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Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: follow-up to the high-level review by the Commission on Narcotic Drugs, in view of the special session of the General Assembly on the world drug problem to be held in 2016**Drug policy provisions from the international drug control Conventions**

The international drug control system is based on three Conventions. The first one, “Single Convention on Narcotic Drugs” of 1961 as amended by the “1972 Protocol amending the Single Convention on Narcotic Drugs, 1961” (referred to as the “1961 Convention” in this document), largely established the system, while the Convention on Psychotropic Substances of 1971 (referred to as the “1971 Convention” in this document) added psychotropic substances to the list of drugs whose use must be limited to medical and scientific purposes. Finally, the “United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988” (referred to as the “1988 Convention”) established a more detailed system of control against the trafficking of illicit drugs with particular attention to the diversion of precursors and money-laundering. This document will discuss the implications of the three Conventions for drug policy.

I. Do the drug Conventions commit governments to implement a prohibitionist regime?

Although the Conventions restrict the use of controlled drugs to medical and scientific purposes, this limitation should not be considered as the justification for a repressive “prohibitionist” regime, but as the foundation of a drug control system protecting the health of people from the inappropriate use of

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narcotic drugs and psychotropic substances. The Conventions indicate that the controlled substances should be used under the responsibility of medical doctors or licensed health professionals to avoid substantial health and security challenges to individuals and communities.

The 1961 and the 1971 Conventions are based upon concern for the welfare of mankind and indicate that narcotic drugs and psychotropic substances under control should be made available exclusively for medical and scientific purposes, requiring States parties to guarantee adequate provision for such purposes.¹ From this perspective, controlled narcotic drugs and psychotropic substances are not prohibited, but (save for the exception made under the Convention) their production, manufacture, export, import, distribution of, trade in, use and possession should be limited exclusively to medical and scientific purposes.²

The approach adopted by the three Conventions is health-centred. The intention is to make essential medications available for the relief of pain and the alleviation of suffering, while protecting the people, particularly the most vulnerable, from the potentially dangerous effects of these controlled drugs. The preamble of the 1961 Convention indicates that the main reason to consider these drugs as dangerous is their capacity to induce “addiction”.³ The drafters of the 1961 Convention were aware of the risk of those controlled drugs to affected individuals, and, in turn, the social and economic dangers related to addictive behaviour. Addiction, a compulsive behaviour related to well-known neurobiological and psychological mechanisms, has been found to undermine personal and social life, requiring individuals to focus their resources on the drug itself, despite the resulting negative consequences.

Because of their pharmacological profile, controlled narcotic drugs and psychotropic substances can compromise health and human safety if used outside the structure of sound medical practice, namely without a medical prescription, at the wrong dosage, for an inappropriate time and outside a clinical setting. As a consequence, the 1961 Convention calls for the establishment of a “drug control system” whereby States parties commit themselves to an accurate and responsible management of these substances.⁴

A medical prescription is commonly necessary to obtain medication from the pharmacy, for non-psychoactive drugs such as antibiotics, or non-controlled psychoactive drugs such as antidepressant or mood stabilizers. In any regulatory framework, it is perfectly reasonable that the use of drugs inducing significant psychoactive effects, possible health damage and carrying a high risk for psychological/physical dependence should be limited to the management of health professionals, and not permitted to be under the control of unqualified individuals through uncertified distribution. Controlled narcotic drugs and psychotropic substances, far from being simply prohibited, are under a control system to avoid dangerous effects that may result from non-medical use. This control system is also intended to prevent an epidemic of “addictive” disorders.

¹ Preamble of the 1961 Convention, second paragraph; preamble of the 1971 Convention, fifth paragraph.

² Art. 4, para. c) of the 1961 Convention; art. 5 of the 1971 Convention.

³ Preamble of the 1961 Convention, third paragraph.

⁴ Preamble of the 1961 Convention, eighth paragraph.

Several countries have indeed used imprisonment and severe punishment as sanctions for the violation of some provisions of the Conventions. Many of them have even included severe punishment and sanctions for the possession of small quantities of controlled drugs for personal use, contributing to the popular discourse of equating drug control with a purely “repressive regime” and the limitation to medical and scientific use with “prohibition”. This is not the vision of the Conventions, which aim at protecting public health, providing a legislative and normative framework that addresses the use of controlled narcotic drugs and psychotropic substances within qualified clinical interventions.

II. Do the Conventions hinder the availability of controlled drugs for medical purposes?

One of the primary aims of the Conventions is to guarantee the availability of essential drugs for medical interventions, as “indispensable” tools for the treatment of a variety of medical conditions, particularly pain and many psychiatric and neurological conditions, while preventing use that is not for medical or scientific purposes.

The control provisions of the Conventions are designed to (a) ensure that controlled narcotic drugs and psychotropic substances are available and prescribed for medical purposes and safely reach patients through a controlled distribution chain and (b) combat illicit activities such as the non-authorized manufacture, trade and distribution of those controlled drugs.

These provisions are designed to serve what the International Narcotics Control Board (INCB) has described as the overall goal of a “well-functioning national and international system for managing the availability of narcotic drugs and psychotropic substances, namely “to provide relief from pain and suffering by ensuring the safe delivery of the best affordable drugs to those patients who need them and, at the same time, to prevent the diversion of drugs for the purpose of abuse”.⁵

Drug control should not interfere with the availability of these medications that are defined as “indispensable” by the 1961 Convention. Availability of and access to essential drugs for the people in need are the primary aim of the international drug control system.⁶

As stated by World Health Organization (WHO), the rational use of controlled medicines — i.e. medicines controlled under the international drug treaties — is crucial to health. Their appropriate medical prescription and administration are essential aspects of good medical practice for pain treatment and other clinical interventions.⁷

⁵ Para. 132 in INCB (2011), “Report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes”. New York 2011.

⁶ Preamble of the 1961 Convention and of the 1971 Convention.

⁷ Page 10 in WHO (2011), “Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines”, World Health Organization, Geneva, Switzerland.

While States are not precluded from adopting measures that are more restrictive than those required by the 1961 Convention when they deem them necessary or desirable to protect public health or welfare,⁸ efforts to limit the use of narcotic drugs and psychotropic substances to medical and scientific purposes “must not adversely affect their availability for such purposes”.⁹ A recent survey conducted by the INCB found that national laws and regulations that were unduly restrictive or burdensome were commonly perceived as a significant limitation on availability.¹⁰

Some of the substances in Schedule I of the 1961 Convention can be described as difficult to handle because of their pharmacological profile. After being tentatively used for therapeutic purposes, and in some cases commercialized by pharmaceutical companies many years ago, some of those substances have been removed from the market because of their physical/behavioural side effects and their unmanageable addictive properties. However, for those medications in Schedule I of the 1961 Convention with well recognised pharmacological effectiveness in medical practice, such as morphine, the 1961 Convention never prohibited medical use, and only requires that they are used under medical supervision.

Schedules II and III of the 1961 Convention list substances that have a widely recognised medical use. When taken without medical advice and/or at the wrong dosage, or without a proper diagnostic process, these psycho-active substances may provoke dangerous reactions affecting behaviour and health, particularly mental health, once again indicating the necessity of responsible medical regulations.

In summary States parties should follow the provisions of the 1961 and 1971 Conventions to protect public health and welfare and the efforts of States to limit the use of narcotic drugs and psychotropic substances to medical and scientific purposes should not create barriers to their appropriate clinical utilization.

III. Do the Conventions treat drug users as criminals who require punishment?

The 1961 Convention recognizes that an unwholesome environment is a primary factor contributing to the susceptibility of individuals to use controlled drugs outside the intended or prescribed medical purpose. The Conventions repeatedly distinguish between drug dealers managing the illicit distribution of controlled drugs, and people affected by social and health problems, and using drugs. Many States implementing the drug control Conventions share the view that the intention of the Conventions was to protect vulnerable groups such as children and adolescents at risk, marginalized persons, individuals affected by social exclusion or disadvantages, or people with a history of affective trauma, psychological problems and mental health concomitant disorders. These vulnerable and at

⁸ Art. 39 of the 1961 Convention.

⁹ Para. 131 in INCB (2011), “Report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes”. New York 2011.

¹⁰ Para. 97 in INCB (2011), “Report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes”. New York 2011.

risk populations are more likely to experiment with drugs in an attempt to cope with difficult conditions, and are at increased risk to develop drug use disorders (abuse and dependence).

As early as 1972, the protocol amending the 1961 Convention recognized the fact that “drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live”.¹¹ The drafters took into consideration the adverse environmental factors that make individuals increasingly vulnerable to drug use and dependence. An unwholesome atmosphere, in fact, references conditions detrimental for the individual’s physical, psychological and moral well-being, prior to exposure to drugs, in turn increasing the risk for substance abuse and undermining an individual’s resilience.

Current scientific evidence, many years after the 1961 Convention was adopted, shows that experimenting with drugs, misusing psychotropic medications, or abusing alcohol at an early age are the result of the interplay of genetic predisposition with environmental factors. Suffering neglect or abuse, growing up in a deprived community, being affected by early psychological problems, being a victim of violence and instability, experiencing poor parenting and social exclusion, all contribute to a susceptibility for drug use initiation, with potential progression to the development of addictive/compulsory behaviour. A growing body of evidence indicates that initiating drug use and the development of dependence cannot be considered as an individual’s isolated choice, but as the behavioural expression of a complex set of psychobiological vulnerabilities and conditions.¹²

In particular, drug dependence is considered by science to be a multi-factorial chronic disease affecting the brain. Three dimensions contribute to the pathogenesis of the addictive disease: (1) the exposure to drugs which affects brain function, (2) the genetic predisposition influencing temperament and personality traits and (3) adverse life experiences. Each of these factors contributes to permanent changes

¹¹ Operative paragraph 1, Resolution III, 1972 amendments to 1961 Convention.

¹² Ezard, N. (2012). Substance use among populations displaced by conflict: a literature review. *Disasters*, 36, 533-557; Pechtel, P., & Pizzagalli, D.A. (2011). Effects of early life stress on cognitive and affective function: an integrated review of human literature. *Psychopharmacology (Berl)*. 214(1):55-70; National Research Council & Institute of Medicine (2009). Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Committee on Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Washington, DC: The National Academies Press; Chermack, S., Stoltenberg, S. F., Fuller, B. E., & Blow, F. C. (2000). Gender Differences in the Development of Substance-Related Problems: The Impact of Family History of Alcoholism, Family History of Violence and Childhood Conduct Problems. *Journal of Studies on Alcohol*, 61, 845-852; Feinstein, E. C., Richter, L., & Foster, S. E. (2012). Addressing the critical health problem of adolescent substance use through health care, research, and public policy. *Journal of Adolescent Health*, 50, 431-436; Shonkoff, J. P. & Phillips, D. A. (2000). From neurons to neighborhoods: The science of early childhood development. Washington, DC: National Academy Press; The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2011). Adolescent substance use: America’s #1 public health problem. CASA, New York; Winstanley, E. L., Steinwachs, D. M., Ensminger, M. E., Latkin, C. A., Stitzer, M. L., & Olsen, Y. (2008). The association of self-reported neighborhood disorganization and social capital with adolescent alcohol and drug use, dependence, and access to treatment. *Drug and Alcohol Dependence*, 92, 173-182; Yoshikawa, H., Aber, J. L., & Beardslee, W. R. (2012). The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. *American Psychologist*, 67, 272-284.

in the brain function that constitute the neurobiological basis for the development of addictive behaviour.¹³

With regards to actions contrary to the provisions of the 1961 Convention, that should be considered punishable offences, Article 36, paragraph 1 (b) of the 1961 Convention clearly states that “when abusers of drugs have committed such offences, the parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, aftercare, rehabilitation and social reintegration”. A similar provision is included in Article 22, paragraph 1 (b) of the 1971 Convention.

The Conventions repeatedly call for social cohesion and the reintegration of drug users, and do not treat illicit drug users and dependent individuals as criminals to be marginalized. The Conventions offer the opportunity for rehabilitation and reintegration into society, not reflecting a punitive attitude. This framework serves to commit States parties to focus on social reintegration of illicit drug users, and the treaties recognize that the people affected by drugs, in particular drug dependent patients, do not need punishment, but social protection, health care and community solidarity.

The issue is reiterated by the Conventions with reference to measures against the abuse of narcotic drugs and psychotropic substances, indicating again, the list of interventions, namely early identification, treatment, after care, rehabilitation, and social integration of drug dependent individuals. The Conventions also require that States parties coordinate their efforts in developing this health-centred approach focused on social cohesion.¹⁴

Regarding possession, purchase or cultivation of controlled drugs for personal consumption, i.e. not for medical or scientific purposes, the 1988 Convention determines that these actions shall be established as criminal offences. However, this obligation is subject to States parties’ constitutional principles or basic concepts of their legal systems.¹⁵ The same Convention also indicates that States parties may provide measures for treatment, education aftercare, rehabilitation or social reintegration as an alternative to conviction or punishment.¹⁶ Therefore, the Conventions do not absolutely *require* the punishment of possession, purchase or

¹³ Costello EJ, Eaves L, Sullivan P, Kennedy M, Conway K, Adkins DE, Angold A, Clark SL, Erkanli A, McClay JL, Copeland W, Maes HH, Liu Y, Patkar AA, Silberg J, van den Oord E. Genes, environments, and developmental research: methods for a multi-site study of early substance abuse. *Twin Res Hum Genet.* 2013 Apr;16(2):505-15. doi: 10.1017/thg.2013.6. Epub 2013 Mar 6; Agrawal A, Lynskey MT. Are there genetic influences on addiction: evidence from family, adoption and twin studies. *Addiction.* 2008 Jul;103(7):1069-81. doi: 10.1111/j.1360-0443.2008.02213.x. Epub 2008 May 20; Rhee SH, Hewitt JK, Young SE, Corley RP, Crowley TJ, Stallings MC. Genetic and environmental influences on substance initiation, use, and problem use in adolescents. *Arch Gen Psychiatry.* 2003 Dec;60(12):1256-64; Feng J, Nestler EJ. Epigenetic mechanisms of drug addiction. *Curr Opin Neurobiol.* 2013 Aug;23(4):521-8. doi: 10.1016/j.conb.2013.01.001. Epub 2013 Jan 29; Wong CC, Mill J, Fernandes C. Drugs and addiction: an introduction to epigenetics. *Addiction.* 2011 Mar;106(3):480-9. doi: 10.1111/j.1360-0443.2010.03321.x.

¹⁴ Art. 38, para. 1 of the 1961 Convention; Art. 20, para. 1 of the 1971 Convention.

¹⁵ Art. 3, para. 2 of the 1988 Convention.

¹⁶ Art. 3, para. 4 (d) of the 1988 Convention.

cultivation for personal use. That is why, under the Conventions, de-penalisation of possession, purchase or cultivation of controlled drugs for personal use is possible, under specific circumstances. It should be noted that de-penalisation does not equal decriminalization: drug possession for personal use remains illegal (a punishable offence), but the action taken in response to this offence does not necessarily lead to punishment. In fact, a more effective alternative to punishment can be social protection and detoxification services, health care, treatment of dependence and reintegration into society.

In this respect, the treaties appear to have intended to discourage the unauthorized possession and use of controlled drugs which, without prescription and outside medical supervision, are considerably dangerous for the individual, his/her family, the community, and can undermine public health. Indicating that an action or a behaviour is illicit, and may constitute an offence, has an important role in terms of communication. The intention is to protect health, exactly as for other behaviours that are considered as illicit acts: driving a car without respecting the rules, owning weapons without a license, discarding contaminated material or managing explosives without appropriate authorization and procedures to protect public health.

In addition, the 1988 Convention indicates that in cases focused on drug dealers, the legislation should identify and divert cases of a minor nature from the criminal justice system. For example, as already happens in many countries, individuals selling a small amount of drugs with the intent to obtain the money to maintain their habit as drug addicts do not receive the same institutional response given to criminals managing drugs as an illicit and profitable business. For these reasons, Article 3, paragraph 4 (c) of the 1988 Convention states that “in appropriate cases of a minor nature”, the parties may provide “as alternatives to conviction or punishment” measures such as education, rehabilitation or social reintegration, as well as treatment and aftercare.

Treatment, as alternative to prison, is mentioned in many provisions of the Conventions, clearly indicating that individuals affected by drug use disorders do not need to be criminally punished.¹⁷

IV. Do the Conventions support unqualified interventions for prevention of drug use and treatment of drug dependence?

The 1961 Convention calls for appropriate measures for drug use prevention and drug dependence treatment, and the necessity to train qualified professionals in the area of drug demand reduction. This emphasizes the necessity for States parties to adopt a science based approach in prevention and treatment.

The Conventions oblige States parties to “take all practicable measures” for the prevention of abuse of controlled narcotic drugs and psychotropic substances and for their early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and to coordinate their efforts to these

¹⁷ Art. 36, para. 1 (b) of the 1961 Convention; Art. 22, para. 2 (b) of the 1971 Convention; Art. 3, para. 4 (b) of the 1988 Convention.

ends. The Conventions also recognizes the necessity to train qualified professionals in these fields,¹⁸ thus emphasizing that prevention of illicit drug use and treatment of drug dependence cannot rely on spontaneous and unqualified initiatives. The prevention of illicit drug use and treatment of drug dependence must be based upon appropriate scientific methods, evidence-based and cost-effective interventions, and good practice indicated by institutional guidelines as a result of scientific findings.

In line with this provisions of the Conventions, the Political Declaration 2009¹⁹ reiterates the commitment to promote and develop primary prevention, early intervention, treatment, care, rehabilitation, social reintegration and related support services, aimed at promoting health and social well-being among individuals, families and communities and reducing the adverse consequences of drug abuse, with interventions based on scientific evidence.²⁰ The existence of a growing body of scientific evidence in addiction medicine permits States parties to apply prevention and treatment methods that have been found effective and cost-effective by science, following the same criteria, indicators and quality standards, as for any other chronic disease.

Qualified and science-based interventions, delivered by well-trained health and social professionals, as required by the Conventions, are the basis for rigorous evaluation applied to prevention and treatment programmes. The lack of measurable results or the impossibility to compare results because of unqualified and spontaneous initiatives in prevention and treatment have reduced the confidence of politicians and policy-makers in drug demand reduction activities, in turn negatively affecting the resources made available by and for States parties in this area.

The Conventions invite State parties to disseminate an understanding about drug and substance abuse and its prevention to all the professional groups involved, and to the public opinion in general, again suggesting the importance of dissipating ignorance and sharing increased knowledge in this area.²¹ The 1961 Convention recognizes that many professional groups are involved in the response to substance abuse problems, including not only the health and social field, but also the criminal justice system, law enforcement organizations, the penitentiary system, the private sector and the media.

The drafters of the Conventions demonstrated forward thinking and vision, in addressing a multi-factorial and complex health issue, such as substance abuse, by implicitly recognizing the importance of a multidisciplinary and comprehensive approach with the involvement of community stakeholders in well-coordinated, qualified interventions. In particular, to disseminate a reliable understanding about drugs and drug addiction to all the professional groups, it is essential to overcome stigma, discrimination, and misleading views about illicit drug users, and it is crucial to enhance social cohesion and support for rehabilitation support services.

¹⁸ Art. 38, para. 2 of the 1961 Convention; Art. 22, para. 2 of the 1971 Convention.

¹⁹ Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, as adopted by the Commission on Narcotic Drugs at the high-level segment of its fifty-second session on 12 March 2009 and by the General Assembly in its resolution A/RES/64/182 (hereinafter referred to as “2009 Political Declaration”), Official Records of the Economic and Social Council, 2009, Supplement No. 8 (E/2009/28), chap. I, sect. C ; see also A/64/92-E/2009/98, sect. II.A.

²⁰ Para. 21 of the 2009 Political Declaration.

²¹ Art. 38, para. 3 of the 1961 Convention; Art. 20, para. 3 of the 1971 Convention.

This vision, supplemented by the new understanding of drug use and addiction afforded to us by scientific research may progressively improve drug demand reduction activities, thus diverting the response from the criminal justice system to the health care system and from a sanction-oriented approach to a health-oriented one.

V. Do the Conventions support compulsory treatment?

The Conventions do not mention and never support “compulsory treatment”.

The 1961 Convention never mentions compulsory treatment. It indicates that States parties may provide treatment, education, aftercare, rehabilitation or social reintegration “in addition to conviction or punishment” or “as an alternative to conviction of punishment”.²²

The 1961 Convention never states that conviction or punishment can or should be offered as treatment. In this sense, presenting detention centres for drug users and drug dependent patients as education, treatment and rehabilitation is inappropriate. In addition, many detention centres utilize outdated methods and non-scientific practice, clearly not in line with the Conventions’ provisions that require qualified interventions delivered by well trained personnel.

Education, treatment, rehabilitation and social reintegration should be offered as opportunities and alternatives to prison for drug users and drug dependent individuals. These interventions should not be imposed. It is obvious that, for drug users committing crimes, the possibility to undergo treatment and attend a detoxification program as an alternative to prison is related to and involves the choice of the patient, and is not imposed by the provisions of the Conventions. Drug dependent patients found guilty of committing a crime should be given the possibility to attend treatment programs as an alternative to prison, or to serve their sentence in prison, on the basis of their free choice.

The legislation in many States parties and international medical standards require that all medical treatment be provided with the free “consent” of the patient. Only in specific cases related to acute and dangerous conditions, including a patient at risk for life and security (psychotic crisis, overdose, risk of violence, suicide attempt), a treatment can be applied as mandatory for a few hours or at most a few days. After this short period, the patient will be in a condition to be autonomous and have the capacity to agree or refuse drug dependence treatment interventions.²³

The wording “rehabilitation” or “social reintegration”, used extensively by the Conventions, also indicates that the goals of the detoxification/recovery process are not social exclusion, segregation in detention centres or application of coercive measures. Rather the aims of the Conventions are to restore citizenship and

²² Art. 36, para.1 (b) of the 1961 Convention; Art. 22, para. 1 (b) of the 1971 Convention; Art. 3, para. 4 (b) of the 1988 Convention.

²³ Principle 11. “Consent to Treatment”. United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, GA 46/119, 1991. World Health Organization (2005b) WHO Resource Book on Mental Health, Human Rights and Legislation. Geneva, World Health Organization.

empowerment, strengthen social cohesion and promote a sense of bonding to the community.

The therapeutic process in addiction treatment, as well as the rehabilitation strategy and related recovery outcome, are based upon establishing an alliance between the patient and the therapist. This is not different from the treatment of any other chronic disease. Through this “therapeutic alliance” a progressive negotiation permits the patient to fully engage in the process of setting goals and working to reach the agreed upon goals of the treatment process. Rehabilitation steps cannot be imposed on a patient, and the process requires patience and long term commitment. Addiction professionals are committed to the full spectrum of recovery services, including accompanying patients who may suffer a relapse to drug using behaviours.

The objectives of the social reintegration process, as well as the educational goals, cannot be reached applying compulsory methods and mandatory treatment programmes for patients. On the contrary, a non-confrontational and supportive approach must be adopted, and interactive cognitive-behavioural methods applied, making drug users and, in particular, addicted patients an active part of their recovery strategy.

VI. Are the Conventions against harm reduction strategies?

The Conventions are not against harm reduction strategies when harm reduction is not carried out in isolation or as an alternative to demand reduction.

At the time the Conventions were drafted, measures to prevent the health and social consequences of drug use and dependence were not as developed as in more recent decades. Thus, the 1961 and the 1971 Conventions only mention “treatment, education, aftercare, rehabilitation or social reintegration”.²⁴ The 1988 Convention called on parties to adopt appropriate demand reduction measures with a view of “reducing human suffering”, based on recommendations of the United Nations and the World Health Organization.²⁵ Commenting on this article, INCB noted that the ultimate aim of the Conventions is to reduce harm.²⁶

Further, the explicitly stated *raison d’être* of the 1961 Convention in general, and of drug demand reduction in particular, is a concern for the health and welfare of human kind in respect to the issue of controlled narcotic drugs and psychotropic substances.²⁷ In line with this view, Member States agreed already in 1988 that “Demand reduction policies shall: (i) Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse;”.²⁸

In 2009, Member States unanimously supported the view that protecting the health of drug users and offering first line social assistance, especially when the patient is not motivated to participate in treatment interventions or has relapsed to drugs after

²⁴ Art. 36, para. 1 (b) of the 1961 Convention; Art. 22, para. 1 (b) of the 1971 Convention.

²⁵ Art. 14, para. 4 of the 1988 Convention.

²⁶ INCB Annual Report 2003.

²⁷ Preambles of the 1961 Convention and of the 1988 Convention.

²⁸ Para. 8 (b), Declaration on the Guiding Principles of Drug Demand Reduction (A/RES/S-20/3).

treatment, is an essential commitment for each Member State. The language adopted in the 2009 Political Declaration to encompass harm reduction measures, a concept with different definitions and political connotations, as a result of decision taken by the High Level segment of the CND, was “attenuating the adverse health and social consequences of drug abuse”.²⁹

There is no conflict between the “measures to reduce health and social consequences of drug abuse” and “drug demand reduction”.³⁰ The measures of harm reduction should be considered part of, or a clinical segment of, a broader continuum of care. The measures to reduce the adverse health and social consequences of drug abuse should include the package of nine interventions to prevent HIV jointly published by UNAIDS, UNODC and WHO, as well as interventions to prevent overdose, the prevention of driving under the influence of drugs, hygienic measures and first line social assistance.³¹

In a number of countries, since the end of the 1980s, Governments have introduced programmes for the exchange or distribution of needles and syringes for drug addicts, to limit the spread of HIV/AIDS. The INCB maintains the position expressed in 1987 that Governments need to adopt measures that may decrease the sharing of hypodermic needles among injecting drug abusers in order to limit the spread of HIV/AIDS, while avoiding to promote drug abuse with such measures.³² In this context, there is some research to demonstrate that needle exchange programmes (NEP) do not increase the incidence of drug use in the area where they are implemented.³³

The INCB reiterated its position in 2000 acknowledging that “harm reduction had a role to play in a tertiary prevention strategy...” i.e. in the protection of the health of drug users. Following the INCB guidance, although harm reduction programmes cannot be considered substitutes for demand reduction programmes, these interventions can be considered to play a role in a comprehensive drug demand reduction and health strategy.³⁴ In this framework, harm reduction interventions should be seen in line with, and not against, the Conventions.

²⁹ Para. 20 of the 2009 Political Declaration.

³⁰ Preface, UNODC (2009), *Reducing the adverse health and social consequences of drug abuse: a comprehensive approach*, United Nations Office on Drugs and Crime, Vienna, Austria.

³¹ WHO (2009), WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, World Health Organization, Geneva, Switzerland.

³² Para. 2 of chapter I. Overview in INCB (1987), *Report of the International Narcotics Control Board for 1987*, International Narcotics Control Board, Vienna, Austria.

³³ Guydish J et al. Evaluating needle exchange: are there negative effects? *AIDS*, 1993, 7:871-876. Hartgers C et al. The impact of the needle and syringe-exchange programme in Amsterdam on injecting risk behaviour. *AIDS*, 1989, 3(9):571-6. Van Ameijden EJ & Coutinho RA. Large decline in injecting drug use in Amsterdam, 1986-1998: explanatory mechanisms and determinants of injecting transitions. *Journal of Epidemiology & Community Health*, 2001, 55(5):356-63.

³⁴ Para. 445 in INCB (2000), *Report of the International Narcotics Control Board for 2000*, International Narcotics Control Board, Vienna, Austria.

VII. Are the Conventions against the use of controlled narcotic drugs in the treatment of drug dependence?

The 1961 Convention, the Psychotropic Convention and the Anti-trafficking Convention, are not against the use of controlled drugs in the treatment of dependence when narcotics or psychotropic substances are used for medical purposes and under medical supervision. The provisions of the Conventions do not pronounce on the clinical choices related to drug dependence treatment and, in particular, do not indicate which medication should be used for pharmacological therapy.

The medical use of narcotic drugs has been defined indispensable for the relief of pain and suffering by the 1961 Convention.³⁵ The text of the Preamble of the 1961 Convention permits the medical use of controlled narcotic drugs and psychotropic substances to alleviate suffering, including suffering related to withdrawal symptoms and related to the conditioned compulsive behaviour of drug dependence.

Some narcotic drugs and psychotropic substances have been found effective in the treatment of medical-behavioural conditions and mental health disorders, requiring measures and special attention to avoid abuse and diversion.

Among the medications for opioid dependence treatment, many studies have documented the safety, efficacy, and effectiveness of long-acting opioids, such as methadone and buprenorphine (substances under control), in the treatment of heroin addiction. The uses of these medications are described in publications by both UNODC and WHO.³⁶ That is why the 2009 Political Declaration states that “Member States should consider developing a comprehensive treatment system offering a wide range of integrated pharmacological (such as detoxification and opioid agonist and antagonist maintenance) and psychosocial (such as counselling, cognitive behavioural therapy and social support) interventions based on scientific evidence, with a focus on the process of rehabilitation, recovery and social reintegration;”³⁷

Using language that refers to methadone and buprenorphine as “substitution treatment” can be misleading and counterproductive. The use of the term “substitution,” referring to the fact that methadone or buprenorphine replace heroin in binding to brain opioid receptors, has been generalized to consider these medications as simple replacements of street drugs. This misleading generalization contributes to the widespread misunderstanding of this treatment approach. Although methadone and buprenorphine are opioids, as are heroin or morphine, their pharmacological properties (the long duration of their binding to the receptors in the brain — 36-48 hours — and their intrinsic specific effects) make them completely different substances, and not a substitution of one for another.

³⁵ Preamble of the 1961 Convention.

³⁶ UNODC (2009), Principles of Drug Dependence Treatment — UNODC/WHO Discussion Paper, United Nations Office on Drugs and Crime, Vienna, Austria. WHO (2009), Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, Department of Mental Health & Substance Abuse, World Health Organization, Geneva, Switzerland.

³⁷ Para. 4 (h) of the Plan of Action of the 2009 Political Declaration.

Firstly and most importantly, methadone and buprenorphine are not rewarding, as heroin or other short-acting opioid agonists are. Secondly, methadone and buprenorphine are long-acting. That is, their effect lasts a long time and prevents withdrawal symptoms and dysphoria from emerging. These factors make them important tools for the treatment of heroin dependence. Appropriate dosages of methadone or buprenorphine cancel the rewarding effect obtained from heroin and allow for pharmacological control of the addictive habit, in particular interrupting the reward/regret compulsory cycle of addiction.

In support of this interpretation, the INCB statement in 2003 indicated that “many Governments have opted in favour of drug substitution and maintenance treatment as one of the forms of medical treatment of drug addicts, whereby a drug with similar action to the drug of dependence, but with a lower degree of risks, is prescribed by a medical doctor for a specific treatment aim. Although results are dependent on many factors, its implementation does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice.”³⁸ As is the case with the concept of medical use, treatment is not treaty-defined. The Conventions are not against the use of controlled narcotic drugs and psychotropic substances in the treatment of drug dependence.

VIII. Are the Conventions against human rights?

The aim of the Conventions is to protect the human rights of vulnerable populations from the dangerous effects of controlled drugs, from the health and social consequences of drug use disorders and from the control of criminal organization dominating the illicit drug market. The drug control system required by the Conventions should never promote violations of human rights.

The Conventions are instruments developed by Member States, through the Economic and Social Council and the General Assembly, bodies of the United Nations established by its Charter, in line with the fundamental purposes of promoting and encouraging respect for human rights and fundamental freedoms. In fact, the 1988 Convention specifically referred to the need to respect human rights in the context of the fight against the illegal cultivation of plants used to produce controlled drugs.³⁹ More recently, in the 1988 Convention and in the 2009 Political Declaration, the Member States of the United Nations unanimously recognised that action in response to the world drug problem requires an integrated and balanced approach, in full conformity with the purposes and principles of the Charter of the United Nations and international law and particularly all human rights and fundamental freedoms.⁴⁰

The Conventions aim to protect the human rights of vulnerable populations from the dangerous effects of controlled drugs, from the health and social consequences of

³⁸ Para. 222, INCB (2003), Report of the International Drugs Control Board for 2003, International Drugs Control Board, Vienna, Austria.

³⁹ Art. 14, para. 2 of the 1988 Convention.

⁴⁰ Para. 2 of the Political Declaration adopted by General Assembly Resolution A/RES/S-20/2 (hereby referred to as “1998 Political Declaration” and para. 1 of the 2009 Political Declaration.

drug use disorders and from the control of criminal organization managing the illicit drug market. The dignity of human beings and their rights to freedom, especially the right to health⁴¹ are essential elements of the drug control system, particularly protecting the rights of children, adolescents and other vulnerable groups.⁴²

Drug use does not enhance capacities and opportunities. It does not open perspectives to improve the quality of life of poor people and does not contribute to successful trajectories and effective educational benefits for children. In contrast, drugs undermine personal and social development, inhibit critical thinking, and deaden autonomy and creative initiatives. In reality, people become dependent on drugs, slaves of drug dealers, isolated from the community, deprived of mental health and cognitive/affective abilities. This is inconsistent with basic human rights. This is particularly the case for individuals most vulnerable to drug use and drug dependence, which in most cases have already suffered a history of disadvantages. Their right to health is particularly relevant.

Concerning the consequences of implementing a drug control system, the 1961 Convention provides for the possibility of not punishing drug users who are in possession of drugs for personal use.⁴³ In practice, this means moving the institutional response to this vulnerable population from the criminal justice system to the health care system. Nothing in the Conventions provides a justification for punishment or other actions directly contrary to human rights, such as torture, humiliation during treatment and coercion, which in some cases have been applied by some Member States in name of drug control. This approach flies in the face of the provisions of the Conventions and misinterprets their object and purpose.

The right to be treated for drug use disorders, without stigma and discrimination is the same as the right to be treated for any other chronic disease in the health care system. This has been recently underlined by the UNODC-WHO Programme for Drug Dependence Treatment and Care. Accordingly, the joint paper “Principles of Drug Dependence Treatment”, published by UNODC and WHO in 2009, recommends respect for the human rights of drug users, and supports access to science based treatment methods, without discrimination, applied with the consent of the patient in conditions that do not degrade individuals receiving treatment itself.

Also the programmes counteracting illegal cultivation should never violate the human rights of the farmers and communities involved. To this purpose, alternative development measures, sustainable livelihood interventions, activities to empower the communities, infrastructures, health care and educational facilities, and security measures should be complementary to and implemented in parallel with eradication measures.

⁴¹ See the preamble of the 1946 Constitution of the World Health Organization, first and second paragraph; the 1965 International Convention on the Elimination of All Forms of Racial Discrimination, Art. 5 (e)(iv); the 1966 International Covenant on Economic, Social and Cultural Rights, Art. 12; the 1979 Convention on the Elimination of All Forms of Discrimination against Women, Arts. 11 (1)(f), 12 and 14 (2)(b); the 1989 Convention on the Rights of the Child, Art. 24; the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, Arts. 28, 43 (e) and 45 (c); and the 2006 Convention on the Rights of Persons with Disabilities, Art. 25.

⁴² Paras. 13-14 of the Plan of Action of the 2009 Political Declaration. See also Art. 33 of the Convention on the Rights of the Child.

⁴³ See question III above.

In particular, the State institutions should protect these populations, agriculturally dependent communities, from the pressure and the violence of criminal organizations with the intent to engage them in the illicit production of narcotics drugs and controlled substances, thus dismantling the economic dependence on which illicit markets rely.

IX. Do the Conventions support the death penalty for drug related crimes?

The Conventions never support the death penalty for drug related crimes.

The Conventions never mention the death penalty. In the case of offences of a grave nature, the Conventions call for imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation.⁴⁴ Moreover, when abusers of drugs have committed such offences, in appropriate cases of minor nature and in the case of possession, purchase or cultivation for personal use, Member States may offer treatment and rehabilitation services as an alternative to conviction or punishment (i.e. to criminal justice sanctions).⁴⁵

In accordance with United Nations policy, UNODC advocates the abolition of the death penalty. The recent resolutions of the United Nations General Assembly in 2007, 2008 and 2010,⁴⁶ supported by an increasing number of Member States, seek to establish an international moratorium on the use of the death penalty with a view to progressing towards abolition. These important resolutions call upon all States that still maintain the death penalty to progressively restrict the use of the death penalty, reduce the number of offences for which it may be imposed, and establish a moratorium on executions with a view to abolishing the death penalty altogether. The resolutions also call upon Member States to follow international standards, such as the International Covenant on Civil and Political Rights which specify that in countries which have not abolished the death penalty, the sentence of death may be imposed only for the “most serious crimes”, which are generally not understood to include drug-related crime.⁴⁷

⁴⁴ Art. 36, para. 1 (a) of the 1961 Convention; Art. 22, para. 1 (a) of the 1971 Convention; Art. 3, para. 4 (a) of the 1988 Convention.

⁴⁵ See question III above.

⁴⁶ A/RES/62/149, A/RES/63/168, A/RES/65/206.

⁴⁷ Drug control, crime prevention and criminal justice: A Human Rights perspective. Note by the Executive Director: E/CN.7/2010/CRP.6-E/CN.15/2010/CRP.1.