3.1
Decriminalisation of people who use drugs

Key recommendations

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

Introduction

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

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

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

Because of the devastating effects of overly repressive approaches to drug control, criminalisation has come under increasing scrutiny. A number of international agencies have now explicitly called for the removal of criminal sanctions against people who use drugs, including the Joint United Nations Programme on HIV/AIDS (UNAIDS),[7] the World Health Organisation (WHO),[8] the United Nations Development Program (UNDP),[9] the Office of the High Commissioner on Human Rights (OHCHR),[10] UN Women[11] and the Organization of American States (OAS),[12] among others.[13]

Box 1 What is decriminalisation?

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

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

The overarching objective of decriminalisation is to end the punishment and stigmatisation of people who use drugs. After drug use has been decriminalised, governments may respond to drug use and associated activities with a variety of approaches, such as referrals to health and social services. Crucially, when implemented under a harm reduction-oriented approach, decriminalisation can provide a supporting and enabling legal framework within which health interventions can be voluntarily accessed without fear of stigma, arrest and detention.[14] The gold standard of decriminalisation is therefore an approach where drug use, cultivation, purchase, possession for personal use and possession of use paraphernalia is no longer punished, and where people are able to access healthcare, harm reduction and treatment services. In practice, some governments have chosen to impose administrative sanctions against people who use drugs. In that case, such sanctions should not result in more severe punishment than those imposed under criminalisation – this will be discussed in more detail below.

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

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

Legislative/policy issues involved

Decriminalising drug use and possession for personal use

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

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

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

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

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

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

Decriminalising cultivation for personal use

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

In Belgium, Spain and Uruguay for example, cannabis social clubs enable people to grow their own plants as part of a cooperative, and only in quantities sufficient for the needs of the club members (these quantities are established by the members themselves). Cultivation and distribution are limited to club members, and cannabis can be consumed on the club's premises or taken away. Membership is prohibited for people under the age of 18. Most clubs limit the number of members. For example, Uruguay established the limit at 45 members, while the Federation of Cannabis Associations in Catalonia set a limit of 655 members – although a series of Supreme Court decisions in Spain have recently set some stricter limits to the number of members for social clubs (in its latest decision, the Supreme Court ruled that a club containing 290 members was unacceptable).[18]

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

Implementation issues involved

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

Box 2 The Portuguese referral model to health services

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

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

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

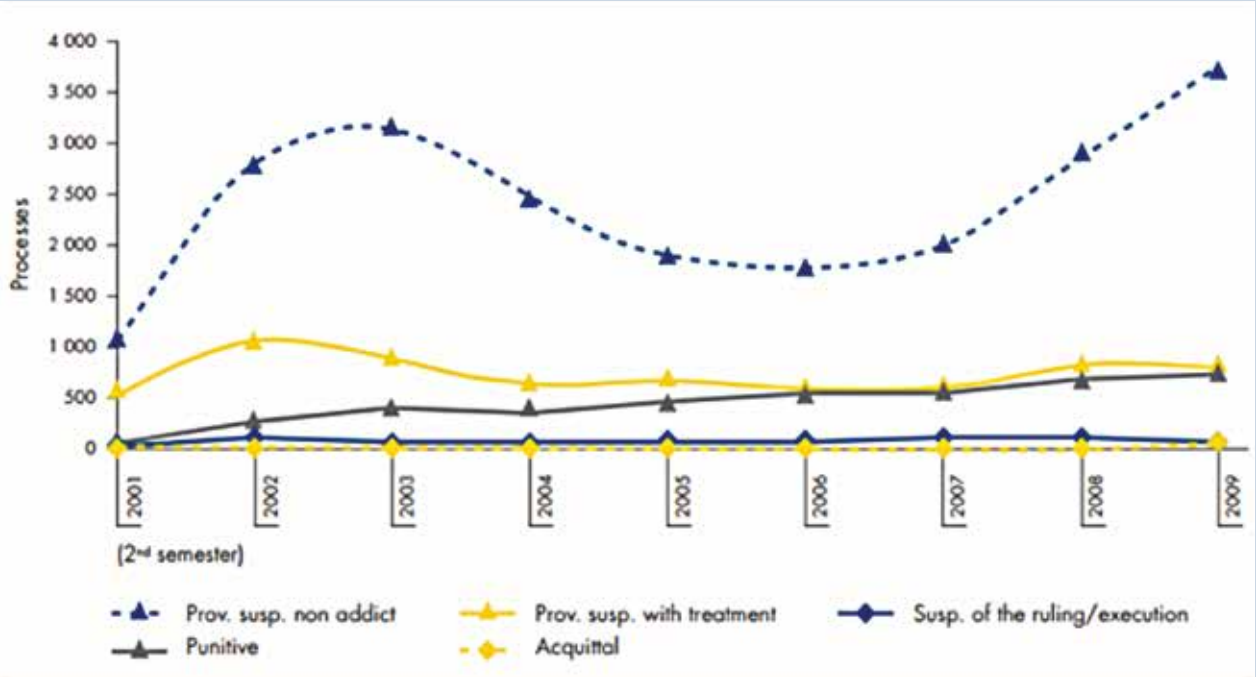
Crucially, the decision to decriminalise drug use was accompanied by significant investments in health interventions, including harm reduction measures (with a new legal basis in the form of Decree-law 183/2001) and drug dependence treatment programmes. As a direct result of decriminalisation, prison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

Credit: Pedro A. Pina

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

Continued overleaf

Figure 1. Application of sanctions by the Dissuasion Commissions, 2001 to 2009[24]



to 28% in 2005 from a peak of 44% in 1999 – taking some of the pressure off the criminal justice system.[25] In the area of health, the number of people using drugs newly diagnosed with HIV decreased from 907 new cases in 2000[26]to 79 in 2012.[27] A similar downward trend was observed for new cases of hepatitis B and C,[28] while the number of drug overdose deaths in Portugal is the second lowest in the European Union.[29] The number of people receiving voluntary drug dependence treatment increased by more than 60% between 1998 and 2008. Over 70% of those seeking treatment received OST.[30] The Portuguese decriminalisation model has therefore been highly successful in offering harm reduction and voluntary treatment services to people who use drugs, with very positive health outcomes.

Differentiating between use and intent to supply

This is one of the main challenges of implementing an effective decriminalisation model. A number of countries have developed quantity thresholds to determine whether drug possession is for personal use or for intent to supply to others. While these thresholds can be useful, they have sometimes proven to be problematic. In some circumstances, for example in Mexico and Russia, the thresholds were set so low that they resulted in more people who use drugs being sent to prison for what was identified as being a 'trafficking' offence (for example, Mexico set out quantity thresholds at 0.5g of cocaine, 0.05g of heroin and one ecstasy tablet[31]). To be effective, quantity thresholds should adequately reflect market realities – taking into account patterns of use, the quantity of drugs a person is likely use in a day, and patterns of purchasing.

Other countries opted not to adopt thresholds and not to define what would be the 'reasonable amounts' or 'small quantities' allowed. They focused instead on other considerations to be taken into account as evidence, on a case-by-case basis – for example, possession of several mobile phones, drugs divided into different packets, money, firearms, or history of drug dependency, etc. This approach, however, also presents disadvantages, including the risk of abuses and corruption from the police or judges.

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

Authority responsible for determining personal use

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

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

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

These implementation issues can be addressed through solid prosecutorial guidance, including a tight oversight and scrutiny of police behaviour, in particular guidance on how to assess the quantity thresholds (for example, on whether to take into account dry weight or wet weight), on how to exercise police discretion, or on charging standards. This will also require police training on drugs and harm reduction, to increase awareness of the need to support a health and social approach towards drug use. Engaging representatives of people who use drugs in the process of designing, managing and evaluating decriminalisation models is also useful to help build trust between communities and the police.[35]

Identifying appropriate responses

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

Credit: Private

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

Box 3 Establishing quantity thresholds in the Czech Republic

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

The study resulted in the adoption of a new drug law in 2009, leading to significant debates to define which amounts of drugs should be characterised as 'greater than small'. A government decree established quantities below which possession would not result in criminal penalties but in a misdemeanour, subject to the imposition of a fine. The government study was instrumental in providing practical information around patterns of drug use and drug markets in an effort to establish adequate thresholds. For instance, noting that patterns of usage varied between people using different drugs, the authors of the study concluded that it would be wise to distinguish between types of drugs in law and policy making.[39] An attempt was made to reflect the study's findings in the law, with a higher threshold being established for cannabis than for other drugs – Government Decree No. 467/2009 established maximum quantities of 15g for cannabis, 1.5g for heroin and 1g for cocaine.[40]

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

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

When referral mechanisms are in place to encourage people to enter voluntary treatment programmes, these should offer a variety of treatment options, including OST. Failure to meet the conditions of the treatment programme should not result in the imposition of a criminal sanction. Portugal, for instance, has adopted an incremental response to drug use. On the first instance, people caught for drug use will see the process suspended, but an administrative sanction may be imposed if they are caught again within a six-month period. However, Portugal also offers a wide range of health and social services to people brought to its Dissuasion Commissions (see Box 2), including referrals to harm reduction and treatment programmes. In the Portuguese case, treatment is never coercive and people who fail to adhere or comply will not be imposed a criminal sanction.[42]

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

Box 4 The Dutch cannabis decriminalisation model

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

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

The 30 years of experience of this policy have also shown that the coffee shop model has successfully enabled people who use cannabis to avoid exposure to 'hard drug' scenes and markets. Heroin and cocaine use in the Netherlands is reportedly lower than the European average,[47] and HIV prevalence among people who use drugs remains low[48] – the country having also established a series of harm reduction services including needle and syringe programmes (NSPs), opioid substitution therapy (OST), heroin-assisted treatment and safe injection rooms early on.[49]

Nevertheless, this model also presents some difficulties, not least the paradox around the fact that although the sale and possession of cannabis are tolerated, supply to the coffee shops (the so-called 'backdoor') continues to be criminalised, and is therefore increasingly controlled by criminal groups and networks. Today, a great majority of the Dutch population is in favour of the full legal regulation of the cannabis market 'from seed to sale', in an effort to end reliance on the black market.[50] And while the government is trying to restrict any activity that would facilitate cultivation by criminalising preparatory acts (such as grow shops),[51] local authorities are increasingly in favour of regulating the backdoor through a new Cannabis Act. A recent report by the VNG – the Dutch local authorities' platform – called on the government to allow regulated cannabis production by introducing licences for growers[52] (see Chapter 3.2 for more details on legal regulation).

Key resources

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