MODULE 8

Decriminalisation and diversion in Asia

Aim of Module 1

To identify the gold standard of decriminalisation and develop effective advocacy interventions to promote both decriminalisation and diversion programmes away from incarceration.

Learning objectives

Participants will gain an understanding of:

- The key components of an effective decriminalisation model
- The various methods for diverting people away from prison and detention, and towards effective and humane health and social services
- How to effectively advocate for decriminalisation and diversion.

Introduction

Drug control has traditionally focused on imposing criminal sanctions agains t all people involved in the illicit drug market, with the hope that harsh criminal sanctions would deter people from engaging in the illicit drug trade. As a result, prisons are now filled with people who use drugs or low-level drug offenders. Recent estimates from the United Nations 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.[1] Nevertheless, the global prevalence of drug use remains as high as ever[2] and this policy has created more harms than the substances they are meant to put under control.

To respond to this situation, some 45 countries and jurisdictions worldwide have decriminalised drug use and refer people who use drugs to health and social services or impose minor administrative penalties. National policies in Asia, however, remain entrenched in a law enforcement-led approach. Even in countries where drug use is not punished with criminal sanctions, harsh administrative sanctions include compulsory detention, urine testing, inclusion in official registries, etc. In this context, it is critical to adequately define what decriminalisation means in practice, how it can be implemented, and what tools advocates can use to influence policies and practices.

In countries or jurisdictions where decriminalisation may not be achievable, a number of diversion mechanisms can be used to ensure that people who use drugs or who have committed low-level, non-violent drug offences do not end up in prison. The second part of this Module will assess how best to advocate for these mechanisms.

SESSION 8.1: **Activity:** The rationale for promoting decriminalisation (60 minutes)

SESSION 8.2: **Presentation:** What is decriminalisation? (20 minutes)

SESSION 8.3: **Activity:** The gold standard of decriminalisation: how it works in practice

SESSION 8.4: **Activity:** Advocating for decriminalisation

SESSION 8.5: **Activity:** Promoting diversion mechanisms for people who use drugs & low-level drug offenders

1. Commission on Crime Prevention and Criminal Justice (2014), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice*, E/CN.15/2014/5, https://www.unodc.org/documents/data-and-analysis/statistics/crime/ECN.1520145_EN.pdf
2. In its 2015 World Drug Report, UNODC declared: 'illicit drug use has in fact remained stable'. See: United Nations Office on Drugs and Crime (2015), *UNODC World Drug Report 2015*, http://www.unodc.org/wdr2015/

MODULE 8

Session 8.1

Activity: The rationale for promoting decriminalisation

60 min

Facilitators' note

This exercise can be replaced by the 'Tree of bad drug policy' exercise included in Module 1 of the Training Toolkit.

In case of time constraints, you can skip this exercise and do a 10-minute brainstorm session with the participants about what they think are the consequences of criminalising/punishing people who use drugs. Note the discussion outcomes onto a flipchart.

Aim – To understand the negative consequences of criminalising and punishing people who use drugs

1. Introduce the aim of the session (slide 3).
2. Split the participants in groups of 5-6 people, distribute them a flipchart and marker pen.
3. Explain that they will work on a cause-and-effects flowchart. Ask them to name a note taker and a rapporteur. Using slide 4, ask each group to:
   a. Write 'Punishment/criminalisation of people who use drugs' in the middle of the flipchart, write 'Effects' at the top of the chart, and 'Causes' at the bottom of the page.
   b. Write 2-3 causes of the problem and link them to the centre of the page with an arrow. Causes can be people, organisations, attitudes, lack of knowledge, etc. Then look at each cause and find a deeper cause, by asking 'what causes that cause?'. Write these down and link them with an arrow.
   c. Write 2-3 effects at the top of the flipchart and link them from the centre of the chart with an arrow. Then look at each effect and ask: 'what further effect(s) will this have?' and add these onto the flipchart, connecting them with arrows.
4. Back in plenary, ask each group to present their work. Allow time for questions and wrap up by presenting the information below if some aspects have not been identified by the participants (slide 5).

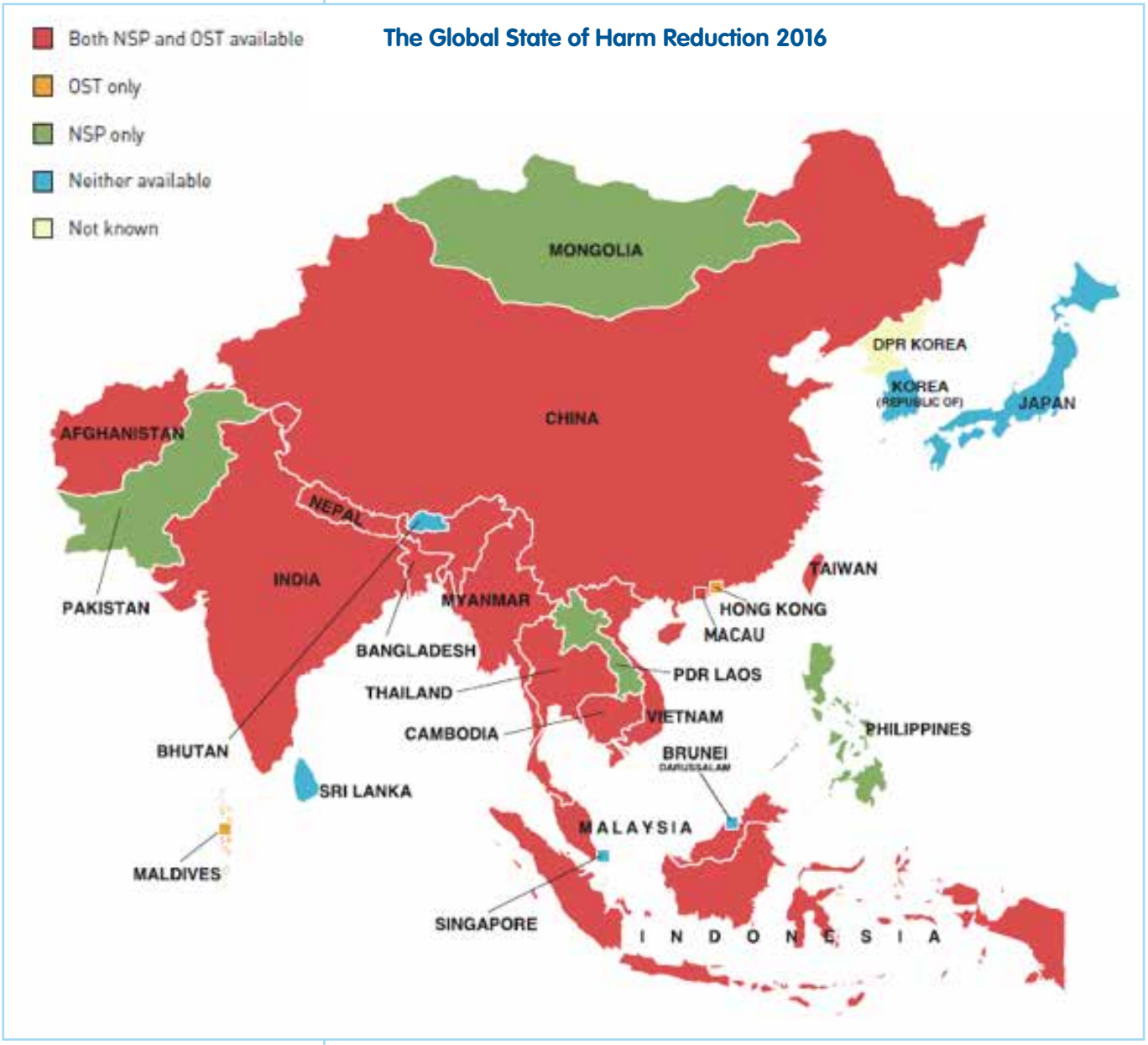
Information to cover in this presentation:

Evidence from countries in Asia and the rest of the world demonstrates that increasing the ferocity of law enforcement or the severity of punishment against people who use drugs does not reduce the prevalence of drug use (slide 5).[1,2]

What's more, the criminalisation of people who use drugs across the region has resulted in immense harms to individuals and societies, including:

- High levels of stigma and discrimination – deterring people who use drugs from accessing essential health and social services such as h arm reduction, treatment, as well as housing, education and employment, further exacerbating their social marginalisation (slide 6).
- An HIV epidemic driven by injecting drug use – in contexts where drug use is criminalised, people who use drugs are deterred from accessing the health services they may need, and are more likely to use drugs in unsafe environments. They may engage in hurried, higher-risk injecting practices including sharing of injecting equipment. This increases their vulnerability to HIV, hepatitis C and

other infections, overdoses and other injuries associated with unsafe injecting practices. According to the UN, there are 255 million people who use drugs worldwide, 12 million of whom inject drugs. Among the latter, 1.6 million (13%) are living with HIV, and 6.1 million (51%) with hepatitis C. In Asia, most countries provide harm reduction services, but accessibility continues to be severely limited[3] (slides 7-8).



- Abuses perpetrated by law enforcement personnel against people who use drugs,[4] including extortion and entrapment, violence and harassment – driving people who use drugs away from life-saving health and social care services (slide 9).[5]
- Prison overcrowding – in many countries, a large portion of the national prison population is comprised of people in pre-trial detention or imprisoned for drug use or minor drug-related offences. The proportion of prisoners held for drug-related offences is estimated at 60% in Indonesia,[6] 64% in Thailand[7] and 70% in Myanmar.[8] This has led to severe overcrowding, reaching 178.6% in Cambodia[9] to more than 500% in the Philippines.[10] Overcrowded prison facilities provide a high-risk environment for the transmission of HIV, hepatitis C and tuberculosis, with public health implications for the entire community[11] (slide 10).

1. Reuter, P. (2009), 'Ten years after the United Nations General Assembly Special Session (UNGASS): assessing drug problems, policies and reform proposals.' *Addiction* **104**: 510-517; Global Commission on Drug Policy (2011), *War on drugs*, http://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf; *Vienna Declaration*, http://www.viennadeclaration.com/the-declaration/#sthash.iBfEILdA.dpuf.
2. United Nations Office on Drugs and Crime (2010), *From coercion to cohesion: Treating drug-dependence through health care, not punishment*, p. 5, https://www.unodc.org/docs/treatment/Coercion_Ebook.pdf
3. Joint United Nations Programme on HIV/AIDS (2013), *HIV in Asia and the Pacific*, pp. 17-18, http://www.unaids.org/sites/default/files/media_asset/2013_HIV-Asia-Pacific_en_0.pdf
4. See e.g. IDLO (2011), *South Asia roundtable dialogue legal and policy barriers to the HIV response* (Rome: IDLO)
5. Global Commission on HIV and the Law (2012), *Risks, rights and health*, http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf; Global Commission on Drug Policy (2012), *The war on drugs and HIV/AIDS: How the criminalization of drug use fuels the global epidemic*, http://globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/GCDP_HIV-AIDS_2012_REFERENCE.pdf
6. As of July 2015, of the population of 105,865 prisoners, 40,075 were on drug use charges and 25,559 on dealing / supply charges: Database of Directorate-General of Corrections, Ministry of Justice and Human Rights, Indonesia (2015), http://smslap.ditjenpas.go.id/public/krl/current/monthly/year/2015/month/7
7. 32nd Asian and Pacific Conference of Correctional Administrators, October 2012, http://www.apcca.org/ uploads/APCCA_Report_2012_Brunei.pdf; Thailand Institute of Justice, (November 2014), *Women prisoners and the implementation of the Bangkok Rules in Thailand*, p. 35, http://www.tijthailand.org/useruploads/files/women_prisoners_and_the_implementation_of_the_bangkok_rules_in_t hailand_tij.pdf
8. Transnational Institute (2015), *Towards a healthier legal environment: Review of Myanmar's drug laws*, p. 8, http://www.burmalibrary.org/docs21/TNI-2015-02-Myanmar-towards_a_healthier_legal_environment-en-red.pdf
9. Data from 2014: International Centre for Prison Studies, *World prison brief*
10. Tupas, E. (2 July 2017), 'Jail facilities congested by 583 percent', *Philstar Global*, http://www.philstar.com/headlines/2017/07/02/1715573/jail-facilities-congested-583-percent
11. United Nations Office on Drugs and Crime (2013), *HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions*: *Policy Brief*, https://www.unodc.org/documents/hivaids/HIV_comprehensive_package_prison_2013_eBook.pdf

MODULE 8

Session 8.2
Presentation: What is decriminalisation?

20 min

Aim – To come up with an acceptable definition of what we mean by decriminalisation, its objectives and the drug-related activities that it should cover

1. Introduce the aim of the session (slide 12).
2. Present the information below along with corresponding slides (slides 13-14). Leave time for the participants to comment on the definition.
3. Distribute the handout 'Decriminalisation in Asia'. Explain that no country in Asia has yet implemented full decriminalisation but that there are some interesting models being implemented on certain substances and in some localities. Tell the participants to keep these in mind during the rest of the Module.

Information to cover in this presentation:

Decriminalisation entails the removal of criminal penalties for drug use and the possession of drugs for personal use, as well as for the possession of drug use paraphernalia (e.g. clean needles and syringes, crack pipes, etc.). In some contexts, this also includes the removal of criminal sanctions for the cultivation and purchase of psychoactive plans for personal use.

The key objective of decriminalisation is to end the punishment and stigmatisation of people who use drugs. Governments may then respond to drug use and associated activities with a variety of approaches, including with referrals to health and social services, but also small fines, community work, etc. Crucially, when implemented under a harm reduction-oriented approach, decriminalisation can provide a supportive legal framework within which health interventions can be voluntarily accessed without fear of stigma, arrest and detention.[1] In countries where having been condemned for a drug offence will exclude a person from accessing housing, welfare and scholarships, decriminalisation can also have a significant effect on people who use drugs.

Decriminalisation processes can be *de jure* and *de facto*. The former involves 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, drug use remains a criminal offence in a country's legislation, but in practice people are no longer prosecuted (for example in the Netherlands). Decriminalisation can focus on a specific drug (usually cannabis), several or all substances (as is the case in Portugal).

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'.[2]

1. Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation
2. For more information about legal regulation, see Chapter 3.2 of: International Drug Policy Consortium (2016), *IDPC Drug policy guide, 3rd edition,* http://idpc.net/publications/2016/03/idpc-drug-policy-guide-3rd-edition

MODULE 8

Session 8.3

Activity: The gold standard: How decriminalisation works

120 min

Aim – To gain an understanding of how decriminalisation works in practice, the possible challenges involved, and define what is the gold standard for an effective model

1. Introduce the aim of the session (slide 15).
2. Explain to the participants that this session will be divided into three steps, during which they will focus on the key aspects of decriminalisation (slide 16):
   - **STEP 1:** Differentiating between possession for personal use and possession with intent to supply
   - **STEP 2:** Identifying who is responsible for determining whether possession is for personal use
   - **STEP 3:** Identifying the adequate response to drug use

STEP 1: Differentiating between possession for personal use and possession with intent to supply

25 min

1. Explain to the participants that the first step – and one of the key challenges – of implementing an effective decriminalisation model is to identify mechanisms to differentiate between possession for personal use and for intent to supply.
2. Ask the participants to brainstorm on the possible tools that can be used to differentiate between personal consumption and commercial purposes and note their ideas on a flipchart (slide 17).

Examples of what participants may come up with

- Amount in possession
- Quantity thresholds
- Evidence of drug use (e.g. person known to be going to drug dependence treatment and/or harm reduction services)
- Possession of firearms and large amounts of money
- Criminal record for previous drug offence

3. Guide the discussions to ask the participants about the pros and cons of each of these methods, especially on using quantity thresholds.
4. Present the information below and corresponding slides (slides 18-21), referring back to the brainstorming session, and ask the participants if they have any further questions or comments.

Facilitators' note

In case of time constraints, the facilitator may decide to split the participants in 3 or 6 groups and have each group focus on one of the components of decriminalisation. Each group can then present their findings to the rest of the participants. In that case, allow time for feedback and comments from the rest of the participants.

Information to cover in this presentation:

A number of countries have developed threshold quantities to determine whether drug possession is for personal use or for intent to supply to others – and although they can be helpful, these threshold quantities are also one of the main challenges in implementing an effective decriminalisation model. Under that model, a person found in possession of a quantity of drugs below the threshold will not be imposed a criminal penalty. Generally, thresholds are defined in relation to specific drugs. They are helpful as they enable police, prosecutors and courts to clearly distinguish between drug use and dealing/supply, but they are also problematic. First and foremost is the fact that there is no international standard on how to low (or high) the right thresholds should be, meaning that the quantities are generally established on an ad hoc basis, and can therefore vary greatly from country to country (see table for example).

Decriminalisation of possession of cannabis[1]

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

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[2]). Similar issues have been reported in Asia to differentiate between use and supply. For example, in Lao PDR, the quantities include 0.2g for heroin, morphine or cocaine, and 0.3g for amphetamines and crystal meth. Excessively low thresholds are also used in Thailand and Vietnam.

To be effective, threshold quantities 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.[3]

Another issue with threshold quantities is the fact that some people may wish to purchase larger quantities of drugs without intent to supply – for example to limit contact with the criminal market and the risks associated with it, for social supply, or because bulk purchases are cheaper.

Other countries have opted not to adopt thresholds and not to define what would be the 'reasonable amounts' or 'small quantities' allowed for personal use. They focus instead on other considerations, 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.

To benefit from the objectivity provided by thresholds, while also considering other factors, decriminalisation should combine indicative threshold quantities with discretionary powers for the police, prosecutor or judge to decide on a case-by-case basis according to all available evidence at hand.[4] 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 in possession of a large amount of drugs was still intending them for personal use, and not for commercial purposes.[5]

STEP 2: Identifying who is responsible for determining whether possession is for personal use

30 min

1. Explain to the participants that the second step is to determine which entity is best placed to determine whether possession is for personal use or for intent to supply.
2. Ask the participants to identify these entities and note them onto a flipchart. Ensure that the participants have identified at least these four entities: police, prosecutors, courts and health/social workers (slide 22).
3. Split the participants into as many groups as the entities identified. Distribute the handout 'The pros and cons of those responsible for determining whether possession is for personal use' to each group, and ask them to identify a note taker and a rapporteur. Explain that they will now be working in groups to identify the positive and negative aspects associated with each entity as they identify whether intent is for personal use or for supply.
4. Allocate one entity per group and ask them to fill in the handout, identifying the positive and negative aspects of their entity being the one responsible for assessing whether drug possession is for use or intent to supply. Go from group to group to facilitate the discussions.

Examples of what participants may come up with:

	Police	Prosecutor	Criminal Court	Health and social workers
Pros	• Avoid risk of pre-trial detention & unnecessary burden on courts • People diverted as early on as possible	• Less lengthy process than if the case went to the courts • More flexibility than courts to impose alternatives to punishment • Can rely on assessments by trained medical professionals before making a decision	• Ensures due process and right of appeal • Allows people to gather evidence	• Trained professionals • Treat people with respect, dignity, no judgement • can give the choice of treatment and harm reduction options • No contact with law enforcement/criminal justice apparatus
Cons	• Risk of corruption, violence, harassment, racial discrimination • Risk of net-widening	• Lengthier process than if the case were resolved by the police • Risk of corruption	• Risk of lengthy pre-trial detention period • Heavy burden on the courts • Often rely on police reports only • Legal representation can be a problem • Courts are bound by the law and have little flexibility for penalties imposed	• Lack of specialised training on harm reduction and different treatment options

5. Back in plenary, ask each group in turn to present their table to the rest of the participants, allow time for questions and comments at the end of each presentation.
6. Wrap-up the session, making sure that the information below has been reflected during the discussions or in your conclusions (slide 23).

Information to cover in this presentation:

There is no perfect model here, and each entity presents both advantages and negative aspects. Nevertheless, to reduce unnecessary burdens on the criminal justice system and to avoid the risk of pre-trial detention,[6] 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. 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 governments establish a decriminalisation policy, they should keep in mind that the overarching objective is to reduce (and eventually eliminate!) the number of people being punished for simple drug use.

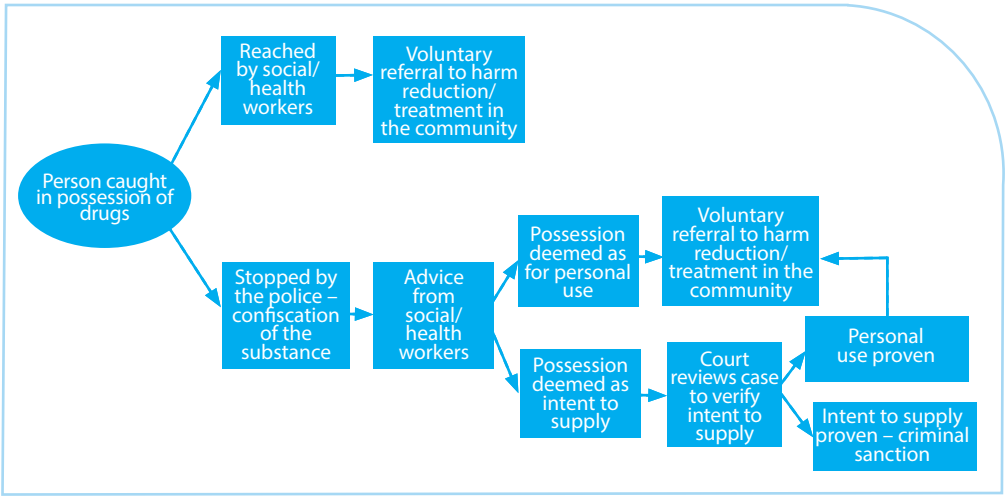
These implementation issues can be addressed through solid prosecutorial guidance, including a tight oversight and scrutiny of police behaviour, in particular guidance on how to assess the quantity thresholds (for example, on whether to take into account dry weight or wet weight), on how to exercise 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.[7]

Health, legal and community workers can also play an important role, intervening at the community level to refer people who use drugs to health, legal and social support services before they come into contact with law enforcement or the criminal justice system. They are also better placed to assess people's specific needs and refer them to the different treatment and harm reduction services available in the community, including: OST, counselling, psychosocial interventions, counselling and treatment for HIV, hepatitis, tuberculosis, etc.

50 min

STEP 3: Identifying the adequate response to drug use

1. Explain that this is the third component of an effective decriminalisation model – and a critical one in Asia, as several countries do not criminalise drug use but impose severe administrative sanctions against people who use drugs (refer back to Sessions 8.1 and 8.2).
2. Ask the participants to return to their group. Distribute a flipchart and marker pens. Ask them to draft a diagram that depicts the journey of a person caught in possession of drugs within a decriminalised model of their choosing, thinking about any penalties imposed, if so, which ones? Any referrals, if so, which ones? What if the person is caught with drugs again? Etc. (slide 24). For each step, add which entity is responsible for the process onto the diagram. Go from group to group to facilitate the discussions.



3. Ask each group to present their diagram to the rest of the participants, allow time for comments and questions.
4. Present the information below to conclude, based on the discussions (slide 25). Ask the participants if they have any further questions.

Information to cover in this presentation:

There is a significant difference around the world on the response given to drug use within a decriminalisation model. As showed in Sessions 8.1 and 8.2, some Asian countries have removed criminal penalties against people who use drugs but maintain highly punitive sanctions for drug use, such as compulsory detention centres, compulsory registration with police, urine testing, etc. The removal of these harsh penalties is essential for an effective decriminalisation model that is based on the principles of public health, harm reduction and human rights.

It is worth reiterating here that the objective of decriminalisation is *to reduce levels of punishment* for drug use, and *improve* their access to *voluntary* harm reduction, treatment and social support services. This means that when referral mechanisms are in place to encourage people to enter voluntary treatment or harm reduction services, they should offer a variety of treatment options, and treatment failure should not lead to the imposition of a criminal sanction.

In some countries – such as the Netherlands and Belgium – no sanction is imposed on people who use drugs, except for the confiscation of the substance. Other countries impose administrative fines. In that case, countries need to be mindful of the fact that if the fine is too high, people who use drugs may be subject to prosecution and or incarceration for failure to pay it – the model would therefore be ineffective. Other forms of administrative penalties such as seizure of passport or driver's licence should be avoided as these can have a negative impact on people's life and ability to work.

Facilitators' note

To conduct this exercise, it may be useful for the facilitator to check the decriminalization e-tool available at: www.decrim.idpc.net, and – if time allows – to present it to the participants at the end of the session.

1. Godwin, J. (2016), A public health approach to drug use in Asia: Principles and practices for decriminalisation (London: International Drug Policy Consortium), http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation
2. See article 478 in: Diario Oficial de la Federación (20 August 2009), Decreto por el que se reforman, adicionan y derogan diversas disposiciones de la Ley General de Salud, del Código Penal Federal y del Código Federal de Procedimientos Penales, http://dof.gob.mx/nota_detalle.php?codigo=5106093&fecha=20/08/2009
3. International Drug Policy Consortium (2016), IDPC Drug policy guide, 3rd edition, http://idpc.net/publications/2016/03/idpc-drug-policy-guide-3rd-edition
4. For a full discussion, see: Harris, G. (2011), Report of TNI-EMCDDA expert seminar on threshold quantities (Transnational Institute & European Monitoring Centre for Drugs and Drug Addiction), http://idpc.net/sites/

default/files/library/thresholds-expert-seminar.pdf; Harris, G. (2011), Conviction by numbers: Threshold quantities for drug policy (Transnational Institute & International Drug Policy Consortium), http://idpc.net/sites/default/files/library/Threshold-quantities-for-drug-policy.pdf

5. International Drug Policy Consortium (2016), IDPC Drug policy guide, 3rd edition, http://idpc.net/publications/2016/03/idpc-drug-policy-guide-3rd-edition
6. 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
7. Godwin, J. (2016), A public health approach to drug use in Asia: Principles and practices for decriminalisation (London: International Drug Policy Consortium), http://idpc.net/publications/2016/03/public-health-ap-

MODULE 8

Session 8.4
Activity: Advocating for decriminalisation

60 min

Aim – To identify avenues, mechanisms and messages to advocate effectively in favour of decriminalisation

1. Introduce the aim of the session (slide 26).
2. Divide the participants into groups of 3-4 people. Give them the scenario below (slide 27):

Scenario: Your NGO is invited at a national drug policy conference organised by the government. You know that the event will involve high-level influential policy makers and police officers, as well as religious leaders and other NGO colleagues. The media will also be present to report on the outcomes of the event. The conference's agenda is mainly focused on drug law enforcement and criminal justice issues, it will therefore be the perfect opportunity for you to highlight the need to decriminalise drug use.

On the day of the conference, you are among 200 attendees. At the coffee break, you manage to get the attention of your target and have 3 minutes to convince them about the need to decriminalise drug use in the country.

3. Explain that the participants will have 20 minutes to prepare a 3-minute role-play (2 will be the NGO representatives, while the third one will represent an advocacy target). Each group should be given a different target to convince:
   - A parliamentarian
   - A high-level police official
   - The head of the national drug control agency
   - A journalist working for an influential media outlet
   - A religious or community leader
   - The director of an NGO working on criminal justice/prison issues
4. Go around each group to help facilitate the discussions and help identify some of the key messages to use for each target.
5. Back in plenary, ask each group (or a select few if you don't have enough time) to do their role-play in front of all the participants. Allow time for comments and suggestions after each role-play. Wrap up by emphasizing the importance of adapting the message to the interests of the audience.

Facilitators' note

Depending on the number of participants, the facilitator may choose to focus only on three or four targets, or to focus on other targets to ensure that the exercise is as adapted and useful as possible for the local context.

MODULE 8

Session 8.5

Activity: Promoting diversion mechanisms for people who use drugs & low-level drug offenders

60 min

Aim – Understanding the various mechanisms available to divert people who use drugs away from incarceration and other forms of harsh punishment, in environments where decriminalisation may not be achievable

1. Introduce the aim of the session (slide 28).
2. Introduce the remarks below to explain what should be un derstood by 'diversion' (slide 29). Distribute the handout 'UN standards and norms on diversion'.

Information to cover in this presentation:

Diversion programmes provide mechanisms to divert people who use drugs away from the criminal justice system (i.e. upon arrest, prosecution, conviction or incarceration) and, where appropriate, towards treatment, harm reduction, counselling and other services. Diversion programmes can be used for a range of offences including drug use and possession, possession of drug use equipment, as well as non-violent offences related to drug use, such as theft and low-level smuggling and dealing. These programmes can be implemented by the police, prosecutors or courts. People who use drugs can also be diverted by community-based health and social before they come into contact with the law enforcement or criminal justice apparatus.

These programmes can have immediate health and welfare benefits for the people who use drugs, while also helping to reduce pressure on the prison system and the courts. They can enhance human security by enabling criminal justice and law enforcement resources to focus on violent crimes that threaten public security, instead of targeting minor drug offenders and people who use drugs.

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

Many countries that have implemented *de facto* decriminalisation rely on police diversion programmes, given the key role police play in ensuring that laws that technically remain in place are not enforced. Diversion programmes can also

play an important role in countries that have taken the further step of removing penalties for these offences from the criminal law (*de jure* decriminalisation). In these countries, diversion programmes can be provided for crimes such as theft, low-level smuggling and dealing where the offence is driven by the person's drug use or dependence.[1]

3. Divide the participants into 4 groups and distribute one case study from the handout 'Case studies' to each group. If you have time, you can distribute two case studies to the participants, if possible different ones (e.g. police diversion and court diversion, or court diversion and diversion by health and social services, etc.). Ask each group to read their case study/ies and respond to the questions below (slide 30). If you have given each group two case studies, as them to compare and contrast them when responding to the questions:
    a. What seems to be the rationale behind this diversion model?
    b. What do you think are the positive/negative impacts of such a model for people who use drugs and/or low-level drug offenders?
    c. How could the model be improved?
4. Back in plenary, ask each group to present their case studies and their responses. Leave time for discussion after each presentation.
5. Conclude by presenting the information below (slides 31-35). Distribute the handout 'Key resources'.

Information to cover in this presentation:

Diversion by the police

Police diversion is usually best as it happens at the earliest stage of the process, and may be effective in contexts where police are able to build trust with communities of people who use drugs. If police corruption is entrenched, however, it may be inappropriate to give police the key decision-making role in the diversion process. Police diversion programmes should include the following features:

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

Diversion by the prosecutor

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

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

Prosecutorial guidelines should ensure that prosecutors base their decisions on an understanding of the distinction between occasional drug use and drug dependence (see Module 6 for more details).

Diversion by the court

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

Sentencing guidelines should support the use of non-custodial sentences for people who use drugs convicted of low-level drug offences or drug-related offences. This may include treatment in the community for those found to be dependent on drugs through a medical assessment.

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

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

Legal aid and access to justice

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

Role of healthcare workers

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

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

1. A full description of diversion mechanisms as they relate to Asia can be found here: Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation

MODULE 8

Handout: Decriminalisation models in Asia

De jure decriminalisation in Asia

Both China and Vietnam have removed criminal sanctions for drug use. However, they have replaced them with highly punitive administrative sanctions such as detention in compulsory centres for drug users (CCDUs). In Lao PDR, the possession of very small quantities of drugs has been decriminalised, but people who use drugs are directed to compulsory treatment and can be imprisoned for relapse. These do not represent models of decriminalisation that comply with principles of human rights, public health, harm reduction and social inclusion.

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

Some legal frameworks do not criminalise **traditional uses** of certain drugs. For example, according to Cambodia's Law on Drug Control of 2011, prosecutors have discretion to relinquish the offender from prosecution if the offence committed in connection with drugs involves a small quantity and is part of customary consumption. Consumption is deemed 'customary' if it does not result in drug dependence and if the person uses the substance as part of ancestral customs that have been practiced over a long period of time.[1] Similarly, India does not criminalise drinks made from cannabis leaves ('bhang'), which are used in Hindu religious festivals.[2] A consultation held in 2015 on decriminalisation of drug use in India recommended removing criminal sanctions for drug consumption for traditional uses: 'Differentiation should be made between substances which have lesser addiction potential and have traditionally been used in the Indian society. Such substances include preparations of cannabis (*ganja, sulpha, etc.*) *and some low potency opioids (doda, bhukki, afeem, etc.)*'.[3]

Proposals for legalising the **medical use** of cannabis are under active consideration in India, where healthcare workers are leading a campaign advocating for legislative reform so that cannabis can be used in the treatment of cancer and other illnesses. Finally, in Nepal and Bangladesh, the police tolerate the possession of cannabis for **religious uses** (but not commercial dealing) during certain festivals e.g. the Shivarati festival in Nepal.[4]

De facto decriminalisation in Asia

Although no country in Asia has fully implemented *de facto* decriminalisation as national policy, in some countries local arrangements operate at specific harm reduction sites where the police have agreed to either avoid arresting people who use drugs or to refer them to health services as an alternative to arrest and prosecution. If an ongoing police commitment to avoid arrests is secured, we are in a local *de facto* decriminalisation model.

In the Philippines, for example, the possession of drugs and drug use equipment is criminalised. To enable a study on a pilot needle and syringe distribution programme, the village of Barangay Kamagayan was designated by the local government in Cebu City as an area where no arrests for possession of drug injecting equipment would be carried out. However, the pilot study was halted in 2015 following opposition from a senator[5] and is now in danger of disappearing with the government's new war on drugs approach.

In some localities in Cambodia, China, Thailand and Vietnam, similar mechanisms have been established to ensure that the police do not arrest people who use drugs, and instead refer them to health and harm reduction services.

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

1. *Law on Drug Control 2011*, Article 53
2. Balhara, Y. & Mathur, S. (2014), 'Bhang - beyond the purview of the narcotic drugs and psychotropic substances act', *Lung India,* **31**(4): 431-432
3. *National Consultation on decriminalization of drug use & access to treatment for vulnerable populations, 15th July 2015*, Ministry of Social Justice & Empowerment India in partnership with Federation of Indian NGOs for Drug Abuse Prevention at India Habitat Centre, New Delhi (unpub. report)
4. As marijuana possession is technically an offence in Nepal and Bangladesh, these are examples of *de facto* rather than *de jure* decriminalization. See: Huffington Post (11 March 2013), *Shivaratri festival in Nepal includes temporary lifting of marijuana ban*, http://www.huffingtonpost.com/2013/03/11/shivaratri-festival-nepal-mairijuan_n_2851875.html
5. Study in Barangay Kamagayan in Cebu by the Department of Health, Philippine National AIDS council, the Cebu City Local Government and Population Services International: Philippine Inquirer (28 May 2015), *Senators want free syringes study halted*, http://newsinfo.inquirer.net/694226/senators-want-free-syringes-study-halted#ixzz3nvA7eL3j

Activity 8.3: The pros and cons of those responsible for determining whether possession is for personal use

Entity responsible: .....

Positive aspects	Negative aspects

MODULE 1

Handout: United Nations standards and norms on diversion

The UN drug control conventions include provisions permitting member states to implement alternatives to conviction or punishment for drug use, and associated offences of possession and cultivation, such as referrals to treatment and education.[1]

At the sub-regional level, the South Asia Association for Regional Cooperation (SAARC) has adopted the same flexibilities in its regional agreement on drugs.[2] To give effect to these provisions, the United Nations Office on Drugs and Crime (UNODC) promotes diversion away from the criminal justice system through the use of alternatives to formal judicial proceedings, detention and punishment for cases of a minor nature, consistent with the *United Nations Standard Minimum Rules for Non-Custodial Measures*.[3]

The **United Nations Standard Minimum Rules for Non Custodial Measures,** also known as the **Tokyo Rules**,[4] provide police, prosecutors and courts with an internationally agreed framework for implementing non-custodial alternatives, consistent with the UN drug conventions. Key provisions include:

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

The **United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders,** also known as the **Bangkok Rules**[5] complement the Tokyo Rules and call on UN member states to establish gender-specific alternatives to pre-trial detention and imprisonment, including provision of the following:

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

1. Article 3(4)(d), *UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988*
2. *SAARC Convention on Narcotic Drugs and Psychotropic Substances*, 1990, http://narcoticsindia.nic.in/upload/download/document_iddbd90a665ea6f292f36ebdb3d442826d.pdf
3. United Nations Office on Drugs and Crime (2013), *Handbook on strategies to reduce overcrowding in prisons*, Criminal Justice Handbook Series, https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf; Commission on Narcotic Drugs (2015), *Background documentation for the interactive discussions on high-level segments to the held during the special session of the General Assembly on the world drug problem in 2016*. E/CN.7/2015/CRP.4, Fifty-eighth session, Vienna, 9-17 March 2015, https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_58/ECN72015_CRP4e_V1501456.pdf result, ala and UK, terminology is NSPs'ce?vors of sexual violence.
4. UN General Assembly (1990), *United Nations standard minimum rules for non-custodial measures (The Tokyo Rules),* A/RES/45/110, http://www.un.org/documents/ga/res/45/a45r110.htm
5. UN General Assembly (2010, *United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok Rules),* A/C.3/65/L.5, http://www.ohchr.org/Documents/ProfessionalInterest/BangkokRules.pdf

MODULE 8

Activity 8.5: Case studies

For the exercise included in Session 8.5, please choose from among the case studies below and distribute one (or two if you have time) to each group.

POLICE DIVERSION

Australia

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

United States

In Seattle, a police diversion model is implemented through a programme called Law Enforcement Assisted Diversion (LEAD), targeting people involved in minor drug offences (such as low-level dealing and possession) or sex work. The police divert them to community-based services, with diversion occurring at the point of arrest. Case managers conduct an assessment that considers substance use frequency and the person's needs in relation to treatment and harm reduction services, mental health problems, and personal relationships. Participants also receive social support to connect them with services such as legal aid, job training and/or placement, housing assistance, and counselling. Success in the LEAD programme is not judged by negative urine tests or abstinence from drugs, but by progress made in improving the participants' overall quality of life, which is assessed by social and health workers. A person can re-enter the programme if they are caught again for a similar offence by the police. An evaluation of the programme showed that people who were diverted to these services were 58% less likely to be arrested for a future offence than those who were not diverted.

Cambodia

Informal police diversion to harm reduction services is encouraged under Cambodia's Police Community Partnership Initiative (PCPI). A Cambodian NGO (KHANA) and the Ministry of Interior implemented PCPI at HIV 'hotspots' in Phnom Penh. Police are encouraged to exercise discretion by referring people who inject drugs to harm reduction services instead of arresting them, provided there is no evidence of drug trafficking. 200 police officers have been trained in harm reduction, along with 150 commune council members, representatives of people who use drugs and other local stakeholders.

China

In Yuxi city, China, the police refer people who use drugs to a community-based treatment centre known as 'Peace No. 1'. Police avoid making arrests for minor drug possession or use in the immediate vicinity of the centre. The goals of this programme are to improve the health of people who use drugs; decrease re-incarceration in compulsory detoxification centres; increase the removal of former drug users from the government surveillance system; strengthen social and familial support for people who use drugs; and improve reintegration of people who use drugs in the community. Peace No. 1 clients can access comprehensive psychosocial and healthcare services, including methadone. Harm reduction training is provided to police across the district.

Thailand

In Thailand, an informal truce was negotiated between civil society health service providers and local law enforcement representatives in Narathiwat Province. The truce was the result of a series of capacity building and sensitisation workshops that were facilitated by a supportive senior Thai law enforcement official. Local law enforcement officers agreed to apply greater discretion, often diverting people who use drugs to health services.

PROSECUTOR'S DIVERSION

Cambodia

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

COURT DIVERSION

Indonesia

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

Malaysia

Drug use in Malaysia carries a penalty of up to two years' imprisonment and a fine, but the government has made progress in moving away from reliance only on detention centres. In 2010, Malaysia established voluntary in- and out-patient 'Cure and Care' centres which provide client-centred treatment and harm reduction services including OST. Adherence to treatment is facilitated by social support. Since 2010, courts have had the option of diverting adults dependent on drugs to a voluntary 'Cure and Care' centre as an alternative to imprisonment or compulsory detention. People arrested for drug use for the first time are placed under the supervision of the government's anti-drug agency for two years, and have to undergo monthly urine tests. After one or two positive urine tests, the courts apply more intensive interventions, including counselling and peer support. After a third positive urine test, the person may be sent to compulsory detention or for treatment at an OST service. A 2015 study found that the risk of relapse for people sent to compulsory detention was 7.6 times greater than for people receiving voluntary treatment. However, the government continues to show reluctance in fully abandoning models of compulsory detention as a form of treatment or rehabilitation.

India

Under Indian law, people dependent on drugs who express willingness to undertake treatment can claim immunity from prosecution, provided the offence they are charged with is drug use or involves a minor quantity of drugs (e.g. no more than 5g of heroin, 25g of opium, 2g of cocaine or amphetamines). Treatment can take place in a hospital or an institution maintained or recognised by the government. At the end of the treatment programme, the court may defer the sentence and release the offender on a bond (a requirement that the offender should not commit another drug offence for a period of up to three years). Criminal proceedings may be reinstated if treatment is not completed. In practice, people are rarely diverted towards treatment and there have been problems with implementation, particularly regarding the lack of clarity about the procedure and its inconsistent application by the courts. In addition, most people are detained in prison while awaiting trial – meaning that a large number of people remain in prison for drug use alone. Finally, under this model, any person caught for drug use – whether dependent or not – can ordered to undergo treatment.

Costa Rica

In 2013, Costa Rica launched a Restorative Justice Project that aimed to reduce the overall prison population. A drug court system was established to target low-level, first-time offenders who committed an offence related to their drug dependence. These court does not deal with people caught with small amounts of drugs for personal use, since drug use and possession for personal use are decriminalised. Low-level offenders are referred to an interdisciplinary and specialised group composed of physicians, psychologists and social workers who tailor their response to the needs of the client. Options include referrals to residential or outpatient treatment.

DIVERSION VIA SOCIAL AND HEALTH WORKERS

Cambodia

Since 2011, Cambodia has provided a legal and policy framework that supports the engagement of healthcare workers in providing harm reduction services (including needle and syringe programmes and opioid substitution treatment) and community-based drug treatment services. Voluntary community-based treatment services have been established that promote a continuum of care and strengthened community mechanisms to provide services and referrals including to harm reduction services. By the end of 2013, over 1,200 people who use drugs were receiving community-based treatment. However, many people who use drugs continue to be held the compulsory detention, including under vagrancy laws and public order powers. There are also ongoing tensions between local law enforcement authorities and health organisations providing harm reduction services to people who use drugs. This indicates the need to ensure that law enforcement officers operating at the local level are fully aware of the nature and purpose of harm reduction programmes, and trained on how to support those measures.

Indonesia

In 2014, seven government bodies signed a memorandum of understanding confirming that 'habitual drug users' would be referred to rehabilitation centres rather than prison. The agreement provides for joint assessment teams of medical and legal personnel at national, provincial and municipal levels to determine whether a suspect is a drug dealer or a user and to propose treatment options to a judge hearing a drug prosecution. However, the system is not operating well in practice, and is plagued by corruption. As a result, people who cannot pay bribes continue to end up in prison even if they are eligible for diversion to treatment. Nevertheless, Indonesia's National AIDS Commission is making progress in implementing its national Community-Based Drug Dependence Treatment (CBDDT) programme. The CBBDT comprises a two-month, individualised inpatient programme followed by an outpatient programme of four months. Implementing organisations are required to adhere to national guidelines that define a minimum standard of drug dependence treatment. A range of services complement the CBDDT approach via referral mechanisms, including harm reduction services, peer support and mental health services. This programme uses indicators of success that focus on improved quality of life and a reduction of risks through a harm reduction approach. PKNI, Indonesia's national network of people who use drugs, provides community-led monitoring of the programme.

Thailand

Under Thailand's drug laws, a committee made up of psychologists, psychiatrists, community health workers and community leaders reviews each case to inform the court on whether a person charged with consumption and possession for personal use should be diverted away from prison towards treatment. Available refarral options include compulsory four-months detention in a compulsory centre for drug users (CCDU); releasing the person to undertake supervised outpatient cognitive behavioural therapy; releasing the person with no further action; or referral to a criminal court for sentencing, which involves a potential prison sentence. OST is not available in CCDUs, the 'treatment' provided is restricted to group work, work therapy, vocational training and physical education, with no input from the patient about their treatment programme. The committee assesses whether the person is an occasional user or is dependent: those deemed to be dependent are detained in CCDUs. Offenders can be held in pre-trial detention with no access to treatment for six weeks or longer awaiting a decision of the committee. The determination of whether the individual is dependent on drugs is usually made on the basis of urine test results alone, without assessing levels of drug use, dependence or related risk behaviours, for example by using the Addiction Severity Index. There is no requirement for the committee to meet the person being assessed, which would enable the person's needs and views to be taken into account in developing treatment plans. Failure to abstain during or after treatment can result in prosecution and imprisonment.

MODULE 8

Handout: Practical steps in implementing decriminalisation and diversion

1. Secure support from across government agencies for decriminalisation and diversion proposals including from agencies with responsibility for drug control, health, law and justice, prisons and public security, and from national human rights bodies.
2. Engage local communities and civil society:
   - Engage communities of people who use drugs and civil society groups in the law reform and policy development process. Ensure that people who use drugs have an opportunity to provide their views on law and policy options, and have access to information and education about how proposed changes to laws, policies and practices will affect their lives.
   - Seek support for law and policy reforms to remove criminal sanctions from professional associations in the areas of medicine, public health, law and corrections.
   - Secure support for law and policy reforms from religious, traditional and community leaders on the basis that the shift to a public health approach to drug use is an issue requiring courage and leadership.
   - Engage the general public in an informed discussion. It may be necessary to conduct community education campaigns to address irrational fears and to reassure the public that decriminalisation does not present a threat to youth, community safety or public security. Community education can reduce the demonisation of people who use drugs and the stigma associated with drug use. Engaging the media to secure public support may be crucial to ensure that legislative proposals do not lead to a backlash that results in counter-proposals that increase criminal penalties and undermine public health objectives.
3. Consider whether *de facto* decriminalisation can be introduced through changes to policy and police practices in advance of legislation to remove criminal sanctions. Explore whether a phased approach to decriminalisation may have a greater chance of success than a proposal to immediately remove all criminal sanctions. For example, the decriminalisation of cannabis or kratom could be piloted as a *de facto* approach before introducing legislation to remove criminal sanctions for use, or possession for personal use, of cannabis and other drugs.
4. Generate consensus on the *objectives* and *scope* of decriminalisation and diversion schemes:
   - Ensure that the objectives of decriminalisation and diversion schemes are clearly focused on reducing harms and improving public health, social inclusion and human rights outcomes, while reducing the punishment and incarceration of people who use drugs.
   - Establish forums for consultation and dialogue involving government, civil society and community stakeholders to garner support for a comprehensive approach that encompasses removal of criminal penalties and other sanctions for: drug use, possession of drugs for personal use, possession of drug use equipment and cultivation of drugs for the purpose of personal consumption. As part of those forums, facilitate dialogue on the implementation of a 'gold standard' model of decriminalisation in which the law is amended so that no criminal, civil or administrative sanctions whatsoever apply, but instead investments are

made to ensure the availability and accessibility of voluntary drug treatment, harm reduction, and social services.

- If administrative sanctions are applied as an alternative to criminal sanctions, ensure these are minor and do not include detention in CCDUs, compulsory registration and monitoring, forced urine testing, or other measures that contradict principles of human rights, harm reduction and public health.
- In relation to possession of drugs for personal use, consider whether quantity thresholds are to be used, and if so, how they will be determined. Thresholds should be realistic and based on research conducted locally that provides evidence of the average quantities consumed and purchased by people who use drugs.
- Make it clear that the proposal is focused on removing criminal sanctions that apply to people who use drugs, and does not focus on the legalisation of illicit drug production and distribution for commercial purposes.

5. Consider budgetary implications, particularly to ensure adequate funding is available for diversion programmes, community-based treatment, health and harm reduction services, counselling and social services for people who use drugs.
6. Identify the upcoming opportunities in the parliament or national assembly to amend legislation to remove criminal and/or administrative sanctions. Parliamentary champions may need to be identified to educate other legislators about law reform proposals and to push for bills to be considered without undue delay.
7. Invest in training and capacity building for law enforcement personnel and healthcare workers so that their roles and responsibilities in decriminalisation and diversion schemes are well understood and delineated.

MODULE 8

Handout: Key resources

- European Monitoring Centre for Drugs and Drug Addiction (2015), *Alternatives to punishment for drug using offenders*, https://dl.dropboxusercontent.com/u/64663568/library/EMCDDA-alternatives-to-punishment-for-drug-using-offenders-2015.pdf
- Fox, E., Eastwood, N. & Rosmarin, A. (2016), *A quiet revolution: Drug decriminalisation policies in practice across the globe, Version 2,* http://www.release.org.uk/publications/policy-papers
- Godwin, J. (2016), *A public health approach to drug use in Asia: Principles and practices for decriminalisation* (London: International Drug Policy Consortium), http://idpc.net/publications/2016/03/public-health-approach-to-drug-use-in-asia-decriminalisation
- Inter-American Drug Abuse Control Commission (2014), *Technical report on alternatives to incarceration for drug-related offenses*, http://www.cicad.oas.org/apps/Document.aspx?Id=3203
- International Drug Policy Consortium (2015), *Comparing models of drug decriminalisation: An e-tool by IDPC*, http://decrim.idpc.net
- International Drug Policy Consortium (March 2016), 'Chapter 3.1 Decriminalisation of people who use', *IDPC Drug Policy Guide, 3rd edition*, http://idpc.net/publications/2016/03/idpc-drug-policy-guide-3rd-edition