Chapter 3: Criminal justice
Chapter overview

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

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

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

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

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

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

Key recommendations

- Drug laws, policies and practices should be reviewed to remove criminal penalties for drug use, possession of drugs for personal use, possession of drug use paraphernalia and cultivation and purchase for personal use.

- The gold standard of decriminalisation is the removal of all punishment for drug use, and the provision of voluntary health and social services, including harm reduction responses and evidence-based drug dependence treatment programmes. If an administrative sanction is imposed for drug use, it should be applied as part of a framework encouraging access to health and social services, and not lead to net-widening.

- Differentiating between personal use and intent to supply should be done via indicative quantity thresholds, as well as an assessment of all evidence available on a case-by-case basis. Even if people are found in possession of quantities above the threshold, mechanisms should be in place to identify whether possession is for personal use or intent to supply.

- Trainings, sensitisation and guidance should be offered to police, prosecutors and judges on drug use, harm reduction, treatment and decriminalisation.

- Decriminalisation measures should be accompanied by investments in health and social programmes to ensure maximum health outcomes.

Introduction

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

Police crackdowns, compulsory urine testing, drug user registration in official government records, or compulsory detention deter people from accessing health and social services. 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.

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), the World Health Organisation (WHO), the United Nations Development Program (UNDP), the Office of the High Commissioner on Human Rights (OHCHR), UN Women and the Organization of American States (OAS), among others.
At the national level, several countries have adopted innovative decriminalisation models. Decriminalising drug use and possession for personal use

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. 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

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. 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).
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...
to 28% in 2005 from a peak of 44% in 1999 – taking some of the pressure off the criminal justice system. In the area of health, the number of people using drugs newly diagnosed with HIV decreased from 907 new cases in 2000 to 79 in 2012. A similar downward trend was observed for new cases of hepatitis B and C, while the number of drug overdose deaths in Portugal is the second lowest in the European Union.

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. 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). 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. 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, 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. 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.

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.
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. People caught using drugs, however, were not criminalised. 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.

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. 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.

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. 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.

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).
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 low48 – the country having also established a series of harm reduction services including needle and syringe programmes (NSPs), opioid substitution therapy (OST), heroin-assisted treatment and safe injection rooms early on.49 Nevertheless, this model also presents some difficulties, not least the paradox around the fact that although the sale and possession of cannabis are tolerated, supply to the coffee shops (the so-called ‘backdoor’) continues to be criminalised, and is therefore increasingly controlled by criminal groups and networks. Today, a great majority of the Dutch population is in favour of the full legal regulation of the cannabis market ‘from seed to sale’, in an effort to end reliance on the black market.50 And while the government is trying to restrict any activity that would facilitate cultivation by criminalising preparatory acts (such as grow shops),51 local authorities are increasingly in favour of regulating the backdoor through a new Cannabis Act. A recent report by the VNG – the Dutch local authorities’ platform – called on the government to allow regulated cannabis production by introducing licences for growers52 (see Chapter 3.2 for more details on legal regulation).

Key resources

Regulated drug markets

Key recommendations

- The responsible legal regulation of drug markets can reduce harms associated with the illicit drug trade and offer improved outcomes on a range of health, community safety and financial indicators – this policy option should therefore be actively and publicly debated and explored.

- Policy makers exploring options for regulation should consider establishing a national expert advisory group to design policy and legal frameworks tailored to meet local needs and priorities. This panel should include expertise from public health, law enforcement, drug policy reform, evaluation and monitoring, alcohol and tobacco regulation, prevention, treatment and harm reduction, as well as representation of people who use drugs and subsistence farmers of crops destined for the illicit drug market.

- Reforms should be phased-in cautiously, using solid and well-funded evaluation and monitoring of impacts built into any legislation and process of change, along with a willingness to adapt approaches on the basis of emerging evidence.

- Particular care should be taken to mitigate risks of over-commercialisation, with public health and community safety remaining the guiding influence for policy design, rather than private profit. Non-commercial models should be considered as viable options, whilst commercial models should mitigate risks of over-commercialisation by learning from the successes and failures of different approaches to alcohol and tobacco control.

- Policy makers should encourage, and meaningfully engage in, debates at high-level regional and UN forums around reforming the global drug control system to accommodate demands for greater flexibility to experiment with regulation models, either independently or alongside any ongoing domestic reform processes.

- Policy makers should encourage the UN to convene an independent expert group to consider the issues raised by legal regulation, implications for the existing treaty system and options for its modernisation and reform.

Introduction

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

The legal regulation of cannabis has been at the forefront of this rapidly evolving debate – particularly since 2012, when cannabis was legalised for non-medical use in the US states of Washington and Colorado. Soon after, Uruguay became the first UN member state to do the same by adopting Law No 19.172. Since then, two more US states (Alaska and Oregon) and the District of Columbia have followed, and several more states are likely to do so in the next few years – in particular California. In 2015, Jamaica legalised cannabis for medical, industrial and religious purposes, and the newly elected Canadian Government has also pledged to legalise cannabis – the first G7 country to do so.
Other developments around the world are also feeding into these ongoing discussions – including the system of legal regulation of the coca leaf in Bolivia, the New Zealand model of regulation for certain lower-risk new psychoactive substances (NSP) (see Box 3 in Chapter 2.1), and the ongoing development of maintenance prescribing to people dependent on heroin and other controlled substances (see Chapter 2.5 for more details).

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

**Legislative/policy issues involved**

There remains some confusion about what the ‘legalisation’ of controlled substances actually means. ‘Legalisation’ is the process by which an illegal product or activity becomes legal. In policy discussions, it is therefore more helpful to refer to the ‘legalisation and regulation’ or the ‘legal regulation’ of a controlled substance (or substances), as this provides a clearer description of the model being proposed and employed. A legalisation process allows for a policy of legal regulation to be implemented. Under legal regulation, substances can be adequately controlled and the regulatory regime can be effectively implemented by government authorities – in an effort to remove the drug trade from the control of criminal groups.62

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

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

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

**Figure 1. Spectrum of drug policy options and their likely effects**65
Implementation issues involved

Reducing health, social and financial costs
The regulation of drug markets is not a ‘silver bullet’ solution to the problems associated with drug use and drug markets. In the short term, legal regulation can only seek to reduce some of the health, human rights, crime and security problems that stem from prohibition-led drug control efforts and those fuelled by the illicit drug market (see Box 2 on Uruguay, as well as Box 3 of Chapter 2.1 for an overview of the New Zealand experience with regards to NPS). However, legal regulation cannot tackle the underlying socio-economic drivers that may exacerbate drug problems within a community – such as poverty, inequality and social marginalisation. Nevertheless, by promoting a more pragmatic public health model and freeing up drug law enforcement resources for evidence-based health and social policy, regulatory models may very well create a more conducive environment for doing so.66

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

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

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

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

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**Box 1 Five basic models for regulating drug availability**

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

Bolivia has denounced the 1961 Convention and then re-accessed it with a reservation on the specific articles that prohibit the coca leaf.

Jamaica has regulated cannabis cultivation and use for religious purposes (see Chapter 4.3 for more details).

New Zealand’s NPS regulation framework is only available to substances not controlled under the UN drug conventions.

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

### Box 2 Uruguay’s legal regulation of cannabis markets

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

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

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

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

### Addressing tensions with the UN drug control conventions

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

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

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

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


Cannabis plant at a Colorado grow house Credits: James Carino, WOLA
3.3 Proportionality of sentencing for drug offences

Key recommendations

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

Introduction

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

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

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

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

- Public health – prisons are a high-risk setting
for the transmission of illnesses such as HIV, viral hepatitis and tuberculosis. HIV infection rates tend to be higher in prisons than in the community as there is very poor coverage of harm reduction services for inmates who use drugs (see Chapter 3.6)

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

- **Development** – Incarcerating farmers engaged in illicit cultivation for subsistence purposes and other low-level actors in the drug market merely exacerbates the poverty and insecurity that are the root cause of their involvement in drug markets.

### Legislative/policy issues involved

#### Defining the concept of proportionality

Proportionality is an internationally recognised legal principle, applicable to a government’s response to activities that cause harm to others. It requires the severity of any punishment imposed to be measured in accordance with the harms caused by an offender’s actions, and the culpability and circumstances of the offender. International human rights, crime prevention and criminal justice instruments contribute to setting standards of proportionality.

For example, article 29(2) of the Universal Declaration of Human Rights states that:

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

The International Covenant on Civil and Political Rights protects many rights relevant to sentencing for drug offences, notably the rights to life, liberty, security of the person, and privacy. In interpreting the application of the Covenant, the Human Rights Committee has found that where a state implements measures to restrict a right protected under...
the treaty, it ‘must demonstrate their necessity and only take such measures as are proportionate to the pursuance of legitimate aims in order to ensure continuous and effective protection of Covenant rights.’ The Committee has further explained that measures to restrict rights protected under the Covenant must be the least intrusive measure required for achieving a legitimate aim.

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

**Applying the legal principles of proportionality to sentencing for drug offences**

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

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

As a result, the conventions recognise the need to establish sentencing frameworks for drug offences that distinguish between:

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

The concept of proportionality of sentencing becomes essential when considering the application of the death penalty for drug offences. According to the UN Human Rights Committee, drug offences do not meet the threshold of ‘most serious crimes’ for which the death penalty may apply under Article 6 of the International Covenant on Civil and Political Rights, as they do not amount to intentional killing. As a result, the imposition of death penalty sentences and executions for drug offences contravene international human rights law. The International Narcotics Control Board (INCB) has encouraged ‘those States which retain and continue to impose the death penalty for drug-related offences to consider abolishing the death penalty for such offences.’

However as of 2015, 33 countries retain the death penalty for drug offences, and at least ten countries impose it as a mandatory sentence, with seven countries still actively executing people convicted of drug offences.

**Implementation issues involved**

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

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

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

**Distinctions should be made between offences related to personal use, and those with intent to supply, to reflect the varying degrees of an offender’s culpability and the harms caused to society by their offence.**
of sustaining his or her own drug use: alternatives to conviction, incarceration and punishment should be implemented, along with referrals to harm reduction and drug dependence treatment, in order to address the root causes of the offence (see Chapter 3.4)

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

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

- People engaged in subsistence-driven cultivation: those involved in illicit cultivation are mostly subsistence farmers in situation of high vulnerability who grow poppy, coca or cannabis as cash crops in order to buy food, clothes, and access to health and education. They should not be criminalised. Instead, a development-oriented approach should be implemented to offer them opportunities for viable and sustainable livelihoods (see Chapter 4.2)

- Dealers engaged in the small-scale sale of controlled substances within a network of friends, and who obtain limited financial gains – these individuals should be offered alternatives to incarceration to ensure that criminal justice systems and prisons are not overloaded with minor, non-violent cases.107 (see Chapter 3.4)

- Drug couriers or 'mules' are individuals engaged in trafficking offences, usually in the transportation of controlled substances.108 They usually come from extremely vulnerable social backgrounds, they put their health at serious risk in return for very low pay, and are often coerced or exploited into carrying drugs.109 For these offenders, severe penalties should not be imposed and alternatives to incarceration should be offered – in particular for women in charge of children or dependents.110 (see Chapter 3.4)

- Serious or organised criminals making large-scale profit, and playing a high-level role in a production or trafficking operation, or organised crime network, often using violence and corruption. These individuals should be imposed more severe penalties – keeping in mind the principle of proportionality across the spectrum of criminal offences, as described above.

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

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

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

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

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

Buen Pastor prison for women in San Jose, Costa Rica
their depressed socio-economic circumstances, prevent them from finding employment post-incarceration, and can have devastating consequences for their dependent children or other family members\(^{113}\)

- The caretaking responsibilities of an offender, especially women who are often the primary caregiver for children and other dependants such as elderly parents or people living with disabilities\(^ {114}\)

- The motivation for financial gain of the offender: several drug-related activities are not motivated by significant financial gain, as is the case for drug mules

- If it is a first-time offence

- No involvement with organised crime or violence.

**Aggravating factors should be considered to determine whether a sentence needs to be enhanced.**
- Motivation for significant financial gain
- Involvement of minors
- Involvement in violent activities, corruption and/or money laundering
- Involvement in organised crime.

**Key resources**


3.4 Alternatives to incarceration

Key recommendations

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

Introduction

As a result of the punitive approaches that have prevailed in international and national drug control regimes, rates of incarceration have steadily increased since the 1970s. The steepest rise has been in the USA. In Latin America, the rate of people incarcerated for drug offences has grown at a faster rate than the overall prison population. Rises have also taken place throughout Europe, Asia, Africa, and Oceania. Currently, although there are large differences between individual countries and between regions, persons convicted for drug offences (drug possession and drug trafficking) make up 21 per cent of the sentenced prison population worldwide.

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

Both mass incarceration for drug offences and prison overcrowding disproportionately affect the most vulnerable groups in society, in particular ethnic minorities. In Europe, for example, most prisoners are from poor communities, and the proportion of immigrants and ethnic minorities is increasing. Similarly, in the USA ‘5 times as many Whites are using drugs as African Americans, yet African Americans are sent to prison for drug offenses at 10 times the rate of Whites’.

In producing countries, incarcerated coca growers and small producers usually belong to the most marginalised sectors of society. Drug offences have played an important role in the significant increase in the female prison population. Over 90% of prison inmates are male; however, over time ‘the total number of female prisoners (who constitute 5-8 per cent of the prison population) grew by 26 per cent between 2004 and 2012 — an increase far higher than that recorded for men (11 per cent)’. A significant percentage of this increase is associated with drug offences – generally of a minor, non-violent nature. For example, ‘in Argentina, Brazil, and Costa Rica, well over 60 percent of each country’s female prison population is incarcerated for drug-related crimes’. In Europe, drug of-
In this context, comprehensive and contextualised alternatives to arrest, sentencing and incarceration should be designed and implemented. Alternatives to incarceration provide more effective and less costly ways to reduce drug-related crime, while also promoting the health and social inclusion of low-level drug offenders by addressing some of the root causes of their involvement in the illicit market.

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

Legislative/policy issues involved

The UN drug conventions include explicit provisions allowing alternatives to conviction or punishment for offences relating to personal use, including pos-
LEAD is a police diversion programme, launched in October 2011 in Seattle, USA. It targets people arrested for minor drug offences and sex work who meet the eligibility criteria: i.e. individuals identified as suffering from ‘substance use disorders’.

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

If the person is diverted into the programme, he/she is connected to a case manager who will decide the type of monitoring arrangement the person will be subjected to, which usually includes a set of services tailored to the individual’s needs. The programme generally involves community-based treatment and support services, guided by harm reduction principles. If the individual complies with the programme and its assessments, he/she is not charged and consequently does not get a criminal record. It is also important to note that the programme has no formal or punitive sanctions for ‘non-compliance’, and a person can re-enter the programme if they fail on the first instance and are caught by the police for a similar offence. Indeed, the reason why the programme was initiated in the first place was for the police to find better ways to deal with the same individuals going in and out of the criminal justice system.

The programme was originally designed as a pilot project, funded by private foundations. LEAD is now funded by the city of Seattle. The first evaluations of LEAD’s effectiveness were published in early 2015. Available data reported reductions in law enforcement costs, as well as increased effectiveness of the programme to reduce recidivism when compared to the traditional criminal justice system. The evaluation concluded that, ‘People in LEAD were 60% less likely than people in the control group to be arrested within the first 6 months of the evaluation’.138
session, purchase, cultivation and production, and for ‘appropriate cases of a minor nature’ not relating to personal use139 – for which states are encouraged to implement alternatives to conviction or punishment, such as education, rehabilitation or social reintegration, and where the offender is found to be dependent on drugs, ‘treatment and aftercare’.140

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

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

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

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

Diversion at arrest and pre-prosecution stages
There are a number of mechanisms at the arrest or pre-prosecution stages that can be used to avoid incarceration. These may involve referrals to an administrative monitoring system, to evidence-based drug dependence treatment where required, or other non-punitive measures such as educational programmes.141 In this case, such mechanisms usually rely on police officers as the key personnel making decisions on whether to divert a person into criminal prosecution or to an alternative mechanism. Several countries have established such diversion systems which may vary greatly, but which usually apply to both people caught for low-level dealing and people arrested for offences motivated by drug dependence.

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

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

Sentencing and post-sentencing alternatives
These alternatives include both diversion through the criminal proceedings and mechanisms to reduce

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**Box 2 The Scottish diversion system**

In Scotland, Procurators Fiscals (equivalent of prosecutors) are responsible for identifying which of those accused of having committed a minor crime and who do not represent a significant risk to the public, should be diverted into social support interventions. Such interventions involve individual and/or group sessions as well as referrals to harm reduction and voluntary drug dependence treatment services, aiming to address a range of issues such as offending behaviours, alcohol and drug use, social skills, education, employment and training. An evaluation of the scheme highlighted the advantages of addressing the needs of drug offenders in a community-based setting, which were shown to be more cost-effective and more likely to result in lower rates of reoffending.143
education and community work. Drug courts and community courts are common examples of such diversion mechanisms.\textsuperscript{146}

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

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

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

**Implementation issues involved**

A set of guiding principles should underpin the design and implementation of alternatives to incarceration:
Adopting a human rights approach
Alternatives to incarceration have to meet international human rights standards. Compliance with the rights to health, life and the prohibition of torture is a central purpose of promoting alternatives. Therefore, any alternative involving ill treatment, including compulsory detention centres, should not be implemented.

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

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

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

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

Angela, 24 years old, sent to six years in prison in Bogota, Colombia, for bringing drugs into a prison.
Promoting proportionate penalties for drug offences

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

Developing a wide range of health and social services

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

Key resources

3.5 Modernising drug law enforcement

Key recommendations

- Illicit drug markets cannot be fully eradicated, but can be managed in a way to reduce the most harmful effects of the drug trade. Drug law enforcement should therefore focus on wider social objectives instead of merely trying to reduce the size of the black market.

- A new and more comprehensive approach should focus on tackling organised crime more broadly, notably corruption and money laundering, as well as other types of smuggling (tobacco, alcohol, weapons, etc.) and criminal activities (extortion, kidnapping, etc.).

- With this in mind, cross-government approaches should be established – police authorities should partner with justice, health, education, welfare services, youth ministries, as well as civil society organisations and representatives of affected communities.

- Efforts should be strengthened on arms control, through disarmament initiatives and initiatives against arms trafficking to help mitigate the harmful effects of the drug trade, given the overwhelming scientific evidence that fewer guns leads to less violence, deaths, and crime.

- New metrics and indicators of drug law enforcement performance – focused on social outcomes rather than interdiction process indicators – should be developed and independently evaluated.

Introduction

The UN drug conventions are based on the belief that there is a simple linear relationship between the scale of the drug market and the level of harm to human health and welfare (i.e., the smaller the market, the fewer the harms).\textsuperscript{155} Partly as a result of that, national drug policies have largely focused on the overall objective of decreasing the size of the illicit drug market, with the ultimate goal a ‘drug-free world’.\textsuperscript{156} In this context, crop eradication (including through aerial spraying with glyphosate), drug seizures, and arrests have been seen as positive steps towards this goal, and therefore often used as indicators of policy success.

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

Drug law enforcement practices have had numerous negative impacts that have outweighed their benefits. First, law enforcement crackdowns on certain drug trafficking routes have led to the emergence of other routes. For instance, until the 1990s, the Caribbean was the primary transit route for cocaine planes, often stopping for refuelling en route to Florida. When US law enforcement stepped up, the Pacific, Central America and Mexico became increasingly used instead, while more cocaine was directed to the European market by air and sea. Officials from Europol and the United Nations Office on Drugs and Crime (UNODC) also noted that more recent law enforcement efforts in the Netherlands, including a total controls policy on flights from specific Latin American countries in the early 2000s, may have led traffickers to use different routes, notably through West Africa, a transit area increasingly af-
fected by the transatlantic cocaine trade. As long as there is demand and profit to be made, traffickers have shown great adaptability and sophistication in their tactics as well. In particular, the vast profits to be gained from illicit drug markets have constituted important economic incentives for criminal organisations’ continued involvement in the drug trade.

Second, national drug policies focused on reducing the size of the drug market have led to more violence and instability. Retail drug markets are not inherently violent; there are a number of more important factors in levels of violence, including demographic factors, such as the age of criminal capos and the geographic concentration of minority groups, levels of poverty, the balance of power in the criminal market as well as the capacity of policing agencies and their choice of strategies. A 2011 study found that ‘gun violence and high homicide rates may be an inevitable consequence of drug prohibition and that disrupting drug markets can paradoxically increase violence’. Examples of drug law enforcement contributing to more violence include Colombia between the mid-1980s and the mid-1990s; Mexico, whose homicide rate nearly tripled between 2007 and 2012; and Brazil, where police officers killed over 11,000 people between 2008 and 2013.

Militarised interventions have proven to be even more problematic. In Mexico, as part of the military crackdown carried out under President Felipe Calderón (2006-2012), over 70,000 people died in drug-related killings, and more than 26,000 disappeared. Between 2007 and 2010, kidnapping increased by 188%, extortion by 100%, and aggravated robbery by 42%. While changes in the balance of powers between the six main ‘drug cartels’ as well as an increased availability of weapons from the USA constituted other important factors in the increased violence in the country, the military response certainly aggravated the situation on the ground. The Mexican government’s military gains against the ‘drug cartels’ La Familia Michoacana and Los Zetas led to the emergence of a new and highly violent group, Los Caballeros Templarios (Knights Templar). Meanwhile, Los Zetas were not defeated but merely displaced to new areas, including Monterrey, Nuevo León and further south near the border with Guatemala.

High-level targeting (also called leadership removal or decapitation) against organised crime groups has proved even less effective in reducing violence than in the case of terrorist organisations. Notably, studies have demonstrated that ‘leadership removals are generally followed by increases in drug-related murders’ and that the ‘competitive structure of the illicit drug market in Mexico has created the paradoxical result that state crackdowns increase incentives for [drug trafficking organisations] to fight turf wars by reducing the costs of fighting against the decapitated [drug trafficking organisation]’.

Interestingly, arresting leaders can result in less violence than killing them and the short-term reduction of violence is even more robust when a mid-level leader, instead of a high-level one, is arrested.

Third, in a context of budgetary pressures, a disproportionate law enforcement focus on drug interdiction has created opportunity costs, diverting crucial law enforcement resources away from prevention...
and investigation. Because of this, murders, kidnappings, sexual violence, and corruption, have arguably been neglected. Mexico’s National Institute for Statistics and Geography estimated that in 2013 almost 94% of crimes were not investigated.174 Similarly, at least 600,000 murders have gone unsolved in the USA since the 1960s.175 In Colombia, 95% of the 3,000 cases of assassination of trade union members of the past 30 years remain unprosecuted.176 In Guatemala, impunity for perpetrators of rape and domestic violence stood at approximately 98% in 2012.177

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

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

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

### Legislative/policy issues involved

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

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**Box 1 Social programmes in Boston and Chicago**

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

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

### Prioritising violence reduction

National drug policies have largely placed priority on reducing the size of the drug market at all costs. Instead, policing designed to proactively shape the drug markets towards more benign, less violent forms, is a more realistic and effective way to mitigate the harms caused by the drug trade, as demonstrated by effective programmes put in place in Bos-
In the early 1990s, Switzerland reformed its drug policy around a ‘Four Pillars’ approach (prevention, treatment, harm reduction and law enforcement), endorsed by the Federal Council in 1994. Police authorities, initially reticent, came to accept the shift in perspective from public order to public health. They were made equal partners with public health officials as the new drug policy was developed and implemented. A cross-government drug committee helped improve communication and coordination between services towards a common strategy. The new drug policy and the introduction of harm reduction programmes contributed to a significant drop in the number of HIV deaths among people who use drugs from the early 1990s to 1998.

Based on the Swiss model, a similar drug strategy emerged in the early 2000s in Vancouver, Canada. The strategy has centred on harm reduction, including measures such as condom distribution, needle exchange, and North America’s first safe injection site, opened in 2003. Despite political difficulties, police authorities have supported Insite in practice, and diverted people using heroin to the site. Protocols between police and harm reduction service providers ensure drug trafficking laws are enforced – open drug dealing is discouraged, while drug users are encouraged to access needed services,’ the Ministry of Health of British Columbia noted. Since 2003, numbers of overdose deaths and new HIV infections among people who inject drugs went down to the lowest on record, and treatment levels have increased considerably.

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

A similar multi-disciplinary approach emerged in the mid-1990s in the UK, involving drug law enforcement cooperation with community policing, health and social authorities, and the justice system. Drug Action Teams were created, and tasked with identifying problems, coordinating the local response and reporting back to relevant national public health authorities. This led to more harm reduction trainings for the police, increased awareness of their role and responsibilities, and greater cooperation between services.

In 2013, an Independent Commission on Drugs convened by the Safe in the City Partnership also highlighted the benefits of collaboration between police, council, health services and community organisations in Brighton & Hove.
tion and input from the local population, civil society organisations and affected communities. Lessons can be learnt from the experience of the Police Pacification Units (UPPs), launched in Rio de Janeiro, Brazil in 2008. In particular, the UPPs’ objective to deliver social services and new infrastructure to boost social and economic development in the favelas could be useful elsewhere. However, the UPPs have also been criticised because of the militarisation of some of the favelas’ communities, leading to tight police controls, arbitrary searches and harassment. Others have raised concerns about the capacity of the UPPs to truly tackle drug-related violence – in fact, out of the 1,000 favelas of Rio de Janeiro, only 17 have been pacified so far, often leading organised criminal groups to move to neighbouring favelas to resume their activities. The UPPs’ mixed results demonstrate the need for sustained efforts in the long term, accompanied by measures such as those designed to reduce economic and social inequalities, improve work conditions, and decrease school dropout rates.

**Building partnerships with health and social authorities**

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

**Tackling corruption and money laundering**

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

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

A World Bank report highlighted a number of measures behind achievements in Georgia: ‘exercising strong political will; establishing credibility early; launching a frontal assault; attracting new staff; limiting the state’s role; adopting unconventional methods; coordinating closely; tailoring international experience to local conditions; harnessing technology; and using communications strategically’. In Croatia, the government created the Bureau for the Suppression of Corruption and Organised Crime, a specialised prosecution service. After early struggles, the Bureau now holds a conviction rate higher than 95%, and has successfully prosecuted a former prime minister, a former vice president, a former top-level general, and other high-level officials. Strengthened legislation, popular support, media scrutiny, and the perspective of European Union membership have been considered as key factors behind this progress.

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

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

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

- **Sunk cost fallacy**, or ‘the idea that a company or organization is more likely to continue with a project if they have already invested a lot of money, time, or effort in it, even when continuing is not the best thing to do’. In other words, we have invested so much money, time and effort in the current drug law enforcement approach, that reforming it is seen by many as a waste, or giving up, while related bureaucracies are now embedded in our law enforcement budgets and infrastructures.

- **A third-rail issue**: Although the debate has significantly evolved in recent years in several countries, a reform of drug law enforcement strategies remains a politically controversial topic. Many politicians remain unwilling to champion more liberal policies by fear of being labelled as ‘soft on drugs’ or ‘weak on crime’.

- **Counter-narcotics aid**: Foreign assistance and training has also disseminated and perpetuated outdated and inadequate drug law enforcement approaches across the world.

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

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

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**Box 4 Examples of new drug law enforcement performance indicators**

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

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

**Indicators measuring drug-related crime:**

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

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

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

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

- How did law enforcement activities impact affected communities’ socio-economic environment and people’s feelings of safety and security?
- Have patterns of drug use and dependence changed as a result of law enforcement actions?
crops eradicated, or extraditions (processes), but rather on evidence of fewer harms associated with the drug trade, and an improved quality of life (outcomes), independently evaluated. 199

**Key resources**

Key recommendations

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

Introduction

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

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

In most countries, prisoners are drawn from the poorest and most marginalised strata of society, with low education, high unemployment rates, and histories of physical or sexual abuse, broken homes and relationships. Many prisoners may have used alcohol and/or controlled substances as a coping mechanism, including to ‘escape’ childhood abuse and violence. In prison, drugs are widely available, and are often used to escape the misery, brutality, lack of privacy, anxiety and chronic insecurity that frequently characterise life within these institutions. Boredom and lack of constructive activities in prison can also increase the likelihood of drug use.
In European prisons, it was found in 2006 that tuberculosis infection was 17 times more likely in prisons than in the general population, and up to 81 times more likely in Eastern Europe. Estimates show that approximately one in three people detained have used drugs at least once while in prison, with the prevalence of drug use varying considerably from country to country. There is also evidence that many prisoners initiate injecting drugs for the first time in prison. While the number of people who inject drugs in the community is only 0.26% of people aged 15-64, the rate is considerably higher in prison. For example, a study found that 23% of prisoners in Australia had injected drugs at some point in prison, as had 39% of male prisoners in Bangkok, Thailand.

While the rate of infections in prisons within and across countries varies considerably, the prevalence of HIV, sexually transmitted infections (STIs), hepatitis B and C as well as tuberculosis is much higher in prison populations as compared to the general population. HIV prevalence has been found to be 50 times higher in some prison settings than in the general population. In Europe, the World Health Organisation (WHO) estimated that one in four detainees (an estimated 2.2 million people) are living with hepatitis C, compared to one in every 50 in the broader community. Similarly, the prevalence of tuberculosis is ‘multiple times higher’ in prisons than it is in the general population. While statistics are hard to come by, in European prisons it was found in 2006 that tuberculosis infection was 17 times more likely in prisons than in the general population, and up to 81 times more likely in Eastern Europe.

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

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

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

- **Human rights obligations:** International human rights obligations include the right to the highest attainable standard of physical and mental health, and prisoners retain their human rights while detained. Governments bear a particular responsibility towards those they deprive of their liberty.

- **Improve drug treatment and prevent recidivism:** Effective treatment for drug dependence in prisons – including opioid substitution therapy (OST) – improves health outcomes and can help to prevent a return to crime after release. Without treatment and a continuum of care, evidence shows a high rate of overdoses, relapse to drug use and recidivism among people who use drugs after they are released from prison.

- **Economics:** Responding to drug-related crime, overdose and blood-borne infections can be very expensive, in particular for illnesses such as HIV that are chronic and may require life-long treatment. There is therefore a powerful economic case to be made for harm reduction and evidence-based drug treatment measures in prisons, as well as in community settings.

### Legislative/policy issues involved

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

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

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

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

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

Healthcare staff in prisons are subject to the same ethical and professional standards as for patients in the community, including adherence to prisoners’ autonomy with regard to their own health, informed consent in the doctor-patient relationship, and confidentiality of medical information – unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others (Rule 32, see also General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights). Information is a precondition for prisoners to be able to give their informed consent to medical interventions. As the Special Rapporteur on the right to health emphasized, ‘informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision’.

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

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

**Box 1 Principles for the provision of healthcare in prison**

- State responsibility
- Without discrimination
- Equivalence of healthcare
- Clinical independence
- Same ethical principles as in the community
- Medical screening upon admission
- Drug dependence treatment
- Mental healthcare
- Continuity of care
acknowledged and rectified by the adoption of the Bangkok Rules. While the Mandela Rules and the Bangkok Rules do not constitute legally-binding treaties, they carry the weight of unanimously adopted standards at the international level. At the regional level, provisions on healthcare in prisons have been incorporated in the European prison rules and the Principles and best practices on the protection of persons deprived of liberty in the Americas.

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

Implementation issues involved

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

Implementing a comprehensive package of services in prison

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

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

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

**Education and information** – As prisoners typically come from the most marginalised groups of society and may have had limited access to healthcare before admission to prison, they are less likely to be aware of health and infection risks. However, the
Drug dependence treatment – With a large number of people dependent on drugs held in custody at any one time, prisons can be an effective setting for a range of evidence-based treatment programmes (for more information on treatment, refer to Chapter 2.5). OST – in particular with methadone and buprenorphine – has proven to be feasible and beneficial in a wide range of prison settings for people dependent on opioids. Yet only 43 countries provided OST in prison settings in 2014. OST has proven to lower rates of heroin use, reduce drug injection, reduce the sharing of injecting equipment, lower rates of fatal overdose (especially post-release), increase adherence to ART, and lower re-incarceration rates. For example, a review of 21 studies on OST in prisons found that it provided an effective way to get people into treatment programmes, reduce risk behaviours, and lower overdose risks upon release. It also found that, where liaison with community-based programmes existed, the prison programmes ensured longer-term benefits (see also the Madrid Recommendations). Drug dependence treatment programmes showed additional positive effects on institutional behaviour and reduced violence. As in the community, however, more attention should be given to substitution treatment options for stimulant dependence (see Chapter 2.5 for more detail).

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

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

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

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- Compliance and success rates of treatment for drug dependence in prisons can be improved by linking treatment progress to prisoner incentives, such as consideration for early release.
- Careful attention needs to be paid to continuity of treatment upon admission and post release.

Spread of infectious diseases can only be prevented if prisoners are given information about means of protection and prevention in a diction that is appropriate to their language skills and education. Health education has also shown to improve adherence to treatment and rises in cure rates. Some prison administrations have used educational videos or lectures to deliver health education, leading to higher levels of awareness. Information material should be developed in consultation with prisoners and prison staff, as it ‘makes the information more sensitive and appropriate to the prison context, increases the sense of ownership among prisoners and contributes to the continuity of the programme’.
• Treatment success and recovery should not be understood solely as abstinence from drug use. Individuals should be encouraged to identify and strive towards their own recovery, which may or may not require abstinence but will always include progressive steps to improve their health and well-being (see Chapter 2.5).

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

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

**Vaccination programmes** – Effective vaccinations exist to protect people against hepatitis B, and incarceration does provide an opportunity to encourage people to take up these vaccinations. However, vaccination schemes should remain voluntary. The UK, for example, established an ‘opt-out’ testing programme for hepatitis B in prisons, whereby all prisoners are offered the chance to be tested for infection, and recommended that all prisoners be vaccinated against hepatitis B. Most prison administrations that have targeted hepatitis A and B vaccination programmes at drug-using prisoners report high levels of engagement and compliance.

**Establishing responsibility / prison management**

It is now widely recognised that prison health services should be integrated into public national health policies and systems. It is also increasingly acknowledged that this can be done most effectively, and that continuity of care is best achieved, when the responsibility for prison healthcare is assumed by the Ministry of Health. Healthcare staff employed by prison services may not be sufficiently in touch with clinical and professional developments in the wider society, may lack independence, or may not be trusted by inmates. Countries such as Italy,
Norway, France, England and Wales and most parts of New South Wales in Australia have already taken this step, with broadly positive results. Ensuring gender sensitivity

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

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

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

With regard to HIV, Bangkok Rule 14 recommends programmes that are ‘responsive to the specific needs of women, including prevention of mother-to-child transmission’, encouraging ‘the development of initiatives on HIV prevention, treatment and care, such as peer-based education’. Further measures should include gender-sensitive support groups, drug education, and psychosocial programmes.

Preventing overdoses

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

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

In the late 1990s, the rate of HIV infection among prisoners who injected drugs in Spain was reported to be around 30% – one of the highest in Europe. The country therefore launched a prevention and control programme for communicable diseases in prison, mirrored in the community. A comprehensive harm reduction approach was adopted based on voluntary testing, confidentiality, free distribution of condoms, OST, NSPs, health-related education, prisoners’ training as health mediators, and parole for terminally-ill prisoners. The impact was significant. Spain has reported that HIV prevalence among prisoners fell from 22.4% in 1995 to 6.3% in 2011, and in one particular prison in the Ourense region, a 10-year review of the NSP found that between 1999 and 2009 the prevalence of HIV infection decreased from 21% in 1999 to 8.5% in 2009, and hepatitis C prevalence from 40% to 26.1%.
Because of this elevated risk, prison services should seek to provide training and information on overdose prevention and emergency responses – both for people who use drugs and for prison staff. Upon release and/or while in prisons, people who use opioids should also be provided with naloxone – a WHO Essential Medicine which quickly and safely reverses the respiratory depression from an opioid overdose (see Chapter 2.4 for more details).

**Addressing post-release issues**

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

As set out by the UNODC, UNAIDS and the WHO, ‘In order to ensure that the benefits of treatment (...) started before or during imprisonment are not lost, as well as to prevent the development of resistance to medications, provision must be made to (...) continue these treatments without interruption’.

This continuity of care is best achieved when community services can provide support to a prisoner in custody and after release and accompany his/her re-entry into the community.

Several studies have suggested that aftercare is needed to optimise the effects of in-prison treatment for drug dependence on reducing drug re-offending.

Continuity of care also requires that medical files follow the prisoner to the relevant public health service upon release (see Rule 26 of the Mandela Rules).

**Key resources**

- United Nations Office on Drugs and Crime, International Labor Organization & United Nations Box 5 **Lichtenberg women’s prison in Berlin, Germany**

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

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


Chapter 3 – endnotes

1. In many countries, drug use continues to be criminalised – even though the UN drug conventions offer considerable flexibility by allowing social and health measures to be used in addition to, or instead of, criminal penalties for people who use drugs and offenders found to be dependent on drugs.


20. The treaty requirements do not differentiate between possession and cultivation for personal use. It is on this basis that first in Spain, and then in other countries, cannabis social clubs started engaging in collective cultivation for personal use. For more details, see: Bevley-Taylor D., Jeloma M. & Blickman T. (March 2014), The rise and decline of cannabis prohibition (Transnational Institute & Global Drug Policy Observatory), https://www.tni.org/files/download/rise_and_decline_web.pdf


23. Ibid


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33. In many countries, people can await their trial for a drug offence for months, sometimes years. In Mexico, 40% of people incarcerated are currently awaiting their trial. In Bolivia, this percentage rises to an alarming 74%. For more information, see: Washington Office on Latin America (December 2010), Systems overload: Drug laws and prisons in Latin America, http://www.wola.org/publications/systems_overload_drug_laws_and_prisons_in_latin_america_0


50. The most recent opinion poll in June 2015 showed support for regulated production reaching 70% of the Dutch population, with strong majority support across voters for all main parties. For an overview of public opinion polls on cannabis in the Netherlands, see: http://druglawreform.info/images/stories/documents/Cannabis_opinion_polls_in_the_Netherlands_June_2015.pdf


53. Ibid


64. For a comprehensive discussion on the regulatory models described here and in Box 1, see: Rolles, S. (2009), After the war on drugs: Blueprint for regulation (Bristol: Transform Drug Policy Foundation), http://www.tdpf.org.uk/resources/publications/after-war-drugs-blueprint-regulation; also see: Caukins, J. et al (January 2015), Considering marijuana legalisation: Insights for Vermont and other jurisdictions (RAND Corporation), http://www.rand.org


133. Matrix Knowledge Group (2007), Transnational Institute & Washington Office on Latin America


137. Ibid.


139. 1988 Convention against Illicit Traffic of Narcotic Drugs and Psychotropic Substances, Article (3)(4)(b), (c) and (d); Bewley-Taylor, D. & Jelsma, M. (March 2012), The UN drug control conventions – The limits of latitude (Transnational Institute & International Drug Policy Consortium), http://idpc.net/publications/2012/03/un-drug-control-conventions-the-limits-of-latitude

140. 1988 UN Convention against Illicit Traffic on Narcotic Drugs and Psychotropic Substances, article 3(c)


145. ‘A drug-free world, we can do it!’ was the slogan of the 1998 United Nations General Assembly Special Session on the World Drug Problem: http://www.un.org/ga/20special/

146. In the USA, the average inflation-adjusted and purity-adjusted prices of heroin, cocaine and marijuana decreased by 81%, 80% and 86%, respectively, between 1990 and 2007, whereas average purity increased by 60%, 11% and 161%, respectively. In Europe ‘during the same period the average inflation-adjusted price of opiates and cocaine decreased by 74% and 51%, respectively. See: International Centre for Science in Drug Policy (2013), New psychoactive substances: risks and controls, http://www.icsdp.org/bmjo_2014


232. Based on a 2010 General Assembly Resolution, a process of review of the UN Standard Minimum Rules for the Treatment of Prisoners (initially adopted by the UN General Assembly in 1955) has resulted in the revision of nine areas, including the incorporation of a number of key safeguards on healthcare into this international standard. The revised Standard Minimum Rules for the Treatment of Prisoners (known as the Mandela Rules) were adopted by the UN Crime Commission in May 2015 and subsequently the Third Committee of the UN General Assembly on 5 November 2015, A/C.3/70/L.3, www.un.org/ua/search/view_doc.asp?symbol=A/C.3/70/L.3


234. Guidelines for prison, detention and other custodial settings of the working group on dual loyalties, para. 12: ‘The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference’

235. WMA Declaration of Tokyo – Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment, adopted in 1975 and revised 2005, para. 5: ‘A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible,’ http://www.wma.net/en/health-topics/health-determinants/prisons-and-health/publications/pre-2005/moscow-declaration-on-prison-health-as-part-of-public-health


239. These principles were developed by Penal Reform International


242. The Convention on the Elimination of All Forms of Racial Discrimination of 1965 (Article 5(e) (iv)) and the Convention on the Elimination of All Forms of Discrimination against Women of 1979 (Articles 11.1 (f) and 12) as well as the Convention on the Rights of the Child of 1989 also recognise the right to health


245. For example, mandatory drug testing in prisons is now carried out in most EU Member States. See: European Monitoring Centre on Drugs and Drug Addiction (2012), Prisons and drugs in Europe – The problem and responses, p. 15, http://www.emcdda.europa.eu/publications/selected-issues/prison


249. Ibid


251. Ibid, p. 70


A medical screening upon admission and thereafter as necessary is prescribed in Rule 30 of the revised Mandela Rules, by a physi-
cian or other qualified health-care professionals, paying ‘particular
attention’ to a number of issues listed, including the identification
of withdrawal symptoms resulting from the use of drugs, medi-
cation or alcohol; and undertaking all appropriate individualised
measures or treatment.

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