



Informal Drug Policy Dialogue

Lisbon 21-22 January 2011

Report



The eighth meeting of the Informal Drug Policy Dialogue series took place in Lisbon on 21st and 22nd January 2011. The aim of the dialogues is to provide a platform for professionals to discuss drug policy issues. The initiative started in Crete in 2004. Subsequent meetings were held in Budapest (2005), Bern (2006), Rome (2007), Berlin (2008), Crete (2009) and Amsterdam (2010). A similar series of events also started in Latin America in 2007 and Southeast Asia in 2008. For the past seven years, the Informal Drug Policy Dialogue series have been a joint initiative of the Transnational Institute and the Andreas Papandreou Foundation (APF). Since 2010, APF has no longer been involved in these dialogues, and the drug policy activities of the organisation have been taken over by the newly established Association Diogenis, Drug Policy Dialogue in South East Europe. Thanks are due to the Portuguese Institute on Drugs and Drug Addiction (IDT) for co-hosting this Dialogue, and to Thanasis Apostolou, Martin Jelsma and Ernestien Jensema for preparing and organising the meeting.

As per the tradition of the drug policy dialogue series, the meeting was held under Chatham House rule to ensure confidentiality and allow participants a free exchange of ideas. Over 50 participants attended the meeting, including policy makers, practitioners, academics, and representatives from non-governmental and governmental organisations. Three themes were discussed: the Portuguese decriminalisation model, cannabis policy reform, and the agenda and global initiatives at the 54th Session of the Commission on Narcotic Drugs. Each theme was prefaced by introductory remarks from key experts, in order to stimulate the discussions. This report highlights the main issues covered during each of the sessions. The ideas expressed in the report are those of the participants in their capacity as experts in the drug policy field, and should not be interpreted as reflecting consensus among the group, or endorsement by the organisers.

Session I – Friday 21st January 2011 (a.m.)

The Portuguese decriminalisation model

The Portuguese Law 30/2000, which came into effect in July 2001, decriminalised possession of illicit drugs for personal use. Those apprehended by the police in possession of illicit drugs for personal use are now sent before dissuasion commissions, rather than criminal courts. Drug users are provided with the opportunity to access drug dependence treatment and other services. What are the outcomes of the Portuguese decriminalisation after a decade of implementation and what is its relevance for national and international drug policy debates?

Decriminalisation in Portugal

Complex historical reasons have led to the Portuguese decriminalisation model. Until the Carnation Revolution, the authoritarian regime of Salazar isolated Portugal from the rest of the world. The return of democracy in 1974, followed by the decolonisation process, brought about opportunities to open Portugal to the rest of the world. Thousands of soldiers and colonists started to come back from the Portuguese colonies, and brought with them large quantities of illicit drugs. Drug use, especially cannabis, became associated with ideas of freedom and spread quickly among the population, while the government struggled to respond to this new development. In the mid-1990s, drug dependence was a major issue in Portugal, with 100,000 people (over 1% of the total population) being addicted to heroin. In 1997 and 1998, the Minister of Youth decided to take action. A multidisciplinary working group was set up to analyse the drug situation and produce a package of recommendations in terms of supply and demand reduction. The proposed recommendations – which included the decriminalisation of possession for personal use, accompanied with programmes on prevention, treatment, harm reduction and social integration – were accepted in their entirety. The project benefited from strong political consensus and support from the population, who had come to consider drug users as victims, rather than criminals.

The Law 30/2000, which decriminalised drug use as well as possession and purchase of illicit drugs for personal use, came into force on 1st July 2001. With this Law consumption, acquisition and possession of controlled substances for personal use not exceeding the amount needed for an average individual use during a period of 10 days became an administrative offence. If there is no indication of trafficking or dealing, the person is sent to a Drug Addiction Dissuasion Commission, which is not within the criminal system, but falls instead under the province of the Ministry of Health. These Commissions, composed of health, legal and social work professionals, evaluate each case with the help of a technical team to assess whether the person is an occasional or a dependent user, or a dealer. The first time, a recreational user is sent to the Commission the procedure is automatically suspended. In case of problematic drug use a sanction can be applied in the first procedure.

In that regard, the Commission acts as a preventative measure for occasional drug users, offering them advice on safe drug practices and on avoiding becoming dependent. On subsequent instances, the Commission can distribute administrative sanctions, or send users to drug dependent treatment, or other health and social services. Administrative sanctions can be suspended or dropped, for example if the user follows a drug dependence treatment. For more information about the dissuasion commissions, please refer to Box 1 below. When the quantity of controlled substances in possession is larger than 10 daily doses or if a person is charged with selling drugs (also in case it is less than max. quantity for personal possession), he/she will be sent to the criminal court.

So far, the Portuguese system has yielded positive results. The lifetime prevalence of drug use among the population aged 16-64 has slightly increased in almost every age group, but since 2003, lifetime prevalence of drug use has decreased among youth aged 15 to 19, as well as among school children has also decreased between 1995 and 2007. While the spread of the HIV epidemic among injecting drug users (IDUs) had largely increased up to 1997, the numbers of infections caused by drug injection have subsequently consistently gone down. The number of individuals accused and convicted for crimes against the drug law has also significantly reduced between 2003 and 2009, hence removing a heavy burden on the criminal justice and prison systems. Since the fear of arrest and incarceration has disappeared and the levels of stigma attached to drug use have decreased, more drug users agree to access the health care services they need. Currently, over 38,000 people follow a drug dependence treatment programme. With regards to law enforcement activities, as police and customs forces have more time and resources at their disposal, they are able to target high level traffickers more efficiently, and increase the number of annual drug seizures.

While illicit drugs used were a top political issue a decade ago, it is no longer a high priority issue during electoral campaigns and among the general public. There is clear political support for the system, and political transitions over the past ten years have not affected the effective implementation of the policy. The recent economic crisis has also left the system unaltered, with only a 4% cut on the overall budget of the programme, whereas the overall budget for the Ministry of Health was cut by 12%.

Potential improvements for the Portuguese model were discussed. Some participants considered that few improvements were necessary, except for the allocation of more funding to the programme. Heroin prescription and drug consumption rooms do not seem to be necessary for the time being, since injecting drug use has decreased significantly over the past few years and only a small group among dependent users would need heroin prescription. Other participants raised questions about whether the model could go beyond decriminalisation, towards legalisation. For the time being, this does not seem to be an option for Portugal.

In terms of impact, it took almost a decade for the Portuguese model to attract international attention. It is the 2008 report from the Cato Institute¹ that put the Portuguese model at the forefront of the drug policy reform debates. In Australia, for example, the report captured the interest of policy makers, after years of inability from the central right government to discuss drug policy issues. However, some scepticism was expressed as to the message of the report – some participants felt that the report put too much importance on decriminalisation and tended to ignore the fact that decriminalisation in Portugal is part of a more complex policy aimed to provide health and social services to those in need. Since 2008, a number of other reports and articles were published on the results achieved so far in Portugal:

- United Nations Office on Drugs and Crime (2009), *2009 World Drug Report*, http://www.unodc.org/documents/wdr/WDR_2009/WDR2009_eng_web.pdf
- European Monitoring Centre for Drugs and Drug Addiction (2009), *2009 Annual report on the state of the drugs problem in Europe*, <http://www.emcdda.europa.eu/publications/annual-report/2009>

¹ Greenwald, G. (2008), *Drug decriminalization in Portugal - Lessons for creating fair and successful drug policies* (Washington D.C.: Cato Institute), http://www.cato.org/pubs/wtpapers/greenwald_whitepaper.pdf

- Hughes, C.E. & Stevens, A. (2010), 'What can we learn from the Portuguese decriminalisation of illicit drugs?', *British Journal of Criminology*, 50(6): 999-1022, <http://bjc.oxfordjournals.org/content/50/6/999.full.pdf+html>
- Drug policy profiles — Portugal, EMCDDA, Lisbon, June 2011

http://www.emcdda.europa.eu/attachements.cfm/att_137215_EN_PolicyProfile_Portugal_WEB_Final.pdf

It was noted that the Portuguese reform came at a time when the current drug control regime was under scrutiny concerning its results, negative consequences and cost-effectiveness. The world was looking for a model that worked and could be adapted to other contexts. The year 2010 has marked an important moment for global drug law reform, with increasing support for the need to change. In particular, the United Nations Secretary General declared: 'I call on all countries to live up to their commitments to enact or enforce legislation outlawing discrimination against people living with HIV and members of vulnerable groups. [...] Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us.'² This statement and the creation of two entities, the Global Commission on Drug Policy³ and the Global Commission on HIV and the Law⁴, demonstrate that discussions on drug law reform have become more acceptable in recent years, and Portugal has greatly contributed to the growing momentum.

According to the UN Secretary General, there is strong consensus across UN agencies about the value of decriminalisation of drug users. When one looks at UN drug control agencies, however, the issue is less straightforward. The International Narcotics Control Board (INCB), for example, was very critical of the Portuguese reform in 2001. When sufficient proof of effectiveness was provided over the years, the INCB became less resistant towards Portugal. Nevertheless, the Board has subsequently shown open disapproval on other decriminalisation initiatives in Mexico, Argentina and the Czech Republic. The United Nations Office on Drugs and Crime (UNODC) is also ambivalent on the issue, but now officially considers that drug users should be treated as patients, not criminals.

There was a general feeling among participants that, to bring discussions forward among UN drug control agencies and national governments, more rigorous analysis and evidence should be provided on the benefits of decriminalisation from regional organisations, NGOs, think-tanks and the academia. For example, the European Commission is currently analysing the consequences of certain policy models on drug issues, including the Portuguese model, and will be releasing a report on the topic in two years. Another positive development would be the publication by the UNODC of technical papers gathering evidence and principles on decriminalisation.

Two main conclusions were drawn from the Portuguese model. First of all, it was made clear that we cannot claim a direct causal effect between decriminalisation and the Portuguese positive developments. However, it is safe to conclude that the decriminalisation system did not have any negative effect on the drugs phenomenon. Second, decriminalisation of possession for personal use alone is not sufficient for tackling drug related problems. Indeed, other countries such as Italy and the Russian Federation did decriminalise possession of small amounts of drugs without recording the positive effects of the Portuguese model. What is needed – and this is where the Portuguese model

² Report of the Secretary-General (7 May 2009), *Progress made in the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS*, United Nations A/63/812, http://data.unaids.org/pub/Report/2009/20090616_sg_report_ga_progress_en.pdf

³ See: <http://www.globalcommissionondrugs.org/>

⁴ See: <http://www.hivlawcommission.org/>

becomes relevant – is a comprehensive package of services and operating mechanisms that tackle the social and health problems associated with drugs. For now, Portugal is the only country that has adopted such a complex system. In June 2011, a conference will be organised by the IDT to celebrate the 10 years of the decriminalisation law, and to officially release data and evidence on the impacts of the law on the drug situation in the country⁵.

Box 1. The Portuguese dissuasion commissions

A limited number of participants had the opportunity to visit the Lisbon dissuasion commission, with the useful guidance of two of the three commission's panellists, Nácia Simões and Nuno Portugal.

There are 18 dissuasion commissions in Portugal, one in each of the country's district, working under the province of the Ministry of Health. Each commission is responsible for the individuals who live in their area. When a person is identified and notified to be presented at the Dissuasion Commission for drug possession, the police are responsible for weighing the drugs seized. If the amount is superior to 10 daily doses, or when there is clear evidence of drug trafficking, the person is automatically sent to court. Otherwise, he/she is referred to a dissuasion commission within a maximum of 72 hours after arrest.

Each commission board is composed of three panellists (a sociologist, a jurist and a clinical psychologist), and a technical support team (composed of social workers and psychologists) responsible for conducting preliminary interviews. These interviews aim to assess the situation of each individual presented before the commission, including the type and frequency of drug use, whether the person is aware of drug related problems, their social and economic background, etc. The interview is followed by a hearing, when the panellists decide which measures or sanctions to undertake according to the situation at hand.

When the person is considered to be a recreational user and it is the first time that they are referred to the commission, the procedure is automatically suspended, and usually closed after three months⁶ if there is no second offence. An internal record is kept for 5 years. This measure is a warning for occasional drug users, and a way to ensure that the person is aware of the risks associated with drug use. If the person has social or health problems, the board can refer them to appropriate services (such as job or health centres). If a recreational user is arrested again, the board can impose administrative sanctions, usually consisting of fines ranging from EUR 25 to EUR 480 (the minimum wage in Portugal), community service, regular visits to a facility, etc.

If the commission considers that the person is dependent on drugs, it can refer them to a drug treatment programme and other healthcare services, but treatment is always voluntary. When the person is referred to treatment, the procedure is suspended for 9 months before it is closed. However, the patient needs to prove that he/she attends the treatment. Referral mechanisms are usually highly efficient, and enable the patient to start the treatment immediately. For individuals younger than 16, the commission cannot open legal proceedings, but can articulate technical interventions to support the user and his/her family. Regarding pregnant drug users, the commission can refer them to appropriate healthcare services, treatment systems and therapeutic communities that provide specific services for pregnant users.

⁵ Due to entry into force of the new Government, a press conference has been organised on the 1th July 2011. See for instance: <http://news.yahoo.com/portugal-drug-law-show-results-ten-years-experts-180013798.html>

⁶ The suspension period can range between 3 months and 2 years

The Lisbon commission deals with an average of 2,000 cases a year, including 1,300 to 1,800 new individuals each year. Only 7% to 10% of individuals are referred a second time to the commission. The main type of drugs involved is cannabis (75% of all cases, 65% for hashish and around 10% for cannabis leaves), cocaine (15%) and heroin (10%). On average, 85% to 90% of recreational users are men between 15 and 25 years of age, mainly students, and 80% to 85% of dependent users are men between 35 and 40 years old. The individuals referred to the commission come from every social class, though the majority is unemployed and/or has a low educational background. It seemed clear from the discussions that the strength of the decriminalisation system is derived from the comprehensive approach adopted in Portugal, including free drug dependence treatment, prevention campaigns, harm reduction services, street teams, and a good referral mechanism through the commissions. Individuals also seem to accept the measures imposed by the commission better than court injunctions (as the sanction to be applied is usually negotiated with the user), and they take advantage of the system to access the services they need.

Lessons learned from the Portuguese decriminalisation model different national contexts

Several national policy makers from across Europe and other regions, including Latin America, have recently visited Portugal to learn more about the system and its results. However, implementing the Portuguese decriminalisation model in other regions of the world would create a number of challenges.

First of all, policy makers should keep in mind that countries have different legal and judicial systems (i.e. civil law or common law), political and administrative realities (i.e. role of the police, corruption, etc.). These differences must be taken into account while designing and implementing a new drug policy.

In Italy, for example, drug possession for personal use has been an administrative offence since 1993. The Italian system is very similar to the Portuguese one, where those caught with small amounts of drugs are sent to commissions rather than criminal courts. However, the average time between referral to a commission and the trial is six months on average. In Italy, there are therefore clear structural and operational barriers to the good implementation of the system.

Drug laws in Argentina still punish possession for personal use, but in 25th August 2009, the Supreme Court declared unconstitutional the arrest and punishment of people caught in possession of drugs for personal use. If Argentina does decriminalise drug use in its national laws, the process will have to be accompanied by a comprehensive package of health and social interventions, which might be more difficult to implement in Argentina than in Portugal because of lack of resources and political will. Another issue in Argentina is the high level of corruption among law enforcement agencies.

Another set of problems relates to the use of quantity thresholds to determine whether to impose a criminal offence or an administrative one. For instance, a person arrested with more than the limit imposed by the threshold, but who intended to distribute them to their social group, rather than selling it, will be considered as a trafficker and be subject to criminal offences. It seems that more criteria should be taken into account than a mere quantity limit, and the final decision should be at the discretion of the judge, using all the evidence available. In addition, the imposition of administrative sanctions can sometimes be more harmful than criminal sanctions. For instance in Argentina, a drug user can be subject to compulsory treatment for an unlimited period of time, as an administrative sanction. Other alternative measures can include confiscation of the offender's driver's licence, which would be much

more harmful for a taxi driver than a criminal sanction, because of the impact of the punishment on his livelihood. Finally, contrary to judicial decisions, these administrative sanctions cannot be appealed. One must be aware of these dangers when deciding to impose administrative sanctions.

Session I (continued) – Friday 21st January 2011 (a.m.)

Quantity thresholds

Various countries in Europe, and more recently in Latin America, have enacted legislative reforms aiming to decriminalise possession of illicit drugs for personal use. These reforms have raised policy dilemmas around the legal distinction between possession for personal consumption and possession with the intent to supply others. Quantity thresholds are regularly used to draw that line, define the severity of trafficking offences, and set up proportional sentences. What can be learned from the current legal practices and would the development of a common set of guiding principles be something to aspire?

For the past decade, there has been a trend, first in Europe, and more recently in Latin America, towards the decriminalisation or depenalisation of possession of illicit drugs for personal use, in an effort to make drug policies more humane and effective. This development has led to legal difficulties to differentiate between possession for personal use, small-scale dealing, and large-scale trafficking. Quantity thresholds have become a useful tool to make these distinctions and impose sentences considered proportionate to the severity of the offence.

Although quantity threshold mechanisms provide objectivity and a harmonised judicial response, setting up such thresholds poses a number of dilemmas: what substances should be involved (all illicit drugs, or only those most used in a given country)? What limits should we impose for each targeted substance? Should we take into account the purity of the substance or the quantity seized on the offender? Should quantity thresholds be the only determinant for the differentiation between user, dealer and trafficker, or should other factors come into play? Should quantity thresholds be reviewed regularly to reflect new developments within a changing drug market? Would an international model or a set of guidelines be useful to help countries define quantity thresholds? Are quantity thresholds necessary?

Divergences in approaches around the world

There is no established model for setting up quantity thresholds around the world. This is both pragmatic, since each country's needs and contexts are different, and inevitable, since each country is sovereign within its territory, as per the Westphalian principle. There are therefore significant differences between the different quantity threshold mechanisms around the world.

Quantity thresholds can be defined by governmental decree, the Parliament, judicial courts or the police. The purpose of quantity thresholds differs from country to country. Thresholds can be used to distinguish between personal use and supply, to define the appropriate sentence attached to the offence or the type of response imposed (administrative or criminal sanction), or as a pragmatic response to overcome corruption or discrimination towards drug users, to bolster statistics to improve public confidence, or as an attempt to save money. Quantity thresholds are binding in certain countries, but may also be presumptive or merely indicative in others.

The definition of thresholds also varies from country to country – they can refer to the street value of a substance, purity, just mass, dose, or the level of harm associated with the substance. In practice, the level of quantity thresholds varies significantly from one substance to another and from one country to another (or from one region to another within a country) for the same substance. In Australia for example, there are significant differences in threshold quantities between MDMA (limit fixed at 2.8 doses), cannabis (limit fixed at 500 doses), and methamphetamine (limit fixed at 50 doses).

Discussion

Quantity thresholds are a useful mechanism to provide objectivity and efficiency in the implementation of drug control. The Czech Republic, for example, recently decriminalised possession of a small amount of illicit drugs by setting up quantity thresholds. The reform enabled the police to refocus their resources towards more important cases involving high level traffickers. However, quantity thresholds also create a number of difficulties.

A set of technical issues are attached to quantity thresholds. For instance, when a person is arrested, should we take into account the purity of the substance or its mass (which includes adulterants)? This has serious implications in countries still using the death penalty. For example, a person arrested with 10g of heroin, including adulterants, will be condemned to the death penalty if the threshold is fixed at that level, whereas a person caught with 1g of pure drugs (which could produce 180g of drugs sounds like too much I think purity is around 30% on average when mixed with adulterants) will go to prison. When the threshold is defined by purity, practical difficulties may arise when law enforcement authorities have to check the purity level of the substance seized (lack of laboratories available and costs of the analysis for example). A strict quantity threshold mechanism can also encourage corruption in countries where there is a high number of prosecutions of drug users and small scale dealers, such as in Argentina.

Sometimes, quantity thresholds do not fit market realities. In Mexico, the *Narcomenudeo* law, which came into force in 2010, decriminalised the possession of small amounts of drugs. However, the law ignored crucial elements of the Mexican drug market. For example, although cocaine is usually sold in the streets in minimum quantities of 1g, the quantity threshold was fixed at 0.5g. As a result, cocaine users are more likely to be convicted for possession.

In such cases, badly defined threshold quantities can cause more harm than good. When setting up such mechanisms, an assessment of possible unintended consequences has to be conducted.

In a constantly changing illicit drug market, quantity thresholds would also have to be constantly reviewed and adapted to new developments. If the thresholds are established by the courts, the system will be flexible enough to adapt easily to new situations. However, difficulties may arise if reforms have to go through a lengthy process within the Parliament.

Finally, it is worrying that the scientific rationale behind setting up quantity thresholds is usually unknown. Today, sentencing drug offenders is often inefficient – in some cases, sentencing is too harsh, in others, too lenient. More studies and analysis needs to be conducted on current threshold mechanisms around the world to evaluate their strengths, weaknesses and lessons learned, including comparative studies on the numbers of drug offenders being sent to prison or diverted to treatment, etc. The participants did agree that there is a need for mechanisms to differentiate drug users, dealers and traffickers, and measures should be taken according to each case. It seems clear that quantity thresholds are not sufficient to draw a clear line between these categories. One alternative raised during the discussion would consist in moving towards the definition of criteria to determine which

category each offender falls into. However, this new mechanism would provide significant discretion to the judge and would therefore not be adaptable everywhere, especially in countries where the justice system weak or corrupt. Another alternative would be to move away from decriminalisation towards a regulated drug market.

To conclude, although no definitive response was brought forward on quantity thresholds, it seems clear that a universally applicable quantity threshold system is not viable. The issue of producers of crops destined to the illicit drug market is often forgotten when thresholds are concerned; the issue should be included in future debates on quantity thresholds.

Session II – Friday 21st January 2011 (p.m.)

The international debate on cannabis policy reform

This session considered the impact of several initiatives and proposals in countries and regions around the world concerning cannabis policy reform. Can we, on the basis of analysis and evaluation of the debates, find common ground for a more consistent and effective policy on cannabis? What are the major impediments to come to practical and realistic decisions on this issue? What can we learn from the recent referendum in California, and the practice and state of the debate in countries around the world? Is there a “spirit of reform in the air” or is this a repetition of moves like so many in the course of the history of cannabis policy? Are we anywhere near a breakthrough toward a legal regulation of the cannabis market?

The cannabis debate in the USA

Over the past few years, the cannabis policy reform debate has gained increasing momentum in the USA. Whereas medical cannabis seems to be well accepted in most of the USA, full legalisation is currently being passionately discussed.

Medical cannabis in the USA

In the mid-1990s, public opinion in the USA was strongly inclined towards cannabis legalisation for medical purposes, and medical cannabis is now widely supported, even among conservative groups. A series of initiatives have recently taken place in several US States, mostly thanks to referendum proposals brought forward by the population. Cannabis policies vary significantly from one State to another. Nowadays, cannabis can be ‘prescribed’ by a physician in 15 States, and cannabis possession is allowed in the District of Columbia, Washington D.C. The maximum cannabis quantity allowed for medical use varies from one district to another. Throughout the USA, 750,000 people currently use medically prescribed cannabis for various reasons, including severe pain relief, as a narcotic, to tackle anxiety, etc. The main issue attached to medical cannabis is that it may be promoted and prescribed too generously by doctors, which puts the system at risk of being undermined.

In the USA, cannabis is currently being cultivated as a normal business for the medical cannabis market. The first wave of cannabis policy reforms enabled the provision of medical cannabis, and the second generation of legislations dealt with the establishment of cannabis dispensaries. These dispensaries function similarly to the coffee shops in the Netherlands. In a few areas, the large number and uncontrolled opening hours of cannabis dispensaries cause nuisance. However, these situations remain exceptional in US territory.

Discussion – Opportunities for wider cannabis legalisation

The main point of discussion was whether this new development regarding medical cannabis could open the way to generalised cannabis legalisation in the USA. Although many other drugs have entered the US illicit market, including heroin and cocaine, cannabis use keeps increasing. Today, between 50,000 and 100,000 people are in prison for a cannabis offence. Arrests have predominantly targeted marginalised, poor and young ethnic minorities. The States of California and New York decriminalised cannabis in the 1970s. However, because these vulnerable populations are easy targets for law enforcement agencies, more people have started to be arrested after decriminalisation legislations had been passed. In other locations, cannabis possession was not decriminalised but drug laws were not implemented, making it easier for users to consume cannabis than in areas where decriminalisation policies were implemented. It became clear that decriminalisation has not been sufficient in solving the issue.

There is growing evidence on the benefits of legalisation, and cannabis legalisation has gained increasing support over the past few years. While only 23% of Americans favoured cannabis legalisation in the 1980s, support for legalisation rose to 36% in 2005, and to 46% in late 2010. In Western countries, over 60% of the youth support cannabis legalisation, whereas older people tend to be against it.

The momentum on cannabis legalisation culminated with the holding of a referendum on Proposition 19 in California, in November 2010. There was much scepticism as to whether the Proposition would be accepted at the time. However, when estimates showed that 55% of the population in California was in favour of the Proposition, Labour units and democratic parties started to show interest in the Proposition, and debates started to take place on the possibilities for cannabis legalisation. In November 2010, the Proposition was finally rejected, with 46% voting in favour and 50% against. However, the initiative constitutes an important step forward for cannabis legalisation debates, and further actions may happen again, not only in California but also in Colorado, Nevada, Oregon or Washington. Experts explained that support for the Proposal decreased when the referendum took place because of problems regarding the details of the provision, for example because some people preferred unenforced prohibition rather than legalisation, or because they wished to see the development of a more sophisticated model than a system based on the Dutch coffee shops. As in previous times, support for cannabis legalisation may fall in the future – support for legalisation fell to 16% at the end of the 1980s from 51% in 1979.

Worries were raised among the participants about the dangers of conflating medical and non-medical cannabis movements, which would end up discrediting both arguments. For example, dangers may arise with overly zealous doctors who tend to prescribe more cannabis than necessary, hence putting at risk support for medical cannabis. Another danger comes from federal courts that may hinder efforts to access medical cannabis – the most important decision taken since 1996 did not involve the idea of medical cannabis itself, but the right for doctors to prescribe it. Federal court decisions could seriously impair the possibility for physicians to prescribe medical cannabis.

It was noted that drug control systems (i.e. why some drugs have become illicit, and others have not) are very much entrenched in history. For example, opium criminalisation derives from discrimination issues against the Chinese, the same goes for crack cocaine and African-Americans, and for cannabis and Mexican communities in the USA. US laws are now embedded in this initial prejudice, with little regard for available scientific evidence. Reference was made to the proposal from the Bolivian government to remove the ban on coca chewing from the UN drug control system, and the firm

opposition from the USA on the matter. Some participants mentioned the fear that, if accepted, this concession might be considered as a first step towards cannabis legalisation, and indeed the wider undermining of the international drug control system.

With regards to the implications of cannabis policy reform for the legalisation of other drugs, it seems unlikely that governments consider that possibility. However, some States have started to consider depenalisation to cut government spending on drug offences. This is the case, for example, in Georgia, where the Public Governor declared that incarceration sentences would be reduced. Therefore, the current economic crisis and the huge US deficit may be an opportunity for further debates in the USA.

The US cannabis policy reform debate and other developments worldwide

Some participants found it remarkable that the movement for cannabis reform is coming from the USA, a country well known for its tough drug control policies. Similar trends have been recorded in a number of other countries. In Mexico, for example, around 33% of the population are in favour of cannabis legalisation. Spain is currently looking into the issue, and in Switzerland, a referendum was held two years ago, but the proposal was eventually rejected.

In other countries, the issue is more dormant. In Canada, where half the population would be in favour of cannabis policy reform, no action is being undertaken to achieve that objective. Medical cannabis was allowed for the first time in Canada through a court room process. This court decision was followed by another one stating that when patients could not grow cannabis themselves, the State should ensure that experts grow it and make it available for their medical use. This raised questions among the participants about the value of pharmaceutical quality cannabis for those in need. In the Netherlands for instance cannabis is grown legally for medicinal purposes by specially licensed cultivators.

In the USA, with cannabis dispensaries, where no quality controls are undertaken. This political issue is far from being resolved. However, cannabis legalisation in a country such as the USA could clearly be a powerful tool to initiate cannabis policy debates in other parts of the world.

Cannabis policy in India

There are at least 10 million regular cannabis users in India. Most users belong to the rural poor and take cannabis out of necessity, to work harder and longer, to relieve hunger, and for medical purposes since few of them have access to healthcare services.

India has conducted much research and analysis on the effects of cannabis and other drugs. Several commissions have established that there was no proof that cannabis caused no irreversible social and health damage. From 1955 to 1959, India even allowed licensed cannabis cultivation. However, after the adoption of the 1961 Unique Convention on Narcotic Drugs, India enacted the Narcotics Drugs and Psychotropic Substance Act in 1985, under which cannabis became a controlled substance. Despite the Act, cannabis cultivation and use have kept increasing over the years. In 1997, the All India Institute of Medical Sciences, the leading research hospital in India, held a workshop with the Ministry of Health demonstrating the harmless effects of cannabis. These findings eventually influenced the government to reduce the penalties imposed on drug users in 2001. However, cannabis possession is still punished by imprisonment. One of the main issues with current Indian laws is that they have been drafted by people with little knowledge of the targeted drugs and the available evidence base.

The drug policy debate in India would benefit from a historical analysis of the developments that took place in drug policy over the past 150 years. India has the oldest drug control regime for opiate industry. 150 years ago, opium destined for China was grown in India. In order to develop colonial agriculture, the British established a drug control system for legitimate opium use. After the decolonisation process in 1947, independent India inherited the system and now allows for medicinal opiates for traditional purposes. Attention is rarely given to this part of India's drug policy because it mostly involves the poor in rural and urban areas, who are not a priority in Indian politics. Today, there are over 3 million opiate users in India. There are some debates now as to whether another exception should be introduced so that opiate dependent users could be prescribed opiates to treat their addiction. Opponents to this proposal have raised issues over the potential of leakage of medicinal opium into the illicit drug market, since India is one of the second largest opium producers after Afghanistan.

Bhang, an extract from the male cannabis plant⁷, is also tolerated in India, and is most commonly found in the Northern and Eastern regions of the country. *Bhang* is commonly drunk with crushed rose petals, melon seeds or almonds, mixed with curd and milk. It is a relatively harmless drink, but it can have strong effects on a first time user. *Bhang* is not considered illicit under the Indian narcotics act, but shops wishing to sell it must get a licence from the government. When the UN drug control conventions were established, India specifically asked for *Bhang* to be excluded from the international drug control system, since it has been used for traditional and religious purposes for over 2000 years.

There is therefore some ambivalence in Indian drug policy. However, despite the exceptions of *Bhang* and medicinal opium, India seems very much prone to keeping a tough approach to illicit drugs, and initiatives such as Proposition 19 in California would be unthinkable in that country. The only reason why India has so far been relatively soft on cannabis is because of lack of law enforcement resources, rather than an implicit acceptance of production and use. Cannabis legalisation is therefore not likely to appear on the Indian political agenda in coming years.

Cannabis policy in the Netherlands

The idea of setting up coffee shops to sell cannabis for personal consumption was introduced in the 1970s, in an attempt to draw a line between 'soft' and 'hard' drugs. At first, coffee shops were only seen as a temporary solution, but the system is still firmly in place today. So far, the delineation between soft and hard drugs has worked well, and it is rare to find drugs other than cannabis in the Dutch coffee shops. Indeed, coffee shop owners quickly realised that it was in their own economic interest to stick to the rules and run their business smoothly, without police interference.

Several studies were conducted to evaluate the impact of the coffee shop strategy on the prevalence of drug use. The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) concluded that cannabis sale in coffee shops did not lead to higher drug use prevalence. It is also worth noting that there are less coffee shops today (around 600), than there were before the previous drug strategy was passed (1500). Little reliable data is currently available on cannabis exportation – available studies show that between 5% and 80% of cannabis is being exported abroad.

A new drug strategy is currently being elaborated by the Dutch government. At first, the process was very rational, involving a committee of wise men responsible for proposing recommendations to the government. However, politicians ignored the work of the committee and started to write an independent proposal. The recent change in government has further hindered the process. For now,

⁷ The 1961 Unique Convention on Narcotic Drugs only controls the 'flowering or fruiting tops' of the female cannabis plant.

political decisions seem unclear and unpredictable. The new government declared that coffee shops would become private clubs, where entry would be restricted to people over 18 years old upon presentation of a club pass. Other restrictions may be established, such as minimum distances between the 'clubs' and schools, which is now set at 250 meters but likely to increase to 350 meters. It is therefore possible that the current drug policy may change radically.

There is one main issue regarding the current Dutch policy – although cannabis sale is tolerated in coffee shops, cannabis production is still firmly prohibited. This “back door” controversy attracts organised crime involved in cannabis growing to supply the coffee shops. However, reducing the number of coffee shops further would also encourage organised crime since consumers would need to find alternative (and illicit) ways to buy cannabis. Although the new clubs system may fight nuisance at the front door of the coffeeshops, the main problems will not be resolved until the government targets the ‘back door’ – that is, the production of the cannabis sold to the coffee shops/clubs. Two main solutions were suggested by the participants – either the coffee shops should be entirely closed, or the Dutch government should regulate cannabis production for licit distribution in the coffee shops.

Discussion

At the European Union level, there has been a strong political switch to the right over the past 18 months, often because of the economic crisis, and the current state of affairs does not encourage governments to take decisions seen as hostile to the population. However, cannabis use is widespread in the EU, and cannabis has been decriminalised in many member states. With the economic crisis and the need to cut government spending (which could be achieved through reduced law enforcement activities towards cannabis users), and to increase government income (which could be achieved through cannabis legalisation and taxation), there might be room for serious debates on cannabis policy reform. In the Netherlands, coffee shops bring an income of EUR 400 million a year to the government. The recent developments in the USA may also foster the debate on cannabis policy reform across Europe.

The participants finally discussed at which level cannabis policy reform could most effectively be raised. At the international level, legalisation is not permitted within the UN drug control conventions. At the EU level, it might be unpractical to reach a common position among member states because of the length with which decisions are usually taken. It seems useful to act at the national or local level. Within Federations, local States or regions they can push for reforms, as was the case in California with Proposition 19. In the Netherlands, the implementation of the national policy is the responsibility of the local government, and as a result, so is the decision to open coffee shops in a given municipality. . What seems to be necessary in the long term is to advocate for approaches that are pragmatic and acceptable for governments.

Session III – Saturday 22nd January 2011 (a.m.)

Global initiatives and the agenda of the 54th Commission on Narcotic Drugs

<p>As per previous years, the CND will gather in Vienna for five days to discuss the drug situation and the implementation of the UN drug control conventions. This session provided information about the upcoming CND meeting and provided an opportunity for the participants to talk about global initiatives that will be taking place in the coming months. Are we moving in the right direction to achieve reforms that will improve the current drug control system?</p>
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The Commission on Narcotic Drugs (CND) is a functional commission of the Economic and Social Council (ECOSOC), and acts as the custodian of the UN drug control conventions. Because the system has grown significantly since its creation, the CND has taken up a new role, as the main policy making body of the UN drug control regime. The 54th Session of the CND will take place from 21st to 25th March 2011 in Vienna, Austria. This year's CND will be chaired by Veronika Kuchynová Smigolová, from the Czech Republic.

The agenda of the 54th Session of the CND

The participants shared their disappointment regarding last year's CND. Much time was wasted during the thematic debate with lengthy national statements which left little time for substantive discussions. Several changes will be taking place this year to remedy some of these weaknesses.

First of all, the timeline of the CND meeting will be more regulated, and priority will be given to discussions, rather than country statements. Member states will be able to make their statements after the opening formalities and Mr. Fedotov's presentation of UNODC's work on Monday morning and Tuesday morning. This will ensure that there is time for interactions among the delegates.

Secondly, the format of the thematic debate has been modified and will now consist of round tables. The round tables will have a maximum of 59 seats distributed according to regional quotas for member States, and between four and ten seats for observers (this includes both non-governmental and governmental organisations). Two representatives per delegation will be able to use the microphone. Three round tables will be held this year and two next year, the topics of which have been decided by each regional group. Each of the round tables will last 90 minutes and will consider the following issues:

- Round table (a) – Regional and international cooperation in combating the world drug problem and its connection with organised crime.
- Round table (b) – Revitalisation of the principle of joint and shared responsibility as the centrepiece of international cooperation to confront the challenges posed by the world drug problem, in a manner consistent with the relevant UN conventions and declarations.
- Round table (c) – Addressing key public health and safety issues such as addictive behaviours of youth and drugged driving.

The Committee of the Whole will start operating on Monday afternoon. This means that there will be less time for delegations to debate and draft the resolutions.

The main highlights from the agenda are as follows⁸:

Monday	
A.M.	Policy objectives of the UNODC drug programme and strengthening the drug programme and the role of the CND; country statements
P.M.	Round tables (two held in parallel in early afternoon, third one held in late afternoon); initiation of the discussions at the Committee of the Whole
Tuesday	
A.M.	Policy objectives of the UNODC drug programme and strengthening the drug programme and the role of the CND; country statements (continued)
P.M.	Implementation of the drug control conventions – presentation from the INCB and

⁸ The full agenda of the 54th Session of the CND is now available online at: <http://www.unodc.org/unodc/al/commissions/CND/session/54.html>

	discussions on availability of controlled substances for medical and scientific medicines
Wednesday	
All day	Implementation of the Political Declaration and Plan of Action on international cooperation towards an integrated and balanced strategy to counter the world drug problem
Thursday	
A.M.	Discussions on implementation of the Political Declaration and Plan of Action (continued)
P.M.	Discussions on drug trafficking
Friday	
A.M.	Adoption of the provisional agenda for the 55 th Session of the CND
P.M.	Adoption of the report of the 54 th Session of the CND

NGOs will be able to participate to the round tables. Whereas NGOs used to be able to make statements only after every country had spoken (time allowing), NGO representatives will now be able to speak at any time during the debates, so long as they are given authorisation by the chairperson. It was made very clear that this could be both positive (if the chairperson is open to NGO involvement in the debates) or negative (NGOs may never have a chance to make a statement). All will depend on the willingness of the facilitator. The Vienna NGO Committee on Drugs (VNGOC, www.vngoc.org) will coordinate NGO interventions during the thematic debate. Outside of the thematic debate, there is considerable ground for action at the CND – NGO representatives can influence the debates by meeting country delegates ‘in the corridors’ of the CND or during side events.

Resolutions

Several resolutions will be brought forward at this year’s CND: a resolution on the importance of conducting comparative studies on different types of illicit drugs (prepared by Finland); the availability of controlled substances for scientific and medical purposes (proposed by Australia); driving and the use of precursors and other drugs (proposed by the USA); and recovery-oriented strategies for demand reduction (proposed by Italy). Further resolutions will be brought forward at the CND, but the themes of these resolutions will be released closer to the CND meeting.

Discussions: The CND – reasons for optimism?

The participants highlighted the disconnect that exists between the activities undertaken by academics, practitioners and other professionals wishing to make a change in current drug policies, and the policies adopted in Vienna. Many highly relevant drug issues are not discussed at the CND, while the Westphalian principles mentioned earlier in this report very much reflect the work undertaken by the CND’s Committee of the Whole.

Recent developments within the UN are most welcome, such as the UN Secretary General visit in Cambodian methadone centres last year, the Annual Report from Anand Grover (UN Special Rapporteur on the enjoyment of the highest attainable standard of health) on the human rights abuses resulting from international drug control, and the positive statements of the UNODC Executive Director, Yuri Fedotov, on drug policy issues. However, the CND remains very hermetic to those new trends. It is necessary to get closer to the CND delegations, especially for countries that are rarely at the forefront of the debates taking place at the meetings, to ensure that relevant issues reach CND discussions.

The difficulties encountered at the CND primarily result from the new role that the CND has taken as the policy making body of the UN drug control system. Some participants raised doubts as to how a

body of 56 sovereign States, with different needs and interests, could bring forward good policy directions. In practice, this has often led to empty consensus or farfetched resolutions. This practice has become known as the ‘Vienna Consensus’.

The Vienna Consensus also leads to financial problems for the UN drug control system. UNODC has an annual budget of USD 250 million, 10% of which comes from the UN overall budget, and 90% from voluntary contributions. Only 5% of these voluntary contributions are allocated to general purposes (this represents about USD 10 million a year), the rest is used for specific projects and activities. The CND therefore only approves a total budget of 10 million a year. This practice means that there is a gap between the CND decisions on which activities should be implemented, and the actual budget of UNODC. In fact, countless numbers of CND resolutions are never implemented because of lack of funding.

Much discussion focused on ways to change the current UN drug control system. Some participants considered that the system was now at its limits and was no longer viable. Many countries have realised that the current regime, which puts together heroin, cocaine and cannabis at the same level, does not reflect available evidence. The debates must move away from ideological thinking and consider evidence for effectiveness. The importance of history was mentioned several times. It is necessary to consider how different attempts to control illicit drugs have worked so far, and build on experience to create a simplified international drug control system, in which countries are able to experiment at the local level and find solutions that best fit their needs.

Other participants suggested that any change in the conventions would not be taking place in the near future, and change has therefore to come from within the current system. With the help of other UN agencies, think-tanks, NGOs, academics and other groups – the UNODC Secretariat could, for example, produce more objective and reliable assessments of the drugs situation through its World Drug Report, technical papers, discussion papers, etc. This work stream would improve the quality of the debates taking place at the CND by bridging the gap between the drug control system and reality, and support advocacy activities and opportunities for reform at the national level. This approach involves breaking the Vienna Consensus by influencing the thinking of member States represented at the UN level. This could be possible through the promotion of human rights and shedding the light on the negative consequences of international drug control through the introduction of resolutions at the CND.

Some participants agreed that changes would come about slowly at the UN level. However, every time an opportunity arises, NGOs and other stakeholders should be ready to argue for better drug policies. This case is becoming stronger and stronger every year, with countries starting to adopt health-based policies. With time, it is possible that the drug control system will gradually be weighted down. Other participants showed scepticism about this idea. The potential for change was recently raised with the Bolivian proposal to remove the ban on coca leaf chewing from the UN drug conventions (see below for more information). Despite the merits of the proposal, a total of 17 governments objected to it. This recent development confirms the fear that it will be difficult to change the system, as many governments consider that any small change to the conventions would open the door for more changes, and therefore weaken the integrity of the system.

Discussions finally focused on examples within the UN system where dysfunctional agencies were reformed to become more efficient. Looking into this experience could provide a good basis for deciding how to proceed with the CND. One example brought forward was that of the Global Fund. Before the creation of the Global Fund, there was a clear divide between the obligations imposed on

developed and developing countries in terms of health promotion. The then UN Secretary General Kofi Annan, declared that the UN was incompetent to solve these issues, and it was decided that a body would be created outside of the system.

The Bolivian proposal to remove the international ban on coca leaf chewing

In 2009, the Bolivian government requested that the UN amend the 1961 UN Single Convention on Narcotic Drugs to remove the ban on coca leaf chewing. Discussions on the proposal were initiated when Evo Morales, the first indigenous Bolivian President, took office in 2006 as part of a political move to protect the rights of indigenous people. UN member States had until 31st January 2011 to contest Bolivia's requested amendment. Throughout January, countries extensively expressed their views on the matter. At the time of the Dialogue, the USA, the UK, Sweden and Algeria had introduced objections to the Bolivian proposal, and Belgian and France were about to submit similar objections.⁹ These objections did not concern the tradition of coca chewing itself but the idea that changing the Convention would touch upon the "integrity" of the Convention.

On the contrary, other states have officially proclaimed their support to the Bolivian proposal, including the Czech Republic, Portugal and Spain. Colombia, which had initially brought forward an objection, subsequently withdrew it. The participants appreciated the efforts from the NGOs seating around the table to raise awareness of the issue among governments, the public sector and the media over the past month.

Questions were raised as to the consequences of such objections. It is the first time that a UN member State has questioned the drug control conventions. The following options are available to the ECOSOC: it could approve the amendment, which would not apply to objecting States; it could reject the amendment (in that case, Bolivia could choose to withdraw from the 1961 Convention); or it could convene a conference to discuss the matter further.

When Evo Morales presented his proposal in 2009, the matter brought considerable attention from the media and the momentum has kept growing ever since. This action was considered as the beginning of a fight to respect and protect indigenous people's rights. An increasing number of organisations have reached out to the media, and articles were published in the Economist, Associated Press, and other smaller newspapers. However, public opinion seems to be focusing much more on the coca leaf itself, rather than on chewing practices as an indigenous right. As with cannabis, opinions on the coca leaf seem to be changing slowly, and the international drug control system is at risk of breaking apart. However, so far, the Vienna Consensus seems to be holding together to block any attempt to establish a more balanced drug control system.

Final discussions on the Bolivian proposal focused on how to keep the momentum going on the issue at the UN level. One option would be to have the UN Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people to push for the issue. This has happened before, when Mr. James Anaya raised concerns about the impact of aerial fumigation on indigenous communities in Colombia, and it could be an important mechanism to bring prominence to the issue. The newly nominated independent expert on cultural rights could also be an important player.

⁹ By 31st January, a total of 17 countries submitted objections to the proposal, including Bulgaria, Canada, Denmark, Estonia, France, Germany, Italy, Japan, Latvia, Malaysia, Mexico, Russian Federation, Singapore, Slovakia, Sweden, UK and USA.

The upcoming European Union drug strategy

The European Union drug strategy will expire in 2012. The period 2011-2012 will therefore be crucial in terms of drug policy reform. Discussions will start in April 2011, and an initial proposal will be brought forward by the European Commission (EC) in September or October 2011.

At the EU level, there have been two main areas of discussions among member states, one focusing on the relation between drugs and security, especially regarding the rerouting of cocaine trafficking routes in Western Africa; and the introduction of new psychotropic substances in Europe. It seems that the main themes of the new strategy will include: drugs and criminal justice, drugs and violence, and health and social issues.

The EC has launched a 2-year project to evaluate the implementation of the drug policy strategy, including in-depth analysis of specific elements of the strategy (such as policing, drug treatment, etc.), along with an assessment of the work of relevant stakeholders and of the coordinating role of the Commission. The main goal of this evaluation process is to assess the added value of the EU drug strategy. For the next two years, drug policy debates will take place at the EU level to review control mechanisms for newly emerged substances. Indeed, one of the main weaknesses of the EU is that it is too slow to conduct risk assessments of new substances and take timely decisions about those considered harmful.

Because of the recent political changes and the economic crisis, and following the decisions taken at the 2009 CND, discussions on harm reduction have become very uncomfortable and are rather evaded. Member states hesitate to raise new issues on illicit drugs and avoid to put sensitive topics on the discussion table. In addition, many knowledgeable policy officials who were keen to bring forward reforms during the elaboration of the previous drug strategy have left their positions, and as a result the Horizontal Drugs Group includes several civil servants with little expertise in drugs issues. However, economic crisis may be *the* opportunity for governments to rethink their drug strategies. UNODC itself recognised that the current drug control strategy was extremely costly. There is a need to push governments to consider how much they are currently spending and compare it with the overall effectiveness of the system. There is a danger that this strategy might backfire, with governments starting to cut down on drug treatment and harm reduction programmes. For example, the Australian government spends $\frac{3}{4}$ of its budget on law enforcement and very little is allocated to treatment – and this segment of the budget is likely to be reduced further in the future. However, governments need to realise how much they are spending on criminal justice and prisons, and what cost-effective alternatives are at their disposal (including drug treatment). A large EU research study is currently being undertaken on the unintended consequences of the drug control regime in several regions of the world, along with a study of which intended consequences have not been met. This report will be released in a couple of years.

There is also room for advocacy action from civil society organisations. The drug policy debate is ongoing and it is up to NGOs to maintain the momentum through networking and communication. Since civil servants only remain in the Commission for an average of three years, it is necessary to constantly remind the Commission that drug policy is still relevant. It would seem useful to publish research papers on topics of interest for the EU, such as the economy of drug markets, the EU and unanswered policy issues, the difference between problematic and recreational drug use, long-term evaluations on the impact of methadone maintenance treatment or heroin prescription programmes, the external EU policy and its unintended consequences, etc. This research would encourage the EU to start talking about these issues when debating the new drug policy strategy since, for the first time,

the Parliament will be involved in the discussions, and the Lisbon Treaty gives room for debating policies on cooperation regarding health issues and cross-border threats.

The main recommendations for civil society involvement in the elaboration of the EU drug strategy are as follows:

- There should be a continuous focus on redirecting the debate towards relevant issues.
- It is necessary to keep an eye on opinion polls, because this would easily help building up interesting debates at the national and EU level.
- There needs to be an assessment of the strengths and weaknesses of the current EU drug policy in order to elaborate a new, more efficient, one.
- Civil society organisations should use the European Commission Civil Society Forum on Drugs to foster discussions and propose recommendations to the European Commission.
- NGO networking and communication should take place and lead the path to the writing of a paper to be presented to the Commission in April. The CND and the International Harm Reduction Conference in early April can be strategic opportunities for NGO representatives to meet and discuss such policies. In the meantime, NGOs should encourage political parties and other relevant stakeholders to reach out to their governments.

Global initiatives at the CND and beyond

There is a positive trend in which the drug policy reform movement is much stronger and geographically diverse than it was in previous years, and our influence has grown accordingly.

Global initiatives at the CND

The International Drug Policy Consortium (IDPC, www.idpc.net), a global network of NGOs and professional networks promoting open and objective drug policies, will be organising a set of interventions at the upcoming CND. In preparation for the CND, IDPC has published a Media Information Pack¹⁰ (a series of background briefings written by drug policy experts on the failings of the current global drug control system – a useful tool to catch the attention of the press on the matter) and an NGO Guide¹¹ providing practical information on the upcoming CND. During the CND, IDPC will be holding a network meeting, and organising a series of lunchtime satellite events. The themes of these events are not fixed yet, but the proposed themes so far are: the Bolivia proposal on coca chewing, diversion from custody to treatment, and overdose prevention. The holding of these events will hopefully stimulate the debates on the resolutions brought forward at the meeting. IDPC and the International Harm Reduction Association (IHRA, www.ihra.net/) will also be reporting live on the CND blog (www.cndblog.org/) about the main highlights happening at the CND. Finally, IDPC will publish a report on the CND proceedings in April 2011.

The Vienna NGO Committee on Drugs (VNGOC, www.vngoc.org/) will update its Guide for NGOs¹² and put together an agenda on every activity happening at the CND. As per previous years, VNGOC will be responsible for the NGO lounge, where it will coordinate advocacy activities and make available a speakers list for NGO representatives wishing to make statements at the Plenary. Daily

¹⁰ Available at: <http://idpc.net/sites/default/files/library/Media%20pack%20update%20February%202011.pdf>

¹¹ Available at: http://idpc.net/sites/default/files/library/idpc-ngo-guide-2011-cnd_0.pdf

¹² Available at: <http://www.vngoc.org/images/uploads/file/CND%202011/Guide%20to%20CND%202011.pdf>

briefings will be taking place every morning in the lounge, and relevant documentation will be put at the disposal of NGO participants. VNGOC will also hold three informal dialogues of 45 to 60 minutes with the INCB, UNODC and CND officials.

The EU will be organising a side event at the CND on how to improve data collection within the European Monitoring Centre on Drugs and Drug Policy (EMCDDA), UNODC and the Inter-American Drug Abuse Control Commission (CICAD), and how to invest more effectively in other parts of the world.

Beyond the 54th Session of the CND

The International Harm Reduction Conference will take place in Beirut in early April. This year, an official conference statement will be released, which will hopefully be brought forward in high level debates at the 55th Session of the CND in 2012.

Transform Drug Policy Foundation (Transform, www.tdpf.org.uk/) will be managing the campaign 'Counting the Costs' for the 50th anniversary of the 1961 Convention, calling for evaluation and scrutiny of the consequences of the international drug control regime. Gathering evidence into briefing papers and reports seems to be a good strategy for the 2012 CND, and this campaign will hopefully have an impact on upcoming drug policy debates at the CND and other forums.

There are a number of new organisations participating to the CND every year, and we sometimes miss opportunities to bring new stakeholders to the table and enlarge the scope of the debates at the CND. There needs to be mentors to shepherd policy makers and new NGO representatives at future CND meetings.

Finally, it was noted that it would be useful to campaign and rally support around the nomination of new members of the INCB in the coming year, since the Board has a lot of influence on the implementation of the drug control conventions by national governments.

Concluding remarks

This Informal Drug Policy Dialogue benefited from unprecedented participation, with the gathering of over 50 experts from different backgrounds to discuss drug policy issues. Overall, much scepticism was raised about the ability for the current drug control system to evolve and adapt to recent developments, brought forward by the positive results of the Portuguese decriminalisation model, proposals for cannabis reform in various regions of the world, or the most recent Bolivian request to remove the international ban on coca chewing. So far, the current system has remained resistant to any form of evolution. Yet, there is room for action, both at this year's CND, with the holding of various advocacy events and private meetings with national and international policy makers; and in the future, with a number of global initiatives that will hopefully lead to a more balanced drug control strategy.

Marie Nougier, Rapporteur

February 2011