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In search of a human rights-based approach to drug policy

An analysis of drug policies in Portugal, Germany and the Netherlands.

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ABSTRACT

Drug policy has been triggering vivid discussions for years. The system of drug control is based on three UN conventions, with the last adopted in 1988. Given the scientific and legal progress around the topic of drugs, it is obvious that these regulations might be outdated and insufficient as state guidelines. Therefore, some states have adopted innovative approaches, focusing on individual drug users rather than just regulating substance use, demand and supply through criminalisation and law enforcement efforts. From these states, the author chose three European countries, that in her opinion present the most human rights-based and evidence-based approaches to drug policy. After presenting the history of drug regulation and the international framework, the author presents German, Dutch and Portuguese drug policies in order to assess their compatibility with the human rights-based approach (HRBA). The assessment is done by analysing some objective data, such as drug use rate and drug-related deaths prevalence and by gathering data on possible limitations of analysed drug policies by conducting interviews with NGOs representatives and social workers in Germany, the Netherlands and Portugal. The thesis concludes with an assessment of the drug policies implemented in Germany, the Netherlands and Portugal, and some suggestions for improvements that could be introduced to make them more human rights-based.

Keywords: Drug policy, human rights-based approach, harm reduction, decriminalisation, people who use drugs, human rights

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List of Abbreviations

CND (UNCND) – United Nations Commission on Narcotic Drugs

CoE – Council of Europe

CRC – Convention on the Rights of the Child

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD – European School Survey Project on Alcohol and Other Drugs

EU – European Union

GO – governmental organisation

HAT – heroin-assisted treatment

HIV – human immunodeficiency virus

HCV – hepatitis C virus

HBV – hepatitis B virus

HRBA – human rights-based approach

ICESCR – International Covenant on Economic, Social and Cultural Rights

IDPC – International Drug Policy Consortium

INCB – International Narcotics Control Board

NGO – non-governmental organisation

NSP – needle and syringe programmes

OST – opioid substitution therapy

PCOB – Permanent Central Opium Board

PDPM – Portuguese Drug Policy Model

PTSD – post-traumatic stress disorder

UDHR – Universal Declaration of Human Rights

UNODC – United Nations Office of Drugs and Crime

UN – United Nations

WHO – World Health Organization

Introduction

This thesis aims to thoroughly examine the drug policies of three European nations: The Netherlands, Germany and Portugal. Their common denominator is focusing on the ability of people who use drugs to seek treatment, while at the same time enforcing laws to prevent drug trafficking.

Despite differences, all of the abovementioned policies have achieved fairly good effects in many areas, including lowering drug-related disturbances, lowering the rate of drug-related deaths, etc. This examination identifies good practices in the three countries but also finds potential drawbacks in the policies under discussion. In light of these drawbacks, this thesis aims to explore possible improvements to a human rights-based approach to drug policy. In the author's opinion, human rights-based policy is a policy that does not impose criminal sanctions on people who use drugs but sees them as sick or vulnerable people and directs specific social policies towards them to help them tackle their addiction, and be able to regain their health. Additionally, a human rights-based approach to drug policy would aim at reducing the stigma widely associated with drug use, which often marginalises drug users, who tend to withdraw from the society that openly condemns them – and this phenomenon occurs even more often in societies where drug use is heavily criminalized. In this way, a human rights-based drug policy protects also the right to non-discrimination and equality.

The right to health, central to the thesis's interest, should be the focal point of every drug policy if it is to be considered human rights-based. The research and analysis conducted within this work will show that relying on this approach ensures respect for human rights while at the same time achieving the policy-makers' goals: *inter alia* lowering drug-related public disturbance, lowering criminal activity, reducing the number of drug-related deaths, lowering the prevalence of drugs among youth, and lowering the rates of transmissions of drug-related diseases such as HIV, HCV and HBV.

However, it is not only the right to health that must be inherently embedded in a human rights-based drug policy. Among others, it is important to specify the right to live in dignity, right to private life, freedom of choice, right to education, rights of Indigenous Peoples, children's rights and the gender dimension of drug policy. This thesis aims at analysing the extent to which drug policies in Portugal, Germany and the Netherlands protect human rights and, subsequently, answer the question of what a human rights-based drug policy can look like in practice.

This work begins with a concise overview of the history of drugs and drug policies across the world. The first chapter focuses on drug policies' aims and their effectiveness. It addresses international guidelines in order to find out what can be understood as a human-rights based approach to drug policy and what its elements are. The second chapter is devoted to presenting European drug policies and in particular, the ones implemented in Germany, the Netherlands and Portugal. These policies are then analysed and compared in the third chapter which is comprised of quantitative analysis of data related to drug use rates, statistics of drug-related deaths by overdose and HIV prevalence. The third chapter is concluded by a summary of good practices observed in analysed countries. Following the analysis, the fourth chapter gathers the knowledge from previous ones, outlining the shortcomings of drug criminalisation approach and analysing shortcomings and possible weak points of drug policies in Germany, Portugal and the Netherlands, partially based on the data analysis, but also on interviews conducted with related NGOs and social workers from countries under research. After both – good policies and shortcomings – are identified, it will then be possible to conclude by answering the questions of what a human rights-based drug policy should look like and to what extent the policies in Germany, Portugal and the Netherlands realise this model.

Research Methodology

In the course of research, a variety of qualitative and quantitative methods will be used. For the literature review, Courtwright's work proved especially useful in understanding the history of drug regulations and its influence on modern shape and tendencies of drug policies. Additionally, the work of Rêgo, Oliveira, Lameira and Cruz (2021) provided an especially useful assessment of the 20-year period of Portuguese drug policy in action, while article by Valadez (2014), albeit focusing on Mexico, provided a great overview of the right to health and its realisation under the United Nations conventions on drugs.

However, it was an article written by Steve Anderson (2012) that inspired this thesis – the author analysed drug policies of Portugal, Germany and the Netherlands and compared them with each other. Anderson, in a very brief work, looked into the use of treatment programmes, role of drug courts, policies regarding the possession of certain drugs and data related to the use of drugs in population – by such approach he was able to measure which policies are the most effective for lowering overall drug use. The study was conducted 10 years ago and from 2012 to 2022 a lot has changed and new data has been

provided – therefore the author of this thesis strongly believes that by analysing the same three countries that Anderson did and broadening the scope of his research, she will be able to perform a more reliable assessment of drug policies in Portugal, Germany and the Netherlands as well as evaluate them from the perspective of human rights.

The international frameworks’ and guidelines’ analysis will be directed at three UN Drug Control Conventions, the EU Drug Strategy 2021–2025 and CoE’s Pompidou Group’s publications. In order to assess the efficacy of the abovementioned policies and show that they prove successful in protecting the right to health (and other human rights), while at the same time realising the standard goals of policymaking, quantitative factors of effectiveness will be taken under consideration. The variety of treatment-related programmes will be analysed together with other accompanying social support structures in order to measure their correlation with achieving the policies’ goals and, more importantly, how they correlate with protecting human rights.

First, data snapshots regarding drug use rates will be examined regarding the time covering last decades. This involves analysing changes in the number of deaths related to drug use (mostly overdose) and prevalence of HIV. Additionally, the author looks into drug prevalence among the youth. For the above, the author will use, among others, data provided by the UN World Drug Report and European Monitoring Centre for Drugs and Drug Addiction, like *European Drug Report 2022* as well as EMCDDA’s reports on particular countries and data from its *Statistical Bulletin*. Additionally, data provided by independent organisations, such as European School Survey Project on Alcohol and Other Drugs (ESPAD), will be used. Lastly, the involvement of different harm reduction programmes will be examined.

There is also a need to measure the efficiency of the policies in lowering the social stigma associated with drug use – given that this factor is not measurable *per se*, the author decided to conduct interviews with NGOs’ representatives and other people involved in implementing the policy in practice (for instance as service providers). Interviews will also be helpful in assessing any possible shortcomings of existing policies and providing future suggestions for improving them.

UN World Drug Reports and the European Monitoring Centre for Drugs and Drug Addiction and its *Statistical Bulletin*, as well as *Country Reports* (previously: *National Reports*), are expected to be remarkably useful. Unfortunately, the most recent data in the *Country Reports* provided by the EMCDDA are from 2019. This data will be combined with the scientific literature on the subject and additional data

gathered by the countries' NGOs which will serve as a cross-check for the facts and figures as well as for providers of non-quantitative data.

I. Drug policies in Europe

The first chapter of this work is focused on providing the reader with an overview of the history of drug policies to show how the approach to drugs has evolved and how access to drugs began to be controlled. It will also help to show the influence of the historical background on modern-day regulations in Europe. Aims of drug policies will be discussed in general later in the chapter together with different approaches to what a drug policy should be – as well as what it actually is and what it triggers in practice. Following the above, the author will outline what a human rights-based approach to drug policy should be focusing on while accentuating that there is still a need to find out what human rights are, especially for the vulnerable, and their need to be protected and respected in regard to drug policy. Lastly, the drug policy frameworks of several international organisations will be presented: The outline of the United Nations, European Union and Council of Europe’s approaches will be set out, and the drug policy instructions set by these organisations will be analysed and serve as primary guidelines.

1.1. The history and the present of drug policies in Europe and the world

The history of **drug prohibition can be dated back to the 7th century**. Its beginning is often attributed to the Sharia law and can be found in the passages from the Qu’ran, prohibiting intoxicants (even though some tend to read it rather as a prohibition only of alcohol drinking). In 1813 in China, the Jiaqing Emperor issued a prohibition decree, regulating *madak* (a blend of opium and tobacco) and pure opium consumption (Caquet, 2022, p. 21) – it was a step further from the 1729 Yongzheng Emperor’s edict prohibiting dealing it and importing *madak* for opium (Courtwright, 2012, p. 17) – nevertheless, the futility of these aspirations is underscored by the fact that in the years of 1815–1839 opium sales rose tenfold in China (Caquet, 2022, p. 27).

In Europe, which was expanding quite rapidly in the sixteenth, seventeenth and eighteenth century, a quick growth in consumption of tobacco, alcohol and other psychoactive substances developed into a way to **supply states with additional revenues** – through taxes on cargo or setting up monopoly systems for certain goods. In the eighteenth century, there were **not many regulations regarding drugs**

in Europe – however, the literature mentions some examples, such as a ban on smoking in buildings that were easily combustible or another ban on selling alcohol to Indian tribes (Courtwright, 2012, p. 17).

The end of the eighteenth and the beginning of nineteenth century is also associated with the birth of the term and understanding of “addiction” or so-called “**discovery of addiction**” (Levine, 1978, p. 144) – manifesting itself in a person losing control over drinking alcohol. The beginning of the nineteenth century brought to the surface also a movement of anti-vice activism that can be attributed to laying the grounds for modern-day anti-drug policies. Scientists, politicians and medical authorities argued that the use of alcohol and other drugs leads to “**personal ruin and racial decline**”, inheriting **diseases by children from their parents** with some eugenicists even advocating for imposing a procreation ban on alcohol addicts, such as Nazi eugenicists, who argued that being an alcoholic should be a ground for forced sterilisation (Courtwright, 2012, p. 19).

Courtwright (2012, p. 19) points out that **anti-vice activism began with concerns of public health, safety, and security, only to develop into campaigns based on ethnic, racial, and class prejudices**. For example, opium smoking was linked to Chinese immigrant workers while Jewish people were seen as inciters of an international trafficking liquor conspiracy. In the second decade of the twentieth century, psychoactive substances regulations were triggered by the first war – for example, the Russian defeat was attributed largely to drinking too much vodka – and so, in 1914, France prohibited absinthe sales, and, in 1916, drug regulations were implemented in Great Britain, and, even Russia, prohibited distilling in wartime (Courtwright, 2012, p. 19). American efforts to forbid alcohol spirits drinking with the 1920–1933 national prohibition misfired and had to end with the Great Depression, due to the need of jobs that breweries could provide (Courtwright, 2012, p. 22).

In the twentieth century, **drug suppression became an international, coherent effort** (Caquet, 2022, p. 14). After the first agreement, regulating alcohol consumption in 1890 – The Brussels Act ratified in 1892 (2022, p. 35) – more international treaties followed in 1912, 1925 and 1931 (Courtwright, 2012, p. 20). The Brussels Act established a geographical zone (between 20° north and 22° south in which importing and distilling alcohol was strictly forbidden (unless the prohibition was suspended by each government and only for non-indigenous populations) (Pan, 1975 p. 35–36). The 1912 Hague International Opium Convention is considered the actual first international treaty on drugs – it entered into force globally in 1919 as a part of the Treaty of Versailles – and linked the question of narcotics with reparations. The 1925 Convention established a control body called a **Permanent Central Opium Board** (PCOB) which started operating 3 years later (McAllistair, 2000, p. 44, 268). Despite having a mandate

even to go as far as imposing sanctions, PCOB was a rather sluggish body, as it still **had to operate under governments and could not afford to embarrass states publicly** – therefore the PCOB decided to work discretely (MacAllistair, 2000, p. 85).

The examples above, though obviously quite selective, picture well the development of drug regulations and their entrance into international law, parallely supported by the state law. **Drug policy began to be seen as a matter of international interest** and has remained as such throughout the twentieth century. In fact, regulations implemented in its second half are still in force (UN Drug Conventions, described in detail in Chapter 1.4.1.). Therefore, the next chapter is dedicated to discussing the aims (declared or deduced) of drug policies implemented in history and an overview of modern-day drug policies' goals.

1.2. What were the aims of drug policy historically – and what has changed

Discussing drug prohibition (or regulation in general) should start with **defining the concept of 'drugs'**. Yet, Caquet notices that for years such prohibition was less about intoxicants or anything that fell into the “quaint” term ‘narcotics’ but rather about what could be done through the means of suppression (2022, p. 12). Caquet calls the term ‘narcotics’ quaint and it has remained so until this day – the question of what a drug is, is not easy to answer. The broadest definition would cover all substances that alter physiology or psychology after consumption (psychoactive substances). However, it is obvious that the term itself has become non-scientific despite its connotations with medical use (the same term is used for instance in English to describe a chemical substance used for treatment). A philosopher, Jacques Derrida, states that “drugs” cannot be found “in nature” – therefore, it is impossible to define what a drug is objectively (1995, p. 229). By referring to drug addiction, he points out that differentiating what a drug is should have grounds in moral, ethical and historical bases – he notices that “concept of drugs is an instituted norm”. Derrida points out that by establishing the definition of a drug and prohibiting drugs in law “we assure the integrity and responsibility of the legal subject” in order to preserve health, security, productivity and orderly functioning of society, culture and social conventions (1995, p. 230). Therefore, it could be assumed that the **concept of drug has to be created in legal terms** and that this concept has to rely on an (often arbitrary) distinction made by law-makers – for instance based on their evaluation of what constitutes ‘a threat to public safety’. Currently, most policymakers rely largely on definitions

provided by international organisations. For instance, the **UN defines drugs in general by their medical definition** as “any substance with the potential to prevent or cure disease or enhance physical or mental welfare; in pharmacology, it means any chemical agent that alters the biochemical or physiological processes of tissues or organisms”. – However, in the international drug control framework, drugs should be understood **as substances in Schedule I and II of the 1961 Convention**. The organisation also distinguishes between **licit and narcotic drugs**, where a licit drug is “a drug that is legally available by medical prescription in the jurisdiction in question, or, sometimes, a drug legally available without medical prescription”, while a narcotic drug, in common parlance and legal usage, would mean any illicit drug, regardless of how it acts pharmacologically (UNODC, 2016, p. 63–64). For the purpose of this work, the author will apply the understanding of the term ‘drugs’ as it was explained in the UNODC’s document.

It is important, for the course of this thesis, to follow the development and changes of drug regulations’ goals over the years as they laid grounds for goals of contemporary drug policies. Coming back to the concept of drugs, Seddon (2016) noted that the term itself developed as a “regulatory construct within a more general matrix of power relations” – he also noticed an interesting distinction between regulating ‘drugs’ and other goods, such as sugar. For instance, the Brussels Sugar Convention created legal grounds of facilitating trade, while the 1912 Hague Opium Convention was created to eliminate trade (p. 413). Seddon concludes that the “regulatory decoupling of ‘drugs’ from other commodities was driven, in quite an important sense, by economics”. Indeed, **economic reasons stood behind a lot of drug regulations** – however, there are many other grounds worth looking into.

“Drug control was born of historical accident, not rational design. **Colonialism**, the backlash against it, and international affairs were the triggers for prohibition, interacting with often superficial beliefs about drugs themselves” – states Coquet (2022, p. 13), and it is hard to disagree after noticing, for instance, how the Brussels Act regulated alcohol distilling and import in Africa. Levine’s explanation of the addiction concept’s birth referred to alcohol, but later the term was transferred to cover opiates and more (Seddon, 2016, p. 397) – the problem of addiction together with the issue of ‘self-intoxication’ became the subject of interest for medical doctors in the nineteenth century. Seddon notes that **self-intoxication was seen as leading to self-enslavement**. Another problem with self-intoxication described by the nineteenth century doctors was **immorality** – people who used drugs were seen as debauched or disreputable and the act of using opium for non-medical purposes was described as ‘vicious’ (Seddon, 2016, p. 401). It corresponds with the **anti-vice activism** from the eighteenth and nineteenth centuries

and the claims that the abuse of alcohol and other drugs (especially opium) leads to **personal ruin, degeneration and racial decline** (Courtwright, 2012, p. 19). In his work, Courtwright (2012) sums up the nineteenth drug regulations prompted by anti-vice activism (often supported by the church – for instance reverend Wilbur Crafts who lobbied against the Philippine opium monopoly) quite accurately. He sees their motivations as revolving around public health, safety and security on the surface, but at the same time being **deeply rooted in ethnic, racial and class prejudices** (Courtwright, 2012, p. 19).

In the nineteenth century, the self-intoxication problem was partnered with the occurrence of **intoxicating other people**, usually for the purpose of criminal acts, such as rape, robbery or coercing someone to sign a valuable security. These practices, together with prevalent practices of poisoning, led to the creation of laws forbidding the use of some substances, labelled ‘dangerous’ – i.e. British 1851 Arsenic Act and the 1868 Pharmacy Act (Seddon, 2016, p. 403).

The **international 1912, 1925 and 1931 treaties** were aimed at limiting narcotic production and use to medical needs and at minimising diversion and non-medical use (Courtwright, 2012, p. 20). An interesting difference in interpretation of these treaties developed among some member countries. Some would opt for providing treatment to people who were addicted to drugs and some would display great concern for ‘national morale’ and send addicts straight to prison. Some of these interpretations did not shy away from racial prejudice. For instance, the Japanese government provided treatment to people addicted to opium in occupied China while opium trafficking was strictly forbidden in Japan, which Courtwright (2012, p. 20) sees as another example of considering other nations racially inferior (because of being prone to drug use and abuse).

The **historical use of psychoactive substances** can be divided into three areas: religious ceremonies (or other **cultural usage**), **medical purposes** and purely **recreational use** for leisure in societies where such leisure was considered socially acceptable (Crocq, 2007, pp. 355–356). To the misfortune of many, what constitutes ‘socially acceptable’ evolved in the West and mirrors the Western perception of psychoactive substances with a history of prohibition directed mostly at people representing other traditions, often depriving them of the ability to practice their traditions. Therefore, in the words of Courtwright, “the legal and cultural privileging of two dangerous drugs, alcohol and tobacco, common in the mid-twentieth century, has given way to the privileging of one dangerous drug, alcohol” (2012, p. 23).

It would be tempting to say that drug regulations stem from the assessment of drugs' harm and the more harmful a drug is, the more restrictive these regulations usually are. However, the reality is very different. Drugs that are perceived as socially acceptable, mainly alcohol or tobacco, are not necessarily the least 'dangerous' – individually or in general to society. It suffices to note that smoking tobacco causes harm not only to the smoker, but can also harm bystanders and alcohol has been shown to take first place among drugs most harmful to society (see figure 1 below).

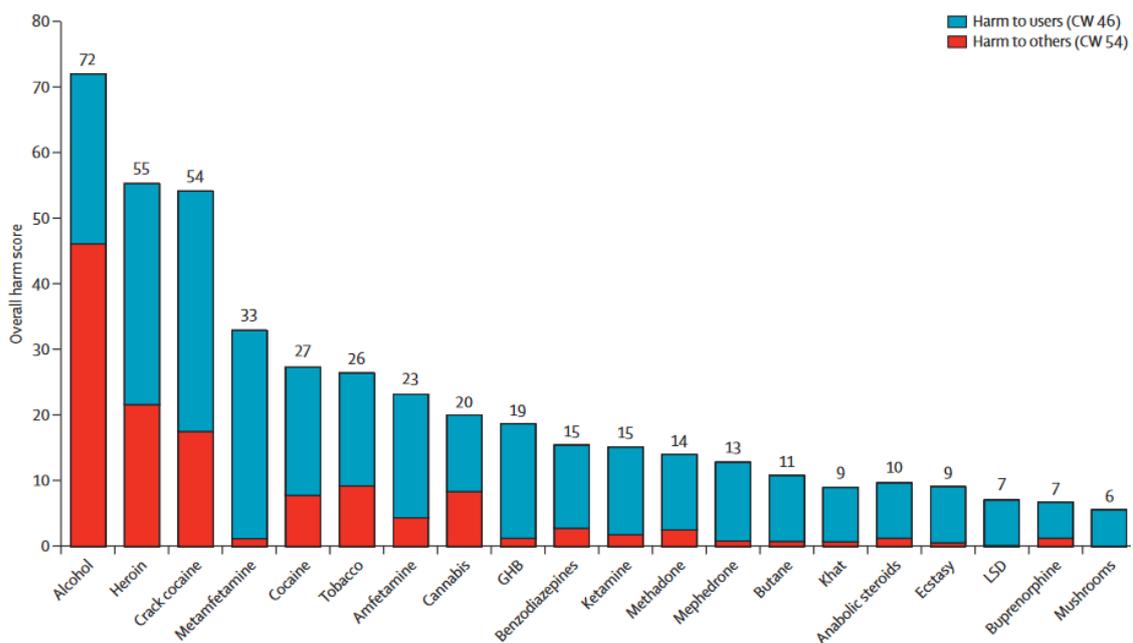


Figure 1. Drugs ordered by how much harm they cause to an individual and to other people (Nutt, King, Philips, 2010, p. 4).

Moving on to more contemporary drug regulations, it is worth repeating that the three UN Conventions on drugs, of which the first was adopted in 1961, are still in force despite controversies around them. The Beckley Foundation and Human Rights Watch stated that the UN drug control treaties (the 1961 Single Convention on Narcotic Drugs as amended, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances) aim at resolving the drug problem principally by punishing drug production and consumption. According to Article 4 of the 1961 Convention, the primary goal is to “limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs” (Valadez, 2014, p. 205–206). However, such approach, prevailing in the second half of the twentieth century seems strongly **out-of-date**. Valadez notices bluntly that, in accordance with

the Article 4 provision, the majority of states see the criminalisation approach as enough to diminish drug production or use – the result of it is that the main targets of states’ drug policies are still the behaviours, while the causes together with effects of the drug problem are not tackled sufficiently (pp. 202–203).

Valadez (2014) argues in his work that the UN drug **conventions do not impose the obligation to criminalise personal drug use on states**. Moreover, in his work, he describes that decriminalisation is allowed while creating a health-oriented system around drug use is an obligation in order to respect the right to health, i.e. under the ICESCR. Valadez’ work marks a step towards validating the new wave of thinking about dealing with the problem of drug abuse in that some states have already implemented decriminalisation measures and decided to focus on health instead of simply punishing the users.

From the above discussion, we can see how a range of differences in the approach to drug policies developed over the years. The first sets a dichotomous difference between the criminalisation approach versus decriminalisation approach. It is important to notice that decriminalisation does not necessarily mean legalisation, but rather not treating drug use as a crime, and, for instance, as an administrative offense. However, this distinction is about the means by which the goals of drug policy are obtained. Another change observed over the years is the change in drug policies’ goals.

As pictured above, the ‘official’ goals of historic polices revolved around protecting national security, morality, sometimes health – but seen, rather, as a value of a ‘healthy society’ than individually, and protecting the society from broadly defined ‘degeneration’, crime and misdemeanours associated with drug use (both criminal activity and public disturbance). Underneath these aims, there were often economic reasons for regulating the drug trade, but also deeply discriminative directives that aimed at restricting cultural freedom or else, but also based on racial prejudices, at indirectly supporting drug usage spread among discriminated against communities.

The issue of setting goals for drug policy was discussed in a paper published by Caulkins and Reuter (1997) – the authors asked a question in the title of their work: “harm reduction or use reduction?” and analysed the U.S drug policy goals over the years. They argued that a harm reduction approach is a prominent alternative to the out-of-date policies focused on use reduction, and provided a concrete distinction between those two approaches. According to Caulkins and Reuter (1997, p. 1147), a policy focused on use reduction would aim at reducing the number of users, the quantity of drugs consumed and money spent by uses, while a policy focused on harm reduction could imply some actions taken to reduce total net harm or reduce the harm to non-users and ignoring harm to users (or even counting it as a good).

This approach symbolises a bridge between the approach focused solely on restricting usage and harm reduction as it is understood today – largely meaning the protection of individuals who use drugs and a focus put on administering them in a safe way.

Caulkins and Reuter’s framework, stemming from the **juxtaposition of use reduction policy and harm reduction policy**, seems very useful for the purpose of this thesis as, in author’s opinion, harm reduction represents the core of a human rights-based approach to drug policy. However, harm reduction is a means that addresses the problem only partially. Referring to Keeney (1992) who states that goals should be selected in accordance to one’s ultimate values, it can be said that a **human rights-based approach to drug policy is not just a policy choice but an obligation** in today’s world where human rights are seen as the core value and *condicio sine qua non* of every society based on the rule of law.

Caulkins and Reuter recognize that harm reduction policy might seem more applicable and make more sense for those who do not see drug use as a problem itself, but are interested instead in dealing with negative phenomena associated with it, such as poverty, health problems, diseases, property crime, reduced productivity or increased crime (1997, p. 1148). As these are some of the problems that a drug policy should deal with, the next chapter attempts to define problematic areas that should be addressed by a drug policy and to find out how a human rights-based approach to drug policy should be shaped to answer them in an effective, human rights-centred way.

1.3. A human rights-based approach to drug policy

In order to answer the research question of this thesis, it is vital to define what is meant and understood by the notion of a human rights-based drug policy. This chapter will attempt to find such a definition, first by approaching a philosophical question of drug morality, then looking into what problems drug policies concern (mostly: what is understood as ‘the drug problem’), what human rights are at stake or under threat of being violated while creating a policy, and finally, how should a policy protect them.

Morality of drugs and drug use – arguments for prohibition

In a liberal society, an opinion that “adults should have the liberty to pursue their own choices so long as they do not harm anyone else” prevails, which contrasts with the legal moralists’ approach, who would neglect all liberal arguments, stating that drug use, as an inherently wrong act, should be prohibited and criminalised as drugs undermine autonomy and are harmful to human beings (Hall, Lucke, 2013, p. 689). The **relationship between drugs, morality and legal regulations** have been a topic of discussions for years now. In his work, Smith (2002) entertains the question if adults have a moral right to the freedom to use dangerous drugs. He notes that on the grounds of respect for individual rights and liberty, everybody is assumed to do as they choose to do with their bodies, including risky or otherwise unhealthy things (such as motor sports or smoking cigarettes). The author develops a range of arguments for prohibiting drugs: they range from the notion that drugs do harm others – they “make less good family members” and “less productive employees” and harm the society by inflicting healthcare costs and causing a burden for economy (Smith, 2002, p. 235) – through to the idea that law should prohibit self-harm and also work towards creating “better human beings” according to the legal paternalism model and human excellence, and on to an argument of traditional conservatism and the assumption that all members of society are responsible for maintaining their culture’s traditional way of life (Smith, 2002, p. 237–239). However, despite outlining such a wide gallery of arguments used over the years by many drug use oppositionists, the author concludes that none of them is convincing enough and that **drug prohibition “is likely to cause more harm than it prevents”** – and even that sustaining a prohibitionist policy, propels and enhances the harms associated with drug use (Smith, 2002, p. 243).

What is a human rights-based approach?

In the United Nations framework, a human rights-based approach (HRBA) is a universal value, stemming from the Universal Declaration of Human Rights that requires human development to proceed according to the normative standards based on human rights and with a goal to promote and protect them. The overarching goal of human development should be to **identify possible inequalities and reduce or eliminate them, as well as get rid of unjust power distributions**, which are seen as a major factor impeding the progress of development of groups of people suffering from discriminatory treatment. In an HRBA, all programmes of **policies should enable realising human rights to the maximum**

possibility, in accordance with the UDHR and other international instruments (United Nations Sustainable Development Group).

What human rights are at stake?

Identifying what rights are especially vulnerable and able to be protected under state regulations is a key to developing a human rights-based drug policy. Harm associated with drug use and the drug trade is a **multidimensional social challenge** and all of its dimensions are deeply interconnected with human rights. Additionally, neglecting some human rights leads to the current prevalence of addiction behaviours and drug abuse, which thrive in environments prone to poverty, homelessness and unemployment. In the author's opinion, this fact supports the standing that it is the state who is the main culprit of most drug problems in the society, and especially the prevalence of addictions. Albeit indirectly, failing to respect, protect and fulfil human rights, such as the right to life in dignity, housing, employment and the right to health causes people to fall into addictive patterns of use. Therefore, it is the state's responsibility to take action and reverse this vicious circle.

It is vital to remark that it might not be possible to state all of the human rights that are at stake when it comes to drug-related harm because the situation is dynamic and develops faster than legal regulations. For example, some drugs that used to be considered harmful, prove helpful in often unexpected contexts, like in the case of therapeutic use of MDMA or psilocybin – and now they can be connected with the right to benefit from scientific progress and the right to highest attainable standard of healthcare. Therefore, it is critical to stay vigilant and alert about human rights issues in drug policy that are likely to emerge with time.

Human dignity, equality, the right to non-discrimination

Human dignity characterises all human beings and signifies one's worth of **respect** and **agency**. Drug users or addicts, on the other hand, are sometimes stripped of this characteristic in the view of the society or the state – either by deeming them the sole culprits of their addiction or by depriving them from agency to decide on their own actions and seeing them as incapable to make responsible choices for themselves (Mills, 2022). This can result in discrimination towards them and infringements of the equality principle. It is important to notice that one of the most effective carriers of discriminatory

attitudes and stereotypes is language – for instance calling people who use drugs ‘addicts’ or ‘junkies’. Such **language contributes to the stigma** associated with them and prevents them from admitting their problem or seeking help. In consequence, discriminatory behaviours and stigma reinforce the threat to human dignity of people who use drugs (Wogen, Restrepo, 2020, p. 52).

Another dimension of unequal treatment when it comes to drugs stems from the history of **racial discrimination** and is visible the clearest in the United States of America – discrimination of Black people. White people are more likely than Black people to use illicit drugs, according to studies – and yet the latter are two-and-a-half times more likely to be arrested for drug possession (and six times more likely in case of marijuana possession) in the United States (Human Rights Watch, 2016, pp. 5–6). This disproportionate enforcement amounts to racial discrimination that causes Black people unfair trauma and anger, and contributes to the stigma of being perceived, also outside of the United States, as more likely to use drugs or be addicted to them. Racial discrimination is therefore an area that should be addressed with certain care and efforts to diminish its influence on providing necessary help *via* a human rights-based drug policy.

The right to health and the right to the highest attainable standard of healthcare

The right to health was first recognized as a human right in Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). It is important that **the right to health is not the same as the right to be healthy**, but it signifies the right to the highest attainable standard of healthcare on equal terms, without any discrimination (CESCR, 2000, p. 5).

Addiction has to be considered first and foremost as a health problem – as a **complex illness, which can cause all range of psychological, physical and social disorders and which can and should be successfully treated**. Health is central to a human rights-based drug policy which should be built around harm reduction programmes, treatment of drug dependence disorders and widespread access to effective medication and therapy, as well as access to substances under the state’s control for medical use. Additionally, there are certain diseases, such as HIV and HCV infections that are more prevalent among groups of people who use drugs and preventing them must take a significant place in drug policy design.

The core means to fulfil the right to health for people who use drugs is implementing **harm reduction programmes** and making them available and accessible to everybody. Harm reduction programmes range from education to needle and syringe exchange programmes (NSP) or widespread drug testing.

Such activities should not only be legal, but steps should be taken that they are never blocked by law enforcement as well (for example by confiscating injecting equipment and discouraging their use) (UNAIDS, 2019, p. 36).

The right to health became especially threatened during the COVID-19 pandemic. Not only did it exacerbate COVID-19 infections of people who were incarcerated, for non-violent drug crimes in addition to other offences, but the psychological stress associated with the pandemic led to more risky behaviours – for instance, in the USA more people started buying fentanyl, which led to a spike in overdose deaths (Malinowska-Sempruch, Lohman, 2021, p. 1). Malinowska-Sempruch and Lohman (2021, p. 2) express their hopes that the pandemic might have an educational value and prompt the development of new drug policies, grounded in social well-being, health and human rights and suggest that experience in regulating harmful substances, like tobacco, sugar or alcohol, might help future efforts to regulate drugs similarly.

One point that needs to be addressed with regard to the right to health is **the right to refuse treatment**. Compulsory treatment, exerted for example in Brazil or China (Stoicescu, Peters, Lataire, 2022, p. 133) violates this right, dehumanises people who use drugs and can be used as a tool of social control. As such, coercive treatment must not be seen as a possible element of a human rights-based drug policy.

Other economic and social rights – right to an adequate standard of living, social security, housing and employment

Drugs and unemployment are two of major factors leading to homelessness (Steen, Mackenzie, McCormack, 2012, p. 13). However, it is crucial to understand that drug addiction or drug use is very often caused by stress associated with day-to-day life struggles. **Inability to pay for rent in time, struggling to make ends meet, living in conditions below average or having little or no income are all enhancing addiction risks**. This is even more severe when the stress is endured for a long time, becomes a chronic condition and increases vulnerability to drug use (Sinha, 2008, p. 107). It has been shown that stable housing and employment are vital for the process of recovery from substance use disorders (SUDs). Stress associated with unemployment, the need to find a job or pay rent can lead to relapse or other forms of substance misuse (Sinha, 2008, p. 114).

Additionally, homelessness itself can be trigger enough to seek out illicit substances as sometimes it is seen as a way to escape dangers of living on the streets. Naturally, this means backfires as drug abuse is also a barrier that prevents exiting homelessness (Johnson, Fendrich, 2007, p. S211). Should the right to an adequate standard of living be fulfilled by the state, drug abuse problems are expected to diminish. Therefore, economic and social rights protection should be embedded deeply in a human rights-based drug policy, and providing a safe environment, in terms of housing and employment among other goals, should be seen as a core element of successful reintegration of people who abuse drugs into society.

Right to benefit from scientific progress

Research on drugs has been stopped or severely slowed down in the second half of the 20th century due to the criminalisation of certain substances. This has severely impacted possibilities for effective treatment for some diseases, including cancer treatment or palliative care. More recently, such studies have been reinitiated and are providing spectacular results. MDMA (\pm 3,4-methylenedioxymethamphetamine)-assisted psychotherapy proves extremely **useful in treatment of chronic PTSD** (Mithoefer *et al.*, 2011) and psilocybin can be used as an **effective aid in treatment of depression** on its various stages with no negative impact on human health or well-being (Daws *et al.*, 2022).

Right to a fair trial, freedom from arbitrary arrest, freedom for torture

Being aware of the prevailing stigma around drug users and stereotypes about drugs, it is possible to assume that additional steps need to be taken to provide the fulfilment of the right to a fair trial, so that judges would not rely on stereotypes but rather on scientific evidence – education on drugs and their influence on people’s life seem fundamental for the protection of rights. Such **education should be provided to public officials, police officers, lawyers** and other people involved in implementing drug policies in practice. Some countries have introduced special courts for drug-related misdemeanours (so-called ‘**drug courts**’), which provide alternatives to incarceration and help users to get treatment.

When it comes to incarceration for drug use when a person is addicted, it is also important to note that forcing a person to go through withdrawal symptoms (‘cold turkey’) without any medication-assisted treatment is a violation of the right to health, to protection from cruel, inhuman or degrading treatment

and even the right to life. Not only does **sudden withdrawal cause mental and physical anguish**, but also prompts risky behaviour such as sharing needles in the detention place. In addition, the combination of trauma from withdrawal and incarceration can lead to suicidal thoughts and attempts (Bruce, Schleifer, 2009, p. 19). In the UK, forcing prisoners with a SUD to go ‘cold turkey’ in prison led to them being paid compensation for this practice, as under a sentence by a UK court in 2006 (Barret, 2006).

Indigenous peoples’ rights, right to enjoy cultural life, freedom of religion

Policies aiming at eradicating the production and use of certain substances can disproportionately affect people who cultivate and use some plant-based narcotics and hallucinogens for **traditional purposes**. Despite some steps taken to legalise cultivation, of for example coca leaves, such as the 1971 UN Convention directive to acknowledge that its use is traditional, the last of the drug conventions returned to advocating for strict measures without taking into consideration if prohibition interferes with indigenous uses – and moreover without demanding consultations with or consent of indigenous populations in the process (Burger, Kapron, 2017, p. 270). Burger and Kapron (2017) outline a few of the **human rights violations that indigenous people are prone to due to reinforced drug policies**: the right to self-determination, rights to lands and resources, right not to be forcibly removed from their lands, right to enjoy their culture, religious rights, right to the conservation of indigenous peoples’ lands, right to health, right to peace and security, and the right to be consulted (pp. 273–274).

Often neglected: women, children, prisoners, and stigma

Additional to the explicitly stated human rights outlined above, there are also some other lenses that a human rights-based drug policy should be observed through and adjusted. The first is the lens of gender and differences between men, women and others when it comes to dealing with drug problems, as studies show that **different genders need different approaches**, and some would even state that the known methods of dealing with addictions, for instance the Anonymous Alcoholics system, is deeply patriarchal and has roots so deep in the male world that it neglects women and is much less useful for them to follow. Whitaker (2019, p. 106) mentions that whilst men usually need to learn humility and lower their ‘ego’, women typically need more self-confidence – therefore (and for other reasons), the most popular addiction treatment programme in the world is not suitable for them. **The gender dimension of drug policy** manifests itself also in family duties for which it is mostly women who are

held responsible, especially when it comes to taking care of children. This fact cannot be overlooked while creating an equal policy because additional responsibilities can severely impair the accessibility of services, such as treatment, and this obstacle is one that can be eliminated, for instance, by providing children's care services for addicted mothers who decide to enrol in treatment programmes.

Another shade of drug policy that needs to be taken into account is education and children's rights – especially **children who use drugs and children whose parents use drugs** – need careful consideration. Education based on prevention, but also harm reduction, could be implemented in schools to reduce the dangers of risky activities. Such education could also help in lowering the stigma associated with drug use or using medical services for treating addiction. An additional problem that should be addressed is the age threshold for treatment services – there should be no minimum age under which treatment is hindered.

As described above, people who use drugs are especially prone to **discrimination**. However, some groups are in danger of being subjected to cross-discrimination on the grounds of other characteristics: for instance, gender, as discussed above, homelessness or being detained. Drug use in prisons is a topic that is often neglected and is an extraordinarily challenging area when it comes to respecting human rights. **Prisoners have been found especially vulnerable** to such diseases as HIV or HCV and HBV infections but when it comes to drug use these come together with unhygienic means of administration, vulnerability to bacterial infections and a higher probability of overdosing (Jürgens, Betteridge, 2005, p. 47, 56). Additionally, specific conditions in prison might be reflected in the ineffectiveness of some harm reduction measures. For example, when a needle exchange programme was implemented in Portugal, no prisoner used the service despite many reports on detained people sharing equipment (Sander *et al.*, 2007, p. 36). Jürgens and Betteridge (2005) clearly outline the broad range of human rights on stake in this environment: “access to HIV and HCV prevention and harm reduction programmes implicates prisoners' right to life, right to security of the person, right not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment, and right to enjoyment of the highest attainable standard of physical and mental health” (p. 57).

The social stigma associated with drug use is a major obstacle in creating a human rights-based drug policy and, therefore, such policy should aim at reducing or eliminating it. The existence of stigma and social marginalisation of drug users may have catastrophic results, such as reluctance to admit one's problem with drugs and seek treatment, deepening of marginalisation, detriment in self-worth and other mental health disorders. As Wogen and Restrepo (2020, p. 53) state: “a person who is being stigmatized,

may perceive that she is not accepted or considered equal, engendering feelings of inferiority, shame, and self-loathing”. It is also important to notice, in line with the authors’ research, that stigma is a multidimensional phenomenon and when talking about it, it is vital to distinguish between its different types. Wogen and Restrepo (2020, pp. 53–55) highlight the existence of **public stigma** (stereotypes prevailing in a social group about some particular group members), **courtesy stigma** (stigma experienced by people close to a targeted group: family members, health professionals, etc.), **structural stigma** (involving discriminatory behaviours from institutions and public officials) and **self-stigma** (when a public stereotype is internalised by a member of the targeted group) which reinforce each other and work to the detriment of life quality standards for people who use drugs.

Human rights under threat with regards to particular drug policy measures

The noted examples of human rights at stake offer an overview of the multidimensionality of policymaking in the area of drug regulations. It is also worth looking at **particular measures typically taken within drug policies to reduce demand and reduce supply** and see what rights they engage. They have been outlined by Barret (2018, pp. 32–41) and are presented in table 1 and table 2 – showing respectively measures and human rights associated with drug demand reduction and drug supply reduction.

Table 1. Human rights engaged in drug demand reduction policy measures (Barret, 2018, pp. 32–36).

DEMAND REDUCTION	RIGHTS ENGAGED
Prevention (Campaigns/Information)	<ul style="list-style-type: none"> ➤ Protection of children from drugs (Art. 33, CRC) ➤ Child’s right to health (Art. 24, CRC) ➤ Child’s right to receive and impart information (Art. 13, CRC)
Prevention (Random testing/sniffer dogs/searches)	<ul style="list-style-type: none"> ➤ Protection of children from drugs (Art. 33, CRC) ➤ Privacy (Art. 8, ECHR; Art. 16, CRC)
Prevention Addressing ‘encouragement’ to use drugs	<ul style="list-style-type: none"> ➤ Freedom of expression (Art. 10, ECHR) ➤ Protection of children from drugs (Art. 33, CRC)
Prevention (Criminalisation of possession for personal use outside of medical and scientific purposes)	<ul style="list-style-type: none"> ➤ Right to privacy (Art. 8, ECHR) ➤ Freedom of thought, conscience and religion (Art. 9, ECHR) ➤ Freedom of expression (Art. 10, ECHR) ➤ Cultural and indigenous rights/expression (Art. 27, ICCPR)
Harm reduction	<ul style="list-style-type: none"> ➤ Right to health (Art. 12, ICESCR) ➤ Right to benefit from scientific progress and its application (Art. 15, ICESCR)

Harm reduction (prisons)	<ul style="list-style-type: none"> ➤ Right to health (Art. 12, ICESCR) ➤ Right to benefit from scientific progress and its application (Art. 15, ICESCR) ➤ Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)
Drug dependence treatment	<ul style="list-style-type: none"> ➤ Right to health (Art. 12, ICESCR) ➤ Right to benefit from scientific progress and its application (Art. 15, ICESCR) ➤ Right to privacy (Art. 8, ECHR) ➤ Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR) ➤ Freedom from arbitrary detention (Art. 5, ECHR)
Drug dependence treatment (prisons)	<ul style="list-style-type: none"> ➤ Right to health (Art. 12, ICESCR) ➤ Right to benefit from scientific progress and its application (Art. 15, ICESCR) ➤ Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)

Table 2. Human rights engaged in drug supply reduction policy measures (Barret, 2018, pp. 36–41).

SUPPLY REDUCTION	RIGHTS ENGAGED
Prosecution	<ul style="list-style-type: none"> ➤ Right to fair trial (Art. 6, ECHR)
Penalties (criminal and civil)	<ul style="list-style-type: none"> ➤ Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR) ➤ Right to family life (Art. 8, ECHR) ➤ Best interests of the child (Art. 3, CRC) ➤ Right to social security (Art. 9, ICESCR) ➤ Protection of property (Art. 1, protocol 1, ECHR) ➤ Presumption of innocence (Art. 6, ECHR)
International assistance: Funding, joint operations, mutual legal assistance, extradition	<p>Various rights are engaged</p> <p>e.g.</p> <ul style="list-style-type: none"> ➤ Right to life (Art. 2, and protocol 13 ECHR) ➤ Freedom from cruel inhuman and degrading treatment or punishment (Art. 3, ECHR)

Human rights-based and evidence-based drug policy as an obligation

The ‘ideal’ of creating a drug-free society persisted for a long time in the world to no avail as drug use rose steadily or stayed at the same level in almost every country in the world (Malinowska-Sempruch, Lohman, 2022, p. 1). The need for a human rights and evidence-based policy is enormous, especially in a globalised society, where stopping a phenomenon by prohibiting it is no longer effective and in fact counter-productive. Human rights under threat as outlined above have been investigated in terms of drug policy for years now, especially by specialised agencies of international organisations. Therefore, it can be said that the need for evidence-based policy can be satisfied by implementing some of these guidelines, as evidence for measures in accordance with human rights is now provided and widely accessible. What is crucial, when analysing them, is to bear in mind that they are based on the paradigm shift that moves the attention from protecting society as a whole and setting the goals, i.e. on reducing demand and supply (usually by criminalisation), to approaching individuals with respect to their human rights. However, despite this shift, many of the policy suggestions made by international and human rights organisations are still capable of fulfilling the ‘traditional’ policy goals, such as reduction in demand and supply, lowering use among youth, lowering death rates among drug users, protecting society from drug-related public disturbance and lowering criminal activity.

1.4. International organisations’ framework and drug policy suggestions

There are three international organisations, crucial for this thesis: **the United Nations, the European Union and the Council of Europe**. For the sake of this work, there is no need to analyse other frameworks, but it is noteworthy that there are other regional organisations that implement strategies on drug policies on other continents – for instance, the African Union Plan of Action on Drug Control and Crime Prevention 2019–2023 (African Union, 2019). However, this chapter will outline the three above-mentioned organisations’ bodies relevant to the area of drug policing and their guidelines on creating a (human rights-based) drug policy.

1.4.1. United Nations

United Nations Drug Control Treaties

The United Nations system of drug control is based on **three treaties** which codify and categorise different drugs in order to make sure that psychotropic substances and narcotic drugs are available for medical and scientific use. They complement each other with the last of them adding provisions on drug trafficking and drug abuse prevention and elimination.

The **1961 Single Convention on Narcotic Drugs** replaced earlier international agreements on opiates, cannabis and cocaine regulations (for instance the 1912 Hague Convention), labelling particular substances as ‘narcotic drugs’ and ranking them, according to harm they do, in categories, called ‘**schedules**’. The most harmful drugs are in Schedule IV. Schedule I follows, then Schedule II and Schedule III. The Single Convention requires the states **to take steps to limit the possession, use, trade in, distribution, import, export, manufacture and production** of scheduled drugs with the exception of medical and scientific purposes. The current number of parties to the Single Convention is 186¹.

Some incoherence entered the UN system in 1971 when the **1971 Convention on Psychotropic Substances** was adopted. Not only the wording was confusing (‘narcotic’ drugs and ‘psychotropic’ substances were not and are not scientific terms and no explanation was provided what the difference between them could be), but also for instance the fact that cannabis and THC (the psychoactive element of cannabis) are regulated in different conventions (Single Convention and the 1971 Convention, respectively) is very incoherent. The main goal of the 1971 Convention was to **expand control over new substances**, also synthetic, while acknowledging the possibility of their medical and scientific use. 184 states are parties to the 1971 Convention on Psychotropic Substances².

The last of the three conventions was adopted in 1988 and entered into force in 1990 – currently, 191 states are parties to it³. **United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** stemmed from the observed phenomenon that first two conventions did not achieve many effects in work against illicit drug use or trade. Scheduling itself was evidently not enough

¹ https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-18&chapter=6&clang=_en#1. Retrieved June 20, 2022.

² https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-16&chapter=6&clang=_en. Retrieved June 20, 2022.

³ https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=VI-19&chapter=6&clang=_en. Retrieved June 20, 2022.

and the United Nations recognised the need to **regulate drug trafficking** specifically. The 1988 Convention covers the issues of drug and precursor chemicals trafficking, and money laundering and it involves provisions guaranteeing international cooperation, for example for the extradition of drug traffickers (UNODC, n.d.-a).

Institutional framework

The main body of the international drug control system, **United Nations Commission on Narcotic Drugs (CND)** was established by the Single Convention as an organ whose responsibility was to guide the development of drug policies around the world, adhering guidelines to the current state of scientific knowledge and new drug-related threats. CND decides, based on medical and scientific research results, on placing particular substances under international control or on the rescheduling of substances already under control. It is an intergovernmental commission of the Economic and Social Council and consists of several offices. One of them is the **UN Office on Drugs and Crime (UNODC)** – created in 1991. Its mission is “to contribute to the achievement of security and justice for all by making the world safer from crime, drugs and terrorism”. UNODC provides support to the governments in strengthening drug control and issues legal expert opinions on drug policy-related matter. The Single Convention established also a monitoring body, **International Narcotic Control Board (INCB)** – a body of 13 experts. Article 9 of the Single Convention gives the INCB mandate to “endeavour to limit the cultivation, production, manufacture and use of drugs to an adequate amount required for medical and scientific purposes, to ensure their availability for such purposes and to prevent illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs”. INCB issues annual reports on the progress of its work and reports to CND on the 1988 Convention implementation in state parties (UNODC, n.d.-b).

WHO plays an essential role in the UN system, also in addressing the drug issue in the world. Its teams, such as Expert Committee on Drug Dependence and Alcohol, Drugs and Addictive Behaviours Unit or Mental Health and Substance Use Department work on the prevention of drug use, the harm related to drug use reduction, improving access to controlled medicines and guidelines on treatment and care of people with drug use disorders. Additionally, WHO and UNODC cooperate closely on issuing joint publications with guidelines on care and treatment of drug use disorders and related matters (WHO, n.d.).

The three UN drug control conventions are widely **criticised for their obsolescence**. Some civil organisations accuse the UN system of leaning clearly towards drug prohibition and law enforcement. However, INCB expressly stated that provisions in drug conventions set minimum standards and – with respect to each state’s constitutional limitations – states have broad powers to establish a system according to the level of tolerance or intolerance towards drugs in the given culture or region (Valadez, 2014, p. 206). For years this framework has led to the phenomenon that currently most countries have adopted the prohibitionist approach. However, some academics argue that not only do the conventions not prohibit decriminalisation of drugs, but it is possible under the current system. For instance, Valadez (2014, p. 224) argues that full enjoyment of the right to health can only be ensured with more flexible interpretation of the conventions and focusing “more on the protection of the individual and not on the amount of narcotics”.

United Nation’s guidelines

The United Nations sees the drug problem as a worldwide problem which needs to be tackled with an integrated and balanced approach and international cooperation. A *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2010, pp. 16–23), devoted to people who use drugs, outlines basic rules of shaping a human rights-based drug policy: harm reduction (including OST and NSP) and evidence-based treatment decriminalisation and de-penalisation, use of human rights indicators and guidelines, and alternative regulatory frameworks for drug control.

A strategy was shaped in 2009 and it was divided in three parts: demand reduction and related measures, supply reduction and related measures and countering money-laundering and promoting judicial cooperation to enhance international cooperation (UNODC, 2009). It is recognised that the main purpose of drug control should be to ensure health, well-being and security of individuals – while at the same time respecting their agency and human rights (UNAIDS, 2019, p. 6). It was also acknowledged in UNODC documents (2009, p. 3) that drug control regime had brought a huge, detrimental side effect by enhancing the need for criminal activity and creating an enormous illicit global drug trade.

Demand reduction and related measures

The fundamental part of reducing demand in the UN guidelines is **reducing drug abuse and dependence through a comprehensive approach**. A comprehensive approach means a multi-dimensional, holistic approach – including **healthcare, social care, criminal justice, employment and education and the participation of non-governmental organisations and civil society** (UNODC, 2009, p. 9). Recently, despite confirming the necessity of the criminal justice sector participation, the UN advocates stronger and stronger for providing alternatives for conviction and punishment, arguing that this solution contributes to effective public health strategy and prevents prison overcrowding while strengthening respect for human rights (UNODC, WHO, 2021, p. 11).

Treatment should be supported by other demand reduction programmes: **prevention, early intervention, care, rehabilitation and other support services** – promoting meaningful livelihood activities and employment is seen as a key to prevention of drug use stemming from a sense of low self-esteem (UNODC, 2009, p. 20). Treatment of the highest ethical standard should be available, accessible, attractive and appropriate, scientific evidence-based and customised to fit the needs of **groups and individuals of special needs** (UNODC, WHO, 2020, pp. 7–14). Especially vulnerable groups who need special care are recognised to be pregnant women, children and adolescence and people in contact with criminal justice system who have drug use disorders (UNODC, WHO, pp. 77–93). Moreover, **voluntary treatment** (or treatment in lieu of criminal punishment, referred by drug courts) is strongly encouraged as any long-term coercive treatment is a violation of human rights and a breach of medical ethics (UNODC, 2010, p. 8). Additional focus is put on access to healthcare services for people who use drugs suffering from infectious diseases such as HIV, tuberculosis, viral hepatitis and sexually transmitted infections (UNAIDS, 2019, p. 6).

States are encouraged to involve the community, non-governmental organisations and civil society in activities on planning, delivery and monitoring of drug demand reduction programmes and provide training for staff delivering the services. Monitoring and evaluation are seen as crucial to the further development of science-based drug policies (UNODC, 2021, pp. 24–25).

Supply reduction and related measures

Reducing supply is encouraged to be undertaken as an international effort in cooperation of law enforcement operations. It should be done by addressing new trafficking trends and reducing violence

associated with drug trafficking. Demand and supply reduction strategies should intersect and there is a particular need to involve private and public services to mainstream health, education and social services (UNODC, 2009, pp. 29–33).

Supply reduction should not however interfere with ensuring access to controlled medicines and the traditional medicinal use of controlled plants. **Indigenous Peoples'** possession, purchase, and cultivation of psychoactive substances, controlled under the treaty system, are encouraged to be decriminalised (UNDP, 2020, p. 24, 26).

As it was pointed out in *International Guidelines on Human Rights and Drug Policy*, every policy should be created on the fundament of basic human rights principles: human dignity, universality and interdependence of rights, equality and non-discrimination, meaningful participation and accountability and the right to an effective remedy (UNDP, 2019, pp. 6–7). These principles, as well as overarching respect for human rights in general, should serve state parties to drug control treaties in treaty interpretation – as follows, **fulfilment of obligations contained in the treaties, cannot justify any human rights violations** (UNDP, 2019, p. 23).

1.4.2. European Union

European Monitoring Centre for Drugs and Drug Addiction

The European Union's approach to drug policy is claimed to be people-oriented and human rights-based. It acknowledges the need for an integrated, evidence-based perspective in steps taken to reduce the drug supply and demand as well as to combat drug-related harm.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the most important body in the area of EU drug policy. Its significance has recently been reaffirmed by the fact that on the 9 June 2022, the Council of the EU adopted its negotiating mandate on the proposal on transforming EMCDDA into a fully-fledged agency called EU Drugs Agency while at the same time strengthening its role (Council of the EU, 2022).

EMCDDA is based in Lisbon and its main role is to provide information on drugs and independent scientific evidence, work on developing evidence-based drug policy guidelines and update knowledge on the dynamics of threats connected with the use of illicit drugs. "The EMCDDA supports EU and

national evidence-based policies by providing factual, objective, reliable and comparable information on drugs, drug addiction and their consequences. This role is grounded in the consensus that sound information is a prerequisite for effective policymaking.” – this mission statement shows the way in which, according to EMCDDA, drug policymakers should adopt when creating policies in their countries: effective policy must be evidence-based and EMCDDA provides this evidence for the EU member states.

The work of EMCDDA is divided into two main parts: **health and security** and its goal is to work towards a healthier and more secure Europe by supporting the EU Member States with reliable, independent data on drug policy and practice. In order to fulfil these two goals, the agency supports policy initiatives in the areas of health and security, provides overviews of drug markets and drug use, supports immediate responses to new health and security threats and assists the EU Member States in understanding the consequences of drug-related crimes and implementing effective harm associated with drug use reduction measures.⁴

In December 2020, the Council of the European Union approved a document called EU Drugs Strategy 2021–2025. It presents the strategy within the three abovementioned policy areas and is accompanied by EU Drugs Action Plan 2021–2025.

EU Drugs Strategy 2021–2025 and EU Drugs Action Plan 2021–2025

The EU Drug Strategy 2021–2025 outlines 8 strategic goals within 3 areas: drug supply reduction, drug demand reduction and drug-related harm reduction. Additional 3 strategic priorities give directions on international cooperation, means of research, innovation and foresight, and coordination, governance and implementation of the drug policy. Strategic goals lay grounds for particular actions outlined in the EU Action Plan on Drugs 2021–2025, intended to aid in creation of a coherent European Union drug policy within the Member States. The Strategy is based on evidence and adopts a holistic, multidisciplinary approach to drug-related areas and phenomena at national and international levels. It was created to aid in protecting and improving societal and individual well-being, enhance security in the EU Member States and increase health literacy in society, all with respect to gender equality and

⁴ Information acquired from: <https://www.emcdda.europa.eu/about/mission>. Retrieved June 22, 2022.

health equity (The Council of the EU, 2021). Priorities of the EU Drug Strategy 2021–2025 and actions in the field of illicit drugs are presented below.

Drug supply reduction

The **first strategic priority** is set on disrupting and dismantling drug-related crime groups within the EU and **preventing crime threats** by addressing security concerns. Special focus is put on vulnerable groups coerced to take part in illicit drugs production or trade. The need to cooperate with third countries considered ‘high-risk’ is recognised in order to track and trace proceedings related to drug crimes more efficiently.

Prevention of smuggling drugs to and from the EU by increasing monitoring of border crossing is the main concern embedded in the **second strategic priority**. It involves increasing monitoring of border crossing and diminishing illegal channels of trade by supporting legal ones. EMCDDA but also Frontex and Europol are prompted to cooperate with customs and exchange customs information to reinforce the Frontex border guards’ capability to detect drug traffickers.

Third goal of the EU Strategy is **targeting drug trafficking** via the internet or postal and express services and encourages Member States to cooperate with the private sector to monitor and investigate these channels. To fulfil this goal, internet monitoring has to be reinforced and the awareness on drug trafficking channels that are currently not monitored in a sufficient way by the law enforcement has to be raised.

The **last strategic priority related to drug supply reduction** covers **illicit production and cultivation of drugs** and preventing trafficking of drug precursors. Additionally, it addresses the environmental damage linked to illicit drug production and trafficking.

Drug demand reduction

The **fifth strategic priority** of the EU in the drug policy area is **education**, disseminating knowledge on drugs and especially **raising awareness on their adverse effects**. It draws the attention to children who are especially vulnerable to misinformation and whose resilience must be strengthened. The Strategy together with the Action Plan recognise that prevention has to be directed at both licit and illicit substances as well as other behaviours and activities that can be addictive.

Another goal associated with the demand reduction is the **sixth priority** – set on **making treatment available** for drug dependant people and ensuring access to it. Additionally, it involves reducing the stigma, strengthening care services and addressing groups with special care needs, such as women or LGBT+ people. Designing appropriate models of care for certain groups is a core for delivering efficient treatment and care.

Addressing drug-related harm

Drug-related harm is covered by the **seventh strategic priority** of the Strategy. It is focused on preventing overdoses and other drug-related deaths as well as reducing the prevalence of drug-related diseases and other detrimental health results of drug use. Moreover, the Strategy encourages promoting civil society participation (funded by the state) and providing alternatives to coercive sanctions. Enhancing the access to effective harm reduction and risk reduction measures involves NSP (needle and syringe programmes), opioid agonist treatment, peer-based interventions and outreach programmes. The Action Plan encourages the EU Member States to cooperate on exchanging best practices and to promote professional training to implement these practices in the most efficient way. It emphasises that treatment must be voluntary, non-discriminatory, gender-sensitive and evidence-based.

Additional attention is brought to **harm reduction in prisons** and in the environments of people who use drugs after their release from prison. The strategy sets the **eighth strategic goal** on assuring equal healthcare in prisons and by probationary services, implementing measures to reduce harm and restricting drug availability in prisons. The Action Plan highlights that services provided in prison should be equivalent to those provided in the community and should include for instance opioid agonist treatment, rehabilitation and recovery as well as providing sufficient care services at every stage of the treatment and after it.

International cooperation. Research, innovation and foresight. Coordination, governance and implementation

Enhancing the role of the EU as an advocate for a people-centred and human rights-oriented drug policy by **strengthening international cooperation** – with third countries and regional and international organisations is the axis of the **ninth strategic priority**. This covers further works on

shaping agendas on drug policy and fostering dialogue in the search for relevant strategies and initiatives with other institutions and third countries. Additionally, the strategy explicitly reaffirms the EU's attachment to adhering to human rights standards as obligatory elements of global drug policies.

The **tenth strategic goal** is focused on building a **comprehensive research evidence base** and enhancing Member States' **foresight capacities** in order to better respond to dynamic changes of drug-related threats. The drug phenomenon should be tackled in a complex, holistic manner with the use of effective and innovative tools by international networks of international and national agents cooperating together.

The **last strategic priority** of the EU Strategy is devoted to ensuring that the Strategy is **implemented in optimal, effective ways** at national levels with the provision of adequate resources by the European Union. This involves maintaining dialogue with the civil society and sharing good practices with other Member States. (Council of the EU, 2020; Council of the EU, 2021; Official Journal of the European Union, 2021).

1.4.3. Council of Europe

The Pompidou Group

The Council of Europe's International Cooperation Group on Drugs and Addictions [previously: Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs] (Pompidou Group) was created in 1971 and became an inter-governmental body within the CoE's institutional framework nine years later. Its mission is to support the decision-makers across member states in developing policies that aim at reducing drug trafficking, dealing with drug-relating disturbances in society, and finding better treatment for drug abuse disorders.

As a platform for intergovernmental cooperation, the Pompidou Group provides its members with a forum for the exchange of good practices regarding their drug policies and addressing challenges related to drug abuse. It promotes the human rights focus with an emphasis on public health and safety and engages multidisciplinary approaches based on evidence to tackle these challenges. Additionally, the institution works to strengthen international cooperation to prevent and combat the illicit production and

trafficking of drugs as well as drug crime in general. It also monitors the compliance of national drug policies with international law.

After 50 years of work, the Pompidou group remains committed to supporting the creation of drug policies that respect human rights. Its publications accentuate the need for an integrated approach, involving the gender dimension, psycho-social support, drug treatment in prisons or, more recently, the influence of the COVID-19 pandemic on people who use drugs. The institution assembles 41 member States and has developed many outside activities, notably, activities in South-East Europe (MedNet, Mediterranean Network), a cooperation with the Inter-American Drug Abuse Commission (CICAD) and, in 2010, the Pompidou Group signed a Memorandum of Understanding with EMCDDA (Pompidou Group, 2021).

Council of Europe's guidelines

The Pompidou Group reaffirms the Council of Europe's core values – human rights, democracy and rule of law – and advocates for implementing a balanced approach to drug policy, the main pillars of which should be actions aimed at **reducing illicit drug supply and demand**. It notes that **all policy elements should be compliant with human rights** and human rights should become and remain the very core of drug policy development, implementation, monitoring and evaluation (Pompidou Group, 2017, p. 3–4).

Designing drug policy: recommendations

According to CoE's policy guidelines on coherent licit and illicit drug regulations (Pompidou Group, 2011), a drug policy should **first and foremost be based on human rights**. Other elements of drug policy are recommended to approach the issue from the public **health angle, focus on supply and demand reduction, target vulnerable groups** to ensure **non-discrimination** and be **evidence-based**. Additionally, CoE recommends that the states should respect the multidimensionality of drug issues and learn from good practices in other states and guidelines set forth by international organisations as well as instruments and mechanisms provided by them (Pompidou Group, 2011, pp. 7–18).

The human rights approach is seen as sometimes conflicting with the public interest and it is recommended that these values should be balanced. The Pompidou Group highlights the importance of

focusing on vulnerable groups and enhancing the policy reach. Moreover, conflicts with public interest seem to fade when the issue is seen from the angle of public health – the Pompidou Group reaffirms that “**policies on psychoactive substances qualify as a public health issue**”. Therefore, prevention is advised and a range of **harm reduction programmes** are recommended for implementation in national drug policies (Pompidou Group, 2011, pp. 7–8).

Harm reduction: recommendations

Risk prevention and harm reduction are significantly connected with the human rights dimension of drug policy – according to the Pompidou Group (2013, p. 8–9), they encompass a broad range of interventions, programmes and policies whose aim is to “prevent, reduce and relieve health, social and economic harms to individuals, communities and societies, resulting from the use of psychoactive substances and addictive behaviour”. Such measures, if embedded into a drug policy, are seen to cause many salutary effects, such as: “reducing morbidity and co-morbidities, improvement of health status, referral into care, treatment and rehabilitation, social stabilisation, reduction of public nuisance, increase of public safety, reduction in acquisitive crime and imprisonment” (Pompidou Group, 2013, p. 9).

The Council of Europe recognises the most common and widespread harm reduction programmes to be NSPs, provision of **condoms** and provision of **clean injection equipment**, and low-threshold substitution treatment. Additionally, CoE recommends other programmes that are not very common, but have proven quite successful in some countries where they have been implemented: Introducing **consumption rooms** where users can take drugs in a safe environment, **drug pharmacological testing**, provision of **clean crack smoking pipes and foils**, **heroin-assisted treatment** and provision of **first aid self-medication** to treat overdoses, for example involving naloxone (Pompidou Group, 2013, p. 10).

Further, the Pompidou Group notes that provision of some services is crucial for reaching the best results in harm reduction. The state and service providers should build a system in which drug users have easy access to and availability of **low-threshold services**, and these services should be promoted with outreach work and motivational activities. The policy should involve **provision of detoxification services and emergency services** to deal with overdoses. Treatment should be accompanied by adequate **psychological, social and health care** – during and after undergoing such a treatment, patients should have the opportunity to get **support for self-help** (Pompidou Group, 2013, p. 11).

Children, prisoners, women and non-binary people

Additionally, the Pompidou Group draws attention to **children whose parents use drugs**, people who struggle with addictions in prisons and advocates for implementing a gender approach in drug policies. It points out that children whose parents use drugs are more likely to engage in risky behaviour in the future and that they suffer from low self-esteem and deficient trust – both in themselves and others. This happens largely because of neglect or even violence that their parents inflict on them (partially due to their own drug dependence) and because of overwhelming feelings of guilt, shame or anger as well as anxiety or depression that are particularly disastrous for children because of their young age (Giacomello, 2022, p. 9–11). The rights of the child lie at the centre of the Council of Europe’s interests and the organisation advocates for implementing a children’s approach to drug policy, which would include, for instance, providing services (i.e. day centres) for children whose parents use drugs for the time their parents use services (therapy, counselling, etc.), share good practices of working with such children among social workers and treatment services, providing children with support and possibilities to express their voices and share experiences and creating educational materials about understanding parental drug dependence (Giacomello, 2022, pp. 85–90).

Gender sensitivity is promoted by the Pompidou Group to policy-makers and practitioners. A gender mainstreaming approach should be implemented in drug policy in an inclusive way towards **women and non-binary persons** across healthcare and criminal justice systems. The Pompidou Group especially emphasises issues faced by women and non-binary persons, who are homeless, in poverty, or suffer from other cross-discrimination, and points out that policies should involve targeted initiatives addressing all dimensions of the gender impacts of drug use. Directives given to practitioners involve implementing gender-sensitive components in prevention and treatment strategies and programmes, which could be done by reflecting on the gender dimension of social norms and interactions and gender-specific aspects of drug use. Additionally, practitioners must remain vigilant for gender-based violence and other sources of trauma, which, together with structural inequalities, may reinforce particular risks and vulnerabilities for non-binary persons and women. The Pompidou Group also points out that women access and complete treatment programmes in smaller numbers than men, which shows the need of making programmes more accessible and available for women, designing them according to gender specifics and promoting them more effectively (Mutatayi *et al.*, 2022, pp. 82–83).

The Pompidou Group also notes that providing good **drug treatment to prisoners** has its effects in drug use reduction and additionally diminishes rates of reoffending. However, providing it is very

difficult in this environment due to the fact that drug use is still illegal in prisons, so providing effective treatment as well as implementing any harm reduction measures is very difficult. Measures recommended to undertake in prisons involve providing specialised counselling on drug-related issues, housing for prisoners who use drugs in which they could be treated and provision of educational materials in different languages (Stöver, Telzrow, 2009, p. 40).

II. Response of the European Countries

2.1. Drug policy regimes across Europe

As pictured above, a theoretical approach to a human rights-based drug policy has been on the agendas of international organisations for years now. The question of why it still remains largely theoretical finds its answer in previous discussions on why and how the criminalisation approach became so strongly embedded in the society. However, some states have adopted at least some of the international organisations' guidelines, respecting first and foremost the rights of individuals who take drugs. The right to health is central to these policies and they employ a range of programmes to ensure it, together with measures taken to demarginalize vulnerable groups and make 'the return to society' possible for affected people. The next chapter is devoted to outlining some of the European drug policies with special attention put on the drug policies of the Netherlands, Germany and Portugal.

Drug prevalence across Europe is very high. European Union institutions alarm, according to the aforementioned data that high drug use among European Union citizens is a complex problem as not only does it complicate the response to most pressing health and social issues, but also triggers them. Among health and social problems that can be influenced by drug use, we can find mental health problems, self-harm, homelessness, youth criminality and exploitation of vulnerable individuals and communities (EMCDDA, 2022, p. 8).

Drug policy regimes across European Union differ among countries. However, it is encouraging that more and more states are adopting decriminalisation steps – most of them do not decriminalise all drugs or every amount. They usually start with a small amount, considering it not harmful for the society as a whole if it is only for personal use. Figure 2 below depicts countries (orange) which removed criminal penalties for some activities regarding drug use.



Figure 2. Countries which implemented a drug policy decriminalising (to any extent) some of the drugs (removing penalties for possession, i.e., of a small amount of a drug) (Talking Drugs, 2022).

Given the prevalence of drugs in the European Union with cannabis being the most commonly consumed drug, but with other, more dangerous (such as cocaine, MDMA or amphetamines, and opioids) rising in popularity as well, the need for an effective and human rights-based, evidence-based drug policies which support and priorities health is evident. The author has chosen to outline and analyse drug policies in the Netherlands, Portugal, and Germany as they all focus on the ability of drug addicts to seek treatment, while at the same time enforcing laws to prevent drug trafficking (Anderson, 2012, p. 5). Moreover, pursuant to enabling the fulfilment of the right to health, they enable a range of additional services, such as harm reduction measures, but also counselling, focusing not only on psychology but also on rehabilitation of an individual as a member of society and supporting a person in, for example, finding housing, employment and building meaningful relationships.

2.2. Case studies

2.2.1 The Netherlands

Drug policy in the Netherlands is based on the division to ‘hard’ and ‘soft’ drugs – the principle of separation of markets (Chatwin, 2003, p. 568). Drug use as such is not a crime, except when it is done in some public spaces, i.e., schools or public transport. In case of possession of small amounts of drugs for personal use, the person will not be prosecuted but drugs will be confiscated anyways – for cannabis, the threshold amount is set at 5 g. It is possible to prosecute an individual in possession of less than this amount in some certain circumstances, according to the Opium Act Directive (EMCDDA, 2019c).

2.2.1.1. *Legal framework*

The core of the Dutch drug policy is the 1976 Opium Act. The first Opium Act was adopted in 1919 and it regulated transporting and dealing drugs, deeming it illegal. It took 50 years to start seeing the prevalence of drugs and drug addictions as social problems and then another twenty to revise the Opium Act and adopt the new version of it in 1976. The aim of the new regulation was “to protect health of individual users, people around them and society as a whole. Priority must be given to vulnerable groups” (Chatwin, 2003, p. 568). It is outstanding that such a progressive act was adopted in a time when most of the other states were adopting very repressive regulations. Dutch policy was based on the conviction that drug addicts are not criminals but patients who need professional help in order to return to health. As they are people who are primary victims of drug problems, it was more realistic, in the eyes of policymakers, to reduce the harm caused by the substance to the users than to struggle in order to achieve a drug-free society. It was quickly understood by Dutch policymakers that the latter goal is unrealistic and unachievable.

The separation between ‘hard’ and ‘soft’ drugs stems from harm and hazard associated with a given substance. Harm (hazard to the individual’s health, potential for addiction, impact on public order) of ‘soft’ drugs is seen as considerably lower than this of ‘hard’ drugs. Among ‘soft’ drugs there are hash, marijuana, sedatives and sleeping pills – listed in the Schedule II of the Opium Act. Heroin, cocaine, amphetamine, LSD or MDMA (also in the form of ecstasy) are labelled ‘hard’ drugs and are listed in Schedule I (Government of the Netherlands, n.d.). New substances are regulated accordingly by making amendments to the Opium Act.

As mentioned before, drug use is not a crime *per se*, but there are some amounts of drugs in possession that are punishable. Additionally, supplying (in any form: possession, cultivation, manufacture) drugs is a crime – punishable by a maximum of 12 years imprisonment. In 2004, the Placement in an Institution for Prolific Offenders Law was implemented and it made treatment for repeated offenders possible. It is conducted in care facilities outside of prison but consists of imprisonment measures and behavioural interventions mix (EMCDDA, 2019c).

2.2.1.2. Institutional framework

The aforementioned goal of the Dutch drug policy (protecting health of individuals who use drugs, people around them and society) is reflected in the range of harm reduction measures, incorporated into the policy. They involve needle exchange programmes, available and free testing for purity of ecstasy pills, reception rooms (consumption rooms) and methadone-assisted treatment, also free from any costs for the user. Additionally, the Netherlands was one of the first countries to test medical marijuana for treating multiple sclerosis (Chatwin, 2003, p. 568).

A series of **policy papers** regulate specific areas of the Dutch drug policy: for instance the paper on medical prescription of heroin or combating drug trafficking and sales to young people. *The letter outlining the new Dutch policy* from 2009, regulates the existence of ‘coffee shops’ – places where a user can buy cannabis, not being exposed to contact with any of the ‘hard’ drugs. Coffee shops used to be open and accessible to everybody but due to the phenomenon of ‘drug tourism’, they are now limited to residents only – however, it is up to local governments to make them available also for foreigners (EMCDDA, 2019). Additionally, the Netherlands introduced **national drug checking programmes**, such as Drug Information and Monitoring System (DIMS) whose responsibility is to examine drug composition and purity or the THC monitor – such institutions check the composition (Trimbos Instituut, 2019, p. 5) and they sometimes even participate in festivals at first aid stations.

Harm reduction programmes in the Netherlands are seen as pioneering, especially given that they were implemented even before the new drug policy of the revised Opium Act in 1976 – first harm reduction services date back to the 1960s. The first agents involved in providing such services were NGOs, municipal health services and faith-based organisations – they provided abstinence-based treatment, detoxifications, and therapeutic communities’ meetings. Some NGOs were involved in supporting people who use drugs in looking for housing or employment, obtaining social support and relevant healthcare. In 1968, the first **methadone-assisted treatments** were set up as the first OST and

thirty years later also **heroin-assisted treatment** joined as a trial and then officially started to figure in the catalogue of offered OSTs in 2006. The NSPs (needle and syringe programmes) started to be offered in the Netherlands as early as the 1970s as a response to an epidemic of HBV. In the same decade consumption rooms started operating in the Netherlands, targeting not only injectors and smokers, but also alcohol users (Grund, Brecksema, 2017, p. 135–136).

Grund and Brecksema (2017, p. 136) point out that “the primary objective of DDP (Dutch drug policy) was never to decrease drug use, but to **contain the associated social and medical problems**”. This viewpoint was confirmed by the policymakers who even admitted that the prevalence of drugs in the society is “almost policy resistant” (Grund, Brecksema, 2017, p. 136).

2.2.1.3 Commentary

The Netherlands is undoubtedly one of the first countries to implement efficient harm reduction. Currently, the main services offered and funded by Dutch Ministry of Health, Welfare and Sports, are: drug consumption rooms, opioid substitution treatment (also with heroin-assisted treatment) and needle and syringe programmes.

Drug consumption rooms (DCRs) are available in the Netherlands but not in a great number – there were 17 identified for the purpose of the study conducted by the Trimbos Instituut experts (van der Gouwe *et al.*, 2022) and it was noticed that a lot of them were transformed into private consumption rooms. What is particularly interesting about Dutch DCRs, they provide not only safe spaces to use drugs, but also basic necessities, such as clothing or food. Additionally, they refer users to further care centres, if it is needed or asked for. The minimum age to use a DCR is usually 21–25 and often the consumption of alcohol or GHB is not allowed (despite rising prevalence of this drug, employees sometimes claim that they do not know how to react to GHB overdose).

The Trimbos Instituut’s study identified 70 centres providing **opioid substitute treatments**. As average patient’s age is above 40 years old and few people tend to enter the treatment, the average age is rising and the number of total patients is going down. Therefore, the study suggests that there is need for additional support services for older patients who are experiencing negative health effects not only because of their long-term drug use, but also due to their age. **Heroin-assisted treatment** is seen as a last-resort means, after other OSTs did not bring expected effects – therefore, there is a considerably smaller number of centres providing it to the patients (17).

Among harm reduction services, there are also centres providing **clean needles and syringes** – they are also frequently associated with other low-threshold services and offer referrals for further care. According to the research, the number of NSP clients is also decreasing (van der Gouwe *et al.*, 2022, pp. 6–12).

Recent research conducted on harm reduction services in the Netherlands revealed some challenging met in the process of providing the services and those expected to become a problem in the coming years. As it could be noticed from the report above, the general **number of patients and clients is decreasing** which in consequence leads some policy makers to reconsider if such a big number of facilities is needed. This is a challenge for service providers who are convinced that maintaining the existing centres is a necessity in keeping in touch with people who use drugs.

Another challenge is an increase in **new target groups** – in the Netherlands, there are more and more migrants (usually labour migrants) from Eastern and Central Europe. Language barriers, lack of necessary documentation and closed environments of migrants living in closed communities are obstacles hindering outreach services. Additionally, harm reduction centres' employees identified many new clients among the youth population, homeless people and people with a mild intellectual disability and pointed out that harm reduction services should include better outreach services towards these groups.

Ageing population and health problems associated with older age are increasingly problematic and harm reduction services try to address these problems with more screenings and social care support. Apart from health problems, older age can also mean **decreased mobility** which poses a threat of not being able to reach a certain harm reduction centre – this problem obviously concerns also people with disabilities who use drugs or people living in poverty. There are reports, throughout Europe, that there is an increasing need to provide specialised harm reduction services for aging people who use drugs. In the Netherlands, some OST centres provide reimbursement for public transport for their patients.

A major, saddening problem in Dutch harm reduction services is the **stigma and prejudices** associated with people who use drugs. What is particularly distressing, people who use drugs experience stigma from their general practitioners and other healthcare specialists – this is an especially prevalent experience for older people who use drugs and use medical services more often due to age-related reasons. This pictures a growing need for more education for (mostly medical) professionals on treating and dealing with people who use drugs.

Drug use patterns are dynamic and new drugs emerge constantly – in Europe, a major problem is increasing use of i.e. pain medications and GHB. In the Netherlands, these issues are hard to address due to **restrictive policies of drug consumption rooms** and a lack of sufficient training for professionals. The challenges listed above clearly show that constant revision of undertaken measures and target groups is needed to ensure the highest attainable standards of harm reduction services (van der Gouwe *et al.*, 2022, pp. 14–16).

2.2.2. Germany

In Germany, it is against the law to possess or purchase drugs – these activities are mentioned as criminal offences (whilst drug use is not because it is considered a part of the German constitutional right to harm oneself) and are punishable by up to 5 years of imprisonment (Böllinger, 2004). However, the drug law is flexible enough to offer alternatives to prosecution when only a ‘small amount’ of a drug is involved and it is clear that it is for personal use. It is up to the Länder, to define what a value for a ‘small amount’ is – all Länder established the number of grams up to which they consider the amount of cannabis ‘small’ and some have even set such a number for other drugs, for instance, heroin, cocaine, MDMA or amphetamine and methamphetamine. Figure 3 pictures values set for cannabis in German states. It can be noticed that these values range from 6 to 15 grams with Berlin region being the most lenient. Additionally, medical marijuana has been legal in the whole country since March 2017.

In contrast to drug possession or acquisition, trafficking activities are punished much more severely – by 10 to 15 years imprisonment. This difference portrays the overarching principle of the policy: to reduce supply by severe punishment and strict law enforcement and to reduce demand according to the principle of “therapy instead of punishment” – if it is possible (Böllinger, 2004, p. 492).

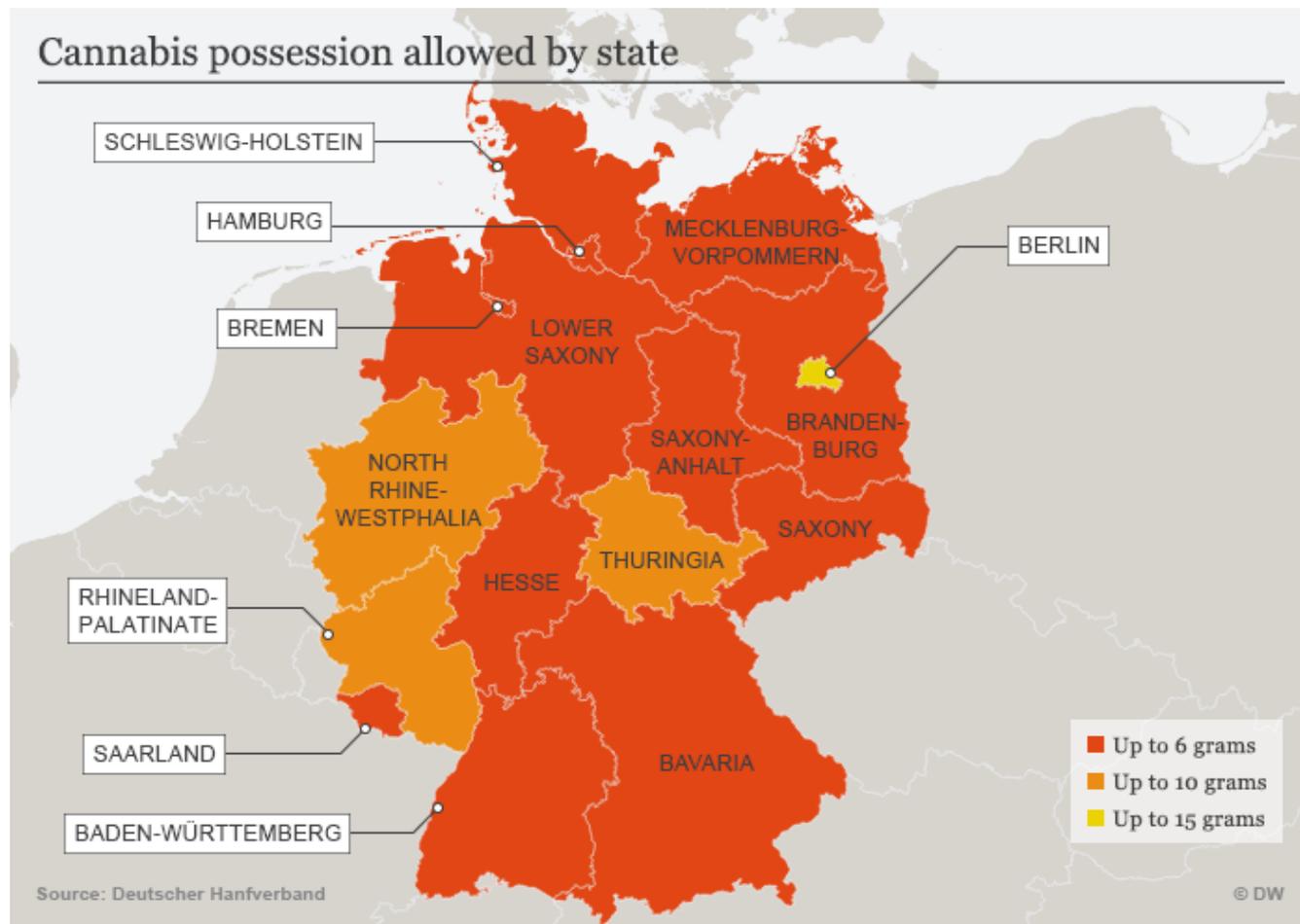


Figure 3. Cannabis possession allowed by German Länder (Schuster, 2018).

2.2.2.1 Legal framework

Betäubungsmittelgesetz (**German Federal Narcotics Act**, abbreviated as BtMG) from year 2000, is the main legal act which defines the shape of drug policy – it divides psychoactive substances into schedules, regulates the legal trade in prescription drugs, regulates criminal and administrative liability and sets out measures that can be taken alternatively to criminal justice measures for drug-dependent offenders (EMCDDA, 2019). Additionally, as a consequence of new psychoactive substances (NPS) emerging on the drug market, Germany introduced the **New Psychoactive Substances Act** in 2016 – however, it does not encompass all of the new substances because of their dynamic entrances on the market (EUCPN, 2018).

German drug policy is characterised by a complex, integrative approach to addiction – therefore it encompasses not only illicit drugs, but also, for example, tobacco, alcohol or psychotropic pharmaceuticals (which furtherly supports the creation of support systems and addiction prevention institutions and measures). In 2012, the **National Strategy on Drug and Addiction Policy** was implemented and it is still current – it stresses the central role of the health policy within the drug policy and the significance of health promotion and prevention.

National Strategy is built on four pillars: **prevention; counselling and treatment, cessation assistance; measures for harm reduction; and repression**. According to the overarching principle of German drug policy outlined above, these pillars create a balance between lenient measures directed at reducing demand and harsh measures to repress drug supply activities. What is remarkable, the National Strategy on Drug and Addiction Policy covers not only substance use and abuse but also other addictive behaviours, such as gambling or playing video games (Neumeier *et al.*, 2021, p. 3, 6).

Drug policy is additionally partially regulated in other areas, for example, through laws protecting non-smokers or the **German Youth Protection Act** (Jugendschutzgesetz, JuSchG) which focuses on prevention measures. Another act that focuses on prevention and obliges providers of rehabilitation services (such as German Federal Employment Agency and German Pension Insurance) to monitor the current situation, identify potential obstacles to efficient rehabilitation (that could lead to chronic illness and/or disability), and suggest possible solutions to prevent them is **German Federal Participation Act** (Bundesteilhabegesetz, BTHG) (Neumeier *et al.*, 2021, p. 6).

2.2.2.2. Institutional framework

Drug policy in Germany is a **shared responsibility of the Federal Government, the Länder and the municipality**. German constitution grants the mandate to regulate criminal law, narcotic drugs law and social welfare law to the Federal Government – therefore it has legislative competence for it and sets standards for drug policy. With respect to the above, Länder implement the law and transfer the national framework into action. They also have some freedom to implement additional provisions, i.e., on addiction support measures.

Since 1998, there has been an office of **the Federal Government Commissioner on Narcotic Drugs**, attached to the Federal Ministry of Health. The role of the Commissioner is to **coordinate the**

drug policy, promote and support initiatives on drug prevention, update the drug policy by developing new methods, responding timely to new problems and generally, to aim to alleviate health, social and mental problems. The Commissioner can suggest new solutions (make proposals) after taking recommendations from experts and is a national representant to the public, the press and at the international level.

The drug policy is implemented at the state level in the four areas: **prevention, treatment, counselling and harm reduction** (the state has the monopoly when it comes to criminal justice and prosecution). These measures are seen as a part of social security system and are therefore financed through state budgets (both federal and Land level or municipalities), but also by health insurance providers and pension insurance providers. Actors who deliver prevention, treatment, counselling and harm reduction services are usually social communities, the church, charities, other agencies (both public and private), and NGOs (Neumeier *et al.*, 2021, p. 14).

2.2.2.3. Commentary

Germany stands out in the group of countries analysed in this thesis due to its federal structure and consequences associated with it. Due to it, the federal strategy merely sets the ground for implementing the drug policy in the states, while it is the Länder, who usually develop their own action plans and strategy to combat drug addiction (Neumeier *et al.*, 2021, p. 15).

Harm reduction: Strategies on the federal level

It is worth noting that German drug policy is remarkably target-oriented, with a focus on children and adolescents. Nevertheless, there is a lot of projects currently running that target specific groups of people, for instance, FriDA – Early intervention in Drug Abuse (targeting minors and their families) or LOGIN – the living situation of adult refugees in Germany (ended at the end of 2021) (Neumeier *et al.*, 2021, p. 18–21). Other projects, also funded by the Ministry of Health, are for example aimed at strengthening parenting skills and developing support networks or – a pioneering pilot programme – a training on take-home naloxone (a life-saving substance if administered to someone who overdosed).

OST is a form of harm reduction and treatment that German Drug Commissioner advocated very strongly for, especially during the COVID-19 pandemic – in April 2020, new framework was created that enabled longer take-home prescriptions and fewer practice visits. Experts are still in discussion whether these provisions should stay in force even after the pandemic.

Harm reduction: Examples among Länder

The majority of care centres and services provided by the Länder, is offered in a holistic manner, which means that an integrative approach to both licit and illicit substances (and also other addictions) is adopted. Care for people who suffer from addiction problem is provided by a very developed network, involving services offered nationwide, both with a goal to prevent (early intervention projects or other activities among at-risk groups) and a goal to treat and provide aftercare. Outpatient addiction counselling, qualified detoxification facilities, withdrawal treatments and transition facilities are offered alongside with complementary services, such as low-threshold facilities, day-care facilities, employment and occupational projects, outpatient assisted living, hostels for young people, socio-therapeutic transitional residential facilities and hostels for homeless (Neumeier *et al.*, 2021, p. 15). Additionally, forming self-help initiatives is encouraged and provided at the Länder level.

Bavaria is an example of state which provides a wide range of services and has implemented its own Strategy to deal with drugs and addiction issues. In order to reach people in rural areas, typically a target difficult to reach, Bavarian government launched an online access to ordering free HIV diagnostic tests, followed by a face-to face counselling session (EMCDDA, 2019a). The Land has implemented behavioural and environmental prevention measures, repression measures to the extent required by the Federal Government and it provides legal addictive substances, support counselling and treatment, partnered with aftercare services for clients who wish to use them. In 2021, the pilot project of drug checking for purity was set up in Thuringia. Despite the Drug Commissioner's strong advocacy for regulating such an inpatient service on the federal level, the project is being delayed in Berlin Senate (Neumeier *et al.*, 2021, p. 8, 21). At the moment, programmes providing overdose emergency training and providing naloxone are carried out in several municipalities, for example Berlin or Frankfurt.

NSP are provided throughout the country through a network of low-threshold services, and even vending machines. Additionally, over 20 drug consumption rooms were available in Germany in 2019 – two of them were mobile and operated in the capital (EMCDDA, 2019a).

The role of NGOs

A lot of social work is delegated by the federal government to the competence of Länder and furtherly, governed by the principle of subsidiarity, to particular associations. For example, the associations of accredited doctors' responsibility is to provide outpatient healthcare. In Germany, there is a big prevalence of private charity organisations who receive public funding (accordingly to criteria from the federal level, Länder or the municipality) and provide socio-therapeutic services to drug users. They focus on providing therapy to their clients, but also on assisting them in every day life and supporting them through encountered problems. Social workers help people who use (or used to use) drugs in looking for employment or housing, and provide counselling. Youth welfare is a very central area for German drug policy and the law guarantees cooperation between GOs and NGOs on this matter (Neumeier *et al.*, 2021, p. 16).

2.2.3. Portugal

The approach that Portugal has taken is the most controversial among those analysed here (and probably in the world as well) and still sparks a lot of discussions as there is no doubt that it can be considered the most liberal and unconventional approach, and even ground-breaking and visionary. **Portugal decriminalised all drugs** (their use, possession and acquisition – at the moment all drugs are decriminalised, as long as the amount possessed does not exceed an average individual use for 10 days) effectively in 2001, introducing PDPM – Portuguese Drug Policy Model. Additionally, the difference between 'hard' and 'soft' drugs is no longer recognised and drug possession is now a misdemeanour (administrative violation) and not a crime. The foundation of Portuguese drug policy is the 'paradigm shift' of moving the focus from the domain of public order to that of public health – and moving the goal of the policy from a utopian concept of a drug-free society to one of health and the psychosocial protection of individual drug users (Rêgo *et al.*, 2021, pp. 1–2).

The shift described above was also accompanied by the introduction of a range of treatment services and a change in drug education. Even though the total number of people who use drugs per 100,000 population is still higher than the average in Europe, data provided by ESPAD confirms that the

percentage of schoolchildren who use drugs and the availability of drugs for children are lower than the European average (Slade, 2021, pp. 4–5).

2.2.3.1 Legal framework

The first Portuguese law on drugs was strongly inspired by the 1961 UN Single Convention on Narcotic Drugs – the Decree-Law n. 420/70, implemented in 1970 bears certain resemblance to the Convention: it criminalises both drug use and drug trafficking. What is surprising (and important also for the analysis of modern-day law), drug trafficking was regulated rather mildly. Policy-makers emphasised the value of public safety (drugs as danger to public health) and the inherent immorality of drugs. Six years later, the Decree-Law n. 792/76 broadened the view of a drug user and acknowledged that drug use and abuse should be understood as a complex medical problem with psychological grounds. This law was also a bedrock of the emergence of the Centre for Drug Study and Prophylaxis. During the sixties and especially during the seventies, the average use of heroin and cannabis in Portugal rose significantly – this phenomenon has been linked to the Salazar dictatorship coming to an end, after which the drugs in Portugal started to be perceived as a serious problem (Cabral, 2017, p. 1).

A big change came with the ratification of the 1971 Convention on Psychotropic Substances which stressed the importance of treatment and social reintegration – albeit 10 years later, this encouraged the implementation of Decree-Law n. 430/83 which put the individual in the centre. Under the Decree-Law n. 430/83, the user started to be seen as a victim of crime (drug traffickers) or pathology. This led to more aggressive penalties for drug trafficking and the introduction of a ‘mixed medical-penal system’, (Costa, 2017, p. 163) which criminalised drug users while at the same time providing them with treatment. The last UN convention on drugs, the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances reasserted a predominantly criminalised policy with some acknowledgement of the complexity of the issue, which was reflected in the Decree-Law n. 15/93. The new Decree-Law exacerbated penalties for possession and buying drugs and added cultivation for personal use to the drug crimes list. Possession was punished by jail time of up to 3 months, except when the amount possessed was bigger than the amount considered as a personal supply for 5 days – then detention could be extended to 1 year. Drug trafficking on the other hand was regulated in more detail – it was still considered a violent crime but additional categories were introduced (‘less severe trafficking’

and ‘dealer/user’), which allowed for somewhat less harsh penalties. However, the number of drug-related crimes rose steadily, despite the new regulations. Therefore, Portuguese policy-makers decided to shift the goal of the policy to public health and the National Drug Strategy was born in 2000 (Rêgo *et al.*, 2021, pp. 3–4).

The National Drug Strategy and the law behind it (Decree-Law n. 30/2000) derogated the criminalisation of all drug use and possession introduced by the 1993 Decree-Law. It is important to distinguish between ‘decriminalisation’ and ‘legalisation’. ‘Decriminalisation’ marks a situation when an act (drug use, possession, etc.) is not considered a criminal offence but a noncriminal sanction can be imposed (for instance coercive treatment or a fine) while ‘legalisation’ means that an act is not sanctioned in any way. The legalisation system has not been adopted in any of the EU states yet. It is also worth noting that some of the EU states adopted a framework of ‘depenalisation’, usually for using cannabis, meaning that personal use is still a crime but imprisonment for it is not possible (Greenwald, 2009, p. 2).

The main goal of the new policy was “widening the social and ‘sanitary’ protection of drug users”. Dividing users into “dependent” and “non-dependent” – and recommending adequate measures according to this division – is a choice made by Commissions for the Dissuasion of Drug Addiction. Even though this dichotomy is considered anachronic – it persists until this day (Rêgo *et al.*, 2021, p. 4). Decriminalisation is the core of PDPM but its success is attributed not only to it but mostly to the range of measures accompanying legislative changes (Rêgo *et al.*, 2021, p. 5).

2.2.3.2. Institutional framework

Commissions for the Dissuasion of Drug Addiction

Imposing administrative sanctions and implementing harm reduction measures is a responsibility of Commissions for the Dissuasion of Drug Addiction. Commissions are teams of experts (usually psychologists, medical doctors and social workers) who are responsible for conducting a psychological assessment of a person who uses drugs, referring this person to health structures and deciding on administrative sanctions or a suspension of a case. The police are the main source of detection of drug use and they refer a drug user to the Commission (Rêgo *et al.*, 2021, p. 5). The Commission’s role is to assess the person referred with regard to the ‘risk’ associated with their drug use. If a person is assessed as ‘low risk’ (first time before the Commission, small amount of drugs), the case might simply be

‘suspended’ and there are no further consequences. If the risk is assessed as ‘moderate’, i.e. when a person returns before the Commission or some other problem is identified by the experts, some means of help are suggested to him or her – for example counselling – but the person does not have any obligation to use the services suggested. When the Commission identifies the person as a ‘dependent’ drug user or deems the individual’s behaviour otherwise problematic, it can refer the person to specialised treatment services (Slade, 2021, p. 1). In accordance with the right to refuse treatment, every medical measure is non-mandatory, yet taking a stand before the Commission is. The Commission, existing under responsibility of the Ministry of Health, is non-judgemental and focuses on the right to health – its main goal is stated in the Decree-Law n. 130-A/2001 as “encouraging adherence to treatment, or the decision to abstain from drug use” (Rêgo *et al.*, 2021, p. 5; Slade, 2021, p. 2).

SICAD (General-Directorate for Intervention on Addictive Behaviours and Dependencies) is the primary body, operating under the Ministry of Health who supports the Ministry in designing the drug policy and conducting research on it. It is the leader of research on drug policy in Portugal and it ensures that national and international cooperation in field of substances and addictions is active. SICAD’s responsibility is also planning, monitoring and evaluating drug demand reduction interventions and harm reduction measures.

Harm reduction measures

When the policy changed, the original goal was to reach heroin- and crack-users who were seen as particularly resistant to traditional approaches. However, as the years passed, harm reduction measures broadened their scope to cover other targets and changed the approach to a more complex one, containing interventions associated with more general well-being of individuals.

Measures implemented in Portugal can be called a ‘weak’ version of harm reduction – it focuses on health rights, while ‘strong’ version would fully recognise the right to use drugs. Services that are provided cover the opioid substitution treatment and (rather rarely) needle and syringe exchange programmes. These services, targeted at so-called ‘pathology’ do not seem to raise any opposition from the society, whilst any other, that would go beyond these basics, spark some resistance. For instance, such social reluctance is seen as a response to suggestions on implementing drug checking services or providing naloxone to individuals for use in case of overdose (Rêgo *et al.*, 2021, p. 6– 8).

The network of harm reduction services providers contains regional health administrations (under the Ministry of Health), NGOs, and public and private treatment service providers, for instance, non-profit organisations. Services are offered with no costs to all people who use drugs and are in need of treatment. The first contact for a client is usually a treatment team that assesses health and social needs of a person and can refer them later to a detoxification unit (public or private) or a therapeutic community (usually privately owned and publicly funded). Treatment teams operate in integrated response centres that provide also psychosocial care and OST. Therapeutic communities usually admit clients for 3 to 12-months long residential treatment programmes, with a possibility to prolong a treatment to 3 years if there is a need for this. Additionally, there are specialised programmes for people who use cannabis and for people who use cocaine. In case of OST, a great facilitation has been implemented in Portugal. It allows any medical doctor to initiate it in case of buprenorphine treatment. Buprenorphine has to be paid for by the patient at the pharmacy, but the National Health Service covers 40% of it. In case of methadone-assisted treatment, it is free of charge but can be started only in a treatment centre (EMCDDA, 2019b).

2.2.3.3. Commentary

There are a lot of critics who argue that Portugal is not doing enough to implement sufficient harm reduction measures – for instance, there are almost no drug consumption rooms (with two exceptions: one in Lisbon and one mobile), no NSPs (also with two exceptions, operated by the NGOs) or naloxone provision outside of medical centres. Despite implementing what is seemingly a very progressive drug policy, medical marijuana was approved by the government only in 2018 and the debates on legalising at least cannabis, as for instance in the Netherlands, are persistently unsuccessful. Additionally, Portugal has done little to reduce stigma in the society where drug use is still associated with either pathology or crime (Rêgo *et al.*, 2021, p. 8, 9).

One of the disturbing changes in the Portuguese decriminalisation law happened in 2008 when the Supreme Court of Justice interpreted the law in a way that **re-established the crime of drug use**. The Court's sentence (n. 8/2008, August 5) deemed drug use a crime when a quantity possessed exceeded the amount allowed for individual use for more than ten days – in such case it is punishable by 11 year of imprisonment or a fine. The argument of the Supreme Court of Justice was a the time that the law

“was not intended to legalize drug use but only to decriminalize less severe consumption” – however, this judgement is still controversial, even among valued judges whose standing is that this approach directly opposes the spirit of decriminalisation law implemented in Portugal (Rêgo *et al.*, 2021, p. 6–7).

More criticism towards Portuguese drug policy stems from the conviction that in line with the **right to refuse a treatment**, appearing before the Commission for the Dissuasion of Drug Addiction should also be voluntary and based on consent (even if administrative sanction would still apply if the person does not appear before the Commission). Moreover, a growing backlash is experienced regarding harm reduction services – there is a consensus on providing basic health services like opioid-assisted treatment, but a lot of social reluctance is met when implementing services for checking drugs for purity or providing naloxone for people who use drugs is suggested. Additionally, studies point out failures in adjusting the policy to **groups with special needs** – such as prisoners or women, and people who use more than one type of drugs (Rêgo *et al.*, 2021, p. 9).

III. A comparative analysis of drug policies in the Netherlands, Germany and Portugal

The author of this thesis was strongly inspired by the work of Anderson (2012) and his study on Portuguese, German and Dutch drug policies. In his paper, Anderson compared the use of treatment programmes and drug courts, policies regarding possession of certain drugs and the use of illicit drugs by population in order to determine which of the analysed policies has had the largest impact on drug use. Despite failing to answer the research question straightforwardly, he did suggest that it was Portugal's policy that influenced the drug use the most. Given the author of this thesis' desire to follow up on Anderson's findings, she will also analyse the drug use over years characteristics in each countries, analysing cannabis and cocaine use among population (and separately among youth) and then follow with visualising statistics on opioid users entering treatment, similarly to Anderson's mode of work.

The author, however, would like to portray the data over the last 20 years, not just the most recent data. She believes that in order to assess (at least partially) the influence of drug policies on the realisation of human rights – here mostly the right to health – there is a need to look at the broader picture. Therefore she will be using data published by the EMCDDA (n.d.) for longest possible periods of time.

After examining the prevalence of certain drug in German, Dutch and Portuguese societies, the author will analyse the numbers of deaths from overdose. Additionally, the gender dimension of this statistics will be involve to monitor if gender inequalities influence harm reduction differences. Moreover, the number of newly reported cases of HIV will be pictured and analysed.

Based on research done and described in the previous chapter, the author will then compare the availability and accessibility of some harm reduction measures in Germany, the Netherlands and Portugal and the stigma associated with drug use in these countries. The chapter concludes with identification of good practices and brief summary of similarities and differences of drug policies in Germany, the Netherlands and Portugal.

3.1. Drug use rates over the years

Following Anderson’s (2012) work, the author analysed the prevalence of cannabis and cocaine in populations of adults and youth (young adults, 15-34 years old. Additionally an attempt to estimate the pattern in opioid use was made, similarly to Anderson’s study on the number of first-time clients for heroin use in treatment (Anderson, 2012, p. 12).

3.1.1. Drug prevalence among adults and young adults – cannabis

Figure 4 depicts the percentage of people in Germany, the Netherlands and Portugal who had come to contact (and used) with cannabis at least once in their lives. A high percentage is not a surprise as cannabis is now rarely seen as a dangerous drug and became even a “social drug” almost as popular as alcohol in many environments.

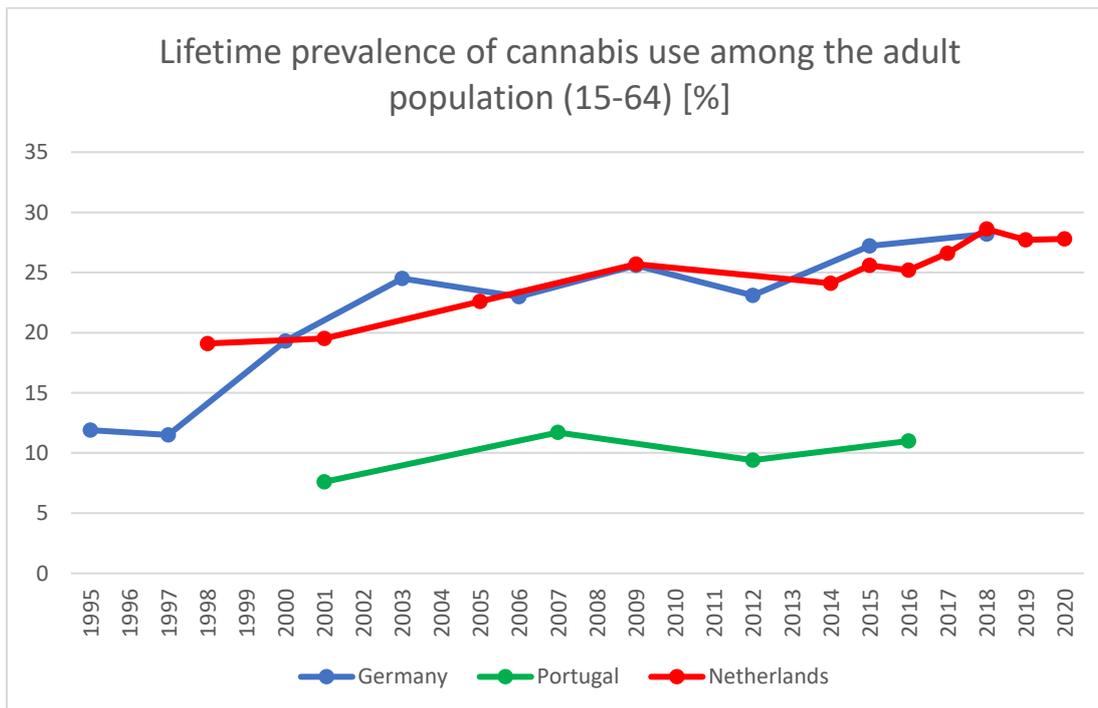


Figure 4. Lifetime prevalence of cannabis use among the adult population (15-64 years old) in Germany, Portugal and the Netherlands.

Similar results are pictured in figure 5 – cannabis, as a social drug, tends to be used at parties and, as a consequence, more by younger population than the older. This finds confirmation on the graph with regards to all three analysed countries.

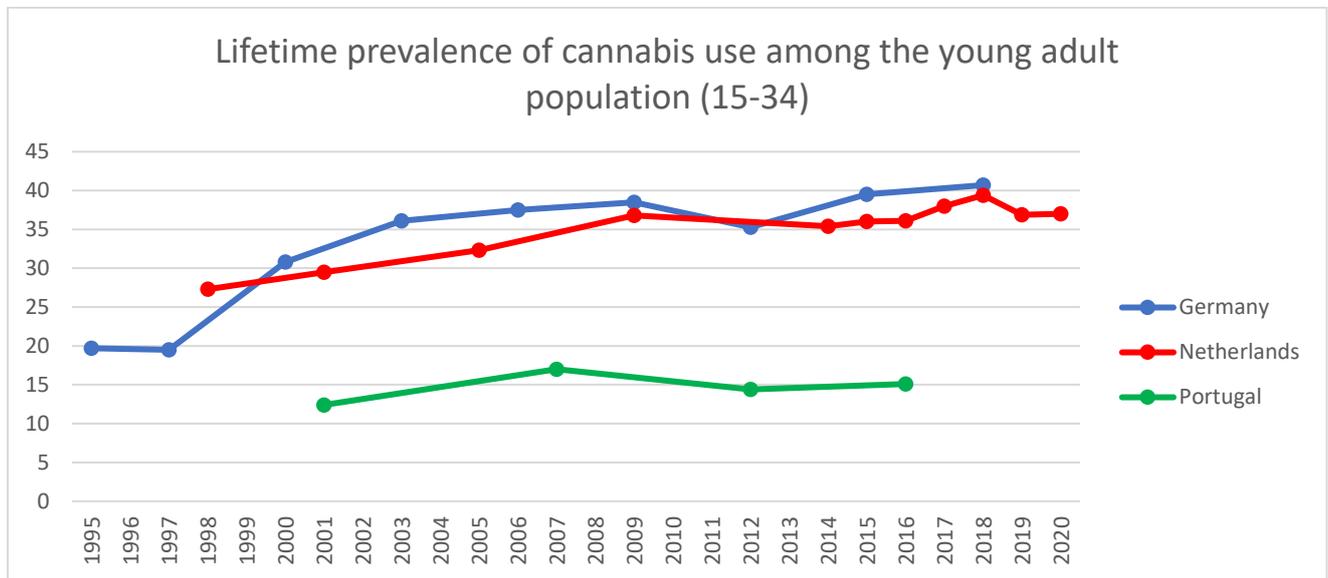


Figure 5. Lifetime prevalence of cannabis use among the young adult population (15-34 years old) in Germany, Portugal and the Netherlands.

3.1.2. Drug prevalence among adults and young adults – cocaine

Cocaine is perceived as a far more dangerous drug than cannabis and it is reflected in statistics. Both Figure 6 and figure 7 show a rise in cocaine consumption among young adults and the population as a whole in Germany and the Netherlands, while Portugal experienced a drop in 2007 when it comes to popularity of this drug.

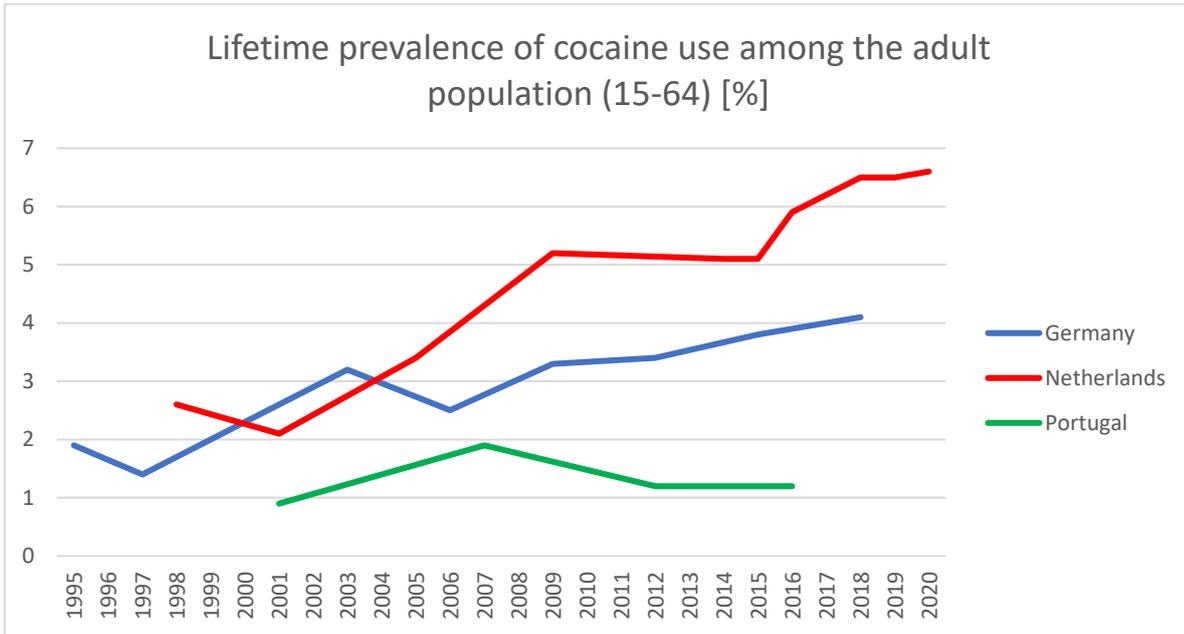


Figure 6. Lifetime prevalence of cocaine use among the adult population (15-64 years old) in Germany, Portugal and the Netherlands.

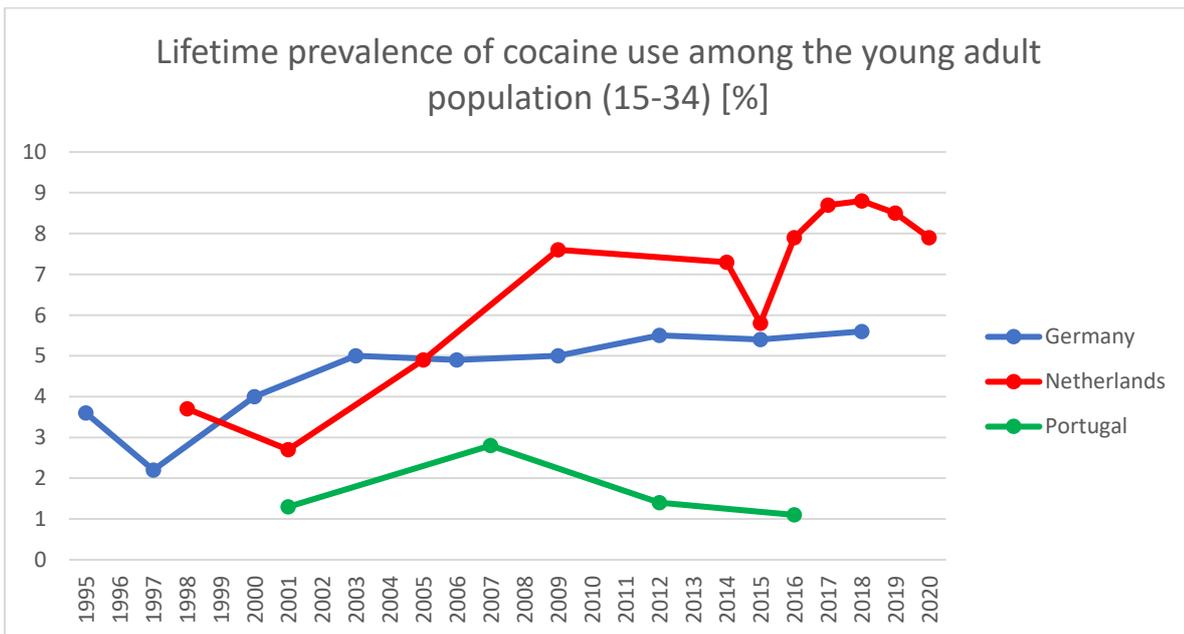


Figure 7. Lifetime prevalence of cocaine use among the young adult population (15-34 years old) in Germany, Portugal and the Netherlands.

3.1.3. Opioid use and treatment for people who use opioids

As many of the harm reduction measures are directed at treating or protecting people who use cocaine, the author wanted to examine heroin use in the three countries' populations. Unfortunately, the data on numbers of people who use heroin is not available. Therefore, she measured the percentage of new clients for (all) opioid use in treatment, following Anderson's (2012) methods. The results show slight lowering of the number of users who seek treatment for the first time and then, stabilisation in Germany and the Netherlands and a sharp rise and then fall in case of Portugal. According to Anderson (2012, p. 12), such result (lowering of the percentage) signifies that "investment in treatment instead of criminal sanctions has resulted in large drops of heroin use in all three countries". He observed and compared the data from 1999 and 2009, getting a sharp decrease as a result, while in figure 8, it is rather a stabilisation of the problem that can be observed – especially in the Netherlands and Germany – this might point to the observation that the treatment services found the equilibrium and are helping a stable number of people.

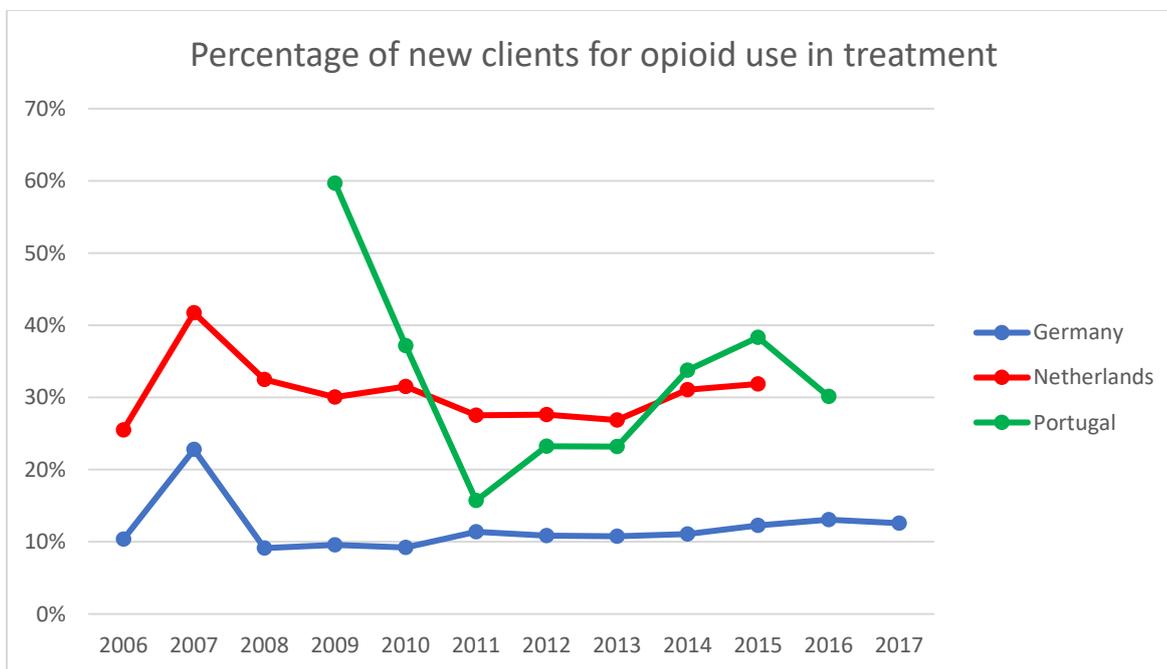


Figure 8. Percentage of new clients for opioid use in treatment in Germany, Portugal and the Netherlands.

3.2. Deaths related to overdose

In the author's view one of the biggest failures that drug policies can cause is a rise in the number of deaths related to drug use. Therefore, statistics on drug overdoses should provide a good reference point to measure how well the right to health and the right to life is protected by the government. It is important to note that overdoses are not only causes of drug-related deaths.

Figure 9 displays the total number of drug overdose in Germany from 1985 to 2020. A spectacular success that can be attributed to new drug policy implemented in 2000, when law allowed for example for the existence of supervised drug consumption rooms. The drop from over 2000 overdoses in year 1991 to 1002 in 2013 is spectacular, but the trend seems to be currently in reverse. This can be possibly attributed to new drugs taking on the market, such as GHB. As it was mentioned before, many service providers or social workers are not properly trained to aid a person who overdoses an unknown or little-known drug.



Figure 9. Number of deaths by overdose reported in Germany in the period 1985-2020.

In figure 10, a rise in the number of overdose deaths in the Netherlands is visible. Given the prevalence of harm reduction services it is quite surprising but looking in figures 9, 10 and 11, a pattern is seen – around 2013, after a decline, the number of overdose deaths starts to rise again despite continuous provision of harm reduction services in analysed countries.

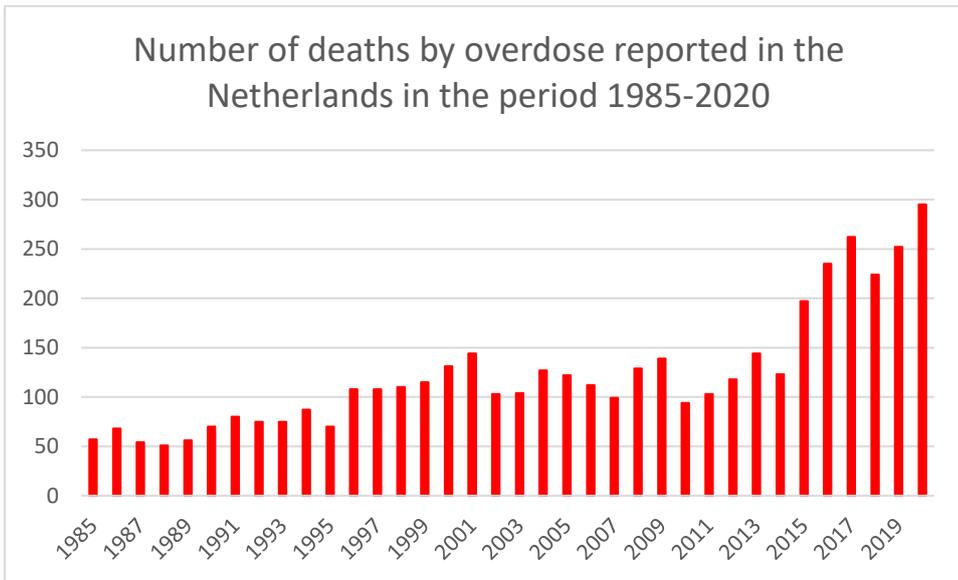


Figure 10. Number of deaths by overdose reported in the Netherlands in the period 1985-2020.

In the author's view, this regularity confirms her assessment that this rise happened due to new, less safe psychoactive substances gaining popularity among people who use drugs. The same pattern can be observed in Figure 11, resulting in eightfold rise in the number of overdose deaths in the period from 2011 to 2019.

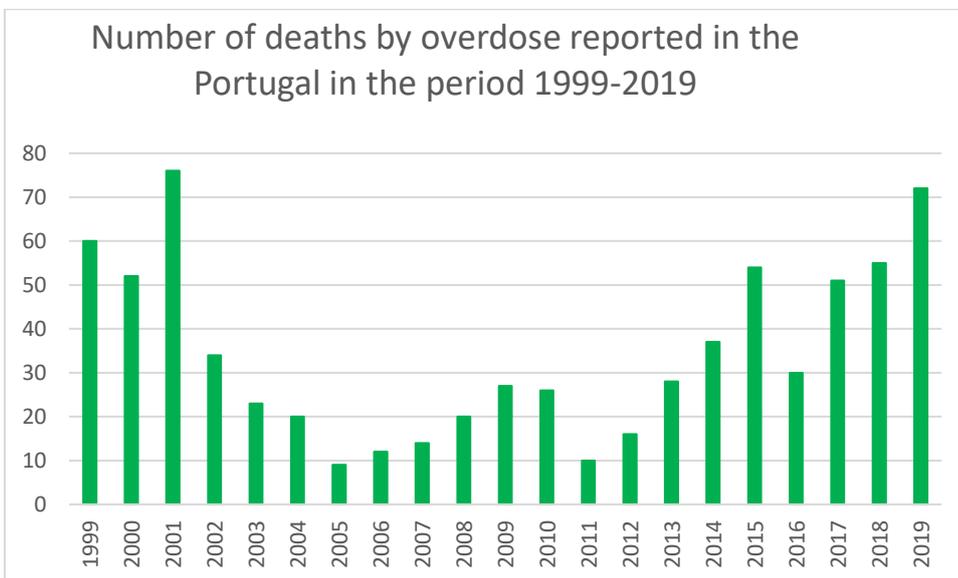


Figure 11. Number of deaths by overdose reported in the Portugal in the period 1999-2019.

Figures 12–14 picture the same statistics that were displayed in figures 9–11 but additionally shown with respect to gender participation in evolving numbers. As was expected, the number of men's deaths of

overdose is overwhelmingly bigger than the number of women’s overdose deaths in every country under analysis – this is of course caused by the fact that more men take drugs than women. However, while in Portugal (25% to 30%) and the Netherlands (13% to 25%), the proportion of woman tends to be rise, in case of Germany women’s and men’s deaths were kept at a similar ratio (around 20%).

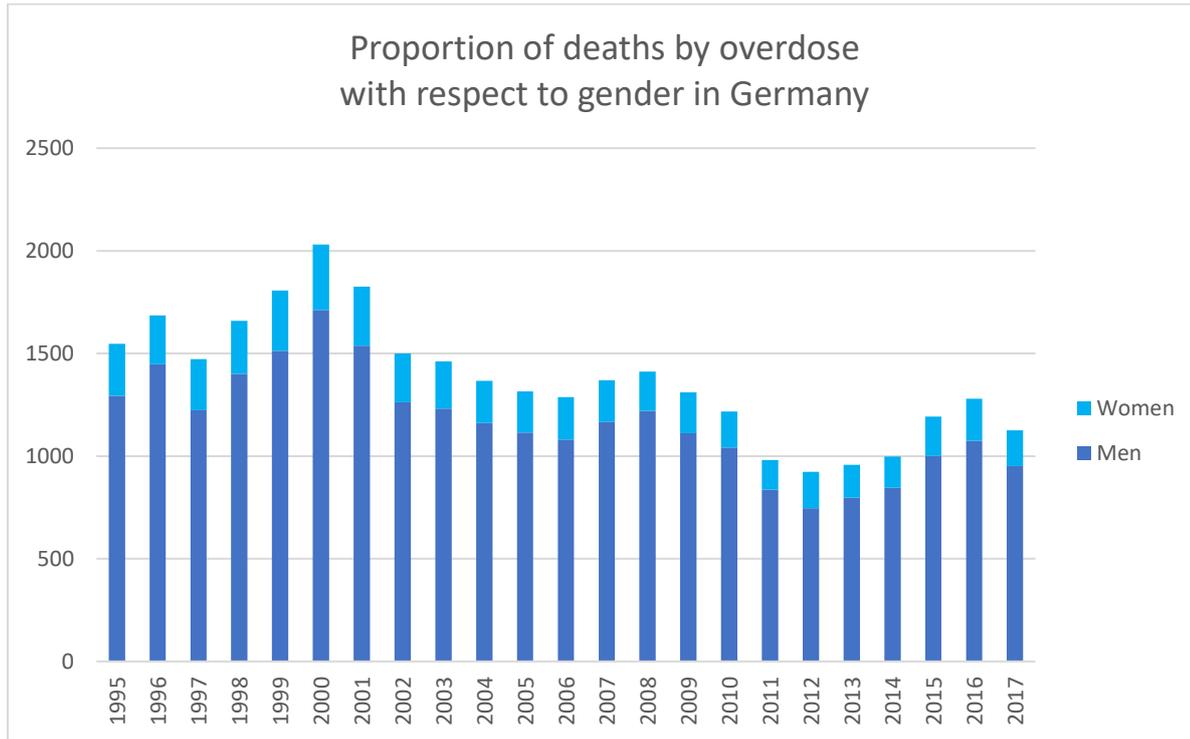


Figure 12. The proportion of deaths by overdose with respect to gender in Germany.

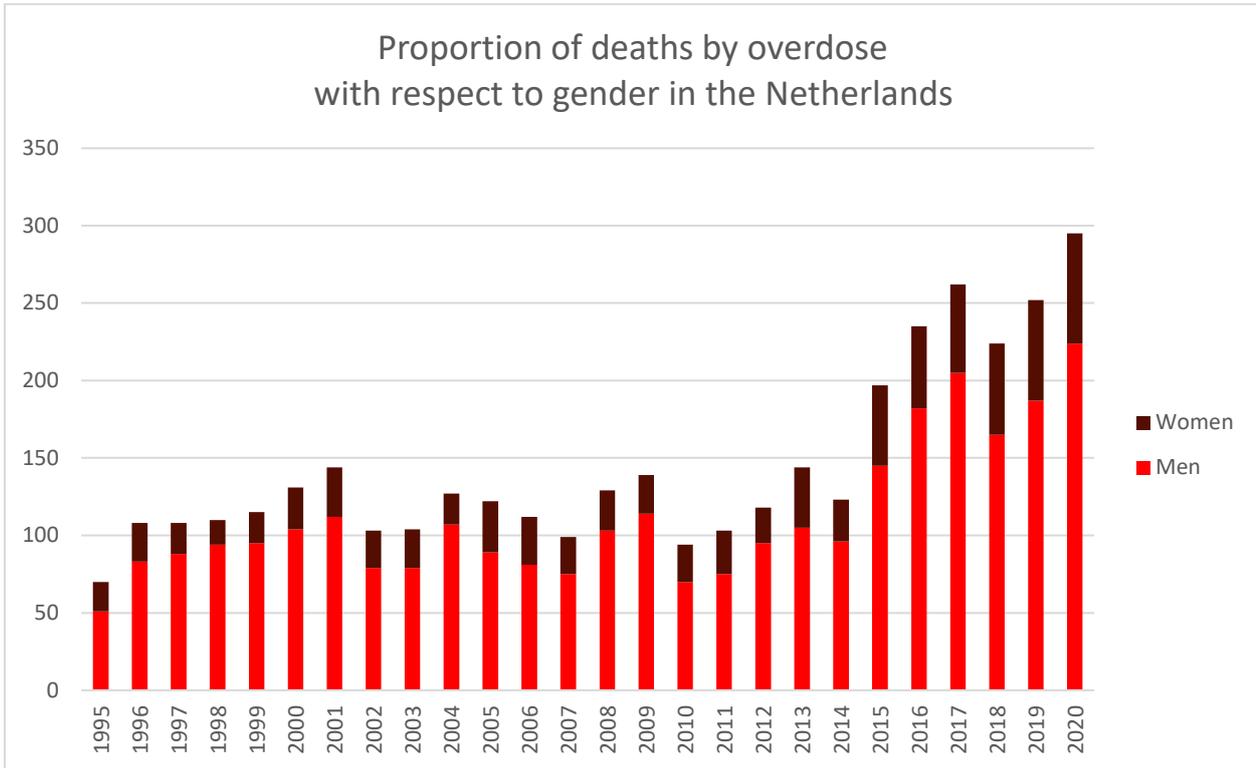


Figure 13. The proportion of deaths by overdose with respect to gender in the Netherlands.

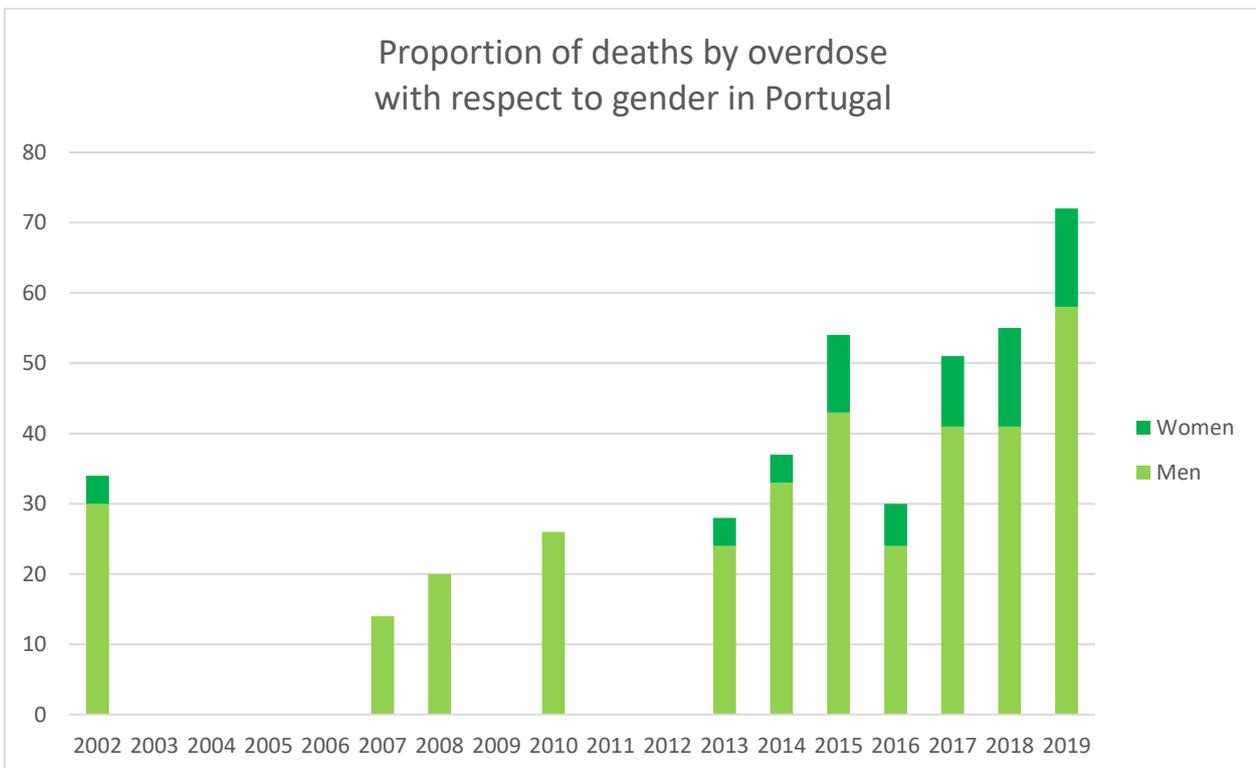


Figure 14. The proportion of deaths by overdose with respect to gender in Portugal.

3.3. Prevalence of HIV

Data pictured below refer to new cases of HIV infection related to drug use. Sharing needles or paraphernalia can lead to HIV and other infections. Statistics on HIV and new cases reported in time can indirectly give information on the efficiency of introduced harm reduction measures, such as NSP.

Figure 15 displays the number of new HIV infections among people who use drugs in Germany – while in the first half of the last decade the number remained relatively stable, it peaked in 2015, rising from 87 in 2009 to 142 in 2015. Currently, a rise is still observed, although very high numbers from 2019 and 2020 might be attributed to COVID-19 pandemic which impaired the availability of NSPs and other harm reduction programmes.

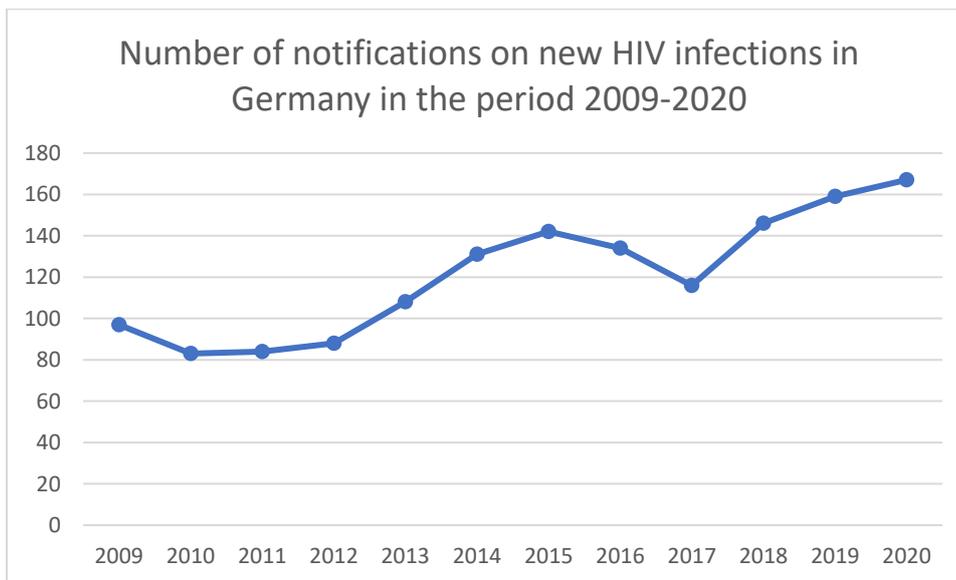


Figure 15. Number of notifications on new HIV infections in Germany in the period 2009-2020.

Small number of reported HIV cases in the Netherlands can be read as a great success of widely implemented needle and syringe exchange programmes (figure 16). It is important to note that while Germany is a huge country, in the Netherlands it is a lot easier to provide services to people who use drugs mostly because of the size of the country and proximity of big cities.

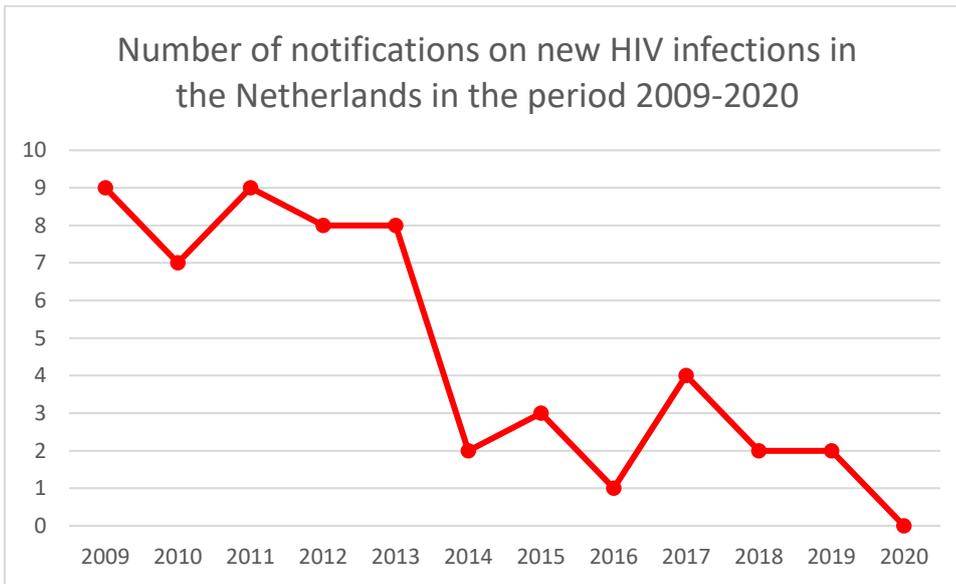


Figure 16. The number of notifications on new HIV infections in the Netherlands in the period 2009-2020.

Figure 17 shows clearly that the number of newly reported HIV cases among people who use drugs is getting smaller and smaller. In the period of 10 years, it went from 275 to only 16.

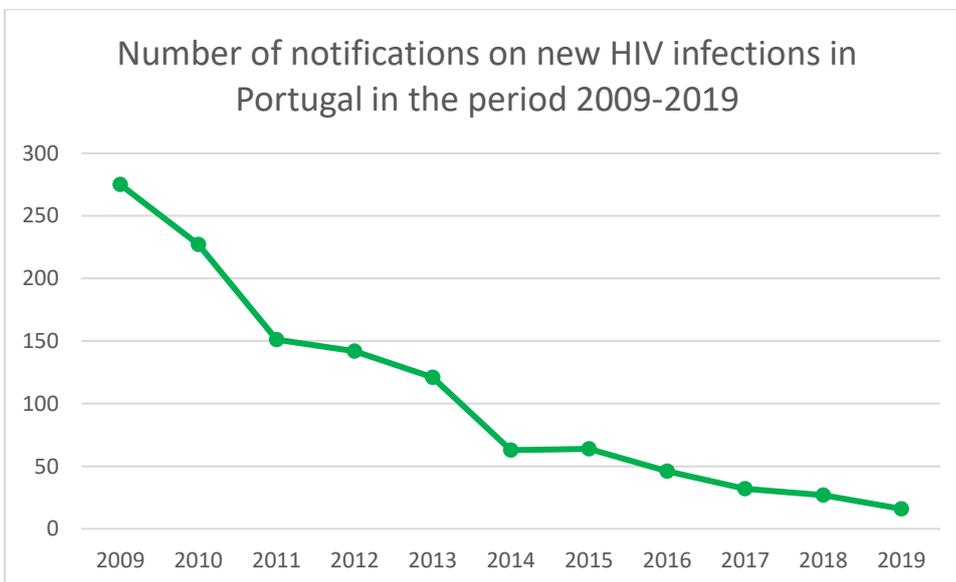


Figure 17. The number of notifications on new HIV infections in Germany in the period 2009-2019.

(EMDDA, n.d.)

3.4. Reflexions on stigma and harm reduction services from the perspective of data

What seems to pose one of the bigger challenges, as is revealed in the course of this thesis, is the social stigma and social exclusion that is experienced by people who use drugs in all of the three analysed countries, despite far-reaching steps taken to reduce these phenomena. As Rêgo *et al.* (2021, p. 8) point out, decriminalisation in Portugal has not proven influential enough. Still, the majority associates drug use with crime and pathology which in consequence triggers social reluctance towards broadening the scope of offered harm reduction services, such as HAT or drug testing for purity.

Martinelli *et al.* (2020), who analysed the stigmatisation of people with mental health and substance addiction in the Netherlands, point out that language can exacerbate or diminish stigmatisation (p. 1504). Even though, in their study, they reach a conclusion that using words such as ‘victims’ or ‘disorder’ do not have an effect on stigmatising individuals by healthcare professionals, it still seems vital to keep in mind that language is a carrier of attitudes and shapes the reality. Another study, by Sattler *et al.*, shows that stigma has a detrimental effect on the lives of people who take drugs and that getting rid of some prejudices is a very complex mechanism (p. 415). Nevertheless, it can be surprising that even countries which fight it by legal means but also education and normalisation, still struggle with the prevalence of social stigma and prejudices experienced by people who use drugs.

When it comes to harm reduction measures, it can be noticed that the Netherlands and Germany implement almost all of the measures recommended by international institutions. Portugal, despite a seemingly progressive approach visible in the decriminalisation decision, fails to provide some of the much-needed facilities, such as drug testing centres or consumption rooms. This is largely an effect of the aversion of society towards people who use drugs.

Nevertheless, all three, Germany, the Netherlands and Portugal have implemented needle and syringe programmes: two former in 1984 (public funds were allocated to NSPs in Germany in 1992 and in the Netherlands in 1986) and the last one in 1993 (and instantly publicly funded). The first NSP in prison was implemented in Germany in 1996 and operated on 10 sources, successfully. Portugal also tried to implement the programme in a pilot programme in Portuguese prisons, however, it was not used by anybody (Rêgo *et al.*, 2021, p. 6). The biggest hope for all of the three policies right now are pilot programmes in action, that aim at providing people with naloxone and training them in using this substance to save a life in case of overdosing.

Another effective and popular harm reduction measure is the opioid substitution treatment – implemented first in 1968 in the Netherlands, in 1977 in Portugal and in 1992 in Germany. Currently, treatments assisted by methadone, buprenorphine and heroin are provided, yet the last one still did not achieve a warm social welcome. Even in Portugal, HAT is not offered and opioid substitution treatments are only methadone- or buprenorphine-assisted (EMCDDA, 2019c). All three of the analysed countries have also implemented OST treatment in prisons: the Netherlands in 1985, Germany in 1992 and Portugal in 1999. Contrary to introducing the NSP measure in prisons, treatment enjoys remarkably bigger popularity (EMCDDA, n.d.)

IV. Human rights-based approach to drug policies based on the right to health

The following chapter is intended to complement the previous one in analysing how well-aligned drug policies in Germany, Portugal and the Netherlands are with human rights. Even though the previous chapter focused on comparing these three policies, this thesis is focused on identifying the good practices within the analysed drug policies rather than finding out which one of them is ‘the best’. Given the variety of measures undertaken, the different history and specific characteristics of each country, it is hard to make such a categorical choice, while the really important question is what can be learnt and improved in existing drug policies.

This chapter begins with outlining the characteristics and limitations of the criminalisation approach. While it has not been outlined earlier, it is important to examine it after gaining a good working understanding of the three decriminalisation approaches in the European countries analysed above. Contrasting the critique of the criminalisation approach with an assessment of German, Dutch and Portuguese drug policies emphasises the amount of work that has been done in the area of drug policing and reaffirms that decriminalisation and a human rights-based approach is clearly superior to criminalisation policy in terms of effects.

Nevertheless, praising drug policies in Germany, the Netherlands and Portugal is not the aim of this thesis and an analysis of their shortcomings is as important in answering the research question as finding good practices. Therefore, this thesis has identified gaps, which point to areas of drug policy that still need attention, improvements or sometimes even a complete change or reaction. This analysis was conducted mainly thanks to the participation through interviews of people, such as social workers and NGO representatives, who deal with drug policies in Germany, the Netherlands or Portugal on a daily basis and provide first-hand views on what works well and what needs improvement in the future.

The last part of this chapter sums up the thesis’ findings by identifying good practices and shortcomings in order to assess to what extent the analysed drug policies respect, protect and fulfil human rights. Additionally, based on findings on shortcomings, some possible improvements to drug policies in Germany, Portugal and the Netherlands are suggested.

4.1. A critique of the criminalisation approach

The criminal justice system has been criticised by many and on many grounds. Watson (1958), a pioneer of connecting the fields of law and psychiatry together was a strong advocate of treating criminals by therapies and not by imprisonment. He noted that penal institutions very rarely provide therapeutic treatment, while almost all criminal individuals and criminal behaviours can first be understood and then addressed therapeutically. In his view, even solely expressing the intention to treat instead of exerting punishment could be salutary (Watson, 1958, p. 630). While, in his discussions, he did not focus on any particular crime, his consideration seems universal and applicable to the subject of this thesis. “Confinement in a hospital-type setting is not an eagerly sought-after experience, but the atmosphere of acceptance of the individual's problems is far healthier than the atmosphere of hate, fear, and rage that exists in the usual penal institution” (Watson, 1958, p. 630) – Watson’s words, even though written over 60 years ago, are still valid, especially when it comes to punishing drug crimes, where the victim and the criminal are often the very same person.

Those who favour criminalisation policies bring up many arguments that present serious threats to society, which is protected – in their opinion – by keeping ‘drug crimes’ in the criminal justice system. They use the same arguments that have been used since the 19th century: Drug use and addiction is a ‘vice’ and causes antisociality; dependence or withdrawal symptoms, caused by addiction to drugs, might severely affect performance in school or at work, be detrimental to relationships, and prompt aggressive behaviours; violence can also be caused by abusing some drugs, especially stimulants; drug addiction can be a part of a ‘criminal attitude’ – if someone is willing to take drugs when it is a crime, they are probably willing to commit other crimes (Solivetti, 2001, p. 17).

Criminalisation policies, practiced in many countries have prevailed around the world for years, which is quite surprising given the lack of positive associated effects – drug use rates and the rate of drug-related crimes stay at the same level when drug use is criminalised (Malinowska-Sempruch, Lohman, 2022, p. 1). Additionally, it can be said that not only do they fail to improve the situation (by diminishing drug use rates or crime rates), but they even cause more harm than good.

First, incarceration or fear of incarceration often has a tremendously destructive effect on people’s mental health and also impairs their willingness to reach out for help. Being forced to use drugs in secret may also result in doing it in less safe ways, for example, in unhygienic environments or without checking

drugs for purity first (Holland, 2020). Incarceration for a non-violent crime such as drug use seems truly excessive and it is important to note that its effect on health can be catastrophic – especially when drug use in prisons is often accompanied by higher risks of HIV or HCV transmission (Csete *et al.*, 2016, p. 1429). Findings confirm also that incarceration for drug use is often pursued in a discriminatory way against racial and ethnic minorities as well as on the basis of gender, which has a particularly significant effect on women of colour (Csete *et al.*, 2016, p. 1429). Moreover, the criminalisation approach is often linked to a lack of harm reduction programmes such as NSP or OST which results in exacerbated HIV and HCV transmission rates and increased deaths by overdose (Csete *et al.*, 2016, p. 1447).

In the case of people who are incarcerated, the criminalisation policy punishes not only them, among others, by impacting their health and well-being, but members of their family who suffer from secondary stigma (courtesy stigma) and are prone to worsening financial situations if the person incarcerated was a provider for the family. Quite often, incarcerated people are additionally punished with ‘returning to nothing’ – a situation where upon returning from prison, a person is left with no support network and often without a place to stay, as a result of abandoning previous apartments or other living arrangements as an effect of incarceration. Even with a stable housing situation, a person with a history of incarceration is sometimes excluded from other rights and social support, for example, public benefits, and is vulnerable to secondary discrimination by being labelled a drug offender, despite having completed their punishment in the eyes of the law (Human Rights Watch, 2016, pp. 132–163).

Additionally, Husak (2003) states that even if addiction is a disease, it is a long way to concluding that drug use itself is a disease, too (p. 511). In fact, addiction is a rare consequence of drug use, so that drug problems are rarely an issue of pure dependence on a substance, rather such issues usually indicate a ‘people problem’ that can be solved by caring about a person and treating an individual, instead of punishing them for substance use (Husak, 2003, p. 510).

4.2. Shortcomings of approaches adopted by the analysed countries

Despite so many overwhelmingly promising results from independent and national bodies on new steps taken within drug policies in Germany, the Netherlands and Portugal in the 21st century, there remains significant space for improvement. The discussion of shortcomings in adopted policies was possible due to interviews conducted by the author of this thesis with NGO representatives and social workers in the

three analysed countries. The policies, all focused mainly on protecting health, were identified as very effective by the employees. However, the interviewees were able to name some of the deficiencies in the programmes their countries have put into action. This chapter presents them in no particular order and does not refer them to any particular country directly because the outlined suggestions were similar for most and are intended to be general characteristics, which serve to highlight existing and potential shortcomings.

The interviews were conducted over a period of three months with seven different organisations from the three analysed countries. Each of the countries has an organisation (or a few), representing it in the IDPC (International Drug Policy Consortium): Akzept in Germany, Stichting Drugbeleid in the Netherlands and APDES (Agência Piaget para o Desenvolvimento) in Portugal. Apart from NGO workers, employees of private companies were also interviewed, for example from Vista from Berlin. The list of questions asked during interviews can be found in the Appendix section. To the author's chagrin, some organisations avoided answering her detailed questions about any shortcomings of the policy or suggestions for its improvement. Nevertheless, interviews were conducted in writing as well as live, via Zoom, and several areas of improvement within German, Dutch and Portuguese drug policies were identified.

The first problem, mentioned by the social workers, was that very often to 'get into the system', a person has to be insured. Obtaining health insurance usually is not difficult for a person who is a citizen or has been awarded a permission to stay in the country but for others, who are immigrants or seeking refuge and still in the process of waiting for a granting of refugee status (or those who have already been denied but will not be deported), it can be nearly impossible or very time-consuming. Additionally, the sheer quantities of documentation needed can account for difficulties in getting into some particular programmes, especially for immigrants who do not speak the language. In many cases, however, social workers and NGO employees help them in collecting everything that is needed.

The gender dimension of drug policy was mentioned by interviewees quite frequently and from many points of view. The first issue that was addressed by them (or rather pointed out as lacking proper address in the policy or approaches) was the lack of differentiation between male and female treatment in the means of work. Even though the approach by definition has to be individual and separately suited to each patient/client, most social workers or NGO representatives participating in interviews did not recall being trained on differences in addiction patterns for men and women, though they acknowledged that such gender-based approach could be useful for their work. Meanwhile, studies on the subject clearly

show that men and women (after simplification and generalisation of data) have typically presented different patterns of use or dependence on drugs. Tuchman (2010) mentions these differences to occur within: “biological and subjective responses to drugs, patterns of use, progression from use to dependence, gender differences in medical consequences, co-occurring psychiatric disorders and substance abuse, women’s history of victimization and violence, midlife and older women, specific barriers to treatment entry, retention, and completion for women” (pp. 127–128). Focusing on specific barriers to treatment entry, it is worth noting that the causes for women vary from economic reasons to family responsibilities partnered with greater vulnerability to feel shame or embarrassment and being more prone to anxiety and depression. All of these are holding women back from seeking treatment and, even if they have started it, from completing it (Green, 2006, p. 57–58).

The children’s perspective also comes to light in these interviews, closely following the gender perspective. Unfortunately, children can impede the ongoing therapy or treatment of a parent and a parent in this context usually means a mother. The interviewees mentioned not only that women are less likely to seek treatment due to family responsibilities, but that sometimes in the process of treatment, therapy or even just assistance, they were forced to ‘choose’ the child or children’s interest over the mother’s while the mother was participating in a treatment programme. Another, obviously more direct, influence of children, exacerbating gender-sensitive differences in substance abuse treatment, were the family responsibilities mentioned before. It was pointed out by some interviewees that should a policy cover childcare services for one or a few hours a week when the mother is having her therapy, her meeting with a social worker or using other forms of services, it would contribute to more gender equality in drug abuse treatment.

Some social workers who participated in the research, mentioned that rules that they follow – regarding for instance the time limitation or the number of absences after which the sessions must come to an end (because the patient is assessed as not cooperating) – are not necessarily adapted to the reality of people suffering from addictions. They highlighted that such people belong to a vulnerable group and are more prone to ‘having a bad day’ or being easily discouraged. However, such regulations are not a part of state drug policy but rather inner (company/organisation) agreement on how to use the budget and fulfil the treatment plan to the fullest and most effective result.

When asked about stigma, the interviewees hesitated and admitted that no research was done on the subject and especially, as it is very hard to measure, there is probably no comparable data from before and after new policies were implemented. In spite of that, the prevalence of stigma was mentioned not

as a result of the policy, but rather as an unaddressed problem that can still cause serious consequences and discriminatory behaviour, even from people who are in the front line of helping people suffering from addictions. One example, described by a respondent, was the dismissive and contemptuous behaviour of paramedics towards people who suffer from alcohol addiction or other drug addictions. This is especially worrying, as it is easy to imagine that when an ambulance is called many times to the same place (or even the same person), it can make paramedics more insensitive, but any hesitation can cost precious seconds that could save a life. However, the interviewee expressed her impression (stemming not only from observing the behaviour, but from the time it took the ambulance to arrive after the call) that even for medical workers, who are expected to treat all patients equally, the value of the life of an alcoholic person is worth less. Respondents also noted that even though some education is now being introduced in school on drugs and harm reduction, there is little education on stigma, its consequences and working or acting against it.

The last problem mentioned by the interviewees was the recent COVID-19 pandemic. As drug addiction is first and foremost a health problem, adding another health issue to the lives of individuals who use drugs obviously meant enhancement of the risks they face. According to some studies (Heimer, McNeil, Vlahov, 2020), the pandemic was disproportionately harmful for vulnerable groups, such as homeless or incarcerated people as well as people marginalised because of substance use, who should be qualified as high-risk populations together with the elderly or people with pre-existing health conditions (p. 448, 454). During the period of the pandemic (mostly due to lockdowns), the number of people who decided to enrol in treatment significantly dropped, for instance, those who enrolled in methadone-assisted treatment in Germany. While in the Netherlands outreach services worked exceptionally well even before the pandemic (Schatz, Schiffer, Kools, 2011, p. 2), some service providers in Germany have decided on investing in and adding outreach responsibilities to their employees' tasks.

4.3. Human rights-based and right-to-health-centred approach to drug policy

The research and analysis conducted above revealed some of the advantages and disadvantages of drug policies in Germany, the Netherlands and Portugal. However, the question of if and to what extent they are human rights-based, cannot find its answer in objective results of data analysis. At this point in the thesis, there is little doubt that regulations of the aforementioned drug policies stem from a strong will to respect, protect and fulfil human rights. A lot of provisions were made in national laws, in order to ensure the best fulfilment of the right to health and many other human rights, described in detail in previous chapters.

However, there are no perfect policies and even the best intentions cannot guarantee the best effects. Imperfections in Dutch, German and Portuguese policies show that policymakers need to be especially vigilant when it comes to drug policy as it requires frequent revision and adjustments to current situations. However, in the case of drug policy, the right to health proves fundamental: harm reduction seems to be the key to a human rights-based approach, based on the principle of voluntary participation and equal availability and accessibility. Such measures as OST, NSP or consumption rooms are extremely useful and protect some human rights without violating others – they must necessarily be identified as great practices, especially when they are complemented by outreach services and are sometimes offered in mobile vehicles.

What is however especially worrying, is the prevalence of stigma associated with using drugs and prejudices which are imposed on people who use drugs even by healthcare professionals. In addition to this, the growing need to provide additional care services to ageing communities is a coming challenge that, if not addressed properly soon, might become a problem in the future. While following the human rights-based approach in the drug policy, it is also important not to forget about the vulnerable groups – after the above analysis, it is clear that sometimes inequality becomes invisible and people might become deprived of essential services in a silent way. This is why it is extremely important to revise drug policies to suit the human rights framework on a regular basis. Reviewing existing policies could spark ideas, for example, for providing childcare facilities for children of parents who participate in treatment or other services. Another much-needed improvement could stem from providing training to i.e. healthcare professionals on how to deal with patients who use drugs.

V. Conclusions

Illicit drugs and other licit psychoactive substances have been a part of people's lives for centuries, their use ranging from religious or traditional purposes, through medical treatment to purely recreational use in societies where such practices were seen as socially acceptable. As years passed, regulations on drugs began to be implemented in national laws: bans or restrictions on use, possession, sale and acquisition, trafficking of alcohol, opium and other substances started to be imposed.

Answer to the research question

A human rights-based drug policy is one that puts human rights over drug policy goals and resigns from setting policy goals whose realisation would put individual's rights in danger of violations. Prioritising human rights in designing drug policy means not only abstaining from interfering with one's rights but also taking positive measures to ensure the fulfilment of the human rights of an individual to a maximum extent. Germany, the Netherlands and Portugal are examples of countries that embraced this responsibility, focusing first and foremost on the right to health but also recognising the drug issue as a complex problem which needs to be treated in a holistic manner.

Despite shifting the focus from public safety to the health of an individual (generally speaking), all of the three countries under analysis seem to achieve great results in the field of both areas. Objective successes, measured in lower numbers of deaths by overdose, less transmission of infectious diseases, and drug prevalence among the youth speak for themselves when it comes to an assessment of reaching these policy goals: public safety and health. The statistics show that resigning from 'traditional' measures does not equal opening the field for violations of any of the society's values or rights. Moreover, it can be stated that policy based on prohibition fails and can even cause more harm than good – unfortunately, too often are drug policies based on an anachronic, prohibitionist, conviction and radiate a deeply unethical understanding of drug issues.

A human rights-based drug policy puts a human being first. It acknowledges the complexity of a drug problem and assesses the needs of an individual with respect to his or her dignity, agency and specific requirements. It is vital, that the policy is based on the principle of non-discrimination and equality and focuses on ensuring that rights of every individual are respected to the maximum extent.

A huge part of drug problems stem from addiction which is mostly a health problem. The fulfilment of the right to the highest attainable standard of healthcare should therefore be the goal of every human rights-based drug policy. This can be achieved by providing accessible and equal health services, including psychological and physical treatment to individuals in need, accordingly to their specific requirements. This approach can be contradictory to what is believed about drugs, but respecting one's agency as well as protecting one's health can require taking such steps as providing clean equipment and safe spaces for administering drugs or engaging someone in an opioid-assisted treatment. These practices should be by now widely recognised as compulsory elements of a human rights-based drug policy.

Acknowledging that drug abuse stems from many causes, such as chronic stress, poverty, low standards of living, uncertainty or vulnerability, allows adopting a holistic approach to drug policy. Basing it on human rights must necessarily mean addressing also other social and economic rights of an individual – only when people feel safe, can they realistically think of making their lives better and meaningful. A policy grounded in guaranteeing social well-being, health and human rights protection has better chances to bring positive effects.

Making a policy equal and non-discriminatory requires a policy maker to step forward and acknowledge the needs of specific groups: indigenous people, women, people in the crisis of homelessness, people living in poverty, people with disabilities, children, prisoners and many others. The complexity of the world of drug use and abuse means that the policy has to be constantly adjusted to suit the people who need it the most.

Portugal, Germany and the Netherlands put the right to health in the focal point of their drug policies. What they all have in common is implementing measures to prevent the human dignity and agency of people who use drugs from being violated. By implementing a set of certain measures they focus on basic human rights and their fulfilment in order to solve the cause of the problem – and not just get rid of the inconvenient effect. They employ a range of harm reduction services to ensure that the right to health is fulfilled and partner them with counselling and social workers who aid people who use drugs on their way to meaningful participation in every aspect of life.

What they sometimes neglect are unfortunately groups with special needs who need a specific approach when it comes to treatment or support. Insufficient education and normalisation cause prevailing stigma and hurtful stereotypes which seriously lower the standard of life of people who use

drugs. Additionally, some harm reduction services tend to meet with social reluctance – the occurrence of which discourages policymakers (perhaps fearing losing political popularity) and hinders the progress that is so much needed, given the fact that the world of drug problems is dynamic, requires fast interventions and quick reactions, not only from service providers but also the creators of policies.

Germany, the Netherlands and Portugal are countries that can be followed as pioneers of modern, human rights- and evidence-based drug policy. There is no doubt that a lot can be learnt from their experiences and that a lot should be learnt. Their drug policies are fundamentally grounded in human rights and realise the principles that every policy should be fulfilling in a democratic state where human rights and the rule of law are respected. Perhaps, the most important quality of a human rights-based policy is its flexibility – the ability to change and adjust when the situation requires such adjustments. Therefore, based on the above research and analysis, it is safe to conclude that Germany, the Netherlands and Portugal realise the principles of human rights in their drug policies. Thanks to their experience they are now encouraging – albeit, naturally, imperfect – examples to follow for the rest of the world.

Limitations

Despite the broad scope of analysis, this thesis could not cover a big part of drug policy, which are regulations on **drug trafficking** nor were the **trends in drug markets** in Europe analysed. This is why it is impossible to draw conclusions on how the policies implemented in Germany, the Netherlands and Portugal influenced the drug markets in Europe and what their direct effects are. Further analysis would be needed to find out if drug supply reduction measures aid in protecting for example public health. The author believes that such research could help in giving a broader image of the complexity of analysed drug policies and their effects.

Another limitation to the thesis stemmed from the fact that the research could not provide **some of the data from after 2018** or 2019 because of the COVID-19 pandemic which suspended the creation of *Country Drug Reports*. The author had hoped that the reports would be provided earlier this year, yet she had to conduct her work on the data covering a less relevant, more confined time period.

When it comes to analysis of some factors describing the efficiency of drug policy in terms of protecting human rights, the author has to admit that some conclusions were impossible to be drawn due to the lack of measurability. For instance, there are no reliable **data on stigma** towards people who use drugs that would cover the examined time period or reflect the influence of implemented measures and

policies on the prevalence of stigma and its different types. A study on the subject should, in author's opinion, be conducted separately and with respect to different interventions and educational measures on the drug problem, in all of the analysed countries.

Additionally, the main limitation of the thesis is the **impossibility to deduce causation depending on correlations shown**. Therefore, the only way to study the policies' compliance with human rights is not by the objective results (although they do support the statement that respecting human rights in drug policy does not have detrimental effects on public health), but by the range of programmes implemented and the number of people who use the services. The author would recommend conducting interviews not only with social workers and NGO representatives but also with people who use (or used to use) drugs whose experience could tell more on the effects of the drug policy implemented and the human rights side of it, than the analysis conducted from 'the outside' could.

Yet, the author's findings based on the interviews conducted with her interviewees add new critiques from the perspective of people working the closest to the policy's target. While there is a lot of literature on decriminalisation's advantages and the superiority of a treatment-based approach over criminal justice approach, there is little knowledge on improving the existing services that are seen as already almost perfect or at least very human rights-based. This is the case of policies implemented in Germany, the Netherlands and Portugal. The author aimed at pointing out that even though three policies can be called human rights-based to a large extent (as they prove to protect and fulfil the right to health and other human rights from many angles), the topic of drugs and drug policing is so dynamic that every policy needs to be continuously updated. The interviews conducted are a vital part of this thesis and provide an overview of what can escape the eye of a policy maker and how important it is to monitor and review drug policy on a regular basis. They created a valuable input and feedback needed to adjust the policies in order to respect, protect and fulfil human rights to a greater extent.

Bibliography

Literature

- African Union. (2019). *African Union Plan of Action on Drug Control and Crime Prevention*. Published Online. Retrieved on July 2, 2022, from: https://au.int/sites/default/files/newsevents/reports/36768-rp-aupa_on_drug_control_2019-2023_final_with_foreword_-_english_.pdf.
- Barret, D. (2006, 13 November). Prisoners poised to win payouts for ‘cold turkey’ drug treatment. *The Independent*. Retrieved July 27, 2022, from: <https://www.independent.co.uk/news/uk/crime/prisoners-poised-to-win-payouts-for-cold-turkey-drug-treatment-424086.html>.
- Barret, D. (2018). *Drug Policy and Human Rights in Europe: Managing tensions, maximising complementarities*. Available Online. Retrieved June 11, 2022, from: <https://rm.coe.int/drug-policyandhumanrights-in-europe-eng/1680790e3d>.
- Böllinger, L. (2004). Drug Law and Policy in Germany and the European Community: Recent Developments. *Journal of Drug Issues*, 34(3), pp. 491–510.
- Bruce R.D., Schleifer R.A. (2008). Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention. *The International Journal of Drug Policy*, 19(1), pp. 17–23.
- Burger J., Kapron M. (2017) Drug Policy and Indigenous Peoples. *Health and Human Rights*, 19(1), pp. 269–278.
- Cabral, T.S. (2017). The 15th anniversary of the Portuguese drug policy: Its history, its success and its future. *Drug Science, Policy and Law*, 3(0), pp. 1–5.
- Caquet, P.E. (2022). *Opium's Orphans: The 200-Year History of the War on Drugs*, Reaktion Books: London-Glasgow. Retrieved on May 1, 2022, from: <http://ebookcentral.proquest.com/lib/unilu-ebooks/detail.action?docID=6915698>.
- Caulkins, J.P., Reuter, P. (1995). Redefining the Goals of National Drug Policy: recommendations from a Working Group. *American Journal of Public Health*, 85, pp. 1059–1063.

- Caulkins, J.P., Reuter, P. (1997). Setting goals for drug policy: harm or use reduction? *Addiction*, 92(9), pp. 1143–1150.
- Chatwin, C. (2003). Drug policy Developments within the European Union: The Destabilizing Effects of Dutch and Swedish Drug Policies. *The British Journal of Criminology*, 43(3), pp. 567–582.
- Costa, E. Consumo de estupefacientes: evolução e tensões no direito português. *Julgar*, 32, pp. 161–180.
- Council of the European Union. (2020). *EU Drugs Strategy 2021–2025*. 114178/20. ANNEX.
- Council of the European Union. (2021). *EU Drugs Strategy 2021–2025 Booklet*. Available Online. Retrieved June 22, 2022, from: <https://www.consilium.europa.eu/media/49194/eu-drugs-strategy-booklet.pdf>.
- Council of the European Union. (2022 June 9). *EU Drugs Agency: Council adopts negotiating mandate on strengthening the role of the agency* [Press release]. <https://www.consilium.europa.eu/en/press/press-releases/2022/06/09/eu-drugs-agency-council-adopts-negotiating-mandate-strengthening-its-role/>.
- Courtwright, D.T. (2012). A Short History of Drug Policy or Why We Make War on Some Drugs but not on Others. *History Faculty Publications*, 23, pp. 17–24.
- Crocq, M.A., Historical and cultural aspects of man’s relationship with addictive drugs. *Dialogues in Clinical Neuroscience*, 9, pp. 355–361.
- Csete, J., Kamarulzaman, A., Kazatchkine, M., Altice, F., Balicki, M., Buxton, J., Cepeda, J., Comfort, M., Goosby, E., Goulão, J., Hart, C., Horton, R., Kerr, T., Lajous, A.M., Lewis, S., Martin, N., Mejía, D., Mathiesson, D., Obot, I., Ogunrombi, A. Sherman, S., Stone, J., Vallath, N., Vickerman, P., Zábanský, T., Beyrer, C. (2016). Public Health and International Drug Policy. *Lancet*, 387(10026), pp. 1427–1480.
- Daws, R.E., Timmermann, C., Giribaldi, B. Sexton, J.D., Wall, M.B., Erritzoe, D., Roseman, L., Nutt, D., Carhart-Harris, R. (2022). Increased global integration in the brain after psilocybin therapy for depression. *Nature Medicine*, 28, pp. 844–851.
- Derrida, J. (1995) *The Rhetoric of Drugs. An Interview*. In: *Points...: Interviews, 1974–1994*, E. Weber (Ed.), Stanford: Stanford University Press, pp. 228–254.

European Crime Prevention Network. (2018). *Crime prevention policy: drug trafficking*. Available Online. Retrieved June 1, 2022, from: https://eucpn.org/sites/default/files/document/files/DE_1.pdf.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2022). *European Drug Report. Trends and Developments*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2019a). *Germany, Country Drug Report 2019*, Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2019b). *Portugal, Country Drug Report 2019*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2019c). *The Netherlands, Country Drug Report 2019*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2018a). *Germany, Country Drug Report 2018*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2018b). *Portugal, Country Drug Report 2018*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2018c). *The Netherlands, Country Drug Report 2018*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2017a). *Germany, Country Drug Report 2017*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2017b). *Portugal, Country Drug Report 2017*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2017c). *The Netherlands, Country Drug Report 2017*. Luxembourg: Publications Office of the European Union.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (n.d.). *Statistical Bulletin*. Available Online. Retrieved July 19, 2022, from: <https://www.emcdda.europa.eu/data>.

- Giacomello, C. (2022). *Children whose parents use drugs. Promising practices and recommendations*. Available Online. Retrieved July 12, 2022, from: <https://rm.coe.int/2021-ppg-27-isbn-children-whose-parents-use-drugs-promising-practices-/1680a602ae>.
- Government of the Netherlands. (n.d.). *How does the law distinguish between soft and hard drugs?* Retrieved July 20, 2022, from: <https://www.government.nl/topics/drugs/how-does-the-law-distinguish-between-soft-and-hard-drugs>.
- Green, C.A. (2006). Gender and use of substance abuse treatment. *Alcohol Research and Health*, 29(1), pp. 55–62.
- Greenwald, G. (2009). *Drug Decriminalization in Portugal. Lessons for creating fait and successful drug policies*. Washington D.C.: Cato Institute.
- Grund, J.P., Brecksema, J. (2013). *Coffee Shops and Compromise. Separated Illicit Drug Markets in the Netherlands*. New York: Open Society Foundations.
- Grund, J.P., Brecksema, J. (2017). *Drug Policy in The Netherlands*. In: *European drug policies: the ways of reform*. R. Colson, H. Bergeron (Eds.), London: Routledge, pp.128–148.
- Hall, W., Lucke, J. (2013). *Drug Decriminalization and Legalization*. In P.M. Miller (Ed.), *Interventions for Addiction: Comprehensive Addictive Behaviors and Disorders* (1st ed., Vol. 3, pp. 645–696). San Diego, CA: Academic Press.
- Heimer, R., McNeil, R., Vlahov, D. (2020) A Community Responds to the COVID-19 Pandemic: a Case Study in Protecting the Health and Human Rights of People Who Use Drugs. *Journal of Urban Health*, 97, pp. 448–456.
- Human Rights Watch. (2016). *Every 25 Seconds. The Human Toll of Criminalizing Drug Use in the United States*. Available Online. Retrieved June 25, 2022, from: https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web_0.pdf.
- Husak, D.H. (2003) The Criminalization of Drug Use. *Sociological Forum*, 18(3), pp. 503–515.
- Johnson, T.P., Fendrich, M. (2007) Homelessness and Drug Use: Evidence from a Community Sample, *American Journal of Preventive Medicine*, 32(6), p. S211–S218.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2019). *Health, Rights and Drugs. Harm reduction decriminalization and zero discrimination for people who use drugs*. Available Online.

Retrieved June 22, 2022, from:
https://www.unaids.org/sites/default/files/media_asset/JC2954_UNAIDS_drugs_report_2019_en.pdf.

- Jürgens, R., Betteridge, G. (2005). Prisoners who inject drugs: public health and human rights imperatives. *Health and human rights*, 8(2), pp. 46–74.
- Keeney, R.L. (1992). *Value-Focused Thinking: A Path to Creative Decision-Making*. Cambridge: Harvard University Press.
- Leuw, E. (1991). Drugs and Drug Policy in the Netherlands. *Crime and Justice*, 14, pp. 229–276.
- Levine, H.G., The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America, *Journal of Studies on Alcohol*, 39, pp. 143–174.
- Lohman, D., Malinowska-Sempruch, K. (2022). From drug prohibition to regulation: a public health imperative. Published Online June 21, 2022. Retrieved July 1, 2022, from: <http://fileserv.idpc.net/library/TheLancet-prohibition-regulation.pdf>.
- Martinelli, T.F., Meerkerk, G.J., Nagelhout, G.E., Brouwers, E., van Weeghel, J., Rabbers, G., van de Mheen, D. (2020). Language and stigmatization of individuals with mental health problems or substance addiction in the Netherlands: An experimental vignette study. *Health & social care in the community*, 28(5), 1504–1513. <https://doi.org/10.1111/hsc.12973>.
- McAllistair, W.B. (2000). *Drug Diplomacy in the Twentieth Century. An international history*. London and New York: Routledge.
- Mills, K. (2022) Drug Use and Dignity. Contributions From The Human Rights Community. Human Rights Pulse. Retrieved June 5, 2022, from: <https://www.humanrightspulse.com/mastercontentblog/drug-use-and-dignity-contributions-from-the-human-rights-community>.
- Mithoefer M.C., Wagner M.T., Mithoefer A.T., Jerome L., Doblin R. (2011). The safety and efficacy of +/-3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: the first randomized controlled pilot study. *Journal of Psychopharmacology*, 25(4), pp. 439–452.

- Morse, S. J. (2012). Legal Regulation of Addictive Substances and Addiction in A. Carter, W. Hall & J. Illes (Eds.), *Addiction Neuroethics: The Ethics of Addiction Neuroscience Research and Treatment*, pp. 261–276. San Diego, CA: Academic Press.
- Mutatayi, C., Morton, S., Robles Soto, N., Pálsóttir, K.I., Vale Pires, C. (2022). Implementing a Gender Approach in Drug Policies: Prevention, Treatment and Criminal Justice. Available Online. Retrieved July 12, 2022, from: <https://rm.coe.int/2022-ppg-implementing-a-gender-approach-in-drug-policies-a-pg-handbook/1680a66835>.
- Neumeier, E., Schneider, F., Karachaliouu, K., Höke, C., Friedrich, M. (2021). *Drug Policy: Germany. 2021 Report of the National. REITOX focal Point to the EMCDDA (Data year 2020/2021)*.
- Nutt, D.J., King, L., Philips, L.D. (2010). Drug harms in the UK: a multicriteria decision analysis. *Lancet*, 376, pp. 1558–1565.
- Office of the High Commissioner for Human Rights (OHCHR). (2016 April 18). Tackling the world drug problem: UN experts urge States to adopt human rights approach [Press release]. Retrieved June 22, 2022, from: <https://www.ohchr.org/en/press-releases/2016/04/tackling-world-drug-problem-un-experts-urge-states-adopt-human-rights?LangID=E&NewsID=19833>.
- Office of the High Commissioner for Human Rights (OHCHR). (2016 April 15). *Joint Open Letter by the UN Working Group on Arbitrary Detention; the Special Rapporteurs on extrajudicial, summary or arbitrary executions; torture and other cruel, inhuman or degrading treatment or punishment; the right of everyone to the highest attainable standard of mental and physical health; and the Committee on the Rights of the Child, on the occasion of the United Nation General Assembly Special Session on Drugs New York, 19-21 April 2016*. Retrieved June 22, 2022, from: <https://www.ohchr.org/en/statements/2016/04/joint-open-letter-un-working-group-arbitrary-detention-special-rapporteurs?LangID=E&NewsID=19828>.
- Official Journal of the European Union. (2021, July 8). *EU Drugs Action Plan 2021–2025*. 2021/C 272/02.
- Pan, L. (1975). *Alcohol in Colonial Africa*. Forssa: Scandinavian Institute of African Studies.
- Pompidou Group. (2011). *Policy paper providing guidance to policy makers for developing coherent policies for licit and illicit drugs*. Available Online. Retrieved June 11, 2022, from:

<https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016806f40ab>.

Pompidou Group. (2013). *Harm Reduction. Policy paper on preventing risks and reducing harm linked to the use of psychoactive substances*. Available Online. Retrieved June 11, 2022, from: <https://rm.coe.int/2013-pg-20-harm-reduction-eng/16807865f4>.

Pompidou Group. (2017). *Pompidou Group statement on bringing human rights into drug policy development, implementation, monitoring and evaluation*. Available Online. Retrieved June 11, 2022, from: <https://rm.coe.int/pompidou-group-statement-on-bringing-human-rights-into-drug-policy-dev/1680770b40>.

Porter, R., Teich, M. (eds.). (1995). *Drugs and Narcotics in History*. New York: Cambridge University Press.

Rêgo, X., Oliveira, M.J., Lameira, C., Cruz, O.S. (2021). 20 years of Portuguese drug policy – developments, challenges and the quest for human rights. *Substance Abuse Treatment, Prevention, and Policy*, 16(59).

Sander, G., Scandurra, A., Kamenska, A., MacNamara, C., Kalpaki, C., Bessa, C.F., Laso, G.N., Parisi, G., Varley, L., Wolny, M., Moudatsou, M., Pontes, N.H., Mannix-McNamara, P., Libianchi, S., Antypas, T. (2016). Overview of harm reduction in prisons in seven European countries. *Harm Reduction Journal*, 13(1), pp. 28–40.

Sattler, S., Escande, A., Racine, E., Göritz, A.S. (2017). Public Stigma Toward People With Drug Addiction: A Factorial Survey. *Journal of studies on alcohol and drugs*, 78(3), p. 415–425.

Schatz, E., Schiffer, K., Kools, J.P. (2011). *The Dutch treatment and social support system for drug users. Recent developments and the example of Amsterdam*. IDPC Briefing Paper. Published Online.

Schuster, K. (2018). 5 facts about cannabis laws in Germany. *DW*. Retrieved June 19, 2022, from: <https://www.dw.com/en/5-facts-about-cannabis-laws-in-germany/a-42709969>.

Seddon, T. (2016). Inventing Drugs: A Genealogy of a Regulatory Concept. *Journal of Law and Society*, 43(3), pp. 393–415.

- Sinha R. (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of New York Academy of Sciences*, 1141, pp. 105–130.
- Slade, H. (2021). *Drug decriminalization in Portugal: setting the record straight*. Bristol: Transform Drug Policy Foundation. Retrieved May 30, 2022, from: <https://transformdrugs.org/blog/drug-decriminalisation-in-portugal-setting-the-record-straight>.
- Smith, P. (2002). Drugs, Morality and the Law. *Journal of Applied Philosophy*, 19(3), pp. 233–244.
- Solivetti, L.M. (2001). Drug Use Criminalization v. Decriminalization: An Analysis in the Light of the Italian Experience. Rome. Published Online. Retrieved June 24, 2022, from: https://www.tni.org/files/publication-downloads/drug_use_criminalization_v_decriminalization.pdf.
- Stoicescu, C., Peters, K., Lataire, Q. (2022). A Slow Paradigm Shift: Prioritizing Transparency, Community Empowerment, and Sustained Advocacy to End Compulsory Drug Treatment. *Health and Human Rights Journal*, 24(1), pp. 129–134.
- Stöver, H., Telzrow, R. (2009). Drug-Treatment Systems in Prisons in Eastern and South-East Europe. Available Online. Retrieved July 12, 2022, from: <https://rm.coe.int/drug-treatment-systems-in-prisons-in-eastern-and-south-east-europe/168075b999>.
- Talking Drugs. (2022). Drug Decriminalisation Across the World. Retrieved July 31, 2022, from: <https://www.talkingdrugs.org/drug-decriminalisation>.
- Trimbos Instituut. (2019). *The Drugs Information and Monitoring System (DIMS). Factsheet on drug checking in the Netherlands*. Available Online. Retrieved 30 July, 2022, from: <http://fileserv.idpc.net/library/cd3e9e11-9555-4f8c-b851-1806dfb47fd7.pdf>.
- Tuchman, E. (2010) Women and addiction. The importance of gender issues in substance abuse research. *Journal of Addictive Diseases*, 29(2), pp. 127–138.
- UNAIDS. (2019). *Health, Rights and Drugs. Harm Reduction, decriminalization and zero discrimination for people who use drugs*. Available Online. Retrieved July 20, 2022, from: https://www.unaids.org/sites/default/files/media_asset/JC2954_UNAIDS_drugs_report_2019_en.pdf.

- United Nations Committee on Economic, Social and Cultural Rights. (2000). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. Retrieved June 13, 2022, from: <https://www.refworld.org/docid/4538838d0.html>.
- United Nations Development Programme (UNDP). (2019). *International Guidelines on Human Rights and Drug Policy*. Retrieved May 30, 2022, from: <https://www.undp.org/sites/g/files/zskgke326/files/publications/UNDP-WHO-UNAIDS-UNHCHR-HRDP-Guidelines-EN.pdf>.
- United Nations General Assembly (UNGA). (2010, 6 August). *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Note by the Secretary-General*. A/65/255. Available Online. Retrieved June 22, 2022, from: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N10/477/91/PDF/N1047791.pdf?OpenElement>.
- United Nations Office of Drugs and Crime (UNODC). (2009). *Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem*. Available Online. Retrieved June 22, 2022, from: https://www.unodc.org/documents/drug-prevention-and-treatment/High-level_segment_Commission_on_Narcotic_Drugs_11-12_March_2209.pdf.
- United Nations Office of Drugs and Crime (UNODC). (2010). *From coercion to cohesion. Treating drug dependence through health care, not punishment. Discussion paper*. Available Online. Retrieved June 22, 2022, from: https://www.unodc.org/docs/treatment/Coercion_Ebook.pdf.
- United Nations Office of Drugs and Crime (UNODC). (2016). *Terminology and Information on Drugs*. Third Edition. Retrieved April 15, 2022, from: https://www.unodc.org/documents/scientific/Terminology_and_Information_on_Drugs-E_3rd_edition.pdf.
- United Nations Office of Drugs and Crime (UNODC). (n.d.-a). *Treaties*. Retrieved April 15, 2022, from: <https://www.unodc.org/unodc/en/treaties/index.html>.
- United Nations Office of Drugs and Crime (UNODC). (n.d.-b). *United Nations Commission on Narcotic Drugs*. Retrieved April 15, 2022, from: https://www.unodc.org/documents/commissions/CND/Index/19-10644_CND.pdf

- United Nations Office on Drugs and Crime (UNODC), World Health Organisation (WHO). (2018). International standards on Drug Use Prevention. Second updated edition. Available Online. Retrieved June 22, 2022, from: https://www.unodc.org/documents/prevention/UNODC-WHO_2018_prevention_standards_E.pdf.
- United Nations Office on Drugs and Crime (UNODC), World Health Organisation (WHO). (2020). International standards for the treatment of drug use disorders. Available Online. Retrieved June 22, 2022, from: <https://apps.who.int/iris/rest/bitstreams/1273579/retrieve>.
- United Nations Office on Drugs and Crime (UNODC), World Health Organisation (WHO). (2021). Treatment and care for people with drug use disorders in contact with the criminal justice system. Alternatives to Conviction or Punishment. Available Online. Retrieved June 22, 2022, from: https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC_WHO_Alternatives.pdf.
- United Nations Sustainable Development Group. *Universal Values. Principle One: Human Rights-Based Approach*. Retrieved April 20, 2022, from: <https://unsdg.un.org/2030-agenda/universal-values/human-rights-based-approach>.
- Valadez, M.A.N. (2014) Drug use and the right to health: an analysis of international law and the Mexican case. *Mexican Law Review*, VI(2), pp. 201–224.
- Van der Gouwe, D., Strada, L., Diender, B., van Gelder, N., de Gee, A. (2022). *Harm reduction services in the Netherlands: recent developments and future challenges*. Available Online. Retrieved July, 2, 2022, from: <https://www.correlation-net.org/wp-content/uploads/2022/03/AF1973-Harm-reduction-services-in-the-Netherlands.pdf>.
- Volkow, N.D. (2021, April 27). Addiction Should Be Treated, Not Penalized. *Health Affairs Blog*. Retrieved July 24, 2022, from: <https://www.healthaffairs.org/doi/10.1377/forefront.20210421.168499/full/>.
- Watson, A.S. (1958). A Critique of the Legal Approach to Crime and Correction. *Law and Contemporary Problems*, 23(4), pp. 611–632.
- Whitaker, H. (2019). *Quit Like a Woman: The Radical Choice not to Drink in a Culture Obsessed with Alcohol*. New York: The Dial Press.

Wogen, J., Restrepo, M.T. (2020). Human Rights, Stigma, and Substance Use. *Health and Human Rights*, 22(1), pp. 51–60.

World Health Organization (WHO). (n.d.). *Drugs (psychoactive)*. Retrieved April 15, 2022, from: https://www.who.int/health-topics/drugs-psychoactive#tab=tab_3.

International treaties and national legal acts

1. United Nations Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol.
2. United Nations Convention on Psychotropic Substances of 1971.
3. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.
4. United Nations Convention on the Rights of the Child.
5. Decree-law n. 420/70, September 3, 1970. In *Diário do Governo* n° 204 – I Série. Ministry of Justice.
6. Decree-law n. 792/76, November 5, 1976. In *Diário da República* n°259 – I Série. Ministry of Justice.
7. Decree-law n. 430/83, December 13, 1984. In *Diário da República* n° 285 – I Série. Ministry of Justice and Health.
8. Decree-law n. 15/93, January 22, 1993. In *Diário da República* n° 18 – I Série. Ministry of Justice.
9. Law n. 30/2000, November 9, 2001. In *Diário da República* n° 276 – I Série.
10. Decree-law n. 130 -A/2001 (January 23, 2001).
11. The Portuguese National Drug Strategy (1999).
12. Opium Act, as after enforcement of the Act of 13 July, 2002, to amend the Opium Act (Staatsblad) [Bulletin of Acts and Decrees] 2002, 520), and the Decree to actualise the Lists I and II of the Opium Act (Staatsblad 2002, 623), which Decree will be enacted simultaneously with the aforementioned Act. Retrieved from: https://web.archive.org/web/20080302223049/http://www.cannabisbureau.nl/pdf/Opiumwet_EN_29nov2004.pdf.
13. Betäubungsmittelgesetz (BtMG). Act on the Trade in Narcotic Drugs. Narcotic Drugs Act. Non-official translation available online. Retrieved June 25, 2022, from: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/Gesetze_und_Verordnungen/GuV/N/Narcotic_Drugs_18_12_2009.pdf.
14. Jugendschutzgesetz (JuSchG). German Youth Protection Act.

Appendix – Interview Questions

- 1) Please describe the role of the organisation.
- 2) When the current drug policy was implemented, what, on the basis of your experience, were its main objectives? What were the most pressing problems (that you observed) to be solved through the implementation of the policy?
- 3) On the basis of your observation, how did the process of implementation of the drug policy proceed? Was it swift, smooth or were there some significant difficulties? What problems were encountered at the beginning and how were they tackled throughout the years?
- 4) Were there any discrepancies between organisation's wishes and the drug policy actually implemented?
- 5) What shortcomings of the current drug policy could you name?
- 6) Does the policy favour any particular group of recipients? (youth/users of a particular drug/representants of any minority or majority/?)
- 7) Has the social stigma directed at drug users lowered in your country over the years of the policy being implemented?
- 8) How is education on drugs and harm reduction conducted among young people (and adults)? Who is responsible for it and what form does it take?
- 9) Did you observe an increasing state influence over civil society organisations, given that the state and NGOs cooperate in the area of drug policy?
- 10) Do you have any further comments or suggestions on what could be improved regarding the current drug policy in the country?