INFORMAL DRUG POLICY DIALOGUE

An initiative of the
Andreas Papandreou Foundation (APF)
and the Transnational Institute (TNI)

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The seventh meeting of the Informal Drug Policy Dialogue (IDPD) series, a joint initiative of the Andreas Papandreou Foundation and the Transnational Institute, took place from 10-12 December in Amsterdam, The Netherlands. The dialogue was co-hosted by the Ministry of Public Health, Welfare and Sports and the Ministry of Foreign Affairs of the Netherlands. Previous meetings have been held in Budapest, Bern , Rome, Berlin, and twice in Kolymbari-Chania, on the island of Crete. Similar dialogue events have also been held in Latin American and Asia since 2007. The organizers of the Amsterdam meeting, especially Thanasis Apostolou, Martin Jelsma and Ernestien Jensema, deserve many thanks.

In order to ensure confidentiality and while providing an open-minded exchange of opinions and experiences among policy officials and non-governmental experts in the field, the meeting was held, as per IDPD tradition, under Chatham House rule that stipulates anonymity. Over 40 people attended the Amsterdam meeting based on personal invitation, with approximately half policy makers and half representatives of non-governmental organizations or academic institutions. The two-day dialogue focused on several themes: law enforcement, human rights and proportionality of sentences; the classification of controlled substances; current developments of the Dutch drugs policy; and various UN-level drug policy developments and preparations for the upcoming CND. Each theme was introduced with remarks from key participants, followed by dialogue and discussion with all. This summary report conveys the highlights of the discussion, although no individuals are quoted, in keeping with the anonymity stipulated by the Chatham House rule. The ideas expressed were those of individuals in their capacity as experts in the field of international drug control, and should not be interpreted as reflecting consensus among the group, or endorsement by the organizers.

Session I – Friday, 11 December, 2009 (a.m.)

Law enforcement, human rights and proportionality of sentences for drug offences

This year, the EMCDDA for the first time presented an overview of the sentences that drug law offenders receive across the European Union[1], providing a more accurate picture of the implementation of EU countries' drug laws and policies, than just looking at the legislation itself. In Australia, Canada and several States in the USA practices of less punitive approaches have been introduced and recently several proposals of legislative reform are discussed in Latin America. There is evidence that these practices do not lead to increased drug use, but does significantly lower pressure on law enforcement agencies and on judicial and penitentiary systems, and it removes barriers for users with problematic patterns of use to approach treatment and harm reduction services.
This session addressed some of the following questions: Did the Council framework decision of 2004 that intended to harmonise sentencing levels in the EU have any effect?[2] What are the possibilities for drug law reform and harmonisation of sentences in the EU? In Latin America several countries (Brazil, Ecuador, Argentina) are considering lowering sentencing levels for small trafficking offences, what are the proposals under consideration and their chances of success? Is there any prospect at all for similar drug law reform in Southeast Asia in the future, being another region with disproportionally high sentencing levels for minor drug offences?

European Union

The enforcement of drug laws and the punishments meted for drug crimes in Europe was the subject of a selected issue report by the EMCDDA, "Drug Offences: Sentencing and Other Outcomes," published in November 2009. The report reveals considerable variation across EU member states in the kinds and quantities of drug crime offences and consequent penalties. Some of the usual caveats apply with regard to methodological challenges in making transnational comparisons—such as incommensurate language, statistical units or counting methods—and in making direct links between offence statistics and sentencing statistics. Furthermore, the EMCDDA sentencing report is a snapshot, not longitudinal, so trends are difficult to identify. Nevertheless, the report does provide a comprehensive analysis of recent European statistics on drug law offences, from personal possession to large-scale trafficking, and their outcomes.

The most common penalties for possession of illegal drugs for personal use in European countries are warnings, fines, and suspended sentences (or discontinuance of proceedings). The trend for this type of drug crime seems to be moving away from prosecution for personal use. However, countries such as the Netherlands, in which trafficking offences outnumber possession offences, are still the exception rather than the rule. In some countries the difference between drug user and drug trafficker can be blurred, especially when an arbitrary threshold quantity is the sole indicator for distinction. Even among countries where exceeding threshold quantities triggers trafficking charges, there is a lack of uniformity in threshold amounts. Where more liberal policy approaches to possession for personal use are established, there may also be an unanticipated and countervailing net-widening effect (e.g. a caution system may encourage police to intervene with more users, whom they might have otherwise have left alone).

More data are needed on why some people who use drugs are still incarcerated, including how approaches other than arrest may better help chronic users (e.g. establishing relationships).

[1] http://www.emcdda.europa.eu/publications/selected-issues/sentencing-statistics
[2] Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking.

Prison sentences are more commonly levied on those convicted of supply offences, although sometimes these may be suspended or relatively short sentences. A 2004 EU Council Framework Decision established minimum provisions of criminal acts and penalties for illegal drug trafficking, which subsequently prompted a number of member states to increase trafficking penalties; however, the Council Framework Decision did not speak to penalties for possession. Maximum possible sentences are almost never applied for trafficking, although sentencing policies in Europe (for trafficking) have increased. This may be a result of the judiciary signalling that relatively few "kingpins," or criminals higher up the supply chain, are being caught (or that fewer are located in Europe); in other words, for every Mr. Big there are likely many more Mr. Mediocres in European prisons.

Countries grappling with the issue of sentencing and reforms are trying to find solutions within the parameters of compliance to UN conventions. The EU can be considered "an emerging zone of pragmatism" with respect to criminal justice. Although one of the core objectives of incarceration is deterrence, it is difficult to detect a relationship between incarceration and reduction of participation in illegal drug markets. Evidence from the United States shows that risk of punishment makes relatively little difference to the prevalence of cannabis use; rather, fashion and popular culture seem to be the biggest influences. Likewise, neither street-level nor high-level dealers seem particularly deterred from the opportunity to make enormous profits by the risk of arrest or imprisonment. There is some evidence that prices for illegal drugs may be marginally higher because of enforcement; however, the long-term trend is a decrease for both wholesale and retail prices. Despite rhetoric among policy-makers who champion "evidence-based" policies, political factors may continue to drive policing and sentencing trends. If so, there may be an increasing "convergence" between potential and actual penalties.

The European Union is often unrealistically expected to achieve policy results in the region, even though on issues such as drug control member states generally deal with problems and solutions as national concerns. Legislation is a relatively ineffective tool at the EU level, as it is not legally binding for the European Court (although that may change with the Lisbon treaty, when all EU legal tools become binding). Nevertheless, decisions such as the Council Framework Decision can helpful to coordinate efforts at a transnational level. The Decision was developed to ensure consistency in drug control legislation across Europe, so it is not easier to be a criminal in one part of the EU than another and so those who do commit drug trafficking offences are punished equivalently everywhere. However, it is also important to note that the Council Framework Decision was intended to apply to legislation, not sentencing. The Decision also suggested that judicial systems need to consider health harms, but the recent EMCDDA report suggests that not much has changed.

The issue of establishing threshold quantities of drugs in order to distinguish between possession for personal use and possession for purposes of trafficking is a significant problem for legislative convergence or harmonization in the EU. International consensus is that there is a difference between consumers and dealers, and quantity is one way to distinguish. However, countries that have decriminalized the possession of small amounts of drugs for personal use often set thresholds that are quite low, so people caught with small amounts above the threshold are given with grossly disproportionate penalties. Such thresholds often do not allow for discretion or mitigating factors, and when the realities of drug law enforcement are taken into consideration (i.e. it is generally much easier for police to apprehend a drug user than a drug dealer), there should be concern that many users end up with long trafficking sentences. Compounding this is the fact that some drug users also engage in small-scale trafficking to support their own habit; however, in order to distinguish between these offences, a subjective judgment is required. We must also keep in mind that people with

addictions are often jailed not for their drug use *per se*, but for other petty crimes they may have committed.

Issues with thresholds have become apparent in several European countries, which may provide some helpful lessons. For example, in Portugal police have changed the way they interact with and interrogate drug users. Prior to decriminalization earlier in the decade, Portuguese police would pressure users into giving information about other users or traffickers; now they have better cooperative intelligence methods. This is one of the reasons that some police officers who were originally opposed to the change to decriminalization are now enthusiastic supporters. In the Czech Republic, the government is currently in the process of revising drug policy that will set threshold amounts of drugs deemed to be for personal use.[3] Italy in 1990 introduced quantities to distinguish users from dealers; however, popular referendum in 1993 resulted in the rejection of quantities, which gave more leeway to police and prosecutors. In 2007, the government re-established threshold quantities, and there is now an increase of small-time users/suppliers punished for trafficking.

Eastern Europe

Post-Soviet countries have a lag in policy in relation to Western Europe, and government decision-makers usually want arguments or evidence from EU countries. This is certainly the case for drug policies, including thresholds for personal use. However, currently only a few EU countries have thresholds (e.g. Portugal), and among these there are competing definitional issues for "single" or "daily" doses. Threshold quantities in post-Soviet states are typically very low, especially for injectable drugs, although they were recently raised in Russia and Kyrgyzstan. In Ukraine, 5 grams is the current threshold for cannabis possession, but it is hard to argue for a higher amount when the Netherlands uses the same quantity in its coffee-shop policies. Polish judges in the past used discretion and professional knowledge to decide penalties (although there were criticisms when instances came to light of some judges ruling that up to a kilogram of cocaine was for personal use). In 2000, discretion was abandoned for mandatory minimums, so now any drug possession offence is penalized by one to three years in prison. Every year in Poland 20,000 people are incarcerated for drug offences (although many will avoid prison through parole processes). Poland has its own standards (lower than EU) on correctional and health programs/policies for drug crimes. Reformers are currently seeking the establishment of an expert panel to advise judges and prosecutors as to whether circumstances (e.g. quantities seized) warrant personal possession or trafficking charges.

In Romania, the criminal justice consequences of illegal drug use are influenced by health policy responses to addiction. The populations of people who use illegal drugs in Romania expanded as a socio-economic consequence of illegal drugs becoming much more widely available following communist rule. Romania has a robust heroin problem, but also an explosion of injection ketamine use. In the early 1990s, very few treatment services or professionals were available in Romania; however, as professionalism in demand reduction has improved, practitioners are better able both to understand and explain drug use trends in that country and to inform policy-making. One of the challenges in developing a coherent response to drugs in Romania is that over the past decade or so, health professionals have been trained by Dutch clinicians, but law enforcement have been trained by US police.

[3] The new Czech rules allow a person to possess up to 15 grams of cannabis, 4 pills of ecstasy, 1 gram of cocaine, 1.5 grams of heroin, or 2 grams of methamphetamine without facing criminal charges. It also allows the cultivation of up to 5 cannabis or coca plants or 40 psilocybin mushrooms. Mescaline-containing cacti, such as peyote or San Pedro, were exempted from the threshold scheduling after lobbying by a Czech cactus-growers association whose members already cultivated in quantities exceeding the five-plant threshold.

Drug users in Romania who come into contact with the criminal justice system (approximately 8% of Romanian prisoners report having used heroin at least once in their lives) have high recidivism rates and their drug problems tend to get worse following release. As in many countries, prisons in Romania function as *de facto* criminality schools, where drug users may be engaged in organized gangs or other types of criminal networks and activity. Following release from prison, drug users with criminal records face considerable challenges in finding legal employment, further increasing the likelihood of a return to crime. The fear that drug-dependent Romanians have of authorities adds another barrier to ensuring that health and other support service workers reach clients. Romanian drug users—at least those who have been in contact with addiction treatment system—are generally a highly mobile population (more than 50% have travelled to other countries, especially EU countries). However, only a small percentage of those who travel abroad continue their treatment while outside Romania.

There is some urgency for the Romanian state to deal with people who use illegal drugs in a way that is more effective in improving health and reducing crime and disorder. The emphasis that the government currently puts on punitive approaches to drug offences is likely to increase further the vulnerability of injection drug users to HIV/AIDS and hepatitis C. Romanian officials need to be advised or otherwise made better aware of the effects of their criminal justice policies on other EU countries, as these diseases can easily move geographically through transient populations. Likewise, they can learn from taking note of HIV rates in neighbouring countries with punitive approaches to drug use that do not have adequate substance dependence treatment services. Romania cannot afford to wait to develop drug policy expertise: more immediate action is needed in developing policies and programs to reduce health and crime problems.

In the United Kingdom, deterrence is often cited as the primary reason for sentencing (despite lack of evidence that it has much effect). As courts often do not often consider personal mitigating factors, the UK has disproportionate sentencing. In 2005, there was considerable debate on thresholds for drug use vs. trafficking. Populist legislation to "get tough on drugs" had been proposed without much debate on what quantities should be used as thresholds. The proposed legislation subsequently went to public consultation, which was criticized by professionals in the drug field; some suggested a "social supply" category for people who trafficked in small quantities among friends. Ultimately, the difficulties and controversies on how to establish thresholds meant the legislation was never enacted. A new sentencing model proposed by a UK justice policy think tank may have unintended consequence of increasing penalties for internal-smuggling importers.

Other Regions

In the Americas, the influence of the US criminal justice model of drug control has resulted in mandatory minimum sentences and low thresholds for trafficking in many countries. However, judges need discretion beyond quantities to determine the degree of trafficking (as is the case Mexico) or how someone should be punished. Thresholds are also problematic because they do not necessarily reflect the hierarchy or value in a criminal organization (e.g. a truck driver may be a mule transporting a huge quantity of drugs, but have little power, influence or reward in the criminal organization he works for). Ecuador is an example of a country that is considering the overhaul of sentencing for both drug users and mules, as the government realized that a lot of small-scale mules (especially women) are engaged in trafficking due to poverty. In the United States, police arrest quotas and work plans are often used as measures of police success, so policing practice reform in that country is as urgent as

sentencing reform. Furthermore, large-scale traffickers, or "big fish," can afford to hire talented lawyers who often succeed in getting acquittals.

Another key issue with threshold quantities is where the burden of proof rests. If the burden of proof is reversed with higher quantities of drugs, it becomes more challenging to achieve justice. The burden of proof must remain on the prosecution to show that, regardless of whether the quantity is above threshold, it was indeed intended for trafficking. However, it was also noted that there is a distinction between legal versus evidentiary burdens of proof in British jurisprudence (as well as in the EU Human Rights Convention). If the burden of proof is established by a claim of possession by a user, then it can still be compliant with human rights. For this reason, some users may support thresholds, as they can feel safer if they know that they possess below the established legal threshold for trafficking.

A more critical perspective on thresholds and sentencing requires asking what governments are hoping achieve through sentencing policies (i.e. are they trying to send a message of deterrence to general population, or actually to reduce crime rates?) and who benefits from more punitive policies. It was noted that public health responses to drugs and drug use are supported by evidence, whereas the same cannot be said of criminal justice responses. Criminal justice policy-makers need to be encouraged to use all available evidence (including long-term outcomes) in developing policies and programs.

It was suggested that increasing the accessibility or uptake of treatment may be a better advocacy position for organization such as EMCDDA to take, rather than drug law, criminal justice, or sentencing policy changes, which are harder to achieve. Treatment for substance dependence (which the WHO recognizes as a disease) has been demonstrated to reduce criminality more effectively than incarceration. The question was raised of how treatment for addictions has been promoted through various treaties and by rapporteurs. In some countries there may be either incentives or barriers to treating addiction as a disease (e.g. treatment costs may be borne by the state) and there may be some human rights disadvantages to treating people who use drugs as having disabilities.

Brazil

The Brazilian drug law of 1976, passed after illicit drug use had become a salient political issue, made only two distinctions for people caught with drugs: user and trafficker. Constitutional reform in 1988 gave judges the power to decide who was a trafficker and who was a user, but inequalities based on racial and class divisions were apparent. In 2006, legislative reform depenalized possession for personal consumption—it was still a crime, but no form of penalty was attached. The 2006 reform also clarified in law the Brazilian government's support for harm reduction, which had been adopted as a response to the spread of HIV/AIDS. At the same time, mandatory minimum prison for trafficking was raised from 5 to 15 years for high-level dealers, and a new intermediate category was established: first-time offender and/or trafficking without gang connection or other compounding factors such as use of weapon. The typical penalty for this new intermediate category is one year in prison, and judges do not have the authority to convert or suspend penalties for convictions. A further complicating factor is that people arrested with drugs must wait in prison for the judgment (i.e. no bail pending trial).

The effects of Brazil's 2006 legislative reform have begun to be studied. Although the Brazilian public believes that they now have "soft" drug laws, there has been a large increase of people in jail for drug crimes (40% over 3 years; 70% of these are in the new intermediary category). These legal changes mean that people without previous connections to organized

crime are being incarcerated in penal institutions that are completely controlled by organized crime groups and essentially amount to recruiting centres for gangs. After release, the ex-convict has few job prospects, but many new gang contacts and affiliations. Furthermore, racial disparities in the application of criminal law have not changed with the new legislation (rich whites are usually convicted as users, whereas poor non-whites are usually convicted as traffickers). Husbands and boyfriends may persuade women to attempt to smuggle drugs into prisons, but if they caught, they too end up imprisoned.

Brazilian authorities have decided to focus police efforts on organized crime groups, which have been gaining power, money and influence in the country. A new organized crime bill has been proposed, to give police greater investigative powers and increased intelligence capacity. Its intent is to focus enforcement on higher-level dealers, rather than the intermediate ones being caught through the 2006 legal change. At same time, some are seeking to give judges more discretion for new intermediate category of dealer.

With the awarding of the 2016 Winter Olympic and Paralympic Games to Rio de Janeiro, there are opportunities for Brazil to consider the role of public events on human rights and to deal with drug issues in an integrated way. Security is clearly a major concern for a large international event like the Olympics, but in Brazil public security is a state, rather than federal, jurisdiction. One innovative approach to systemic change in the security apparatus of the state is to offer substantially increased salaries for police officers who complete a new training program that is informed by human rights and public health concerns. This example suggests that Brazil may be acknowledging the harms of prohibition and that changing enforcement policies and practices is a necessary reform. Brazil has also established a commission to inform policies relating to the religious and ceremonial use of ayahuasca, a brew made from indigenous Amazonian plants, one of which contains the controlled substance dimethyltryptamine.

In the Latin American region more generally, public opinion is still very conservative; demands for changes in drug policies are coming not so much from public, but rather from government agencies. For example, recent changes in Argentina have come through the judiciary, when the Supreme Court ruled that it is unconstitutional to criminalize drug consumption. Likewise, Ecuador is reforming its criminal code with a more liberal approach towards many criminal justice matters, including drugs. In 2009, Ecuadorian President Correa made a pardon for small-time dealers, such as mules. In Mexico, although the government is militarizing the drug war, new legislation has decriminalized and established threshold quantities for personal consumption. Colombia has also made some legislative changes with respect to consumers. Most notable in the region is the Bolivian government's attempt to garner respect for traditional coca chewing practices, by trying to separate cocaine production and trafficking from coca cultivation and personal use.

Southeast Asia

Drug policies in Southeast Asia are a function of its unique historical and cultural situation. There has been considerable Western influence on governmental structures in the region, but not always a readily corresponding fit between local norms and more modern principles: collective rights have traditional precedence over individual human rights. Therefore, government programs may emphasize community empowerment over protection of individual human rights (for example, communities may be offered financial or other incentives to be "drug free"). Compulsory treatment is common in many Asian countries, as it is believed that authoritarianism is effective and that government toughness can create behaviour change. Most national drug policies in Southeast Asia follow a ruling elite model (i.e. broad

stakeholder input is not often sought or incorporated) and evidence from scientific research in Western countries is difficult to import, as they do not get much profile in media or public discourse. Conservative attitudes among politicians and senior officials (and often the general public) mean drug use is seen as a criminal justice rather than a public health problem. More specifically, the structure of national drug organizations in Southeast Asia usually ensures that management personnel come from a law enforcement background, and are thus more concerned about security than public health.

At Asian regional meetings, law enforcement is usually the primary discussion, with some secondary attention to demand reduction, but harm reduction or other policy reform issues are not on the agenda. Nevertheless, while the regional drug policy focus has traditionally been on supply and demand reduction, harm reduction has been gaining some traction in countries such as Malaysia, Myanmar, Vietnam and Thailand. For example, Response Beyond Borders is an Asian initiative to work with parliamentarians to deal with HIV transmission by injection drug use (Asian Solutions to Asian Problems). This initiative convenes its second regional meeting in Bangkok in January 2010. In some Southeast Asian countries, while governments formally frown upon needle exchange services, NGOs have been quietly allowed to be pilot them.

In Thailand, drug law enforcement policies are a function of social and economic factors that are similar to other Southeast Asian states. As with many of its regional neighbours, Thai government budgets emphasize supply reduction over demand reduction, and sentences for drug offences in Thailand are not in line with principles of proportionality. The 2003 war on drugs executed by the Thai government had positive political impacts; many Thai people supported the initiative (and believed that it needed to be sustained), so it was useful for politicians seeking re-election. However, NGO criticisms of the Thai government have prompted learning about harm reduction and movement towards incorporating it into government policies. For example, there has recently been a proposal to add harm reduction to the mandate of the Thai National Narcotic Control Board. Thailand is also learning from EU member states, the USA and Australia about more progressive and humane drug policies. The government is looking at legalization of *kratom* (an indigenous stimulant in south Thailand), which Thai law currently prohibits as a narcotic. The Thai government is seeking input from international experts and organizations to improve policy responses to this and other kinds of drug use.

Conclusion

International drug policy is in a phase of experimenting and searching for different solutions —the question is whether this will bear fruit soon, or take a long time. For international relations theory, the breakdown in consensus that emerged in from the 2009 High-level Segment of the CND represents a weakening of the strict prohibitionist norm that upholds the international regime. However, ostensible movement towards softening prohibition should not be confused with a movement towards wholesale regime change. Change is a slow, iterative process, especially when the current international drug control system limits what is possible in terms of policy alternatives and innovations, so it is unlikely we will see a major paradigm shift in the near future.

Movement for change in enforcement and punishment of drug offences is manifest in what is termed depenalization or decriminalization in EU countries such as the Czech Republic, Portugal and the Netherlands. In January 2010, the Czech Republic establishes standardized threshold limits to distinguish personal possession as a misdemeanour offence and trafficking as a criminal offence, a change both the media and the public have been generally supportive

of. Although Czech drug policy was already firmly committed to evidence-based and public health-focused policies and programs, its new decriminalization measures make it a leader among EU member states moving away from punitive responses to drug use. Portugal's 2001 decriminalization of controlled substances for personal possession has remained an effective policy for that country, which over the past decade has seen reduced rates of consumption and better engagement in health and addiction treatment services. Portuguese drug policy changes to distinguish possession from trafficking have generated results that other countries might want to replicate. Likewise, in the Netherlands personal consumption is decriminalized and judges have discretion to determine difference between personal use and trafficking. The public health outcomes of Dutch drug policies are good relative to other countries, but concerns both domestically and regionally have grown in recent years about the Netherlands as a transit/producer country. Some suggest that the criminal element of cannabis production means that while the use of the plant itself may be comparatively harmless, its overall social effects are deleterious. A consequent renewed enforcement effort in the Netherlands focusing on organized crime has effectively cracked down on cannabis and MDMA production. This has resulted in displacement of these activities to other EU countries, but no indication of overall decreased availability or use of drugs or a curtailing of organized crime.

Some of the downsides of decriminalization, or at least the use of the term, were pointed out, inasmuch as it is an ambiguous word and can be translated into practices of questionable consistency with human rights (such as coerced treatment without trial or due process). Similarly, as there is increased legal tolerance for use, there is often a corresponding intolerance for trafficking, despite evidence that the illegal drug market (like any other) is consumer-driven. The focus on organized crime that often accompanies decriminalization for personal use exacerbates the threat to public safety and security. However, as the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances stipulates that possession of controlled substances must be established as a criminal offence, member states interested in reform struggle to decide whether they create increased tension between national policies and international obligations, or whether they simply exploit legitimate wiggle room in the conventions.

Session II – Friday, 11 December, 2009 (p.m.)

Classification of Controlled substances & Drug Policy in the Netherlands

This session looked at the classification of controlled substances on an international level and nationally. What is the exact difference between the controls attached to the various schedules of the UN drugs conventions? Is there a scientific logic behind the division between narcotic and psychotropic drugs? What are the different national scheduling models? What are the main criteria the WHO Expert Committee uses in its recommendations? What is the role of the INCB?
Much debate is currently going on about the classification of drugs in countries like theUK and The Netherlands. In both countries, recently recommendations of the mandated scientific expert committees have been rejected. Also, in both countries there has been an exercise to elaborate a ranking of drugs according to their relative harmfulness which triggered questions about the rationality of current classification and the distinction between 'licit' and 'illicit' drugs. In The Netherlands the distinction between 'hard' and 'soft' drugs is under reconsideration.
What is the situation in other countries? To what extent can national scheduling systems diverge from the UN system? What lessons can be learned about the apparent tension between scientific evidence and policy making? Is there a case to make for a more refined classification system and more tailored control measures for specific subgroups of substances? What would the ideal model look like?

WHO

The World Health Organization plays a key role in the international classification of controlled drugs and substances. The WHO's Expert Committee on Drug Dependence (ECDD)—at the request of member states (through the UN Secretary General), the CND or participants of the Committee—evaluates the medical and scientific evidence for the health impacts of psychoactive substances to make recommendations about their appropriate scheduling. These recommendations are submitted to the CND, which has the authority to make decisions for the international drug control system. The WHO also nominates candidates for three of thirteen INCB posts, to which board members are appointed by ECOSOC for five-year terms. The ECDD, as well as key staff and working groups, try to reflect gender and regional balances in their composition. While the WHO's recommendations must be based on medical and scientific knowledge, the CND's decisions may take administrative, social, criminal and economic matters into consideration. This mandate difference sometimes leads to significant political tensions, as the international drug control system attempts to balance limiting availability of controlled drugs in the interest of prevention, while at the same time ensuring availability for legitimate (and often essential) medical uses. Since in many countries there is little or no access to controlled substances for analgesia or for opioid maintenance treatment, the WHO complements work by NGOs such as Human Rights Watch in operating a program to promote access to controlled medications.

Primary issues on the WHO's agenda at present include dealing with questions about the health impacts, medical utility and appropriate scheduling for psychoactive substances such as ketamine, benzylpiperazine (BZP), gammahydroxybuturic acid (GHB) and its prodrug cousin, gammabutyrolactone (GBL), and cannabis seeds, all substances with increased public profile and political concern in various parts of the world. A new opioid medication, tapentadol (sold under the trade name Nucynta), is under scrutiny, although pharmaceutical interests appear to favor keeping it out of the international convention schedules. A working group on cannabis will make recommendations on cannabis seeds for the 53rd CND, and Bolivia has requested a review of the health impacts of coca leaf chewing. Some of these issues are very politically sensitive and so will be challenging.

In the 1970s, the CND passed a resolution providing guidelines for the WHO's ECDD to follow in its decision-making processes; it has been updated several times, and was revised again recently to address outstanding issues relating to peer review by outside experts, and also to include aspects relating to medical availability of controlled substances. A report on guidance for the WHO review of psychoactive substances for international control drew on an internet consultation from UN member states (proposed by New Zealand) was posted online in December 2009.[4] An example of the political tensions the WHO faces with respect to its decision-making process can be found in ketamine, a dissociative anesthetic that was reviewed by the ECDD at its 34th meeting in 2006, but for which recommendations were deferred (while non-medical use of ketamine is a growing social concern in some regions, such as East Asia, it is also on the WHO Model List of Essential Medicines and an important anaesthetic medicine in many developing countries). However, at least one INCB member has spoken publicly about the need for scheduling ketamine because of its potency as an anaesthetic. Despite a lack of international direction for its control, ketamine was scheduled in the UK in 2005 and since then ketamine use has risen substantially; however, no epidemiological evidence was gathered prior to the scheduling change, so it is difficult to know the impacts of the policy change. Politics were also evident in the rejection at the 50th CND of an ECDD recommendation to reclassify dronabinol (or synthetic THC) from

[4] The report is available online at: www.who.int/medicines/areas/quality_safety/ReportInternetConsultation_vs161209.pdf

Schedule II to Schedule III of the 1971 Convention; the ECDD continues to stand by its interpretation of evidence and consequent re-scheduling recommendation. These and other experiences (such as the quashed 1995 WHO/UNICRI report on cocaine,[5] or the general unavailability in some countries of essential medicines such as morphine) demonstrate to the WHO that it needs to be cautious on scheduling recommendations.

UK's ACMD

The relationship between knowledge and power, or at least science and politics, has become a significant issue in the UK in regards to its Advisory Council on the Misuse of Drugs (ACMD). The ACMD was established as a provision of the 1971 *Misuse of Drugs Act* to provide drugs policy advice to government based on best scientific and medical evidence. It is comprised of at least 20 volunteer members, selected for their technical expertise in fields such as medicine, pharmacy, chemistry, or problem drug use. The council developed a nine-point risk assessment matrix to assess drug harms, and its advice is not limited just to appropriate scheduling of controlled substances, but also to other issues like prevention and harm reduction. According to the legislation, government is obliged to consult with ACMD before changes could be made to domestic scheduling, and for 37 years its recommendations were always followed. At the High-Level Segment of the 52nd CND, the UK government re-affirmed a commitment to evidence for its drug policy decisions.

In 2009, however, tensions between the ACMD and government became increasingly apparent. Home Office decisions and communications on drugs policy matters were alleged to be using selective evidence, and did not reflect or acknowledge overall conclusions of the ACMD. In February 2009, the Home Secretary rejected ACMD recommendations to downgrade MDMA (or ecstasy) from class A to class B and said scientific evidence needed to be balanced by policy-making considerations. The ACMD's chair at the time, Dr. David Nutt, publicly criticized the government for its lack of attention to scientific evidence about drugs, and in September 2009 he was fired for allegedly undermining the government's efforts to give clear messages about the dangers of drugs. Subsequently, several other committee members resign in sympathy, and spontaneous public and media support emerged for Dr. Nutt and his principled stance in speaking truth to power and commitment to evidence-based drug policy.[6]

A meeting on international drug policy scheduling concerns, hosted by TNI in Amsterdam in December 2009, highlighted similar tensions between science and politics in the international drug control arena. It identified issues such as procedural problems stemming from the genesis of the international conventions (e.g. public health vs. commercial interests), latent cultural prejudices that colour the pursuit of evidence, and the dissemination of politically-charged misinformation that does not meet rigorous scientific standards. Participants noted the WHO's limited scope of inquiry, which excludes social harms from their considerations, as a problem with the UN scheduling system. They also pointed out that member states' actions/priorities do not reflect the nuances of the conventions (e.g. allowances for medical uses are not given nearly the same attention as anti-diversion and punitive concerns) and that part of this is due to the strict channels by which scientific evidence may inform international drug control.

[5] Although the Cocaine Project report was never formally endorsed or released, it is available online at: http://www.tni.org/archives/docs/200703081409275046.pdf

[6] In January 2010, Dr. Les Iverson was appointed new chair of the ACMD and Dr. Nutt launched a parallel, truly arms-length (although unofficial), advisory body, the Independent Scientific Committee on Drugs, to provide scientific input to the UK public and political discourse on drug policy.

Some considerable discussion emerged around the status and implications of Bolivia's political direction to reschedule coca leaf within (or remove it entirely from) the international control system. Two articles from the 1961 Single Convention, Articles 3 and 47, are potential mechanisms for such change, although at present Bolivia has only proposed an amendment based on the latter. However, it was noted that coca leaf is so thoroughly embedded in the text of the 1961 Convention that changes these may be insufficient to achieve what Bolivia is seeking. Another procedural problem is that it is difficult for the CND to judge the reasonableness of Bolivia's request without medical or scientific foundation, and the fate of the 1995 report on coca does not bode well for generating future WHO input on the matter that would have any political traction. Even if the WHO's ECDD were directed to investigate coca, its limited medical/scientific mandate precludes it from considering broader issues such as rights of indigenous peoples. It was observed that the 1988 Convention does acknowledge the traditional uses of coca leaf, but it does not overturn the 1961 Convention (in fact, it re-validates its call to eliminate the practice of coca chewing). The coca issue will most likely be put forward as a resolution at the 2010 CND, but it remains to be seen whether Bolivia can garner any significant support for this issue. A larger issue stemming from this is what benefits might accrue from allowing natural coca products on the international market.

The challenges of international scheduling faced by the WHO in relation to other UN bodies and the role of scientific evidence in drug policy-making in the UK both suggest that even if a perfect ranking/scheduling system were created, there would still be barriers to translating or applying such knowledge to health and criminal justice policies in particular member states. The German experience classifying Spice—a novel herbal product containing the synthetic chemical JWH-018, which has psychoactive effects very similar to cannabinoids— illustrates an issue common to many countries, in that few have a mechanism for expediting classification. The German Ministry of Health had the power to declare a one-year ban on the product pending further investigation and the establishment of more permanent control procedures, but not all countries have such mechanisms. In 2008, Ukraine undertook a process to look at unclassified substances after a concerted campaign by health stakeholders to ask government to control the production and use of tramadol, an opioid that became available in the 1990s and 2000s. It was estimated that 100 million doses were produced in Ukraine (although the domestic market needed only 10 million). As methadone was not available before 2008, tramadol was also used as substitution treatment for heroin dependence. After much media debate and public dialogue, tramadol was classified as a narcotic drug by Ministerial order in 2009 and many illegal tramadol users switched to other opioid substances. The WHO ECDD reviewed the medical and scientific evidence on tramadol in 2006, but did not recommend its inclusion in the convention schedules.

In summary, the scheduling of controlled substances remains a challenge at both the UN level and for individual member states. As both the pharmaceutical industry and independent (sometimes illicit) chemists continue to develop novel psychoactive chemicals, issues of whether or how to schedule such compounds are unlikely to be put to rest any time soon. Likewise, the tensions between political drug control imperatives and less overtly ideological scientific understandings of drugs will ensure this issue remains a hot topic in the future.

Dutch Drug Policy – Update

The Netherlands has for several decades explored drug policy options that diverged from the dominant international punitive approach to drug control, and taken more pragmatic approaches to addressing addiction and problematic substance use. However, during the 2008 debate for UNGASS review preparation, the Dutch Parliament asked for a review of national drug policy and the government pledged to develop a new drug policy paper. The idea was to

have a full and comprehensive review of the Netherlands' drug policy over the past 35 years, with everything on the table for consideration and evaluation. To this end, the Trimbos Institute and the Scientific Research and Documentation Centre were contracted to do a joint evaluation and report on the findings, and an Advisory Committee on Drugs Policy was struck. In July 2009, the evaluation report and Advisory Committee's recommendations were submitted to Parliament, and in September 2009 the Ministers for Health, Justice, the Interior, and Youth and Families responded with a letter outlining the future of Dutch drug policy.

The evaluation results showed that the Netherlands' drug policy has been broadly adopted in practice. Harm reduction was determined to be largely successful (i.e. a match between intentions and outcomes) and rates of most kinds of drug use are below the international average for the general population, although 15 to 16 year-olds have rates of cannabis use above the international average (but still below countries such as the US, the UK and Canada). It found that vulnerable youth have higher rates of high-risk drug use, and that services/interventions for this group are not as robust as they should be. There was also an increase in cannabis users seeking treatment for dependent use, and evidence of organized crime involvement in cannabis cultivation and export. Finally, the report suggested that coffeeshops have evolved from being small-scale outlets geared to local users in order to separate "soft" and "hard" drug markets, to being larger commercial enterprises (in some cases chains of retail shops) catering largely to visitors and generating public order issues in border towns. In short, from a health perspective, things are going well in the Netherlands, but from public nuisance and criminal justice perspectives, there are issues.

The multi-sectoral Advisory Committee on Drug Policy reviewed the evaluation and prepared recommendations for a government response, suggesting that re-focused drug policy should: focus on young people to reduce the onset of problematic alcohol and other drug use and prevent social marginalization; restore coffeeshops to their original intent (i.e. small, local); improve the fight against organized crime; establish a drug authority, in order to be more flexible with respect to new trends in drug policy. The government response to the Advisory Committee, outlined in a September 2009 letter from responsible ministers, agreed for a change of course based on these recommendations. Specifically, it promised to foster a dynamic national drug policy, to tackle problematic drug use among young people more vigorously, and to pilot different regulatory options for scaled-down coffeeshops. It agreed to move forward with an implementation plan for these changes after a parliamentary debate. Part of the commitment to dynamic drug policy includes the establishment of a Ministerial team with an appointed project leader, in order to respond more flexibly to developments in drug use and organized crime. One of its initial tasks is to undertake a review of the Netherlands' *Opium Act* classification system in light of the new drug policy objectives. The classification system review will be conducted in 2010 according to the findings of the National Institute for Public Health and the Environment (RIVM) study on the rankings of drugs, and will be expected to contextualize its analysis in the broad context of harm to health and society (including nuisance, crime and organized crime). The classification review committee will also be asked to consider connections with other national legislation and international agreements.

The renewed focus on young people in Dutch drug policy includes the promotion of debate on alcohol policy, as there are worrisome trends in youth binge drinking. Some discussion has occurred on the discrepancy between age restrictions for purchasing alcohol (16 years) and those for cannabis (18 years), although alcohol age limits will not be changed within the current government's mandate. School-based prevention will also put a renewed emphasis on identifying and responding to problematic drug use earlier, especially for vulnerable youth. The program "Drugs and the Healthy School" will be expanded from its current reach of

about 60% of schools to 100% in the coming years, and programs will also be rolled out to educate parents about alcohol and other drugs.

The new approach to coffeeshops in the Netherlands reaffirms the value of separating the markets for cannabis and other illegal drugs, and the value of decriminalizing the possession of cannabis for personal use. The majority of the general public and most politicians still accept the rationale for coffeeshops, but there is a movement to reduce their density in some jurisdictions and to be more sensitive to the issues some coffeeshops create in border towns. Current policies allow adults to purchase up to 5 grams of cannabis over the counter (pressure from governments in neighbouring countries resulted in a raising of the minimum age restriction for purchase from 16 years to 18 years). The government's new policy for coffeeshops is to encourage innovation through pilot projects, conducted in cooperation with municipal councils and coffeeshop owners. As coffeeshops require a license to operate, the government has been able to make some progress in curtailing problematic outlets by revoking or refusing to renew licenses (a license can also be revoked if the owner gets a criminal conviction). One remaining outstanding issue for Dutch cannabis policy is the sourcing of wholesale product, or the "back door" question. While the retail side of the cannabis trade is regulated, the production and wholesale side of the trade remains illegal. Law enforcement officials have cited the inconsistency in these two aspects of cannabis policy as one of the reasons for a rise in organized crime in the Netherlands (which is consistent with the policy evaluation finding that success in demand reduction has not been matched by success in supply reduction). Although political factors have led to a decision to focus on combating organized crime within the country, displacement to neighbouring countries is expected and recent evidence suggests it is already happening.

In conclusion, Dutch drug policy is undergoing a recalibration to more effectively balance supply reduction, demand reduction, and harm reduction approaches. The rise of organized crime in the past decade, while by no means unique to the Netherlands, has heightened public and political concerns about the violence associated with the illegal drug trade and the movement of such criminal groups into the legitimate business world. At the same time, public opinion is firmly supportive of harm reduction as a humane and effective way to deal with drug issues. A few deaths associated with psilocybin mushrooms in the early 2000s led to public debate and subsequent prohibition of hallucinogenic fungi, despite a lack of evidence that such a policy change would reduce risks or harms. However, heroin substitution programs were not controversial in the Netherlands, especially after they were established without any serious problems to public health or safety. Although not every such intervention is universally accepted, the overall approach is embraced by the public and the Netherlands remains committed to policies that are among the most liberal in the EU.

Session III - Saturday, 12 December, 2009 (p.m.)

UN-level Drug Policy Developments: Preparations for the 53rd Session of the CND and other UN-level meetings

The report of the 52nd session of the Commission on Narcotic Drugs, including the Political Declaration and Plan of Action, has been adopted on the 30th July 2009 at the substantive session of the ECOSOC. At the same ECOSOC meeting a resolution on the UNAIDS programme explicitly supported harm reduction approaches to HIV prevention amongst drug users. The year 2010 is Universal Access Year aiming to make universal access to treatment, care, prevention and support services on HIV/AIDS a reality. What does this mean for prevention and treatment among drug users? What is the state of affairs after the adoption of the Political Declaration on Drugs? What will

be the main issues at the 53rd CND? What resolutions can be expected? What are other important international events on the drugs issue in 2010 we should take action on? And regarding NGO participation to the CND: is there a follow up on the "Beyond 2008" process?

The political climate in Vienna was somewhat subdued following the High Level Segment of the 52nd CND and the failure to reach a consensus in language supporting harm reduction for the Political Declaration. The repercussions of this are being felt in various ways in different states. The Czech Republic wants to continue fighting for inclusion of harm reduction at the CND. The UK remains a strong proponent of harm reduction and HIV prevention, but even it is not as outspoken as before. In Germany, recent elections and a new government (meaning a new health minister and new drug coordinator) have left something of a leadership vacuum for drug policy that country, although it is expected to remain supportive of the EU drug strategy. France seems to be tired of the harm reduction discussion and wants now to focus on the security dimensions of drug policy. Understandably, some smaller countries that embrace harm reduction are being less forthright in expressing their support.

The EU itself seems to have moved away from harm reduction language (as evident in the sanitization of a speech without due process because of pressure from a country antagonistic to harm reduction). While conservative EU countries may now feel more confident to be outspoken against harm reduction, it is important to remember that only a few EU states explicitly blocked harm reduction at the 52nd CND. EU countries need not just to champion progressive drug policy at CND, but to be more vocal and consistent in Brussels—this pressure can come at both state level and from civil society. The momentum of EU states with conservative approaches to drug policy may be checked somewhat by the rotation of the presidency from Sweden to Spain in January 2010. It has been suggested that during its tenure the Swedish presidency felt emboldened to push conservative national priorities more than would be usual or appropriate. The EU presidency rotation could bode well for more enlightened leadership on drug policy in the short term, as the position is an effective means by which to garner broader regional support for draft resolutions at the CND.

Some participants expressed the sentiment that although the 2009 CND was challenging and demoralizing, it is important not to give up, but to continue building on what successes are being realized. There have been successes since—for example, a resolution from the UNAIDS Program Coordinating Board that referenced harm reduction, and similarly heartening language in human rights resolutions at ECOSOC. Likewise, a few progressive resolutions were put forward at the UN's Human Rights Council recently, including one on HIV that included reference to harm reduction (which received no objections from either the US or Russia) and another on access to essential medicines (although implications for pain treatment or substitution treatment were not focused on). There may be other opportunities to further advance progress on drug policy-related matters at upcoming sessions of the Human Rights Council. It was noted that the WHO/UNAIDS Technical Guide definition of "harm reduction" works in the HIV prevention world, and so as long as HIV is a focus, this term may be acceptable for otherwise ambivalent states.

However, despite these incremental movements forward, an omnibus drugs resolution in New York in September was a disappointment. Few people with appropriate knowledge about drug issues were able to attend the meeting, so appropriate harm reduction language did not get in. Overall, despite some political wins in the Political Declaration, many feel that the momentum for harm reduction has been lost and now fear some political backlash. Some have suggested that it might be worthwhile making the breakdown in agreement about harm reduction at the CND much more public, showing "consensus" to be the illusion that it is. From the EU perspective, some feel that the battle was fought and lost; there was excitement

for a few years, but now in preparation for the 53rd CND, it feels like it did a decade ago. While it is early still to have details on resolutions for the 53rd CND, two draft resolutions have been circulated to date. One of these deals with controlled substances that are also essential medicines and the INCB's work to ensure member states balance their supply-reduction efforts with the imperative for legitimate medical uses. The other addresses universal access to anti-retroviral therapies and the prevention of HIV/AIDS.

Beyond the EU, the initial excitement that the election of US President Obama brought to the international drug policy world has faded somewhat. Many are wondering whether the US will follow through on a commitment to put forward a resolution at the 53rd CND on universal access to essential medicines. However, the US also remains a reason for optimism, as it is clearly showing a new approach to collaboration and partnerships. This promise holds especially for HIV/AIDS issues, where harm reduction language has been accepted by the US in other international forums beyond the CND. If agreement can be solidified in this domain (for example at the UNAIDS PCB in May or at ECOSOC in July 2010), it could help for transferability to US drug policy staff in Vienna. Optimism also comes from Iran, where on World AIDS Day the government announced that harm reduction services were having an impact on reducing HIV transmission. From another perspective, Russians have not been constructive in promoting health interventions at the international level, and a Russian INCB member is pushing very conservative policy ideas at INCB. If the US were to become less antagonistic towards harm reduction, Russia would be the only real big holdout at the UN. It was also noted that the Global Fund recently extended HIV prevention funding to Russia, which is an opportunity to continue pressing for harm reduction.

At present, the incremental progress in diplomacy that the UN sometimes achieves seems difficult to see in drug policy. Like-minded states need to think strategically about how to foster meaningful dialogues and reinsert progressive ideas at future CND meetings in Vienna. A sub-item on understanding addiction as chronic multi-factorial health problem (in a resolution brought forward by Swedes) could be an entry point for human rights discussion. A forthcoming UN Human Rights report at the CND may allow for a revitalization of momentum in reforming international drug policy. Support for harm reduction may also be strengthened in the short term by fostering connections among UN bodies. As the UNODC has responsibilities to ensure HIV treatment and support for prisoners, and the UNAIDS Programme Coordinating Board has passed resolutions for UNODC to take action to scale up HIV preventions, the CND ought to be supportive of initiatives like the UK universal access resolution. NGOs and civil society will continue to have an important role on the international stage, educating politicians and bureaucracies about harm reduction and encouraging them not to be afraid of publicly supporting such policies and programs.

Other matters at the upcoming 53rd CND include a working group to explore revising the Annual Reports Questionnaire (ARQ), which will need to go in front of the CND for endorsement. This initiative is focused on trying to simplify and improve knowledge base for the UNODC's World Drug Report. However, the working group's composition means it could be somewhat fractious, so there is a need to monitor its progress and be protective and/or supportive when appropriate. Information and data collection by the UNODC is a key issue to champion, as so much of international drug policy planning is done in the dark. The VNGOC has championed the value that NGOs can add to the process and quality of data collection is one area that NGOs may be able to add value. There will also be a side meeting of a donor coordination working group, at which the US is showing some leadership by chairing. A reference group for HIV will launch a report on prevalence figures for harm reduction. The UNODC's Health and Human Development section has been meeting with stakeholders and preparing a draft document on coerced treatment, which early reports

suggest is significantly improved from initial versions. The International AIDS Society will be promoting the XVIII International AIDS Conference (AIDS 2010) at the CND, with the hopes of engaging supply reduction stakeholders to educate and ensure they understand the importance of their policies/practices on implementation of HIV prevention programs.

The US drug policy position internationally is very mixed, with some positive movements on the demand reduction side, but not much change in supply reduction side. The new Director of the Office of National Drug Control Policy (ONDCP) has renounced "war on drugs" rhetoric, and some domestic policy changes seem to signal change, but without unequivocal high-level leadership in Washington, it will be business as usual for the international drug war bureaucracy. The ONCDP and the State Department lead the delegation at the CND, but committed drug warriors are still very much entrenched in these organizations and so they cannot be expected to be champions of change. For example, at the Inter-American Drug Abuse Control Commission (CICAD)/OAS meeting in September in Sao Paulo, harm reduction language was put forward by Brazil for inclusion in the development of a hemispheric drug strategy. However, the only overt support came from Uruguay, while others were either silent or, following the position of the US delegation, opposed. An improved US attitude to, and cooperation with West Africa, although mostly focused on supply reduction, may also provide opportunities to move demand reduction and harm reduction discussions forward in that region.

Civil Society & NGOs

The role that civil society can play in building government support for harm reduction should not be underestimated. For example, if civil society could be better engaged in G77 countries, they would play a vital role in shaping global policy. The power of NGOs, academics, community organizations and other such groups lies in their ability to mobilize one another through networks. They can relay news and information among different nodes of domestic and foreign policy matrices, providing updates and education for governments. However, NGOs need to provide input in a timely fashion and try to inform government representatives, rather than persuade them. One challenge is that every country has different timeline and way to prepare for the CND and other international meetings. Thus, NGOs need to be better aware of these variances for focused activism (diplomats and government representatives can be helpful in navigating such procedural issues). Meetings such as *in camera* international policy dialogues are useful for this kind of networking activity, but the engagement needs to happen outside of the worlds of Vienna and New York.

Since 1983, the VNGOC has been a key mechanism for NGOs to interface with governmental and inter-governmental organizations on the topic of drug policy. For several years leading up to the 52nd CND, the VNGOC (in partnership with the UNODC) led the Beyond 2008 process, which gathered civil society input on drugs from a wide range of perspectives and generated a declaration and three resolutions presented at the 2009 High Level Segment. An independent evaluation has since been conducted and found that Beyond 2008 was successful at highlighting NGO contributions and achievements in drug control and at adopting a set of principles to guide future drug policy deliberations. However, it was found not to have achieved its third objective of improving collaboration mechanisms among NGOs, governments and UN agencies proposing better or innovative ways of working with UNODC and CND.

NGO input on CND work depends to some degree on the chair of the Commission. The new chair is reputed to be keen on NGO involvement, but wants to avoid attacks directed at individual member states. It was noted that some member states are hostile towards NGOs,

while others (e.g. the UK and Canada) involve NGOs through their national delegations. VNGOC has had a long-standing goal to encourage states to add NGOs to their national delegations to CND, so NGOs might want to approach governments about including adequate NGO representation on delegations. VNGOC also recently met with UNODC and the incoming CND chair to discuss arrangement of informal NGO dialogues in Vienna in March 2010.

Other opportunities for civil society to engage in drug policy issues during 2010 will happen through the work of the International Drug Policy Consortium, a global network of NGOs and professional networks advocating for open and objective debate in drug policy. The IDPC currently has 44 members from a variety of fields worldwide, and is continuing to expand, with another five members due to be joining before the end of year. The IDPC's primary focus for the past few years was civil society engagement in the lead up to the 2009 CND and High Level Segment, for which it prepared numerous advocacy notes and briefing papers on the key issues. However, the IDPC is also trying to engage other parts of UN. For example, in partnership with the Global Fund, UNAIDS and the International Harm Reduction Association (IHRA), the IDPC hosted a satellite event at the high-level segment of the ECOSOC meeting in July 2009 (where the theme was "Global Health") to raise again the issue of system incoherence around drug control and the weakness of the political declaration on harm reduction and HIV that came out of the HLS. The IDPC, IHRA and Human Rights Watch are also collaboratively engaging with the UN Human Rights mechanisms in Geneva, an ongoing initiative that may include a side event on drug policy and human rights at the Human Rights Council next year.

For the upcoming 53rd CND in March, 2010, IDPC will continue its work on contributing to better civil society engagement. This includes coordinating access to pooled ECOSOC passes, publishing guidance notes in advance of the meeting, and arranging side events. IDPC will prepare information packages for journalists that provide summaries of the key issues and players. IDPC is also working with the VNGOC to seek facilities/supports for civil society representatives, although space, materials and lack of resources are ongoing challenges. Not knowing well in advance who from the NGO community will show up is a challenge, as is not knowing what draft resolutions will be on the table. These circumstances mean that better partnerships with member states and other NGOs are required to help information be disseminated more effectively. VNGOC expects to be able to secure an NGO lounge, which may be used for display and distribution of NGO publications and materials. VNGOC also hopes to improve liaisons with the CND secretariat and to ensure a smooth process for NGO representatives to participate at the CND plenary. Side events planned with the help of NGO coalitions are focused on such issues as championing access to essential medicines, building on the joint WHO-UNODC program on treatment and care, and promoting the AIDS 2010 conference.

In addition to the 53rd CND, upcoming events on global drug policy matters include the 12th UN Congress on Crime Prevention and Criminal Justice in Salvador, Brazil, 12-19 April 2010. One of the themes of the Congress is children, youth and crime, so it will be a good opportunity to promote the importance of prevention and education focused on problematic drug use, and of treatment as a preferable alternative to criminal justice sanctions such as incarceration. The IHRA's 21st International Harm Reduction Conference will take place in Liverpool, where the first international conference was held in 1990, from 25-29 April 2010, with a theme of "Harm Reduction: The Next Generation." The 14th International Anti-Corruption Conference (IACC) will be held in Bangkok, Thailand in November 2010 on the theme, "Restoring Trust: Global Action for Transparency," and could be a valuable forum for NGOs to contribute to drug policy discussions. The next UN High Level meeting on

HIV/AIDS will take place in 2011 and universal access to anti-retroviral therapies (ARVs) will be a central theme (currently only 15 countries have set targets for access to ARVs for IDUs). The International AIDS Society's AIDS 2010 conference, 18-23 July 2010, will be a major opportunity for drug policy and health discussions to move forward. NGOs should think about booking space in the Global Village (which is activist-oriented) or commercial space. The conference will have a plenary on drug policy and how it impacts HIV issues, as well as a plenary on prisons and HIV.

For the first few weeks of July, immediately prior to the start of the AIDS 2010 conference, the AIDS Foundation East-West (AFEW) will be organizing harm reduction tours on mini-buses from Vienna to various Eastern European cities. AFEW is a humanitarian public health NGO that works in Eastern Europe and Central Asia to reduce the impact of HIV and AIDS by actively seeking international and regional exchanges. For the harm reduction trips, AFEW is seeking to partner with local organizations to conduct information tours in Eastern Europe and Central Asia under the AFEW umbrella. AFEW wants to send positive messages to delegates and reporters who may be arriving early to show that harm reduction works. Tours will focus on the issues specific to the region, including IDUs, but also vulnerable groups such as MSM and prisoners. The organizers can be contacted at:

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Concluding Contributions

A final contribution at the dialogue pushed thinking beyond the current regime of international drug prohibition. In November 2009, the UK's Transform Drug Policy Foundation launched *After the War on Drugs: Blueprint for Regulation*, a document that grapples with the question of alternatives to the status quo and outlines a vision of how a post-prohibition world could look. The *Blueprint* provides an impetus to open dialogue about supply-side regulation and talk about it dispassionately and rationally. Its analysis draws on lessons learned from best practices in regulating tobacco, alcohol, pharmaceutical control, as well as sex work, gambling, and other risk activities. The *Blueprint* lays out five models for regulating supply and availability for currently illegal drugs: prescription, pharmacy sales, licensed sales, licensed premises, and unlicensed sales. It proposes that regulatory models be premised on an evidence-based scale of risk and harms (which requires distinguishing primary pharmacological harms from secondary policy-related harms). Since its release (available in English, Portuguese and Spanish), the *Blueprint* has received positive media coverage. Transform Drug Policy Foundation also advocates using policy impact assessments as another way to move the drug policy reform issue forward. In many countries, these are a standard government tool for assessing effectiveness of policy or legislation.

A lesson on changing political discourse about drug policy can be learned from experiences in the Vancouver, Canada. Local activists, health advocates and drug users inverted the political risk around harm reduction in the late 1990s and early 2000s, to the point where local municipal elections saw candidates trying to outdo each other on the matter how much they supported harm reduction. Recent polls show that three-quarters of Vancouver residents support the city's Four Pillars approach (prevention, treatment, harm reduction, and enforcement) to problematic drug use. Vancouver has been able to establish pilot supervised

injection sites and heroin prescription research in the past decade, initiatives which have contributed to improved public health and safety in the city (including declining HIV infections due to IDU). In 2005 the Vancouver city council endorsed a plan entitled *Preventing Harm from Psychoactive Substance Use*, which calls for a consideration of alternatives to prohibition as a means of drug control. The City of Vancouver is a central partner, along with local NGOs, of the SafeGames 2010 initiative to promote harm reduction, low-risk drinking and safer sex during the 2010 Winter Olympic and Paralympic Games in February.

Final thoughts also turned to the International Drug Policy Dialogue process. There was some discussion about whether more concrete actions could be identified, such as objectives to achieve at the CND. However, TNI/APF responded that while some actions can easily be identified through IDPDs, they do not consider it appropriate to create an operative function for the dialogue events. This is partly because the dialogues are focused on facilitating knowledge sharing and networking opportunities, but also because other groups (e.g. IDPC) may already be providing such function. The importance of communicating after IDPD meetings was raised as an item to follow-up on, perhaps through an e-mail list to share information. An IDPC representative suggested it could host a calendar of human rights/drug policy events (i.e. timing, planning, activities). Overall, participants indicated that the meetings are valuable opportunities for information exchange and networking.

Kenneth W. Tupper, Rapporteur
February 2010