
Belgium	3

Table 5 Use of quantity thresholds to decriminalise drug possession for personal use

Germany	A person is not prosecuted for possession of a small amount of drugs, as defined by quantity thresholds. The definition of ‘small amount’ varies in different German states for different substances. With regard to cannabis, these limits vary from 6 to 15 grams; for cocaine the range is 1 to 3 grams. Some states do not have statutory threshold limits but instead look to judicial precedent to establish limits on quantities of drugs. ¹⁰²
Spain	If the police find a person in possession of up to 5 days’ worth of drugs (200 grams of cannabis, 25 grams of cannabis resin, 2.4 grams of ecstasy, 3 grams of heroin, 7.5 grams of cocaine) the person is likely to face an administrative penalty issued by the police. Such sanctions may include a fine, suspension of driver’s licence or firearms licence, or other minor penalties. If a person is found with a quantity above the threshold, they may go before a court or a local safety board. The court or board considers a range of factors to determine whether the drugs were intended for personal use or for trade, including the quantity of the drug, whether the individual is a known user, where the drugs were found, how they were stored, and the presence of large quantities of cash.
Portugal	Possession for personal use is decriminalised. However, if a person is found with more than 10 days’ worth of personal supply of a drug, the person is referred to a criminal court, where criminal charges are possible. The thresholds between a non-criminal offence and supply are specified as follows: 2.5 grams for cannabis oil; 5 grams for cannabis resin; 25 grams for cannabis leaf; 1 gram for ecstasy and heroin; and 2 grams for cocaine.
Estonia	Possession for personal use is decriminalised. However, if a person is found with more than ten times the single dose of an average user, the person may be prosecuted for supply. ¹⁰³

the quantity of drugs a person will likely use per day, and patterns of purchasing.

Experiences in Asia and other regions have shown that thresholds that are set at unrealistically low levels are likely to confuse trafficking with possession for personal use. For example, Lao PDR has a system through which people found in possession of small quantities of drugs can be diverted to ‘treatment’ in CCDUs rather than prosecuted. However, when the thresholds used to define small quantities were established at unrealistically low levels in 2012 (0.2 grams for heroin, morphine, or cocaine; or 0.3 grams for amphetamines, crystal methamphetamine, or other psychotropic drugs),¹⁰⁴ there was a sharp rise in the number of prosecutions for drug possession, resulting in increased levels of imprisonment.

Another risk associated with thresholds is the fact that people who use drugs who possess larger quantities for personal use will be presumed to be involved in drug trafficking. There are many circumstances in which a person might have a certain quantity of drugs, but with no intent to supply. For example, a person may want to buy in bulk to limit contact with the criminal market or because bulk purchases are cheaper.

Therefore, if a government chooses to adopt threshold quantities, the quantity involved should not be the *only* or *determining* factor in distinguishing between possession for personal use and possession for supply – thresholds should ideally be *indicative*. Other factors relating to the circumstances of the individual should also be considered, such as a history of drug dependence, or conversely the possession of several mobile phones, a large amount of money, drugs divided into different packets or firearms.

When a country decides not to establish specific quantity thresholds, guidelines should be available to police, prosecutors and judges to assist them to differentiate between the possession of drugs for personal use, and possession with intent to supply. For example, such guidelines could address the issues of motivation and role of the person in relation to supplying drugs for profit.

Misuse of threshold quantities in some countries in Asia

Threshold quantities are used in Asian countries where possession for personal use continues to be criminalised, in order to define different penalty levels or to determine whether an offender may be ordered to attend a compulsory treatment programme or be detained at a CCDU. For example, in Thailand if a person is arrested in possession of less than 0.1 gram of heroin, 0.5 milligrams of methamphetamine, or 5 grams of marijuana, a judge can forward the case to a committee composed of criminal justice and medical personnel for assessment for compulsory drug detention or treatment as an alternative to prison.¹⁰⁵ Vietnam also has a system whereby people who use drugs are referred to ‘treatment’ in CCDUs, but may be prosecuted and imprisoned if found in possession of drugs above the applicable threshold (0.1 gram of heroin or cocaine, 2 grams of other substances in solid form, or 1 gram of opium resin).¹⁰⁶

2.5 Removing severe administrative punishments for people who use drugs

Some Asian countries have removed criminal penalties against people who use drugs, but maintain highly punitive administrative sanctions for drug use, including detention in CCDUs (e.g. China, Lao PDR, Vietnam), compulsory registration of people who use drugs with law enforcement agencies, and urine testing. These do not represent approaches to decriminalisation that are consistent with principles of human rights, public health, harm reduction and social inclusion. Removing severe administrative punishment of people who use drugs is essential for progress to occur in moving to a model of decriminalisation that is evidence based and complies with principles of public health, harm reduction and human rights.

China¹⁰⁷

Although China has removed criminal penalties for drug use, the system of administrative sanctions that applies remains highly coercive. China's *Anti-Drug Law* of 2008 provides for 'community treatment' and 'compulsory isolated detoxification'. There are strict requirements for compulsory registration to enable monitoring of people who use drugs by the police. The coercive nature of both 'community treatment' and 'compulsory isolated detoxification' undermine their effectiveness as a health response.¹⁰⁸

The police can order people detained for drug use to receive 'community treatment' for three years if they are determined to be dependent on drugs. However, this determination can be based on a single urine test, and the police are not required to involve medical staff in the assessment. Therefore, it is likely that many people who use drugs but who are not dependent are subject to community treatment orders. Failure to comply with treatment requirements under a community agreement triggers the imposition of compulsory isolated detoxification, the length of which is up to two years. A person arrested for drug use may be detained at a police facility for detoxification for the first three to six months, and then transferred to a CCDU where they may be required to work for up to six hours each day. After release, the person is monitored by police and may be subject to random interrogations and forced urine testing for a further three years during which they may be sent to a CCDU again if they relapse.

As drug use is an administrative offence, offenders do not have a right to legal representation or the other due process protections usually available for a criminal trial.

The regulations allow lawyers to assist detainees, but in reality they are seldom available. A person may lodge an administrative appeal against the decision. However, higher police officials rather than an independent body decide the appeal.

Vietnam¹⁰⁹

Drug use was decriminalised in 2009 by removal of the offence from the Penal Code.¹¹⁰ However, drug use is an administrative violation that can result in an order to attend a CCDU (known as a '06 Centre') for up to two years.¹¹¹ 06 Centres resemble labour camps, with military drills and chanting of anti-drug slogans. Repeat drug offenders are subject to an additional period of 'post-detoxification management' for between one and two years.

In 2012, legal reforms were introduced to allow people to have court hearings and legal representation in court before being subject to an order to attend a CCDU. The extent to which people who use drugs are able, in practice, to access legal representation and court hearings is unclear.¹¹²

The administrative detention system undermines the achievement of the government's HIV prevention and harm reduction goals.¹¹³ Those who have been detained in 06 Centres often refuse to access harm reduction services as doing so would advertise to the police that they have relapsed, which can result in prison or a further term in a 06 Centre. Reasons for avoiding health care include the fear of records being shared with police increasing the risk of arrest and fear of stigma.¹¹⁴ Relapse rates amongst former detainees are very high (often over 90%) with a majority of detainees having been detained at least once before.

A policy decision in 2013, known as the *Renovation Plan on Drug Treatment*, confirmed the transition to community-based treatment.¹¹⁵ 80 of the 107 detention centres will be transformed to provide voluntary community-based treatment, social and occupational services, including psychological support and aftercare along with drug treatment services such as detoxification, OST and relapse prevention.¹¹⁶ The *Renovation Plan* aims to reduce the number of people who use drugs detained in CCDUs from 63% in 2013 to 6% by 2020.¹¹⁷ However there are concerns that the community-based treatment models will retain coercive aspects, such as police supervision and punitive responses to relapse.

2.6 Transitioning from CCDUs to voluntary treatment and services

In many Asian countries, the dominant model for responding to drug use over the past 20 years has been compulsory detoxification in government clinics and/or lengthy periods of detention in CCDUs (e.g. Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand and Vietnam). The policy of drug detention is based on flawed assumptions that punishment will serve as an effective deterrent to future drug use, and that physical discipline is essential to cure dependence. The exact number of people detained in CCDUs in these countries is unknown, but unpublished data collected by the UNODC indicates that almost half a million people are detained in seven countries.¹¹⁸ Other estimates have reported between 300,000 and 500,000 people detained in China alone.¹¹⁹

The detention of people who use drugs takes many forms across the region, and CCDUs vary in terms of management, conditions and the treatments offered. Typical characteristics of these centres include:¹²⁰

- People are subject to lengthy periods of compulsory confinement, followed by periods of supervision in the community
- Many people are sent to these centres with no appropriate medical or psychological examination or an adequate assessment and diagnosis of their drug use including screening to differentiate between recreational or dependent use. This accounts for the large number of people who are sent to centres who are not drug dependent
- People dependent on drugs are rarely medically supervised, and where medical treatment is available, it is generally restricted to the acute withdrawal phase
- Treatment is generally restricted to detoxification and abstinence-based approaches that are often not voluntary or evidence-based. Substitution therapy or other forms of evidence-based treatment options are rarely available
- Many centres are staffed by security personnel rather than health workers, and there is often a lack of due process, e.g. lack of legal representation, trial or hearing, judicial oversight or appeal rights. People may be admitted under police or public security orders, or at the request of family members
- Essential health services are scarcely available, if at all. Most centres lack any form of HIV prevention including condoms and sterile needles and syringes. In most centres, the only HIV prevention measures available are basic information materials. HIV testing is carried out in some countries (e.g. China and Vietnam), however it is mandatory, and detainees are rarely told of their results or linked to HIV treatment and care upon diagnosis
- Forced labour, physical exercises, prayer and/or military style 'boot camp' training are required as part of the 'rehabilitation' programme
- Offenders may be monitored after release but there is little or no aftercare provided
- There have been reports of physical and sexual violence

and other human rights violations in some centres, e.g. in Cambodia, Lao PDR and Vietnam.¹²¹

CCDUs have been subject to widespread criticism due to the lack of evidence of their effectiveness in addressing drug dependency, concerns about the lack of due process, exacerbation of health harms, and widespread reports of human rights violations. High relapse rates (often more than 90%) following release from centres have been reported in China, Malaysia, Vietnam and Cambodia, as well as high rates of overdose upon release.¹²²

In 2012, a cross-agency statement from 12 UN agencies called for the closure of CCDUs.¹²³ In 2014, the Global Fund to Fight AIDS, Tuberculosis and Malaria also called for the closure of these centres and committed not to fund programmes in these facilities.¹²⁴ Similarly, the UNODC has been critical of the lack of evidence to justify detention in compulsory centres:

*Many countries provide long-term residential treatment for drug dependence without the consent of the patient that is in reality a type of low security imprisonment. Evidence of the therapeutic effect of this approach is lacking, either compared to traditional imprisonment or to community-based voluntary drug treatment. It is expensive, not cost-effective, and neither benefits the individual nor the community.*¹²⁵

Decriminalisation will not be effective in achieving positive health outcomes unless it is accompanied by a commitment to phase out CCDUs and transition to voluntary, community-based treatment, harm reduction and social services. Additionally, the dominance of compulsory models in Asia means that voluntary, community-based treatment as a more effective alternative is not well understood in the region, even though it has been found to be much more effective than compulsory treatment in many contexts globally.¹²⁶

In a positive move towards phasing out CCDUs, China and eight Southeast Asian countries agreed in 2012 to reallocate resources from CCDUs to voluntary treatment services.¹²⁷ This commitment was reconfirmed at a regional meeting in Manila in 2015 that agreed to a roadmap to voluntary community-based services for people who use drugs in Asia.¹²⁸ At national level, Vietnam is an example where the country is encouraging moves towards phasing out many compulsory centres and increasing the amount of resources available for voluntary community-based treatment (see **section 2.5**). Malaysia has also made progress over the last decade in reducing reliance on CCDUs.

The transition to voluntary community-based services will require sustained commitment by multiple governmental stakeholders including health, drug control and law enforcement agencies. It will require investment in establishing community-based services in areas of need, and training and capacity-building of public health, public security, criminal justice and civil society groups, as well as communities of people who use drugs to ensure their involvement in the development, delivery, monitoring and evaluation of services.¹²⁹

2.7 Promoting voluntary referrals to health and social services

As highlighted throughout this report, the gold standard of decriminalisation is to remove all punitive responses to drug use, hence providing an enabling environment for people who use drugs to access health and social services without fear of sanctions, stigma or discrimination. In such an environment, access to harm reduction and drug dependence treatment should be voluntary, and relapses in drug use should not result in punishment. Healthcare and community workers play a critical role in assessing the specific needs of people who use drugs and referring them to health services including 'low threshold' services that are easy to access for marginalised clients, as well as hospitals, specialised clinics, welfare support, housing and social services.

Involuntary treatment or detention should only be permissible in crisis situations

According to principles of medical ethics and human rights, any form of involuntary treatment or detention for the purpose of treatment can only be used in a very narrow range of rare and exceptional crisis situations, and for the short-term only (i.e. maximum of a few days):

- where the person is at high risk of injuring him/herself or others, i.e. their conduct poses an imminent threat to themselves or others
- the period of detention is strictly time-bound to a limited number of hours or days, which is no longer than strictly clinically necessary
- the treatment provided is evidence-based and
- there are no other reasonably available, appropriate and less restrictive means of response.¹³⁰

In certain circumstances, coercive treatment may also be appropriate if the person lacks mental capacity to consent to treatment and requires an urgent treatment intervention. However, drug use and dependence are never a sufficient condition to identify a person as 'mentally incompetent'. If a person is subject to coercive, mandatory or compulsory treatment, due process protections must be afforded to the person including the right to legal representation, right to respond to allegations, to be given a statement of the reasons for the decision and a right to appeal the decision to an independent body that will consider the appeal within a reasonable timeframe.

Good practice in the provision of drug dependence treatment

The following are characteristics of good practice in the provision of drug dependence treatment:

- people are treated with respect, dignity and without judgment
- people are provided a choice of treatment and harm reduction options
- people are able to set their own goals and outcomes for treatment success – although abstinence may be a worthy goal, it may not be achievable or appropriate to all

- programmes are supportive of the person's goal of improving their health and overall well-being, and avoid relying on punishment
- recovery is assessed as any positive step or change that leads to the improvement of the person's health, well-being and overall quality of life¹³¹
- drug dependence treatment is holistic with attention to other health and social issues (e.g. housing, employment and legal aid).

Key features and principles of community-based treatment

Community-based approaches to treatment enable healthcare and social workers to develop a personal treatment plan to respond to the specific needs of the patient.¹³² The UNODC has issued a Guidance Document for Southeast Asian countries that outlines the key features and principles of community-based treatment,¹³³ which include:

- Participation of people who are affected by drug use and dependence, families and the community-at-large in planning and delivery of the treatment services
- Comprehensive approach, taking into account different needs including health, family, education, employment, and housing
- Informed and voluntary participation with respect for human rights and dignity, including client confidentiality
- Acceptance that relapse is part of the treatment process and will not stop an individual from re-accessing treatment
- Delivery of services in the community, that is, as close as possible to where clients live
- Close collaboration between civil society, law enforcement and the health sector.

Engaging health and community workers in promoting voluntary access to services

Portugal (see **Box 5 in section 2.3.1**) and Switzerland (see below) provide examples of good practice in how to engage health and community workers in a decriminalised environment. Policy makers should view the positive outcomes of the Portuguese and Swiss models of decriminalisation in light of the significant investments in public health initiatives that were made in conjunction with decriminalisation, including funding of outreach, treatment and harm reduction services and building the capacity of healthcare workers.

Switzerland¹³⁴

Switzerland's policy response to drugs combines partial decriminalisation with investment in health and harm reduction services. Possession of small amounts of cannabis has been decriminalised. Possession and use of other drugs may still attract a criminal penalty; however, where small quantities are involved, a person usually receives a waiver of prosecution, a waiver of sentence or a warning.¹³⁵

Healthcare and social workers are funded to intervene in public order incidents prior to police involvement. For example in the city of Zurich, the government established a partnership approach between public security and public health partners called 'Security, Intervention, Prevention'.¹³⁶ This involves outreach social services working in close cooperation with the police with shared information systems. Daily meetings are held between the police, social service and healthcare workers. Outreach workers are able to mediate public order issues by approaching people who use drugs respectfully and without stigma, with the intention of providing help before the police intervene. In this way, health and social workers can play a role in reducing contact of people who use drugs with the criminal justice system. If people who use drugs are held in custody, they can access comprehensive health services inside police lock-ups (remand centres). There are voluntary drug and alcohol treatment and welfare services in the community. Drug dependence treatment is covered under health insurance schemes.

Switzerland has also invested heavily in harm reduction services including OST, NSPs and drug consumption rooms. The country pioneered a new model of heroin-assisted therapy in which long-term users of opioids who have failed on traditional OST programmes using methadone or buprenorphine are prescribed pharmaceutical heroin, which is injected under medical supervision. The programme has reduced the risk of overdose, as well as the involvement of people who use drugs in low-level dealing. The success of this approach has led to similar programmes being launched in other countries including Canada, Germany, the Netherlands, Spain and the UK.¹³⁷

The Swiss system has resulted in an elimination of drug injecting in public areas, an improvement in public safety, and improved health outcomes for people who use drugs including a reduction in heroin use, the transmission of blood-borne diseases and overdose deaths.¹³⁸

Chapter 3

Mechanisms to divert people away from the criminal justice system

3.1 Overview of diversion

Diversion programmes provide mechanisms to divert people who use drugs away from the criminal justice system (i.e. upon arrest, prosecution, conviction or incarceration) and, where appropriate, towards treatment, harm reduction, counselling and other services. Diversion programmes can operate for a range of offences including drug use and possession, possession of drug use equipment and non-violent offences related to drug use, such as theft and low-level smuggling and dealing.

Diversion programmes have immediate health and welfare benefits for the people who use drugs who participate in the programmes, while also helping to reduce pressure on the prison system and the courts. Diversion programmes can enhance human security by enabling criminal justice and law enforcement resources to focus on serious crimes that threaten public security, instead of minor drug-related offences and people who use drugs.

Diversion programmes should be implemented in moving towards health-based responses to drug use.

They can be implemented in contexts where drug use remains criminalised in order to reduce the health and social harms, as well as the economic costs, associated with criminalisation. They can also be implemented in contexts where drug use has been decriminalised. In fact, comprehensive, non-punitive diversion programmes play a key role in many of the decriminalisation models implemented in other regions of the world.

Many countries that have implemented *de facto* decriminalisation rely on police diversion programmes as a component of the model, particularly given the key role that police play in ensuring that laws that technically remain in place are not enforced. Diversion programmes can also play an important role in countries that have taken the further step of removing penalties for these offences from the criminal law (*de jure* decriminalisation). In these countries, diversion programmes can be provided for crimes such as theft, low-level smuggling and dealing where the offence is driven by the person's drug use or dependence.

3.2 UN standards and norms on diversion

Box 7 The United Nations Standard Minimum Rules for Non-Custodial Measures (The Tokyo Rules)¹³⁹

The Tokyo Rules provide police, prosecutors and courts with an internationally agreed framework for implementing non-custodial alternatives, consistent with the UN drug conventions. Key provisions include:

- The criminal justice system should provide a wide range of non-custodial measures, taking into account the observance of human rights, the requirements of social justice and the rehabilitation needs of the offender.
- Consideration shall be given to dealing with offenders in the community, avoiding as far as possible resort to formal proceedings or trial by a court.
- Non-custodial measures should be used in accordance with the **principle of minimum intervention**. Non-custodial measures shall not involve undue risk of physical or mental injury to the offender and the dignity of the offender shall be protected at all times.
- **Police and prosecutors should be empowered to discharge an offender pre-trial or impose non-custodial measures in minor cases.**
- Pre-trial detention shall be used as a means of last resort and shall be administered humanely and with respect for the inherent dignity of human beings.
- The Rules encourage the use of **non-custodial sentencing options** including verbal sanctions, such as admonition, reprimand and warning; conditional discharge; suspended or deferred sentence; community service orders or referral to non-institutional treatment.
- Drug treatment should only be conducted by professionals with suitable training and practical experience. Failure of a non-custodial measure, such as a drug treatment programme, should not automatically lead to incarceration. Instead, other suitable alternatives to imprisonment should be sought.

The UN drug control conventions include provisions permitting member states to implement alternatives to conviction or punishment for drug use, and associated offences of possession and cultivation, such as referrals to treatment and education.¹⁴⁰ At the sub-regional level, the South Asia Association for Regional Cooperation (SAARC) has adopted the same flexibilities in its regional agreement on drugs.¹⁴¹ To give effect to these provisions,

the UNODC promotes diversion from the criminal justice system through the use of alternatives to formal judicial proceedings, detention and punishment for cases of a minor nature, consistent with the *United Nations Standard Minimum Rules for Non-Custodial Measures* (see **Box 7**).¹⁴²

Evidence suggests that for people found to be dependent on drugs, referral to health and social services can help break the cycle of dependence, reoffending and imprisonment (including pre-trial detention).¹⁴³ Systems to divert minor drug offenders who are dependent on drugs towards evidence-based drug dependence treatment and reintegration services can also reduce pressure on prisons, incidence of crime, and relapse rates. Where referrals to harm reduction and health services are available, diversion programmes can also lead to reductions in the transmission of blood-borne viruses such as HIV and hepatitis.

Diversion programmes are most effective when they:

- Are tailored to the specific needs of different sub-populations, including programmes for women (see **Box 8**) and young people¹⁴⁴
- Use eligibility criteria and programme requirements to target the level and type of intervention according to the nature of an individual's drug use or dependence, and the severity of drug-related offending, and

Box 8 The Bangkok Rules: promoting non-custodial and diversionary measures for women¹⁴⁵

The *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders* ('the Bangkok Rules') complement the Tokyo Rules and call on UN member states to establish gender-specific alternatives to pre-trial detention and imprisonment, including provision of the following:

- options for diversion measures and pre-trial alternatives to detention, taking account of the history of victimisation of many women offenders, as well as their background, caretaking responsibilities, and family ties.
- alternatives for women that combine non-custodial measures with interventions to address the most common problems leading to women's contact with the criminal justice system, including women-specific drug treatment programmes that offer childcare services.
- drug treatment services accessible to women that are women-only, gender-sensitive and trauma-informed, and do not involve detention, through diversion or alternative sentencing measures. The provision of such services can also serve as a crime prevention measure.

- Refer to treatment, education and counselling that is evidence based, humane and flexible, thereby providing less punitive and more effective options for improved health and social reintegration outcomes than prison.

To enhance effectiveness, countries should establish a broad range of diversion programmes at different stages

of the criminal justice process, as outlined in the following sections, including:

- diversion by police
- diversion by prosecutors, and
- diversion by judges at pre- and post-sentencing.

3.3 Diversion by police

Police diversion can occur either pre-arrest or at the post-arrest/pre-court stage. Police diversion is often preferable to diversion at a later stage as it avoids the imposition of formal criminal charges and pre-trial detention. The traditional role of the police is to ensure that offenders are arrested and brought before the courts to face conviction and sentencing. In such diversion schemes, police are given the role of referring people away from the criminal justice system and/or towards health and social services. In some schemes, the police have discretion to issue cautions whereby offenders are given a verbal warning with no further penalty, and in some countries the police can issue on-the-spot fines, similar to issuing a traffic violation (e.g. the Czech Republic, Switzerland and some Australian states).

Police diversion may present some challenges. For example, as the police usually regard the enforcement of criminal law as their primary role, diversion programmes may be considered counter to the dominant organisational culture. Police may also be resistant to implementing health-oriented diversion programmes if they view drug use as the result of 'individual weakness' or 'moral failing', rather than as a complex health and social issue. There may also be a high degree of distrust of the police by people who use drugs due to prior experience of police abuse and corruption.¹⁴⁶

Another risk of giving police a central role in diversion is 'net-widening', whereby increased police powers and low threshold quantities result in more people who use drugs in contact with the criminal justice system rather than less (for example, this has been observed in some parts of Australia).¹⁴⁷

As a result, in designing and implementing police diversion schemes, policy makers should consider police trainings and other capacity-building efforts on drug use, harm reduction and drug dependence treatment, as well as the promotion of the programme to people who use drugs and associated communities. Engaging representatives of people who use (or previously used) drugs in the process of designing, managing and evaluating police diversion can help build trust between communities and police. Engaging police officials from jurisdictions with experience in implementing diversion programmes may also be helpful. On this basis, countries should consider introducing police diversion schemes with the following features:

- If drug use continues to be a criminal offence, focus on people found in possession of minor amounts of drugs or drug use equipment
- If drug use is decriminalised, then police diversion schemes should focus on people dependent on drugs who commit minor, non-violent offences – such schemes could also operate in jurisdictions that have not decriminalised drug use
- Include an option for police to take no further action, or

to simply issue a caution to a person for drug use, possession of drug use equipment, or possession or cultivation for personal use

- Diversion may involve referrals for medical assessment by trained medical staff and, where the person is drug dependent, evidence-based treatment undertaken by accredited treatment agencies. Failure to complete a treatment programme, or relapse in drug use, should not result in a criminal sanction
- Diversion mechanisms should adopt clearly defined eligibility criteria. Police diversion schemes may exclude people who have been charged with a violent crime or more serious drug offences
- Admitting culpability for an offence should not be a requirement to enter a police diversion scheme.¹⁴⁸ This requirement may deter people from admitting their drug dependence, therefore preventing referrals to health and education services.

Examples of good practice in police diversion

• Australia

Each Australian state and territory has developed different police diversion schemes. Some operate under a *de facto* decriminalisation approach, while others operate in contexts where criminal sanctions have been abolished and replaced by administrative sanctions. The police can exercise discretion to divert people who use drugs to counselling, education and health services. In some states, administrative penalty schemes allow the police to issue on-the-spot fines for minor drug offences (e.g. for possession of cannabis in South Australia).

The Police Drug Diversion Program in the Australian state of Tasmania applies to people found in possession of any illicit drug.¹⁴⁹ Different procedures apply for diverting offenders away from the criminal justice system depending on the type of drugs involved. In the case of cannabis, offenders found with up to 50 grams of cannabis are cautioned instead of charged. They may be cautioned three times in ten years. Information and referral to counselling are provided on the first and second caution. On the third caution, the offender is referred to the Alcohol and Drug Service for a health assessment and brief intervention or treatment. Further offences may result in a criminal conviction.

• USA

Several cities have introduced police diversion for low-level, non-violent drug offenders. For example, in the city of Seattle, an innovative police diversion model is implemented through a programme called Law Enforcement Assisted Diversion (LEAD),¹⁵⁰ targeting people involved in minor drug offences (such as low-level dealing and possession) or sex work. Police divert them to community-based services, with diversion occurring at the point of arrest. Case managers conduct an assessment that considers substance use

Box 9 The Law Enforcement and HIV Network (LEAHN)

LEAHN promotes the effective engagement of law enforcement personnel – especially police – in national HIV responses, through peer support, professional development, advocacy and networking.

LEAHN manages a network of Country Focal Points (CFPs) – serving or retired police officers who take on the task of educating law enforcement peers about HIV and harm reduction approaches to policing key affected populations. CFPs also promote joint activities between police and vulnerable communities. Over 20 CFPs are involved in Bangladesh, India, Indonesia, Nepal, Thailand and Vietnam. The full list of CFPs is available at www.leahn.org.

LEAHN also facilitates improved working relationships between law enforcement and civil society organisations implementing HIV-related activities. LEAHN and its CFPs can act as a bridge between community and law enforcement representatives and support formal and informal partnerships towards effective public health and public security responses.

frequency and the person's needs in relation to treatment and harm reduction services, mental health problems, and personal relationships. Participants also receive social support to connect them with services such as legal aid, job training and/or placement, housing assistance, and counselling. Success in the LEAD programme is not judged by negative urine tests or even abstinence from drugs, but by progress made in improving the participants' overall quality of life, which is assessed by social and health workers. It is important to note that a person can re-enter the programme if they are caught again for a similar offence by the police. An evaluation of the programme showed that people who were diverted to these services were 58% less likely to be arrested for a future offence than those who were not diverted.¹⁵¹

Police collaboration in support of harm reduction: examples of good practice in Asia

In some parts of Asia, although drug use remains illegal, the police are encouraged by health authorities to adopt a tolerant and pragmatic approach to allow NSP and OST services to operate and to play an active role in reducing the health harms affecting people who use drugs. As the police come into regular contact with people who use drugs, they can be key players in offering advice and information, facilitating access to harm reduction services, and ensuring rapid responses to overdoses (see **Box 9** on the Law Enforcement and HIV Network).¹⁵² Even in a criminalised environment, the role of the police in supporting harm reduction can include:

- The referral of people to drug dependence treatment programmes, harm reduction programmes and other types of health services, welfare, housing and employment assistance

- The provision of a supportive environment for harm reduction services by not arresting people who use drugs in the vicinity of drop-in centres, NSP or OST sites, or other health services frequented by people who use drugs, such as specialised clinics. It is important that police have a supportive and constructive relationship with initiatives designed to reduce drug harms such as drop-in centres, NSPs, OST, peer educators and outreach workers.¹⁵³
- Avoiding arrests at the scene of a drug overdose therefore encouraging people to ring for medical help without delay or fear of prosecution.

Good practices of police diversion have been developed in several sites in some Asian countries. For example:

- Informal police diversion to harm reduction services is encouraged under **Cambodia's** Police Community Partnership Initiative (PCPI). A Cambodian NGO (KHANA) and the Ministry of Interior implemented PCPI at HIV 'hotspots' in Phnom Penh. Police are encouraged to exercise discretion by referring people who inject drugs to harm reduction services instead of arresting them, provided there is no evidence of drug trafficking. 200 police officers have been trained in harm reduction, along with 150 commune council members, representatives of people who use drugs and other local stakeholders.¹⁵⁴
- In Yuxi city, **China**, police refer people who use drugs to a community-based treatment centre known as 'Peace No. 1'. Police avoid making arrests for minor drug possession or use in the immediate vicinity of the centre. The goals of this programme are to improve the health of people who use drugs; decrease re-incarceration in compulsory detoxification centres; increase the removal of former drug users from the government surveillance system; strengthen social and familial support for people who use drugs; and improve reintegration of people who use drugs in the community. Peace No. 1 clients have access to comprehensive psychosocial and healthcare services, including methadone. Harm reduction training is provided to police across the district.¹⁵⁵
- In **Vietnam**, the Center for Supporting Community Development Initiatives supports local authorities to implement voluntary and community-based treatment in Bac Giang province. The voluntary drug treatment model in Bac Giang consists of a voluntary drug treatment centre and five community drug counselling and treatment sites.¹
- In **Thailand**, an informal truce was negotiated between civil society health service providers and local law enforcement representatives in Narathiwat Province. The truce was the result of a series of capacity building and sensitisation workshops that were facilitated by a supportive senior Thai law enforcement official. Local law enforcement officers agreed to apply greater discretion, often diverting people who use drugs to health services.¹⁵⁷

3.4 Diversion by prosecutors

Prosecutors generally have discretion not to proceed with criminal charges under certain circumstances. These circumstances are usually defined by the criminal law and prosecutorial guidelines. The Tokyo Rules encourage prosecutors to consider alternatives to prosecution.¹⁵⁸

Where appropriate and compatible with the legal system, the police, the prosecution service or other agencies dealing with criminal cases should be empowered to discharge the offender if they consider that it is not necessary to proceed with the case for the protection of society, crime prevention or the promotion of respect for the law and the rights of victims. For the purpose of deciding upon the appropriateness of discharge or determination of proceedings, a set of established criteria shall be developed within each legal system. For minor cases the prosecutor may impose suitable non-custodial measures, as appropriate.

The role of prosecutors differs between legal systems. The civil law and socialist law systems found in many East Asian countries take a different approach to prosecutor roles compared to common law countries (the former British colonies in South Asia and Southeast Asia). Prosecutors may have much less discretion regarding the decision to proceed with a case in civil law and socialist law systems compared to common law countries. However, according to the *Tokyo Rules*,¹⁵⁹ (see **Box 7 in Section 3.2**) special provisions can be made to exercise discretion in drug cases.

Prosecutors should be encouraged not to prosecute minor drug offences taking into account the availability of alternatives to prosecution, such as a caution, warning or referral to social or health services. Guidelines can be developed to advise prosecutors not to proceed with prosecution for minor drug offences, or to impose conditions on offenders if they decide not to prosecute, e.g. requiring the person to undergo a counselling session and/or drug dependence assessment with a health professional, in order to identify any need for treatment and referral to other health, harm reduction or social services.¹⁶⁰ Guidelines can ensure that prosecutors rely on the assessment of an appropriately trained health professional as to a diagnosis of drug dependence and the need for treatment before a decision is made to refer a person to treatment.

Example of diversion by prosecutors: The case of Cambodia

Under Cambodia's *Law on Drug Control* of 2011, before making a decision to prosecute a person for drug use, the prosecutor may provide guidance to the person to accept treatment if the person is certified by a medical professional as being dependent on drugs. If the person agrees to accept treatment and rehabilitation, the prosecution can be put on hold.¹⁶¹

3.5 Diversion by courts

3.5.1 Overview of court diversion models

A variety of models of court diversion from the criminal justice system have been developed worldwide. Some are implemented by ordinary criminal courts, while others are implemented by specialised courts (referred to in some countries as 'drug courts').

Criminal courts in many Asian countries already have a well-established role in linking drug offenders to treatment and can order drug offenders to attend compulsory treatment including detoxification in clinical settings or 'treatment' and 'rehabilitation' in CCDUs. In some cases, this is considered part of the sentence for the offence, and/or treatment may be provided in a prison or similar correctional setting (e.g. Hong Kong, Indonesia, Taiwan, Republic of Korea). However, this usually occurs through a punitive process of forced treatment by court order under police or government supervision, rather than as part of a supportive and voluntary process designed to promote access of offenders to community-based education, harm reduction, treatment and care options.

In other parts of the world, less punitive systems operate in which courts can divert people to a community-based treatment programme based outside of prison or detention centres.¹⁶² Good practice in delivering drug dependence treatment requires services that are based on scientific evidence of effectiveness, tailored to the needs and preferences of the individual, and that comply with human rights norms and respect for the dignity of the patient (for more information on good practice in the provision of drug dependence treatment, see **section 2.7** on promoting voluntary referrals to health and social services).¹⁶³

3.5.2 Examples of court diversion in Asia

Many countries (including Afghanistan, India, Bhutan, Indonesia, Malaysia, the Maldives, Thailand and the Philippines) have introduced systems whereby courts can order people arrested for drug use or possession for personal use to attend 'treatment' as an alternative to prison. In some countries, people arrested for drug use or possession are detained in CCDUs, ostensibly for 'treatment' and 'rehabilitation' (as outlined in **section 2.6**), although community-based treatment options are sometimes also available.

Court diversion schemes in Asia face significant implementation challenges, and, due partly to resource and capacity constraints, remain largely punitive in nature. Indeed, most court diversion models in the region do not distinguish between people dependent on drugs and those who do not experience problems with their drug use, leading many people who do not require treatment to be ordered into a CCDU or other type of 'treatment' programme.

The following examples illustrate the variety of punitive and non-punitive approaches to the role of courts in linking

people to treatment and services that already exist in Asia. Effective court diversion models should be non-punitive, evidence-based and fully compliant with public health, harm reduction and human rights principles.

Indonesia: Court diversion to community-based treatment¹⁶⁴

Starting in 2009, courts in Indonesia have been able to order people arrested for drug use to attend treatment facilities in hospitals, CCDUs or community-based programmes as an alternative to prison. Since then, the courts have had the option of seeking advice from medical experts on treatment options for people who use drugs including community-based services. Examples of court diversion to community-based services remain rare, however, due to a range of factors including limited availability of such services and lack of awareness of the judiciary. In practice, therefore, courts have been slow to implement this diversion scheme, and the incarceration rate of people for drug use has increased since the diversion policy was introduced. The quality of community-based services also varies greatly. For example, many religious-based services only offer strict abstinence programmes and do not implement evidence-based interventions (for further details on Indonesia's diversion policy, see **section 3.6.2** on engagement of health, community and legal aid workers).

Malaysia: Voluntary Cure and Care Centres and community supervision and treatment programmes¹⁶⁵

Drug use in Malaysia carries a penalty of up to two years' imprisonment and a fine.¹⁶⁶ The government has made progress in moving away from reliance only on detention centres to a range of options, including community-based treatment centres. In 2010, Malaysia established 'Cure and Care' centres providing drug dependence treatment and harm reduction services. There are three types of centres: Cure and Care Rehabilitation Centres (compulsory detention, equivalent to a CCDU); Cure and Care Centres (voluntary inpatient services); and Cure and Care Service Centres (voluntary outpatient services). Cure and Care Service Centres provide client-centred treatment and support services including OST. Adherence to treatment at the voluntary Cure and Care Service Centres is facilitated by social support.

Since 2010, courts have had the option of ordering adults dependent on drugs to attend the Cure and Care Centres or Service Centres as an alternative to incarceration in prison or a Cure and Care Rehabilitation Centre. As an alternative to prosecution and incarceration, people arrested for drug use for the first time are placed under the supervision of the government's anti-drug agency for two years. In 2015, over 50,000 people were under community supervision. People under community supervision undergo monthly urine tests. After one or two positive urine tests, the courts apply more intensive interventions, including counselling and

peer support. After a third positive urine test, the person may be sent to compulsory detention in a Cure and Care Rehabilitation Centre or for treatment at an OST service.¹⁶⁷

A 2015 study found that the risk of relapse for people sent to compulsory detention was 7.6 times greater than for people receiving voluntary treatment.¹⁶⁸ However, the government continues to show reluctance in fully abandoning models of compulsory detention as a form of treatment or rehabilitation.

India: Immunity for people arrested for drug use who attend drug treatment¹⁶⁹

Under Indian law, people dependent on drugs who express willingness to undertake treatment can claim immunity from prosecution, provided the offence they are charged with is drug use or involves a minor quantity of drugs (e.g. no more than 5 grams of heroin, 25 grams of opium, 2 grams of cocaine or amphetamines).¹⁷⁰ Treatment can take place in a hospital or an institution maintained or recognised by the government or a local authority.¹⁷¹ Upon completion of treatment, the court may defer the sentence and release the offender on a bond (a requirement that the offender not commit another drug offence for a period of up to three years).

Criminal proceedings may be reinstated if treatment is not completed. This approach has the potential of being a useful mechanism for diversion. However, it is rarely applied in practice and there have been problems with implementation, particularly regarding the lack of clarity about the procedure and its inconsistent application by the courts.¹⁷² In addition, most people are detained in prisons while awaiting and during a court hearing. In practice, therefore, a large number of people remain incarcerated for drug use alone.¹⁷³ Finally, the fact that a person caught for drug use and possession for personal use – whether dependent or not – can be ordered to complete treatment is also an inappropriate use of treatment programmes.

Bhutan: Withdrawal of prosecution for people who complete treatment

Bhutan has a provision whereby people who are charged with possession of drugs for personal use may be ordered by a court to report to an approved treatment centre. If the person undertakes and successfully completes treatment without committing any further offence, the court may allow the prosecution to be withdrawn.¹⁷⁴

The Philippines: Order to attend compulsory 'treatment' and 'rehabilitation'

In the Philippines, it is compulsory for courts to refer people dependent on drugs to treatment and rehabilitation in a government centre for six months for their first offence. A Drug Abuse Treatment and Rehabilitation Centre, operated by the Department of Health, has been established in every region. In reality, the capacity of many of these rehabilitation centres to offer evidence-based treatment is very poor. In 2015, the government agreed to pilot community-based drug dependence treatment services, which could provide an alternative to detention in compulsory centres.¹⁷⁵

3.5.3 Specialised drug courts¹⁷⁶

Specialised drug courts were first established in the USA in 1989. Since then, they have been introduced in Australia, Europe, North America and Latin America, and are being considered by some Asian countries.¹⁷⁷ For example, in response to an escalation of heroin use, a specialist drug court was established in the Maldives in 2011 to divert drug offenders to compulsory detoxification, treatment and rehabilitation.¹⁷⁸ In 2014, Vietnam's Deputy Prime Minister instructed the Supreme People's Court to develop a pilot drug court after visiting a drug court in the USA.¹⁷⁹

Although models of drug courts vary greatly, they typically operate through the following process:

- The court approves a treatment plan, developed by a multidisciplinary team
- The court closely monitors progress of the person in following the treatment plan
- A system of reinforcement and reward operates, e.g. reduction of time in the treatment programme for compliance, and sanctions including imprisonment for non-compliance
- People must generally plead guilty as a condition of drug court participation, and if they complete the court-prescribed treatment plan, their prison sentence may be deferred or suspended.

The target group for drug courts varies from country to country, and within countries. In the USA, drug courts tend to target people who use drugs and in possession of small amounts of drugs, including people who are found to be dependent on drugs – although there are problems with court decisions made in the absence of any medical assessment of drug dependence.¹⁸⁰ In Latin America, most drug courts target people who use drugs and those caught in possession of small amounts of drugs. In Australia, some drug courts focus on repeat offenders whose criminal activities may include non-violent, drug-related offences such as theft that are the direct result of long-term drug dependence.¹⁸¹

Drug courts have faced a number of criticisms.¹⁸² First, models targeting people charged only for drug use or possession for personal use continue to address drug consumption as a criminal, rather than a health and social, issue.¹⁸³ Second, the decision on whether an offender is dependent or not – and whether the offender is therefore in need of treatment – is ultimately made by judges, instead of trained medical professionals. Third, in many contexts the creation of drug courts has not been accompanied by the development of evidence-based treatment programmes. The lack of effective treatment available in the programmes that people are ordered to attend by drug courts has unsurprisingly often led to high rates of relapse (see also **section 2.7** on the exceptional, crisis situations which may permit involuntary treatment).¹⁸⁴ Finally, the imposition of criminal punishment for people failing their treatment or relapsing goes against the scientific understanding of drug dependence whereby relapses are a likely occurrence.¹⁸⁵ In countries such as the USA, criminal sanctions imposed

on a person having failed the treatment programme often end up being more severe than if the person had been prosecuted under normal court proceedings.¹⁸⁶

Additional challenges in applying a drug court model in low- and middle-income countries generally include:

- A lack of resources to enable drug courts and judges to case manage each offender
- A lack of resources to support multi-disciplinary teams involved in developing treatment plans and tailoring health and social responses to the needs of each person
- A lack of evidence-based drug dependence treatment, rehabilitation and support services. For example, in 2013 drug offenders assessed by the Maldives Drug Court as eligible for treatment were reportedly temporarily detained in prisons because the country's few detoxification centres were all full and unable to accommodate new patients.¹⁸⁷

Given that the quality of treatment impacts the outcomes of a drug court, countries are encouraged to first invest in ensuring the availability of evidence-based treatment before allocating the significant resources required to institute drug courts. Policy makers should bear in mind that the overall objective of such schemes is to *reduce* the number of people who use drugs sent to prison, and to *improve* health outcomes. Countries considering drug courts in Asia should be mindful of the concerns that have been raised above, and ensure that any mechanism put in place does not result in the application of more punitive measures against people who use drugs.

3.5.4 Good practice in court diversion

Below are some principles supporting good practice for court diversion programmes. These principles apply both to general criminal courts and to specialised drug courts:¹⁸⁸

- Court diversion should not apply for people whose only offence is drug use, possession or cultivation of small quantities for personal use, or possession of drug use equipment – they should be able to access diversion programmes at an earlier stage, i.e. before or immediately after police arrest. Therefore greater investment should be made in establishing police or prosecutor diversion, rather than court diversion

- Diversion decisions should be based on a professional assessment of the health, welfare and support needs of people who use drugs
- The programmes should ensure access to a continuum of evidence-based drug dependence treatment and other health and social services – this should incorporate harm reduction measures such as OST, and not be based solely on abstinence
- Treatment programmes should be tailored to the specific needs of women, young people and minority ethnic groups to ensure positive health outcomes
- Partnerships between the courts and community-based organisations should be established to generate local support and enhance programme effectiveness
- Ongoing case management should include the social support necessary to achieve social reintegration, and a non-judgmental approach to drug use
- If drug testing is being used, it should be a tool to inform treatment responses, not to trigger punishment
- Relapse should be recognised as a normal part of recovery. Failure to complete a treatment programme or the renewed use of drugs should therefore not lead to the imposition of criminal sanctions or punishment.
- Post treatment and aftercare services should enhance the long-term effects of treatment programmes, and rely on a network of health and social support services.

Costa Rica: managing the risks of drug courts

Costa Rica has adapted the drug court model to ensure it does not result in the application of punitive measures for people dependent on drugs. Costa Rica's drug court does not target people caught with small amounts of drugs for personal use, since drug use and possession for personal use are decriminalised. In 2013, the country implemented a Restorative Justice Project that aimed to reduce the overall prison population. A drug court system was established to target low-level, first-time offenders who committed an offence related to their drug dependence. Offenders are referred to an interdisciplinary and specialised group composed of physicians, psychologists and social workers who tailor their response to the needs of the client. Options include referrals to residential or outpatient treatment.¹⁸⁹

3.6 The role of healthcare, legal and community workers in diversion schemes

3.6.1 Principles for engagement of healthcare, legal and community workers

Health, legal and community workers can play an important role in promoting a public health approach to drug use. They can intervene at the community level to refer people who use drugs to health, legal and social support services before they come into police contact (see the example of Switzerland in **section 2.7**). They can provide a holistic health assessment to inform the decision of the police, prosecutors and courts in relation to which diversion response would be most appropriate for people who use drugs, and how to claim and defend those rights (see the example of East Java Action and LBH Masyarakat in Indonesia in **section 3.6.2, Box 10**).¹⁹⁰

It is good practice for diversion programmes to include a mechanism through which qualified health professionals are engaged in the assessment of an individual's needs (see the examples of Portugal in **section 2.3.1, Box 5**, and the LEAD programme in the USA in **section 3.3**).

Healthcare workers can assess whether any of the following options are appropriate: detoxification, OST, residential rehabilitation, psychiatric and psychological interventions, counselling, group programmes for relapse prevention, and access to testing, counselling and treatment for HIV, hepatitis, tuberculosis and other diseases. Importantly, health professionals can assess drug dependence and any need for treatment, recognising that only about 10% of people who use drugs experience drug dependence.¹⁹¹ Where drug treatment is required for an individual, health professionals can also advise on referrals to the most suitable treatment service (see **section 2.7** for good practice in providing drug dependence treatment and community-based treatment).

Diversion also provides an opportunity to assess needs in relation to accommodation and housing, welfare entitlements, employment and vocational services, education and training, and family counselling – all of which may benefit from the expertise of health, legal and social workers. In addition, health, legal aid and community workers can engage in long-term partnerships with the police and people working in the justice sector to ensure that the response to drug use is coherent and based on health and human rights imperatives. Healthcare workers may also have a role in coordinating comprehensive aftercare and links to longer-term voluntary treatment services.

Given the critical role of health, legal aid and community workers in ensuring the effectiveness of decriminalisation and diversion responses to drug use, they should be involved in monitoring and evaluating the quality and outcomes of those measures.

3.6.2 The engagement of health care, legal and community workers: Experiences in Asia

Cambodia

Since 2011, Cambodia has provided a legal and policy framework that supports the engagement of healthcare workers in providing harm reduction services (including NSP and OST) and community-based drug treatment services.¹⁹² Voluntary, community-based treatment services have been established that promote a continuum of care and strengthened community mechanisms to provide services and referrals including to harm reduction services. By the end of 2013, over 1,200 people who use drugs were receiving community-based treatment services in Cambodia.¹⁹³ Despite this positive development, however, the compulsory detention of people who use drugs still occurs in Cambodia (including under vagrancy laws and public order powers).¹⁹⁴ There are also ongoing tensions between local law enforcement authorities and health organisations providing services to people who use drugs in Cambodia, particularly NSPs.¹⁹⁵ This indicates the need to ensure that law enforcement officers operating at the local level are fully aware of the nature and purpose of harm reduction programmes, and trained on how to support those measures.

Indonesia¹⁹⁶

In 2014, seven Indonesian government bodies signed a memorandum of understanding confirming that 'habitual drug users' would be referred to rehabilitation centres rather than prison. Officials from the National Narcotics Agency, the Health Ministry, the Supreme Court, the Attorney General's Office, the National Police and the Social Affairs Ministry signed the document. The agreement provides for joint assessment teams of medical and legal personnel at national, provincial and municipal levels to determine whether a suspect is a drug dealer or a user and to propose treatment options to a judge hearing a drug prosecution. However, evidence indicates that the system is not operating well in practice, and is plagued by corruption. As a result, people who cannot pay bribes continue to end up in prison even if they are eligible for diversion to treatment.¹⁹⁷

Nevertheless, Indonesia's National AIDS Commission is making progress in implementing its national Community-Based Drug Dependence Treatment (CBDDT) programme. In 2015, the programme was being implemented in 20 facilities operated by community-based organisations in 15 cities and reached over 2,100 clients.¹⁹⁸ This programme uses indicators of success that focus on improved quality of life and a reduction of risks through a harm reduction approach. The CBDDT comprises a two-month, individualised inpatient programme followed by an outpatient programme of four months. Implementing organisations are required to adhere to national guidelines that define a minimum standard of drug dependence treatment. A

Box 10 Providing legal assistance to people who use drugs: The LBH Masyarakat example

LBH Masyarakat provides free legal services for people who use drugs, and empowers people who use drugs to provide community legal assistance, including as trained paralegals.¹ LBH Masyarakat works closely with paralegal workers and the communities or family members of people who use drugs to gather witnesses, prepare legal defence arguments, and collect supporting evidence including psychiatric or medical assessments that show a history of dependence and treatment needs. Their legal assistance includes representation in support of a client's diversion at any stage from police investigation to the court hearing. Although police are permitted to divert a case away from prosecution under existing regulations, they are often not willing to divert people who use drugs towards treatment options (which they are also authorised to do since drug use remains criminalised under the drug law). Judges are also able to exercise their discretion in favour of diversion, including upon receiving expert witness testimony and other supporting evidence.

range of services complement the CBDDT approach via referral mechanisms, including harm reduction services, peer support and mental health services. PKNI, Indonesia's national network of people who use drugs, provides community-led monitoring of the programme.

Some civil society organisations, including East Java Action and LBH Masyarakat (see **Box 10**), offer legal assistance to people who use drugs to ensure the access of people who use drugs to these diversion programmes.

Thailand

Under Thailand's drug laws, a committee made up of psychologists, psychiatrists, community health workers and community leaders reviews each case to inform the court on whether a person charged with consumption and possession for personal use should be diverted away from prison to treatment.²⁰⁰ The options available to the committee include referral of the person to compulsory four-months detention in a CCDU; releasing the person to undertake supervised outpatient cognitive behavioural therapy; releasing the person with no further action; or referral to a criminal court for sentencing, which involves a potential prison sentence. The committee assesses whether the accused is a user or is drug dependent: those deemed to be dependent are detained in CCDUs. Failure to abstain during or after treatment can result in prosecution and imprisonment.

While the law ostensibly provides a framework for addressing health needs, the system has been criticised as failing to provide access to evidence-based treatment. In Thailand, the determination of whether an individual is dependent on drugs is usually made on the basis of urine test results alone, without assessing levels of drug use, dependence or related risk behaviours, for example by using the Addiction Severity Index.²⁰¹ There is no requirement for the committee to meet the person being assessed, which would enable the person's needs and views to be taken into account in developing treatment plans.²⁰²

Another concern with the procedure is that offenders may be held in pre-trial detention with no access to treatment for six weeks or longer awaiting a decision of the committee.²⁰³ Many detainees, who by law are considered as 'patients', therefore continue to be treated as criminals as they may be subject to incarceration in either prison or a CCDU. As OST is not available in CCDUs, the 'treatment' provided is restricted to group work, work therapy, vocational training and physical education, with no input from the patient about their treatment programme. All patients participate in the same programme.²⁰⁴ There is little evidence that this approach has been effective in improving health.

Chapter 4

Conclusions and recommendations: Principles and priorities

Guiding principles

Governments should commit to legal and policy responses to drugs that are based on evidence and comply with the principles of harm reduction, human rights and social inclusion.

National policy and planning frameworks

Governments should abandon the pursuit of achieving a 'drug-free society' as a policy priority. National drug policies should instead focus on enhancing public health, reducing the social and economic harms associated with drug markets and drug use, improving the protection of human rights, and supporting the social inclusion of vulnerable and marginalised communities of people who use drugs. Planning for the development and implementation of decriminalisation and diversion programmes needs to be based on data and evidence (e.g. the effects of criminalisation and punishment on the health and quality of life of people who use drugs), and directly involve affected communities, particularly people who use drugs, to ensure the effectiveness of those measures.

National priorities should include:

- **Decriminalisation:** Conduct comprehensive legal and policy reviews, based on data, evidence and consultations involving local communities, experts and people who use drugs, to inform national plans that map each country's path towards the removal of criminal penalties and other punishment for drug use, possession of drug use equipment, and possession and cultivation of drugs for personal use. Each country needs to take into account a range of factors including the role and capacity of police, prosecutors, courts and health-care workers to engage effectively in the decriminalisation model.
- **Diversion:** Develop and introduce programmes through which the police, prosecutors and/or courts divert people who use drugs away from the criminal justice system, and, if required, towards harm reduction, health and social service options. In a decriminalised environment, these diversion schemes should focus on people whose offences are related to their drug dependence.
- **Health and harm reduction services:** Establish, expand and strengthen harm reduction services and voluntary, community-based drug treatment services, to ensure improved outcomes for health, human rights and social inclusion.

Compulsory registration and detention centres

In line with UN recommendations, governments should immediately close down CCDUs, promote access to voluntary community-based treatment, harm reduction and social services, and remove compulsory requirements for registration of people who use drugs with law enforcement agencies.²⁰⁵

Threshold quantities

Threshold quantities can be helpful where they are part of

a broader package of health-oriented reforms, and used to decriminalise possession of small quantities of drugs for personal use and/or to guide police, prosecutors and/or judges in diverting people who use drugs away from the criminal justice system. If a country decides to use quantity thresholds, the following factors should be considered:

- The quantity specified should be realistic and based on evidence regarding patterns of use (e.g. the quantity of drugs that a person is likely to possess for consumption purposes) and patterns of purchasing (quantity of drugs that a user is likely to purchase for personal use, e.g. supply for a reasonable number of days)
- Where threshold quantities are prescribed, these should only be considered as indicative. Police, prosecutors and judges should retain the discretion to decide on a case-by-case basis according to all available evidence whether a case based on possession of drugs should proceed or be dismissed
- The determination of possession for the purposes of supply should be made on the basis of multiple factors, including the role and motivation of the accused in the supply transaction, and subject to judicial oversight. Such measures help ensure that people who use drugs are not mistakenly sentenced for a drug supply offence.

Promotion of evidence-based treatment and harm reduction services

Treatment services for drug dependence should be voluntary, evidence-based and required to comply with international standards on drug dependence treatment. In particular, services should recognise that no single treatment method is suitable for all individuals dependent on drugs. Rather, a comprehensive array of services should be offered to respond to the complex health and social issues associated with drug dependence. Matching treatment settings, interventions and services to each individual's particular needs is critical to treatment success, that is, improved quality of life.

Positive urine tests should not be used or accepted as evidence of drug dependence. In diversion mechanisms, police, prosecutors and/or judges should be required to base their decisions on a medical assessment that establishes drug dependence based on internationally agreed criteria.

Governments should adopt and scale up harm reduction interventions and ensure that their access is not conditional on the registration of people who use drugs in registries accessible by law enforcement agencies. Harm reduction interventions such as OST and NSPs should be provided both in the community and in prisons and other closed settings, and not hampered by law enforcement practices such as arrest.

Diversion by the police

Police diversion may be effective in contexts where police are able to build trust with communities of people who use drugs. If police corruption is entrenched, it may be

inappropriate to give police the key decision making role in the diversion process. Police diversion programmes should include the following features:

- Police diversion may include a decision to take no further action, issue a caution and/or to provide referral to health and harm reduction services
- Where people are found in possession of small amounts of drugs or drug use equipment, diversion should occur before a charge is entered
- The programme should involve an educational component. This may include provision of information by a police officer on harm reduction or referral to health, drug treatment, harm reduction or community support services
- Arrest quotas for drug use, possession of drug use equipment, and possession and cultivation for personal use should be abolished.

Diversion by the prosecutor

Prosecutorial guidelines should require prosecutors to consider not proceeding with a prosecution for drug use, possession or cultivation for personal use and possession of drug use equipment, and for minor, non-violent offences relating to a person's drug use or dependence. For such offences, prosecutors should be able to decide either that:

- the prosecution will not proceed and no further action will be taken, or
- the prosecution will not proceed conditional upon an offender attending a harm reduction service, a treatment programme (if required) or other social services.

Prosecutorial guidelines should ensure that prosecutors base their decisions on an understanding of the distinction between occasional drug use and drug dependence – only those who are dependent on drugs could benefit from a referral to treatment.

Diversion by the court

Courts should have the option to impose no penalty and not to enter a conviction for drug use, possession or cultivation for personal use and possession of drug use equipment, and for minor, non-violent offences relating to a person's drug use or dependence (e.g. theft, low-level smuggling or dealing). Where court diversion programmes operate, they should supplement police and prosecutors' diversion schemes. Courts should be able to offer diversion options to people who use drugs arrested for more serious drug-related offences, rather than merely for drug use. It is preferable for people facing a potential charge of drug use or possession of small quantities for personal use to be diverted at police or prosecutor stage, rather than by the court.

Sentencing guidelines should support use of non-custodial sentences for people convicted of drug offences

or drug-related offences. This may include treatment in the community for those found to be dependent on drugs through a medical assessment.

Courts should have access to multidisciplinary advice for assessment of options. It is critically important that the process enables courts to distinguish between (i) people who use drugs occasionally, recreationally and/or without experiencing problems, and (ii) people who are drug dependent and could benefit from access to treatment. Courts should offer:

- pre- and post-sentencing referrals to voluntary, community-based treatment, harm reduction and social service options
- individualised treatment, harm reduction and social support options.

Legal aid and access to justice

People who use drugs should have access to independent legal advice and representation as an integral aspect of any diversion programme to ensure that they are informed of their legal rights, and able to defend their case at all stages of the process.

Role of healthcare workers

Healthcare and community workers can support the implementation of decriminalisation and diversion programmes by:

- intervening at the community level to refer people who use drugs to support in advance of police contact
- providing health assessments to inform the decision of police, prosecutors and the courts in relation to diversion
- providing a holistic assessment and response to the needs of people who use drugs diverted away from the criminal justice system
- engaging in partnerships with communities, police and other people working in the justice sector to promote harm reduction and public health approaches
- adopting minimum quality standards to ensure that drug dependence treatment programmes are evidence based and respect the human rights of people who use drugs
- monitoring and evaluating the quality and effectiveness of decriminalisation and diversion models.

The process of decriminalising drug use and/or implementing diversion measures involves the consideration of several factors, including the need to garner public support. For suggestions on practical steps to take in preparing for the implementation of such measures, please refer to **Annex 2**.

Annexes

Annex 1 Decriminalisation and diversion programmes under the UN drug conventions

The three UN conventions on drug control are:

- The Single Convention on Narcotic Drugs (1961) as amended by the 1972 Protocol;
- the Convention on Psychotropic Substances (1971); and
- the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

The purpose of these conventions is to establish international control measures with the aim of ensuring that drugs are available for medical and scientific purposes, while preventing them from being diverted into illegal channels. The treaties also include general provisions on the trafficking and use of drugs.

Historical context²⁰⁶

Prior to the drug conventions, several Asian countries participated in the global opium and cocaine industries, supplying pharmaceutical companies in the West and Japan. In the negotiations for the 1961 Convention, several of these countries played a lead role in what was known as the 'organic states' group. As producers of the organic raw materials for most of the global drug supply, Asian countries had been the focus of international drug control efforts. They were also countries with a long history of drug use within local cultures, with drugs such as cannabis having religious significance and cannabis and opium being used across the region in traditional medicine.

India, Turkey, Pakistan and Burma took a leading role in the 'organic states' group, which also included the coca-producing states of Indonesia and the opium- and cannabis-producing countries of South and Southeast Asia. They supported national control efforts based on local conditions and were wary of strong international control bodies. They resisted the strengthening of international control because existing restrictions on production and export had directly affected their domestic population and industry. Although relatively powerless against the prohibitionist countries, such as the USA, they sought development aid to compensate for losses caused by the introduction of strict controls.

Drug use and possession for personal use under the UN drug conventions²⁰⁷

The fundamental objective of the conventions, as stated in their preambles, is to protect the 'health and welfare' of humanity.

Drug use was omitted from the articles of the UN drug conventions listing the drug-related acts that must be declared a criminal offence. The UN conventions do not oblige countries to impose any penalty (criminal or administrative) for drug use as such. This is explicitly stated in the Commentary to the 1988 Convention regarding article 3 of the Convention on 'Offences and Sanctions': 'It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence'.²⁰⁸

The conventions also grant States flexibility with respect to criminalisation of possession for personal use, although the provisions are more restrictive than in relation drug consumption or use.²⁰⁹ The criminalisation of drug possession is referred to in the 1988 UN Convention, which states:²¹⁰

Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

This article allows governments some discretion on whether or not to criminalise possession for personal use.

Firstly, the Article states that the measures a member state is required to adopt are subject to its 'constitutional principles and the basic concepts of its legal system'.²¹¹ This means that member states can opt out of the requirement to criminalise possession for personal consumption if it would be unconstitutional (for example, based on the right to privacy or liberty under the national constitution) or otherwise contrary to their legal systems.²¹²

Secondly, under this article, member states are only required to adopt measures for criminalising possession of drugs for personal use where possession is contrary to the 1961 or 1971 Conventions. In articles 36(1)(a) and 2(5)(b), the 1961 Convention can be understood to require the criminalisation of the use of drugs, such as cannabis and heroin, only if it is considered by a state to be appropriate on public health grounds.

Article 33 of the 1961 Convention provides that 'The Parties shall not permit the possession of drugs except under legal authority' and solely for medical and scientific purposes. Further, article 36(1) obliges the parties to declare possession a punishable offence. However, the Convention's emphasis on tackling trafficking suggests that countries are not obliged by virtue of article 36 to declare simple possession for personal use a criminal offence, particularly if there are strong public health grounds not to do so. This opinion is backed up by the history of the wording of article 36, which was originally entitled 'Measures against illicit traffickers'. A similar situation applies in the 1971 Convention.²¹³

Furthermore, and more fundamentally, the drug control conventions must be interpreted in relation to the specific challenges and measures in place in each country, as well as in the context of member states' overriding human rights obligations under international law.²¹⁴ The purpose of the UN, as set out in the UN Charter, includes the promotion of solutions for international social and health problems, as well as universal respect for human rights. Governments have obligations under the right to health to take all necessary steps for the prevention, treatment and control of diseases, to ensure access to essential medicines, to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health.²¹⁵

Under international law, restrictions on human rights may be imposed if they are prescribed by law, non-discriminatory and impose restrictions that are no more than is necessary to achieve a legitimate aim. The state therefore has the burden to justify that the criminalisation of drug use or possession and cultivation of drugs for personal use meets this test.²¹⁶ Protecting public health is a legitimate aim, but imposing criminal sanctions for drug use and possession for personal use has exacerbated the health and social harms associated with drug use, and is neither necessary nor proportionate – arrest and incarceration are disproportionate measures and can affect access to fundamental rights to health, work, education, housing, vote and separate parents from children. States can use non-criminal, public health measures to address drug dependence and drug use, including providing voluntary access to evidence-based drug treatment, harm reduction services, and social support.²¹⁷

Alternatives to conviction and punishment

Article 3(4)(d) of the 1988 Convention provides:

The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.

UN member states adopted a *Declaration on Drug Demand Reduction* in 1999 following discussions at the UN General Assembly Special Session on drugs in 1998, which includes this provision:

*In order to promote the social reintegration of drug-abusing offenders, where appropriate and consistent with the national laws and policies of Member States, governments should consider providing, either as an alternative to conviction or punishment or in addition to punishment, that abusers of drugs should undergo treatment, education, aftercare, rehabilitation and social reintegration.*²¹⁸

A 2012 resolution adopted by the UN Commission on Narcotic Drugs noted the language on alternatives to criminal sanctions in the UN drug conventions, and encouraged member states ‘...to consider allowing the full implementation of drug-dependence treatment and care options for offenders, in particular, when appropriate, providing treatment as an alternative to incarceration...’ The Commission further adopted a resolution in 2015 calling on member states:

*through collaboration between the health and justice authorities, to use a wide range of alternative measures to conviction or punishment for appropriate drug-related offences of a minor nature in order to improve public health and safety for individuals, families and societies.*²¹⁹

Annex 2 Practical steps for implementing decriminalisation and diversion

1. Secure support from across government agencies for decriminalisation and diversion proposals including from agencies with responsibility for drug control, health, law and justice, prisons and public security, and from national human rights bodies.
2. Engage local communities and civil society:
 - Engage communities of people who use drugs and civil society groups in the law reform and policy development process. Ensure that people who use drugs have an opportunity to provide their views on law and policy options, and have access to information and education about how proposed changes to laws, policies and practices will affect their lives.
 - Seek support for law and policy reforms to remove criminal sanctions from professional associations in the areas of medicine, public health, law and corrections.
 - Secure support for law and policy reforms from religious, traditional and community leaders on the basis that the shift to a public health approach to drug use is an issue requiring courage and leadership.
 - Engage the general public in an informed discussion. It may be necessary to conduct community education campaigns to address irrational fears and to reassure the public that decriminalisation does not present a threat to youth, community safety or public security. Community education can reduce the demonisation of people who use drugs and the stigma associated with drug use. Engaging the media to secure public support may be crucial to ensure that legislative proposals do not lead to a backlash that results in counter-proposals that increase criminal penalties and undermine public health objectives.
3. Consider whether *de facto* decriminalisation can be introduced through changes to policy and police practices in advance of legislation to remove criminal sanctions. Explore whether a phased approach to decriminalisation may have a greater chance of success than a proposal to immediately remove all criminal sanctions. For example, the decriminalisation of cannabis or kratom could be piloted as a *de facto* approach before introducing legislation to remove criminal sanctions for use, or possession for personal use, of cannabis and other drugs.
4. Generate consensus on the *objectives* and *scope* of decriminalisation and diversion schemes:
 - Ensure that the objectives of decriminalisation and diversion schemes are clearly focused on reducing harms and improving public health, social inclusion and human rights outcomes, while reducing the punishment and incarceration of people who use drugs.
 - Establish forums for consultation and dialogue involving government, civil society and community stakeholders to garner support for a comprehensive approach that encompasses removal of criminal penalties and other sanctions for: drug use, possession of drugs for personal use, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption. As part of those forums, facilitate dialogue on the implementation of a 'gold standard' model of decriminalisation in which the law is amended so that no criminal, civil or administrative sanctions whatsoever apply, but instead investments are made to ensure the availability and accessibility of voluntary drug treatment, harm reduction, and social services.
 - If administrative sanctions are applied as an alternative to criminal sanctions, ensure these are minor and do not include detention in CCDUs, compulsory registration and monitoring, forced urine testing, or other measures that contradict principles of human rights, harm reduction and public health.
 - In relation to possession of drugs for personal use, consider whether quantity thresholds are to be used, and if so, how they will be determined. Thresholds should be realistic and based on research conducted locally that provides evidence of the average quantities consumed and purchased by people who use drugs.
 - Make it clear that the proposal is focused on removing criminal sanctions that apply to people who use drugs, and does not focus on the legalisation of illicit drug production and distribution for commercial purposes.
5. Consider budgetary implications, particularly to ensure adequate funding is available for diversion programmes, community-based treatment, health and harm reduction services, counselling and social services for people who use drugs.
6. Identify the upcoming opportunities in the parliament or national assembly to amend legislation to remove criminal and/or administrative sanctions. Parliamentary champions may need to be identified to educate other legislators about law reform proposals and to push for bills to be considered without undue delay.
7. Invest in training and capacity building for law enforcement personnel and healthcare workers so that their roles and responsibilities in decriminalisation and diversion schemes are well understood and delineated.

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In this report, the International Drug Policy Consortium (IDPC) offers recommendations based on evidence and examples of good practice to inform a shift in policy responses to drug use in Asia away from criminalisation and punishment, and towards public health and harm reduction.

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.

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