

# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Criminal law issues



# 1

This model law resource consists of eight modules, addressing the following issues:

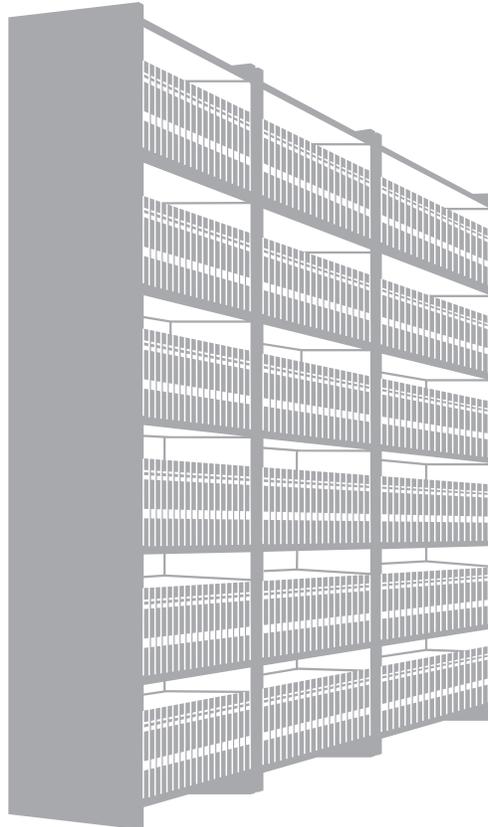
1. Criminal law issues
2. Treatment for drug dependence
3. Sterile syringe programs
4. Supervised drug consumption facilities
5. Prisons
6. Outreach and information
7. Stigma and discrimination
8. Heroin prescription programs

This module, and the other modules, are available in multiple languages on the website of the Canadian HIV/AIDS Legal Network at [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy).



Canadian  
HIV/AIDS  
Legal  
Network

Réseau  
juridique  
canadien  
VIH/sida



# Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS

Criminal law issues



# **Legislating on Health and Human Rights: Model Law on Drug Use and HIV/AIDS Module 1: Criminal law issues**

© 2006 Canadian HIV/AIDS Legal Network

Further copies can be retrieved at [www.aidslaw.ca/drugpolicy](http://www.aidslaw.ca/drugpolicy)  
or obtained through the Canadian HIV/AIDS Information Centre  
([www.aidssida.cpha.ca](http://www.aidssida.cpha.ca))

## **Canadian cataloguing in publication data**

Module 1: ISBN 978-1-896735-65-8  
Complete series: ISBN 978-1-896735-64-1

## **Authorship and acknowledgements**

Richard Pearshouse is the primary author of this resource. Richard Elliott and Joanne Csete wrote text of legal provisions and prefatory notes, and reviewed the entire resource. Invaluable research assistance was provided by Tim Franklin, Sarom Bahk, Katie Gibson and Sara Kushner.

This resource was reviewed by a number of outside reviewers. Special thanks go to Scott Burris and Anya Sarang. Thanks also to the participants of the consultation meeting in Vilnius, Lithuania (7–8 November 2005) who provided feedback and advice on a draft version of this resource: Larisa Bashmakova, Holly Catania, Eszter Csernus, Rumen Donski, Joze Hren, Erik Iriskulbekov, Ainagul Isakova, Murtazokul Khidirov, Vlad Klisha, Tommaso Marilli, David Otiashvili, Ekaterina Paniklova, Alexandr Rumantsyev, Atanas Rusev, Vera Sergunina, Alex Shoshikelashvili, Raminta Stuikyte, Rusudan Tabatadze, Andrey Tolopilo and Thomas Zabransky. We also thank others who provided additional comments on the draft.

Thanks to Glenn Betteridge for his assistance. Lada Mirzalieva provided useful references to legislation from former Soviet Union countries. Thanks to David Garmaise for copyediting the English text, to Liana Ibragimova for translating the resource into Russian, and to Leah Utyasheva for editing the resource in Russian. Cover design was done by Oblik Communications, and layout by Vajdon Sohaili.

Funding for this project was provided by UNAIDS, the International Affairs Directorate of Health Canada, the John M. Lloyd Foundation, and the Open Society Institute. Funding for the consultation meeting in Vilnius, Lithuania was provided by the Conference Secretariat of the Canadian International Development Agency and the Open Society Institute. The opinions expressed in this publication are those of the authors and do not necessarily reflect the official views of Health Canada.

## **About the Canadian HIV/AIDS Legal Network**

The Canadian HIV/AIDS Legal Network ([www.aidslaw.ca](http://www.aidslaw.ca)) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

# Introduction

UNAIDS (the Joint United Nations Programme on HIV/AIDS) suggests that approximately 30 percent of new HIV infections outside sub-Saharan Africa are due to contaminated injection equipment.<sup>1</sup> In eastern Europe and Central Asia, the use of contaminated injection equipment accounts for more than 80 percent of all HIV cases.<sup>2</sup> Yet, globally, less than five percent of people who inject drugs are estimated to have access to HIV prevention services,<sup>3</sup> and even in regions where they account for the majority of HIV infections, people who use drugs are routinely excluded from HIV/AIDS care and treatment.

Many countries with injection-driven HIV/AIDS epidemics continue to emphasize criminal enforcement of drug laws over public health approaches, thereby missing or even hindering effective responses to HIV/AIDS. There is considerable evidence that numerous interventions to prevent HIV transmission and reduce other harms associated with injection drug use are feasible, effective as public health measures and cost-effective.<sup>4</sup> Despite such evidence, millions of people around the world who use drugs do not have access to such services because of legal and social barriers.

International human rights law establishes an obligation on states to respect, protect and fulfill the right to the highest attainable standard of health of all persons, including those who use drugs. Other human rights are equally relevant in the context of the HIV/AIDS epidemic. When human rights are not promoted and protected, it is harder to prevent HIV transmission, and the impact of the epidemic on individuals and communities is worse. Consequently, UN member states have committed to

enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups ....<sup>5</sup>

---

<sup>1</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, May 2006, p. 114. At [www.unaids.org/en/HIV\\_data/2006GlobalReport/default.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp).

<sup>2</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, p. 114.

<sup>3</sup> United States Agency for International Development et al, *Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003*, June 2004. At [www.futuresgroup.com/Documents/CoverageSurveyReport.pdf](http://www.futuresgroup.com/Documents/CoverageSurveyReport.pdf).

<sup>4</sup> See, for example, N. Hunt, *A review of the evidence-base for harm reduction approaches to drug use*, Forward Thinking on Drugs, 2003. At [www.forward-thinking-on-drugs.org/review2-print.html](http://www.forward-thinking-on-drugs.org/review2-print.html).

<sup>5</sup> *Declaration of Commitment on HIV/AIDS*, UN General Assembly, Res/S-26/2, 27 June 2001, para. 58. At [www.un.org/ga/aids/docs/aress262.pdf](http://www.un.org/ga/aids/docs/aress262.pdf).

UN member states have also committed to ensuring that a wide range of HIV prevention programs is available, including the provision of sterile injecting equipment and harm reduction efforts related to drug use.<sup>6</sup>

The widespread legal, social and political ramifications of the HIV/AIDS epidemic make it necessary to review and reform a broad range of laws. Some countries have adopted national HIV/AIDS laws, but these laws often ignore crucial policy issues, as well as human rights abuses that perpetuate the HIV epidemic. This is particularly true with respect to illegal drug use. HIV prevention, care and treatment services operate best within a clear legal framework that specifically protects the human rights of people who use drugs and enables harm reduction measures to mitigate the impact of HIV. A legislative framework can provide clarity and sustainability for such services. This is particularly important, given the often dominant approach of criminalizing illegal drug use and people who use drugs, which creates additional barriers to delivering health services. Law reform is not a complete solution to effectively addressing the HIV epidemic among people who use illegal drugs, but it is a necessary and often neglected step.

## **The model law project**

In early 2005, the Legal Network established a project advisory committee and, in consultation with the committee, developed a plan to produce model law that would assist states in more effectively addressing the HIV epidemic (and other harms) among people who use drugs, based on evidence of proven health protection and promotion measures, and in accordance with states' human rights obligations.

Comprehensive consultations were conducted during the drafting of the model law. A draft version of the model law was reviewed by a group of legal experts, harm reduction advocates and government representatives from central and eastern Europe, and countries of the former Soviet Union, during a meeting in Vilnius, Lithuania (7–8 November 2005). The document was modified in line with this feedback and recommendations. In early 2006, the model law was circulated in electronic form to a large number of people and organizations, providing a further opportunity to modify and strengthen the resource. This final document has, therefore, benefited from the thinking of a wide range of experts in the fields of HIV/AIDS, human rights and drug policy.

## **About this resource**

This model law resource is a detailed framework of legal provisions and accompanying commentary. It makes reference to examples of law from those jurisdictions that have attempted to establish a clear legal framework for addressing HIV/AIDS issues among people who use drugs.<sup>7</sup> This resource also incorporates human rights principles and

---

<sup>6</sup> *Declaration of Commitment on HIV/AIDS*, para. 52.

<sup>7</sup> References to national legal instruments are included in order to demonstrate the feasibility of establishing progressive legal frameworks so that law reform in other jurisdictions can be informed by such examples.

obligations of states throughout the document. It is annotated in order to highlight critical issues and evidence that supports the measures proposed.

This model law resource is designed to inform and assist policy-makers and advocates as they approach the task of reforming or making laws to meet the legal challenges posed by the HIV epidemic among people who use drugs. The model law resource is not intended for any one country or set of countries. Rather, it is designed to be adaptable to the needs of any of a wide number of jurisdictions. In some instances, the model law presents different legislative options for implementing states' human rights obligations. It is hoped that this resource can be most useful for those countries where injection drug use is a significant factor driving the HIV epidemic, and particularly for developing countries and countries in transition where legislative drafting resources may be scarce.

The model law resource consists of eight modules, addressing the following issues:

- (1) Criminal law issues
- (2) Treatment for drug dependence
- (3) Sterile syringe programs
- (4) Supervised drug consumption facilities
- (5) Prisons
- (6) Outreach and information
- (7) Stigma and discrimination
- (8) Heroin prescription programs

Each of the eight modules in this series is a stand-alone document. Each module begins with the introduction that you are reading now; the text of the introduction is identical in all of the modules.

Following the introduction, each model provides a prefatory note, model statutory provisions and a list of selected resources. (Taken together, the model statutory provisions in all eight modules would form a model law addressing HIV/AIDS and drug use.)

The prefatory note presents a rationale for reforming laws and policies in the area covered by the module. This is followed by a discussion of the relevant UN conventions on drug control, and of states' human rights obligations in this area.

The section on model statutory provisions contains provisions that could be included in a model law on HIV/AIDS and drug use. The provisions are divided into chapters, articles, sections and subsections. The first chapter ("General Provisions") describes the purpose of that Part of the model law, and provides definitions for many of the terms included in the provisions.

---

These references do not imply that the actual practice in the jurisdictions cited represents "best practice." There is often a long way to go in ensuring that actual practice conforms to these legal undertakings.

Some of the provisions are accompanied by a commentary. The commentary provides additional information on, or rationale for, the provision in question. For some model statutory provisions, two options are presented; a note inserted into the text indicates either (a) that one or the other option should be selected, but not both; or (b) that one or the other option, or both options, can be selected. As well, some of the provisions have been labelled as “optional.” This means that these provisions may or may not be applicable, depending on the situation in the country.

The section on selected resources contains a short list of resources which the Legal Network considers to be particularly useful. There are two subsections: one on articles, reports and policy documents, and one on legal documents.

The model law resource is heavily footnoted. The notes provide additional information on the issues being addressed, as well as full references. If the same source is cited more than once in a module, the second and subsequent references to that source are somewhat abbreviated (usually just the name of the author, or organization, and the title of the article or report).

# Module 1: Criminal Law Issues

*Module 1 contains a prefatory note which discusses the rationale for reforming criminal laws that relate to drug use, and which describes relevant international laws and policies, including human rights obligations. This is followed by a section on model statutory provisions. Module 1 concludes with a note about drug treatment courts (see annex) and a list of recommended resources.*

## Prefatory Note

### Rationale for reform

Adopting policies that reduce drug use and the negative health consequences of drug use often poses difficult political challenges. Traditionally, policies on drug use have focussed on both supply and demand reduction. Reducing supply of and demand for drugs are clearly elements of health policy wherever drug use poses a serious threat to public health. But care must be taken to ensure that the nature and implementation of supply and demand reduction policies are consistent with states' human rights obligations. In particular, policies and programs that result in compromising the health and human rights of people who use drugs, including increasing their vulnerability to HIV infection, should be avoided. The underlying issue is what kinds of efforts, and in what combination, will have the greatest positive impact on drug use and the type, severity and distribution of harms.<sup>8</sup>

Supply and demand reduction policies that are primarily or wholly dependent on the criminal law enforcement framework frequently have a negative impact on the health and the human rights of people who use drugs. Such laws, policies and law enforcement practices can conflict with the goals of public health authorities and undermine the ability of these authorities to intervene and the efficacy of their interventions. Criminal law enforcement should not exacerbate existing social problems (through excessive criminal sanctions) or disrupt treatment and harm reduction services. Approaches to drug use that are based primarily on criminal prohibitions and penalties may increase, rather than decrease, the harms of drug use in a number of ways:

- When drugs can be purchased only on the underground market, they are of unknown strength and composition, which may result in overdoses or other harms to people who use drugs.
- Fear of criminal penalties and the high price of drugs can push people to consume drugs in more efficient ways, such as by injection rather than, for example, by

---

<sup>8</sup> S. Burris and S.A. Strathdee, "To serve and protect? Toward a better relationship between drug control policy and public health," *AIDS* 20(1) (2006): 117–8.

smoking, which may contribute to the transmission of HIV and other blood-borne diseases.

- Because sterile injection equipment is not always available — and its availability may be impeded by drug paraphernalia laws and other criminal measures — people who use drugs may have to share needles and equipment, which further contributes to the spread of infection.
- Significant resources are spent on law enforcement, money that could instead be spent on the prevention of drug dependence and the expansion of treatment facilities for people with drug dependence. These are more effective ways to reduce demand for drugs, and they avoid damaging health and human rights.

In some situations, violations of the human rights of people who use drugs have been demonstrably linked to law enforcement-based approaches to drug use. For example, there are documented cases of illegal police searches, arbitrary arrests, prolonged pre-trial detention, as well as unwarranted use of force, harassment and extortion on the part of police and border guards towards people who use drugs.<sup>9</sup> Other reports document cases of detainees who are questioned while they are in drug withdrawal and experiencing pain and confusion, or who are denied the right to a lawyer.<sup>10</sup> Such human rights abuses are abhorrent in themselves. They also drive people who use drugs further underground, thus preventing a vulnerable population from seeking and using health and social services.

Strict law enforcement practices may impede access to essential health care services among people who use drugs.<sup>11</sup> Criminal sanctions may make it difficult for health professionals to reach people who use drugs with essential health information and services; may make people who use drugs afraid to seek health or social services on their own initiative; may make service providers shy away from providing essential education on safer use of drugs or materials for the safer use of drugs (e.g., distributing sterile injection equipment), for fear of being seen to condone or promote drug use; and may

---

<sup>9</sup> See, for example, Human Rights Watch, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation*, April 2004 (at <http://hrw.org/reports/2004/russia0404/>); Drug Law and Health Policy Network, *Drug Policies = Death: HIV/AIDS in Central and Eastern Europe — A Report by the Drug Law and Health Policy Network on the Current Impact of Law and Policy on Spread of HIV in Central and Eastern Europe and the Former Soviet Union*, July 2002 (at [www.drugpolicy.org/docUploads/drugpolicies\\_death.pdf](http://www.drugpolicy.org/docUploads/drugpolicies_death.pdf)); A. Alexandrova, *Reforming Drug Policy for HIV/AIDS Prevention — Focus: Georgia, Kyrgyzstan, Russia, Ukraine and Tajikistan*, Open Society Institute, 2005.

<sup>10</sup> See, for example, Human Rights Watch, *Fanning the Flames: How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan*, June 2003; Human Rights Watch, *Abusing the user: police misconduct, harm reduction and HIV/AIDS in Vancouver*, 2003. Available via [www.hrw.org](http://www.hrw.org).

<sup>11</sup> See, for example, T. Kerr et al, “The public health and social impacts of drug market enforcement: a review of the evidence,” *International Journal of Drug Policy* 16 (2003): 210–220; E. Wood, “Displacement of Canada’s largest public illicit drug market in response to a police crackdown,” *Canadian Medical Association Journal* 170(10) (2005): 1551–1556; L. Maher and D. Dixon, “Policing and public health: law enforcement and harm minimization in a street-level drug market,” *British Journal of Criminology* 39(4) (1999): 488–512; S. Burris et al, “Addressing the ‘risk environment’ for injection drug users: the mysterious case of the missing cop,” *The Millbank Quarterly* 82(1) (2004): 131–135.

foster prejudicial attitudes towards people who use drugs, directing action toward punishment of the “offender,” rather than fostering understanding and assistance.

## **Decriminalization or depenalization of drugs for personal use**

In light of these public health concerns, this model law recommends the decriminalization or depenalization of drugs for personal use.<sup>12</sup> An essential element of the criminal law enforcement framework is the laws and policies providing for criminal (and administrative) sanctions for drug use (or, sometimes, consumption), possession and (in some legal frameworks) acquisition.<sup>13</sup> Some governments have established, by law or policy, standards for judging whether a quantity of illegal drugs possessed by an individual is for personal use.<sup>14</sup> When such offences involve a quantity of a drug for personal use, the individual might be not be subject to any charges or might be subject only to an administrative penalty. Chapter II of the model statutory provisions in this module provides a legal framework to lessen the severity of punishments for drug use and possession for personal use. It does so by providing for a distinct Schedule (called, for the purposes of the model law, Schedule A) which would include a list of certain controlled substances and provide a guideline amount for “personal use” for each substance on the list.<sup>15</sup> The model law does not include an actual Schedule A, as the

---

<sup>12</sup> See, also, Legal Working Party of the Intergovernmental Committee on AIDS, *Final Report*, Department of Health, Housing and Community Services [Australia], 1992, c.8.

<sup>13</sup> Note that the model law that follows refers to “use” and “possession,” because the crime of acquisition in some legal systems would be covered in others by possession. It does not decriminalize trafficking, manufacturing and cultivation, nor importing nor exporting. Note, also, that the model law does not address the use of certain drugs (notably marijuana) for personal consumption for medicinal purposes. In Canada, *The Marijuana Medical Access Regulations* (2001) establish a licensing scheme regulating the use of medical marijuana by some people who are suffering from serious illnesses. The Regulations can be accessed at <http://lois.justice.gc.ca/en/C-38.8/SOR-2001-227/index.html>. Although they provide an important illustration of tempering criminal laws on drugs to accommodate health concerns, the Regulations have been criticized for establishing an unwieldy applications process, complicated distribution policies and financial restrictions.

<sup>14</sup> The mode of calculation of such quantities is done differently in differently countries. Some countries determine quantities on the basis of “small” or “large” portions, and some countries define quantities by a maximum threshold per substance, or by the weight of active chemical substance, while other countries use a multiple of “daily doses.” Still others take monetary value as the basis. Note that among the EU countries that make a distinction between “small” and “large” quantities of narcotics, only four have attempted to fix the “small” quantity by specifying a precise weight. Rather, the more common approach is to leave this interpretation “to prosecutorial or judicial discretion, with knowledge of *all* of the surrounding circumstances, to determine the true intention behind the offence.” See European Monitoring Centre for Drugs and Drug Addictions, Legal Database on Drugs, *The role of the quantity in the prosecution of drug offences*, ELDD Comparative Study, April 2003. Available via <http://eldd.emcdda.eu.int>.

<sup>15</sup> Though drug conventions such as the 1961 *Single Convention on Narcotic Drugs* include schedules into which illegal drugs and other controlled substances are classified, the Conventions do not explicitly require parties to adopt these schedules. While states are bound to maintain restrictions on the substances listed in the schedules of these Conventions, they are permitted under the Conventions to exempt from penalty substances whose use may have medical or scientific value. States may classify controlled substances as they determine appropriate, within the boundaries of the Conventions.

content of such a list will depend on the pre-existing framework for categorizing controlled substances in each country.<sup>16</sup>

The establishment of such personal use standards should be a key point of drug law and policy. However, it should be noted that in some countries, notably in the former Soviet Union, although governments have ostensibly sought to decriminalize minor drug offences, they have set the personal use quantities so low that possession of virtually any quantity of an illegal drug exceeds the personal use cut-off.<sup>17</sup> While the model law proposed here does not specify quantities for personal use in Schedule A, the spirit of this proposal is that such standards should reflect a reasonable estimate of a quantity that is meaningful for personal use but too small to matter for consumption beyond one individual.

### **Alternatives to imprisonment**

Another essential component of the criminal law framework is imprisonment. From the perspective of HIV prevention, the imprisonment of people on charges relating to their personal drug use is problematic. The notion that imprisoning people who use drugs decreases the spread of blood-borne diseases, including HIV/AIDS, is false. In many cases, prisoners have some access to drugs but little or no access to drug dependence treatment, opioid substitution treatment or sterile injecting equipment. As a result, policies that perpetuate the incarceration of people who use drugs exacerbate the spread of disease. The World Health Organization (WHO) has stated that prisons are high-risk environments for HIV transmission and other drug-related harms.<sup>18</sup> The European Union's Action Plan on Drugs (2005-2008) calls for member states to "further develop

---

<sup>16</sup> Such quantities for personal use may be found in various instruments: sometimes in national regulations, sometimes in guidelines from the Public Prosecutor, and sometimes in guidelines from the Ministry of Justice or the Ministry of Health. In Austria, the amounts are set out in Ordinances no. 377 and 378 from the Federal Ministry of Labour, Health and Welfare and the Federal Ministry of Justice (1997). In Finland, official direction comes from the Office of the Prosecutor-General in VKS: 2002:3 (September 2002). In Portugal, under art. 5 of the *Law No. 30/2000*, which entered into force on 29 November 2001, anyone arrested in illegal possession of up to 10 daily doses will be charged and referred to the Commissions for the Dissuasion of Drug Addiction, an authority which will undertake an administrative procedure against the offender. The daily doses are set in Portaria no. 94/96 of 26 March 1996. In the Czech Republic, the amounts are established in an Instruction of the Supreme Public Prosecutor, no. 6/2000. In the Netherlands, the *Opium Act Directive* of the Public Prosecutor's Offices, entered into force on 1 January 2000, establishes the amounts and modifies prosecutorial discretion according to the amounts and nature of the substances.

<sup>17</sup> See, for example, Human Rights Watch, *Ukraine: Drug law reforms would threaten HIV/AIDS fight* (open letter to president of Ukraine), 3 August 2005; Human Rights Watch, *Russia: Letter protesting repeal of recent drug reforms* (open letter to Russian president), 11 May 2005. Both documents are available via [www.hrw.org](http://www.hrw.org).

<sup>18</sup> WHO Europe, *Status Paper on Prisons, Drugs and Harm Reduction*, May 2005. Available via <http://www.euro.who.int>.

alternatives to imprisonment for drug abusers and drug services for people in prisons, with due regard to national legislation.”<sup>19</sup>

The model statutory provisions in Chapter III of this module are designed to establish a legal framework allowing offenders to be diverted from imprisonment to alternative measures in a way that is respectful of the human rights of people who use drugs. The framework set out in Article 6(a) creates a basis for implementing a quasi-judicial commission with the authority to administer non-custodial penalties for the acquisition, possession and use of controlled substances in amounts intended only for personal use. Penalties include fines, attendance at educational sessions and an option to undergo treatment in the case of drug dependence.<sup>20</sup> Article 6(b) sets out a framework for non-custodial penalties, including access to drug dependence treatment programs, after conviction in a criminal court. These articles apply to those who are tried for drug-related offences for personal use. Excluded from these alternative measures are people who are convicted of trafficking and offences such as exporting or importing.<sup>21</sup> Also excluded are those convicted of non-drug offences (e.g., assault, theft, robbery or vandalism).<sup>22</sup>

## International law and policy

In legislating in the area of controlled drugs and substances, countries must necessarily have regard to their obligations under applicable international law. This includes both drug control treaties and international human rights law.

---

<sup>19</sup> European Council, *EU Drugs Action Plan (2005-2008)*, 2005/C168/01, Objective 13.

<sup>20</sup> This framework for a non-criminal hearing is modeled on Portugal’s Commissions for the Dissuasion of Drug Addiction to penalize offenders for drug-related offences involving quantities for personal use. The Portuguese commissions may administer non-custodial penalties after an assessment of the offence and the circumstances of the offender, and may refer offenders who are dependent on drugs to drug dependence treatment. See Portugal’s *Law No. 30/2000*.

<sup>21</sup> However this approach could be expanded to other offences under the relevant drug legislation, such as possession for the purpose of trafficking or trafficking itself, if the quantities involved are small. This would recognize the fact that a significant number of people who use drugs may also engage in small-scale trafficking to support that dependence. Laws in Austria, Portugal and Germany also have specific offences for trafficking in small quantities or “less serious trafficking.” For example, Austria’s *Narcotic Substances Act* specifies a “threshold quantity,” below which a trafficking offence engenders a much lower penalty; see *Narcotic Substances Act*, (BGBl I 112/1997), ss. 28, 30. Similarly, the trafficking provisions in Germany’s *Narcotics Act*, ss. 29–30a, make a distinction between “insignificant quantities” and “not insignificant quantities.” Spain’s drug law does not create a separate offence for small-scale trafficking, but nonetheless states: “More severe custodial sentences ... shall be imposed ... [w]here the quantity of toxic drugs, narcotics or psychotropic substances involved in the acts referred to in the previous article is large”; see *Organizational Law No. 10 of 23 November 1995, Concerning the Penal Code*, ss. 368, 369(3).

<sup>22</sup> However, this approach could also be extended to a number of other, non-violent crimes that may often be associated with the possession or use of illegal drugs, such as prostitution-related offences and minor property crimes.

## UN conventions on drug control

The UN's three major drug control conventions are:

- the 1961 *Single Convention on Narcotic Drugs*;<sup>23</sup>
- the 1971 *Convention on Psychotropic Substances*;<sup>24</sup> and
- the 1988 *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.<sup>25</sup>

These conventions can be interpreted so as to permit approaches that treat drug use as a health concern, including various harm reduction measures. The conventions allow states some flexibility in the extent to which they criminalize possession and use of controlled substances. There is increasing evidence that criminal prohibitions do not address — and can even worsen — some of the harms associated with problematic drug use. The widespread epidemic of HIV among people who use illegal drugs, particularly by injection, highlights the limits and problems of an approach that is strictly or overwhelmingly focused on criminalization and the imposition of harsh penalties. Therefore, it is important that states considering reform of domestic legislation be aware of the flexibility that is allowed under the international drug control conventions.

The UN drug control conventions may be correctly interpreted to support the implementation of such harm reduction measures as opioid substitution treatment, sterile syringe programs, supervised drug consumption facilities, and heroin prescription programs.<sup>26</sup> The UN Drug Control Program (UNDCP), located within the UN Office on Drugs and Crime, issued a legal opinion to the International Narcotics Control Board (INCB) concluding that all of these measures can be seen as consistent with the three UN drug control conventions.<sup>27</sup>

First, both the 1961 *Single Convention on Narcotic Drugs* and the 1971 *Convention on Psychotropic Substances* allow for the production, distribution or possession of

---

<sup>23</sup> *Single Convention on Narcotic Drugs*, 1961, UN, 520 UNTS 331, as amended by the *1972 Protocol Amending the Single Convention on Narcotic Drugs*.

<sup>24</sup> *Convention on Psychotropic Substances*, 1971, UN, 1019 UNTS 175.

<sup>25</sup> *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, UN Doc. E/CONF.82/15 (1988), 28 ILM 493 (1989).

<sup>26</sup> British Institute of International and Comparative Law, *Opinion on the legality of health promotion measures in light of the United Nations drug conventions regime*, October 2003. At [www.senlisouncil.net/documents/BIICL\\_opinion\\_HR](http://www.senlisouncil.net/documents/BIICL_opinion_HR).

<sup>27</sup> UNDCP (Legal Affairs Section), *Flexibility of treaty provisions as regards harm reduction approaches*, Decision 74/10, UN Doc. E/INCB/2002/W.13/SS.5, 30 September 2002. At [www.tni.org/drugsreform-docs/un300902.pdf](http://www.tni.org/drugsreform-docs/un300902.pdf). The INCB assesses states' compliance with the treaties, but does not have the power to interpret or adjudicate them in any binding way.

controlled substances for “medical and scientific purposes.” States determine how they will interpret and implement these provisions in their domestic law.

Second, the drug control conventions also note the importance of measures aimed at protecting and promoting the health of those who use drugs. The 1961 *Single Convention on Narcotic Drugs* requires the government to “to give special attention to and *take all practicable measures* to provide treatment, education, aftercare, rehabilitation and social reintegration of drug users” (Article 38; emphasis added). In addition, even though there is a requirement to criminalize possession other than as may be allowed for medical and scientific purposes, the convention states that measures for treatment, care and support of people who use drugs may be provided “either as an *alternative to conviction or punishment* or in addition to conviction or punishment” (Article 36(2); emphasis added).

The 1971 *Convention on Psychotropic Substances* contains the same obligation to “take all practicable measures” for the care, treatment and social reintegration of people who use drugs (Article 20), and the same provision allowing for measures of treatment, care, rehabilitation and social reintegration “as an alternative to conviction or punishment” (Article 22). At the 1998 UN General Assembly Special Session on Drugs, the General Assembly adopted a *Declaration on the Guiding Principles of Drug Demand Reduction*, in which it declared that demand reduction policies should aim not only at “preventing the use of drugs” but also at “reducing the adverse consequences of drug abuse.”<sup>28</sup> In 2000, the UN adopted a position paper in which it recognized that “[d]rug abuse problems cannot be solved simply by criminal justice initiatives. A punitive approach may drive people most in need of prevention and care services underground.”<sup>29</sup> Harm reduction measures — such as prescription of opioids or opioid substitutes, programs ensuring access to sterile drug use equipment, and drug consumption facilities that provide less harmful methods of using drugs and access to other health services including drug dependence treatment — fall under the rubric of providing treatment, education, care and rehabilitation to people who use drugs and of facilitating their social reintegration. As such, they are permissible under the 1961 and 1971 UN conventions on drug control.

Third, the 1988 *Convention Against Illicit Traffic*, the primary focus of which is criminalizing trafficking (not the individual drug user), has often been incorrectly interpreted as requiring the full criminalization of any possession of a prohibited drug. Article 3(2) says that each state party to the Convention must make it a criminal offence under its domestic law to intentionally “possess, purchase or cultivate narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.” However, the obligation to impose criminal sanctions goes no further than the equivalent obligations in the 1961 and 1971 Conventions. The 1988 Convention only requires signatory states to

---

<sup>28</sup> General Assembly Resolution A/RES/S-20/4 (1998).

<sup>29</sup> UN, *Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System*, approved on behalf of the Administrative Committee on Coordination by the High-Level Committee of Programmes, 1<sup>st</sup> regular session of 2001, Vienna, 26-27 February 2001, E/CN.7/2002/CRP.5, 12 March 2002, p.12. At [www.cicad.oas.org/en/Resources/UNHIVaids.pdf](http://www.cicad.oas.org/en/Resources/UNHIVaids.pdf).

criminalize possession for personal consumption that is “contrary to the provisions” of the 1961 and 1971 Conventions. Thus, the flexibility found in the two earlier conventions is preserved. As noted above, those Conventions include a number of provisions that make it legally permissible to remove, at least to some degree, the criminalization of people who use or possess drugs — if, for example, decriminalization is in pursuit of “medical or scientific purposes” or forms part of practicable measures to provide care, treatment or support to people who use drugs. It is incorrect to interpret the 1988 Convention as requiring the complete criminalization, without exception, of possession of a drug for the purposes of personal consumption.

It is also incorrect to conclude that the 1988 Convention requires the imposition of prison sentences for possession for personal consumption. Article 3(4) says that, in the case of the offence of possession, purchase or cultivation for personal consumption, a state may provide for “measures for the treatment, education, aftercare, rehabilitation, or social reintegration” of the offender, “either as an alternative to conviction or punishment, or in addition to conviction or punishment.” Just as with the 1961 and 1971 Conventions, the 1988 Convention does not require criminal penalties such as incarceration or other harsh measures for those convicted of possession of controlled substances for personal consumption. States can adopt laws and policies that focus more on treating drug use and dependence as health issues, rather than imposing harsh criminal penalties.

Finally, it should be remembered that the 1961 and 1971 Conventions, although they require states to impose restrictions on the manufacture, export, import, distribution, use and possession of the controlled substances, also say that a state’s obligations under the conventions are “subject to its constitutional limitations.”<sup>30</sup> In the case of the 1988 Convention, the state’s obligation to criminalize personal possession, purchase or cultivation contrary to the 1961 and 1971 Conventions is explicitly stated to be “subject to its constitutional principles.”<sup>31</sup> Such constitutional principles usually include respect for and protection of human rights; in some countries, international legal obligations (such as human rights) are explicitly incorporated into domestic law by the constitution. Therefore, uniform measures and responses are not required; states have discretion to determine the policies they wish to adopt, in line with the constitutional principles reflected in their own domestic legislation, including respecting and protecting the human rights of people who use drugs.

---

<sup>30</sup> *Single Convention on Narcotic Drugs*, 1961, art. 36; *Convention on Psychotropic Substances*, 1971, art. 22.

<sup>31</sup> *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, art. 3(2).

## Human rights obligations

In enacting and implementing domestic legislation and policy, governments must also consider their obligations under international law to respect, protect and fulfill human rights. Under the *Charter of the United Nations*, all member states have a binding treaty obligation “to take joint and separate action” to achieve the purpose of the UN, including promoting “solutions of international ... health problems” and “universal respect for, and observance of, human rights and fundamental freedoms for all.”<sup>32</sup> The UN Charter also expressly states that, in the event of a conflict between a country’s obligations under the Charter and their obligations under any other international agreement, their obligations under the former prevail.<sup>33</sup> This means that countries cannot validly implement international drug control treaties in ways that contradict their obligations to solve health problems and respect human rights.

For more than fifty years, all UN member states have repeatedly reaffirmed and recognized their obligations under the *Universal Declaration of Human Rights*, which states that “everyone has the right to a standard of living adequate for health and well-being,” including “medical care and necessary social services.”<sup>34</sup> In 1993, at the World Conference on Human Rights, all participating states affirmed that the “protection and promotion” of human rights “is the first responsibility of Governments.”<sup>35</sup> The adoption and implementation of domestic legislation and policy on drug control need to reflect this stated priority. At the 1998 UN General Assembly Special Session on Drugs, UN member states declared that action against drugs requires “an integrated and balanced approach in full conformity with the purposes of the *Charter of the United Nations* and international law, and particularly with full respect for ... all human rights and fundamental freedoms.”<sup>36</sup>

States that are parties to the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) have recognized the right of every person to enjoy “the highest attainable standard of physical and mental health.”<sup>37</sup> The states also have a binding legal obligation to take steps to realize fully this right, including those steps “necessary for ... prevention, treatment and control of epidemic, endemic ... and other diseases” and “the

---

<sup>32</sup> *Charter of the United Nations*, UNTS 993 (entered into force 24 October 1945), art. 55, 56.

<sup>33</sup> *Charter of the United Nations*, art. 103.

<sup>34</sup> *Universal Declaration of Human Rights*, UN General Assembly, Resolution 217 A(III), UN GAOR, 3<sup>rd</sup> Session, 183<sup>rd</sup> plenary meeting, 71, UN Doc. A/910 (1948), art. 25.

<sup>35</sup> *Vienna Declaration and Programme of Action*, UN GAOR 1993, World Conference on Human Rights, 78<sup>th</sup> Session, 22<sup>nd</sup> plenary meeting, UN Doc. A/CONF157/23 (1993), part I, art. 1.

<sup>36</sup> UN General Assembly, Political Declaration, Resolution A/RES/S-20/2, UN GAOR, 20<sup>th</sup> Special Session, 9<sup>th</sup> plenary meeting, 10 June 1998.

<sup>37</sup> *International Covenant on Economic, Social and Cultural Rights* (ICESCR), UN General Assembly, 993 UNTS 3, 1966, art. 12.

creation of conditions which would assure to all medical services and medical attention in the event of sickness.”<sup>38</sup> The UN Committee on Economic, Social and Cultural Rights, the expert body charged with assessing states’ compliance with their obligations under the ICESCR, has explained that “the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”<sup>39</sup> In addition, the *International Covenant on Civil and Political Rights* (ICCPR) states that every person has the inherent right to life.<sup>40</sup> The Human Rights Committee, the expert body charged with addressing states’ compliance with their obligations under the ICCPR, has explained that this right “should not be interpreted narrowly” and that governments must adopt positive, proactive measures to protect human life, including measures that can help reduce the spread of epidemics.<sup>41</sup>

The spreading HIV epidemic, and the other harms encountered by people who use drugs in unsafe ways or conditions, highlight that governments have good public health reasons to ensure that their domestic legislation and policies on drug control do not contribute to these harms and do not impede health promotion efforts among people who use drugs. However, governments also have legal obligations to act. The implementation of various harm reduction measures is not only permissible under the international drug control treaties but is also consistent with — and arguably required by — states’ obligations under the international law of human rights. The UN’s position paper on *Preventing the Transmission of HIV Among Drug Abusers* explicitly notes that the *Universal Declaration of Human Rights* and human rights principles are part of the foundation for HIV prevention efforts in this field.<sup>42</sup> Drawing upon international human rights instruments, in 1998 the Office of the UN High Commissioner on Human Rights and UNAIDS produced *HIV/AIDS and Human Rights: International Guidelines*, which provide expert guidance to states on how to respond to HIV/AIDS through legislation, policies and practice that protect human rights and achieve public health goals. That guidance includes the basic recommendation that “[c]riminal law should not be an impediment to measures taken by States to reduce the risk of HIV transmission among injecting drug users and to provide HIV-related care and treatment for injecting drug

---

<sup>38</sup> ICESCR, art. 12.

<sup>39</sup> UN Committee on Economic, Social and Cultural Rights, The Right to the Highest Attainable Standard of Health, General Comment 14, UN Doc. E/C12/2000/4, 2000. Available via [www.ohchr.org/english/bodies/cescr/comments.htm](http://www.ohchr.org/english/bodies/cescr/comments.htm).

<sup>40</sup> *International Covenant on Civil and Political Rights* (ICCPR), UN General Assembly, 999 UNTS 171, 1966, art. 6.

<sup>41</sup> UN Human Rights Committee, The Right to Life (Art. 6), General comment 6, UN Doc. HRI/GEN/1/Rev.1, 6, 1982.

<sup>42</sup> UN, *Preventing the Transmission of HIV Among Drug Abusers: A Position Paper of the United Nations System*.

users.”<sup>43</sup> The Guidelines thus recommend that states should “review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations.”<sup>44</sup>

---

<sup>43</sup> Office of the High Commissioner for Human Rights (OHCHR), and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, 1998, Guideline 4, para. 29(d). Available via [www.ohchr.org/english/issues/hiv/guidelines.htm](http://www.ohchr.org/english/issues/hiv/guidelines.htm).

<sup>44</sup> OHCHR and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights*, Guideline 4.

# Model Statutory Provisions

## Chapter I. General Provisions

### Article 1. Purpose of this Part

The purpose of this Part is to:

- (a) decriminalize or depenalize the use and possession of controlled substances in a quantity for personal use;
- (b) decriminalize the use and possession of controlled substances for use in opioid substitution treatment;
- (c) provide a framework for processing controlled substances-related offences before a quasi-judicial commission; and
- (d) establish sentencing measures for those convicted of the use and possession of controlled substances in a quantity for personal use, as an alternative to incarceration, including non-compulsory measures to facilitate the treatment, education, after-care, rehabilitation and social integration of people who use controlled substances.<sup>45</sup>

### Article 2. Definitions

For the purposes of this Part, the following definitions are used:

“Administrative offence or penalty” means an offence or penalty that does not entail a criminal record.

“Controlled substance” means a substance included in the Schedules of the [applicable drug legislation].

“Decriminalization” means removing an offence from the criminal law and may, but need not, include establishing that offence as an administrative offence attracting administrative penalties.

“Depenalization” means ceasing to apply penalties, criminal or administrative, for certain offences. The offence may remain prohibited and arrests may still be made for commission of the offences, but no sanctions are applied.

---

<sup>45</sup> This language is consistent with the provisions of the 1961 and 1971 UN drug conventions that allow states to provide alternatives to conviction and punishment and that authorize states to implement measures aimed at these objectives. See *Single Convention on Narcotic Drugs*, 1961, art. 36, para. 1(b); and *Convention on Psychotropic Substances*, 1971, art. 22, para. 1(b).

“Dependence” means the criteria for dependence in the International Classification of Diseases (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria.<sup>46</sup>

“Drug dependence treatment” means a formalized program with specific medical or psychosocial techniques aimed at managing or reducing a client’s dependence on one or more controlled substances, thereby improving the general health of the client. Such measures may include opioid substitution treatment, residential or out-patient services, administration of medicines to reduce cravings or diminish the impact of using controlled substances, psychiatric and psychosocial support services and supervised support groups.

“Opioid substitute” means any drug approved by the [relevant drug regulatory authority] for medical use in opioid substitution treatment, including but not limited to methadone and buprenorphine.

“Opioid substitution treatment” means the administration of an approved opioid, pharmacologically related to the opioid that produced the original dependence, to people with such dependence, for achieving defined treatment aims.<sup>47</sup> This term includes maintenance treatment.

“Possession” means being in the actual possession or custody of a person, or being in any place (whether or not that place belongs to or is occupied by that person) for the use or benefit of that person or of another person.

“Use” means, in respect of a substance included in the Schedules of the [applicable drug legislation], to introduce a controlled substance into the body of a person, including smoking or inhaling fumes caused by heating or burning the substance.

**Note:** Schedule A, accompanying this Act, provides a list of controlled substances for which a quantity for personal use attracts an administrative penalty but no criminal penalty (pursuant to Article 4(a)) or (in the alternative) neither a criminal nor an administrative penalty (pursuant to Article 4(b)). Schedule A shall specify the quantities for personal use for each substance included in the Schedule, which shall serve as a guideline for determining whether the amount in question is for personal use.<sup>48</sup>

---

<sup>46</sup> The ICD-10 diagnostic guidelines can be found at [www.who.int/substance\\_abuse/terminology/definition1/en/](http://www.who.int/substance_abuse/terminology/definition1/en/). The DSM-IV definition is provided in *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, ed. 4.* (Washington DC: American Psychiatric Association, 1994). At <http://allpsych.com/disorders/substance/substancedependence.html>.

<sup>47</sup> Adapted from WHO/UNODC/UNAIDS, *Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004, p. 12. At [www.who.int/substance\\_abuse/publications/en/PositionPaper\\_English.pdf](http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf).

<sup>48</sup> Schedule A is a category which, for the purposes of the model law, would include a list of certain controlled substances and provide a guideline amount for “personal use” for each substance on the list. It therefore establishes a legal mechanism to distinguish between those who possess illegal drugs for their

## Chapter II. Status of Controlled Substances

### Article 3. Modification of list of controlled substances

Substances may be added to Schedule A accompanying this Act if the [relevant public health authority] determines it is advisable for a public health, medical or scientific purpose or is otherwise in the public interest.<sup>49</sup>

#### Commentary: Article 3

Schedule A provides a framework for the reclassification by the relevant public health authority of controlled substances for the purpose of decriminalization or depenalization. Possession and use of specified quantities of substances classified in Schedule A which are intended for personal use, may be deemed not to carry a criminal sanction in the case of decriminalization, and neither a criminal nor an administrative sanction in the case of depenalization. Criminalization complicates efforts to implement public health strategies and harm-reduction approaches to drug use by stigmatizing and marginalizing people who use drugs, decreasing their contact with health authorities and increasing health concerns associated with drug use, such as overdoses and the transmission of infections.<sup>50</sup> To be able to implement effective strategies for better reaching people who use drugs and enacting harm-reduction programs, public health authorities may add controlled substances to Schedule A if it is advisable for public health, medical or scientific purposes. This could include substances for medical and therapeutic use, as well as substances for which decriminalization or depenalization for offences related to personal use can reasonably be expected to reduce the public health effects of drug use.

### Article 4. Decriminalization and depenalization of controlled substances for personal use

[Two options for Article 4 are provided below (4a and 4b). One or the other should be selected, but not both.]

---

personal use and those who possess larger quantities for trafficking. Thus, the quantity possessed would provide a guideline (for prosecutors or judges) in determining whether the amount is for personal use.

<sup>49</sup> This language is derived from s. 56 of Canada's *Controlled Drugs and Substances Act*, 1996. This section states: "The Minister [of Health] may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest."

<sup>50</sup> See J. Godinho and J. Veen, "Illicit drug policies and their impact on the HIV epidemic in Europe," in WHO Europe, *HIV/AIDS in Europe: Moving from Death Sentence to Disease Management*, 2006.

## Option 1: Article 4(a). Decriminalization of controlled substances for personal use

Notwithstanding [relevant drug legislation], the use and possession of a controlled substance listed in Schedule A in a quantity for personal use shall not constitute a criminal offence under said legislation but shall constitute only an administrative offence.

### Commentary: Article 4(a)

In general terms, decriminalization involves removal of a conduct or activity from the sphere of criminal law. In the context of drug law and policy, decriminalization is the process by which a jurisdiction replaces certain criminal offences in its drug laws with administrative offences, or (alternatively) the abolition of all offences. The provision above is intended to remove certain activities from classification as criminal offences and deal with them through administrative measures.<sup>51</sup> Following the decriminalization of certain offences, the activities constituting the offences remain illegal; however, the sanctions applied are generally less punitive than incarceration.<sup>52</sup>

The association of criminal offences and penalties with drug use, particularly injection drug use, contributes significantly to the advance of HIV/AIDS epidemics in a number of countries. The incarceration associated with criminal offences and the stigmatization arising from criminality exacerbate the risk of HIV transmission through unsafe drug use and the risk of harm to people who use drugs and who are already living with HIV/AIDS. The existence of criminal penalties for drug possession or consumption may drive people who use drugs towards unsafe practices, including syringe sharing and injection in unsanitary environments. People who use drugs may shy away from health care facilities for fear of arrest, and thus fail to receive necessary education, testing and treatment relating to blood-borne illnesses. Similarly, health care providers may be reluctant to offer services to people who use drugs for fear of appearing to condone or promote drug use.<sup>53</sup> Persons who are incarcerated face further risk of exposure to HIV infection

---

<sup>51</sup> It should be noted, however, that in certain countries, administrative measures are included in a criminal record.

<sup>52</sup> Administrative sanctions can include fines, suspensions of government-issued licenses, such as driving licenses, and warnings. For instance, Portugal's *Law No. 30/2000* provides a number of alternatives to incarceration, including fines in accordance with the type and amount of drug possessed and the circumstances of the offences, as well as non-pecuniary penalties such as warnings, suspensions of professional and other licenses, prohibitions on attending certain locations, and travel restrictions (see art. 17). It should be noted that in some cases, administrative penalties have actually been harsher than criminal sanctions, so decriminalization and depenalization cannot always be seen as less punitive approaches. In this model law, however, the objective is to present options for less punitive approaches that are consistent with treating drug use and dependence as public health issues.

<sup>53</sup> See Canadian HIV/AIDS Legal Network, *Injection Drug Use and HIV/AIDS* (Fact Sheet), 2005. A discussion of the effects of stigmatization and marginalization of drug users and people living with HIV/AIDS in Eastern and Central Europe, and their connection with the HIV/AIDS epidemic, may be found in Drug Law and Health Policy Network, *Drug Policies = Death: HIV/AIDS in Central and Eastern Europe*.

through injection drug use while imprisoned, through a combination of high HIV rates in prisons and unsafe injection practices, such as syringe sharing.<sup>54</sup> Furthermore, prison conditions, especially those associated with overcrowding, greatly increase the risk of secondary infections, such as tuberculosis, for HIV-positive prisoners.

Decriminalization allows drug use and drug dependence to be treated as a public health concern rather than a criminal problem.<sup>55</sup> Decriminalization should result in the removal of criminal sanctions from activities such as acquisition and possession for personal use, and consumption of drugs.

Decriminalization requires the specification of quantities of illegal drugs for personal use in order to distinguish those quantities from larger-scale possession for the purposes of trafficking. Specification of these quantities is found in a variety of documents in countries that have already undertaken decriminalization, depending on the way in which controlled substances are categorized in those countries. Effective decriminalization requires defining quantities for personal use in a way that realistically reflect the nature of drug use.<sup>56</sup>

---

<sup>54</sup> Despite a prohibition on the possession and use of illegal drugs in prisons, the availability and consumption of drugs remains common in most prison systems. For a discussion of drug use and unsafe injection practices in prisons, and the successful experience of numerous countries in implementing access to sterile syringes in prisons, see Canadian HIV/AIDS Legal Network, *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*, 2<sup>nd</sup> ed, 2006. At [www.aidslaw.ca/Maincontent/issues/prisons/pnep/PNEP-report06.pdf](http://www.aidslaw.ca/Maincontent/issues/prisons/pnep/PNEP-report06.pdf).

<sup>55</sup> A 2004 report by the UN Office on Drugs and Crime (UNODC) recommends the primacy of a health care approach to HIV/AIDS over a criminal approach. “A comprehensive package of measures ... usually includes treatment instead of punishment for persons convicted of minor drug offences, since incarceration usually increases the risk of HIV transmission. The scientific evidence and the experience with such programmes strongly indicate that the above-described package is effective in reducing the risk of HIV transmission among injecting drug users and the risk of HIV diffusion from infected drug users to the general population.” See Commission on Narcotic Drugs, *Strengthening strategies regarding the prevention of HIV/AIDS in the context of drug abuse: Report of the Executive Director*, E/CN.7/2004/3, March 2004, p. 6.

<sup>56</sup> Decriminalization of possession of certain drugs for personal use has been achieved within many European countries through legislation specifically addressing offences related to personal use. For instance, see Italy’s Law No. 162 of 26 June 1990, s. 15(1), which provides that “[a]nyone who unlawfully imports, acquires or in any way possesses narcotic and psychotropic substances in doses no greater than the daily average requirement for personal use alone ... shall be liable to the administrative sanction ...” Similarly, as part of a drug strategy that uses a non-criminal tribunal to assess and administer penalties to people who use drugs, Portugal’s *Law No. 30/2000*, art. 2, declares that “the consumption, acquisition and possession for own consumption of plants, substances or preparations listed in the tables referred to in the preceding article constitute an administrative offence.” The article goes on to clarify that “the acquisition and possession for own use of the substances referred to in the preceding paragraph shall not exceed the quantity required for an average individual consumption during a period of ten days.” A study of E.U. drug legislation proposes a “classification of users on the one hand and traffickers on the other in order to highlight the necessary distinction which has to be made between social and public health policies to aid users and addicts and measures to combat drug trafficking”; see A Decourrière, *Legislation and Regulations on Drug Trafficking in the EU Member States*, February 2001, p. 67. At [http://ec.europa.eu/justice\\_home/doc\\_centre/drugs/studies/wai/doc\\_drugs\\_studies\\_en.htm](http://ec.europa.eu/justice_home/doc_centre/drugs/studies/wai/doc_drugs_studies_en.htm).

– OR –

## **Option 2: Article 4(b). Depenalization of controlled substances for personal use**

Notwithstanding [relevant drug legislation], the use and possession of a controlled substance listed in Schedule A in a quantity for personal use shall attract neither a criminal penalty nor an administrative penalty.

### **Commentary: Article 4(b)**

Depenalization refers to a situation in which legal prohibitions still exist for certain offences, but no sanctions (criminal or administrative) are applied. In the context of drugs and the people who use drugs, this means that prohibition on drugs and drug-related offences may still exist, but penalties are not applied for the acquisition, possession or use of small quantities of drugs intended for personal use. Depenalization provides the same benefits associated with decriminalization, facilitating reduction of the harm caused by drug use through increased access to safe use practices, education and health care, and avoidance of prison sentences for people who use drugs. Depenalization may further reduce the stigmatization attached to drug use and people who use drugs, and may further decrease public expenditures on sanctioning offenders who otherwise pose no risk to the community. Depenalization of small quantities of drugs may be achieved by legislation stating that possession or use of quantities of controlled substances for personal use shall not be penalized. It may also be achieved through non-legislative directives or guidelines directing law-enforcement or legal officials not to penalize offenders for minor drug-related offences.<sup>57</sup>

## **Article 5. Legalisation of opioid substances for opioid substitution treatment**

Notwithstanding [relevant drug legislation], the use, possession and distribution of an opioid substitute for medical or therapeutic use in opioid substitution treatment shall not constitute an offence.

### **Commentary: Article 5**

The legalization of opioid substances for use in opioid substitution treatment (OST) is necessary in order to treat drug dependence as a public health concern. OST is intended to reduce or eliminate the use of illegal opioids such as heroin by stabilizing people who are dependent on drugs for as long as is necessary to help them avoid harmful patterns of

---

<sup>57</sup> For instance, though the Netherlands' *Opium Act* prohibits the possession of any quantity of controlled substances, under the *Opium Act Directive* of 2 November 2000, issued by the Board of Procurators General, possession of less than 30g of cannabis product for personal use will usually result in police dismissal of any charges. According to the Directive, possession of a limited quantity of "hard" drugs will result in prosecution only where it would "support aid for users."

opioid use and associated risk behaviours such as syringe-sharing.<sup>58</sup> OST has been recognized by WHO as an effective, safe and cost-effective means of reducing opioid dependence and reducing related risks such as HIV/AIDS transmission.<sup>59</sup> There is consistent evidence from a large body of controlled trials and longitudinal studies that OST is one of the most effective forms of therapeutic treatment for opioid dependence.<sup>60</sup>

Methadone, the most common opioid used in OST, has been shown to be effective in hundreds of scientific studies to reduce drug-related harm without negative health consequences.<sup>61</sup> Both methadone and buprenorphine have been included on the WHO model list of essential medicines.<sup>62</sup> By providing a means of reducing or eliminating opioid injection, OST helps mitigate the spread of HIV/AIDS by reducing high-risk behaviour associated with opioid use, such as the sharing of needles or other equipment to inject heroin.

The legalization of opioid substances for medical and therapeutic use is therefore an important element in reducing the harm that opioid use and HIV/AIDS poses to individuals and communities. The use of opioid substances for therapeutic purposes is consistent with the 1961 *Single Convention on Narcotic Drugs* and the 1971 *Convention on Psychotropic Substances*. Both conventions permit the manufacture, transport, distribution, possession and use of controlled substances for medical, therapeutic and scientific purposes. Furthermore, the 1988 *Convention Against Illicit Traffic* does not prohibit states from allowing or providing access to OST medicines such as methadone and buprenorphine for medical purposes.

---

<sup>58</sup> M.C. Donoghoe, “Injecting Drug Use, Harm Reduction, and HIV/AIDS,” in WHO Europe, *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management*.

<sup>59</sup> WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*.

<sup>60</sup> WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, p. 18.

<sup>61</sup> M.C. Donoghoe, *Injecting Drug Use, Harm Reduction, and HIV/AIDS*, p. 49.

<sup>62</sup> WHO, *Model List of Essential Medicines*, revised March 2005. At [www.who.int/medicines/publications/essentialmedicines/en/](http://www.who.int/medicines/publications/essentialmedicines/en/).

## Chapter III. Alternatives to Criminal Prosecution and Penalties

### Article 6. Alternatives to criminal prosecution and penalties

[Two options for Article 6 are provided below (6a and 6b). One or the other should be selected, but not both.]

#### Option 1: Article 6(a). Referral to quasi-judicial commission

- (1) Notwithstanding the provisions of [relevant drug legislation], the possession and use of quantities of controlled substances listed in Schedule A for personal use shall not constitute a criminal offence.
- (2) The offences referred to in Section (1) shall be processed, and penalties applied if applicable and necessary, by a quasi-judicial commission (“the Commission”).
- (3) The Commission shall include a legal expert, as well as other experts such as medical practitioners, psychologists, social service workers or others with appropriate expertise in the field of drug dependence.
- (4) The rules of procedure governing the proceedings of the Commission, including the admissibility of medical evidence, shall be determined by the [relevant justice authority] and the [relevant health authority].
- (5) In arriving at the appropriate penalty for a person apprehended by police for the offences referred to in Section (1), the Commission shall consider:
  - (a) the seriousness of the act;
  - (b) the relative degree of fault;
  - (c) the type of substance involved in the offence;
  - (d) the public or private nature of the offence and, if relevant, the location of the offence;
  - (e) the personal circumstances, namely economic and financial, of the offender; and
  - (f) whether the offender is an occasional, habitual or dependent drug user.<sup>63</sup>
- (6) The Commission may apply penalties including, but not limited to, one or more of the following:

---

<sup>63</sup> These provisions are based on Portugal’s *Law No. 30/2000*, art. 15.4, which provides circumstantial factors for the Commissions for the Dissuasion of Drug Addiction to apply in arriving at sanctions for a person apprehended for drug-related offences. Technical aspects for implementing *Law No. 30/2000*, including procedural concerns, are supplemented by Portugal’s *Law No. 130-A/2001*.

- (a) a notice of caution;
  - (b) a fine in proportion to the amount of the controlled substance possessed for personal use, taking into account the economic situation of the alleged offender;
  - (c) restriction on travel or attendance in certain places; and
  - (d) suspension of driving or professional licences.<sup>64</sup>
- (7) The penalties applied by the Commission shall not include custodial penalties.
- (8) If the person apprehended for the offences referred to in Section (1) is found by the Commission to be dependent on a controlled substance, the Commission may order that the person attend a specified number of meetings with the provider of a drug dependence treatment program, the purposes of which shall be to ensure the person is aware of the program's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the program. The Commission may not compel the person to undergo drug dependence treatment.

### **Commentary: Article 6(a)**

This framework offers a means of assessing the offences of persons apprehended for drug offences and applying sanctions which respect the circumstances of the offence and the offender, including the nature of his or her use and dependence on drugs. The applicable sanctions are not criminal and do not entail findings of guilt or imposition of a criminal record; nor do they involve custodial penalties. They focus on deterrence of drug use through imposition of administrative sanctions proportionate to the offence and circumstances of the offender and seek to encourage drug dependence treatment where it is deemed necessary. The management and determination of the person's case by commissions consisting of legal, medical, health and social experts are consistent with approaching drug use as a health concern rather than a criminal concern. This approach is intended to reduce the harm associated with injection drug use, including HIV/AIDS, by keeping people who inject drugs out of prison.

This framework for diversion from criminal prosecution is loosely based on Portuguese law for drug-related offences involving quantities of controlled substances for personal use only.<sup>65</sup> Implementation of this framework is intended to be accomplished in conjunction with decriminalization or depenalization of the possession of controlled substances for personal use and consumption.<sup>66</sup> Preliminary studies on the effects of the Portuguese law have indicated a low level of repeat offences and a low level of non-compliance with treatment by offenders, as well as significant savings in court and prison

---

<sup>64</sup> These administrative penalties are based on those found in Portugal's *Law No. 30/2000*, art, 16, 17.

<sup>65</sup> See Portugal's *Law No. 30/2000*.

<sup>66</sup> Article 2.1 of Portugal's *Law No. 30/2000* states that acquisition, possession and use of quantities of drugs for personal consumption only shall constitute an administrative, not a criminal, offence, thereby decriminalizing those offences.

systems. Furthermore, this approach has not led to a significant increase in drug use in Portugal.<sup>67</sup>

– OR –

## Option 2: Article 6 (b). Non-custodial sentencing measures

(1) Notwithstanding the provisions of this or any other Act, where

- (a) a person is found guilty in a court of law of the offence of use or possession of a controlled substance contrary to [relevant drug legislation];
- (b) in the court's opinion, taking into account the quantity of the substance possessed and all other relevant circumstances of the case, the use or possession of a controlled substance was for the purpose of personal use; and
- (c) the applicable sentence would ordinarily include a custodial sentence;

a court shall, rather than imposing a custodial sentence, order one or more of the following:

- (a) direct that the person be discharged absolutely or on the conditions prescribed in a probation order;<sup>68</sup>

---

<sup>67</sup> Studies have stated that although not enough time and experience has been accumulated for a thorough evaluation, positive indications regarding the effectiveness of Commissions for the Dissuasion of Drug Addiction have been apparent, and the studies have recommended the continuation of the program; see Instituto da Droga e da Toxicodependência, *Avaliação da Estratégia Nacional de Luta Contra a Droga*, 2005. Portugal's *National Drug Strategy 2005-2012* continues to support decriminalization of possession and use of drugs for personal consumption and the role of Commissions for the Dissuasion of Drug Addiction in processing drug offences; see Instituto da Droga e da Toxicodependência, *Plano Nacional Contra a Droga e as Toxicodependências, 2005–2012*, IDT, 2006. In addition, an INCB assessment determined that the provisions of *Law 30/2000* remain consistent with obligations under international treaties and conventions; see INCB, *Report of the International Narcotics Control Board for 2004*, 2004, para. 538. At [www.incb.org/incb/en/annual\\_report\\_2004.html](http://www.incb.org/incb/en/annual_report_2004.html). See also L. Allen, M. Trace, and A. Klein, *Decriminalisation of drugs in Portugal: a current overview*, Briefing Paper, Beckley Foundation, 2004.

<sup>68</sup> Some of the language of this subsection comes from Canada's *Criminal Code*, s. 730. Under that legislation, a discharge means that the person is deemed not to have been convicted of the offence (despite the fact that the court has made a determination of the accused's guilt). The person does not acquire a criminal record, although there is a record of the court having ordered the discharge. In the case of a *conditional* discharge where a probation order is issued, if the person does not comply with the terms of that probation order, the court may revoke the discharge and instead convict the person and impose the sentence originally anticipated. In some cases, there may also be an additional penalty for the breach of the order. (This would also result in the person having a criminal conviction on his or her record.) Typically, a probation order includes conditions such as (1) keeping the peace and being of good behaviour; (2) appearing before the court when ordered to do so; and (3) notifying the court or probation officer of any change of name, address, employment or occupation; and may include further conditions, such as (4) reporting to a probation officer on a regular basis; (5) remaining within the court's jurisdiction; (6) not possessing a weapon; (7) performing community service; and (8) participating in a drug dependence treatment program (if the person agrees).

- (b) suspend the passing of sentence and direct that the person be released on the conditions prescribed in a probation order;<sup>69</sup>
  - (c) fine the person, if the court is satisfied that the person is able to pay the fine;<sup>70</sup>
  - (d) order that the person serve the sentence through community service, subject to the person's complying with the conditions of a conditional sentence order;<sup>71</sup>  
or
  - (e) make a supervised attendance order with the consent of the person requiring him or her to attend a place of supervision for such time as is specified in the order and, during that time, to carry out such instructions as may be given to him by the supervising officer within the lawful exercise of that officer's authority.<sup>72</sup>
- (2) As a term of a probation order or a conditional sentence order in Section (1), the court may order that the person attend a specified number of meetings with the provider of a drug dependence treatment program, the purposes of which shall be to ensure the person is aware of the program's services that may assist in overcoming drug dependence and to determine whether the person wishes to avail himself or herself of the services of the program. The court may not compel the person to undergo drug dependence treatment.
- (3) The court may make an order as described in Section (1) if the court considers it to be in the best interests of the accused and not contrary to the public interest,<sup>73</sup> having regard to the age and character of the offender, the nature of the offence and the circumstances surrounding its commission.<sup>74</sup> In making such a determination, the court shall consider the results of any clinical assessment that may have been made under Article 7 below.

---

<sup>69</sup> Some of the language of this and the previous subsection comes from Canada's *Criminal Code*, s. 731. Unlike a discharge, in the event of a suspended sentence, the person has been convicted (and therefore has a criminal record of that fact), but the court decides to suspend the imposition of the sentence that would normally be applicable and instead orders an alternative disposition. If the person breaches the terms of a probation order, the court could revoke the order and impose the sentence that would ordinarily have run if sentencing had not been suspended. See also Italy's *Law No. 162* of 26 June 1990, s.2 (1), on suspension of the enforcement of the detention order.

<sup>70</sup> Some of the language of this subsection comes from Canada's *Criminal Code*, s. 734.

<sup>71</sup> This wording is based on Canada's *Criminal Code*, s. 742.1.

<sup>72</sup> This wording is based on the U.K.'s *Law Reform (Miscellaneous Provisions) (Scotland) Act 1990*, s. 62.

<sup>73</sup> This wording is based on Canada's *Criminal Code*, s. 730.

<sup>74</sup> This wording is based on Canada's *Criminal Code*, s. 731.

## Article 7. Voluntary access to clinical assessment

- (1) If there is information that a person was dependent on a controlled substance when he or she committed an offence, or is dependent at the time of sentencing following a finding of guilt, the court may order an urgent clinical assessment by a qualified health professional to determine, to the extent possible, the nature of the substance(s) consumed by the person and his or her condition at both the time of the offence and the time of the examination.<sup>75</sup>
- (2) A copy of the clinical assessment shall be provided to the court, to the prosecutor and to the accused person, as well as to the service provider at any drug dependence treatment program the person attends pursuant to a court order.
- (3) A person always retains the right to refuse to participate in a clinical assessment, and no penalty of any kind shall be imposed for such refusal.

### Commentary: Articles 6(b) and 7

These articles on alternatives to custodial sentencing measures are intended as an alternative to the provisions decriminalizing or depenalizing use and possession of controlled substances in Schedule A for personal use, and to the provisions providing for referral of such offences to a quasi-judicial commission. In other words, if the choice is made that these activities will continue to be processed through the criminal justice system and attract criminal penalties, then alternatives should be available at the stage of imposing sentence that mitigate the severity of the criminal law and that are more open to protecting the health of the individual and public health in general.<sup>76</sup> The purpose of this legislation is to introduce judicial flexibility into sentencing for drug offenders. It includes several options for non-custodial sentencing that do not involve drug dependence treatment. This is consistent with the notion that treatment for drug dependence should be non-coercive.

The approach outlined establishes the court's authority to issue a wide variety of orders that, whatever conditions may be attached, are intended to keep out of prison a person who is convicted of a drug-related offence. One of these powers is to order a person convicted of a drug-related offence to meet with the provider of drug dependence treatment programs. This approach takes advantage of the person's contact with the criminal justice system to facilitate voluntary access to drug dependence treatment and other health services. International legal instruments provide support for treatment as an

---

<sup>75</sup> This wording is derived from Portugal's *Decree-Law No. 15/93*, ss. 52(1)–(2).

<sup>76</sup> See, for example, the Legal Working Party of the Intergovernmental Committee on AIDS [Australia], *Final Report*, 1992. Recommendation 8.5 states that "injecting drug users found guilty of minor drug offences should be kept out of the prison system; legislation should enshrine the principle of non-custodial sentences for relevant offences, and remove any mandatory sentences for minor offences." For more information on developing alternatives to prison in developing countries, see: V. Stern (ed), *Alternatives to Prison in Developing Countries* (London: International Centre for Prison Studies, King's College, University of London, 1999).

alternative to sentencing. The 1961 *Single Convention on Narcotic Drugs* provides that “as an alternative to conviction or punishment ... such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration.”<sup>77</sup>

---

<sup>77</sup> *Single Convention on Narcotic Drugs*, 1961, art.36.1(b). Similar provisions are found in the *Convention on Psychotropic Substances*, 1971, art. 22.1(b), and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 1988, art. 3.4(c).

## Annex: Drug Treatment Courts

Measures associated with the provisions of this module, particularly those concerning alternatives to sentencing measures, are intended to be implemented within the normal court system, and do not recommend or propose the implementation of drug treatment courts. Drug treatment courts were first developed in the early 1990s in the United States, and have also been implemented in Canada, Australia and the United Kingdom. While there is a wide variety of models for drug treatment courts, the defining characteristic is court-imposed drug dependence treatment as a part of sentencing.<sup>78</sup> Drug treatment courts employ the weight of the criminal justice system to order people who use drugs to undergo treatment.

Though drug treatment courts attempt to reduce harm to those accused of non-violent drug-related offences by diverting them from the penal system and assisting in rehabilitation, the fact that participants enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the human and legal rights of the offender. These implications include possible violations of the right to due process and the principle of presumption of innocence.<sup>79</sup> The U.S. and Australian drug court models confer broad authority upon judges to penalize drug offenders for breaching treatment conditions, which could result in incarceration. Thus, “drug court participants who fail to remain drug-free (which is not uncommon among drug-addicted individuals) may be incarcerated on the original charge without trial.”<sup>80</sup> There is also the fear that in some cases, the drug court participant may not have gone to jail if he or she had been prosecuted through the regular system, given that many first-time and lesser charges do not result in incarceration.<sup>81</sup> Furthermore, drug courts occasionally impose a greater sentence on the offender than the regular sentence would have been, leading to violations of due process.<sup>82</sup>

The right to due process may also be infringed by the diminished adversarial aspect characteristic of drug treatment courts. Drug treatment court judges and counsel are often

---

<sup>78</sup> L. Harrison and F. Scarpitti, “Progress and issues in drug treatment courts,” *Substance Use & Misuse* 37(12–13) (2002): 1441–1467.

<sup>79</sup> Article 14(1) of the ICCPR states that “[i]n the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law ....” See, also, *European Convention on Human Rights and Fundamental Freedoms*, art. 6.

<sup>80</sup> King County Bar Association Drug Policy Project, *Report of the Task Force on the Use of Criminal Sanctions*, October 2001, p. 43. Available via [www.kcba.org](http://www.kcba.org).

<sup>81</sup> K.M. Blankenship and A. Smoyer, *Drug Policy: Definition, Discussion & State Variation*, Yale University Center for Interdisciplinary Research on AIDS, Policy Update, 2004, p. 8.

<sup>82</sup> T. Makkai, “Drugs courts: issues and prospects,” *Trends and Issues in Crime and Criminal Justice* 95 (1998): 7. See, also, Kim M. Blankenship and A. Smoyer, *Drug Policy: Definition, Discussion & State Variation*, p. 8.

more oriented towards ensuring the offender undergoes treatment, and less emphasis may be placed on the truth-finding aspect of court procedure.<sup>83</sup> As a result, those accused in drug treatment courts often must “forgo those fundamental principles and safeguards of justice meant for their own protection.”<sup>84</sup>

A further concern is that persons accused of drug offences may enter treatment programs simply to avoid incarceration. (This could include some persons who are not drug-dependent, raising questions about the ethics of treatment that is not medically indicated.) In such circumstances, the decision by the accused to undergo treatment may not represent a genuine choice made with fully informed consent. Evidence has demonstrated that persons entering drug treatment programs without informed, voluntary consent may not benefit from the program and may be less likely to succeed, leaving them vulnerable to custodial penalties.<sup>85</sup> As the freedom of choice between incarceration and drug treatment may be elusive, the possibility of entering a treatment program under the threat of incarceration may also violate the right to security of the person and the prohibition on cruel, inhuman and degrading punishment and treatment found in a number of international instruments.<sup>86</sup>

These human rights concerns reveal the limitations of addressing the needs of people who use drugs through the imposition of drug dependence treatment by courts. Drug treatment courts “do not resolve the underlying problems created by a system that attempts to address drug use as a criminal justice matter rather than as a public health matter.”<sup>87</sup> Drug treatment courts have not demonstrated any advantage over the regular system for prosecuting and penalizing people who use drugs, whether with respect to a significant reduction in recidivism by offenders sentenced to treatment or with respect to other concerns such as cost-effectiveness.<sup>88</sup> Drug courts raise substantial concerns regarding possible infringements of human rights.

---

<sup>83</sup> B. Fischer, “‘Doing good with a vengeance’: a critical assessment of the practices, effects and implications of drug treatment courts in North America,” *Criminal Justice* 3(3) (2003): 227–248 p. 239.

<sup>84</sup> B. Fischer, “‘Doing good with a vengeance’: a critical assessment of the practices, effects and implications of drug treatment courts in North America,” at 240.

<sup>85</sup> See D. James and E. Sawka, “Drug treatment courts: substance abuse intervention within the justice system,” *Isuma* 3(1) (2002). See, also, C. Kirkby, “Drug treatment courts in Canada: who benefits?,” in John Howard Society, *Perspectives on Canadian Drug Policy* Vol. 2, 2004, p. 63.

<sup>86</sup> Article 9.1 of the ICCPR and Article 5.1 of the *European Convention on Human Rights and Fundamental Freedoms* guarantee security of the person. Prohibitions on cruel, inhuman and degrading punishment and treatment are found in Article 7 of the ICCPR and Article 5 of the *Universal Declaration of Human Rights*. Note that Article 7 of the ICCPR also contains a prohibition on medical or scientific experimentation without consent. In some cases, novel drug treatment programs assigned in drug courts may implicate this clause.

<sup>87</sup> King County Bar Association Drug Policy Project, *Report of the Task Force on the Use of Criminal Sanctions*, pp. 40–41.

<sup>88</sup> Though preliminary evaluations, such as that conducted on the drug treatment court program in Vancouver, Canada, indicate moderate trends towards reduced recidivism rates for those that have actually

## Selected Resources

*This section provides a list of resources that the Legal Network considers to be particularly relevant.*

### Articles, reports and policy documents

Allen, L., M. Trace and A. Klein. *Decriminalisation of drugs in Portugal: a current overview*. Briefing Paper. The Beckley Foundation, 2004. At [www.internationaldrugpolicy.net/reports/BeckleyFoundation\\_BriefingPaper\\_06.pdf](http://www.internationaldrugpolicy.net/reports/BeckleyFoundation_BriefingPaper_06.pdf).

British Institute of International and Comparative Law. *Draft fourth framework convention on risk management*. 2003. At [www.senliscouncil.net/documents/BIICL\\_HR\\_Framework#search=%22Draft%20fourth%20framework%20convention%22](http://www.senliscouncil.net/documents/BIICL_HR_Framework#search=%22Draft%20fourth%20framework%20convention%22).

Christie T, and J.F. Anderson. “Drug treatment courts are popular but do they work and are they ethical and appropriate for Canada?” *Health Law in Canada* 23(4) (2003): 70–79.

Council of the European Union. *Recommendation on the prevention and reduction of health-related harm associated with drug dependence* of 18 June 2003. 2003/488/EC.

European Monitoring Centre for Drugs and Drug Addiction. *Illicit Drug use in the EU: Legislative Approaches*. EMCDDA, 2005. At <http://eldd.emcdda.europa.eu/?nnodeid=5175>.

European Monitoring Centre for Drugs and Drug Addictions, Legal Database on Drugs. *The role of the quantity in the prosecution of drug offences*. ELDD Comparative Study, 2003. At <http://eldd.emcdda.europa.eu/?nnodeid=5175>.

European Parliament. *Recommendation to the Council and the European Council on the EU drugs strategy (2005-2012)*. A6-0067/2004, 15 December 2004.

---

completed mandated treatment programs, these evaluations tend to be hampered by methodological inadequacies which obscure drawing conclusions about the success of drug treatment courts. See B. Fischer, “‘Doing good with a vengeance’: a critical assessment of the practices, effects and implications of drug treatment courts in North America,” p. 231. For an evaluation report on the Vancouver drug treatment court, see Orbis Partners, *Drug Treatment Court of Vancouver Program Evaluation, Second Outcome Report*, April 2005. Other justifications for drug treatment courts, such as cost effectiveness, are difficult to measure and demonstrate. Given that many offenders sentenced in drug treatment courts return to the criminal court system for failures to fulfill their treatment obligations, the savings allegedly achieved by drug treatment courts by diverting offenders from the criminal justice system may not be significant. See C. Kirkby, “Drug Treatment Courts in Canada: Who Benefits?,” p. 66.

Fischer, B. “‘Doing good with a vengeance’: a critical assessment of the practices, effects and implications of drug treatment courts in North America.” *Criminal Justice* 3(3) (2003): 227–248.

Godinho, J and J. Veen. “Illicit drug policies and their impact on the HIV epidemic in Europe.” In WHO Europe, *HIV/AIDS in Europe: Moving from Death Sentence to Chronic Disease Management*, 2006. At [www.euro.who.int/InformationSources/Publications/Catalogue/20051123\\_2](http://www.euro.who.int/InformationSources/Publications/Catalogue/20051123_2).

OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights*, 1998.

OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights: Revised Guideline 6 — Access to Prevention, Treatment, Care and Support*, 2002. At [www.ohchr.org/english/about/publications/docs/g6.pdf](http://www.ohchr.org/english/about/publications/docs/g6.pdf).

UNAIDS. *Handbook for Legislators on HIV/AIDS, Law and Human Rights*, 1999. At [www.ipu.org/PDF/publications/aids\\_en.pdf](http://www.ipu.org/PDF/publications/aids_en.pdf).

WHO/UNODC/UNAIDS. *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004. Available via [www.who.int/substance\\_abuse/publications](http://www.who.int/substance_abuse/publications).

WHO. *Model List of Essential Medicines*, revised March 2005. At [www.who.int/medicines/publications/essentialmedicines/en/](http://www.who.int/medicines/publications/essentialmedicines/en/).

## Legal documents

*Criminal Code*, R.S., 1985, c. C-46, ss. 730 to 742.1. [Canada].

*Law No. 30/2000* of 29 November 2000 [Portugal].

*Opium Act Directive*, Public Prosecutor’s Offices, entered into force 1 January 2000 [Netherlands].





Canadian  
HIV/AIDS  
Legal  
Network | Réseau  
juridique  
canadien  
VIH/sida

**Canadian HIV/AIDS Legal Network**  
**1240 Bay Street, Suite 600**  
**Toronto, Ontario**  
**Canada M5R 2A7**  
**Telephone: +1 416 595-1666**  
**Fax: +1 416 595-0094**  
**E-mail: [info@aidslaw.ca](mailto:info@aidslaw.ca)**  
**[www.aidslaw.ca](http://www.aidslaw.ca)**