ALTERNATIVE MODELS TO PUNITIVE DRUG POLICY

Submission in Spring 2019 to the International Commission of Jurists in response to their call for civil society consultation to help develop "principles that address the detrimental impact on health, equality and human rights of criminalization with a focus on select conduct in the areas of sexuality, reproduction, drug use and HIV."

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This submission examines alternatives to the prevailing legal model of criminalizing and penalizing the use of drugs. It draws from various national models as well as recommendations by international institutions. While these approaches are not without their flaws and limitations, they provide a crucial starting point for developing principles concerning drug policy and human rights. The submission was prepared by the Human Rights Clinic of the University of Miami School of Law (HRC) in partnership with the Estonian Association of People Who Use Psychotropic Substances (LUNEST) and the Eurasian Harm Reduction Association (EHRA).[1]

Introduction

Since the establishment of the United Nations (U.N.) Single Convention on Narcotic Drugs in 1961, governments across the world have made concerted efforts to prohibit and penalize the use, sale, and possession of drugs.[2] Yet the market for illegal drugs has grown dramatically worldwide, with dire financial, social, and political costs: increased drug-related violence,[3] unprecedented incarceration,[4] record health epidemics,[5] and the diversion of state resources from other causes.[6] There remains little to show for these costs: The global illicit drug market is worth an estimated $320 billion,[7] and many of the countries with the most draconian drug policies face the highest rates of substance abuse, HIV/AIDS, violent crime, and overdose deaths—all of which undermine a myriad of human rights, including the right to health, economic and social protection, and freedom from violence.

Alternative Policies and Approaches

Most research indicates that countries that have decriminalized or depenalized drugs have not experienced any significant or long-term increase in either drug use or drug-related deaths. On the contrary, these alternatives have often mitigated or reversed these problems and led to other benefits, from reduced stigma towards people who use drugs, to significant declines in overdoses. These national models thus provide critical empirical evidence to underpin international legal principles regarding drug policy and human rights.

A. Portugal's Public Health Approach to Illicit Drugs

About twenty years ago, Portugal was suffering from one of the worst drug epidemics in the world: an estimated one percent of the population was dependent on heroin alone, while half of those in prison were convicted of drug offenses.[8] The subsequent strain on the criminal and public health systems prompted the government, in 2001, to decriminalize the possession or use of *any* drug, from cannabis to heroin. Anyone caught with a small amount of an illicit drug will have their contraband confiscated and be summoned to an interview by the "Commission for the Dissuasion of Drug Addiction" (Portuguese acronym: CDT).[9] There is one CDT in each of Portugal's eighteen

[1] Please see **Appendix I** for a more detailed description of these organizations.
[2] United Nations Treaty Collection (UNTC), Chapter VI, Narcotic Drugs and Psychotropic Substances, Single Convention on Narcotic Drugs, 1961, as amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961, New York, 8 August 1975 | 186 parties as of 07-02-2019 treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-18&chapter=6&lang=en.
[3] The Drug Problem in the Americas: Studies—Drugs and Security, Organization of American States, pp. 10-12, www.cicad.oas.org/drogas/elinforme/informeDrogas2013/drogasSeguridad_ENG.pdf.
[4] *Penal Reform International* (2013) p. 3, www.cdn.penalreform.org/wp-content/uploads/2013/05/PRI_war-on-drugs-briefing_March-2013.pdf.
[5] 2018 Global State of Harm Reduction, *Harm Reduction International* www.hri.global/files/2018/12/10/GlobalOverview-harm-reduction.pdf
[6] Betsy Pearl, "Ending the War on Drugs: By the Numbers", *Center for American Progress* (27 June 2018) www.americanprogress.org/issues/criminal-justice/reports/2018/06/27/452819/ending-war-drugs-numbers.
[7] *Supra* note 3, p. 5.
[8] Naina Bajekal, "Want to Win the War on Drugs? Portugal Might Have the Answer", *TIME* (1 August 2018) www.time.com/longform/portugal-drug-use-decriminalization.
[9] Criminal penalties remain for drug producers, dealers, and traffickers. *See* Claudia Hammond, "Lisbon's light-touch drugs policy", *BBC News* (8 June 2009) www.news.bbc.co.uk/2/hi/programmes/from_our_own_correspondent/8106689.stm

districts, most of which are based in nondescript buildings. Each CDT is comprised of three people—a social worker, a psychiatrist, and an attorney—who together provide a broad range of sanctions as an alternative to legal or criminal proceedings. Depending on what they find, these include one or more of the following:

- Fines ranging from 25 to 150 euros, depending on the person's income.
- Suspension of the individual's professional license.
- Prohibition on visiting certain places, such as nightclubs, and from traveling abroad.
- Requirement to report periodically to the committee (akin to supervised release).
- Rescission of the right to own gun.
- Confiscation of certain personal possessions.
- Ending certain public benefits.[10]

Those determined by the CDT to be drug dependent may be ordered to attend drug rehabilitation in lieu of sanctions or incarceration. Portugal maintains an extensive public network of treatment facilities, detoxification units, outpatient centers, and other specialized services for substance abuse. This treatment infrastructure is coordinated by the Ministry of Health and is made free to those referred by the CDT or seeking treatment.

Portugal is also a pioneer in OST, which gives people who use opioids an alternative substance under a supervised and controlled setting, thereby helping them to wean off or manage their dependence. OST also prevents HIV infections and overdoses. Since drug use is no longer a criminal matter, people who use drugs are no longer in fear of seeking help, and the rate of drug treatment rate has subsequently increased by as much as 60 percent.

The results of this approach have been resoundingly successful: the rate of drug-induced deaths is now five times lower than the European Union average; the HIV infection rate has plummeted from 104.2 new cases per million in 2000 to only 4.2 cases per million in 2015; the percentage of people incarcerated for drug offenses has nearly halved from 44 percent in 1999 to 24 percent as of 2013; and drug use has declined overall among 15- to 24-year-olds, the demographic most at risk of using drugs.[11]

B. Uruguay's State Regulated Drug Market

With the passage of Law 19172 in December 2013, Uruguay become the first country to establish a legal nationwide market for nonmedical cannabis.[12] The driving force of this effort was reducing crimes and social problems associated with the illegal production and sale of marijuana, the most popular drug in the country.[13]

Uruguay's response was to not only legalize marijuana, but to have the government play a direct role in its cultivation, production, and sale. This was done largely to placate the international community and drug monitoring bodies such as the International Narcotics Control Board (INCB). Hence the government opted for a strict regulatory system and based its reform on promoting human rights (namely the rights to health and security).[14] Uruguay also framed its new policy as a cautious and pragmatic "experiment" that it would be willing to abandon if the results were poor.[15] Interestingly, there was little popular support for the measure, with 58-74

[10] Mirjam van het Loo, et al. "Decriminalization of Drug Use in Portugal: The Development of a Policy." *The Annals of the American Academy of Political and Social Science*, vol. 582 (2002) pp. 49–63. JSTOR www.jstor.org/stable/1049733.
[11] "European Drug Report:", *EMCDDA* (2015) www.emcdda.europa.eu/attachements.cfm/att_239505_EN_TDAT15001ENN.pdf.; *See also* DPA Report 2017, *Drug Policy Alliance*, www.drugpolicy.org/resource/its-time-us-decriminalize-drug-use-and-possession
[12] Beatriz Caiuby Labate; Clancy Cavnar, *Prohibition, Religious Freedom, and Human Rights: Regulating Traditional Drug Use*. Springer Science & Business Media (2014). pp. 307.
[13] Casey, Nicholas, "Uruguay Legalizes Pot, Recasting Drug War", *The Wall Street Journal* (10 December 2013); *See* Watts, Jonathan, "Uruguay legalises production and sale of cannabis", *The Guardian* (10 December 2013). One in five Uruguayans had tried cannabis, with an estimated 115,000 being regular users out of a total population of 3.4 million.
[14] John Hudak, Geoff Ramsey, and John Walsh, "Uruguay's cannabis law: Pioneering a new paradigm" WOLA Center for Effective Public Management at Brookings (March 2018).
[15] "Uruguay considers legalising marijuana as 'experiment', says President Jose Mujica". *News.Com.Au* (7 August 2013).

percent of the population expressing opposition.[16] The bill passed the lower house by the minimum required votes and won the upper house by only three votes before being signed into law by the president.[17]

Law 19172 prohibits cannabis use indoors and bans any form of advertising or promotion.[18] It also establishes a new regulatory body that oversees implementation of the law: The Institute for the Regulation and Control of Cannabis (IRCCA), whose board includes officials from the Ministries of Public Health; Social Development; and Livestock, Agriculture, and Fishing. It provides three legal methods for lawfully accessing cannabis to citizens or legal residents eighteen years or older: *Homegrown*, wherein each household registers with the government to grow six female flowing cannabis plants for personal consumption (of no more than 480 grams annually); *cannabis clubs***,** registered cooperatives of between 15 and 45 members that can grow up to 99 plants (though no more than 480 grams can be dispensed to members annually, and any surplus must be given to authorities); and *commercial companies/pharmacies***,** which must be licensed and regulated by the government. Individuals can purchase up to 10 grams weekly but must be registered in a national database that includes their fingerprints, which must be scanned with each transaction.[19]

C. Switzerland's Multifaceted Four Pillars

In the 1980s, Switzerland endured a severe and highly visible problem with illegal drugs, particularly opioids. In 1994, after consulting with members of law enforcement, public health, and civil society, the Swiss government responded with a new drug strategy made up of "four pillars:" *prevention, treatment, harm reduction, and law enforcement*.[20] The core of the policy was the gradual implementation of OST programs based on public health approaches that centered on treating dependence. Although the Four Pillars policy was the first of its kind on a national level, the first safe injection site opened as early as 1982, in response to alarmingly high HIV rates among people who inject drugs. This was the earliest of several "autonomous centres" established and run by people who use drugs, who were otherwise forced to fend for themselves.[21]

Over time, cities and cantons (federal states) began shifting their approaches from waging a war on drugs to simply managing their consumption. The Swiss federal structure permits a fair amount of local and canton autonomy, allowing each political unit to experiment with responses to the particularities of drug use in their jurisdictions. Major cities such as Zurich and Berne led the way due to their high-profile drug scenes, providing useful laboratories from which other cantons, and ultimately the national government, could draw from.[22]

By promoting its Four Pillars approach as a matter of both public safety and social inclusion—and including input from stakeholders across different professions and communities—the Swiss government managed to build a broad and diverse coalition of supporters, including from its conservative and liberal wings. Like Uruguay, Switzerland was cognizant of going against the grain of harsh drug enforcement; accordingly, it took into account the major U.N. drug conventions by remaining within the general prohibition framework—many drugs remain illegal to consume and sell—but adding a new principle that people who use drugs but who are unable to quit their dependence still have rights, such as the right to life and to health.[23]

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[16] "El 74% de los uruguayos está a favor de la venta de marihuana con fines medicinales", *El Observador* (5 December 2013), www.elobservador.com.uy/nota/el-74-de-los-uruguayos-esta-a-favor-de-la-venta-de-marihuana-con-fines-medicinales--201312514290 (Spanish).
[17] Malena Castaldi and Felipe Llambias, "Uruguay becomes first country to legalize marijuana trade", *Reuters* (11 December 2013) www.reuters.com/article/us-uruguay-marijuana-vote/uruguay-becomes-first-country-to-legalize-marijuana-trade-idUSBRE9BA01520131211.
[18] Ley 19172. Marihuana y sus derivados. Control y regulación del Estado de la importación, producción, adquisición, almacenamiento, comercialización y distribución. *Poder Legislativo de Uruguay* (20 December 2013) Available at: www.legislativo.parlamento.gub.uy/temporales/leytemp2762533.htm (Spanish).
[19] Ella Jordan, "Marijuana legislation in Uruguay" (Nov. 23, 2018) *Centre for Public Impact*, www.centreforpublicimpact.org/case-study/marijuana-legalisation-in-uruguay/
[20] Savary, Hallam, and Bewley-Taylor, "Briefing Paper Eighteen – The Swiss four pillars policy: an evolution from local experimentation to federal law", *Beckley Foundation Drug Policy Programme* (2000), pp. 1-3 www.idpc.net/sites/default/%20files/library/Beckley_Briefing_8.pdf
[21] *Id*
[22] *Id.* at p. 3.
[23] *Id.* at pp. 3-4.

The Four Pillars particularly targeted the 10-15 percent of people who use heroin who were considered heavy consumers and accounted for 30-60 percent of the demand for illegal drugs. Due to the greater availability of OST—backed by the government's assurance of helping people who use drugs—those struggling with their dependence on drugs now had a steady, legal means for seeking treatment. This not only helped people who use drugs to reduce their need for illegal heroin, but it also allowed them to cut off their dependence on dealers.[24]

The results have been dramatic: the number of new registrations by people who use drugs in Zurich, once an epicenter of the drug scene, fell from 850 in 1990 to 150 in 2005. Participants in the program saw a 90 percent reduction in property crimes and an 85 percent reduction in petty theft. Between 1991 and 2004, drug related deaths fell by more than half, while levels of injection-related HIV infections were reduced by 80 percent within a decade of the Four Pillars being adopted. By helping the people who use drugs most heavily, illegal drug sales and trafficking declined, and people who use drugs casually found it more difficult to contact to sellers.[25]

In summary, Switzerland took a pragmatic, multipronged approach to drug policy that generally criminalizes use, possession, and sale, yet provides a way out for those who are dependent. By seeking and incorporating different perspectives, it also managed to change attitudes that were historically harsh towards drug use: In a 2008 referendum, close to 70 percent of voters voted in favor of establishing the Four Pillars model in Swiss legislation.

Recommendations

A 2008 resolution sponsored by Uruguay at the U.N. Commission on Narcotic Drugs—entitled "Strengthening cooperation between the U.N. Office on Drugs and Crime and other U.N. entities for the promotion of human rights in the implementation of the international drug control treaties"—sets forth vital principles that can guide legal and political systems. Its central aim was to ensure that human rights were taken into account when implementing the main international drug control treaties that account for the prevailing criminalization model worldwide: The Single Convention on Narcotic Drugs; the Convention on Psychotropic Substances (1971); and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).[26] The resolution urged an "integrated and balanced" approach to drug control that must conform with the Universal Declaration of Human Rights, the U.N. Charter, principles of nonintervention and state sovereignty, and fundamental human rights and freedoms. Essentially, drug control should never supersede human rights and well-being.

Two years later, the UN Special Rapporteur on the Right to Health, Anand Grover, submitted a report to the U.N. General Assembly that reaffirmed these principles: "When the goals and approaches of the international drug control regime and international human rights regime conflict, it is clear that human rights obligations should prevail." [27] The report was critical of how international drug control treaties lacked consideration of human rights and identified the global war on drugs as creating "more harms than the harms it seeks to prevent." It highlighted the varied ways that drug criminalization negatively impacts the realization of several human rights:

- "Overly punitive" sentencing violates the human rights of people who use drugs, particularly in the 32 jurisdictions where drug offenses are capital crimes.
- People who use drugs are forced underground and therefore deprived of access to essential medications and treatment, particularly for those with HIV/AIDS.
- Drug criminalization creates institutionalized and social stigma and discrimination towards people who use drugs, increasing their risk of physical and mental illness.
- Communities that are already marginalized and persecuted bear the brunt of the war on drugs.
- People who use drugs or who are drug dependent are subjected to forced tests, medically dubious treatments, and/or abuse masquerading as medical intervention.

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[24] Killias, M. and Aebi, M.F. "The impact of heroin prescription on heroin markets in Switzerland," *Crime Prevention Studies,* Vol. 11 (2000) www.popcenter.org/library/crimeprevention/volume_11/ 04-Killias.pdf.

[25] *Supra* note 2, p. 7; *see also supra* note 23.

[26] Resolution 51/12, (2008) www.unodc.org/documents/commissions/CND/Drug_Resolutions/2000-2009/2008/CND_Res-2008-12e.pdf

[27] Anand Grover, UN Special Rapporteur. "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (6 August 2010), ¶ 10 www.ohchr.org/Documents/Issues/Water/Contributionsstigma/others/SPhealthI.pdf.

The report concludes that drug control policies must prioritize adopting a "human rights-based approach" and urges reform at all levels of policymaking.

These findings, and the liberalizing trend among nations across the world, reflect a growing realization that drug control policies are fundamentally at odds with human rights, compassion, and public safety. Several recommendations and principles can be drawn from these conclusions:

- Decriminalize the use of drugs and possession of drugs for personal usage, which drives many of the human rights violations that women who use drugs face.
- Providing interventions focused on addressing the harms associated with the use of psychoactive drugs without necessarily discouraging their use. These include needle and syringe programs, substitute medications, drug-consumption rooms, overdose prevention practices, and outreach programs.
- Accepting and promoting OST as an evidence-based approach to treating dependence.
- Ensuring reduction interventions directly address the diseases that disproportionately impact communities that use drugs, such as HIV/AIDS and Hepatitis C.
- Implementing less restrictive drug control policies such as decriminalization or depenalization. States can liberalize drug policy within the framework of the drug control treaties through avenues such as Article 3(2) of the 1988 U.N. Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which states that obligations to criminalize possession for personal consumption are superseded by the party's "constitutional principles and the concepts of its legal system."[28]
- Adopting parallel policies and programs that address the needs of people who use drugs. In Portugal's model "decriminalization occurred alongside other efforts, including significant expansion of drug treatment programs, drug education and refocusing of police efforts on interruption of trafficking operations."
- Acknowledging that policy changes such as decriminalization are less effective without attending reforms in treatment, harm reduction, education, and other interventions.
- Using human rights indicators and guidelines to ensure that drug control does not undermine a State's obligation to the human rights and freedoms of its people based on constitutional and/or international

Steps that lawmakers can take to fulfill these recommendations include:

- Ensuring that all harm reduction measures and drug-dependence treatments, particularly OST, are available to people who use drugs, especially those who are incarcerated.
- Decriminalizing or depenalizing the possession and use of drugs.
- Repealing or significantly reforming laws and policies inhibiting the delivery of essential health services to people who use drugs.
- Reviewing law enforcement drug control complies with human rights obligations.
- Amending laws, regulations, and policies to increase access to controlled essential medicines.

These recommendations were reaffirmed in a subsequent statement to the U.N. General Assembly in April 2015 by Grover's successor, Dainius Pūras, which described punitive drug policies as failures stemming from ignorance of the realities of drug use and drug dependence. The report subsequently urged an ethical and human rights-centered approach to drug control as the primary solution.[29]

[28] The report highlights Argentina as an example, which took steps to decriminalize drugs for personal consumption after its highest court ruled that criminal sentences for personal use are unconstitutional.
[29] A/HRC/29/33, www.hr-dp.org/contents/1541

APPENDIX I
DESCRIPTION OF ORGANIZTIONS

LUNEST ESTONIAN ASSOCIATION OF PEOPLE WHO USE PSYCHOTROPIC SUBSTANCES	Estonian Association of People Who Use Psychotropic Substances is a probono, voluntary, private-law, non-profit organization of natural persons and legal entities acting in common good. The mission of the association is to represent the Estonian community of people who use drugs and advocate for their human rights. Address: Tuuslari 2-18, Kohtla-Jarve, Estonia 30321
ehra eurasian harm reduction association	Eurasian Harm Reduction Association (www.harmreductioneurasia.org) is a non-for-profit public membership-based organization which strives for a progressive human rights-based drug policy, sustainable funding advocacy and quality of harm reduction services oriented on the needs of people who use drugs in Central and Eastern Europe and Central Asia. Address: Verkių g. 34B, office 701 LT – 04111, Vilnius, Lithuania
MIAMILAW UNIVERSITY OF MIAMI SCHOOL OF LAW Human Rights Clinic	The Human Rights Clinic of the University of Miami School of Law (HRC, www.law.miami.edu/hrc) works for the promotion of social and economic justice globally and in the United States, with a particular focus on gender justice. HRC draws on international human rights laws and norms, along with domestic law and policy. It engages in multidimensional advocacy strategies, which include documentation and report-writing, litigation, media engagement, work with legislative and administrative bodies, campaigning, community organizing, and global networking to develop practical solutions and promote accountability on the part of state and non-state actors. Since its founding in 2010, HRC has litigated and engaged in advocacy before international and regional human rights bodies on issues of domestic violence and other forms of gender-based violence, including Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the African Court on Human and Peoples' Rights, the African Commission on Human and Peoples' Rights, United Nations treaty monitoring bodies, and the United Nations Human Rights Council. Address: 311 Miller Drive, Room E295A, Coral Gables, Florida 33146 USA