Distr.
RESTRICTED
E/INCB/2002/W.13/SS.5
30 September 2002

UNITED NATIONS
INTERNATIONAL NARCOTICS CONTROL BOARD Original: ENGLISH

Seventy-fifth session
Vienna, 30 October - 15 November 2002
Item 4 of the provisional agenda

FLEXIBILITY OF TREATY PROVISIONS AS REGARDS HARM REDUCTION APPROACHES

(Decision 74/10)

Prepared by the Legal Affairs Section
UNDCP

I. JUSTIFICATION

1. During its seventy-fourth session, the INCB requested UNDCP to develop for its consideration, a legal position on the flexibility of the treaty provisions as regards harm reduction approaches (decision 74/10). The UNDCP 's Legal Affairs Section (LAS) has prepared the present document in response to this request.

II BACKGROUND

2. As the Board is no doubt aware, the concept of *harm reduction* is relatively new, developing only in the last decade, to encompass a variety of approaches to reducing the damage caused by drug abuse to individual and collective health, social and economic welfare.

3. Being this recent *harm reduction* was not foreseen by any of the international drug control treaties[1]. Therefore, there is no treaty-based definition for it and there are no specific treaty provisions that may be applied to the concept as such, at least not in general terms. A useful, albeit non-binding definition has been outlined by UNDCP in its publication *Demand Reduction – A glossary of Terms*, as follows:

> *"Harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinance."*

4. In its annual report for 1993[2] the Board stated a clear opinion on harm reduction:

---

[1] Namely, the single Convention on Narcotic Drugs, 1961, or that Convention is amended by the 1972 Protocol, the Convention on Psychotropic Substances, 1971, and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

[2] E/INCB/1993/1.

"29.The Board acknowledges the importance of certain aspects of "harm reduction" as a tertiary prevention strategy for demand reduction purposes. The Board considers it its duty, however, to draw the attention of Governments to the fact that "harm reduction" programmes are not substitutes for demand reduction programmes."

5. In 2000[3], the Board further elaborated while reviewing the situation in Europe:

"444.Drug policy discussions in western Europe have focused on the implementation of harm reduction activities such as the establishment of drug injection rooms or the effectiveness of heroin maintenance programmes. Following the attention given to harm reduction in western Europe, it appears that some countries in central and eastern Europe have also started to put more emphasis on harm reduction.

"445.The Board acknowledged many years ago, in its report for 1993,[45] that harm reduction had a role to play in a tertiary prevention strategy for demand reduction purposes. However, the Board also drew attention to the fact that harm reduction programmes could not be considered substitutes for demand reduction programmes. The Board would like to reiterate that harm reduction programmes can play a part in a comprehensive drug demand reduction strategy but such programmes should not be carried out at the expense of other important activities to reduce the demand for illicit drugs, for example drug abuse prevention activities.

"446.Since some harm reduction measures are controversial, discussions of their advantages and disadvantages have dominated the public debate on drug policy. The fact that harm reduction programmes should constitute only one element of a larger, more comprehensive strategy to reduce the demand for illicit drugs has been neglected. The Board regrets that the discussion on drug injection rooms and some other harm reduction measures has diverted the attention (and, in some cases, funds) of Governments from important demand reduction activities such as primary prevention or abstinence-oriented treatment."

6. UNDCP has yet to adopt an official position on *harm reduction*. With this in mind, an approach to this issue is currently being considered. Any such position would naturally bear in mind that UNDCP cannot endorse activities that are found to be in breach of the conventions, or the legalisation of the non-medical use of drugs in any form. UNDCP would, however, support a balanced approach that would match supply reduction measures and prevention, treatment, and rehabilitation initiatives, with programmes aimed at reducing the overall health and social consequences and costs of drug abuse for both the individuals and their communities. This would be fully consistent not only with the Declaration on the Guiding Principles of Drug Demand Reduction (Resolution A/RES/S-20/4) of the General Assembly Special Session (GASS-1998), but also with the stated position of the INCB. Moreover, this approach would also be in accord with the United Nations system 's position on *Preventing the Transmission of HIV among Drug Users*, as approved in February 2001.

III. LEGAL CONSIDERATIONS

7. Already in their preambles, the international drug-control treaties set a general obligation on Parties, to limit the use of drugs to medical and scientific purposes. This is not only one of the main purposes of the Conventions, but also a substantial part of the spirit in which they were negotiated and brought into force. The opponents of harm reduction may find this fundamental obligation difficult to reconcile with some, if not most, of the programmes and practices undertaken as part of harm reduction policies.

8. Admittedly, articles 33,36 and 38 of the 1961 Convention, articles 20 and 22 of the 1971 Convention, and article 3 of the 1988 Convention, create even more specific obligations on Parties. Among them:

a. Not to allow the possession of drugs except under legal Authority.

---

[3] E/INCB/2000/1.

b. To make criminal offences the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the Conventions.

c. To make criminal offences the public incitement or induction of others, by any means, to commit any of the above offences, or to use narcotic drugs or psychotropic substances illicitly.

d. To make criminal offences the participation in, association or conspiracy to commit, attempts to commit and aiding, abetting, facilitating and counselling the commission of any of the above offences.

e. To take all practicable measures for the prevention of drug abuse and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of drug addicts.

9. The first four are very straightforward, and lend themselves to few contradicting interpretations, for instance on the issue of penalties. The last one is not so clear-cut, since given its very nature, compliance with this obligation will necessarily depend on the interpretation by the Parties of concepts like prevention, treatment, rehabilitation and social reintegration, which are not defined by the treaties. State practice has shown that such interpretation may vary greatly from country to country and with it their understanding of how best to handle their respective drug-abuse related problems, while complying with their treaty-based obligations.

10. On the latter, it is worth noting that the treaties, also in their preambles, express their concern for the health and welfare of mankind, and for the health and social problems resulting from abuse. This might easily be construed as clear intent on the part of the treaties to combat drug abuse out of concern for its health and welfare consequences. Proponents of *harm reduction* might view this, in combination with the provisions of article 14,paragraph 4 of the 1988 Convention, as an express consent to alleviate the human suffering associated with drug abuse through *harm reduction* policies.

11. The provisions in article 14 go even further, authorising Parties to base their demand reduction measurers on recommendations of, *inter alia*, the United Nations. General Assembly resolution A/RES/S-20/4 (Declaration on the Guiding Principles of Drug Demand Reduction) would no doubt qualify as a United Nation's recommendation. In this respect, it should be noted that this resolution clearly states that:

"(b) Demand reduction policies shall:
(i) Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse;
(ii) ...
(iii) Be sensitive to both culture and gender;
(iv) Contribute to developing and sustaining supportive environments."

12. From this, it could easily be argued that the Guiding Principles of Drug Demand Reduction provide a clear mandate for the institution of harm reduction policies that, respecting cultural and gender differences, provide for a more supportive environment for drug users. The implementation of such a mandate would of course be open to the Public interpretation.

13. Although General Assembly resolution A/RES/S-20/4 does not carry the legal weight of a treaty, and is in fact non-legally binding, it does reflect the evolution in the outlook of Parties on the drug abuse problem and the best means to cope with it. It also reflects a consensus of the international community on how to deal with drug abuse prevention and treatment.

IV. CASE REVIEW

14. To get a clearer view of the legal implications of *harm reduction* policies under the treaties, it is necessary to look at specific programmes and their components. This section will attempt to do that, without going too much into the technicalities of each approach, which the Board has reviewed extensively in the past.

15. For that purpose, four types of *harm reduction programmes* (substitution/maintenance treatment, drug-injection rooms, needle/syringe exchange and drug-quality control) are reviewed below.

Substitution and Maintenance Treatment

16. Substitution treatment can be defined as the prescription of a drug with similar action to the drug of dependence, but with lower degree of risk, with specific treatment aims. At present, most substitution programmes prescribe *methadone*. Other drugs prescribed for substitution purposes are buprenorphine (Australia, Austria, Belgium, Denmark, Finland, France, Germany, India, Italy, Switzerland and United Kingdom), LAAM (Denmark, Portugal, Spain and United States of America), dihydrocodeine (Belgium, Germany, Hungary and Luxembourg), codeine (Switzerland) and morphine (Austria, Guatemala, Mexico and Switzerland)[4].

17. In its more traditional approach (methadone) substitution/maintenance treatment could hardly be perceived as contrary to the text or the spirit of the treaties. It is a commonly accepted addiction treatment, with several advantages and few drawbacks. Although results are mixed and dependent on many factors, its implementation along sound medical practice guidelines would not constitute a breach of treaty provisions.

18. The situation becomes more complicated with other approaches, both older and newer, like the dispensing of opium to opium addicts (India, Pakistan) or heroin to heroin addicts (Switzerland), respectively. The Board has reviewed both issues in the past.

19. In these cases, whether the respective approach is or is not perceived as legitimate under the treaties would greatly depend on the definition of *treatment* that is being used. As is the case with the concept of medical use, treatment is not treaty-defined, therefore the Parties and the Board have enough flexibility to adopt a definition of the term for their own use. Such a definition would evidently be non-binding under the treaties, but serve only for practical purposes.

20. In this respect, what was said at the seventy-fourth session of medical use in respect of the provision of opium to opium addicts (E/INCB/2002/W.2/SS.2, paragraphs 97 and 98) would apply mutatis mutandis to the dispensation of opium to opium addicts or heroin to heroin addicts as substitution/maintenance treatment in a *harm reduction* strategy (see Annex I).

Drug-injection Rooms

21. This approach entails the establishment, or allowing the establishment of facilities where intravenous (IV) drug abusers may inject themselves. The stated purpose of such a practice would be to provide addicts with a hygienic environment where to inject, reducing their exposure to infectious diseases and making available minimum health services to them.

22. Drug-injection rooms are currently operating in Australia (on a trial basis), Germany (as a recently legalised practice), Spain (municipal regulation) and in the Netherlands and Switzerland (tolerated without a clear legal status). Discussion of the feasibility of having them has already begun in Canada and Norway. In Luxembourg they seem to be permitted under the law, but it is not clear whether they are actually permitted

[4] Definition and data provided by UNDCP/DRS and taken from E/INCB/2002/W.2 (paragraphs 15 and 62).

by the authorities. The actual modalities differ from country to country, in some a broad range of medical and therapeutic options are offered, on a voluntary basis, with the use of the facilities; in others, such options may be very limited.

23. It might be claimed that this approach is incompatible with the obligations to prevent the abuse of drugs, derived from article 38 of the 1961 Convention and article 20 of the 1971 Convention. It should not be forgotten, however, that the same provisions create an obligation to treat, rehabilitate and reintegrate drug addicts, whose implementation depends largely on the interpretation by the Parties of the terms in question. If, for example, the purpose of *treatment* is not only to cure a pathology, but also to reduce the suffering associated with it (like in severe-pain management), then reducing IV drug abusers exposure to pathogen agents often associated with their abuse patterns (like those causing HIV-AIDS, or hepatitis B) should perhaps be considered as treatment. In this light, even supplying a drug addict with the drug he depends on could be seen as a sort of rehabilitation and social reintegration, assuming that once his drug requirements are taken care of, he will not need to involve himself in criminal activities to finance his dependence.

24. Needless to say that, to be consistent with a comprehensive demand-reduction strategy, any such approach would also require counselling and other health and welfare services, aimed at promoting healthier life-styles and, eventually, abstinence.

25. Encouraging addicts to use drug-injection rooms could arguably be construed as *inciting* to or *inducing* the illicit use of drugs, contrary to article 3, paragraph 1 (c)(iii) of the 1988 Convention. Some might also see it as association with, aiding, abetting and facilitating the *possession* of drugs as foreseen in article 3, paragraph 1 (c)(iv) of the Convention.

26. In this respect, one should bear in mind the element of *intent* required in paragraph 1 of article 3, and recall the position of the Commentary on the 1988 Convention:

> "3.7 The various types of conduct listed in article 3,paragraph 1,are required to be established as criminal offences only "when committed intentionally", unintentional conduct is not included. It accords with the general principles of criminal law that the element of intention is required to be proved in respect of every factual element of the proscribed conduct. It will not be necessary to prove that the actor knew that the conduct was contrary to law..."

27. It would be difficult to assert that, in establishing drug-injection rooms, it is the intent of Parties to actually *incite* to or *induce* the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the *possession*[5] of drugs.

28. On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options. Albeit how insufficient this may look from a demand reduction point of view, it would still fall far from the intent of committing an offence as foreseen in the 1988 Convention.

Needle-or Syringe-Exchange

29. This is rather straightforward strategy to reduce the risk of contagion with communicable diseases to IV drug abusers who share needles or syringes. It has been introduced in many countries around the world, to help reduce the rate of intravenous transmission of HIV and other transmittable diseases.

30. Regardless of its modalities, its health and social benefits need to be weighted on a case by case basis. As a separate approach to reducing health and social harm, it can be seen as very close to that of drug-

[5] Possession as such should be a punishable offence under article 3, paragraph 2 of the 1988 Convention. This is not the case for personal use.

injection rooms. In fact, for needle-or syringe-exchange a legal argumentation not very different from that in paragraphs 23 to 28 above could be made.

Drug-quality Control

31. This is one of the newest *harm reduction* approaches being implemented in some European countries. It aims at reducing fatalities due to the impurity and/or adulteration of substances, and consists of providing abusers with free quality-control analysis for drugs, whether at places where drugs are frequently abused (e.g., rave parties) or at designated government facilities.

32. This has obvious short-term benefits for abusers, and in the medium term it may help reduce health costs for drug intoxication treatment and drug-related death cases. Albeit, in the long term, unless it is accompanied by counselling and other demand reduction activities, it will not help combat drug abuse. To the contrary, given the wrong message on the risks of drug abuse it may convey and the false sense of safety it may give, specially to young, first time users, it may well help increase the abuse of substances like ecstasy.

33. This is perhaps the strategy that is hardest to reconcile with the obligations set forth in article 18 of the 1961 Convention and article 20 of the 1971 Convention. The argument of minimising *human suffering*, by reducing hospitalisation and death rates, could of course be made in its favour. However, the defeatism at the base of this approach, and the misleading message it sends to society at large, run contrary to the spirit of the Convention.

34. As regards punishable offences under article 3,paragraphs 1 (c) (iii) and (iv) of the 1988 Convention, this approach would also lack the element of *intent* required by the Convention for the establishment of offences.

V. CLOSING COMMENTS

35. It is evident that new threats like growing rates of intravenous HIV transmission of serious illness or of youth death from impure *ecstasy* at rave parties require that governments come up with new strategies to cope. It could even be argued that the drug control treaties, as they stand, have been rendered out of synch with reality, since at the time they came into force they could not have possibly foreseen these new threats.

36. Nonetheless, no matter how true those arguments may prove, the legal obligations derived from the international drug control treaties remain. The unfortunate facts that illicit drug markets are taking over parts of urban areas or of drug abusers poisoning themselves with adulterated substances do not invalidate the Parties obligation to combat drug abuse. If anything, these new trends make it all the more urgent for them to find new ways to substantially reduce the illicit demand for drugs. Even leaving the definition of treatment, rehabilitation or social reintegration to Parties, it seems clear that fulfilling their obligations under the treaties should be more comprehensive than just alleviating the harm associated with drug abuse.

37. It seems evident that all-encompassing positions on *harm reduction* are of very little practical use. The variety and complexity of current harm reduction policies warrant that national and local initiatives be individually evaluated as to their merits and consequences. In this, the Board has broad enough a mandate under the Conventions to review these policies and their implementation, and in cases in which irrefutable breaches to the Conventions are found, to act on its findings and seek out a remedy for the problem.

Annex I

SUBSTITUTION TREATMENT OF OPIOD ADDICTION

(E/INCB/2002/W.2/SS.2) [Extracts]

Regarding the qualification of the provision of opium to addicts, Parties would have three possibilities under the Single Convention as follows:

- Medical use: if providing opium to addicts is to be considered a type of substitution or maintenance program, as could be argued extrapolating the definitions given in paragraphs 16 and 17,above, it would become a legitimate medical practice, and should therefore be deemed as medical use under the Convention.

- Quasi-medical use: if the practice is to be considered rather as a quasi-medical use of opium, then any Government still permitting it, pursuant or not to a reservation under article 49 of the Single Convention should have abolished it since late 1979.In this context, any continuation or extension of this practice, including the reopening of registries originally established for this purpose, is contrary to the provisions of the Single Convention. It should be noted here that according to the information so far available, this practice, as allowed in India and Pakistan would not qualify as quasi-medical use under the definition quoted in paragraph 77 above, which is, however, not legally binding.

- Non-medical use: if providing opium to addicts is not deemed a legitimate treatment method and, therefore, non-medical use of a narcotic drug, the practice as such would be a violation of the Single Convention that should have never been permitted by any Party.

That being said, it should be emphasised that the power to qualify their providing of opium to addicts under one or another of the above possibilities remains with India and Pakistan, respectively, without prejudice to any opinion the Board may have with respect to sound medical practice in drug-addiction treatment.