INFORMAL DRUG POLICY DIALOGUE

An initiative by the
Andreas G. Papandreou Foundation (APF)
and the Transnational Institute (TNI)

2007

Rome – Informal drug policy dialogue – 9 & 10 November 2007

REPORT

Introduction

The fourth meeting of the TNI/APF informal drug policy dialogue initiative took place in Rome on 9 and 10 November, 2007. The meeting was co-hosted by the Italian Ministry of Social Solidarity, which generously provided hospitality and logistical support. There were around 40 participants from 15 countries and three international organisations.

The two-day dialogue was divided into eight sessions: (1) developments in harm reduction, in the light of the CND 2008 session; (2) an assessment of the consequences of drug law enforcement with regard to the prison system in the UK and in Latin America; (3) the Italian experience of allocating confiscated criminal assets to social projects; (4) the WHO programme on access to controlled medications; (5) a speech by Minister of Social Solidarity Paolo Ferrero; (6) the 1998 UNGASS review in the context of institutional reform, system-wide coherence and cooperation between agencies; (7) the issues of a) a possible new control model for cannabis and b) a reassessment of the coca leaf with regard to the UNGASS evaluation in 2008; (8) expectations of the Thematic Debate in 2008 and the period of global reflection leading to the Ministerial meeting in 2009.

Participants were also invited to visit Fondazione Villa Maraini, a therapeutic centre in Rome operated by the Italian Red Cross, where they were welcomed by the Chairman of the Italian Red Cross and founder of the centre, Dr Massimo Barra. After lunch at Villa Maraini its director gave a tour of the premises and explained the range of therapeutic services provided. The lunch and visit were greatly appreciated by all participants.

The meeting was guided by 'the Chatham House Rule' to encourage both a free exchange of thoughts and confidentiality at meetings. Individual contributors therefore remain anonymous and some tactical discussion points have been omitted from this report. The format of the meeting was informal and interactive. For each session a number of people were requested to provide inputs. They were not asked to

prepare and deliver full speeches but rather to provide introductory remarks to spark off the round table discussion. Most of the time was devoted to an open discussion between all participants. This report provides an overview of the views expressed during the meeting that taken together reflect the overall tone of the meeting. These do not represent conclusions, however, and the views expressed do not necessarily represent majority opinions of those present.

Friday 9 November

Session I

New developments in the field of Harm Reduction. Possible initiatives at the CND 2008 and strategic considerations for the ministerial segment in 2009.

A look at the latest developments with regard to harm reduction policies, the need for up-scaling of basic services for HIV/AIDS prevention and the 'frontline' of heroin prescription and drug consumption rooms. UNODC has significantly expanded its HIV/AIDS programme thanks to support from harm reduction-friendly donor countries. Could the next CND or the 2009 Ministerial Meeting be the opportune moment to end ambiguity and to achieve full acceptance at the UN drug control agencies of harm reduction practices including? What more can be done so improve UN system-wide coherence on the harm reduction issue?

Drug consumption rooms

The first drug consumption room in Germany was opened in Frankfurt am Main in 1994. Today there are 28 consumption rooms in six federal states or *Laender*, which provide several hundred injecting places used by several thousand users several times a day. Their objective is to minimize the risks and problems resulting from illicit drug use to users and to the society around them. Drug consumption rooms are licensed by the *Land* authority, and are an integral part of the assistance offered to drug users, who may consume drugs in a protected setting in hygienic facilities under supervision of a multiprofessional team.

All 28 consumption rooms are continually being evaluated by the *Land* authorities and by independent scientific institutions. Ten consumption rooms were evaluated in the *Land* of Nordrhein-Wesfalen between 2001-2006. The results showed that there had been a total of 642,373 consumption contacts and 1,320 users per month. The principal age group (50% of users) was 26-35 years old. There had been 26,780 referrals to other services; 117,341 medical interventions; 1,710 severe emergency cases and 330 deaths avoided. In terms of policy impact, drug consumption rooms are politically accepted in Germany, even if not all *Laender* have implemented them. They have proved to be expensive but cost effective. They have led to an overall improvement in health care, assistance and relief strategies, and have helped the public to understand the drug problem better. INCB visited Germany in 2003 and made clear its disapproval of drug consumption rooms. However neither German politicians nor the public would be ready to consider closing the facilities.

Diamorphine-assisted treatment:
The German Federal Ministry of Health initiated a project on diamorphine-assisted treatment in 2002, jointly with three *Laender* and six cities. The main objective was to investigate whether, in a structured treatment setting, the prescription of diamorphine (pharmacologically pure heroin) to severely dependent heroin users would have better effects in terms of health stabilisation and decrease of illicit drug use than methadone treatment. The study was designed as a multi-centre study with 1020 patients randomized to either methadone or diamorphine. Both groups took part in a structured psycho-social care programme.

The results indicated a significant benefit of diamorphine over methadone treatment, with 57.3% of the diamorphine group showing health improvements and decreased illicit drug use against 44.8% of the methadone group. After two years of diamorphine treatment, 27 % had taken a job. There was a significant reduction in delinquency after one year, which was reduced from 55% to 39% in the diamorphine group compared to 58% to 55% in the methadone group. An extension of the clinical trial to end July 2010 has allowed around 300 patients to continue receiving diamorphine treatment.

The current German Narcotics Act still prohibits heroin outside clinical trial. The Health Ministry prepared a draft regulation to allow diamorphine treatment within the regular health care system but no bill has been formally introduced, due to differing views among coalition partners in the *Bundestag*. Despite this, the *Bundesrat*, the chamber representing the federal states, has launched such a procedure which has been supported by 13 out of the 16 *Laender.* For the time being, one cannot predict if this law will be approved by the Bundestag.

Harm reduction in practice
In Germany harm reduction is called ‘survival assistance’ and is viewed as the fourth pillar of national drug strategy. The UN drug control bodies (CND, INCB, UNODC) have been reluctant to adopt the term, although in its 2003 annual report, INCB acknowledged harm reduction as a tertiary prevention strategy for demand reduction purposes. It has also approved needle exchange and substitution treatment as being within the terms of the conventions.

The conventions are more flexible than people believe, and it may not be worthwhile trying to change them. One option might be to propose a new Declaration on Demand Reduction which would a) underline the Guiding principles of Drug Demand Reduction adopted by the General Assembly in 1999 and b) add a complementary statement of principles on harm reduction. The text could be modelled on the EU Recommendation of 2003 or on the results of the EU’s 2007 evaluation. It could be prepared during the ‘period of reflection’ between 2008-2009.

Harm reduction in transitional and developing countries:
Harm reduction looks very different from the perspective of transitional and

developing countries. Malaysia, China, Indonesia, and Morocco are all countries with injection-driven HIV epidemics that are only now beginning to introduce harm reduction in the form of needle and syringe programs or opiate substitution treatment.

Many of these countries remain silent at CND meetings, and this underscores the need for a Declaration on harm reduction. INCB's support of harm reduction measures should be explained and communicated on a wider scale to developing countries. The trials done in Germany and Switzerland are neither understood nor accurately known about in developing countries, who experience a kind of 'death by pilot': a succession of small pilot programmes which are begun but not expanded. There have been positive experiences in Latin America in harm reduction but countries are afraid to risk criticism by bringing these into an international forum. It is widely believed that needle exchanges are illegal in the U.S. whereas many operate in the country. Countries with experiences to share should be encouraged and empowered.

UNODC was given a mandate within the UN system to guide the response to drug-related HIV and AIDS. This unit has grown, but it cannot heal an essentially schizophrenic approach in UNODC to public health and public order. UNODC supports needle exchange and substitution treatment, but also supports the punitive drug law enforcement actions undertaken by interior ministries. The INCB does not exert itself to call for expansion of such measures as substitution treatment, or comment on frequent rights violations in the name of drug control. This is one of the greatest impediments to the implementation of harm reduction programmes.

It is extremely difficult to obtain data for the numbers of individuals imprisoned for possession of drugs for personal use. In many countries, 'treatment' is often incarceration by another name. In China, problem drug users often remain in prison for a year before any treatment is offered. Some 85,000 people in Vietnam are in compulsory 'treatment' but are often held in military style boot camps. Opponents of harm reduction put treatment forward as an alternative, but more scrutiny is necessary of what passes for treatment. INCB has a mandate to monitor the conventions but operates this as a supply side mandate only, and largely ignores the lack of service provision on the demand side.

The 1998 UNGASS was noticeable for the absence of discussion of AIDS, although explicit guarantees were given at the 2001 HIV/AIDS UNGASS with regard to individual dignity and human rights. NGOs have done much in terms of HIV activism and these efforts should be translated into the 2008 evaluation. Nonetheless, caution must be used. HIV-specific harm reduction has different aims to those of drug harm reduction in general, and an exclusive focus on HIV/AIDS could limit the type of interventions offered.

Harm reduction starts with prevention and aims at preventing use altogether. But it accepts some taking of illegal drugs and that people need help to reduce harmful

consequences of use if they cannot give up. Harm reduction includes short term goals or 'half tone' policies, which are not necessarily the same as long term goals.

Public order benefits and the cost effectiveness of harm reduction are the only arguments that politicians will listen to. Public awareness must also be raised. There has been some progress within the EU in that drug policy is now nearly always led by health ministries, whereas the interior ministries led on this issue in the past. In Germany a study was done of the cost-saving aspects of heroin prescribing policies, including the reduction of crime costs.

Supply side harm reduction

One notable feature of policy evaluation is the difficulty of assessing the impact of supply side interventions. Efforts have been made to provide these but criteria are lacking. This is in strong contrast to demand side interventions which are subject to constant evaluation. The difficulties of bringing harm reduction principles into supply could be overcome if harm reduction is recognized as a set of criteria for making choices, not a set of programmes. This approach recognises that certain illicit activities will occur, but that steps can be taken to reduce harm from them.

Conclusions/Recommendations, Session I:

- Harm reduction should be understood as a criterion for making policy choices, rather than a description of a set of programmes.
- More attention should be paid to supply measures and the extent to which they a) achieve the goal of reducing drug harm to society and/or b) cause additional costs and adverse consequences.
- Health and HIV issues should be at the forefront of the UN debate.
- The EU Council Recommendation on harm reduction should be an integral part of the new Declaration on Demand Reduction. The new slogan should be "Universal access to treatment!"
- The political segment of CND 2009 should state that harm reduction is an integral part of global drug policy.

Session II

Drugs and prisons: State of affairs, an assessment of the consequences of drug law enforcement on civil liberties and prison overcrowding. What are better and more effective alternatives?

Many countries continue to enforce 'deterrent' sentences against drug users that include long prison sentences and to arrest and imprison large numbers of drug users, small dealers, couriers, etc. Incarceration rates thus continue to grow in many countries. There is a need for a better common understanding of distinctions between drug use, possession for personal use, production/cultivation for personal use, micro-trade (street-level dealing, small trade of raw materials, couriers) and drug trafficking. What kind of law reform initiatives could reduce prison populations and the burden on the justice system without increasing levels of drugs consumption?

With regard to drugs and prisons there are three potential policy issues:

1) the use of imprisonment for violation of drug laws
2) the impact of enforcing drug laws on prison populations; and
3) the use of imprisonment for other offences committed by drug users such as property offences.

Some country facts

The UK does not imprison many people for low level drug offences or possession but imprisons a large number for drug-related offences. Around 3,000-4,000 people are imprisoned each year with possession offences but for the vast majority, the drug law offence is tacked on to a custodial offence for other crimes. In contrast, the US prison population is largely dominated by people in prison for drug law violations. A maximum sentence is very rarely used in the UK for drug offences. Furthermore there is a distinction between the theory and practice of the law. Most countries have tough laws and tough rhetoric but lax enforcement The US is perhaps the only country where law and practice of the law largely coincide, with strong enforcement levels for drug law offences and associated crimes.

The Netherlands has no official policy on not enforcing the law, but a practice of not doing so. In contrast several countries, including India and Iran, have very harsh laws on the statute book, but the vast majority of drug users escape the net altogether, and the law if implemented would place an intolerable burden on the justice system. There is always a big gap between the overall number of users and those who get caught. Everywhere, levels of enforcement vary, and those whose drug use is more street visible tend to get arrested more. Inevitably this means the poorest social classes.

A distinction is usually made between users and possessors on the basis of whether they are involved in the market in some way, and therefore thought to profit. Many arrestees could be dealt with in either way. The way in which the drug laws are enforced is crucial, but there is a great deal of discretion. Many people in the UK are charged with the offence of possession with intent to supply, but do not make much gain from this activity. When a country's drug problem becomes more visible, law enforcement is brought in to try to reduce the problem. For example Georgia has recently ratcheted up its drug laws. Even among the 27 EU member states, much political capital has been expended on the idea that you can enforce your way out of a drug problem. This is based on the notion that harsh laws implemented harshly will deter. Although the deterrence principle tends to drive public investment, the evidence base does not substantiate it.

There are various alternatives.

1) Go for non-enforcement, as many countries do.
2) Decriminalize drug use and/or possession, either on a de facto or *de iure* basis, and encourage users into treatment. This has been the Portuguese policy, and it

has worked well. It has taken much pressure off the criminal justice system and police procedures.

3) Depenalisation. In the UK many people arrested for drug possession are given a caution, and no criminal record is created. This was extended in 2004 when cannabis was declassified from a Class B to a Class C drug. Paradoxically this has led to an almost doubling of numbers of people arrested. Before cannabis was declassified the police were discouraged from making arrests because of all the paper work. Now they make arrests but do not have to process offenders through the criminal justice system.

Ideally, issues of proportionality, non stigmatisation and human rights should be at the forefront of government thinking, but governments will only reconsider their policy in the light of public expenditure savings, that is, if they are concerned about the cost of pursuing people through the criminal justice system, the cost of having a lot of marginalised people in custodial care or if there are criminal justice logjams.

In Italy approximately 42 per cent of people entering prison are charged with drug law offences and drug-related offences. More than 90 per cent are small dealers, thus here too enforcement concentrates on the weakest part of the chain. Because the 1988 convention penalises possession for personal use, even countries that apply harm reduction have to accommodate this somehow. This is a problem to be overcome.

The fact that 30 countries still apply capital punishment for drug offences should be more widely known. They include Saudi Arabia, China, Singapore and Thailand. Most people in prison for drug law violations would be much better off in therapeutic structures. People will find access to drugs even in prisons. Examples of best practice regarding drug services in prisons can be found among others in Switzerland and Germany.

Latin America

With the assistance of TNI, prison statistics were gathered for seven countries for the years 2000-2005: Mexico, Brazil, Peru, Colombia, Argentina, Ecuador and Bolivia. All could be described as fragile democracies with weak institutions, and share the problems of cocaine production and distribution. All seven have implemented the international drug control instruments drawn up by the UN and by the Organisation of American States, as well as those sponsored by US governments, such as Plan Colombia.

There is a prevalent belief in each of the countries that drugs are a problem not only of public security and order but of national security. The public, through the media, call on politicians to apply more pressure. This results in curtailment of human rights and the non application of due process. Most domestic criminal codes do not distinguish between trafficking offences and those relating to smaller quantities of production and transportation. In Ecuador and Peru, people arrested on drug offences

cannot be given any benefits of sentence reduction. In Peru, police can arrest and hold someone on suspicion of a drugs offence without bringing charges. In Colombia, 16,000 people, or 23 per cent of the prison population, are incarcerated for drugs offences. In Mexico, although the offences may be the same, only eight per cent of the prison population is incarcerated for drug law violations, and 54 per cent are in prison for violent offences. In most countries, people in prison for drugs frequently do not have a definitive sentence and should be released but judges refuse permission. The media regularly reports that most crimes are committed under influence of drugs, and this influences sentencing, but such legal interpretations have no data to justify them.

In Bolivia and Ecuador, the judicial system puts the greatest pressure on the weakest links of the chain, namely on peasant farmers and those involved in the early stages of transforming coca to cocaine. This takes no account of rural poverty and marginalisation. Drug policies based only on criminal law are creating a humanitarian crisis: the number of arrests keeps rising and there is chronic overcrowding in all prison infrastructures. Narcotics policies are an obstacle to any attempt to reform the administration of justice

Conclusions/Recommendations Session II:

- The UNGASS process should include a review of drugs policies in the light of human rights and the rule of law, and of the consequences of applying drug law enforcement measures indiscriminately.
- Work should be done on the lack of efficiency of the deterrent effect of prison.

Session III

Social spending of confiscated criminal assets. The Italian experience

In most countries confiscated drug money or other proceeds from crime stay in the hands of the police or prosecution to be used for law enforcement purposes. In a few countries, such as Switzerland and Luxembourg, schemes have been set up to divide such funds over different departments, including health services and development projects. Italy has a particularly interesting policy to use seized properties for social purposes.

The association *Libera* was formed in 1995 from the realisation that the anti-Mafia struggle could not depend only on the police and judiciary, but required civil society to create an alternative culture to that of the Mafia. In 1995 Libera obtained more than a million signatures on a petition for a law that would reallocate assets confiscated from the Mafia to social projects. The law was passed in 1996, and has allowed vehicles, property and agricultural land to be allocated to and managed by cooperatives run by young people, to whom it has given an occupation. Last year the law was extended to cover assets confiscated from those convicted of corruption. Whereas many countries pass confiscated assets to police forces or sell them off, their allocation to socially useful purposes is unique to Italy.

Session IV

Access to controlled medications. The WHO Programme

Drug control regulations, if overly restrictive, can hamper access to controlled medicines for therapeutic use. A balance must therefore be struck between medical and regulatory requirements. 50 years of abuse prevention has led to overly strict rules or inappropriate implementation of the international drug control treaties in many countries. As a result, the medical use of controlled substances has been hampered and in some cases prohibited. Annually, up to 10 million people suffer from lack of access to controlled medications. A WHO programme –in consultation with the INCB- aims to improve legitimate medical access to all medications controlled under the drug conventions.

The issue of access to controlled opiate medications is among central issues to the three UN conventions, to ensure access for medical need (both for pain and treatment of opioid dependence) and to minimize availability for abuse.

Evidence shows that opioid substitution treatment is effective treatment of opioid dependence and reduces harms in many ways. There may be 11-14 million people around the world who may be in need of this, although probably no more than a million are actually receiving it. Many countries are currently attempting to expand their opioid substitution programmes, including China, which has established 1500 methadone treatment centres in recent years. One issue is how to improve access to opioids for treatment without also making opioids available to the illicit market.

INCB monitors the quantities of morphine used in each country. INCB figures show that currently the global average per head of population usage of morphine is 5.85 mg per year. Austria uses 90 mg per year, the US 55mg and the UK around 29 mg, whereas the Netherlands uses 15mg and Japan 4mg (2005 figures). The reason for Austria's large usage is due to use of morphine as an opioid substitution agent for the treatment for drug dependence.

These figures appear to demonstrate on the one hand that in many countries people are not receiving morphine who need it, and on the other hand usage in some countries far outstrips medical need. There may be many reasons for these disparities, including the cost of morphine preparations. It has been suggested that the international monitoring system contributes to the underusage of morphine in some countries. For example: countries are required to notify INCB of their estimate more than 12 months ahead; many countries find it difficult to fill out their applications to INCB; central government has to make the application but does not receive the relevant information from health institutions; sometimes governments are reluctant to ask for extensions to their quota, fearing that they will be challenged on their extra needs. INCB is usually quite responsive if countries do ask for an increase in quotas. Apparently Ukraine used the wrong form to update a request to change its quota, resulting in a six-month delay in methadone supplies. To improve access to controlled medicines, including opioids, while facilitating compliance with the UN conventions is the main goal of a new WHO programme that is planned to be implemented in collaboration with INCB.

Conclusions/Recommendations, Session IV:
Civil society might have a role to play in helping countries to prepare their estimates for opiates and other drugs for INCB, or there might be advantages in INCB or WHO being more proactive in helping countries with this. The concurrent morphine underusage and overusage by different countries suggests that current practice may not be resulting in the best balance between availability for medical need and availability for abuse.

Session V
Speech by Paolo Ferrero, Minister of Social Solidarity, Italy

The minister welcomed participants and thanked them for bringing much-needed scientific expertise to the drugs debate. In Italy it is difficult to discuss the issue of drug dependence rationally, since it is used as a rabble-rousing, populist issue. Opposition to harm reduction means that little can be achieved. The Turin City Council is currently debating the opening of injection rooms in the city, but is unable to proceed for legislative reasons. Abroad, the priority should be to separate the interests of peasant farmers, who deserve help, from traffickers who should be prosecuted. In this sense the Ministry supports the proposal passed by the European Parliament to buy part of the opium produced in Afghanistan as well as initiatives being taken by President Morales in Bolivia to legalise the coca leaf.

In Italy there seem to be no real 'lifestyle' borders between legal and illegal substances, yet there is considerable hypocrisy. Alcohol is widely advertised as being associated with an attractive and successful lifestyle, and while the substance may change, the idea remains. The minister proposed a law to ban daytime advertising of alcohol on TV, to limit alcohol advertising to the characteristics of the different products (without any association with attractive lifestyles) and to oblige producers to put an alcohol warning on bottles, advising consumers not to drive. The proposal is still under discussion as it could negatively impact on Italian wine production.

The minister outlined five goals he wished to achieve for Italian drug policy:
1. To introduce harm reduction on a much wider scale.
2. To mitigate the effects of repression at the low end of the market.
3. To make a clear distinction between consumption and trade.
4. To categorize the different substances by harmfulness; currently there is one table for all substances.
5. To increase resources for drug services and treatment.

The minister also undertook to support the idea of organizing a dialogue between experts and fellow politicians to consider the UNGASS evaluation on the basis of scientific evidence rather than political ideology.

In the discussion with the minister it was pointed out that the question of purchasing a part of the Afghan opium production was first promoted by the Senlis Council some years ago. There are however many technical aspects surrounding production for the licit trade in opiates which would have to be studied in fine detail, for example regarding quality control. The surge in opium production in Afghanistan is a relatively recent phenomenon: in the 1970s production was low, and was concentrated in the areas later controlled by the Northern alliance. The problem has been the result of conflict and other problems in society. The other social problems in Afghanistan should be solved before trying to solve the opium poppy issue.

Saturday 10 November

Session VI

Evaluating the UN drug control system. The 1998 UNGASS review in the context of institutional reform, system-wide coherence and cooperation between UN agencies: an overview of issues, options and obstacles.

Weaknesses in the UN drug control system have often been identified, related to the functioning of the key organs UNODC, INCB, and the CND, related to collaboration with the wider UN system (WHO, UNAIDS, UNDP, etc.) and related to the outdated character of several treaty provisions. What has been attempted to date to achieve more structural reform? Are existing evaluation mechanisms capable of bringing the need for reform to the table? Tensions have arisen about the way the INCB performs its duties and about its legal interpretation of the conventions. INCB reports and letters have condemned policy practices that the concerned countries consider to be defendable. The conventions describe the Board's mission explicitly in terms of co-operation and dialogue. Is the INCB overstepping its mandate? How could a neutral and evidence-based role of UNODC as a centre of expertise be strengthened? How can these issues be related to the UN call for more 'system-wide coherence' and 'delivery as one'?

Background

The international drug control system has been in continuous evolution since 1961. While the Single Convention focused on the cultivation of plants with narcotic properties, the 1971 Convention was created by the wish of the pharmaceutical companies to keep psychotropic drugs separate. The 1988 Convention introduced the crime of drug money laundering but also obliged member states to criminalise a wide range of drug-related activities.

In 1993, with all three conventions in place and with the expiry of the transitional period of 25 years established under the 1961 convention, a three-day high level meeting was held during the General Assembly. The tone was set by a letter from Mexico, which pointed out that that illicit cultivation was continuing, drug consumption had increased and criminal organisations were expanding. It made reference to a variety of issues such as precursors, money laundering and alternative development, and mentioned the need to review drug classification with reference to WHO, alluding to the possibility of cannabis being taken out of the conventions

altogether. It also requested that more attention be given to the demand for drugs. This marked the beginning of the move towards a 'more balanced' approach.

The early 1990s was a period of increasing polarisation across the world. It was clear that the aims of the conventions had not been met and that the market was growing rather than shrinking. Tougher sanctions were imposed through a wave of repressive legislation. The message was, "the 1988 convention has teeth but now we have to make it bite". At the same time many European countries were starting a harm reduction approach, and were applying more leniency with regard to cannabis. In the same period WHO had two research programmes running on coca issues and cannabis. The findings of these research projects were viewed with outrage by many governments.

INCB's annual report for 1994 highlighted a number of outdated provisions and contradictions within the conventions. An advisory committee was set up to look at how the drug control system could be improved. It recommended that the status of coca and cannabis be re-examined, and suggested looking more closely at harm reduction and decriminalisation policies. However CND decided not to implement any of the recommendations of the advisory group and INCB's list of recommendations to resolve the contradictions in the conventions was never acted on. In the end the 'reconsider' lobby was neutralised. Some of Mexico's concerns were eventually addressed at the 1998 UNGASS, when the principle of alternative development was accepted for the first time, and when a precursors action plan and the Guiding Principles on demand reduction were introduced.

UNGASS ten years on

With the 2008 UNGASS evaluation the dilemma is with us again : to reconsider or reaffirm. There has clearly been a stabilisation of the market, although 'containment' may not be the appropriate description. Harm reduction has become more widespread, largely due to HIV/AIDS, but prison populations have increased. Inside the broader UN system there has been a debate on UN reform and system wide coherence. With regard to drugs, inconsistencies have worsened. Several problems need to be addressed:

1. Harm reduction. Part of the UN (the larger part) uses the language and practice of harm reduction as a matter of course, whereas under pressure from the US, UNODC, INCB and CND do not.
2. UN coherence and responsibilities. There is more tension now between INCB and WHO over scheduling issues (eg over Khat, dronabinol/delta-9-THC) where WHO has the primary responsibility.
3. The tensions between the drug control treaties and practices and other UN treaties, principles and practices – for example human rights violations in the context of drug law enforcement. The UN drug agencies do nothing to prevent these.
4. The transparency of the UN drug control process and the associated NGO community. All UN agencies have established procedures for NGO participation and

transparency of procedures, including the availability of documents, while the drug agencies still have a poor record in this regard.

The Executive Director's report on the UNGASS evaluation will almost certainly state that the drug consumption problem has been contained. It will be argued that most goals have been achieved, that there have been great advances in money laundering, in precursor legislation and in treatment availability. The truth is that consumption has grown in countries where before it was insignificant. Containment is not a satisfactory answer, and patterns of consumption are very complex.

Colombian government officials acknowledge privately that current drug policies do not work, and at the 2008 CND Colombia may say that eradication is not a valid policy. Many Colombians think cocaine should be legalised. An alternative solution must be found, which should include a debate about causality and about why both coca and opium are concentrated in very few countries. If this is not done the errors of the past will be repeated. Some 15 years ago the big Colombian cartels were destroyed. The new cartels were fragmented and they subcontracted out their armed services. Left and right wing paramilitary groups became involved. From being run by mafia-type drug lords, now the organisations are run by warlords who use funds to reinforce territorial control. This is not containment. Solving the problem has become much more difficult.

Data problems

The evaluation will try to focus on results, but UNODC's data are very contradictory, and it can only use data provided by governments. If one takes the figures at face value Colombia has eradicated more coca cultivation than estimates of cultivation pre-eradication, so there should be none left. In Colombia every sprayed crop is counted as eradicated, and this system leads to errors of double counting. The basis for the 'containment' conclusion is based on BRQ answers, but these cannot be trusted. UNODC does not have the capability to ensure that BRQs are properly completed, and has no means of knowing the basis on which answers are made. Responding countries do not use the same methodologies and there are wide inconsistencies. The mandate for the World Drug Report states that it should be 'authoritative, objective and scientific', but UNODC does not have enough staff to do serious statistical analysis. .

The Expert Working Group seems to have concluded that the BRQ is not a good instrument and does not give a basis for impact assessment. On the positive side, it has caused a focus on demand reduction in countries where this did not exist before. One should be cautious in disparaging the BRQ because many countries will use this as an excuse to do nothing.

UNODC, crime and terrorism

There is a tendency within UNODC to focus more on terrorism and to move drug issues into this field. If the shift continues UNODC will have a completely new

dynamic: the name and organisational focus will shift towards terrorism, crime and drug control, because this is where the money is. While drug control should not be seen through primarily through a crime prism, the Crime Commission is strongly rooted in human rights issues, and this approach could be useful. The five-yearly crime congress could even be a model for meetings with a wider range of participants.

In the UK drugs is called a 'cross cutter' because it affects all parts of society and is seen through the different perspectives of young people, health and crime. A powerful coordination mechanism exists to resolve tensions between them. The problem is that in the UN system there is no such mechanism for drug control, but this could be a recommendation for 2008-9. Alternatively, rather than create a new inter-agency coordination body, UNODC could be asked to integrate WHO and UNAIDS expertise into its work and into CND meetings to a greater extent.

Conclusions/Recommendations, Session VI:
It is recommended that

- The functioning and mandate of INCB be examined, and the boundaries of its mandate established;
- The mandate of WHO, which was largely taken away in the early 1990s, should be re-established and its authority at CND meetings reaffirmed.
- The capacity of UNODC to undertake statistical analysis should be strengthened.
- A study should be made of the relationship between UN drug control and other UN treaties, and of certain legal aspects of the conventions. The aim should be to bring more rationality and evidence into the debate.

Session VII

Towards another control model for cannabis and a reassessment of the coca leaf? Exploration of the possibilities to raise these issues as part of the UNGASS review.

Questions can be raised about the logic behind the current system of classification under the UN treaties. In spite of the existence of various schedules, no distinctions are made on the basis of harmfulness within the main group of controlled substances. Cannabis is scheduled along with other 'most dangerous drugs', placed even under a stricter regime than cocaine. And coca leaf is treated as if it is comparable to cocaine or heroin. Such classifications seem to be outdated and not consistent with several national legal systems. Is a different control model for cannabis –the most commonly used illicit drug- conceivable? Should coca leaf not be taken out of the treaty schedules altogether? Is there space to find a more culturally sensitive approach to plants with psychoactive or mildly stimulant properties, and to distinguish more between problematic, recreational and traditional uses?

Cannabis policy in the Netherlands
The main focus of drug policy in the Netherlands since 1976 has been separation of markets. Coffee shops were established in the 1980s and at their peak in the late

1990s, numbered 1,200. Today there are 720. Local authorities are responsible for authorising coffee shops and on the whole are positive about them, so they will not be abolished. After some concerns about health - there has been an increased demand in recent years for help for cannabis users - the quantity of cannabis allowed per person was lowered from 30 gm to five. Prevention interventions also operate within coffee shops.

The new Dutch government wants to modify cannabis policy. The decision has been driven by crime data and by new developments in the health sector, in particular mental health. The international context is also important. Issues such as trade and cultivation are continually being discussed. The Netherlands is restricted by what it can do by the international context and because it always works with coalition governments. The data on prevalence of cannabis use in the Netherlands seem to prove that there is no link between availability and consumption. This is an important issue which opens up the need to do prevention efficiently.

Changes to the conventions?

Cannabis could be taken out of the system all together or else its scheduling could be changed. The 1961 convention could be modified using the procedures outlined in Article 5. Cannabis is currently in Schedule 1 and in Schedule 4, implying little or no medical use, but much new evidence is now available on the therapeutic benefits of cannabis, so there are grounds for reopening the debate and reviewing its position. There might be support for an international treaty on cannabis such as exists for tobacco. It is not necessary to press for legalisation.

Neither the UK, the German, Italian nor the Dutch government are likely to support any move to weaken the status of cannabis at the international level at this point in time. The UK reclassified cannabis from a Class B to a Class C drug in 2004, for which it received much criticism from INCB and also from the UK media about "going soft" on drugs. The last Italian government upgraded the status of cannabis in 2006, and it will be hard enough for the current government to reverse this.

The WHO Expert Committee on Drug Dependence discussed the scheduling of dronabinol and delta-9-THC with a view to moving them from Schedule II to Schedule III or IV of the 1971 convention. Recommendations in this sense were made, but the INCB was opposed and the CND blocked it, and refused to consider rescheduling the substances. This issue was intensely discussed within INCB. It was recognised that a move from II to a lower Schedule would have an impact on the 1961 convention. The President of INCB warned against the move and warned UNODC's Executive Director not to support it.

Bolivian drug policy

The Report of the UN's Commission of Enquiry on the Coca Leaf of May 1950 made reference to a species of 'Andean man' with specific physiological characteristics that resulted from living at high altitudes. It has taken decades for this kind of language

to be formally reversed in international jurisprudence. The Unesco Convention on the Protection and Promotion of Cultural Expressions which entered into force on 18 March 2007 recognizes equal dignity for indigenous peoples. The UN General Assembly in 2007 also adopted a Declaration on the Rights of Indigenous Peoples, and promised that there should be no discrimination regarding the exercise of indigenous practices.

The 1961 Single Convention was ratified in 1976 when Bolivia was living under a military dictatorship; only in 1982 with the transition to democracy could Indians could walk freely wherever they wished. The first indigenous President of Bolivia, Evo Morales, was elected in 2006. For the first time, Bolivia has a drugs strategy based on social participation that protects human rights and works with farmers, not against them. Forced eradication did not work and led to systematic violations of human rights and abuses by anti narcotics police. Although US officials were in constant touch with Bolivia over counternarcotics, only a brief mention was ever made in US reports of human rights violations. Eradication is not necessarily a violation of human rights if alternative livelihoods are provided, but interventions must be proportionate to the aims they seek to achieve.

The government's aim is to end the exploitation of coca production by cocaine traffickers, while promoting licit coca uses and to protect the livelihoods of farmers, for whom coca leaf may be the only means of survival in a country where 60 per cent of the population lives below the poverty threshold. The new system allows each farmer to cultivate one *cato*, or a field of 40 x 40 metres, which brings in $100 per month. The government compensates loss of revenue with seeds or other agricultural assistance, but not with cash. The government's firm intention is to depenalise the coca leaf.

The amounts required for traditional use of coca should be established, and it could be useful to establish an estimates system as exists for opium. The EU has offered to finance a study to look at how many hectares Bolivia needs, but there is a lack of trust on both sides and it took a long time before the government agreed on the terms to undertake the survey. Estimates of the total requirements for coca will be made to provide for the traditional chewing, the drinking of coca tea and other proposals including the industrialisation of coca for example into toothpaste or other products. Bolivia has not begun to move a formal request for coca leaf to be rescheduled, but if rescheduling is to feature in the 2008-9 review process the government needs to lead the way and provide compelling evidence for rescheduling.

There is not much room for optimism here, especially given the talk of a cocaine epidemic in Europe. An opportunity for dialogue could be the meetings between the Horizontal Drugs Group of the EU and the Latin American Countries (GRULAC). If Bolivia undertook a regional study, it might find some support in the EU, and then it could go to CND.

Conclusions/Recommendations, Session VII:

- In spite of many valid questions about the 1961 scheduling of cannabis, political obstacles prevent countries to formally request a review; more informal discussions are required before the debate can be opened about the potential of other models of regulation for cannabis.
- Mechanisms should be in place to ensure that human rights principles are applied at the point of drug control.
- A resolution could be put forward at the 2008 UNGASS review that makes explicit reference to the adoption of the Unesco convention and the recent UN Declaration on the Rights of Indigenous Peoples, reminding CND members of their obligations.
- A study should be done on the link between supply and demand and the extent to which local production of coca leaf impacts on cocaine consumption in the rest of the world. There is an automatic assumption of cause and effect, but it should be reviewed.
- Bolivia might consider doing a study on the therapeutic potential of coca in treating cocaine addiction, as exists with opiate substitution treatment for heroin. (A trial is currently running in Bolivia using sweets made from coca to treat cocaine dependence.)

Session VIII

What to expect from the UNGASS review process: the Thematic Debate in 2008, the period of global reflection and the Ministerial Meeting in 2009?

In March 2008 there will be a two-day Thematic Debate to discuss the UNGASS review report prepared by UNODC. A year long 'period of global reflection' will afterwards lead up to a Ministerial Segment at the CND in 2009. What are the procedural aspects that still require clarification? What space will there be for civil society to participate in the different stages of the process? What will be the key issues on the table? What kind of improvements in the functioning of the UN drug control system could be expected or aimed at?

The 1998 UNGASS made explicit reference to the engagement of civil society in the 10-year process, but established no mechanism for this to happen. The Vienna NGO Committee on Narcotic Drugs was asked to provide input. Three objectives were set:

Objective 1: to highlight NGO achievements in the field of drug control, with emphasis on contributions to the 1998 UNGASS Action Plan, in areas such as policy, community engagement, prevention, treatment, rehabilitation and social reintegration.
Objective 2: to review best practices related to collaboration mechanisms among NGOs, governments and UN agencies in various fields, and to propose new and improved ways of working with the UNODC and CND.
Objective 3: to adopt a series of high-order principles, drawn from the Conventions and their commentaries, that would be tabled with UNODC and CND, for their consideration and serve as a guide for future deliberations on drug policy.

The third objective is considered the most important. NGOs working in the drugs field have been asked to respond to a series of questions relating to each objective, concerning evaluations of policy effectiveness, negative and positive aspects of projects implemented and experiences of collaboration with the governmental sector. 500 responses have already been received, and another 500 are expected. A series of Regional Consultations is underway, involving approximately 500 NGOs around the world. These consultations will not just be relevant to the UNGASS review but also to identify key issues for the period of reflection for the high-level segment in 2009. The Committee will present a conference room paper to CND in March 2008, and a global forum in Vienna involving 300 NGOs is scheduled to take place in July 2008.

Several governments, including the UK and the US, are already preparing for 2008, and in early December there will be a meeting of the African Union in Libya at which members will discuss their positions vis à vis the UNGASS review.

It is vital to see what opportunities there are to influence the actions and priorities for the future. One could hope that on certain crucial issues, countries will decide in advance first, what they hope to achieve, second, a fall back position and third, 'red lines' which they will not cross. These lines should be coordinated with other countries. Some are of the opinion that it would be better to have a statement saying no agreement could be reached on harm reduction than to accept another watered - down resolution.

NGOs have to push the discussion before national governments and force discussion of the issues, as has happened in the Netherlands in 2003 during the UNGASS mid-term review. Now the Dutch parliament has again asked the government to state what its position will be at the UNGASS review.

INCB and its mandate

At the margins of the 2007 CND Norway took the initiative to open a debate on the function and role of INCB. It stemmed from concerns about INCB's transparency and accountability, the secretive way in which it operates and the tone of its reports, which sometimes contain imprecise information. The aim is not to undermine INCB but to help it become more relevant and more credible. The informal group, chaired by Norway with Brazil as co-chair, has until now consisted of ten countries. Norway began by sending a letter to the President of INCB requesting a dialogue with the Board, but was informed that a meeting was not appropriate. There has been no formal contact with the Board members, only with the President and the Secretariat. The Secretariat offered a briefing on INCB's work and there was some discussion but no real progress was made. INCB has important responsibilities as guardian of the conventions, but these should include a preparedness for dialogue, given that an international treaty is a contract *between* states parties. Other countries have expressed their interest in joining, and the group's work will start afresh. It has no pre-ordained plan, other than to encourage the Board to work in a more analytically robust, transparent and accountable way.

Conclusions/Recommendations, Session VIII:
As regards the outcome of the 2008 review, one could hope that:

- Progress could be made towards a more humane, evidence-based and compassionate approach to drug control.
- Inconsistencies could be addressed and overcome.
- Harm reduction principles could be embedded in any future text.
- Greater system-wide coherence could be provided through principles that are encapsulated in all UN treaties.
- Data and data collection methods could be improved.

The reflection period would be the appropriate time to examine the role and mandate of INCB, to look at UNODC (in terms of its overall role rather than micromanagement), to review the functioning of CND and to strengthen the governance of the international drug control system. This could be done with a Resolution to CND in 2008 and subsequently a Declaration in 2009 which would set markers for future action.

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November 2007