Recommendations of the Civil Society Forum on Drugs for the 2019 Ministerial Segment

September 2018

Member States will gather in Vienna in March 2019 for a Ministerial Segment at the 62nd Session of the Commission on Narcotic Drugs to take stock of progress achieved over the past ten years, and to delineate the next phase in global drug strategy for the coming decade. In this contribution, the EU Civil Society Forum on Drugs (CSF) offers recommendations to feed into the discussions in the lead up to, and during the 2019 Ministerial Segment. The contribution also provides examples of good practice on different drug policy issues, from across EU countries, to inform global drug policy debates.

Recommendations for civil society participation

Civil society organisations are critical partners in the design, implementation and evaluation of drug policies, having access to those most affected on the ground, and having a broad range of experience and expertise in many aspects of global drug control. It is therefore important that civil society is meaningfully engaged in the 2019 process. We call on member states to:

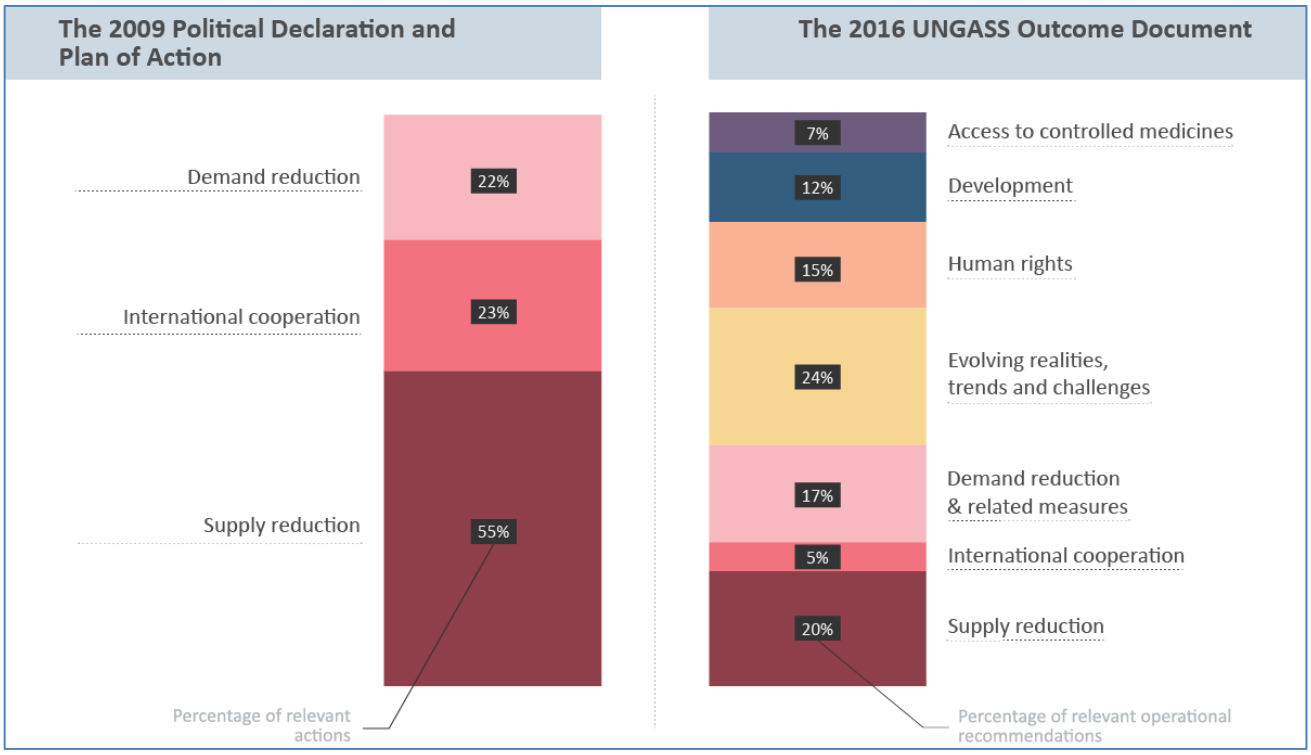
- Promote civil society participation in their statements at the UN
- Support the Civil Society Task Force (CSTF) in government statements and positions, and allocate funding for the Task Force
- for the organisation of a civil society hearing in late 2018 to feed into the 2019 Ministerial Segment with a civil society position paper drafted by the CSTF and presented as an official document at the Ministerial Segment
- Include civil society representatives in governments' official delegations at the Ministerial Segment.

Recommendations and best practice examples on key drug policy areas

The UNGASS Outcome Document, adopted in April 2016, is the most recent global consensus on drug control.[1] It captures all thematic areas covered in the 2009 Political Declaration,[2] but also expands on critical aspects of drug policy, in particular issues related to essential medicines, human rights and development, including the Sustainable Development Goals (SDGs). The UNGASS Outcome Document also provides a more balanced approach to drug policy as compared to the 2009 Political Declaration and Plan of Action which focused overwhelmingly on supply reduction efforts (see Figure 1).

In this section, we therefore provide recommendations aligned with the seven thematic chapters of the UNGASS Outcome Document.

Figure 1. Comparing the structure and number of actions/recommendations of the 2009 Plan of Action with that of the 2016 UNGASS Outcome Document[3]



Source: International Drug Policy Consortium, 2018

1. Demand reduction and related measures

- Create a stronger link between human rights and health in drug policies, interventions and programmes.
- Ensure better involvement of affected populations, including people who use drugs, families, women, children and youth at risk, people in recovery and recovered users, in the design and implementation of drug policies and programmes.
- Promote improved access to health interventions for those who need them, including access to evidence-based prevention, drug dependence treatment, recovery and rehabilitation services, risk and harm reduction services, and treatment for drug-related health harms (such as HIV, hepatitis, overdoses, etc.). Services and interventions available should better address co-morbidities.
- Allocate greater funding for prevention, risk and harm reduction, treatment and care, recovery and rehabilitation interventions. Consider reallocating a portion of drug policy funding directed at addressing crime, towards drug prevention, risk and harm reduction, recovery, rehabilitation, treatment and care.[4]
- Ensure greater access to drug services for people in closed settings, including prisons (see Box 1).
- Promote the European minimum quality standards for demand reduction[5] as well as the UN international standards on prevention[6] and treatment,[7] as well as the UN Technical Guide on HIV prevention among injecting drug users[8] across UN member states.
- Develop a new set of human rights indicators to measure the health outcomes of drug policy and WHO recommended programmes.
- Consider policy alternatives that go beyond the extremes of tough prohibition and legalisation. This includes developing alternatives to incarceration or punishment for drug offences and promoting access to harm reduction, drug dependence treatment and other health and social interventions.

Box 1. Tackling drug dependence in French penal institutions

According to several studies,[9] the prevalence of drug dependence is very high among inmates. In France, the last numerical estimates from 2016 showed that 30% of people entering prison suffered from excessive use of alcohol and/or illicit drugs. Since January 2017, the main professional French network in addictology (Fédération Addiction) has been involved in a project in France that aims to coordinate with medical and penitentiary staff to identify people suffering from alcohol or drug dependence – in collaboration with the French government. The project aims to improve the identification and evaluation of people dependent on drugs and alcohol, raise awareness among penitentiary and medical staff about drug and alcohol dependence, and improve coordination among those different stakeholders.[10] In 2017, inventories were drawn up in two different penal institutions in order to provide specific training for health professionals working in prisons. The project will be expanded to 10 additional institutions with the objective of producing and disseminating training materials to health professionals and penitentiary staff in 2019.

2. Improving access to controlled medicines

- Commit to ensuring adequate and affordable access to internationally controlled drugs for medical purposes, such as for pain relief, palliative care and other diseases like multiple sclerosis, etc.
- Promote access to internationally controlled substances for research and scientific purposes, while preventing diversion (see Boxes 2 and 3).
- Increase education of healthcare professionals in the correct use of opioids to ensure that patients with pain are managed effectively.

Box 2. Improving access to essential medicines: The ATOME project

Evidence for the use and efficacy of strong opioids, such as morphine for the management of moderate to severe pain is well-documented and evaluated. Many people develop pain, particularly towards the end of life. Over 70% of patients with advanced cancer will experience severe pain at some time in the progression of the disease, but pain is also very common in other diseases, such as heart disease, respiratory disease and neurological disease.

The availability of opioid medication varies greatly across the World. 90.5% of the morphine consumption in 2013 was from Europe, USA, Canada, Australia, New Zealand and Japan, although these countries account for only 18.9% of the population.[11] In Europe the ATOME study found that opioid consumption is low or very low in 12 countries with many restricting opioid use by legislation.[12] Although there are fears of the misuse of medication there is little evidence to support these fears:

- It has been suggested that 21-29% of patients receiving opioids 'misuse' them, but this also includes non-compliance, such as not taking medication regularly as instructed – seen in about 25% of all prescribed medication
- Although 60-100% of people with substance abuse disorder have taken prescription opioids, only a very small number (0.01% to 4%) of people treated with opioids for pain go on to develop dependency.[13]

Up until 2014 there was limited access to opioid medication in Turkey. In 2014, the Access to Opioid Medication in Europe (ATOME) project sought to overcome barriers to opioid use for medical purposes. In 2010, the adequacy of opioid use in Turkey was assessed at 7% and there were administrative requirements in the prescription, dispensing and distribution of morphine and there was a lack of clarity in the language used about 'toxic substances causing 'intoxication'. The ATOME Project made many recommendations and oral morphine was produced and palliative care was partially reimbursed in state hospitals. Opioids are now

more widely available and palliative care is expanding. This case study showcases the key role of the ATOME project in promoting better access to essential medicines, in particular in Eastern Europe.[14]

Box 3. Ensuring better access to medicinal cannabis for children with epilepsy[15]

The number of countries allowing some form of medicinal cannabis for a number of ailments has significantly increased in the past decade. Today, 48 countries have such systems in place.[16] In response to the rapid expansion of medicinal cannabis worldwide, the International Narcotics Control Board (INCB) released guidelines for member states to follow to ensure compliance with the UN drug control treaties.[17] In addition, for the first time in 83 years, a scientific assessment by the WHO Expert Committee on Drug Dependence (ECDD) on cannabis and its derivatives is underway. In its provisional conclusions, the ECDD recommended that pure CBD 'should not be scheduled within the International Drug Control Conventions'. The ECDD also decided to proceed to a critical review of cannabis plant and resin, extracts and tinctures of cannabis, Delta-9-THC and isomers of THC, with conclusions planned to be released on time for the 2019 Ministerial Segment.[18]

In the UK, a recent scandal involving a 12-year old boy whose anti-epileptic medicine (cannabidiol oil) was confiscated by customs agents at a London airport showcased the urgent need to review drug legislations and ensure broader access to medicinal cannabis for children with epilepsy.[19] As a result, the UK Home Office announced that it would make certain products available on prescription imminently based on advice from medical authorities – and would reschedule cannabis to Schedule 2 of the Misuse of Drugs Regulations 2001.[20]

3. Drugs, and human rights, youth, children, women and communities

- Commit to a strong human rights approach to drug control, to ensure that drug laws are designed and implemented in full conformity with international human rights law.
- Promote a regular and systemic assessment within the UN human rights and drug control systems of the human rights impact of drug markets and drug control policies among members of most affected communities – and welcome in this regard the report of the Office of the High Commissioner for Human Rights on human rights considerations associated with UNGASS implementation, published in September 2018.[21] We encourage UN member states to call for UNODC to include an assessment of the human rights impacts of drug control in its annual World Drug Report.
- Promote the abolition of the death penalty in all circumstances.
- Commit to ending arbitrary detentions and closing down compulsory detention centres and any other practices amounting to torture and cruel, inhuman and degrading treatment or punishment in the name of 'drug treatment', and denounce these practices as violations of international human rights law.
- Recall Member States' obligation to protect children and youth from illicit drug use and provide them with youth-friendly prevention, harm reduction and drug dependence treatment programmes, in accordance with the Convention on the Rights of the Child.
- Adopt and implement drug policies and programmes that are implemented in a non-discriminatory way and are responsive to the needs of women and girls, ethnic minorities, LGBTQ+ communities, indigenous groups, children and youth.
- Promote the meaningful participation of those affected by drugs and drug policy in the design and implementation of drug policies and programmes that affect them at local, national, regional and international level.
- In accordance with the right to the highest attainable standard of health, ensure access to evidence- and human rights-based drug dependence treatment and rehabilitation such as opioid substitution

treatment and recovery services, as well as services for HIV, hepatitis C and STI testing, prevention, care and treatment that respond to the needs of women, children and youth. Services should also include legal support and protection from sexual, economical, physical and institutional violence, including law enforcement bodies.

- Reaffirm sexual and reproductive health and reproductive rights as human rights, integral to achieving transformative sustainable development across social, economic, and societal dimensions.
- Commit to eliminating the social stigma experienced by people having or recovering from drug dependence. Special attention should be paid to ending stigma against people who use drugs in healthcare settings, the workplace and the media.[22]
- Commit to making international funding conditional to a human rights-focused drug control strategy – i.e. refusing to fund any drug policy or programme that may lead to violations of basic human rights.
- Prioritise research and rigorous evaluations of drug policies and programmes to assess their effectiveness, in particular with regards to the achievement of specific Sustainable Development Goals (SDGs), and strengthen connections and collaboration with researchers, policy makers and practitioners.
- Strengthen systematic and coordinated data collection, as well as analysis and use of data disaggregated by sex, age, sexual orientation and gender identity, disability, place of residence, ethnicity, income and other factors to effectively monitor on human rights progress in drug policies.

Box 4. Ending the death penalty for drug offences

International human rights mechanisms and the INCB have all concluded that drug offences do not meet the threshold of 'most serious crimes', which are the only crimes under international law to which the death penalty may be applied.[23] However, 33 jurisdictions worldwide still retain capital punishment for drug-related crimes.[24] In addition to the serious human rights implications of such an approach, available evidence shows that the death penalty has no measurable impact on deterring involvement in drug-related offences, the prevalence of drug use and drug-related health and social harms.[25]

A growing number of UN agencies and governments have called for an end to the death penalty for drug offences, including the UNODC[26] and the INCB.[27] The wide opposition to capital punishment for drugs culminated at the 2016 UNGASS, where 66 member states spoke against the practice,[28] although it was eventually omitted from the UNGASS Outcome Document.[29]

At national level, positive trends have recently been documented, with the number of reported executions (excluding those carried out in secret) dropping from over 600 in 2010 to 280 in 2017.[30] Various countries have either removed the death penalty from their legal system, allowed more discretion for judges when imposing the sentence (e.g. India[31] and Malaysia[32]) or limited its scope (e.g. Singapore[33]). Other initiatives aimed at curbing the use of the death penalty were adopted by Thailand[34] and Palestine.[35] One of the most significant developments was the amendment approved in November 2017 by Iran which raised the minimum quantity of drugs required to incur capital punishment.[36] This reform had impressive effects, with the number of executions for drug crimes dropping from 242 in 2017 (an average of one execution every 1.5 days), to just three in the first seven months of 2018.[37]

Nevertheless, in parallel various member states are currently considering bills that would reinstate the death penalty for drug offences, including the Philippines,[38] Bangladesh[39] and Sri Lanka.[40] In addition, other countries which had previously abandoned or strongly limited this practice resumed executions – in particular Indonesia and Singapore[41] – while other countries, such as Saudi Arabia, continue to execute large numbers of drug offenders each year.

4. Supply reduction and related measures

- Adopt new indicators of success, focusing on outcomes such as reduced criminal activity, improved access to evidence-based and effective prevention, risk and harm reduction, treatment and recovery services, reductions in drug market-related violence and corruption, improved access to essential medicines, etc.
- Ensure the proportionality of sentences for drug offences, and provide a clear definition of the concept as it relates to drug control.
- Consider the use of restorative justice approaches for drug-related offences and drug-related contexts of community conflict.

Box 5. Reducing drug market-related violence in Northern Ireland[42]

In 2008, in the city of Derry/Londonderry, in Northern Ireland, the abuse of drugs and alcohol among young people was so serious and caused so many social problems that a paramilitary force derived from the IRA, the RAAD (Republican Army Against Drugs) was founded on the objective of using violence against those who take or sell drugs as a form of deterrence. The group used methods such as beatings, shooting at the knee or the forced exile of those whom they considered as traffickers. In 2012 Andrew Allen, a father of two children and allegedly a drug trafficker, was killed. The group also shot a 19-year-old boy on the knees who later committed suicide. It is estimated that some 200 people were forced by the RAAD to leave the city. Police interventions, trying to solve the situation by applying more coercion, only served to increase the levels of violence suffered by the community.

In view of this extremely violent situation, an Ulster University team initiated a process of dialogue between associations working with people who use drugs, community members and public authorities, in order to find solutions to the problem and tackle the violence. Through a series of dialogues and public conferences, guided by the principles of restorative justice, participants concluded that a solution purely based on security and the use of force could not end the problem. In addition, it was agreed that increased participation of affected families was necessary.

As a result of this initiative, the University established a community education course for families and volunteers, in which 60 people were trained in the consequences of alcohol and drug abuse. Importantly, even though it did not entirely eliminate violence, the restorative justice approach allowed a dialogue about painful issues to groups that are suffering harm and violence, and thus enabled them to reach agreements aiming to improve coexistence in such difficult circumstances.

5. Evolving reality, trends and existing circumstances, emerging and persistent challenges and threats, including new psychoactive substances

- Ensure a person-centred approach for service design and delivery to ensure that the needs of the target groups (for example, homelessness, mental health, use of NPS) are being adequately addressed.
- Promote an open debate on whether the current global drug control system has been effective in achieving its stated objectives, based on the latest available data and evidence. This should cover the importance of implementing the UN drug conventions based on a human rights approach, the need to use the flexibilities allowed in the conventions for alternative approaches, and an analysis of the tensions existing between international drug control obligations and new realities from the ground.

Box 6. Chemsex support at '56 Dean Street'

Chemsex is defined as a 'sex and drug' trend connected with gay culture, in particular with injecting drugs such as methamphetamines, mephedrone or GHB/GBL in sexual contexts. It has emerged, has been facilitated and is on the rise thanks to social and sexual networking apps. The practice is linked with an increase in sexually transmitted-infections such as HIV and hepatitis.

'56 Dean Street' is a friendly and free NHS (UK National Health Service) sexual health and HIV/GUM clinic in the heart of London, UK. The Chemsex support programme at Dean Street includes a ChemSex Care Plan,[43] an online tool which men can use on their own, but which is also designed to be used by healthcare professionals together with their client. For a worker who has limited knowledge or experience with chemsex, the care plan provides a structure for a conversation and intervention options. It is available in 15 different languages.

The care plan aims to help people identify a goal and work towards it. It asks men to reflect on what they like and dislike about chemsex and what they want to change. The tool helps men identify 'trigger' situations when they may have cravings and to think about how they will manage them. The programme also strongly promotes much more regular HIV testing, enabling clients to initiate anti-retroviral therapy as early as possible while encouraging safer sexual behaviours for those who have already contracted the virus. Thus, the service deals with sex as well as drug use for its target population.[44] Since 2015, there was an 80% decrease in new HIV diagnoses at 56 Dean Street, showing the positive impact of such a programme.

Box 7. Responding to health concerns over the use of NPS[45]

The coming onto the market of new psychoactive substances (NPS) corresponds to an evolution in the drug using community. The UNODC estimated that more than 800 NPS had flooded the global drug market over the past ten years.[46] The health risks associated with the use of NPS are difficult to evaluate, while their commercial profile makes them easily available on a large scale. The expanding reach of the dark net facilitates online payments and safe delivery of these substances, in a way that generally evades traditional drug law enforcement. In parallel, traditional harm reduction and drug dependence treatment services are often not adapted to prevent or address some of the risks associated with NPS consumption. The involvement of people who use NPS is therefore critical to develop and expand services that are better adapted to respond to their needs. Such services have included:

- Measures to improve personal hygiene and nutrition in low-thresholds drop-in centres, sharing of information on how to improve diets and getting adequate rest[47]
- Information on how to inject or smoke more safely
- Drug checking services, allowing people to ascertain the content, purity and strength of their drug to reduce risks of overdoses and undesired or unexpected effects from ingesting toxic and/or dangerous contaminants.[48]
- Peer-led information sharing, reviews and feedback on drug purchases and use in online forums, and harm reduction advice on the dark net
- Housing first programmes and the provision of basic healthcare, food distribution and employment services to reduce marginalisation and associated harms (see Box 9 below for more information).

6. Development

- Frame alternative development programmes within a broad development approach focusing on a reduction of poverty and social inclusion, improved access to legal markets, a protection of the

environment, as well as the development of basic infrastructure, education, social protection, access to housing and employment opportunities.

- End aerial spraying, which has proven ineffective and harmful to people's health and the environment.
- Ensure that alternative development programmes do not only focus on rural areas in producing countries, but also on urban areas in producer, trafficker and consumer countries, where tackling the involvement in the drug trade requires a thorough development programme focused on poverty alleviation and strengthening community resilience and solidarity.
- Remind member states of their obligation to achieve the SDGs, and ensure a stronger involvement of the United Nations Development Programme in global drug policy.
- Ensure the meaningful participation of affected communities, including indigenous groups, in the design and implementation of programmes and policies that affect them.
- Establish new and long-term indicators for alternative development programmes based on the Human Development Index.

Box 8. Boosting employment: The INSOLA project

SDG 8 calls the international community to promote inclusive and sustainable economic growth, full and productive employment and decent work for all. Spain has one of the highest unemployment rates in Europe. However, civil society has gained significant expertise to effectively improve the employability of those most vulnerable populations.

The INSOLA Project ('*Inserción Sociolaboral'*) is a national innovative programme run by the Association Proyecto Hombre and supported by the European Union Fund.[49] It aims at boosting employment for people under drug dependence treatment in urban and rural areas of Spain. Achieving adequate, non-precarious work becomes necessary for social re-entry in an increasingly complex socio-economic world. This project consists of designing and systematically implementing personalizsd itineraries which includes mentoring, social skill-building, vocational courses, back to study, professional practices in companies, job-seeking networks amongst other actions. It focuses on those cases with special vulnerability such as women, co-morbidities, offenders, youth, homeless or elderly people. From 2016 to 2019, more than 4,600 people dependent on drugs will have benefited of the INSOLA Project all over Spain. The social impact of the project is being evaluated. Every participant is being followed up during and after concluding the intervention by individually impact indicators.

Box 9. Housing first programmes to tackle marginalisation

Housing first programmes were initiated in the USA in the 1990, and is based on the idea that housing is the first need that has to be provided to tackle possible risks and harms. It relies on giving a home to a person in need, without expecting anything in return. In France, the decree generalising the 'housing first' experimentation came into effect in January 2017[50] and has been put into practice by the government in collaboration with civil society. Since 2011, the programme had already been experimented in four cities – Lille, Marseille, Toulouse and Paris. It provides persons with no permanent home, and suffering from severe psychological disorders or in situation of drug dependence (around 70% of the beneficiaries) with direct access to a home in which they benefit from support provided by health and social professionals.

In April 2016, an assessment carried out by the French government showed encouraging results. The scientific study analysed a sample of 720 people. Four years after the beginning of the programme, 85% those who were granted an accommodation were still living in it, hospitalisation periods had been reduced by 50% in comparison to the control group, and they all managed to restore social links with friends and family.[51]

7. Strengthening international cooperation

- Ensure systemwide coherence within the UN system, by facilitating the systematic and meaningful participation of all relevant UN agencies in global drug policy debates, in particular the WHO, UNAIDS, OHCHR, UNDP, UN Women and others.

What's next: Recommendations for the 2019 Ministerial Segment

We propose these following actions:

- The opening session should include high-level speakers from a variety of UN agencies, including the UNODC, INCB and WHO, as well as the UN Secretary General, followed by speakers from UNAIDS, OHCHR, UN Women, UNDP, UNICEF and others, as the EMCDDA. Civil society, represented by the CSTF, should also be given a speaking slot at the opening session.
- The two roundtables should focus on:
    - Roundtable 1: Evaluating progress made against the objectives set out in the 2009 Political Declaration and Plan of Action on drug control
    - Roundtable 2: The way forward: operationalising the UNGASS Outcome Document within the broader framework of the SDGs and other UN priorities of protecting health, human rights, and promoting peace and security.
- The targets included in paragraph 36 of the 2009 Political Declaration should not be extended. Instead, the discussions should focus on the implementation of the UNGASS Outcome Document, as well as on considering how global drug policy can feed into the achievement of the SDGs for the period 2019-2030.
- The 'outline' on the way forward should include clear actions, the key stakeholders responsible for them, the establishment of new metrics and indicators aligned with the SDG, as well as defined timelines and monitoring mechanisms for a mid-term and final review of progress made. This timeline should be aligned with the achievement of the SDG, that is, run between 2019 and 2030. The post-2019 drug strategy should ensure that all relevant UN agencies are included in the debates, to promote better coherence in policy goals and discussions across the UN family.

The Civil Society Forum on Drugs (CSFD) is an expert group of the European Commission that was created in 2007 on the basis of the Commission Green Paper on the role of civil society in drugs policy in the EU. Its purpose is to provide a broad platform for a structured dialogue between the Commission and the European civil society which supports drug policy formulation and implementation through practical advice. The CSFD is consistent with the EU Strategy on Drugs 2013-2020 and the new Action Plan on Drugs 2017-2020 both of which require the active and meaningful participation and involvement of civil society organisations (CSOs) in the development and implementation of drug policies, at national, EU and international level. Its membership comprises 45 CSOs from across Europe and representing a variety of fields of drug policy, and a variety of stances within those fields. Membership is renewed every three years, and the last call was in March 2018. List of CSFD members:

1. *ABD - Associació Benestar i Desenvolupament*
2. *AFEW International*
3. *AIDES*
4. *Ana Liffey Drug Project*
5. *APDES - Agência Piaget para o Desenvolvimento*
6. *APH - Association Proyecto Hombre*
7. *ARAS - Romanian Association Against AIDS*
8. *Citywide Drugs Crisis Compaign*
9. *De Regenboog Groep*
10. *Dianova International*
11. *Diogenis Drug Policy Dialogue*

12. *EAPC - European Association for Palliative Care*
13. *EATG - European AIDS Treatment Group*
14. *ECAD - European Cities Network for Drug Free Societies*
15. *EFSU - European Forum for Urban Security*
16. *ENLACE*
17. *EURAD*
18. *EuroTC - European Treatment Centres for Drug Addiction*
19. *EUSPR - European Society for Prevention Research*
20. *FAD - Fundación de Ayuda contra la Drogadicción*
21. *Federation Addiction*
22. *FEDITO BXL*
23. *Forum Droghe*
24. *FUNDACIÓN ATENEA*
25. *GAT - Grupo de Ativistas em Tratamentos*
26. *HRI - Harm Reduction International*
27. *IDPC - International Drug Policy Consortium*
28. *INPUD - International Network of People who use Drugs*
29. *IREFREA - Instituto Europeo de Estudios en Prevención*
30. *MAT - Magyar Addiktológiai Társaság*
31. *Médicos del Mundo España*
32. *PARSEC Consortium*
33. *Polish Drug Policy Network*
34. *Prekursor Foundation for Social Policy*
35. *Proslavi Oporavak*
36. *Romanian Harm Reduction Network*
37. *Rights Reporter Foundation*
38. *San Patrignano*
39. *SANANIM*
40. *SDF - Scottish Drugs Forum*
41. *UNAD*
42. *UTRIP*
43. *WFAD - World Federation Against Drugs*
44. *WOCAD*
45. *YODA - Youth Organisations for Drug Action*

Endnotes

[1] See CND resolutions 60/1 (2017) and 61/10 (2018)

[2] Except for the topic witness protection, mentioned in Paragraphs 61 and 62 of the Plan of Action

[3] Note that the 2009 Political Declaration and Plan of Action includes a total of 224 actions, while the UNGASS Outcome Document includes 103 operational recommendations. Drawn from: International Drug Policy Consortium (2018), *10-year review of successes and failures of global drug policy: A civil society shadow report* (in preparation)

[4] For more information, visit: https://www.hri.global/10by20

[5] Available here: http://www.emcdda.europa.eu/news/2015/eu-minimum-quality-standards_en

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[7] United Nations Office on Drugs and Crime & World Health Organization (March 2017), *International Standards for the Treatment of Drug Use Disorders*, http://www.who.int/substance_abuse/activities/msb_treatment_standards.pdf?ua=1

[8] World Health Organization, United Nations Office on Drugs and Crime & UNAIDS (2013), *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*, http://www.who.int/hiv/pub/idu/targets_universal_access/en/

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[10] https://www.federationaddiction.fr/un-projet-pour-ameliorer-le-reperage-des-addictions-en-prison/
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[18] See: http://www.who.int/medicines/access/controlled-substances/UNSG_SignedDGletter.pdf?ua=1
[19] Busby, M. (16 June 2018), 'Home Office looks at allowing cannabis oil for boy with epilepsy', *The Guardian,* https://www.theguardian.com/politics/2018/jun/15/mothers-plea-for-uk-to-legalise-cannabis-oil-charlotte-caldwell-billy
[20] Home Office (26 July 2018), *Cannabis-derived medicinal products to be made available on prescription*, https://www.gov.uk/government/news/cannabis-derived-medicinal-products-to-be-made-available-on-prescription
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