Canadian Drug Policy Coalition
Coalition canadienne des politiques sur les drogues

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

Promoting Smart Policy on Drugs: Brief to the Minister of Health

Prepared for the 59th session of the UN Commission on Narcotic Drugs
and the
UN General Assembly Special Session on the World Drug Problem

National Working Group on UNGASS on Drugs
Supported by the Canadian Drug Policy Coalition and Canadian HIV/AIDS Legal Network

February 2016

Introduction

The UN General Assembly Special Session on the World Drug Problem (UNGASS) in April 2016 is a significant opportunity for Canada, in collaboration with other Member States, specialized UN agencies and civil society organizations, to:

- engage in an open and honest discussion about how the international drug control treaties are – and are not – working;
- explore and debate the rationale for considering alternative approaches; and
- promote the development and implementation of more effective responses to "the world drug problem" based on public health principles, respect for human rights and scientific evidence.

The Canadian Drug Policy Coalition (CDPC) and the Canadian HIV/AIDS Legal Network work with a network of national and international organizations to promote a rigorous review process for the international drug control system to consider its successes, failures and challenges as a key outcome of the UNGASS. CDPC is also a member of the Civil Society Task Force for the UNGASS and is working with partners in North America to engage in a broad consultation on issues of importance to the UNGASS. The Legal Network works with a range of national and international organizations responding to HIV and related human rights concerns, including the rights implicated in drug policy (e.g., right to health, freedom of expression, freedom from arbitrary detention and from cruel and degrading treatment, protection from discrimination and others). In 2015, the CDPC and the Legal Network worked with partners to convene a national working group (members listed in Appendix A) to prepare a set of policy options for civil society to put forward during the UNGASS and to strategize on how best to engage in the UNGASS process.

Why this meeting is an important moment in international drug policy development

The UNGASS is the result of a joint call in 2012 from the presidents of Mexico, Colombia and Guatemala, three countries devastated by an intense war with drug cartels in recent years. They called on the UN General Assembly to "review the approach" of present drug policies and to "exercise its leadership… and conduct a profound reflection to analyze all available options, including regulatory market measures, in order to establish

a new paradigm that prevents the flow of resources to groups involved in organized crime."[1] In 2013, UN Secretary General Ban Ki-moon urged "Member States to use these opportunities to conduct a wide-ranging and open debate that considers all options."[2]

The UNGASS presents an opportunity for a real change in how "the world drug problem" is framed and country level responses are implemented – but only if enough Member States heed the call for an open, honest debate. The foundational treaty of the current international drug control system was signed more than 50 years ago. Since that time, ample scientific evidence has emerged on effective ways of preventing drug-related harms and treating people with problematic substance use, as has evidence of the human rights violations and public health damage that the current prohibition oriented system has engendered. That evidence makes a compelling case for reform of the current system. Therefore, as civil society partners in this work, we urge Canada to take strong leadership in working with Member States, specialized UN agencies and civil society organizations toward the goal of reforming the current international system and approach to the world drug problem.

The National UNGASS Working Group has put together the following priority issues for your consideration as negotiations proceed in the lead up to the UNGASS and to the upcoming session of the UN Commission on Narcotic Drugs (CND) (March 9-17, 2016), where much of the substance of the UNGASS outcome document will be decided.

Recommendations

1. Promote and implement a public health approach to drugs, based on evidence and human rights

Increasingly, there is rhetorical agreement among UN Member States, including in forums such as the CND, that the response to problematic substance use should reflect a "public health approach." However, often there is little understanding of, or agreement as to, what this means; numerous countries profess to pursue such an approach despite their policies and practices that in fact run contrary to public health. It is, therefore, important that more countries, including Canada, articulate explicitly in such international forums what is — and what is not — meant by a "public health approach" to drugs.

A public health approach is an organized, comprehensive, multi-sectoral effort directed at maintaining and improving the health of populations, incorporating evidence-informed policy and practice and based on principles of social justice (including equity and the protection and promotion of human rights, and the right to the highest attainable standard of health).[3,4] A public health approach is driven by identifying and then acting on those determinants of health which need to be addressed. This includes physical, biological, psychological, social (e.g. wealth distribution, education, housing, social inclusion), and ecological determinants of health, as well as the determinants of social and health inequities (including discrimination in various manifestations). In the case of Indigenous peoples in Canada, those determinants include the legacies of colonialism and its ongoing racism, social exclusion, and denial of cultural continuity and self-determination. A public health approach recognizes that problematic substance use is often symptomatic of underlying psychological, social, or health problems and inequities, and emphasizes evidence-based, pragmatic initiatives aimed at achieving sustained improvements in health. An ethical and effective public health approach includes the perspective of people who use substances or are affected by problematic substance use.[5]

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[1] Joint Statement, reproduced in G. Murkin, "Latin American leaders call on the UN to explore alternatives to the war on drugs," October 8, 2012. Online: http://www.countthecosts.org/blog/latin-american-leaders-call-un-explore-alternatives-war-drugs.
[2] "Secretary-General's remarks at special event on the International Day against Drug Abuse and illicit Trafficking," June 26, 2013. Online: http://www.un.org/sg/statements/index.asp?nid=6935.
[3] Canadian Public Health Association. *A New Approach to Managing Illegal Psychoactive Substances in Canada* (Ottawa: CPHA, 2014).
[4] Health Officers Council of British Columbia. *Public Health Perspectives for Regulating Psychoactive Substances - What we can do about alcohol, tobacco and other drugs* (2011).
[5] Canadian HIV/AIDS Legal Network. *Nothing About Us Without Us - Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative*. Toronto: Legal Network, 2005.

The goal of a public health approach is to maximize benefits and minimize harms of drugs, promote the health and wellness of all members of a population, reduce inequities within the population, and ensure that the harms associated with interventions and laws are not disproportionate to the harms that may be associated with the drugs themselves. A public health approach ensures that a coherent set of interventions, policies, and programs is implemented, and their beneficial effects and adverse consequences are tracked.

A public health approach is directed by focusing a public health lens on a situation and clearly articulating underlying assumptions, vision, goals and objectives. A public health approach is implemented through a variety of both universal and targeted strategies, including: broader health promotion initiatives, including access to a spectrum of health services, housing and other social services; evidence-based measures aimed at preventing problematic drug use; programs to reduce harms associated with drug use (e.g., services to prevent injection-related infections; and equipping people who use drugs, those around them, service providers and first responders with training and tools to respond to emergencies such as overdose); and ensuring adequate, good quality services for people who develop problems with substance use, including treatment of problematic use. A public health approach includes ongoing research, monitoring and evaluation, to identify harms and ensure evidence-based initiatives to address them.

Drug "use" is but one indicator among many in assessing harm and benefits of particular policies and programs, and reducing drug use per se — much of which is not harmful or problematic — is not necessarily the objective of public health based initiatives.[6] Over-emphasis on trying to reduce or prevent the use of drugs tends to target, blame and stigmatize people who use drugs, often ignoring the structural and other determinants of (problematic) use. Consequently, it often leads to ill-advised punitive, discriminatory and draconian policies, including mass incarceration[7] and other significant human rights violations,[8] which not only do little to protect and promote the health of people who use drugs and of communities, but in fact produce or compound harms associated with problematic drug use.

In contrast, a public health approach means treating problematic drug use as a health issue requiring health promotion strategies and programs,[9] psycho-social support and health services, rather than as a matter primarily for prohibition and punishment. Using the HIV context as an example, UNAIDS has put forward "a public health and rights approach to drugs" as a contribution to the UNGASS discussions, with several policy and operational recommendations.[10] (Those recommendations are reproduced in Appendix B.)

Therefore, we urge Canada to support adoption of a public health approach to guide the reformed system, and support the UNAIDS recommendations in the UNGASS process and outcome document.

2. Support harm reduction as a key component of a comprehensive response to drugs

We also encourage Canada to strongly advocate for harm reduction policies, practices and programs as a key component of any public health approach to address drug-related harms. To take just one drug-related harm as an example, UNAIDS has reported that the international community has failed to reach the goal of reducing HIV among people who inject drugs by 50% by 2015.[11] We can and must do better. National strategies to

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[6] M. Roberts, D. Bewley-Taylor & M. Trace. *Monitoring Drug Policy Outcomes: The Measurement of Drug-related Harm.* London: Beckley Foundation, 2006.

[7] E. Drucker. *A Plague of Prisons: The Epidemiology of Mass Incarceration in America*. New York: New Press, 2011; M. Alexander. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York: New Press, 2012.

[8] D. Barrett, R. Lines, R. Schleifer, R. Elliott & D. Bewley-Taylor. *Recalibrating the Regime: The Need for a Human Rights-Based Approach to Drug Policy*. London: Beckley Foundation and International Harm Reduction Association, 2008.

[9] World Health Organization. *Ottawa Charter for Health Promotion*, Geneva: WHO, 1986. Online: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

[10] UNAIDS. *A Public Health And Rights Approach to Drugs*. Geneva, 2015. Online: http://www.unaids.org/sites/default/files/media_asset/JC2803_drugs_en.pdf.

[11] Ibid.

address the "world drug problem" must include at least the key interventions outlined in the *WHO/UNODC/UNAIDS Technical Guide* (2012 revision) as part of a comprehensive approach for addressing HIV among people who inject drugs. These include harm reduction measures such as needle and syringe programs (NSPs), opioid substitution treatment (OST) such as methadone and buprenorphine, and condom distribution programs for people who use drugs and their sexual partners. (See Appendix C for the list of needed interventions as part of a public health approach to drugs.) Additionally, cultural connection and access to culturally relevant services are identified as key sources of resilience for Indigenous people vulnerable to or living with HIV/AIDS. As the three relevant specialized UN agencies point out in the *Technical Guide*, these initiatives are supported by comprehensive scientific evidence.[12] In addition, the *Technical Guide* acknowledges that, "although the WHO has not reviewed the evidence on the effectiveness of supervised drug consumption/injection facilities in preventing HIV infection, evaluations in high-income countries where these facilities have been implemented have reported reduced risk behaviours among attending clients."[13]

Harm reduction is an increasingly important component of responses to substance use in Canada and globally. In fact, Canada has historically been among the global leaders in scaling up harm reduction interventions such as OST and NSP, as well as exploring innovations such as supervised consumption services, heroin-assisted treatment programs and distribution of sterile crack-smoking equipment. We are concerned that Canada has, in recent years, relinquished its traditional leadership role in facilitating dialogue and building consensus internationally towards comprehensive public health responses to substance use. A public health approach recognizes the human rights of people who use drugs and includes a comprehensive package of health-based interventions such as harm reduction initiatives and the full implementation of drug treatment programs based on sound scientific review and evidence. The term "harm reduction" is well understood in the scientific literature and can be easily clarified per the UN agencies' *Technical Guide*.

Therefore, we urge Canada to resume its leadership role in the promotion of a public health approach, including explicit, firm support for harm reduction interventions in international negotiations and policy.

3. Pursue and support the decriminalization of possession of drugs for personal use as essential to a public health approach

While there may be widespread rhetorical affirmation that a public health approach to drugs is desirable, there is less agreement on removing a significant barrier standing in the way of implementing such an approach — namely, the criminalization of possession for personal use of scheduled drugs. As stated succinctly by the UN Special Rapporteur on the right to the highest attainable standard of health, in his recent letter to the UNODC Executive Director: "At the root of many health-related problems faced by people who use drugs is criminalisation itself, which only drives issues and people underground and contributes to negative public and individual health outcomes."[14]

The continued criminalization of people who use drugs undermines efforts to address the health needs of people struggling with problematic drug use, and thereby undermines public health more broadly. It prevents people from seeking services; it blocks the development of services because needed resources are diverted to the criminal justice system (including correctional facilities) and because people with drug problems, when regarded as criminals, are not seen as deserving of services; and it undermines human rights and supports discrimination against people who use drugs. Indigenous populations, particularly women, children, and youth, and those with mental health and/or substance use issues, are vulnerable populations that are

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[12] *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for HIV Prevention, Treatment and Care of Injecting Drug Users, 2012 Revision*. Geneva: WHO Press, 2012. Online: http://www.who.int/hiv/pub/idu/targets_universal_access/en/.

[13] Ibid. Page 22

[14] D. Puras, UN Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health. *Open letter to UNODC Executive Director Yury Fedetov, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS)*, dated December 7, 2015.

disproportionally affected by criminalization and criminal justice approaches that flow from this policy such as mandatory minimum sentencing practices.[15] Indigenous people comprise 22.8% of the total incarcerated population, although they comprise just 4% of Canada's population[16]

The data clearly demonstrate that, despite criminal prohibitions, the number of countries in which people inject drugs is growing, with women and children becoming increasingly affected. Outside of sub-Saharan Africa, injection drug use accounts for approximately one in three new cases of HIV. In some areas where HIV is spreading most rapidly, such as Eastern Europe and Central Asia, HIV prevalence can be as high as 70% among people who inject drugs, and in some areas more than 80% of all HIV cases are among this group.[17] Several studies have demonstrated that Indigenous populations in regions across Canada are acquiring HIV at a disproportionately higher and faster rate than the general Canadian population: almost 60 per cent of HIV infections among Indigenous people between 1998 and 2005 were attributable to injection drug use.[18]

The *Vienna Declaration*, the central policy position articulated at the XVIII International AIDS Conference in Vienna in 2010 and signed by the global medical and scientific leadership of the fight against HIV/AIDS, clearly presented evidence that "national and international drug surveillance systems have demonstrated a general pattern of falling drug prices and increasing drug purity—despite massive investments in drug law enforcement" and that "there is no evidence that increasing the ferocity of law enforcement meaningfully reduces the prevalence of drug use." Given the rise of injection drug use in many countries and its significant impact on the HIV epidemic, vigorously encouraging countries to shift their priorities towards comprehensive public health responses to drug use should be a high priority.[19]

Several states have addressed these concerns by decriminalizing drug possession for personal use. Portugal, Uruguay, Colombia, the Czech Republic, as well as numerous U.S. states, are among the jurisdictions experimenting with decriminalization (i.e., removal of criminal penalties) for drug use or possession – and some have moved further to implement various models of regulation of some drugs (e.g., cannabis).[20] Portugal decriminalized the possession of all formerly-illegal drugs in 2001, complemented by investments in health and other services. Although decriminalization of personal possession still leaves control of the market in the hands of organized criminals, the results did show a subsequent decrease in the number of people injecting drugs and in the number of people using drugs problematically, as well as decreasing overall drug use trends among young people (those aged 15-24).[21] A scientific consensus has emerged that policies of drug prohibition and criminalization exacerbate the negative health and social outcomes for people who use drugs.

Such evidence and experience has supported the conclusion in the recent report of the Organization of American States, *The Drug Problem in the Americas,* that "decriminalization of drug use needs to be considered as a core element in any public health strategy."[22] Considering alternatives to criminalization and other penalties for drug use or possession of drugs for personal use has also been urged by the Special Committee of the Senate of Canada (in relation to cannabis specifically),[23] by the current and former UN Secretaries-

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[15] *Health, Crime, and Doing Time: Potential Impacts of the Safe Streets and Communities Act on the Health and Well Being of Aboriginal People in BC,* Office of the Provincial Health Officer, 2013.
[16] Annual Report of the Office of the Correctional Investigator 2013–2014
[17] 2008 Report on the global AIDS epidemic. The Joint United Nations Programme on HIV/AIDS; Geneva, 2008.
[18] Public Health Agency of Canada. *HIV/AIDS Epi Updates, November 2007*. For additional data demonstrating the disproportionate impact of injection drug use – and hence related drug policy and programmes – in the HIV epidemic among Indigenous peoples in Canada, see: Public Health Agency of Canada, *Population-Specific HIV/AIDS Status Report: Aboriginal Peoples* (Ottawa, 2010).
[19] *Vienna Declaration*. Online: http://www.viennadeclaration.com/the-declaration.
[20] International Drug Policy Consortium. "E-tool: Comparing models of drug decriminalization." Online: http://decrim.idpc.net/; Drug Policy Alliance. "Fact Sheet: Approaches to Decriminalizing Drug Use & Possession." February 2015. Online: http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Approaches_to_Decriminalization_Feb2015.pdf.
[21] A. Rosmarin & N. Eastwood. *A Quiet Revolution: Drug Decriminalization Policies in Practice Across the Globe*. London: Release, 2012. Online: http://www.release.org.uk/publications/drug-decriminalisation-policies-in-practice-across-the-globe.
[22] *The Drug Problem in the Americas*. Organization of American States, 2013.
[23] Senate Special Committee on Illegal Drugs. *Cannabis: Our position for a Canadian public policy*. Ottawa: 2002. Online: http://www.parl.gc.ca/content/sen/committee/371/ille/rep/summary-e.htm.

General,[24] by the Global Commission on Drug Policy[25] and the Global Commission on HIV and the Law,[26] by UN special rapporteurs on human rights and a wide range of human rights organizations, by public health professionals such as the Canadian Public Health Association[27] and the American Public Health Association,[28] and by specialized UN agencies such as UNAIDS,[29] UNDP,[30] UN Women,[31] the UN High Commissioner for Human Rights,[32] WHO[33] and UNODC (although this last agency has since sought to backtrack from its policy position under pressure from at least one Member State).[34]

Decriminalizing the possession of drugs for personal use is a permissible option under the current drug control treaties to address the harms of substance use. Furthermore, forgoing the enforcement of laws prohibiting the personal possession of drugs also allows states to redirect limited public budgets towards efforts to address the social determinants of harmful substance use.

Therefore, in advocating for a comprehensive public health approach to drugs, we urge Canada to emphasize that decriminalization of drug possession for personal use is a key component of implementing such an approach.

4. Supporting countries' flexibility to experiment with alternative, health-oriented approaches to drug policy

According to data from UNODC, the promised "significant reduction" in global drug supply and demand, explicitly articulated in the Declarations from the 1998 UNGASS on drugs and the High-Level-Segment of the 2009 CND session, have not been achieved. There is little reason to think that more of the same strategies and approaches will somehow begin to produce a different result. In the spirit of the call from the three Latin American presidents that triggered this year's upcoming UNGASS, now is the time to consider alternative, evidence-informed approaches to addressing drug-related problems which better protect human rights and improve public health. UNODC has repeatedly called for "a comprehensive approach to better coordination" of supply and demand reduction measures – i.e., heavily skewed toward enforcement of criminal prohibitions –

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[24] Text of speech by Kofi Annan to UN General Assembly reproduced in "Kofi Annan makes call to legally regulate drugs at the World Health Assembly," Transform Drug Policy Foundation, 20 May 2015, online: http://www.tdpf.org.uk/blog/kofi-annan-makes-call-legally-regulate-drugs-world-health-assembly; UN Secretary General Ban Ki-moon, Statement: Secretary-General's message on International Day Against Drug Abuse and Illicit Trafficking, June 26, 2015. Online: http://www.un.org/sg/statements/index.asp?nid=8763.

[25] Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies That Work* (2014), online: http://www.gcdpsummary2014.com/#foreword-from-the-chair.

[26] Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health (July 2012), online via www.hivlawcommission.org.

[27] Canadian Public Health Association. *A New Approach to Managing Illegal Psychoactive Substances in Canada.* Ottawa: CPHA, 2014.

[28] American Public Health Association. Resolution: Defining and Implementing a Public Health Response to Drug Use and Misuse (November 5 2013). Online: http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse.

[29] UNAIDS. *A Public Health And Rights Approach to Drugs*. Geneva, 2015.

[30] UNDP, Perspectives on the Development Dimensions of Drug Control Policy (New York: UNDP, March 2015). Online: https://www.unodc.org/documents/ungass2016/Contributions/UN/UNDP/UNDP_paper_for_CND_March_2015.pdf.

[31] UN Women, *Policy Brief: A Gender Perspective on the Impact of Drug Use, the Drug Trade, and Drug Control Regimes* (New York: UN Women, July 2014). Online: https://www.unodc.org/documents/ungass2016/Contributions/UN/Gender_and_Drugs_-_UN_Women_Policy_Brief.pdf.

[32] UN General Assembly. *Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights.* UN Doc. A/HRC/30/65 (4 September 2015). Online: http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx.

[33] WHO. *Policy brief: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.* Geneva: WHO, July 2014. Online: http://www.who.int/hiv/pub/toolkits/keypopulations/en/.

[34] UNODC. *Briefing paper: Decriminalisation of Drug Use and Possession for Personal Consumption*. 2015. Online: http://www.undrugcontrol.info/images/stories/documents/unodc-brief-decrim.pdf. See also: S. Rolles. "The truth behind the UNODC's leaked decriminalisation paper." IDPC Blog, 26 October 2015. Online: http://idpc.net/alerts/2015/10/the-truth-behind-the-unodc-s-leaked-decriminalisation-paper.

among Member States, yet there has not been an appreciable improved outcome in terms of reduced supply or demand.[35]

Not surprisingly, numerous countries are dissatisfied with the international drug control status quo, are launching domestic reforms and are seeking to modernize and improve the international system. Many are implementing programs and policies that have been criticized by some other powerful Members States or sometimes deemed by entities such as the International Narcotics Control Board (INCB) to be contrary to their treaty obligations — often incorrectly, as a matter of law. These include harm reduction measures such as drug consumption rooms, e.g. Vancouver's highly-successful, internationally-known Insite, previously criticized by the INCB despite the clear permissibility of such health services under the treaties[36] —and which the Supreme Court of Canada declared, as a matter of constitutional right, that Canada's criminal prohibition on drugs could not be allowed to impede.[37]

Canada's commitment to implementing a regulatory regime for adult access to legal non-medical cannabis within a public health framework is an example of the policy experimentation that is beginning to take place as countries look to new ways to reduce the scale of illegal markets. Regulation is a key part of a public health approach to substances. Canada is not alone in experimenting with regulatory options for cannabis. Several U.S. states have implemented legal cannabis regulatory frameworks and Uruguay is the first country to move toward implementing a legal market for cannabis on a nationwide scale. The value of these approaches over simple decriminalization of personal possession is that they remove control of the market from illegal producers and distributors, undermining criminal organizations. Of course, challenges are emerging as countries implement various degrees of decriminalization of possession of drugs for personal use and full legal regulation of cannabis. Tensions are growing between Member State practice and outdated treaties – or unjustifiably inflexible and incorrect interpretations of those treaties. In addition, as has been seen in the case of Bolivia's decision to enter a reservation to the 1961 Single Convention in relation to traditional uses of coca, Indigenous uses of psychoactive substances in ceremonial or health-related contexts is another source of tension within the drug control discussions which is relevant to Canada.

Therefore, we urge Canada to advocate for an open discussion and recognition of the lack of success with respect to supply and demand reduction, and to support flexibility – including the use of the flexibility found within the existing drug control conventions – for Member States to experiment with and adopt different, evidence-informed policy and programmatic approaches to address the "world drug problem," including measures to reduce the harms associated with drugs.

5. Respect, protect and promote human rights

By consensus, in both the CND and the UN General Assembly, Member States have explicitly directed that drug control efforts must be in conformity with the standards of international human rights.[38] All of UNODC's programs, policies and technical advice must further the realization of human rights, and cooperation between the UNODC and Member States must have as an outcome the development of States' capacities to meet their human rights obligations.[39]

In addition to access to care and health and mass incarceration, human rights violations of great concern when

[35] D. Werb et al. "The temporal relationship between drug supply indicators: an audit of international government surveillance systems." BMJ Open 2013; 3:e003077, doi:10.1136/bmjopen-2013-003077.
[36] Flexibility of Treaty Provisions as Regards Harm Reduction Approaches. United Nations Drug Control Program, Legal Affairs Section. 2002
[37] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.
[38] E.g., 1998 UNGASS Declaration, para. 8; CND, 53rd Session, Resolution 53/2, para 2. Online: https://www.unodc.org/documents/commissions/CND/Drug_Resolutions/2010-2019/2010/CND_Res-53-2.pdf
[39] *UNODC and the promotion and protection of human rights: Position Paper*. Vienna: UNODC, 2012.

it comes to drug control policies, and very much at play in the international discussions leading up to the UNGASS, are the following:

- Torture and Drug Detention Centres: Drug detention centres are places where persons who use or are suspected of using drugs are confined, often without any due process, and compelled to undergo diverse interventions such as forced labour and military style drills, as well as being subjected to involuntary medical interventions (often without scientific foundation), physical, sexual and psychological abuse, the denial of adequate medical care and nutrition, and other forms of torture and cruel, inhuman or degrading treatment or punishment. These types of interventions disregard medical evidence.[40] As noted by the UN Special Rapporteur on Torture, these programs violate international law and are "illegitimate substitutes for evidence-based measures, such as substitution therapy, psychosocial interventions and other forms of treatment given with full, informed consent."[41] While a wide range of UN and international organizations have jointly called for their closure, it remains the case that hundreds of thousands of people are detained in such centres; the international community, including Member States at the CND and UNGASS, must continue to press for their closure to end the widespread, gross human rights violations documented as occurring routinely in such centres.

- Use of the Death Penalty for Drug Offences: Some countries continue to use the death penalty for drug crimes. The death penalty is ineffective as a policy measure and an abhorrent violation of human rights. The use of the death penalty for punishment for drug offences violates international law.[42] This position has been asserted by the UN Human Rights Committee, the body of independent experts mandated with monitoring the implementation and interpretation of the International Covenant on Civil and Political Rights,[43] the UN High Commissioner for Human Rights[44] and by the UNODC.[45]

Therefore, we urge Canada to join with other Member States, UN and international agencies, and civil society organizations in opposing, in the strongest possible terms, the use of drug detention centres and the egregious use of the death penalty for drug-related offences, and to work toward ending these human rights abuses.

6. Ensure full access to essential medicines

Ensuring the availability of controlled substances for medical and scientific purposes is a fundamental objective of the UN drug conventions and an obligation of Member States. To date, however, few countries have achieved this objective, and in its 2014 Annual Report, the INCB concluded that 5.5 billion people live in countries with "low levels of, or non-existent access to," controlled medicines. In a 2015 report, the Global Commission on Drug Policy called this a "global crisis of inequitable access to controlled medicines" that is being stoked by the international drug control system.[46] We urge Canada to press for a concerted UN-wide

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[40] World Health Organization. *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam* (2009); Human Rights Watch. *Torture in the Name of Treatment: Human Rights Abuses in Vietnam, China, Cambodia, and Lao PDR* (2012), p. 4.

[41] United Nations General Assembly. *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*. UN Doc. A/HRC/22/53 (February 2013); See also: R. Elliott et al. *Treatment or Torture?: Applying International Human Rights Standards to Drug Detention Centers*. New York: Open Society Foundations, 2011. Online: http://www.opensocietyfoundations.org/sites/default/files/treatment-or-torture-20110624.pdf.

[42] R. Lines. *The Death Penalty for Drug Offences: A Violation of International Human Rights Law*. London: International Harm Reduction Association, 2007. Online: http://www.ihra.net/files/2010/07/01/DeathPenaltyReport2007.pdf.

[43] UN Human Rights Committee. Concluding Observations: Thailand, CCPR/CO/84/THA (8 July 2005), para. 14; Concluding Observations: Sudan, CCPR/C/SDN/ CO/3 (29 August 2007), para. 19.

[44] UN General Assembly. *Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights.* UN Doc. A/HRC/30/65 (4 September 2015). Online: http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx

[45] UNODC. *Drug Control, Crime Prevention and Criminal Justice: a Human Rights Perspective:* Note by the Executive Director. Presented to the UN Commission on Narcotic Drugs, Fifty-third Session, Vienna, 8–12 March 2010. Doc. E/CN.7/2010/CRP.6*–E/CN.15/2010/CRP.1*

[46] Global Commission on Drug Policy. *The Negative Impact of Drug Control on Public Health: The Global Crisis of Avoidable Pain*. 2015.

effort to close the gap in the availability of and access to controlled substances for medical use, which must include the WHO, UNODC, INCB and UNDP.

Appropriate access to pain relief medications is strongly supported by CND Resolutions 53/4 and 54/6, adopted by Member States in 2010, and World Health Assembly Resolutions WHA67.19 (Strengthening of palliative care as a component of comprehensive care throughout the life course) and WHA68.15 (Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage). Despite broad international support for these commitments to improve access to essential health services, too often these resolutions have been undermined by Member States and by the INCB, who have called for additional essential medicines (specifically, at this time, ketamine) to be placed under international control, by-and-large ignoring the impact that these controls would have on access for medical uses in low-income countries.

With regard to ketamine, the WHO has repeatedly found that international controls are inappropriate. In 2015, the WHO's Assistant Director General for Health Systems and Innovation stated that placing the medicine under international control would constitute a "public health crisis" by depriving billions of patients access to safe surgery. Despite this, several Member States continue to persist in their calls for international controls on this essential medicine.

Therefore, we urge Canada to engage other Member States in recognizing and reinforcing the leading role of the WHO as the primary specialized agency for health within the UN system (including the drug control system, according to the 1961 and 1971 Conventions).

We further urge Canada to recognize and advocate for the authority and role of the WHO in assessing substances for international control through the Expert Committee on Drug Dependence, strengthening access to controlled medicines, and executing its responsibilities under the international drug control treaties on medical and scientific matters. The WHO should be given the oversight role to ensure that the drug control conventions and system support a public health approach, given the clear failure and harms consequent to the current criminalization oriented focus.

We further urge Canada and other Member States to emphasize the obligation of the INCB to ensure the availability of controlled substances for medical and scientific purposes. It is vital that the efforts of UNODC and the INCB, in their efforts to prevent the diversion of narcotic drugs and psychotropic substances, do not create inappropriate regulatory barriers for access to controlled substances as medicines.[47]

7. Ensure diverse representation at key international meetings on drugs

The recent COP 21 on climate change in Paris demonstrated a renewed approach by Canada in engaging key stakeholders in climate change talks. The annual review of the UN drug conventions provides a similar opportunity to bring diverse representation to bear on a critical global health issue that, like climate change, requires thoughtful and innovative ways to address the impact of drug-related harms, including collaboration with civil society organizations and various orders of government.

The UNGASS provides an opportunity to bring strong civil society voices to bear on the development of global drug policy. The participation of civil society organizations in drug control policy debates is vital to the success of efforts to address drug issues. Because of their engagement in affected communities, civil society organizations have unique and valuable contributions to make to these debates, to knowledge translation to the public and to the implementation of policy and program on the ground. Civil society participation has been

[47] See: WHO Executive Board. "Strengthening of palliative care as a component of integrated treatment within the continuum of care": Resolution EB134.R7 (2014); United Nations Millennium Development Goals Gap Task Force. "Millennium Development Goal 8: The global partnership for development: making rhetoric a reality" (2012). Online: http://www.un.org/millenniumgoals/2012_Gap_Report/MDG_2012Gap_Task_Force_report.pdf.

particularly important in the preparations for the UNGASS. Civil society, often working with Member States and UN agencies, has had significant influence on the development of the policy discussion around the UNGASS and has facilitated a great deal of input from a broad range of experts.

Globally, municipalities working on drug policy issues have played a critical role in developing effective and comprehensive responses to drugs, often leading the way for changes at the national level. In addition, indigenous peoples in Canada and around the world often are disproportionately affected by the implementation of the global drug treaties and domestic law enforcement, have been exploring culturally appropriate responses. We note as well that the interests of young people feature prominently in the UNGASS session, described as aiming for "A Better Tomorrow for the World's Youth."

Therefore, we urge Canada to include and support the participation of local governments, indigenous peoples, and civil society (including youth as well as people who use drugs) on the official Canadian delegation to key international drug policy meetings, including the annual sessions of the Commission on Narcotic Drugs and the upcoming UNGASS meeting in April.

8. Reject ill-conceived and unrealistic demands for a "drug-free world"

In its 1998 Special Session on drugs, the General Assembly called for a "drug-free world." The notion that such a goal is achievable has been demonstrated to be patently absurd. It does not acknowledge the reality of drug use and reiterates an objective increasingly recognized as unrealistic.

Such a simplistic declaration also undermines efforts to address the harms that may be associated with drug use through a range of evidence-based programs and services, and instead emphasizes abstinence-based approaches that do not work for all people – and are even sometimes used as an excuse to deny or impede the development of a comprehensive set of evidence-based programs and services. Furthermore, the goal of being "drug-free" can and has been used to "justify" the discriminatory mass incarceration that has been seen in numerous countries (including the United States and Russia), and the use and persistence of draconian, human rights-violating measures such as torture, drug detention centres, and the death penalty for drug crimes.

Therefore, we urge Canada to oppose insertion of "drug-free world" language within UN documents as unrealistic and counter-productive.

9. Promote and adopt more comprehensive and sophisticated indicators for evaluating the impacts of drug policy

In preparation for the UNGASS, the United Nations System Task Force on Transnational Organized Crime and Drug Trafficking has facilitated input from all relevant UN agencies on the impacts of drug policy on their respective mandates. Indeed, given the broad consensus that global drug policy does not occur in a vacuum, there is increasing interest in reprioritizing the metrics and indicators used to evaluate the impacts of drugs and drug policy to account for the multilateral objectives of health, peace and security, development and human rights.

As has been observed by the International Centre for Science in Drug Policy (ICSDP),[48] to date, Member States and other institutional actors have prioritized a small set of indicators to evaluate the effectiveness of drug policy, as a result of a narrow focus on reducing the demand and supply of illegal drugs. These include the price and purity of illicit drugs, the perceived availability of illicit drugs, the number and volume of illicit drug seizures, the number of drug-related arrests and incarceration, and the level of drug use in the general population (with no discrimination between problematic and non-problematic forms of drug use). Even using these narrow

[48] ICSDP. Open Letter: A Call for Reprioritization of Metrics to Evaluate Illicit Drug Policy. January 21, 2016. Online: http://www.icsdp.org/read_the_open_letter.

indicators, drug policies have not, by and large, demonstrated their effectiveness, providing further reason for ensuring, as recommended above, that states have flexibility to experiment with different approaches.

Furthermore, the narrow set of evaluative drug policy indicators currently in use provides little insight into how drug policies affect peace and security, development and human rights, and the health issues that intersect all three of these pillars. The limitations of this approach are apparent, given that many of the key activities of the CND, UNODC or INCB, such as HIV prevention and ensuring access to essential medicines, are not systematically evaluated by Member States in the context of drug policy. Expanding the set of drug policy indicators to include those that measure health, peace and security, development, and human rights impacts at the local, national, regional, and international levels would enable Member States to assess the diverse impacts of drugs and drug policies, to place drug policy more effectively within wider national and international policy goals, and to implement more targeted and effective drug policies and interventions.

The UNGASS represents a rare opportunity to move towards drug policies informed by health concerns and that effectively address the three UN pillars of peace and security, human development and human rights. This meeting of the General Assembly is also a unique opportunity to ensure system-wide coherence, specifically between the goals of drug policy and the UN's 17 Sustainable Development Goals, which encompass a range of issues relevant to drug policy, including health, poverty, criminal justice, and gender equality. Doing so will require Member States and other institutional actors to revise the range of indicators used to assess and improve the effectiveness of drug policy.

As noted above, a public health approach would instead require a broader, more sophisticated set of indicators – such as those recommended by the ICSDP in its open letter to Member States and UN agencies.

Therefore, we urge Canada to support a formal revision of the metrics used to evaluate drug control policies, and to prioritize indicators that provide specific evidence on the health, peace and security, development, and human rights impacts of drugs and drug policies.

10. Establish a Post-UNGASS mechanism for review: an Expert Advisory Group

This UNGASS could mark the beginning of a process of modernizing the global approach to drugs using the significant evidence that has emerged since the advent of the drug treaties. Given the reality that many issues will not be resolved by this UNGASS, the creation of a mechanism for continuing the review and modernization of the UN drug control system would be an important development that can be achieved at the UNGASS in 2016.

Two submissions of note for a review mechanism have been put forward in the UNGASS process, which can serve as a catalyst for moving forward. Uruguay has called for a the establishment of a Consultative Group of Experts with the task of developing operational recommendations to improve the functioning and harmony of the drug control system in the UN.[49] The International Drug Policy Consortium, a global civil society organization of which CDPC, the Legal Network and several other Canadian organizations are members, has also called for an Expert Advisory Group to address new challenges and tensions within the UN system, such as those raised by the regulated cannabis markets emerging in various jurisdictions.[50]

Therefore, we urge Canada to consider supporting the creation of a mechanism or mechanisms that could facilitate an informed discussion as Member States work towards a new Political Declaration of the General Assembly in 2019.

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[49] National Drug Board, Presidency of the Republic, *Uruguayan Position before UNGASS 2016: Strategic axes for a comprehensive approach to drug policy, Uruguayan contribution to the outcome document of UNGASS to be prepared by the Commission on Narcotic Drugs for the Special Session of the UN Assembly World Drug Problem 2016* (August 20, 2015).

[50] International Drug Policy Consortium. *IDPC recommendations for the "ZERO DRAFT" of the UNGASS Outcome Document*, IDPC Advocacy Note, July 2015, p. 5.

Appendix A: UNGASS Working Group

In 2015, the Canadian Drug Policy Coalition and the Canadian HIV/AIDS Legal Network convened an ad hoc working group to prepare for the upcoming UNGASS on the World Drug Problem in April 2016.

We would like to acknowledge the support and contributions of the UNGASS Working Group members.

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Walter Cavalieri, Canadian Harm Reduction Network
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Richard Elliott, Canadian HIV/AIDS Legal Network
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Craig Jones, NORML Canada
Cécile Kazatchkine, Canadian HIV/AIDS Legal Network
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Dr. Mark Ware, Alan Edwards Pain Management Unit, McGill University
Frank Welsh, Canadian Public Health Association (CPHA)
Dan Werb, International Centre for Science and Drug Policy (ICSDP)
Krysta Williams, Native Youth Sexual Health Network
Kassandra Woods, Assembly of First Nations (AFN)

Appendix B: UNAIDS recommendations for a public health and rights approach to drugs[51]

Five Policy Recommendations

1. Recognize that the overarching purpose of drug control is first and foremost to ensure the health, well-being and security of individuals, while respecting their agency and human rights at all times.

2. Ensure accountability for the delivery of health services for people who use drugs by including public health and human rights pillars in the framework of the UNGASS outcome document that incorporate clear objectives for reducing new HIV infections and protect and promote the rights of people who inject drugs.

3. Commit to fully implement harm reduction and HIV services, as outlined in the *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (15)*.

4. Commit to treating people who use drugs with support and care, rather than punishment. UNAIDS believes that this objective can only be achieved by implementing alternatives to criminalization, such as decriminalization and stopping incarceration of people for consumption and possession of drugs for personal use.

Ten Operational Recommendations

1. Ensure that all people who inject drugs, including people in prisons and other closed settings, have access to harm reduction services to prevent HIV infection, including needle and syringe programmes, opioid substitution therapy and antiretroviral medicines.

2. Ensure that all people who inject drugs and are living with HIV have access to lifesaving antiretroviral therapy and other health services to manage tuberculosis, viral hepatitis and sexually transmitted infections. In addition, ensure adequate availability and access to opioids for medical use towards reducing pain and suffering.

3. Ensure that all people who use drugs have access to non-coercive and evidence informed drug dependence treatment that is consistent with international human rights standards and the UNODC and WHO *Principles of drug dependence treatment*
(16). All forms of compulsory drug and HIV testing and drug treatment should be replaced with voluntary schemes. The use of compulsory detention centres for people who use drugs also should cease, and existing centres should be closed.

4. Adapt and reform laws to ensure that people who use drugs do not face punitive sanctions for the use of drugs or possession of drugs for personal use. Countries should consider taking a range of measures including alternatives to criminalization, incarceration, penalization and other penalties solely based on drug use or possession of drugs for personal use. These measures include decriminalization, steps to reduce incarceration or removal of administrative penalties and de-penalization.

5. Ensure that the human rights of people who use drugs are not violated, by providing access to justice (including through legal services), prevention, treatment and other social services. Adopt smart policing measures to encourage people to access public health services.

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[51] Excerpted from: UNAIDS. *A Public Health And Rights Approach to Drugs*. Geneva, 2015. Online: http://www.unaids.org/sites/default/files/media_asset/IC2803_drugs_en.pdf

6. Recognize that stigma and discrimination impede access to HIV prevention, treatment and other health and development services, and ensure that all people who use drugs are not discriminated against while accessing health, legal, education, employment and other social protection services.

7. Recognize that incarcerating people in prisons increases their risk of drug use, HIV infection and other health conditions, and take steps to ensure that harm reduction and other health services are available in prisons in parallel with efforts to reduce the number of people being incarcerated for non-violent drug offences.

8. Ensure widespread availability of naloxone among health workers, first responders, prison staff, enforcement officials and family members as a life-saving public health measure to enable timely and effective prevention of deaths from opioid overdose among people who use drugs.

9. Support and empower community and civil society organizations, including organizations and networks of people who use drugs, in the design and delivery of HIV, health and social protection services.

10. Undertake a rebalancing of investments in drug control to ensure that the resources needed for public health services are fully funded, including harm reduction for HIV infection, antiretroviral therapy, drug dependence treatment and treatment for hepatitis, tuberculosis and other health conditions.

Appendix C: Interventions to address HIV/AIDS among people who inject drugs

The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime (UNODC) have identified the following 9 core interventions as key to a comprehensive response to HIV/AIDS among people who inject drugs:[52]

- Needle and syringe programmes
- Opioid substitution therapy and other drug dependence treatment
- HIV testing and counselling
- Antiretroviral therapy
- Prevention and treatment of sexually transmitted infections
- Condom programmes for people who inject drugs and their sexual partners
- Targeted information, education and communication
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis.

In addition, the agencies have noted that "this list should not, however, rule out the delivery of additional interventions – as pilot programmes or full-scale interventions – where the local context requires them. (…) For example, although WHO has not reviewed the evidence on the effectiveness of supervised drug consumption/injection facilities in preventing HIV infection, evaluations in high-income countries where these facilities have been implemented have reported reduced risk behaviours among attending clients."[53]

[52] *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for HIV Prevention, Treatment and Care of Injecting Drug Users, 2012 Revision*. Geneva: WHO Press, 2012, at p. 10ff. Online: http://www.who.int/hiv/pub/idu/targets_universal_access/en/
[53] Ibid., p. 22.