In Search of Rights:

Drug Users and State Responses in Latin America

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In Search of Rights: Drug Users and State Responses in Latin America

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EXECUTIVE SUMMARY

This report presents the results of the most recent study by the Research Consortium on Drugs and the Law (*Colectivo de Estudios Drogas y Derecho*, CEDD). The study, entitled "In Search of Rights: Drug Users and State Responses in Latin America," analyzes States' responses to the consumption of illicitly used drugs,[1] focusing on two key areas–criminal justice responses and health responses–in eight Latin American countries: Argentina, Bolivia, Brazil, Colombia, Ecuador, Mexico, Peru, and Uruguay.

An international consensus appears to be emerging that drug use is not a criminal matter, but a health issue. Nevertheless, as shown by the country investigations that are part of this study, Latin American government responses to the use of illicit substances remain predominantly punitive and handled through the criminal justice system; it is through judicial, rather than healthcare, institutions that states address the illicit use of drugs and drug users. Even in countries in which drug use is not a crime, persistent criminalization of drug users is found.

Treating drug use (and users) as a criminal matter is problematic for several reasons. First, as an earlier study by CEDD shows, responses that criminalize drug users are often ultimately more hazardous for the users' health than the drug use itself and do not help decrease levels of use (either problem or non-problem use).[2] Second, as this report shows, the criminal justice response contributes to a climate of stigmatization of and discrimination against users, reducing the likelihood that police and the judicial system will take an impartial attitude toward them. Third, the criminalization of drug users is a poor use of public resources in both the public security and health sectors. Finally, this approach to drug use–through criminal justice institutions–violates various fundamental rights of users, including the rights to health, information, personal autonomy and self-determination. All of this violates various national and international human rights norms that States are obligated to uphold.

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[1] The term "illicitly used drugs" reflects the legal reality created by the international drug control treaties. States that are parties to the treaties are generally obliged "to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs" included in scope of control of the treaties (Article 4, General Obligations, 1961 Single Convention on Narcotic Drugs). Governments are further obliged to ensure that possession of controlled drugs "shall be a punishable offense" (Article 36, Penal Provisions, 1961 Single Convention). Thus, under the treaties, the non-medical, non-scientific use of controlled drugs is not permitted, and their possession is punishable. Therefore, throughout this report we refer to illicitly used drugs. When referring to consumers, however, we have simplified the language to "drug users." While recognizing that this term includes drugs used licitly and illicitly, we are referring to illicitly used drugs unless otherwise stated.

[2] Rodrigo Uprimny, Diana Guzman and Jorge Parra, "Addicted to Punishment: the Disproportionality of Drug Laws in Latin America," 2012. Available at: http://drogasyderecho.org/assets/proportionality-colombia-(addicted-punishment).pdf

The following is a summary of the studies' key findings:

- Most public policies related to drug use in the countries studied take a punitive and prohibitionist approach that does not distinguish among different types of use and/or among substances or users; they are therefore inadequate for addressing the harm caused by problem drug use.

- In all of the countries studied, there is strong discrimination against and stigmatization of drug users. Even in countries where use of those substances is not criminalized, we found that consumers are often treated as criminals. This leaves users outside the reach of health systems.

- In all the countries studied, we found that drug users are criminally prosecuted. In Argentina, Ecuador, Mexico and Bolivia, drug use is not a crime. Nevertheless, according to the study in **Argentina**, in a sample from 2011, nearly 75 percent of the cases involving drug law violations that were initiated by security forces in the Federal Criminal Court in the city of Buenos Aires were for possession of drugs for personal use. In **Ecuador**, 5,103 people are presently incarcerated for possession of narcotic or psychotropic substances, of a total of 6,467 convicted on drug-related charges. In **Mexico**, 140,860 people nationwide were arrested for drug use between 2009 and May 2013, and investigations were opened in 53,769 cases in the federal system during that period. In **Bolivia**, 6,316 people were arrested for drug possession (mainly cannabis) between 2005 and 2011, although possession is not classified as a crime.

- The criminal justice response puts drug users in a vulnerable position before the authorities, exposing them to corruption, extortion, physical abuse, sexual abuse, arbitrary detention and other violations of their fundamental rights.

- Largely because of the stigmatization of drug use, users suffer constant violations of their fundamental rights, including the rights to health, self-determination and free personal development, the right not to suffer discrimination, and the right to information and due process.

- The governments studied emphasize controlling the supply of illicitly used drugs over addressing drug use, or demand, which has a negative impact on the ability to provide adequate social and public-health responses to drug use and contributes to the violation of present and future users' rights to health.

- There is a marked paucity of information about consumption and a lack of systematization of that information and, in some cases there are methodological and conceptual problems in the gathering of information about drug use. That often leads to an exaggeration of the problem of consumption of illicitly used drugs and hinders the formulation and development of informed policies based on empirical information.

- By emphasizing a criminal justice approach over a health-related approach, governments have abdicated their responsibility to users who need treatment, leaving the private sector as the main provider of treatment and rehabilitation services. We found that States often do not regulate and/or oversee private centers, many of which operate informally, using treatments that have no scientific basis. Abstinence-based treatment models predominate in both the public and private sectors and there is little emphasis on harm reduction programs, which have proven more effective in mitigating the negative effects of illicit use of drugs.

- Throughout the region, drug users–even when their use is not problematic–can be subjected to treatment involuntarily, forcibly or semi-forcibly. This means that scarce public-health resources that could be used for people who do want and need treatment are used for people who neither need nor want it. Given that situation, the proposal of drug courts offers an alternative to incarceration. One concern, however, is that this proposal is seen as a healthcare response, when its components are still of a criminal justice nature and risk reproducing all of the problems within the criminal justice system with regard to drug use.

RECOMMENDATIONS

1. Users or consumers of illicit substances must be recognized as being subjects of rights. These include the right to self-determination and free personal development, the right not to suffer discrimination, the right to health and the right to due process.

2. Drug use is a social and health issue that requires non-punitive public policies. Criminal law should never be applied in cases of drug use and simple possession or as an excuse to protect health. Possession and cultivation for personal use should therefore be effectively decriminalized by changing criminal laws and/or by correcting the practices of law-enforcement agencies and judicial authorities.

3. States should redirect the priorities of their drug policies, placing much more emphasis on demand and doing so through health services and education programs.

4. Governments should establish and implement inclusive, evidence-based social and health policies that respect human rights, with increased budgets; accessible, high-quality public services; monitoring capacity; and periodic evaluation of the implementation of policies and their impact.

5. Drug policies should not be based on prejudices or stereotypes, but on reliable scientific information. Governments should make a greater effort to identify, gather, systematize and disseminate relevant information about types of use, users, the supply of services, and the production and distribution of substances.

6. Governments should also provide users with information about potential harm from the use of legal and illegal drugs, measures for mitigating the risks related to their use, and treatments that are available if needed.

7. Drug policies, including education and prevention programs, should distinguish among different forms of use -infrequent non-problem use, frequent problem use, frequent non-problem use, and infrequent problem use and differences in the substances themselves.

Governments should also recognize that not all drug use is problematic or implies dependence that justifies state intervention.

8. Uruguay's initiative to create legal, regulated cannabis markets, including cannabis clubs, deserves international and regional support. Similar initiatives to promote legal, regulated cannabis markets should be promoted in other countries and localities (like those in the U.S. states of Colorado and Washington).

9. Governments should design and implement treatment and rehabilitation programs based on scientific evidence and with harm reduction approaches to mitigate the negative consequences and risks that can result from drug use.

10. Governments should oversee treatment and rehabilitation services provided by the private sector. Therapeutic centers that emphasize isolation or forced or unpaid labor should be replaced by evidence-based programs.

11. The State, as a rule, cannot force treatment. In extreme cases where internment may be advisable, State intervention must be based on two principles: informed consent and compulsory rehabilitation as a last resort, always with strict observance of individual guarantees.

12. Thresholds of legal quantities for personal use should be used to set minimum quantities below which a person cannot be considered a dealer; nevertheless, it should not be assumed that a person possessing an amount exceeding the threshold can be punished for distribution and trafficking, because the State must prove intent to sell or distribute. Thresholds must also be based on users' practices and not set arbitrarily, always ensuring that users are protected.

13. Although promoted as an alternative to incarceration, drug courts remain primarily a criminal justice response, rather than a social or health-oriented response. Instead of replicating the US drug courts model, Latin American countries should explore other alternatives to incarceration and the decriminalization of possession for personal use in order to reduce the number of people incarcerated for possession for personal use and for minor, non-violent drug offenses.

INTRODUCTION

Despite the importance placed on drug control in Latin America, relatively little attention has been paid to drug users, people's reasons for using drugs, forms of use and the contexts in which different substances are used. This has led to neglect of the relationship between users and the State and a general lack of knowledge about key questions such as: Who uses drugs? What rights do those people have? When is State intervention in drug use justified? Which types of interventions are justified? What form should those interventions take? How do States currently respond to drug users?

This report includes a summary of recent country investigations by members of the Research Consortium on Drugs and the Law (*Colectivo de Estudios Drogas y Derecho*, CEDD) of illicit use of drugs and States' responses. Each country study analyzes how a particular state responds to drug consumption, focusing on two key areas: criminal justice responses and health responses. The studies begin with a description of current laws and public policies related to the illicit use of drugs, followed by an analysis of how those laws and policies are implemented. The studies show that in most of the countries analyzed, the State takes a repressive, prohibitionist approach that, in practice, translates into a series of direct violations of the fundamental rights of drug users.

The report is divided into three parts. The first part presents the prevailing international drug control regulations. The second is a summary of the country studies of consumption and government responses in Argentina, Bolivia, Brazil, Colombia, Ecuador, Mexico, Peru and Uruguay. The third part includes a series of conclusions drawn from a comparison of those studies, along with recommendations that we hope will contribute to the development of fairer and more proportionate drug policies that are consistent with users' fundamental rights.

Why study illicit use of drugs and the response by States?

There is a certain degree of international consensus that drug use is not a criminal matter, but a health issue.[1] The 2013 OAS report, *The Drug Problem in the Americas* notes, for example, that various world leaders, academics and representatives of civil society agree on the need for "an approach in which drug use is treated as a public health issue and consumption reduced through evidence-based prevention campaigns. Among other recommendations, they also encourage experimenting with legal regulation models for certain drugs."[2] Nevertheless, the responses of Latin American States to the use of illicit substances remains predominantly punitive, and it is through institutions of the criminal justice system, rather than the health system, that these countries address the illicit use of drugs and drug users.

This is problematic for several reasons. First, as already noted, dealing with drug use (and users) through the criminal justice system is inappropriate for addressing potential problems resulting from the use of legal and illegal substances (Global Commission on Drug Policy, 2011). In terms of protection of users, earlier CEDD studies show that responses that criminalize drug users are often more harmful for the users' health than the drug use itself, and that they are not useful for lowering rates of drug use (problem or non-problem).[3] Moreover, as this report shows, the criminal justice response contributes to a climate of stigmatization of and discrimination against users, which makes it less likely that they will receive impartial treatment from police and the judicial system. Addressing consumption through criminal justice institutions ultimately infringes on various fundamental rights of users, including the rights to health, information, personal autonomy and self-determination. All of this violates various national and international human rights norms that States are obligated to protect.

The criminalization of drug users represents a poor use of public resources allocated to both public security and the health sector. For police, prosecutors and judicial systems, such criminalization implies the use of scarce resources that could be allocated to address and prosecute behaviors that have a greater impact on society, such as violent robbery, rape,

[1] In most cases, consumption does not have significant negative effects for the individual drug user or for society (Mitchel, 1990) and the most harmful effects are the result of the current prohibitionist regime, which exposes users to risk by criminalizing them. See "Scenarios for the Drug Problem in the Americas 2013 – 2025," OAS, 2012, Pathways. See also the Declaration of Antigua, Guatemala, "For a comprehensive policy against the world drug problem in the Americas," by the OAS General Assembly. Available at: http://www.cancilleria.gov.co/newsroom/news/declaracion-antigua-guatemala-politica-integral-frente-al-problema-mundial-las-drogas

[2] See "The Drug Problem in the Americas," OAS, 2013, p. 5.

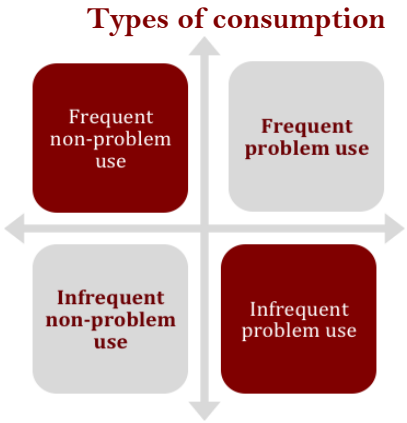
[3] Rodrigo Uprimny, Diana Guzman and Jorge Parra, "Addicted to Punishment: the Disproportionality of Drug Laws in Latin America," 2012. Available at: http://drogasyderecho.org/assets/proportionality-colombia-(addicted-punishment).pdf

kidnapping or murder. For the health sector, the compulsory treatment to which some countries subject users–whether or not they are dependent drug users–takes away valuable resources that could be dedicated to prevention campaigns or evidence-based treatment. For users who need treatment, the allocation of resources for mandatory treatment often means losing access to voluntary treatment services offered by public sector institutions. Compulsory treatment rarely has a positive outcome, because the voluntary nature of treatment is an essential factor in determining whether that treatment succeeds or fails.

In addition to the recognition of the problems caused by the criminalization of drug users, experts generally agree on three key ideas:

i) The need to differentiate among different types of consumption;
ii) The need to distinguish among types of substances and their effects on different people;
iii) The need to recognize that there should not be just one response to drug use.

i) One key element for the formulation of rational, proportional public policies on drugs is acceptance of various types of use of drugs, legal and illegal. At the very least, distinctions must be made with regards to the frequency of use and the effects of drug use on the community. While consumption may be frequent or occasional, the effects can be problematic or non-problematic. As the Advisory Commission for drug policy in Colombia (2013:19) notes, it is possible to identify at least four types of drug use: frequent non-problem use, frequent problem use, occasional non-problem use, and occasional problem use. Determining ways in which frequent or occasional problem use negatively impacts users, their families and their communities is also important.



Source: Advisory Commission on drug policy in Colombia (2013).

This classification shows that not all drug use is problem use or justifies coercive action by the state. It is also important to recognize that the use of some drugs (such as alcohol and cocaine) has pharmacological effects on people that can affect their judgment. If a person commits a crime while under those effects, the state could legitimately act coercively, using criminal law, but to address a violent act, not to punish or target drug use. In that sense, when problem drug use has significant negative effects on people's health, healthcare institutions, rather than the criminal justice system, should intervene to address the problem.

ii) To adequately address consumption, it is also important to recognize that not all controlled substances have the same effect on individuals. As the OAS report states, "Scientific evidence shows that these individuals exhibit different characteristics and live in different environments that in turn make them vulnerable to substance abuse to a greater or lesser degree".[4] Risk and other factors contribute to the development of problem use of substances. Therefore, drug policies should be based on available empirical evidence about how those substances affect the body, how they are used and consumption habits.

iii) Distinguishing among types of use and substances points to the need for governments to not rely on a single response. Occasional, non-problem use does not justify intensive or coercive state intervention, although the state does have the obligation to inform users about the risks of using different substances. Problem use could imply state intervention, but from a health–and rights-based approach, rather than a criminal justice approach. That means governments must allocate resources to the health system for the prevention and treatment of problem drug use.

The CEDD research team believes it is necessary to develop an empirical understanding of drug use in the region and study how governments actually respond to it. The key premise is that only with specific information can current drug policies be reoriented away from a criminal justice approach toward one centered on public health, human rights and harm reduction.

[4] See "The Drug Problem in the Americas," OAS, 2013, p. 64.

ABOUT CEDD

CEDD is a consortium that includes researchers -mainly lawyers- from eight Latin American countries, along with representatives of organizations that support the consortium: the Washington Office on Latin America (WOLA) and the Transnational Institute (TNI). The purpose of the consortium is to analyze the regional impact of criminal legislation and juridical practice related to controlled substances. CEDD seeks to produce information about the characteristics and costs, both social and economic, of drug policies in Latin America. By doing so, CEDD seeks to encourage informed discussion of the effectiveness of current drug policies and recommend alternative approaches for more just and effective policies. The researchers meet periodically to discuss drug-related issues and develop national and regional studies on the topic.

The group's first project was an extensive study of the impact of drug laws on penitentiary systems in eight Latin American countries (that study, *Systems Overload: Drug Policies and Prisons in Latin America*, can be found at: http://druglawreform.info/en/publications/systems-overload)

In its second major investigation, the consortium focused on the issue of proportionality and drug policies in each country. The studies from that project show how punishment for drug crimes in the region and treatment of those accused of violating drug laws are disproportionate to the harm caused by drug crimes and are sometimes more harmful than the behaviors they seek to punish. The proportionality studies also show the multiple costs of current policies for governments as well as for significant sectors of society.

The individual country studies on proportionality, as well as the longer country studies of drug use and state responses, can be found on the CEDD Web site: http://drogasyderecho.org

GLOBAL NORMS AND PRINCIPLES ON THE RIGHTS OF PEOPLE WHO USE DRUGS

Pien Metaal

"Stigma and discrimination against drug users hinder their access to health services and treatment"
(Pan-American Health Organization, web site: Alcohol and substance abuse facts)

To assess State responses to the use and users of controlled substances, it is necessary to analyze the global norms and principles that theoretically form the basis for national legislation and regulations on the topic.

This chapter begins with a description of the international norms on drugs, or the international conventions that are the basis of the legal frameworks in all of the countries included in the study. It then examines human rights norms, followed by specific situations in which the drug user is seen from other rights perspectives–as a patient, consumer, person, child, citizen, etc.–and the steady increase in guidelines and handbooks produced by UN agencies, especially the UN Office on Drugs and Crime (UNODC).

The influence that international treaties on drugs have had on the design of national legislation is important to highlight. Governments often use these legal instruments to justify punitive laws and practices. This has also emerged as a decisive or limiting factor in current discussions in various countries about the need to change existing norms and policies.

International drug conventions also rigidly delimit interpretations of consumption, prescribing one-size-fits-all solutions that are out of step with the real world. However, there is a trend toward more differentiated interpretations that seek to design national policies and laws that are better adapted to each country's situation. As part of a visible paradigm shift, the trend in relevant multilateral bodies, such as within the UN and the Inter-American system, is increasingly to move away from an exclusively criminal approach to the possession of drugs for personal use.

1. International conventions on drugs

One of the key principles of the conventions is protection of the health of drug users. The 1961 Single Convention on Narcotic Drugs, which establishes the international legal framework for medicinal and scientific use of certain substances, begins as follows:

> *Concerned with the health and welfare of mankind...*
>
> *Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes...*

Once the convention was ratified and took effect, any use of the listed substances that does not qualify as medical or scientific use under national regulations, became a matter of concern:[1]

> *Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind...*

Defining as addiction any use of these substances other than medical or scientific use, in the strict sense of the word, marked the beginning of the restriction and formal denial of recreational use of controlled substances by international regulations, and the consideration of such use as a problem. In the language of drug control treaties, the term "drug abuse" is commonly used to refer to anything other than medical or scientific use. It is therefore not the substance itself that merits being considered "illicit," but the context of its use. The use of the substance is illicit if it does not fall within the uses defined in the treaty.

Nevertheless, the 1961 treaty takes a different approach to traditional use. Article 49 states that "A Party may at the time of signature, ratification or accession reserve the right to permit **temporarily** in any one of its territories:"

a) The quasi-medical use of opium;
b) Opium smoking;
c) Coca leaf chewing;
d) The use of cannabis, cannabis resin, extracts and tinctures of cannabis for non-medical purposes; and
e) The production and manufacture of and trade in the drugs referred to under (a) to (d) for the purposes mentioned therein.

[1] The French and Spanish versions use the term "moral health," which could be interpreted differently from the English phrasing, which refers to "health and welfare of mankind."

Article 49.2 set a deadline for abolishing or prohibiting such use within 15 to 25 years of the date the convention comes into force, with no escape clause for any country that wants to protect the use of the proscribed plants, which is ancestral in all of those cases.

Article 38 of the Single Convention originally established that with regard to "treatment of drug addicts:"

> *The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.*
> *If a Party has a serious problem of drug addiction and its economic resources permit, it is desirable that it establish adequate facilities for the effective treatment of drug addicts.*

The term addict or addiction refers not only to substances that produce physical dependence, according to the Commentary on the Single Convention, but also to "the habitual use of other substances subject to the Single Convention but not producing physical dependence, such as cocaine, cannabis and cannabis resin."[2] This clearly refers to recreational use.

Regarding what is meant by establishing "adequate facilities for the effective treatment of drug addicts," as indicated in the second paragraph of the original text of Article 38, the Commentary clarifies that although the Plenipotentiary Conference did not "reject the idea of the usefulness of compulsory treatment," suggested in an earlier version of Article 38 which went much further ("The Parties shall use their best endeavours to establish facilities for the compulsory treatment of drug addicts in closed institutions"), it advised that the Convention not establish a specific treatment as the only valid one, although the conference did define the use of in-patient facilities as most effective for this purpose.[3]

The Protocol amending the Single Convention of 1961, approved in 1972, changed the title and content of Article 38 and emphasis was placed on the need to provide access to treatment and rehabilitation as an alternative to incarceration.

The title and text of Article 38 of the Single Convention were modified as follows:

Article 38. Measures against the abuse of drugs

[2] Commentary on the 1961 Single Convention on Narcotic Drugs, Commentary on Article 38, p. 487, United Nations, New York, 1989.
[3] Ibid., p. 488.

1. The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.

2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.

3. The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.

This protocol's significance is that it allows states to adopt less punitive measures for drug users, particularly replacing incarceration with treatment. This now serves as the legal basis for European countries that have alternative policies for users, including treatment options and harm reduction interventions.

The next relevant norm for defining the treatment of consumers of drugs whose uses were restricted, the 1988 Convention, was even more influential. In it, the series of norms agreed upon by the international community established that countries should use criminal sanctions to address the trafficking of drugs for uses that were not licit under the Single Convention (medical or scientific). Drug use as such, however, was not included among the types of crimes listed in Article 3.1.a, "Offences and sanctions," of that convention.[4]

The implication is that the signatory countries are not required to punish consumption; in practice, however, that remains part of drug control efforts and various countries punish drug use. According to the 1988 Convention, it is a crime to incite or induce consumption; Article 3.1.c.iii refers to:

Publicly inciting or inducing others, by any means, to commit any of the offences established in accordance with this article or to use narcotic drugs or psychotropic substances illicitly.

This article establishes one important exception:
"Subject to its constitutional principles and the basic concepts of its legal system."

[4] For a more detailed discussion of this point, see: "The Limits of Latitude: the UN Drug Control Conventions," Dave Bewley-Taylor and Martin Jelsma, Drug Law Reform Series No. 18, TNI, March 2012.

This escape clause also applies to possession, cultivation and purchase for personal use, although in practice, national legislation rarely makes use of the exception for other types of crimes. The range of offenses described by the 1988 Convention in this regard is very broad and detailed.

Meanwhile, the 1988 Convention also sets guidelines for treatment of the "criminal," in Article 3:

> *b) The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.*
>
> *c) Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.*
>
> *d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.*

The Commentary on the Convention of 1988 also indicates that these provisions were mainly designed for people who use drugs, who, in the language of the treaty, are known as "addicts." Consistent with the definition used in the 1961 treaty, any use of drugs that is not medical or scientific is considered abuse or addiction. It is also noteworthy that treatment is considered an alternative or supplement to criminal sanctions or sentences, providing a rationale for legislation for compulsory treatment. In some ways, this mindset persists in the model promoted by the Organization of American States (OAS) and other multilateral bodies or drug courts (see below).

The Commentary on the 1988 Convention also includes an extensive paragraph explaining what is meant by "treatment." Particularly noteworthy is the description referring to treatment as an alternative measure:

> *…treatment is sometimes made a condition for avoidance of imprisonment. The aim is to take into account the medical condition of the offender while keeping him or her away from an environment where treatment would be minimal and the opportunity for*

further drug abuse great. Such measures are therefore not necessarily more lenient than imprisonment nor much different in concept than punishment.

It continues by noting that there are controversial issues, such as "civil rights issues raised by internment for indefinite periods."[5]

In short, international drug treaties influence the development of national legislation in two ways: first, they call for the restriction of any use of controlled substances other than for medical or scientific purposes; and second, they order the criminalization of offenses, which, while excluding use–although in contrast explicitly prohibiting traditional uses–leave open the option of using compulsory treatment to punish the user for dodging this restriction, violating his or her fundamental rights.

2. International human rights treaties

In theory, human rights treaties are considered to take precedence over drug treaties or any other treaty. In practice, however, the matter still awaits full global consensus. Not all countries in the world consider human rights more important than other issues, and in countries where their precedence is recognized, fundamental rights are still violated frequently. The tension between these two areas has been widely acknowledged over the past decade. Frequent drug users are presented as a "social ill" that threatens public health and the values of the people and the nation. Stripped of their human characteristics, people who use drugs are often excluded from the sphere of human rights.[6]

This section describes the general principles established in various basic human rights treaties recognized and promoted by the United Nations, followed by specific laws and principles that apply to drug users in treaties recognized worldwide. It concludes with relevant reports published in recent years on the rights of users or related norms.

The UN drug conventions must be interpreted in conjunction with international human rights treaties, because of their recognized order in the hierarchy of international law. This limits the excesses justified under those treaties and increases the legal legitimacy of their positive elements, such as those related to access to essential controlled medications and freedom to expand harm reduction.

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[5] Commentary on the 1988 Convention, Second part, Substantive Provisions, p. 88.

[6] *Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy*, Beckley Foundation.

As noted, the UN conventions do not criminalize drug use or possession for personal use under certain parameters and they allow national governments to offer alternatives. The International Narcotics Control Board (INCB) and UNODC would do well to advocate for these alternatives to avoid excesses resulting from strict interpretation of the conventions. Because of the ineffectiveness of criminalization in affecting the level of use and drug-related harm, it is difficult to understand how criminalizing use or personal possession can be considered a proportionate response, given the violation of the right to privacy or to religious or cultural expression.[7]

Nevertheless, some aspects of the drug treaties cannot be reconciled with human rights legislation, particularly the prohibition of certain traditional, cultural and indigenous practices. These conflicts must be addressed by the parties to the conventions.

All UN agencies are required to promote human rights by virtue of their establishment within the framework of the UN Charter. Various human rights treaties and norms of different generations, such as the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention against Torture and other Cruel, Inhuman or Degrading Treatment and Punishment and other conventions on the human rights of specific groups or particular issues (such as women, migrant workers, people with disabilities, racism) analyze countries' commitments to fundamental human rights under the UN Charter and the provisions of the Universal Declaration of Human Rights. These treaties also require the states that ratify them to respect, protect and enforce the rights they enshrine. The question, therefore, is: What human rights violations occur in the name of drug control?[8]

The right to life

Article 3 of the Universal Declaration of Human Rights and Article 6 of the International Covenant on Civil and Political Rights.

Thirty-three countries worldwide maintain the death penalty in their legislation as a possible punishment for drug-related crimes. Although only some of them perform executions, hundreds of people are executed each year. Capital punishment for drug crimes does not meet the criterion of "most serious crimes" under the International Covenant on Civil and Political Rights.

[7] Ibid.

[8] For an extensive discussion of the issue, see: http://www.tni.org/es/briefing/derechos-humanos-y-politicas-de-drogas

The right to health

The Constitution of the World Health Organization; Article 12 of the International Covenant on Economic, Social and Cultural Rights; Article 24 of the Convention on the Right of the Child, and other sources.

People who use drugs have the right to high-quality healthcare services that are available, accessible, acceptable and adequate.

In various countries, criminal laws prohibiting the provision or possession of syringes create a climate of fear among people who use drugs, leading them to avoid potentially life-saving HIV-prevention services and other health services. This encourages risky behaviors and facilitates the spread of blood-transmitted diseases, such as HIV and hepatitis C.

Access to essential medicines is one of the minimum basic requirements recognized in the right to health. Because of legal and political restrictions on some essential medicines, such as morphine, tens of millions of people suffer from moderate to severe pain. Access to methadone and buprenorphine as substitution treatment for dependent users of opioids is also obstructed and is even illegal in some countries, violating the protection of those people's health.

Several countries use compulsory detention and rehabilitation centers for drug users, as a form of treatment for dependence on substances. These centers are often run by police or supervised by judiciary personnel who lack medical training. Some centers are even accused of using experimental treatments without patient consent (see also the right to inherent human dignity in Article 10 of the International Covenant on Civil and Political Rights).

The right not to be subjected to torture or other forms of cruel, inhuman or degrading treatment or punishment

International Covenant on Civil and Political Rights; Convention against Torture; and Convention on the Rights of the Child.

In his report, the former UN special rapporteur on torture and other cruel, inhuman or degrading treatment and punishment, Manfred Nowak, notes the challenges that punitive policies pose for criminal justice systems, in terms of both absolute numbers and the special needs of drug users in prison. Manfred Nowak and his successor, Juan Méndez, have called for increased use of harm reduction interventions in detention centers.

Many drug users in prisons and mandatory treatment centers have complained of being subjected to beatings, sexual aggression, forced fasting and humiliating treatment. The

withdrawal syndrome has also been used to obtain money or information from people who use drugs; police beatings of suspects to get information from them are also common.[9]

The right not to be subjected to forced labor

Article 8 of the International Covenant on Civil and Political Rights.

Compulsory treatment centers for drug users sometimes use forced labor as "therapy," coercing patients to work without pay.

Right to due process and a fair trial

Article 9 of the International Covenant on Civil and Political Rights.

Because of the large number of drug-related detentions, the criminal justice system tends to be overwhelmed and people suspected of having committed a crime sometimes remain in preventive detention for months.

Drug users in compulsory treatment centers are often arrested and sent to those centers automatically, without the guarantee of a fair trial. In some countries, drug users, whether or not they are dependent, are forced to go to those centers. This means that the system does not differentiate between users who really need treatment and those who do not.

In some countries, special courts have been established or are used to try people suspected of drug trafficking, such as Iran's Revolutionary Court.

The right not to be the object of discrimination

International Convention on the Elimination of All Forms of Racial Discrimination of 1960; Convention on the Elimination of All Forms of Discrimination against Women of 1979; and International Covenant on Civil and Political Rights of 1966.

Because of the great social stigma associated with drug use, drug users are the object of discrimination in the workplace and in their communities.

In some countries, drug control laws are enforced in ways that discriminate against minority ethnic groups, indigenous peoples and women. Women and pregnant women who use drugs are especially stigmatized.

[9] Report of the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Human Rights Council A/HRC/10/44, 14 January 2009.

The right to adequate living conditions and the gradual realization of economic, social and cultural rights
1966 International Covenant on Economic, Social and Cultural Rights.

It is common knowledge that illicitly used drugs tend to be produced by farmers in the world's poorest and most vulnerable communities. Crop eradication campaigns can have a devastating effect on farmers and their families, leaving them without alternative means of subsistence.

Alternative development programs that are not designed and sequenced appropriately can also be devastating for these communities.

Economic, social and cultural rights of indigenous peoples
Article 14(2) of the United Nations Convention against Illicit Traffic of Narcotic Drugs and Psychotropic Substances of 1988; ILO Convention No. 169 on Indigenous and Tribal Peoples in Independent Countries of 1989; United Nations Declaration on the Rights of Indigenous Peoples of 2007 (Articles 11, 12, 24, 26, 27); International Covenant on Civil and Political Rights; Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination and other sources.

Indigenous peoples are impeded from producing and consuming controlled substances that they have used for centuries for traditional purposes. This is the case, for example, of the coca leaf in Latin America, kratom in Thailand and Myanmar, and opium throughout Southeast Asia.

Rights of the child
Article 33 of the Convention on the Rights of the Child: "States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances."

The current drug control system does not protect children in the way that would be expected. Use of drugs among young people is greater than ever, and when children begin using drugs they are often not provided with treatment or harm reduction services. In most countries, children who use drugs are criminalized, and they often carry that burden for the rest of their lives. The children of people who use drugs are also stigmatized and if the parents are sent to

prison or detention centers, the children are at high risk of committing crimes or also using drugs themselves.

Children are among the groups that lack access to essential pain relief medications that are subject to control.

Children can be incarcerated with their mothers when the mothers are convicted of drug crimes, because they have nowhere else to go.

Children can lose their lives or be orphaned because of drug-related violence.

The UN Committee on the Rights of the Child has urged that children who use drugs not be criminalized, that they be provided with accurate and objective information about drugs, and that they be offered treatment services adapted to their needs. The same committee has criticized aerial spraying in Colombia and the use of minors in the Mexican armed forces to fight in the war on drugs.

In conclusion, human rights norms and principles are highly relevant for the field of drug control. In the past decade, there has been increasing awareness of that relevance in discussion and in documents published by drug control agencies.

3. From coercion to cohesion: UN treatment norms

Although the constitution of the World Health Organization (WHO) establishes that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," there are few special reports on countries' compliance in the case of dependent drug users who need social and health assistance. In recent years, however, the UN has been paying more attention to the matter.

One relatively recent example is the 2009 annual report by the Human Rights Commission's special rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health, which devoted a section of the chapter on "Vulnerable groups and informed consent"[10] to "persons who use drugs". Based on the right to health, and in particular informed consent, it notes the need to ensure the highest protection against stigmatization or discrimination for any reason, identifying in particular persons who use drugs, including alcohol.

[10] Term used in the medical world that indicates a mentally competent patient's free, voluntary and conscious agreement with a procedure affecting his or her health, after receiving the information necessary to make a decision.

The Grover Report[11] was the first to identify drug users as a group whose rights were being violated. The right to informed consent is important for this discussion, precisely because drug users have been made invisible as a result of the stigma they suffer because of their habits. Many are committed to residential treatment programs beyond the control of health authorities and their families.

The following conclusions of the report could help make drug-related health practices more visible:

> *Persons who use drugs are often perceived as being dangerous to themselves and unable to make the "right" decision. Prohibitions against their behaviour threaten their ability to refuse testing and treatment. Informed consent is obviated by compulsory drug and alcohol testing when such testing is linked to non-consensual treatment consequences.*
>
> *In addition to being generally ineffective, largely conducive to relapse and demotivating, compulsory drug dependence treatment is often associated with prolonged isolation, detention without judicial oversight and government registrations constituting violations of the right to privacy. In some countries, persons who use drugs are subjected to compulsory treatment and HIV/AIDS testing, and to "therapy" constituting cruel, inhuman or degrading treatment or punishment nationally endorsed by existing legal frameworks for drug control. Persons undergoing drug dependence treatment are often unaware of its nature, duration or experimental status. Conditions in compulsory treatment centres often present additional health risks owing to exposure to infectious diseases and lack of qualified staff able to address emergencies or provide medically managed drug treatment.*
>
> *Treating persons who use drugs as criminals is counterproductive from a right to health perspective. States should change legislation that supports criminalization based on non-consensual testing. Any routine drug or alcohol testing should be consensual to encourage appropriate conditions of counselling and treatment, and implemented in a non-discriminatory, transparent and inclusive way. Testing and treatment protocols should treat drug dependence like any other healthcare condition.*
>
> *Guidelines for drug dependence treatment should endorse only voluntary evidence-based treatment (such as opioid substitution therapy) and provide for adequate training of staff. Treatment that is not evidence-based should never be used, and voluntary treatment services should be scaled up and accessible to marginalized groups.*

The United Nations, particularly UNODC, has produced a series of publications, documents and handbooks on principles and practices related to both health policy and prison

[11] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Anand Grover, United Nations, 2009, A/64/272, New York.

policy. For example, in 2007 UNODC published the *Handbook of Basic Principles and Promising Practices on Alternatives to Imprisonment*,[12] which devotes a section of the "Special Categories" chapter to "drug offenders," mentioning two alternatives to incarceration of drug users: decriminalization and diversion. The handbook considers the former strategy controversial and the latter promising. One formal expression of the latter is drug courts or drug treatment courts.

In 2008, UNODC and the World Health Organization (WHO) issued a discussion paper on "Principles of Drug Dependence Treatment,"[13] which contains nine principles meant to "encourage Governments and other partners to take concerted action for the implementation of evidence-based drug dependence treatment services, which respond to the needs of their populations."[14] Two principles, described below, are particularly relevant to this report.

The fourth principle refers to "Drug dependence treatment, human rights and patient dignity," and states, "Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination."

In defining actions, the following points are highlighted:

- Not discriminating against patients because of past or present drug use.
- Applying the same ethical standards to treatment of drug dependence as any other health condition.
- Access to treatment and care services for patients who are not motivated and those in prison.
- No procedure should be forced on patients, except in a situation that poses high risk to self or others.
- In countries where possession of drugs is punishable by law, treatment should be offered as an alternative, with the possibility of choosing freely between treatment and the penal sanction.
- There should be no discrimination, on any grounds, and no violation of human rights.

[12] https://www.unodc.org/pdf/criminal_justice/07-80478_ebook.pdf
[13] http://www.unodc.org/docs/treatment/Principles_of_Drug_Dependence_Treatment_and_Care.pdf
[14] Introduction, p 1. Discussion paper - Principles of Drug Dependence Treatment.

Principle 6 refers to "Addiction treatment and the criminal justice system," and states that "Drug related crimes are highly prevalent," including: "offences to which a drug's pharmacologic effects contribute; offences motivated by the user's need for money to support continued use; and offences connected to drug distribution itself." In defining actions, the following points stand out:

- Schemes for diversion from criminal justice to treatment;
- Human rights;
- Continuity of services;
- Continuous care in the community;
- Neither detention nor forced labor has been recognized by science as treatment for drug use disorders.

In 2010, UNODC issued an important discussion paper entitled, "From Coercion to Cohesion: Treating drug dependence through health care, not punishment,"[15] which basically outlines a new, health-oriented approach to drug dependence, suggesting alternatives to the penal approach and opening discussion about compulsory treatment. The foreword to the paper states that "treatment offered as alternative to criminal justice sanctions has to be evidence-based and in line with ethical standards."

It also mentions compulsory treatment, which is relevant for the rights of drug users: "Drug dependence treatment without the consent of the patient should only be considered a short-term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary-based treatment. Human rights violations carried out in the name of 'treatment' are not compliant with this approach."

One chapter addresses the issue of specialized drug courts. The paper defines them as a form of treatment and considers them "effective" as an "alternative to criminal justice sanctions." According to the paper, experience with drug courts "confirmed that drug courts significantly reduced drug use and crime." Nevertheless, significant criticism of this "alternative model" has arisen, which will be discussed below. This seems to be the beginning of a broad consensus among multilateral organizations to replicate that model in Latin America, although numerous elements of its reported success are being questioned.

[15] http://www.unodc.org/documents/hiv-aids/publications/Coercion_Ebook.pdf

In March 2012, a joint statement[16] was issued by 12[17] UN agencies under the leadership of UNAIDS calling on governments to "to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community." The statement outlines a series of actions by which the agencies "are committed to work with countries to find alternatives to compulsory drug detention and rehabilitation centres, including through technical assistance, capacity building and advocacy." It lays out areas in which they can assist:

- Sharing of information and good practices on voluntary, evidence-informed and community- and rights-based programmes for people who use drugs, those who engage in sex work, and children who have been victims of sexual exploitation;
- Dialogue with policy-makers to increase support for voluntary, evidence-informed and rights-based treatment and programmes for drug dependence;
- Multisectoral collaboration among law enforcement, health, judiciary, human rights, social welfare and drug control institutions to assist in developing frameworks of action to support voluntary and community-based services for people who use drugs, those who engage in sex work and children who have been victims of sexual exploitation;
- Establishment of services to address the root causes of vulnerability (e.g. poverty, gender inequality and the lack of sufficient family and community support structures).

More recently, in April 2013, UNODC explicitly spoke out on compulsory treatment in the case of Brazil, in an article Gilberto Gerra,[18] chief of UNODC's department on Drug Prevention and Health.

The UN is sending clear signals that it is serious about its role in guiding governments through the confusing legal world of drugs, defining them in ways that are consistent with global human rights principles. All of these documents and norms consider drug users within the health system or in treatment centers as people who are ill, with

[16] http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf

[17] Office of the United Nations High Commissioner for Human Rights; Office of the United Nations High Commissioner for Refugees; International Labor Organization; World Health Organization; United Nations Entity for Gender Equality and the Empowerment of Women; Joint United Nations Program on HIV/AIDS; World Food Program; United Nations Development Program; United Nations Organization for Education, Science and Culture; United Nations Population Fund; United Nations Children's Fund; United Nations Office on Drugs and Crime.

[18] http://www.unodc.org/lpo-brazil/es/imprensa/artigos/2013/04/08-treating-drug-dependence-from-coercion-to-cohesion.html

established pathologies. It is important to ask, however, where the existing framework has a place for users who are not ill and who do not commit crimes, but who are detained and prosecuted by legal systems, considering that most people who use controlled substances do not have problems related to that use.

4. The user: between health and criminal justice approaches

One specific group of relevant established rights are those of patients, which, from the standpoint of medical ethics, contain a series of principles that are important for people whose use of substances is part of a medical phenomenon or whose use has become a medical problem. As noted at the beginning of this chapter, it is not the substance that defines abuse, but the context. It is important to remember that the majority of real health problems are related to alcohol and tobacco use. It is the use of other drugs that is considered illicit. Because those drugs are prohibited, those who use them are considered criminals.

An important step is needed to arrive at recognition of the rights of drug users. According to international norms and many countries' laws, *all* use of certain substances is considered problem use and this is reflected in national legislation. As a result of the global drug control system and international treaties, drug use other than medical or scientific use is considered abuse or addiction. As a result, all drug use becomes a medical issue or a problem, and all users are considered ill. Recreational drug use is a non-existent category, although most drug use is actually not problem use from a public health standpoint.

This has created a contradiction, turning drug use into a medical issue, in which the drug user, instead of being considered a criminal, should be treated as a patient in order to escape prosecution in the judicial system. The call for respect for the rights of drug users is currently moving in this direction, on the grounds that drug use is a public health issue and therefore should be part of public health policy. That rhetoric, however, has obvious limitations.

Discussion of whether recreational drug use is a right is implicitly part of the policy debate when it refers to possession for personal use or cultivation of plants for personal use. In several countries, new legislation recognizes this type of use of psychoactive substances and seeks to regulate the market for them. The right to use drugs as an individual right is explicitly part of the discourse of liberal politicians and economists, but it is also a key element

in various rulings by appeals courts and constitutional courts in some countries in recent decades.[19]

Nevertheless, for people who use drugs and who have problems because of that habit, guaranteeing access to public health services is crucial, as it is for any citizen with any illness. It should in no way contravene their right to health, despite the stigma attached to drug use or the fact that they have an illicit habit. It should be clear, therefore, that in practice, existing norms are contrary to the enjoyment of that right.

5. Tensions between drug courts and the right to health

One example of this contradiction is drug courts, also called drug treatment courts, which have been implemented or are in a pilot phase in 12 Latin American countries, with the idea of expanding them to more. They are strongly promoted as a "third way" for the region by multilateral agencies that see them as a successful model and present drug courts as indicative of a paradigm shift in drug policies, moving from a punitive to a public health approach. There are various myths about their usefulness and success, which are closely related to the exercise of the rights and guarantees of people who use drugs.

The idea behind drug courts is to offer people who commit non-violent offenses and who have problems with the use of illegal substances (not including alcoholics, although drug treatment courts in Nuevo León, Mexico, do consider them) the option of treatment instead of prison. The diversion of these people from the judicial system to the health system aims to reduce the prison population, reduce the costs and time invested in drug cases by the judicial system, and lower recidivism rate for crimes. The state's response, through drug courts, is seen as a way to help these people recover from problem use, although that appears to be a secondary goal.

The model is based on four key elements. First, the person who is accused of having committed a crime, and who admits to drug use, becomes the beneficiary of a suspension of criminal prosecution or the sentence. Second, that person is offered treatment and sometimes other social services. Third, the treatment is established and supervised by a judge or court that is responsible for monitoring compliance with the conditions that are set, including monitoring hearings and periodic testing to determine if the person has used drugs. Fourth, in

[19] The legally protected interest defended or manifested in various decisions refers to "harm to third parties" or the "inalienable nature of the individual body", "the right to make decisions about one's own body." These are rulings by the highest courts in Colombia, Argentina and Brazil.

case of non-compliance with the conditions set by the drug courts, sanctions are imposed, which can lead to the person being removed from the program. Compliance, on the other hand, can result in rewards, and if the treatment is successful, the sentence may be significantly reduced or lifted.[20]

The main problem with the way the courts actually work is that penalization is maintained for people who do not complete treatment successfully, as there is always the option of punishing them with incarceration. Freedom is conditional, depending on the success of treatment, which is problematic in principle and often fails, because the model is generally based on total abstinence from use. Instead of considering the right to treatment as the starting point, this model actively promotes using the criminal justice system to force people into treatment, ignoring this right.

Meanwhile, experience in the United States shows that the number of people who come into contact with the judicial system through the courts actually increases; in other words, instead of decreasing, the number of cases increased. As the country studies presented here also show, government infrastructure for treatment is inadequate and what is offered by private entities is seriously lacking in terms of quality control and monitoring. A shift toward more treatment and less incarceration should also be accompanied by greater public investment in treatment services.

Conclusions and recommendations

International laws that form the basis of state responses to drug users send mixed signals about the protection of users' rights. Under international treaties, drug users theoretically enjoy protection once they are considered addicts or patients in the healthcare system. An increasing number of norms and documents explicitly recognize the need to respect the human rights of drug users, the system of assistance created for them and the role governments play in enforcing those rights.

Meanwhile, because recreational use of psychoactive substances that are controlled under international legislation is a non-existent category, the vast majority of people who use drugs, and who are not considered problem users, are considered to be outside the law. Because this group constitutes a considerable number of the people currently prosecuted in

[20] For an extensive discussion of this issue, see: "Drug Courts: Scope and Challenges of an Alternative to Incarceration," Diana Guzmán, IDPC Briefing Paper, May 2012: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2184815

the judicial system, international laws could be considered inadequate and out of step with reality.

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DRUG USERS IN ARGENTINA: A "PROHIBITIONIST-ABSTENTIONIST" FRAMEWORK

R. Alejandro Corda, Araceli Galante, Diana Rossi.

This country study shows that the government's response to drug use (or "narcotic drugs"[1]) in Argentina is based on a framework of various hegemonic arguments that emerged over the course of the 20th century. The prohibitionist approach has had various impacts on users, who have suffered the brunt of its main expression: criminal punishment. It has also shaped other responses, such as prevention and treatment. Despite various initiatives or reforms, the main components of this approach appear to remain in effect.

1. Construction of the "prohibitionist-abstentionist" framework

In the early 20th century, administrative legislation was developed that regulated the sale and importation of illicitly used substances and punished pharmacies and drugstores that did so outside of licit channels with fines. One of those norms (the decree of May 17, 1919) was the first specific norm on particular substances (including "opium and its preparations, Indian *cáñamo*, morphine..., cocaine"). It required intervention by health authorities prior to importation and established a system for recording the existence and sale of the substances.

Information from that period reveals that these substances were sold not only in pharmacies and drugstores, but also illicitly by people who peddled them in parallel with other illicit activities.[2] They were mainly used by people of a relatively well-off social class and those who frequented nightspots. Although there were cases of problem use, this was not a widespread problem. The attitude toward users at the time was reflected in terms such as "vice-plagued" and "contagious," utilized in defense of prevailing societal norms.

In 1924, a significant movement influenced by various positivist schools of thought at the time–hygienist, legal medicine, defense of society–won approval of the first criminal law on these substances. Law 11,309 added the terms "narcotics" and "alkaloids" to the Criminal

[1] This is the term used in Argentinean law to define substances related to behaviors that are classified under criminal law. As in international norms on rights, the law refers to a list included in Decree 299/10.This chapter also uses the terms "psychoactive substances" or "drugs" to refer to narcotics and/or other substances whose related behaviors are not addressed, or are addressed to a lesser degree, by criminal law (e.g., alcohol, tobacco, certain medications, inhalants, etc.).

[2] Bard, L. (1923). *Los Peligros de la Toxicomanía. Proyecto de ley para la represión del abuso de los alcaloides.* Buenos Aires: Talleres Gráficos Argentinos.

Code and made it a crime to smuggle them into the country or sell controlled substances without a medical prescription; those and other offenses were punishable by six months to two years in prison. Lesser penalties (three months to one year in prison) were levied for "sale or delivery or provision ... by persons not authorized to sell medicinal substances." Because of complaints about the limited scope of the text, a modification (Law 11,331) two years later allowed possession of those substances to be punished with six months to two years in prison, without differentiating between dealers and users. Interpretation by judges finally confirmed the latter, which was not clear in legislative debates.

Nevertheless, enforcement of the law apparently was not widespread until the second half of the 1960s, when international legislation began to have a greater influence on national laws and new measures were implemented to provide assistance to users.

The 1961 UN Single Convention on Narcotic Drugs was approved by Argentina in 1963. Law 17,567 of 1968 modified the Criminal Code again, increasing sentences (now with one to six years in prison) and types of punishable behavior, following the model of international legislation. Although it punished illegitimate possession, it excluded possession for personal use. Law 17,818 of 1968 also regulated administrative matters related to narcotic drugs, in accordance with the Single Convention. That same year, a reform to the Civil Code included the possibility of requiring compulsory treatment for "addicts" in in-patient facilities and restricting their legal capacity.

Other provisions addressed assistance to users. In 1966, the Toxicology Assistance Fund (*Fondo de Ayuda Toxicológica*, FAT) was established in the toxicology department of the University of Buenos Aires School of Medicine, the first institution specializing in the treatment and rehabilitation of dependent drug users. In 1973, the National Social Re-education Center (*Centro Nacional de Reeducación Social*, CENARESO), the first specialized, dedicated, residential center for treating the use of these substances, was established. The first "communities of life" (*comunidades de vida*), communities formed by users, frequently connected with evangelical churches, were also established. In 1972, the National Commission on Addictions and Narcotics (*Comisión Nacional de Toxicomanías y Narcóticos*, CONATON) was created as part of the Ministry of Social Development. This may have been the first government agency charged with designing policies related to these substances.

As the decade went on, a new rhetoric emerged, that of "national security," based on similar arguments for the defense of societal norms, but now justified as attacks on the nation.

Those arguments were clearly seen in discussion of the first special law on narcotic drugs.[3] In 1974, Law 20,771 was passed, expanding penalties and the list of punishable offenses. Prison sentences for trafficking crimes increased from 3 to 12 years, and possession of drugs–even for personal use–was made punishable by one to six years in prison. Along with the criminal penalty, the possibility of ordering a "curative security measure" (compulsory treatment) for dependent users was also included. In short, drug use was treated as a crime and an illness.

This attitude was reflected in a 1978 Supreme Court decision (the Colavini ruling) that confirmed the constitutionality of punishing possession for personal use. That ruling associated "addiction" with "common and subversive crime" and identified it as a cause of "the destruction of the family, a basic institution of our civilization." It also equated users with traffickers and concluded that "anyone possessing a prohibited drug constitutes an indispensable element for trafficking."

In the 1980s, with the return to democracy, tension became evident between restoring the guarantees lost under the de-facto government and the emergence of a new concern: public security in urban areas.[4]

In 1985, the National Commission for the Control of Drug Trafficking and Drug Abuse (*Comisión Nacional para el Control del Narcotráfico y el Abuso de Drogas*, CONCONAD) was formed as part of the Ministry of Health and Social Action. The commission was made up of various ministries, as well as the armed forces, academics and well-known individuals and organizations. In 1986, the Supreme Court issued the "Bazterrica" ruling, declaring that punishment of possession for personal use, as addressed in Law 20,771, was unconstitutional. Also of significance, in 1982 the Catholic Church's "Journey Back" ("*Viaje de Vuelta*") treatment center was created; it became an important player in defining the issue, as discussed below.

Over the course of the 1980s, the human immunodeficiency virus (HIV) pandemic also broke out, particularly affecting injecting drug users.[5] This reinforced the tendency to see drug users as dangerous, because they could be possible transmitters of a pandemic associated with death.

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[3] The user ("addict") was identified as a person who, by giving in to his "vice," "not only destroys himself, but also ... causes harm to those around him." Users were equated with traffickers on the grounds that "any drug addict is potentially a drug trafficker; it is therefore necessary that, besides individual responsibility, the person be forcibly admitted to a treatment center." The behavior of both traffickers and users thus became "attacks on national security."

[4] Zaffaroni states: "Since 1985, there has been an onslaught under the guise of *public security ideology*, supported by advertising campaigns by mercenary communicators and political patronage operators. In the area of legislation, the urban or public security ideology translated into Law 23,737 of 1989 on narcotic drugs" (Zaffaroni et al., 2011, p. 186).

[5] The first case of acquired immunodeficiency syndrome (AIDS) attributed to injecting drug use was diagnosed in Argentina in 1985. By 1996, half of the AIDS cases among males over age 12 were attributed to sharing drug paraphernalia, according to bulletins published by the Ministry of Health.

But it was toward the end of that decade and the beginning of the next that the framework that would–and still does–mark the next two decades finished taking shape. The UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was signed at the end of 1988. It accentuated the punitive aspects of the international oversight system for those substances, including–with reservations–punishment of possession for personal use.

In mid-1989, the Programming Secretariat for Prevention of Drug Addiction and Combating Drug Trafficking (*Secretaría de Programación para la Prevención de la Drogadicción y Lucha contra el Narcotráfico*, SEDRONAR) was established. This secretariat in the office of the president, which gained additional powers over the years, became the main defender of that framework. The same year, a new special narcotics law (N° 23,737) was approved; it is still in force today. It again expanded the list of behaviors and penalties for trafficking crimes, this time with sentences ranging from 4 to 15 years in prison. Simple possession is punishable by one to six years in prison, and possession for personal use is punishable by one month to two years in prison, with the possibility of diverting the process to a "security measure" that is considered curative (for someone who is "dependent") or educational (for someone who is a "beginner" or who is "experimenting"). Once again, drug users were seen as both criminals and persons with an illness.

In 1990, a new Supreme Court decision (Montalvo) reaffirmed the constitutionality of punishing possession for personal use. It reflected both the defense of societal norms argument (a user with a contagious vice against which it is necessary to "protect the community" and equating users with traffickers) and the national security argument (drug use affects "the very survival of the nation").

During the 20th century, therefore, arguments regarding the defense of societal norms and a national and public security approach to the "drug" issue gradually accumulated, overlapped and were reinforced by the international drug control treaties. By the late 1980s and early 1990s, a "prohibitionist-abstentionist" framework had been created that was reflected in the criminal justice response and mainly targeted drug users. On the grounds that any use other than for "medical or scientific purposes" should be considered illicit, not only was more emphasis placed on controlling production and trafficking, but drug users were included in that category. They were thus defined as "criminals" and "sick." Images were created–contagious, vice-plagued, dangerous, people incapable of taking care of themselves or others–that drove coercive state responses, such as criminal law and diversion to residential or compulsory treatment.

As discussed below, however, that framework also disrupted or impeded the development of other, non-compulsory state responses to drug users. Despite various reform efforts, the framework not only persisted, but was reinvented.

2. Conditions and contradictions in implementation of the framework

The framework described above outlines a policy on illicitly used drugs that affects users in various ways. This section analyzes data about drug use and the questions raised by the development of a hegemonic discourse.

2.1. Data about use of narcotic drugs and other psychoactive substances

The development of this framework was plagued by a lack of information. Although a specific agency was created in 1989 to coordinate policies and Law 23,737 was passed, it took 10 years to compile initial information about drug use among the general population. The results indicated that "social drugs" (tobacco and alcohol) and even some medications used "illicitly" were more widely used than most "narcotic" drugs, and that one out of every 10 people (about 60,000) had used them at some time in their lives (SEDRONAR, n/d). Although there had been other studies—mainly surveys about use, although not always comparable with one another—it was not until 2005 that the Argentinean Observatory on Drugs (*Observatorio Argentino de Drogas*, OAD) was created as part of SEDRONAR and surveys were conducted that could be compared with the agency's previous studies. Nevertheless, various sources of information can be used to reconstruct the impact of the use of criminal law and other government responses.

Notably, behaviors related to alcohol and tobacco are regulated by administrative legislation, much of which has been developed in recent years. The national Law for Combating Alcoholism (N° 24,788) was passed in 1997 and its implementing regulations were

finalized in 2009.[6] In 2011, Law 26,687 was passed, regulating tobacco, and its implementing regulations were approved in 2013.[7]

2.2. Criminal law aimed at users

The main government response resulting from the "prohibitionist-abstentionist" framework has been punitive. Enforcement of the law on narcotic drugs and actions by criminal justice agencies has gained strength since the 1990s, and users have been the group most affected.

Information about actions by law enforcement agencies shows that prosecution of drug-related crimes has been increasing since the 1990s. Historically, this has been concentrated in major urban areas, particularly the city of Buenos Aires and the surrounding part of the province of Buenos Aires (greater Buenos Aires).[8]

Information from the city of Buenos Aires in the 1990s shows that prosecution of users who were transiting peaceably through public areas has been the common denominator. An analysis by the Ministry of Justice's Criminal Policy Office (*Dirección de Política Criminal*, DNPC) of 292 cases in 1996 found that 70.1 percent of the accusations involved possession of drugs for personal use (Art. 14, Paragraph 2 of Law 23,737), 23.9 percent were classified as simple possession of drugs (Art. 14, Paragraph 1 of Law 23,737), and only 4.7 percent involved crimes related to drug trafficking (with or without aggravating circumstances). That study made it possible to establish the following profile of the accused: male, young, Argentinean, single, without a criminal or prison record, arrested on the street, carrying less than five grams of cocaine or marijuana, who was not committing any other crime, and who carried no weapons (DNPC, n/d).

Except in some specific cases, users have not ended up in prison; however, contact with the criminal justice system has had–and continues to have–various repercussions.

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[6] This legislation prohibits selling to anyone under 18 and using in public places; violations are punishable by a fine or by closure of the establishment. It also prohibits drinking contests involving alcoholic beverages, which are punishable by six months to two years in prison -plus closure of the establishment- with injury or death considered aggravating circumstances. It also includes provisions related to advertising and transit and requires the health system to provide prevention, assistance and rehabilitation and creates the National Program for Prevention and Combating of Excessive Consumption of Alcohol, which was implemented in 2010.

[7] This prohibits—with some exceptions—"publicity, promotion and sponsorship of products made with tobacco, directly or indirectly, through any means of dissemination or communication." It also regulates the packaging and composition of products, as well as sale—prohibited to anyone under age 18—and specifies public places where smoking is prohibited. Violations of this law are punishable with fines, confiscation and destruction of the products or closure of the establishment.

[8] Corda, R. (2012). *Sistemas desproporcionados. Desproporción y Costos Económicos, institucionales y humanos de la política sobre estupefacientes en Argentina*. Buenos Aires: Intercambios, UBA.

Although jurisprudence has changed since the 2009 Supreme Court ruling in the Arriola case, which again concluded that the article punishing possession for personal use was unconstitutional as long as it "does not bring with it a specific hazard or harm to the rights or goods of third parties," gray areas remain. Moreover, police practices appear not to have changed much, as the text of the law criminalizing possession is still in effect.[9]

Apart from the outcomes of legal proceedings against users, contact with the criminal justice system—either during brief detention in a police station or through a criminal trial—can affect people in various ways. A previous study showed how users tend to be subject to abuse by security forces or suffer various consequences while in detention. Entering the criminal justice system, regardless of how the proceedings end, implies a stigma that tends to impede the exercise of other rights, such as obtaining employment or official documents.[10]

The situation of users who grow cannabis for their own use merits special attention. Judges' opinions are divided; while some treat this like possession for personal use and close the cases, other cases go to trial with the accused charged with drug trafficking. In some cases, people have spent some time (days or months) in prison, with the risk of a four-year prison sentence.[11]

2.3. The "abstentionist" model: injecting drug use and HIV in the 1990s

The dominant "prohibitionist-abstentionist" framework also conditioned the government's slow response to transmission of HIV among injecting drug users, who had to find their own ways to reduce the rate of death and illness among their population in the 1980s and 1990s.

Messages in prevention campaigns focused on abstinence. Campaigns such as "Sun without drugs" or "Why drugs?" advocated that people not start using drugs or give up drug use altogether. No option was provided for people who could not or did not want to stop using them. The latter category includes users of injecting drugs, which proliferated during the 1990s with the decrease in cocaine prices, especially in poor neighborhoods in Buenos Aires and the surrounding area.[12] This group was affected not only because drug users were

[9] Corda, R. (2010). "A un año del fallo 'Arriola'. Cambios, tensiones y resistencias," in: *XI Congreso Nacional de Sociología Jurídica y I Latinoamericano de Sociología Jurídica.* Buenos Aires: Sociedad Argentina de Sociología Jurídica – Universidad Nacional de Buenos Aires (UBA).
[10] Corda, R. (2012). *Sistemas desproporcionados. Desproporción y Costos Económicos, institucionales y humanos de la política sobre estupefacientes en Argentina.* Buenos Aires: Intercambios – UBA.
[11] *Ibid.*
[12] Touzé, G.; D. Rossi, P. Cymerman, N. Ereñú, S. Faraone, P. Goltzman, E. Rojas and S. Vázquez (1999). "Prevención del VIH-sida en usuarios de drogas. Resultados de un proyecto de investigación e intervención." Buenos Aires: Intercambios.

considered "criminals," but also because of the association with death that accompanied the spread of HIV/AIDS.

Despite this, SEDRONAR did not carry out specific studies about types of use that would inform either public policy on these substances or policies for prevention of infections transmitted by sexual activity or blood. Not until the late 1990s did the Ministry of Health estimate the number of injecting drug users (49,993 male and 14,565 female injecting cocaine users nationwide) and the number of them living with HIV/AIDS (between 12,137 and 34,538 people).[13] A comparative analysis of 22 studies of HIV in injecting drug users conducted in Argentina between 1987 and 1999, in different populations and using different methodologies, showed that more than 95 percent of injecting drug users who participated in those studies injected cocaine and that the HIV infection rate in that group ranged from 27 percent to 80 percent.[14]

Despite this situation, the implementation of different types of interventions, such as those based on harm reduction, was rejected. The head of SEDRONAR at the time said, "There are countries that give addicts disposable syringes '*to prevent contagion.*' Some voices have been raised in Argentina calling on authorities to do the same thing. And those same voices have protested our refusal. We are opposed because we are convinced that giving syringes to young people is the same as simply telling them, '*kill yourselves if you want to. You don't matter to us, as long as you don't kill anyone else*" (cited in Touzé, 2006: 72).

The lack of effective State response had fatal consequences for many injecting drug users and their relatives and friends in Argentina in the 1990s. Drug policy thus became trapped in a framework that meant it failed to comply with its stated objective of protecting "the health of humanity."

2.4. Treatment for use of narcotic drugs and other psychoactive substances

With regards to public health and treatment, responses for users of narcotic drugs went hand in hand with the "security measures" of criminal law, which affected their relationship with the health sector.

[13] Procupet, A. (2001). "Situación epidemiológica de los usuarios de drogas inyectables enfermos de sida en Argentina." In: *Ensayos y Experiencias*, Year 7 N° 39, *VIH/SIDA y Drogas: Reducción de Daños, Intervenciones comunitarias, Alternativas desde la educación*. Red Argentina de Reducción de Daños (REDARD),Novedades Educativas.

[14] Sosa Estani, S.; Rossi, D. and Weissenbacher M. (2003). "Epidemiology of HIV/AIDS in Injecting Drug Users in Argentina. Prevalence of Infection," in: *Clinical Infectious Diseases*, 37 (Suppl. 5), p. 338-342.

Although Law 23,737 was passed in 1989, it was not until 1995 and 1996 that laws 24,455 and 24,754 were passed, requiring both health insurance systems (workers' health organizations) and prepaid healthcare companies, which complement public health services, to cover HIV/AIDS treatment and provide "coverage for medical, psychological and pharmacological treatment of people who depend physically or psychologically on the use of narcotic drugs," as well as "coverage of programs for the prevention of AIDS and drug addiction."

Article 2 of Law 24,455 specifically referred to security measures in the following terms: "The detoxification and rehabilitation programs mentioned in Articles 16, 17, 18 and 19 of Law 23.737 must be covered by the health insurance system of which the person to whom the curative security measure will be applied is the beneficiary. In these cases, the judge must communicate the need for and conditions of treatment to the corresponding health insurance system." This consolidated the role of an actor outside of the health system—the criminal justice system—in the admission, treatment and release of users, even in sub-sectors of the private and public health insurance systems.

SEDRONAR also issued various regulations, either creating programs or setting minimum conditions for treatment programs, which were in line with the need to comply with those security measures. Some of those norms are based on the hemispheric drug strategy, adopted by the Organization of American States' Inter-American Drug Abuse Control Commission (CICAD), which stated that "demand remains a powerful driving force for the production of and traffic in drugs."

The association between narcotic drug use and crime appears to have been established through social constructs about narcotic drug use and drug users developed by specialists working on measures for addressing the issue. In one study by Intercambios between 2005 and 2008, many professionals explained that dependence led users to obtain substances any way they could, even by prostitution or crime, and referred to "addiction" as a growing problem that could end in death. These social constructs about drug use and users helped legitimize an assistance system centered on residential treatment for users, which could be compulsory. The social image of users as incompetent also limited the possibility of developing prevention and assistance programs that included users as subjects of rights (Galante, *et. al.*, 2006; Pawlowicz, *et. al.*, 2006).

3. Changes, proposals and resistance to the framework

The framework discussed here not only has determined state responses related to narcotic drugs, but it has also persisted in the face of various reforms or reform efforts in recent years. It has served to complicate or block reforms or has led to the proposal of alternatives that are presented as novel, but which turn out to be more or less the same approach in a different guise.

In mid-2012 there were eight proposals by various political groups for modification of the Narcotic Drugs Law, which would have eased criminal punishment of users and eliminated security measures. Some even proposed the decriminalization of small-scale dealers. Various responses to these proposals emerged. One former head of SEDRONAR (*Diario de Cuyo*, 2012). and various representatives of the Catholic Church (Diario Tiempo Argentino, 2012; Conferencia Episcopal Argentina, 2012) ended up supporting the inclusion of drug use in the criminal law as a means for referring users to treatment, although they paradoxically maintained that users should not be criminalized.

Drug courts, or drug treatment courts, supported by CICAD, have also been discussed as an alternative. Though they are presented as a new option, in reality drug courts adhere to the same concept of referring users to treatment through the criminal justice system, an approach that has proven its limitations and prejudices.

Conclusions and recommendations

Policies related to illicit use of drugs in Argentina have resulted from a "prohibitionist-abstentionist" framework that put users of those substances in the paradoxical position of being "criminals" and "sick." That framework took shape throughout the 20th century because of various hegemonic discourses–hygienist, social defense, national security and public security–which consolidated the government's response to drug in the early 1990s.

The main state response was punitive, resulting in the criminalization of the drug user population with consequences stemming from both contact with the justice sector and the difficulties that created in terms of social inclusion. In addition, prevention was framed only in terms of abstinence, with no attention to the possible problematic consequences of certain types of use, which were fatal among injecting drug users in the 1990s. Meanwhile, public health services were linked to the criminal justice response, reinforcing the latter's role in the provision of assistance to users.

Because of the consequences of government responses based on the framework described here, new approaches must be considered. Public policies based on principles different from those supported by this framework should be developed. Drug users should no longer be considered "criminal" and "sick" or "ill" and must become subjects of rights. Over the past decade, various actors–including users' groups, political movements, non-governmental organizations and even some government agencies (especially those related to health, education and justice)–have raised the issue of the rights of users. Debate has focused on the decriminalization of cultivation and possession of drugs for personal use, but the social consensus necessary to achieve this still appears to be lacking. Instead, initiatives such as drug courts appear to reaffirm the "prohibitionist-abstentionist" framework.

Recognizing that there can be different degrees of problems with drug use is important. These different degrees, along with other characteristics of use (type of substance, context, etc.) merit the development of various types of responses in terms of prevention, treatment and social integration. Whatever the response, however, it should never be linked to criminal punishment.

The use of criminal law to punish drug users only adds problems–due to the existence of criminal proceedings and their consequences–to those that may, or may not, have already existed. Draft legislation currently in congress should move ahead in an effort to remove drug users, including those who grow cannabis for their own use, from the scope of criminal law.

With regard to provision of health services to users, a shift is needed from a model that sees drug users as incompetent and dangerous to one based on the expansion of opportunities and assistance so that they have greater possibilities for caring for their health, whether or not they have decided to stop using drugs. To achieve this, guaranteeing assistance for particularly vulnerable groups is crucial, as is including users in the design and implementation of prevention and assistance programs.

Finally, public policies related to drugs should be based on scientific facts and ethical principles, with participation by civil society, academics and users of substances as subjects of rights.

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DRUG USE AND DRUG USERS IN BOLIVIA

Gloria Rose Marie de Achá

The purpose of this study is to illustrate the situation of drug users in Bolivia and institutional responses toward them. To date, both issues have been affected by the focus on interdiction and criminal punishment, while drug use itself has received little attention in the design and implementation of drug control policies.

In January 2006, the government of President Evo Morales announced a new drug policy under the slogan, "Coca, yes; cocaine, no," and launched a process known as "nationalization" of the drug control strategy implemented by the National Council for Combating Illicit Drug Trafficking (*Consejo Nacional de Lucha contra el Tráfico Ilícito de Droga*, CONALTID).[1] Within this framework, issues related to prevention, treatment and rehabilitation were included in the Strategy for Combating Drug Trafficking and Reaffirming the Value of the Coca Leaf 2007-2010 and the new Policy Strategy against Drug Trafficking and Reduction of Surplus Coca Crops 2011 - 2015. In general, CONALTID acknowledges that drug use in the country has increased, although it has not reached alarming levels.

1. Drug use and users

Although CONALTID is responsible for all areas of drug policy, little systematic information exists regarding drug use. Monitoring tools, such as the Bolivian Observatory on Drugs (*Observatorio Boliviano de Drogas*), are not yet operational. The following are the main available sources of information about drug use.

[1] The National Council for Combating Illicit Drug Trafficking (*Consejo Nacional de Lucha contra el Tráfico Ilícito de Droga*, CONALTID), which is made up of various ministries, is the highest-ranking Bolivian government agency responsible for defining and implementing policies for addressing the trafficking of drugs and controlled substances. Its task is to coordinate demand reduction; supply reduction; alternative, integral and sustainable development; control measures; the drug observatory; international cooperation; and program evaluation.

1.1. National data on drug use

Study of Drug Use in Bolivia 1992-2010 (CELIN)

A comparative study by the Latin American Scientific Research Center (*Centro Latinoamericano de Investigación Científica*, CELIN) of those between ages 12 and 65 provides drug use prevalence rates (the frequency with which an event occurs in the entire population). The study indicates that alcohol and tobacco use are the most widely used licit drugs and cannabis is highest among illicitly-used drugs. The following table shows prevalence by year.

Table 1. Prevalence of drug use in past year (absolute numbers)

Illicit Substances	2000	2005	2010
Cannabis	73.045	104.149	151.167
Cocaine base (*pasta base de cocaína*)[2]	37.009	60.726	80.704
Cocaine hydrochloride	37.740	52.238	90.127
Hallucinogens	17.531	3.918	8.193
Inhalants	87.897	29.710	43.425
Licit Substances	**2000**	**2005**	**2010**
Alcohol	2.110.021	1.989.924	2.490.776
Tobacoo	1.141.447	1.201.790	1.468.656

Source: Compiled by the author based on results of the CELIN study,
Drug Use in en Bolivia 1992-2010 (urban study – population ages 12 to 65 years)

CONALTID study of Drug Use Prevalence in Households - 2007

In 2007, CONALTID sponsored a study of the prevalence of drug use in households in 10 Bolivian cities. The results indicate that one of the main problems among Bolivians is the high use of licit drugs: alcohol is the licit drug with the highest rate of consumption in the country, followed by tobacco. Percentages of illicit use of drugs are far lower than those of alcohol and tobacco use.

[2] Please note that although different terminology may be used in different contexts, the Spanish term *pasta base de cocaína* has been translated throughout the text as cocaine base.

Andean Epidemiological Study of Drug Use in the University Population, Bolivia Report - 2012

Results of this study, coordinated by the Andean Community and conducted by the Organization of American States' Inter-American Drug Abuse Control Commission (CICAD), show an increase in cannabis use among Bolivian university students, from 2 percent according to a similar study in 2009 to 3.4 percent in 2012.

Assessment by the Vice Ministry of Social Defense and Controlled Substances– 2013

In late September 2013, the Vice Minister of Social Defense and Controlled Substances, Felipe Cáceres, presented the "National Plan for Reduction of Demand for Drugs in Bolivia 2013-2017,"[3] which contains an assessment of drug use–licit and illicit–in the country. The results indicate that alcohol and tobacco have the highest prevalence of use in the population. The figures for illicit use of drugs are based on earlier studies by CONALTID; the assessment shows the following data, by city.

Table 2. Annual prevalence of illicit use of drugs (percentage of population)

City	Cannabis	Inhalants	Cocaine base	Cocaine	Ecstasy
La Paz	15,2%	0,7%	0,1%	0,2%	0,4%
Cochabamba	5,9%	1,3%	0,1%	0,1%	0,0 %
Santa Cruz	1,8%	0,6%	0,0%	1,5%	0,0%
Oruro	0,8%	0,3%	0,1%	0,0%	0,0%
Chuquisaca	1,7%	0,3%	0,5%	0,1%	0,0%
Potosí	0,0%	0,0%	0,0%	0,0%	0,0%
Cobija	1,1%	0,8%	0,3%	0,0%	0,0%
Tarija	1,9%	0,3%	0,0%	0,1%	0,0%
Trinidad	0,5%	0,5%	0,0%	0,2%	0,0%
El Alto	0,5%	2,1%	0,0%	0,1%	0,0%

Source: *Viceministerio de Defensa Social y Sustancias Controladas – Secretaría del CONALTID* (2013) *"Plan Nacional de Reducción de la Demanda de Drogas en Bolivia 2013-2017"*

The assessment, however, offers no significant commentary on or interpretation of these data.

1.2. The approach to drug users

[3] Viceministerio de Defensa Social y Sustancias Controladas – Secretaría Técnica del CONALTID (2013).

Provisions of the Law on the Regime Applicable to Coca and Controlled Substances (Law 1008), which took effect in 1988, apply to drug users. Article 33 of Law 1008 defines drug use as the "occasional, periodic, habitual or ongoing use of controlled substances." This provision does not distinguish between problem and non-problem use, or between habitual and occasional use; on the contrary, it considers any drug user, even the occasional user, to constitute a risk or danger to society. Following that logic, Article 49 of the law establishes compulsory treatment for both dependent and occasional users.

As a result, although neither use nor possession of substances for personal use is a crime under Law 1008, it justifies the stigmatization and criminal prosecution of users. Possession of minimum amounts presumably for personal use opens the door of the criminal justice system to users. While use itself is not punished, Article 49 amounts to punishment of possession for personal use.

With this criminalization, issues such as the rights of drug users or harm reduction are sidelined from the national debate; therefore, no space exists for promoting an approach other than the prohibitionist and punitive response of Law 1008.

2. The regulatory framework

The following are significant aspects of the current regulatory framework related to illicitly used drugs.

Law on the Regime Applicable to Coca and Controlled Substances (Law 1008) of July 19, 1988

In addition to Articles 33 and 49, cited above, which define drug use and drug users, Law 1008 contains provisions referring to the so-called stages of "treatment, rehabilitation and reintegration into society."

Supreme Decree Nº 28631 of March 8, 2006, and Supreme Decree Nº 29894 "Organizational Structure of the Executive Branch of the Plurinational State" of February 7, 2009

Both establish government ministries' functions with regard to drug use. The Ministry of Health and Sports is responsible for designing policies, strategies and plans for prevention, rehabilitation and reintegration of people with drug dependencies.

Supreme Decree Nº 0649 of September 29, 2010

This decree modifies the structure of the National Council for Combating Illicit Drug Trafficking (*Consejo Nacional de Lucha contra el Tráfico Ilícito de Droga*, CONALTID).

3. Institutional responses

3.1. Historical background

In Bolivia, as in other countries in the region, institutional responses to illicit use of drugs, in terms of prevention, treatment and rehabilitation, were implemented as part of a criminally oriented drug control system supervised by police and the Ministry of the Interior.

The first formal law on drugs in Bolivia was the Narcotic Drugs Law signed on January 10, 1962. In 1973, the National Office for Control of Hazardous Substances (*Dirección Nacional de Control de Sustancias Peligrosas*, DNCSP) began functioning as part of the Ministry of the Interior, Immigration and Justice to respond to the increase in drug production and trafficking. Secondarily, it was given responsibility for prevention, treatment and rehabilitation. In 1975, the National Institute of Research on Drug Dependency (*Instituto Nacional de Investigación en Farmacodependencia*, INIF) was created under the DNCSP to oversee treatment and rehabilitation.

In the area of drug use prevention, according to the Vice Ministry of Social Defense and Controlled Substances, "between 1979 and 1980, preventive actions focused on a government initiative, carried out by the Prevention Department of the National Police's Office of Control of Hazardous Substances, which was part of the Ministry of the Interior" (*Viceministerio de Defensa Social y Sustancias Controladas*, 2013). The National Office of Integral Prevention of Drug Dependencies and Mental Health (*Dirección Nacional de Prevención Integral de Drogodependencias y Salud Mental*, PREID) later took charge of these efforts and "between 1982 and 1984, preventive actions began with funds from the Embassy of the United States of America for social mobilization and publicity campaigns" (*Viceministerio de Defensa Social y Sustancias Controladas*, 2013).

In 1986, the National Office of Integral Drug Abuse Prevention, Treatment, Rehabilitation and Reintegration into Society (*Dirección Nacional de Prevención Integral del Uso Indebido de Drogas, Tratamiento, Rehabilitación y Reinserción Social*, DINAPRE) began

operating, and Councils on Prevention, Treatment and Rehabilitation of Drug Dependence (*Consejos de Prevención, Tratamiento y Rehabilitación de Drogodependencia*, COPRE) were created in each department. In 1995, the COPRE in the department of Tarija became the National Institute of Drug Dependence and Mental Health (*Instituto Nacional de Drogodependencias y Salud Mental*, INTRAID), which is now one of the few centers in the country that specializes in treatment and rehabilitation.

3.2. Government policies and programs

The Bolivian government's greatest progress on matters related to drug use appears to be in the area of prevention, through national and departmental campaigns and training and information programs targeting different sectors of the population. These are organized by agencies of the executive branch (including the Special Force for Combating Drug Trafficking, as described below) and local governments.

The goals of the Strategy for Combating Drug Trafficking and Reaffirming the Value of the Coca Leaf 2007-2010 included strengthening public policy for the prevention of drug use and treatment of dependent users. It is not known if any evaluation was done that might indicate how well that goal was met. Nevertheless, the new government strategy, called the Policy Strategy against Drug Trafficking and Reduction of Surplus Coca Crops 2011-2015, reported progress in strengthening local governments to take action to prevent drug use. The agency responsible for promoting those actions was the Ministry of Interior's Vice Ministry of Social Defense and Controlled Substances, which functions as an operational arm of CONALTID.

The Vice Ministry of Social Defense and Controlled Substances also oversees the Special Force for Combating Drug Trafficking (*Fuerza Especial de Lucha contra el Narcotráfico*, FELCN), a police force charged with interdiction of drug trafficking. It is also responsible for national drug use prevention activities, including workshops and demonstrations against drug use and drug trafficking.

The Ministry of Health's minimal participation in prevention, treatment and rehabilitation activities is noted by the CICAD Evaluation Report on Bolivia's Progress on Drug Control for 2007 to 2009. The report notes that although the Ministry of Health and Sports is responsible for designing and implementing public policies related to drug abuse, during the study period that ministry did not have budget funds allocated to treatment programs (CICAD-OAS, 2009).

3.3. National Plan for Reduction of Demand for Drugs 2013-2017[4]

In September 2013, the Vice Ministry of Social Defense and Controlled Substances presented the National Plan for Reduction of Demand for Drugs in Bolivia 2013-2017, implementation of which will require an investment of US$49.9 million.[5] Its drafting created a venue for inter-agency coordination in which the Ministry of Health and Sports also participated, although the Vice Ministry of Social Defense and Controlled Substances continues to take the lead on this issue.

3.4 Bolivian Observatory on Drugs

In 2004, the Bolivian Observatory on Drugs (*Observatorio Boliviano de Drogas*) was created by a multi-ministerial resolution to promote research and generate specialized information about drugs as part of the national strategy for 2004-2008. It operated for four years, until 2008. Its reactivation has been pending since then; so far no action has been taken, even though the observatory is an essential tool for developing policies to reduce drug use.

3.5. Private institutions

Treatment and rehabilitation in the country is mainly provided through private initiatives. "Since the mid-1980s, some centers were in operation providing religious-oriented therapy or operating as shelters," according to the Bolivian Association of Therapeutic Communities (*Asociación Boliviana de Comunidades Terapéuticas*, ABCT).[6]

The National Plan for Reduction of Demand for Drugs notes that in 1998, the then-Vice Ministry for Prevention and Rehabilitation drew up the first list of organizations implementing so-called "treatment and social reintegration" programs, which showed that 62 percent of the centers were evangelical organizations, 14 percent were professional medical centers, 10 percent were interdisciplinary centers, 7 percent were non-professional centers and 7 percent were Catholic centers (*Viceministerio de Defensa Social y Sustancias Controladas*, 2013).

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[4] Viceministerio de Defensa Social y Sustancias Controladas – Secretaría Técnica del CONALTID (2013)
[5] http://www3.abi.bo/nucleo/noticias.php?i=2&j=20130925132455
http://www.unodc.org/bolivia/es/stories/presentacion_plan_reduccion_demanda_de_drogas.html
[6] http://abct-bolivia.org/historia.html

According to the national plan, the centers "often use methodologies that are inappropriate and not in accordance with the user's situation, which led to a low success rate as of the exit year: 14 percent" (*Viceministerio de Defensa Social y Sustancias Controladas*, 2013).

4. Criminalization of Users

"Because there is no organized (police-type) campaign against users that searches places where drugs are used, the drug addicts caught by the radio-cruiser patrol are those who are found in the street or are the subject of complaints because of their behavior; the others are protected by cultural tolerance or because their families cover for them, or are simply abandoned." This statement was made in the 1978 Report on Drug Abuse and Prevention and Education Measures in Bolivia, prepared by the DNCSP with support from UNESCO (DNCSP/UNESCO, 1978).

As of 1976, because of an administrative regulation, drug users were required to pay a fine to the Ministry of the Interior, consolidating the process that labeled them "deviant subjects" and made them the object of criminal punishment.

4.1. Precedents in the "Law of Vagrants and Idlers"

> *In October 1986, Roberto Pérez Franco, who had been sent to the Espejos Rehabilitation Farm because of his drug addiction, went with a work crew to do forced labor. He was very weak and collapsed along the way. The police officer guarding him hit him in the ribs with a stick. He managed to reach the work place, but collapsed again, upon which the same police officer hit him again twice on the back of the neck. Roberto suffered violent convulsions and died* (Amnesty International, 1990).[7]
>
> *In July 1988, Edwin Parada Vaca, a student who was addicted to drugs and was sent to the Espejos Farm at his family's request, was murdered after attempting to escape. "They took us all to the river to wash our clothes, ... he was with the group that was led by Solíz. He made him cross to the riverbank and told him to assume the "tripod" position [with hands behind his back, bent forward so head touched the*

[7] Amnesty International: Report, *Bolivia: tortura y ejecuciones extrajudiciales de detenidos en la Granja de Espejos*, 1990. Available at: https://www.amnesty.org/es/library/asset/AMR18/002/1990/es/cb66f105-ee6d-11dd-96f1-9fdd7e6f4873/amr180021990es.html

ground] on top of a rock, and fired at the ground, which frightened him, and he said, "No, my corporal, don't do this to me." He ordered him to assume the "tripod" position again, firing a second shot that struck him in the leg, and then a third that hit him in the ribs. ... Another police officer was there. He took the revolver away from Corporal Solíz and, so that he would not suffer, he shot Edwin in the back of the neck, killing him instantly" (Amnesty International, 1990).[8]

In 1951, Decree Law Nº 2740 gave the Bolivian police the power to identify people as "vagrants and idlers" through police courts, a provision formalized by the Organic Law of the National Police of April 8, 1985. In fulfillment of those provisions, the police conducted regular sweeps in which they tended to arrest drug users, who were then determined to be vagrants and idlers and were sent to rehabilitation farms operated by the police.

The farms were closed thanks to investigations by international organizations, which proved reports of murder, torture, forced labor and other violence used, at the discretion of the police, against those incarcerated there. "The case that made the biggest impression on me was in Bolivia, in Santa Cruz de la Sierra, and involved the Espejos Farm, in 1989[…] It operated like a concentration camp under the command of Colonel Camacho and 30 guards, with 120 to 130 boys detained in conditions of slavery. We found people who had died and were buried there, and found that they allowed prisoners to try to escape, then shot them as they did so […] we recorded information about 53 graves, we exhumed 5, and it was determined that all had died by violent causes. There was an immediate intervention, and Camacho was sentenced to 17 years in prison. The farm was closed and the law was abolished."[9]

4.2. Implementation of Law 1008

Juan Sergio is 23 years old, is a habitual user of cocaine base and has been incarcerated for 10 months in San Sebastián Prison in Cochabamba, accused of the crime of drug trafficking, and could be sentenced to 10 to 25 years in prison. He was arrested on the street, in a police sweep, when he had just bought one gram of base for his personal use. He was taken to the FELCN along with the other people detained

[8] Amnesty International, Ibid.

[9] Interview with Alejandro Inchaurregui, forensic anthropology expert. Available at: http://w1.lmneuquen.com.ar/08-04-06/n_sociedad10.asp

in the operation, and like them was accused of the crime of drug trafficking and sent to prison as preventive detention. After he had been in detention for several weeks, representatives of organizations that work with young drug users talked with the prosecutor about the possibility of considering Juan Sergio a drug user, thus avoiding a sentence for trafficking. Juan Sergio had to wait several more weeks for toxicological tests to be done, because the legal paperwork was slow and because he did not have money to pay for the tests. The results of the toxicological tests finally reached La Paz, and they classified him as a habitual drug user. He is now waiting for the legal paperwork to speed up so he can be excluded from the drug trafficking case and freed.

The case of Juan Sergio is an example of the criminalization of drug users under Article 49 of Law 1008, which states that the minimum amount for immediate personal use will be determined after a ruling by two experts from a public institute on drug dependency. If the amount is greater than that deemed necessary for personal use, it falls under the classification in Article 48 of the law corresponding to drug trafficking, which is punishable by 10 to 25 years in prison.

To avoid being accused of drug trafficking, a habitual drug user must prove that the amount in his or her possession was for personal use. In Cochabamba, an average of three cases a week are referred by the FELCN to the Viedma Hospital's Toxicology Center for such tests; in 50 percent, the outcome is positive for drug use. There have been cases of people detained for carrying only half a marijuana cigarette. Besides blood and urine tests, there is the possibility of testing hair; that test is more expensive, however, and is only done at the toxicology laboratories of the Forensic Investigations Institute (*Instituto de Investigaciones Forenses*, IDIF) in La Paz.

The people who do not avoid criminal prosecution are habitual users who sell small amounts of drugs to support their personal use. Because Law 1008 does not include the category of small-scale sale dealing; those people must therefore be charged with drug trafficking.

Based on data provided by FELCN, the National Statistics Institute (*Instituto Nacional de Estadística*, INE) records the following data about people arrested for possession of drugs, for drug trafficking and for investigation.

Table 3. Persons arrested for possession of drugs, by type of drug

Description	2005	2006	2007	2008	2009	2010	2011
Bolivia	951	837	998	807	654	823	1.246
Cocaine Hydrochloride				38	34	35	41
Cocaine base				369	296	325	452
Cannabis				400	324	463	753

Source: National Statistics Institute (*Instituto Nacional de Estadística*, INE)

Possession of drugs, understood as the possession of the amount for personal consumption, is not classified as a crime in Bolivia. If the quantity possessed exceeds the personal use amount, however, legislation allows for two possibilities: It is either for use or for trafficking. That reasoning provides the basis for detention, after police arrest, of people found to be in possession of an illicit substance.

Table 4. Persons arrested for drug trafficking, by type of drug

Description	2005	2006	2007	2008	2009	2010	2011
Bolivia	2.314	2.381	1.806	1.447	1.865	1.373	**1.598**
Cocaine Hydrochloride				230	286	242	262
Cocaine base				1.125	1.329	939	1.048
Cannabis				92	250	192	284

Source: National Statistics Institute (*Instituto Nacional de Estadística*, INE)

In contrast to arrests for drug possession, as shown in Table 3, cannabis is less prevalent in arrests for drug trafficking; 65 percent of people arrested were detained for trafficking of cocaine base, only 17 percent for trafficking of cocaine hydrochloride and another 17 percent for cannabis.

A more in-depth analysis is impossible because of the lack of available official information and because the existing data are not specific enough or broken down.

4.3. Plan Chachapuma

On April 19, 2013, the Public Security Plan known as Chachapuma ("puma man," in the Aymara language) was launched. According to the commander general of the police, General Alberto Aracena, "The police will work to arrest people who sell and consume alcohol openly

on the street or in hotels. As an institution responsible for the public order, we will not allow minors to be poisoned with alcohol and drugs."[10]

Interior Minister Carlos Romero reported that crime rates decreased in the past two months as a result of Plan Chachapuma. "The curve decreased by 70 percent in the department of Santa Cruz", he said, and he did not rule out the possibility of achieving similar results in all regions of Bolivia.[11] However, the overall data reported about the operations carried out and the number of people arrested does not seem to indicate an effective decrease in crime rates.

In any event, the constant comments by police officials responsible for Plan Chachapuma about arrests for the use of drugs used licitly and illicitly shows that the government continues to see drug use as a law enforcement issue.

4.4. Drug use in prisons

A study carried out in 2007 in prisons by the Latin American Scientific Research Center (*Centro Latinoamericano de Investigación Científica*, CELIN) indicated that 25 percent of the prison population used cocaine (13 used cocaine base and 12 percent used cocaine hydrochloride). A recent study by the General Penitentiary Office (*Dirección General de Régimen Penitenciario*) establishes that 38 percent of the country's prison population uses cocaine, "a situation that makes it impossible for inmates to begin timely rehabilitation," according to the director general of the Penitentiary Office, Ramiro Llanos.[12]

Whether or not the General Penitentiary Office will implement specific programs for prevention of drug use or for treatment and rehabilitation, however, remains to be seen. Nor is it known if any evaluation has been done of the police's performance in guarding penitentiaries or whether prison staff members responsible for allowing drugs into prisons have been punished. Given the situation in the prisons, it is crucial for the government to assume its responsibilities.

[10] http://www.eldiario.net/noticias/2013/2013_06/nt130619/sociedad.php?n=77&-policia-intensifica-operativos-con-el-plan-chachapuma

[11] http://eju.tv/2013/06/romero-comportamiento-criminal-disminuy-en-santa-cruz-gracias-al-plan-chachapuma/

[12] http://www.opinion.com.bo/opinion/articulos/2013/0709/noticias.php?id=99998

Conclusions and recommendations

"Drug addicts end up in mental hospitals or with religious groups," said a news report published in *La Razón* in June 2003. Eleven years later, the situation is much more serious, as drug users can be sent into the criminal justice system or rounded up by police.

This approach ignores discussion of the cultural, social, family and individual factors related to drug use and the fact that the drug issue exists within the framework of social interaction. Meanwhile, drug users continue to be scapegoats for a society faced with the problem of use of psychoactive substances, towards which the government has taken an authoritarian approach. The government's response is mainly in the hands of the police and the criminal justice system. Lack of information is also a problem, with an Observatory that is not operating. Other problems include lack of public responses, since most treatment programs are private efforts, lack of government oversight of the private sector and an obvious lack of budget funds.

Given this situation, the following recommendations are proposed:

- The current approach–which only criminalizes and stigmatizes drug users without contributing to a reduction in levels of drug use–should be modified.
- Drug policy must take into account the rights of users, and supervising both public and private treatment and rehabilitation programs must therefore be a priority.
- Legal reforms are necessary, including the repeal of Law 1008, which makes addressing drug use and abuse the responsibility of the police. Prevention, treatment and rehabilitation must be part of public health policy.

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State Responses to Drug Use in Brazil: A Critical Analysis of Criminal and Civil Public Policies[1]

Luciana Boiteux and João Pedro Pádua

One of the weakest links in the chain of government action on drugs (especially illicitly used drugs) is the user, who is targeted by a punitive State through the criminalization of drug-related behaviors. Users are also the targets of a paternalistic State[2], which treats them as sick people who must be "reintegrated into society" or made the objective of "assistance networks" simply because they use drugs that are considered illicit.

The purpose of this text is to investigate the regulatory structure and operation of Brazil's paternalistic approach to users of some drugs, with an emphasis on practical outcomes identified through official data.

1. Regulatory frameworks for punitive control over drug users

The health-related legal framework as applied to drugs in Brazil (including prevention, assistance and reintegration into society) is a wide and complex tangle of various levels of legal norms, with many contradictions and asymmetries, as described below.

The history of the punitive approach to drug control in Brazil is marked by the influence of the international conventions. Until the end of the 19th century, the issue had little importance, because the prohibition of marijuana in Rio de Janeiro in 1830 was considered an exemplary measure for controlling the large black and slave population in what was then the country's capital (Fiore, 2007).

In the 1930s, cannabis was added to the list of prohibited substances, instigating its use was made a crime, and the penalty for selling illicitly used drugs was increased to five

[1] This study was carried out with assistance from student researchers from the Drug Policy and Human Rights Research Group of the FND/UFRJ Human Rights Laboratory: Luciana Peluzio Chernicharo (Master's student, PPGD/UFRJ, CNPq fellow), Natalia Sant'anna (UFRJ PIBIC/CNPq fellow), Roberto Brito (Young Talent/UFRJ/CNPq fellow) and Kathleen Feitosa (graduate, FND/UFRJ). The authors would like to thank colleagues who reviewed the paper, Luis Fernando Tofoli, professor of the School of Medical Sciences of the State University of Campinas and Dênis Roberto da Silva Petuco, doctoral candidate in the graduate program of social sciences at the Federal University of Juiz de Fora, for their valuable contributions to the final version of this paper.

[2] "Paternalism" refers to any government action that seeks to use coercive juridical norms to impose on citizens a certain ethical conception of what constitutes a good and decent life. In the case of users of drugs that are considered illicit, paternalism takes these two forms: It imposes conceptions of what is good by punishing behaviors contrary to that view and it reinforces concepts of what is good through the creation and proliferation of an assistance (and health) network.

years. Since then, significant oscillation has taken place regarding criminalization of users. The 1932 Compendium of Criminal Laws listed the crime of "sale of narcotic drugs." The Law on Oversight of Narcotic Drugs (1938) considered "possession," but not use, of illicit substances without a medical prescription to be in violation of the law, punishable by a penalty similar to the one for trafficking, from one to four years. The 1940s brought a change in the criminal regime applicable to drug users, as possession of drugs for personal use was decriminalized in the 1940 Criminal Code.

Between the 1930s and 1950s in Brazil, forced treatment, including compulsory residential treatment, was stipulated for drug users. The prevailing view was that the user was sick, needed treatment and should not be sent to prison; meanwhile, penalties for the sale of drugs grew progressively more severe. The predominant view, therefore, was medical and hygienist–not only with regard to drugs, but also with regard to behaviors generally regarded as marginal (such as gambling). That hygienist view served as the inspiration for compulsory residential treatment that still exists as public policy today.

In 1968, during the civilian-military dictatorship, 13 days after Institutional Act- 5 which closed the Brazilian Congress,[3] Decree Law Nº 385/68 was issued. It again criminalized the possession of drugs and equated it with the crime of trafficking, with penalties of one to five years in prison and a fine. That regime remained in effect until the passage of Law Nº 6.368/76, which replaced the earlier legislation and revoked Article 281 of the Criminal Code.

Despite differentiating the behavior of the user from that of the trafficker, the 1976 law, which was in force for 30 years, described "new stereotypes and a new legitimizing of punishment," with stigmatization of the "internal enemy"–the drug trafficker–while making penalties for the user more flexible, which characterized drug control efforts in Brazil from then on.

During the transition toward democracy, criminal policies ironically became harsher with the inclusion of the concept of "aberrant crimes"[4] in the text of the newly promulgated 1988 Constitution (Article 5, XLIII of CF/88) and the equating of "traffic of narcotic drugs" with this type of crime in the Aberrant Crimes Law (Nº 8,072/90).

[3] Acto Institucional Nº 5 of December 13, 1968, which reduced guarantees and closed Congress. The Civilian-Military Coup occurred in Brazil in 1964.

[4] "Aberrant crimes," as subsequently define in Law No. 8.072/1990, have a much harsher legal regime than other crimes under Brazilian law. Among other things, cases involving these types of crimes subject defendants to longer prison terms, have harsher prison regimes and are not subject to presidential pardon.

After 30 years, a significant change occurred when Law Nº 11,343/06, which is still in force, depenalized[5] drug use in Brazil. This law, established by SISNAD,[6] was considered progressive. It stipulates abuse-prevention measures, as well as assistance and reintegration into society for drug users and addicts; norms were established to punish the unauthorized production and illicit traffic of drugs; and new crimes were defined, such as the shared use of drugs and collaboration with drug trafficking. This law contains significant positive principles and recognizes users' rights related to autonomy and freedom; it also takes an interdisciplinary approach to the issue. Guidelines are also stipulated for prevention of drug use, such as "recognition of risk reduction," which is considered an important difference between this law and the one from 1976.[7]

The greatest novelty in the 2006 law, however, was the depenalization of possession and cultivation of plants for personal use. Under this law, there is no longer a possibility of a prison sentence for those identified as users, who are only subject to alternative penalties. Intermediate categories of crimes formerly equated with drug trafficking, such as inducing/instigating use or shared use of drugs were also introduced, with reduced sentences.

Despite the legal provisions for depenalization, the law does not contain objective criteria for differentiating a user from a trafficker; this is left to the police and judiciary to determine subjectively. The law therefore did not change the profile of people convicted for drug crimes in Brazil; instead, it actually led to an increase in the penalty for drug trafficking from three to five years in prison. This, in turn, is one of the main factors behind the increase in Brazil's prison population in recent years.[8] Of particular concern, many users are now incarcerated as traffickers.

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[5] The term "depenalization" is used here as a synonym for "de-imprisonment," equivalent to replacing a prison sentence with alternative sanctions. Under Article 28 of the drug law, there is no provision for incarceration as a penalty for this crime; alternative sanctions are the only option. This was the term most widely used in Brazil (it even appears in an appeals ruling by the Federal Supreme Court, which addressed the matter in RE 430.105, handed down on February 13, 2007, Rel. Min. Sepúlveda Pertence).

[6] National System of Public Drug Policies (*Sistema Nacional de Políticas Públicas sobre Drogas*).

[7] See: Boiteux, Luciana (2006b). *A nova lei antidrogas e aumento da pena do delito de tráfico de entorpecentes* [A new anti-drug law and the increase in the penalty for the crime of drug trafficking]. *Boletim IBCcrim.* 167 (14), October, p. 8-9.

[8] Incarceration for drug trafficking crimes increased by about 111 percent after the 2006 law took effect. *Cf.* Boiteux, Luciana and João Pedro Pádua (2013). *A desproporcionalidade da lei de drogas: os custos humanos e econômicos da atual lei de drogas no Brasil* [Disproportionality of the drug law: the human and economic costs of the current drug law in Brazil]. Rio de Janeiro: UFRJ and Psicotropicus.

2. Public policies and problem drug use

In Brazil, the government officially adopted two "National Plans", in 2002 (during the government of Fernando Henrique Cardoso) and in 2005 (during the Lula government), which contain general guidelines for state policy on the subject.

The 2002 plan (corresponding to Executive Decree Nº 4,345/02) established a policy divided into the traditional triumvirate of prevention, treatment and punishment. The alarmist and emotional tone is notable, as reflected in the following excerpt from the plan: "Inappropriate use of drugs is currently a serious and persistent threat to humanity and the stability of the political, economic, social and cultural structures and values of all states and societies." The plan even mentioned "adverse effects created by drug abuse [such as] the association of traffic of illicit drugs and related infractions, generally transnational in nature, with crime and violence."

The official policies of 2002 defended the drug supply reduction model as a goal to be attained through criminal justice procedures. At the same time, it made prevention a priority, referring, although timidly, to a harm reduction strategy implemented in conjunction with demand reduction strategies.

In 2005, during the Lula government, a new National Policy on Drugs was drawn up. In general, this policy placed priority on "prevention of drug abuse, as a more effective and less costly intervention for society," and stipulated "the right of every person with problems stemming from drug abuse to receive adequate treatment." It also recognized the "differences between a user, a person who abuses, an addict and a drug trafficker." Perhaps the most important point of the National Plan of 2005 was the recognition of the "harm reduction strategy stipulated by Article 196 of the Federal Constitution, as a measure for preventive intervention, assistance, and promotion of health and human rights," and the fact that the latter was regulated in the chapter on guidelines.[9]

The prohibitionist approach, although more moderate, was maintained with "reduction of the drug supply by the coordinated and integrated action of the bodies responsible for criminal justice procedures (...) that seek to implement punitive actions and bring criminal charges against those responsible for the production and traffic of prohibited substances." Punitive and unrealistic security policies continue today, with the idea of

[9] The 2005 plan outlined principles of the system, as well as guidelines for implementing those principles. It should also be noted that even before the drug plan was drafted, the Ministry of Health had issued Decree Nº 1.028 of July 1, 2005, which finally provided regulations for Brazil's, harm reduction policy.

"effective" punishment. In short, both national plans contain criminal and punitive policies outlined in general measures, most of which are punitive.

Brazil is currently undergoing a period of change, with marked contradictions. On the one hand, those opposed to mental hospitals are promoting the implementation of measures that are leading to the gradual disappearance of insane asylums and a decrease in the number of beds in psychiatric hospitals. On the other hand, a public policy on crack is being developed that favors compulsory treatment of users in private centers, which constitutes an intensification of the conservative hygienist mindset that characterized legislation in the first half of the 20th century.

Harm reduction policies are defined as any assistance strategy targeting people who cannot or do not want to stop using drugs. Policies include the adoption of safer strategies for use, as well as social, educational and health policies that do not require abstinence.[10] Although recognized in laws and regulations, harm reduction efforts are still rarely implemented in the country.

In Brazil, drug policies have taken two opposite directions. While official criminal justice policy has become increasingly punitive for traffickers, public health policy has advanced in the adoption of more humane measures that recognize and guarantee the rights of users. This is due to the close link between harm reduction and the movement opposing mental hospitals, which share an "ethic of care" and respect for the rights, individual liberties and personal autonomy.

Similarly, in the face of the AIDS epidemic in the 1990s, pioneering pilot programs were implemented in the country for distribution of syringes to users of injected cocaine.[11] Various Brazilian municipalities adopted that policy as a public health strategy, with good results.

According to Andrade (2011), however, the evolution of harm reduction policies in Brazil has not been linear; there has been a decrease in the number of programs since 2004. The reasons are diverse and range from the decentralization of funding of programs for states and municipalities to a lack of specific regulations other than the generic decree of 2005.

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[10] Petuco, Dênis Roberto da Silva (2001). *Entre imagens e palavras. O discurso de uma campanha de prevenção ao crack* [Between images and words. The discourse of a campaign for prevention of crack use]. Master's thesis submitted to the Graduate Program in Education at the Federal University of Paraíba. Available at: http://denispetuco.com.br/imagensepalavras.pdf

[11] After these initiatives, between 1995 and 2003 more than 200 harm reduction programs began in the country. *Cf.* Andrade, Tarcísio Matos de (2011). *Reflexões sobre políticas de drogas no Brasil* [Reflections on drug policies in Brazil]. *Ciência & Saúde Coletiva*, 16 (12), 4665-4674. Available at: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S141381232011001300015&lng=pt&tlng=pt.10.1590/S1413-81232011001300015. Retrieved January 4, 2014.

Although the most progressive harm reduction measures–such as substitution treatment and drug consumption rooms–are not prohibited under Brazilian law, the lack of regulation of those measures makes it difficult to obtain funding for them and can even lead promoters of harm reduction to fear retaliation from authorities, as has occurred in the past.[12]

In mental health policy, one advance is Law Nº 10,216/2011 (Psychiatric Reform Law), which addresses the rights of patients with mental health problems. That law resulted from a campaign waged by the movement against insane asylums in Brazil, which has opposed the commitment of patients to psychiatric hospitals like the asylums that were common in the past. This law stresses an open format for treatment and states that internment should be the last resort. The law considers in-patient treatment in institutions to be harmful to people with mental illnesses. It also establishes principles for care and sets out the rights of patients.

Brazilian law currently provides for three basic types of referral to in-patient treatment: voluntary, involuntary[13] and "compulsory."[14] Compulsory treatment is defined as exceptional, although it can be ordered "by the competent judge" as long as legal due process is guaranteed and with the active participation of the patient or his or her representative.

Since 2001, recognition of drug users' rights has been part of the regulatory framework for health care, even when the person is in a healthcare network. One important discrepancy from this overall scenario, however, is Brazil's policy on crack, which is influenced by media handling of the topic.[15]

As noted previously, Brazil's legal framework for health, as it relates to drugs, is a broad and complex tangle of various levels of legal norms, with many contradictions and asymmetries. To understand the place of these norms in Brazilian law and how they shape the system for legal treatment of drug use and users of licit or illicitly used drugs, the legal definition of a drug user, the institutional design of the government's health-related efforts, and the development of norms related to crack are reviewed below.

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[12] Around 1989, a group of professionals that implemented the first needle-exchange program in Brazil—in the city of Santos, in the state of São Paulo—was the target of a criminal lawsuit by the local Public Ministry, which accused it of instigating drug use. The case was dropped, but the program was ended.

[13] Involuntary treatment also depends on the patient's will, but is prescribed by a doctor for a specific patient and is subject to mandatory oversight by the Public Ministry, which must be notified within 72 hours.

[14] Under Brazilian law, "compulsory" treatment is ordered by a judge, based on "the security conditions of the establishment for the protection of the person who is ill, other patients and the employees."

[15] For more on criticism of the implementation of Law 11.216/01 for crack users, see Boiteux, Luciana (2013). *Liberdades Individuais, Direitos Humanos e a Internação Forçada em Massa de Usuários de Drogas* [Individual Liberties, Human Rights and Massive Forced Treatment of Drug Users"]. *Revista Brasileira de Estudos Constitucionais (RBEC), 25 (7), January-April*, p. 53-80.

As noted previously, the 2005 plan recognized the need to differentiate types of drug users based on their patterns of use. As expected, therefore, the regulatory framework for prevention and assistance to drug users considered that distinction. Nevertheless, there is great variation in this area. Of all the norms studied,[16] only two[17] establish a legally relevant distinction between drug users who are not dependent or problem users and those who are. Significantly, one of the two legal norms establishing this distinction is related to a licitly used drug: alcohol. There is a clear contrast between the regulatory framework for licitly used drugs and regulatory frameworks for illicitly used drugs, in terms of distinguishing between responsible use and problem/dependent use.

Following the spirit of earlier norms, the Drug Law Nº 11,343/06 divides the government's health-related action on drugs into two areas: "prevention" and "assistance and reintegration into society," and implements harm reduction as a component of both. A breakdown of "treatment," which falls under "assistance and reintegration into society," follows the health-related institutional configuration that guides the Ministry of Health's actions.[18]

Those components should be consistent with each other and have complementary goals, according to each patient's situation. One notable component is "specialized psychosocial assistance," including Psychosocial Assistance Centers (CAPs, for their Portuguese initials), and "temporary residential assistance," which includes so-called therapeutic communities. With regards to crack, these take the form of compulsory drug treatment centers.

In 2010, however, the national policy took an even more conservative turn with Decree Nº 7,179/2010, which established the "Integrated Plan for Combating Crack," during the last year of the Lula government. Created at a time when there was considerable public alarm about an alleged crack "epidemic," it is noteworthy that this plan was drafted in the

[16] For more detail about this analysis, see the full version of this study.

[17] CONAD Resolution 3/2005, which establishes the National Plan on Drugs (currently in force), and Decree 6.117/2007, which defines the main principles and preventive objectives of the National Plan on Alcohol (also currently in force). Decree 6.117/2007 does not equate users with addicts and defines "responsible use" as a public policy goal. Decree GM/MS 3.088/2011 also differentiates indirectly between problem and non-problem users by establishing that the Psychosocial Care Network (*Red de Atención Psicosocial*, RAPS) will be aimed only at "persons who suffer mental problems, including those with needs stemming from their use of crack, alcohol and other drugs," without making any other mention of "consumer" and without equating consumers with addicts (as Law 11.343/2006 did, for example).

[18] Decree GM/MS 3.088/2011 includes six components of the Psychosocial Care Network (Article 5): basic health care, specialized psychosocial care, emergency care, transitory residential care, hospital care and a de-institutionalization strategy.

office of the president and issued by decree, rather than by the Health Ministry or SENAD (which is now part of the Ministry of Justice).[19]

According to Nappo, Sánchez and Ribeiro (2012), "the Federal Government and Brazilian society speak and act in response to a crack epidemic that was exacerbated by the media," while, according to available data, "crack use among students did not increase in the proportions presented by the media in Brazil." Hence, "the term epidemic has been used improperly to represent the statistical prevalence of crack use."[20]

The following year, at the start of the Dilma Rousseff government, Decree Nº 7,673/2011 was issued, establishing a "new" anti-crack program called "Crack can be conquered," which was divided into three parts–assistance, prevention and law enforcement–and integrated a public security approach into the health discourse. In the regulatory sphere, the decree profoundly changed the model that had predominated until then: in addition to being a presidential decree, it concentrated all areas of public action into a single instrument, similar to the drug law, but did so through an administrative measure issued by the executive branch. The law also changed the way citizens affected by the decree were characterized, referring to them as "users of crack and other drugs," a phrase that would subsequently be repeated in other norms, including those of the Ministry of Health. This signaled a shift in the Ministry of Health's approach, from viewing alcohol as the drug most used by Brazilians to seeing crack as the main problem, with no concrete evidence for that policy choice.

3. Drug use in Brazil

In international geopolitics, Brazil is not a producer country, but serves as a route for the transit of drugs traditionally produced in neighboring countries. Those drugs are exported to consumer markets in North America and Europe via Brazil and also consumed in the country.

Data about drug use in Brazil are taken from SENAD's official information, which is based on household censuses in Brazil's capital cities (not in the entire population) in 2001 and 2005, and the most recent census, carried out in 2013, which focused on crack use, but also gathered data about other drugs.[21]

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[19] Based on the provisions of Decree Nº 7.426/2011.

[20] Nappo, Solange Aparecida; Zila M. Sanchez and Luciana Abeid Ribeiro (2012). *Is there a crack epidemic among students in Brazil? Comments on media and public health issues. Cadernos Saúde Pública* [online]. 28 (9), p. 1643-49.

[21] The analyses were based on these surveys, which, despite their limitations (they include data only from capital cities, not the entire country), are considered reliable by the government and experts.

In the comparison between household censuses (2001-2005), the information gathered shows no great variation in use of these substances. However, a small increase was found among survey respondents in lifetime prevalence, particularly for alcohol, during the years studied.[22]

Table 1. Prevalence of drug use among interviewees in 108 Brazilian cities with more than 200,000 inhabitants (2001-2005)[23]

Drug	Prevalence of use (%)			
	2001	2005		
	Lifetime	Lifetime	Year	Month
Alcohol	68.7	74.6	49.8	38.3
Tobacco	41.1	44.0	19.2	18.4
Marijuana	6.9	8.8	2.6	1.9
Solvents	5.8	6.1	1.2	0.4
Benzodiazepines	3.3	5.6	2.1	1.3
Orexigenics	4.3	4.1	3.8	0.1
Cocaine	2.3	2.9	0.7	0.4
Syrups (codeine)	2	1.9	0.4	0.2
Stimulants	1.5	3.2	0.7	0.3
Barbiturates	0.5	0.7	0.2	0.1
Steroids	0.3	0.9	0.2	0.1
Opioids	1.4	1.3	0.5	0.3
Anticholinergics	1.1	0.5	0.0	0.0
Hallucinogens	0.6	1.1	0.3	0.2
Crack	0.4	0.7	0.1	0.1
Merla	0.2	0.2	0.0	0.0
Heroin	0.1	0.1	0.0	0.0
Any drug other than alcohol or tobacco	19.4	22.8	10.3	4.5

Source: SENAD/CEBRID/II Household Census on Psychotropic Drug Use in Brazil, 2005.

Following a global trend, marijuana remains the most-consumed illicitly used drug in Brazil, with a 6.9 percent lifetime prevalence of use based on data from 2001. This percentage is well below that of the United States, at 34.2 percent, and the United Kingdom and Denmark, at 25 percent and 24.3 percent, respectively.[24]

[22] Source: SENAD/CEBRID/II Household Census on Psychotropic Drug Use in Brazil, 2005.

[23] Month and 12-month prevalence of use data are not available for 2001.

[24] According to Carlini, E.A. [*et al.*] (2002). *I Levantamento domiciliar sobre o uso de drogas psicotrópicas no Brasil: estudo envolvendo as 107 maiores cidades do país: 2001* [*First Household Census on Psychotropic Drug Use in Brazil: study involving the 107 largest cities in the country*, 2001]. São Paulo: CEBRID – Centro Brasileiro de Informações sobre Drogas Psicotrópicas: UNIFESP – Universidade Federal de São Paulo.

In Brazil, a larger percentage of people report licit drug use, while a small percentage report problem use of drugs considered illicit. Among illicit substances, marijuana is indicated as the drug with the largest percentage of people who reported problem use.[25]

Table 2. Drug dependence[26] among interviewees in 108 Brazilian cities with more than 200,000 inhabitants (2001-2005)

Drug	Dependence (%)	
	2001	2005
Alcohol	11.2	12.3
Tobacco	9.0	10.1
Marijuana	1.0	1.2
Solvents	0.8	0.2
Benzodiazepines	1.1	0.5
Stimulants	0.4	0.2

Source: SENAD/CEBRID/II Household Census on Psychotropic Drug Use in Brazil, 2005.

Another significant figure comes from the Fiocruz study of vulnerable crack consumers (2013), an important and current source of information on the topic in Brazil.[27] According to that study, approximately 0.81 percent of the population of Brazilian capitals and the Federal District uses crack and similar products regularly. One estimate of the percentage of users of other illicitly used drugs (except marijuana) is 2.28 percent,[28] while crack users make up 35 percent of drug users in the capital cities. Crack, therefore, is not the drug most widely used in Brazil.

The Fiocruz study also shows that most crack users in Brazil are from vulnerable groups; they are black or of mixed race, young (about 30 years old, on average), male, single (which shows a relaxing of family ties), have little formal education, and use multiple substances (more than 80 percent of crack users also use alcohol and tobacco) and they use the substance in public. It is only visible, therefore, to the extent that it makes other people uncomfortable in public places, because crack use is associated with various social vulnerability factors, such as lack of housing and basic services, and, in general, greater social inequality.

[25] Source: CEBRID.

[26] The criterion used by the SENAD/CEBRID study corresponded to SAMHSA.

[27] The study, "*Estimativa do Número de Usuários de Crack e/ou similares nas Capitais do País*" [Estimates of the Number of Users of Crack and/or Similar Substances in the Capitals of the Country], was launched in 2013, coordinated by Francisco Inácio Bastos in association with SENAD.

[28] That is, approximately 1,035,000 users.

Conclusions and recommendations

By taking a paternalistic approach, ambiguously divided between assistance from and punishment by the government, Brazil has created complex regulatory frameworks that are contradictory and difficult to coordinate, as in the case of the forced integration between "law enforcement" and "prevention/treatment" in regulations on crack. These oscillating public policies appear to have no effect on indicators, patterns and types of use or users, especially crack users, who have attracted the most government attention recently.

While the federal government continues to take a very conservative stance in its drug policies, there are signs of change in both the executive branch and the judiciary. Three significant initiatives in 2014 demonstrate the ambiguities in Brazilian policy. Two recent pieces of draft legislation in Congress propose a change in cannabis policy; one authorizes the cultivation of marijuana at home for medicinal or recreational purposes, while the other attempts to regulate the production and sale of marijuana in Brazil. In addition, a very recent decision by the Federal Court of Brasília requires the National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária*, ANVISA) to make a medication from cannabidiol (CBD), which is derived from marijuana, available to treat a child with epilepsy.[29]

Given the situation, we make the following recommendations:

1. Decriminalize all behaviors associated with drug use as a means of eliminating the punitive aspects of the government's approach. The social stigmatization of drug users should be abandoned in order to facilitate health and harm reduction responses, and the punishment/abstinence paradigm that currently prevails should be eliminated.

2. Establish, in ordinary law, a secure, detailed and unified regulatory framework for risk and harm reduction in order to create a single paradigm for policies for prevention and assistance to dependent drug users.

3. Establish public prevention policies that differentiate between problem or dependent users and non-problem users; the latter should be targeted only with prevention policies, as that type of use does not require assistance or treatment policies.

4. Abandon policies of compulsory or forced treatment of users–both problem and dependent–save for exceptional cases, upon medical recommendation, and only when necessary and for the shortest time possible.

[29]http://oglobo.globo.com/sociedade/maconha-brasil-discute-mudancas-mas-nao-vai-votar-agora-12105622#ixzz2yRcsVIMP

5. Separate, in public policies and concrete actions, prevention and assistance measures from law enforcement or punishment; these should be implemented by different agencies and with different and differentiated goals.

6. Allocate a larger part of the government's budget for drug-related initiatives for both licitly and illicitly used drugs to prevention and treatment, reducing funds for punitive actions, which have proven costly and inefficient.

7. Orient drug policy toward substances that cause more harm to public health, especially alcohol, and adopt harm reduction strategies for crack, using evidence-based criteria and approaches.

8. Promote more in-depth debate about the regulation of marijuana and other drugs that are currently illicit, within a framework of guarantees for users' human rights and with special emphasis on the therapeutic use of these substances.

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POLICIES ON ILLICIT USE OF DRUGS IN COLOMBIA[1]

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Although Colombia historically has been considered primarily a producer country, use of controlled substances is increasing. According to the Ministry of Social Protection (*Ministerio de Protección Social*, MPS) and the National Office on Narcotic Drugs (*Dirección Nacional de Estupefacientes*, DNE) (2009: 71), in 2008, 9.1 percent of Colombians had used drugs at least once in their lives, and at least 300,000 abused drugs or were dependent.[2] Although not all use is problem use, these statistics point to the need for the government to develop policies, within a framework of respect for human rights, that avoid the risks and harm that can result from the use of controlled narcotic substances.

This chapter explores the government's response to users of these substances, based on a review of current legislation, regulations and public policies and an analysis of how they are implemented. It focuses specifically on two main components of that response: care and treatment of problem use, and police and judicial handling of cases involving users. This emphasis was chosen because during most of the past century, the government's response was punitive and included both prosecution for possession of substances and compulsory treatment for those considered to be addicts. Although the punitive emphasis has varied since possession for personal use was decriminalized in 1994, these two components facilitate an analysis of the general approach of the government's response and its scope and limitations.

Three basic conceptual assumptions guide our analysis. First, we assume that in a democratic country, illicit use of drugs by adults[3] falls under the principle of autonomy and therefore cannot be penalized unless it affects the rights of third parties.[4] However, because it can have negative health consequences and because some users may develop a drug dependency, the government also has the responsibility to develop various types of policies to dissuade people from using drugs and reduce risks and harm. Second, we believe that all

[1] This paper is an abridged version of Uprimny, et al. 2014. We are grateful for the valuable comments from CEDD researchers, as well as those of Coletta Youngers (WOLA) and Mauricio Albarracín (University of the Andes).

[2] Most recent studies (Comunidad Andina de Naciones 2013, p. 69) suggest that the earlier figures may have increased in recent years, as one out of every six university students in Colombia (16.7 percent) used some illicit drug in the past year, and of that number, 29 percent are dependent drug users.

[3] The use of psychoactive substances, legal or not, by minors falls into the category of problem use. Addressing it, however, requires consideration of particular elements that are beyond the scope of this study; for that reason, in this chapter we refer only to use by adults.

[4] This is the basic idea behind Ruling C-221 of 1994, as discussed below.

policy in this area should take a human rights approach and avoid the stereotypes that have guided the government's prohibitionist response in recent years. And third, we assume that there are different types of use and that the government should take a differentiated approach to them.[5]

Our analysis is based on a varied methodology involving analysis of regulatory frameworks, administrative records and quantitative databases, as well as visits to treatment centers for problem users, observation of court proceedings and 79 semi-structured interviews with experts, drug users, police, prosecutors, judges, directors of treatment centers and public health officials in Bogotá, Medellin and Cali.[6] The results of the study are presented in three parts: i) the regulatory framework and current public policy, ii) the government response in the area of health care and rehabilitation; and iii) the response of the police and judicial system to users of controlled substances.

1. Regulatory and public policy framework on drug use

The basically punitive response to drug use that characterized most of the 20th century[7] began to change in 1994 with Constitutional Court ruling C-221. This ruling established that drug use and therefore possession for personal use, could not be penalized and that treatment could not be compulsive. Although decriminalization was limited to amounts legally defined as a personal dose,[8] in 2008 the Supreme Court expanded the scope of the ruling with the

[5] It is thus possible to distinguish between non-problem and problem use. The former refers to use by adults that does not affect their life and health or the rights of third parties. This is the case, for example, with recreational use. Problem use is i) that which creates a risk to third parties (e.g., driving under the influence of alcohol or marijuana); and ii) use that significantly affects people's health and everyday lives to the extent that they can no longer function. While the government should only take dissuasive action against non-problem use, in the latter case, it should develop policies aimed, for example, at punishing risky activities, and adopt prevention, mitigation and recovery strategies. This definition of types of use is a proposal developed by the authors based on a report by the Advisory Commission on Drug Policy in Colombia (2013, p. 18-20).

[6] The main rationale for the choice of these cities is their high rates of use. According to the MPS and DNE (2009: 69), the prevalence of use in the past year was 7.93 percent in Antioquia, 5.24 percent in Valle and 4.76 percent in Cundinamarca (including Bogotá), which are the highest in the country. In addition, according to the most recent assessment of treatment centers for problem users (MPS, 2004: VI), most of these services are concentrated in these three departments and in Risaralda. The geographic area is therefore representative in terms of both drug use and availability of rehabilitation services.

[7] Uprimny, R. et al. (2014). Entre el estigma y el derecho: consumo de drogas y respuesta estatal en Colombia. Bogotá: Dejusticia.

[8] Article 2. J. of Law 30 of 1986, the National Narcotic Drugs Statute (*Estatuto Nacional de Estupefacientes*), defines the concept of dosage for personal use as "(…) the quantity of narcotic drug that a person carries or keeps for personal use. The dosage for personal use is an amount of marijuana not exceeding twenty (20) grams; an amount of marijuana hashish not exceeding five (5) grams; an amount of cocaine or any cocaine derivative not exceeding one (1) gram, and methaqualone not exceeding two (2) grams. A narcotic drug that the person possesses for the purpose of distribution or sale is not considered a personal dose, regardless of the quantity."

definition of "supply dose„ understood as the amount of a controlled substance that, although *slightly* exceeding the personal dose, was for personal use and therefore, not subject to criminal prosecution.[9]

Nevertheless, critics of the decriminalization of drug use convinced the national Congress to approve Legislative Act 02 of 2009, which incorporated prohibition of illicit use of drugs into the country's Constitution. In addition, in 2011 Law 1453 was approved, eliminating the provision of the Criminal Code that exempted possession of psychoactive substances for personal use from criminal punishment. With these reforms, once more Colombia appeared to be criminalizing possession of drugs for personal use. The Constitutional Court stepped in again, however, with Sentence C-574 of 2011, which reaffirmed that under Colombia's Constitution, criminal punishment of possession for personal use is not allowed, even when the amounts exceed the personal dose. The Supreme Court has also used this criterion in recent decisions.

In the area of health care for drug users, the government implemented at least three important measures at the national level. First, the 2007 National Policy for Reduction of Use of Psychoactive Substances and their Impact (*Política Nacional de Reducción de Consumo de SPA y su Impacto*, PNRCSI) takes a comprehensive approach to the issue in four operational areas: prevention of use, mitigation, recovery and response capacity building. Second, ministerial resolutions 1315 of 2006 and 1441 of 2013 define the criteria for treatment services for problem users. And third, Law 1566 of 2012, which orders that any pathology resulting from the use of these substances be addressed by the General Health Social Security System and that any necessary medications, treatments or medical procedures be included in Obligatory Health Plans (*Planes Obligatorios de Salud*, POS) within 12 months after the time the law took effect (31 July 2012).

Hence, in Colombia today drug use is prohibited, but not penalized. In addition, based on the most recent jurisprudence and legislation, users have rights that must be guaranteed by the state, and a punitive response must give way to one that emphasizes public health and harm reduction. Nevertheless, the constitutional and legal framework contains some ambiguities that could affect users' rights. These include both the constitutional prohibition and a series of definitions and categories that, among other things, hamper recognition that there are different types of use and substances and include similar punishments for simple

[9] Supreme Court of Justice. Criminal Cassation Chamber. Sentence of July 8, 2009. Case No. 31531. M.P. Yesid Reyes Bastidas. In this case, the criminal cassation chamber considered the appeals court ruling against a person who was arrested carrying 1.3 grams of cocaine, an amount that exceeded the personal use threshold by 33 percent.

possession and trafficking. The following section examines how this regulatory and policy framework functions in practice.

2. Use of controlled psychoactive substances and the judicial system

Although use of controlled psychoactive substances is not punishable by law in Colombia, the evidence suggests that some users could be charged in the criminal justice system simply for possession. Therefore, the practical conditions under which a user can be pursued by police or prosecuted are analyzed below. This includes a description of how police, prosecutors and judges interpret and act on possession of drugs for personal use, explaining what happens in cases of possession of substances legally considered to be a personal dose and what happens when the quantity exceeds that amount and tends to be associated with drug trafficking.

Although **possession of a personal dose of drugs** is not a criminal offense, police tend to confiscate the drug to meet previously-defined institutional quotas. According to interviews with national police officers, these targets are set weekly and by action zones in the *Tables of required minimum actions* (*Tablas de acciones mínimas requeridas*, TAMIR). Whether the targets are met depends on the total amount of substances confiscated. In other words, for the police, it is useful to confiscate any amount of illicit substance in someone's possession, even when it does not exceed the legal threshold for personal use.

Police contact with drug users can also occur at the request of citizens, who tend to associate drug use with insecurity.[10] Based on interviews with users and police, we found, as did Lemaitre and Albarracín (2011 pp. 254 and 255), that police pursuit of users of controlled substances is disproportionately more likely when people correspond to certain profiles (young men who are from lower socio-economic levels or indigent), which are associated with security problems, such as theft, assault, brawls and community complaints. The stereotypes do not come only from citizens; police officers sometimes exercise their authority more severely with some people than others, such as by subjecting only some people to searches.

Once a police officer becomes aware of a case of drug possession, he or she can let the person go, detain the person on administrative grounds or take the person to the prosecutor's office for a determination of whether to open a criminal investigation. The first option tends to occur when the amount carried is clearly below the quantity permitted for personal use; in

[10] According to surveys by Ciudades Cómo Vamos 2012, a high percentage of respondents reported that "drug trafficking/addiction" was one of the most serious security problems in their neighborhood (34 percent of those surveyed in Medellín, 47 percent in Cali and 50 percent in Bogotá).

contrast, the third case occurs when the amount appears to exceed the legal threshold. Administrative detention occurs in cases in which the police consider that the person's emotional state is such that detention is necessary to keep the person from committing a crime. In Cali and Medellin, people are detained in police stations or, in some cases, the Immediate Assistance Centers (CAI),[11] although these are not ideal places for the protection of people in temporary detention, according to Constitutional Court Ruling C-720 of 2007. Bogotá, meanwhile, has a facility specifically for temporary detention, the Permanent Justice Unit (*Unidad Permanente de Justicia*, UPJ). Users, however, have reported that the treatment they have received from police transporting them to that unit and during their stay there is violent and degrading.[12]

Although police norms provide for temporary detention, the problem lies in the broad discretion given to the police officer to decide who to detain, on what grounds, for how long (always less than 24 hours, in any case) and under what conditions. The users interviewed indicated that when they came into contact with police, they felt their rights were violated for two main reasons: First, because of abuse of power on the part of the police officers; and second, because of corruption. Regarding the latter problem, the interviewees said that the reason the police had detained them or prolonged the initial encounter was to ask for money.

In cases in which the **amount of the substance exceeds the personal dose**, the police generally take the drug users to the Immediate Reaction Units (*Unidades de Reacción Inmediata*, URI) of the Attorney General's Office. This completes the police phase and begins the investigation, which is followed by the judicial phase. The main problem faced by users of controlled substances in these two phases, however, is the legal uncertainty perpetuated by prosecutors and judges, which makes it impossible to know when a case involves possession for personal use and when it involves possession for the purpose of trafficking or what punishment will be imposed in either case.

The Attorney General's Office has adopted a policy (Directive 01 of 2012) for handling cases based on prioritizing the most serious cases, focusing more on cases of drug trafficking than on possession, and in cases of possession, focusing on those involving larger, rather than

[11] The Immediate Assistance Centers (*Centro de Atención Inmediata*, CAI) are small police units that are meant to bring the police closer to the community in all parts of the city.

[12] Regarding detention conditions in the UPJ, one user interviewed said that anyone who has to spend the night there discovers that the conditions are not the same for everyone. There is the "lower level," the area that is most unpleasant and in the worst condition, where the treatment is most humiliating and where people who live in the street are generally sent; and there is the "upper level," which also has poor conditions, but is somewhat "less scary." This user also said that in any prison, one does not survive without money. Interview with Ángel. User of psychoactive substances, Bogotá, July 31, 2013.

small, quantities. Nevertheless, the idea of prioritizing the handling of drug-related criminal cases has met with a varied response. Some prosecutors still disagree with the idea of prioritizing drug-related crimes, out of a legal and moral conviction that even cases involving minimal amounts of drugs should be prosecuted. Some also do not follow the prioritization guidelines out of fear that they could later face charges for breach of duty.

The legal uncertainty created by the variety of criteria used by the Attorney General's Office in cases of drug possession also exists in the judiciary. Although the judges interviewed identified a series of indications for determining when a case involves trafficking, in cases of possession there is no agreement about the amount that constitutes the *supply dose*. For example, while one judge[13] reported considering that *slightly* exceeding the amount for personal consumption could include carrying up to five times the personal dose, another judge said that *slightly* could not mean carrying more than twice the amount allowed for personal use.[14]

Finally, among both the prosecutors and judges interviewed, a generalized idea prevails that the drug is for personal use when the person carrying it is a user with dependency problems. In other words, in the discussion of proof, they equate "addict" with "possession with the intent to use," which would eliminate the possibility of convicting the person for drug trafficking. For that reason, an important part of the defense strategy is to try to demonstrate that the defendant has problems with drug use. This, however, assumes a limitation–not imposed by the high courts–on recognizing other types of use, specifically non-problem use, as legal. Regarding this, one drug user interviewed said, *"(…) to exercise a civil right, you have to declare that you are an addict."*[15]

3. Treatment and problem use

The Colombian government is required to respect and guarantee the rights of users of controlled narcotic drugs, particularly their right to health. This implies guaranteeing a sufficiently wide range of health services aimed at keeping illicit use of drugs from causing disproportionate harm to users' health. Moreover, such services must be in strict compliance

[13] Interview with criminal judge of the Cali circuit. Judiciary. Cali, June 20, 2013.
[14] Interview with criminal judge of the Medellín circuit. Judiciary. Medellín. June 17, 2013.
[15] Interview with Juan. User of psychoactive substances. Bogotá. July 25, 2013.

with the criteria of availability, accessibility, acceptability and quality as identified by the UN Committee on Economic, Social and Cultural Rights.[16]

Rehabilitation services are highlighted in this study for two reasons: 1) their importance in assistance for and treatment of problem use; and 2) it is an area in which serious human rights violations can occur. Specifically, the current government response in the area of rehabilitation for dependent drug users is explored and information presented on the current state of i) the availability of rehabilitation services for problem users; ii) government control and the quality of those services; and iii) how accessible they really are to dependent drug users.

The ***availability*** of rehabilitation services presents the following characteristics. First, treatment services are concentrated in large cities. According to the Ministry of Social Protection (MPS) (2004), in 2004 in only 84 of the more than 1,000 Colombian municipalities was there at least one treatment center in operation. Similarly, in 2013, according to the registry of providers of health services, services for drug use existed in 25 of the country's 32 departments, and the vast majority were concentrated in capital cities.

Second, treatment services for rehabilitation are mainly private. In 2004, according to the MPS, 82.3 percent of the treatment centers operating in the country were private, 13.4 percent were public and 4 percent were mixed. The first two groups point to possible constraints on the availability of supply and its accessibility, as geographic and economic barriers could mean that treatment is not accessible to all of those with problem use who want it.

Third, the supply is characterized by a variety of treatment approaches. One sign of this is that the MPS (2004) found that 27.4 percent of the centers identified themselves as religious, 61.8 percent as lay and 10.8 percent as mixed. Similarly, in the interviews conducted in treatment centers, a wide variety of intervention models were found, ranging from a comprehensive clinical approach to models based on Scientology, to therapeutic communities, theotherapy and other alternative models.

Finally, the fourth characteristic of the availability of treatment services is that, according to the interviews, most Drug Addition Assistance Centers (*Centros de Atención en Drogadicción*, CAD) operate clandestinely, because they are not legally authorized[17] to provide

[16] Committee on Economic, Social and Cultural Rights (2000). General Comment No. 14: The right to the highest attainable standard of health.

[17] The Ministry of Health has issued two resolutions (1315 of 2006 and 1441 of 2013) establishing formal requirements for authorization of CADs (e.g., minimum characteristics for rooms in residential centers). To receive legal authorization, each treatment center must submit a request to the appropriate health authority, which is responsible for

treatment services to drug users. Some interviewees stated, for example, that 80 percent of the CADs in Antioquia are not legally authorized[18], that 180 of the 201 centers operating in Valle del Cauca are not authorized[19] and that only 25 percent of the CADs in Colombia have complied with authorization procedures.[20] This tends to affect the quality of treatment, because it implies lack of government oversight, which can lead to inappropriate forms of treatment.

With regard to ***government control and the quality of treatment services,*** departmental and municipal public health officials interviewed identified four institutional problems facing the system for monitoring and control of treatment centers: i) the lack of effective institutional coordination between municipal and departmental health entities; ii) insufficient institutional capacity (especially human resources) to actively seek out unauthorized centers; iii) the difficulty of visiting some illegal centers that operate in remote rural areas; and iv) the difficulty of shutting down unauthorized centers, because it is not clear what to do with the patients who are there.

Overall, government control of treatment centers appears to be inadequate, especially in the case of clandestine centers, which, as noted above, constitute the majority. Perhaps because of this, the study found significant indications that human rights violations against drug users persist in some treatment centers. Interviewees said they knew of cases of aggression and abuse in these centers. The reported practices include shock therapies, rape in centers operating in Bogotá, tying patients to wooden poles and leaving them in the sun for several days in Valledupar, and compulsory treatment for drug users with no differentiation between recreational and problem use. Regarding the latter, in one therapeutic community, those interviewed admitted having engaged in compulsory treatment in the past:

> *(…) we did shock therapy, really strong, where someone would attack the kid anytime, anywhere. We also did forced treatment, where a relative would call me and tell me where in Bogotá I'd find the kid, and I would go with two other people, and we'd tie him up and bring him, whether he wanted to come or not; that's called forced*

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verifying compliance with the formal requirements established in the ministerial resolutions; it will then register the establishment as a Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*, CAD). If this procedure is not followed, these establishments will not be recognized by the Colombian health system and will not be considered to be providers of health services for drug users.

[18] Interview in Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*) No. 2, Medellín, June 17, 2013.

[19] Interview in Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*) No. 5, Cali, June 20, 2013.

[20] Interview in Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*) No. 13, Bogotá, July 30, 2013. These figures are not necessarily supported by studies. They are calculations made by the interviewees based on their experience and which they have identified in various events in which they have participated.

treatment. In Bogotá, there are various foundations that work that way. So we had one tied up in the laundry area, one on the second floor, one tied to the bed. But none of those kids recovered.[21]

Although we cannot confirm that these cases are widespread or exclusive to this type of treatment center, they should call the government's attention to the need for stronger policies for controlling these health services.

Finally, regarding ***effective access to treatment***, although this is a health service covered by the General Health Social Security System, users must either pay the price of the intervention or seek a judicial order to gain access. According to interviews at treatment centers, this occurs because some Service Provider Entities (*Entidades Prestadoras de Salud*, EPS) still resist covering treatment programs or provide only partial coverage, because the programs are long and expensive.

In addition, the supply of rehabilitation services for people with problem use is very small for particularly vulnerable groups. For example, although the demand for treatment services for women has increased, they do not have access to many treatment centers, because many are exclusively for men. In four CADs where interviews were conducted, the interviewees explained that they do not provide services for women because it would be more expensive and romantic relationships could occur between patients. This, however, constitutes a barrier to access for women drug users, who have the right to receive differentiated treatment that takes into account the exclusion factors and stigma that affect them.[22]

Similarly, people living in the street, people with HIV/AIDS and the LGBTI community face barriers of access to treatment centers. First, they lack the personal identity documents necessary for admission to the health system and there is inadequate inter-agency coordination to solve that problem. Second, some CADs deny access to people with contagious infectious diseases because that would mean higher costs for the institution and they could be shunned by the other patients. And third, some centers have policies that openly discriminate on grounds of sexual orientation. As noted at one therapeutic community based on theotherapy:

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[21] Interview in Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*) No. 11, Bogotá, July 23, 2013.

[22] For example, according to an interview at a well-known foundation in Bogotá, there are cultural reasons that make it more difficult for families to acknowledge a woman's drug use because of an image of the mother as transmitter of values; as a result, family support networks for women are much weaker than those for men. The same interviewee indicated that many patients must face, on their own, difficult administrative processes to regain custody of children who were taken away from them because of the problem drug use; this confirms that this is a highly vulnerable population that faces barriers to successful completion of rehabilitation treatment.

A normal man arrived, but as the days passed, we started to realize. I told him no, you can't be here, they sleep here. Imagine, we have minors here. So I decided it wasn't wise to have him. Not because I have anything against homosexuals, but because people who have problems with addiction have weak characters, so it's very complicated.[23]

Conclusions and recommendations

In recent years, Colombia has experienced significant changes in regulations and public policies on illicit use of drugs, shifting from an eminently punitive approach to one based primarily on public health. Drug use currently is not penalized, although there is a constitutional provision prohibiting it (Article 49 of the Constitution). This shift has been accompanied by the adoption of public policies that consider drug use a public health issue, as adopted in 2007.

Despite this progress, however, the government's response to drug users continues to have significant limitations. For example, in practice, although drug use is not penalized, users may be criminalized and can receive stiff penalties simply for possession; this occurs in criminal proceedings in which there are serious problems with judicial safeguards in the investigative and trial phases. Even if users are not charged with crimes, they can be detained by police, either to confiscate the substances they are carrying so the police can meet their weekly seizure quotas, or for temporary detention in special units or police stations. These cases are accompanied by reports of abuse of power and corruption on the part of the police.

Users also encounter situations that threaten their rights to health. Although Colombian law recognizes that drug users have rights—such as the right to access to voluntary treatment—and there is a national policy on drug use that includes fundamental mechanisms for exercising those rights, access to treatment has various limitations. Treatment facilities are highly concentrated in cities, and many are not registered; as a result, many clandestine centers operate with no government oversight. Even those that are officially authorized have only scant oversight by official agencies. Accreditation of treatment centers is provided by the Ministry of Health and appropriate agencies, based on compliance with basic formal requirements, but the quality of the treatment and care received by users is not considered. As a result, although this affects drug users' right to health, there is no full

[23] Interview in Drug Addiction Assistance Center (*Centro de Atención en Drogadicción*) No. 11, Bogotá, July 23, 2013.

guarantee of effective compliance with all aspects of that right, particularly the availability and quality of health services provided.

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THE HEALTH RESPONSE TO THE ILLICIT USE OF DRUGS IN ECUADOR

Jorge Vicente Paladines

Although Article 364 of the Constitution prohibits sending people who use drugs into the criminal justice system, Article 62 of the Law 108 on Narcotic or Psychotropic Substances criminalizes "having" or "possessing" controlled substances.[1] Presently, 5,103 people are incarcerated, having been convicted on those grounds.[2] Amid these contradictions, on May 17, 2013, the Organization of American States (OAS) published the report entitled, "The Drug Problem in the Americas." Besides insisting on a review of policies and legislation and urging the *de facto* decriminalization of illicit use, the report reinforces a public health approach, focusing discussion on the treatment and rehabilitation of users.

The decriminalization of illicit use of drugs is a standard by which governments focus on the use of health policy instead of punishment. But how has Ecuador applied the right to health to drug users? What health policies have been used to address this problem? Is there a prohibitionist bias in the social approach to illicit use of drugs? And is treatment provided by the government? Based on these questions, the social and legal conditions and policies that govern the rights of drug users in Ecuador are analyzed, using a methodology based on the phases of *preventive medicine*. The stages of analysis are the primary, secondary, tertiary and quaternary approaches to public treatment of illness. These, in turn, must comply with the three major obligations that the World Health Organization specifies for governments (WHO, 2008: 25-28): to respect the enjoyment of rights, protect or ensure that third parties not interfere in the right to health and implement any policy or legislative measure to fully realize that right.

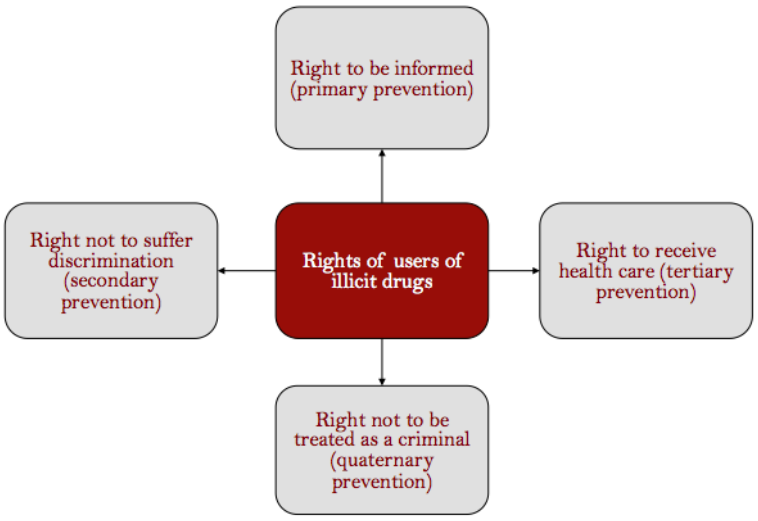
Primary prevention is related to information and awareness about the possible harm done by drug use. With secondary prevention, the groups in which use of drugs, licit or illicit, could exist are identified. Tertiary prevention consists of therapeutic treatment programs for drug dependence. Quaternary prevention involves the suspension or elimination of measures that lead to harmful treatment or practices that are not effective, necessitating other forms of

[1] The penalty for *possession*, according to Article 62 of Law 108, is 12 to 16 years in prison.

[2] Case Document Management System (*Sistema de Gestión Documental por Procesos*, SGDP) of the Public Defender's Office of Ecuador (*Defensoría Pública del Ecuador*), in comparison of information with the Drug Observatory (*Observatorio de Drogas*) of the National Council on Control of Narcotic and Psychotropic Substances (*Consejo Nacional de Control de Sustancias Estupefacientes y Psicotrópicas*, CONSEP), from January 2007 to February 11, 2014.

treatment for problem drug use. Ultimately, the goal is to see how, in practice, a social and political approach can operate in parallel to the criminalization of illicit use of drugs, and whether or not some elements of criminal prohibition are reproduced in health care.

Figure 1. Rights of drug users



Source: Compiled by Author

1. Primary prevention and the failure to recognize illicit uses

The first step in preventive social policies on drugs is based on multiple campaigns to promote rights related to the prevention of licit and illicit use. The primary message is rooted in the *ethos* of preserving "the physical and moral health of humanity," which the international conventions on drugs of 1961 and 1971 have incorporated into their preambles to proscribe so-called "abuse." So although the use of alcohol and tobacco–as well as a number of foods such as sugars and fats–can also cause dependence, Ecuador's current Organic Health Law *emphatically* prohibits the recreational or voluntary use of narcotic and psychotropic substances,[3] as stated in Article 51:

> The production, commercialization, distribution and *use* of narcotic and psychotropic drugs and other addictive substances is prohibited, *except for therapeutic use by medical*

[3] Ecuador's Organic Public Health Law defines narcotic and psychotropic substances to be those known as *illegal drugs*. Without absolutely prohibiting their use, it gives differentiated treatment to tobacco and alcoholic beverages through different provisions for prevention, such as those in Articles 39 and 46.

> *prescription*, which will be controlled by the national health authority in accordance with the provisions of the relevant legislation, is prohibited (emphasis added).

When regulations do not allow for voluntary or recreational use of controlled drugs and reduce their use to medical, scientific or therapeutic uses, a single ethical framework for prevention is established. This excludes other intervention models that might incorporate other kinds of information and messaging to make them more inclusive. The result is a binary approach in which messages focus on risk and are aimed at those who *should not be* users, without including those *who are*.

This has created an ambivalent prevention scenario, however, because while the sale of alcohol to children and adolescents is prohibited, as is its sale[4] to adults during certain hours,[5] campaigns promoting beer consumption stand out among sponsorships of Ecuador's national soccer team.[6] This is in express violation of Article 48 of the same Organic Health Law, which states:

> Advertising of alcoholic beverages can never be linked to health, *success in sports* or the image of the woman as a sex symbol. The national health authority will monitor and control compliance with this provision (emphasis added).

Photo 1. Ecuadorian national soccer team sponsored by Pilsener beer company

Photo of Ecuador's national soccer team and the logos of its sponsors, including the Pilsener beer company[7]

[4] As of midnight from Monday through Thursday and 2 a.m. on Friday and Saturday, and for 24 hours on Sunday.

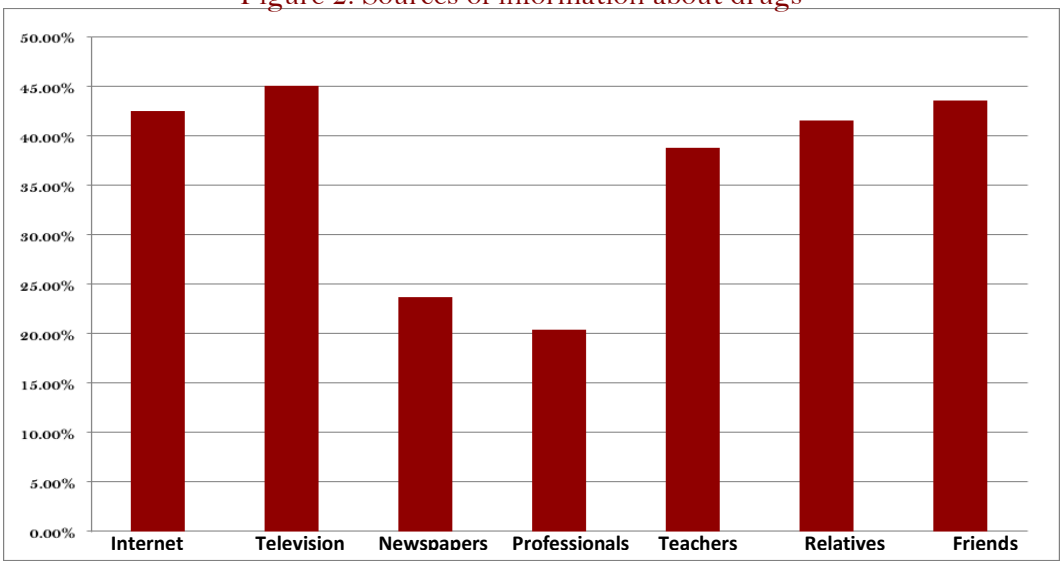
[5] Executive Decree No. 1470. Also, Article 40 of the Organic Health Law states: *"The distribution or delivery of tobacco products, whether free or for in exchange for payment, to anyone under age 18, as well as their sale or consumption in educational and health establishments and places where medications are sold, is prohibited."*

[6] According to the Fourth National Survey on drug use, conducted by CONSEP among 514,962 students between ages 12 and 17 nationwide and published in December 2012, 32.3 percent of those who admitted consuming alcohol in their last year in school said that their alcoholic beverage of choice was beer.

[7] Image taken from: http://sinmiedosec.com/ranking-de-selecciones-fifa-agosto-2013/ (retrieved 30/09/13).

Directly, indirectly or subliminally, the population is informed about drug use by sources such as television, internet, relatives or friends, using language charged with prejudices and myths about their use, with no regard for users' real experiences.[8]. Thus, 45 percent of the students surveyed in 2012 in Ecuador said they received information about drugs from television, 43.5 percent from friends, 42.5 percent from internet and social networks, 41.5 percent from relatives such as parents and siblings, 38.7 percent from teachers, 23.7 percent from magazines or newspapers, and 20.4 percent from professionals trained in prevention.

Figure 2. Sources of information about drugs



Source: Fourth national survey of drug use among students ages 12 to 17
Compiled by: *Observatorio Nacional de Drogas* (CONSEP: 2012)

Information campaigns do not contain a primary prevention message aimed at current drug users. On the contrary, their educational messages target the population that is not involved in illicit use and have a clearly abstention-oriented message. The promotion of this policy of abstinence has a corollary in legal norms: any illicit use is prohibited or is not legally tolerated. For example, Article 20 of Law 108, authorizes police officers to enter private homes in the case of a complaint about illicit use of drugs:

> The owners, administrators or managers of places of residence or collective gathering will notify the police or the closest CONSEP office of the existence of circumstances that lead to the assumption of the presence in the interior or surroundings of those

[8] Tenorio, R. (2009). *El sujeto y sus drogas.* Quito: Editorial El Conejo.

places of *nuclei of drug use* or the practice of illicit traffic of controlled substances (emphasis added).[9]

2. Secondary prevention and the approach to adolescent drug use

Secondary prevention involves identifying the people who fall into two categories: those at risk of illicit use of drugs and those involved in illicit use. In Ecuador, however, it is difficult to obtain *a priori* information about the entire population that engages in the illicit use of drugs. Reports come from the "National Surveys on Drug Use among Middle-School Students" prepared by the CONSEP Executive Secretariat, which show that in 2012, the average age at which adolescents first used drugs was 14.3 years, while in 2008 and 2005, it was 13.8 years. Although the age of first drug use among adolescents had gone up, the Ministry of Education issued Ministerial Agreement 208-13 of July 8, 2013, creating the *National Education System free of tobacco, alcohol, narcotics, hallucinogens or any type of psychotropic and narcotic substance*. Article 4 of that agreement states:

> … within educational establishments, no one can keep on their person or in their clothing, bags, daypack or anywhere else any amount of substances to which this Ministerial Agreement refers. If any member of the educational community finds such substances, regardless of the quantity, *they will immediately notify the highest authorities of the establishment and the nearest police unit or officer, who will be responsible for confiscating the substances and executing the appropriate procedure*, notwithstanding the actions established in Articles 326 and 327 of the Code for Children and Adolescents (emphasis added).

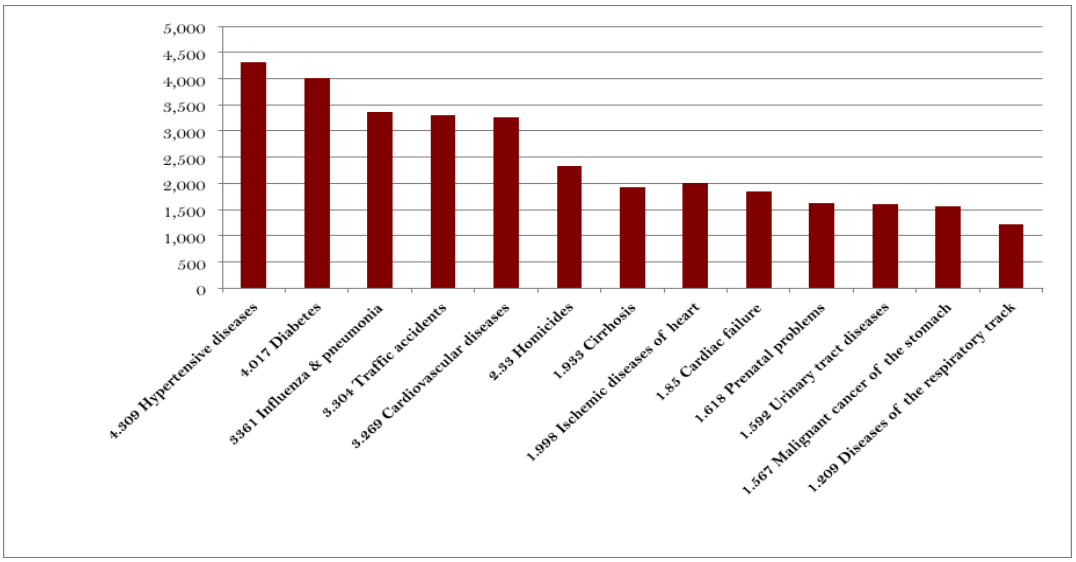
Despite the assumptions about the illicit use of drugs among students, in reality the substance most consumed by this segment of the population is alcohol. In fact, at least 82 percent said they had never even been offered or shown marijuana, and only 0.07 percent of students admitted using it daily or almost daily during the two years before the survey. This indicates that the prevention strategy for school-age students is badly targeted or focused, at least given the cited evidence.

[9] During the past year, anti-drug police have searched homes for the purpose of interrupting the illicit use or consumption of drugs in so-called "clandestine parties." In addition, the police carry out training in schools on drug-use prevention. See: http://www.elcomercio.com/seguridad/Policia-colegios-Guayaquil-droga-marijuana-estudiantes-Dinapen_0_966503492.html (retrieved 17/10/13).

The selection of the groups in which to sample drug use—segments of the adolescent population—reflects two over-diagnosed affirmations: a) alcohol is the drug most often consumed in schools; and b) most drug users are not in the segments between ages 12 and 17.

Of all deaths reported in 2010 (61,681 young people/persons), several of the 13 causes of death (with more than 1,000 deaths each) imply some relationship to the excessive use or consumption of carbohydrates, sugars and their chemicals, and could also be associated with alcohol consumption. For example, 4,017 people/adolescents died of diabetes, 3,304 in traffic accidents, 1,933 of cirrhosis, and 1,567 of malignant stomach cancer.

Figure 3.Principal causes of mortality in Ecuador



Source: Compiled by author with information from INEC (2010: 475-480)

These deaths cannot be blamed directly on the use or consumption of alcohol; nevertheless, it is difficult to conclude that they are related to illicit use of drugs. Of all the probabilities, alcohol is more likely related to some of the causes of death in the country.[10]

3. Tertiary prevention and spiritual, rather than evidence-based, treatment

For many years, public health in Ecuador was in the hands of the church. Its displacement came as health officials began to appropriate the ideas of European *hygienism*, which gained a

[10] According to the Ministry of Coordination of Security, between January and July 2013, the rate of traffic accidents related to alcohol use was 7.73 percent (2013: 17).

foothold in the areas of contraception, life expectancy, mortality and anomia (Kingman, 2008: 273). Some social conduct was also "sanitized" through punitive social control of behaviors that altered norms of urban life, which were included in the Criminal Code that was in effect until 2014, such as: "*Those who, without being habitual drunks, were found in a state of inebriation in any public place,"* and *"Those who in their taverns accept people in a state of inebriation or who sell them liquors of any type or allow them to continue drinking them,"* among others.[11] The Civil Code also maintained openly discriminatory provisions. Article 110.9 established that drug abuse or habitual inebriation could be grounds for divorce; and Article 477 provides for any person who is habitually inebriated or addicted to drugs to be given a guardian for administration of his or her property, as the person is legally declared incompetent.

This reaffirms the social convention that sees illicit use of drugs as a transgression of the generally accepted rules of behavior and any transgressor as simply a *deviant.* This idea has influenced not only the private sphere–in families–but also the state. Both sectors consider rehabilitation for drug dependency not only a curative mechanism, but also a form of exclusion or separation from the public arena. The therapeutic rehabilitation of users who demand illegal substances is therefore seen as a solution, and policies reflect a code of health/illness that imposes a hygienist policy on them just because they are users.

From the standpoint of the rule of law, anyone who uses drugs licitly or illicitly is exercising the free development of personality and free will. Shifting the problem to the health arena, however, makes drug use a disorder. Yet for years there have been complaints around the world about the crisis in the definition of mental health, particularly given pharmaceutical and rehabilitation companies' clear interest in having an ever-longer list of "disorders" in the Diagnostic and Statistical Manual of Mental Disorders (Basaglia: 1972,Cooper: 1986; Szasz: 1994; Goffman: 2001).

Apart from these issues, in Ecuador, psychiatric institutions continue their efforts to "rehabilitate" people with drug dependencies in so-called therapeutic communities or addiction treatment units. Only four therapeutic communities are relatively public, while more than 400 are private. Most of the communities emphasize a spiritual or religious approach to the problem.

Because of this asymmetry, the Ministry of Public Health has conducted a study to budget the cost to the state of building, equipping and staffing a therapeutic unit for 30

[11] Paladines, J. (2010). "Las dos velocidades de la reforma penal y la crítica a la dialéctica legislativa." In: *Revista Pensamiento Penal* (virtual), No. 104, Sección Doctrina, Buenos Aires.

patients; the cost would be US$14,373,781, while the monthly per-patient cost would be US$67 (*Ministerio de Salud*, 2012: 7 and 10).

Table 1. Some religious therapeutic communities in the city of Quito

Name of therapeutic community or center
Camino a la paz
Centro de Recuperación en sus pisadas
Centro de Tratamiento Corazón de Dios
Centro de Rehabilitación Ave Fénix
Instituto Psiquiátrico Sagrado Corazón
Centro de Recuperación Puente A La Vida
Centro de Recuperación Vida Nueva
Centro Terapéutico Manantial
Comunidad Terapéutica San José de Guamaní
Centro de Orientación Juvenil La Dolorosa
Centro Terapéutico Una Luz en La Tormenta
Centro de Recuperación Plan Vida
Centro de Reposo San Juan de Dios
Clínica Nuestra Señora de Guadalupe
Comunidad de Ayuda Volver a Empezar
Centro para Adicciones Dando Una Mano
Centro Terapéutico Femenino Victoria
Comunidad Terapéutica Luz de Esperanza
Centro Terapéutico Caminando a la Libertad
Centro de Recuperación Fuente de Amor y Paz
Centro Cristiano para Adicciones Cristo Vive

Source: Compiled by author with information from *Ministerio de Salud Pública* (2012)

A considerable number of therapeutic communities have operated clandestinely and without official permits. In the last quarter of 2013 alone, more than 500 people were freed and more than 20 rehabilitation clinics were closed (*El Comercio*, 2013: 7), with revelations of cruel abuse of their patients. To address the historical neglect of government control of the mostly private therapeutic communities, on May 11, 2012, the Ministry of Public Health issued Ministerial Agreement No. 00000767. The agreement created the "Regulations for oversight of recovery centers for treatment of persons with addiction to or dependence on psychoactive substances." Article 5 classifies the centers as: 1) Transient detoxification centers, where treatment can last up to 28 days; 2) Therapeutic communities, where patients can stay from six months to two years; and 3) Integral recovery centers, where the stay can last between seven and 25 months.

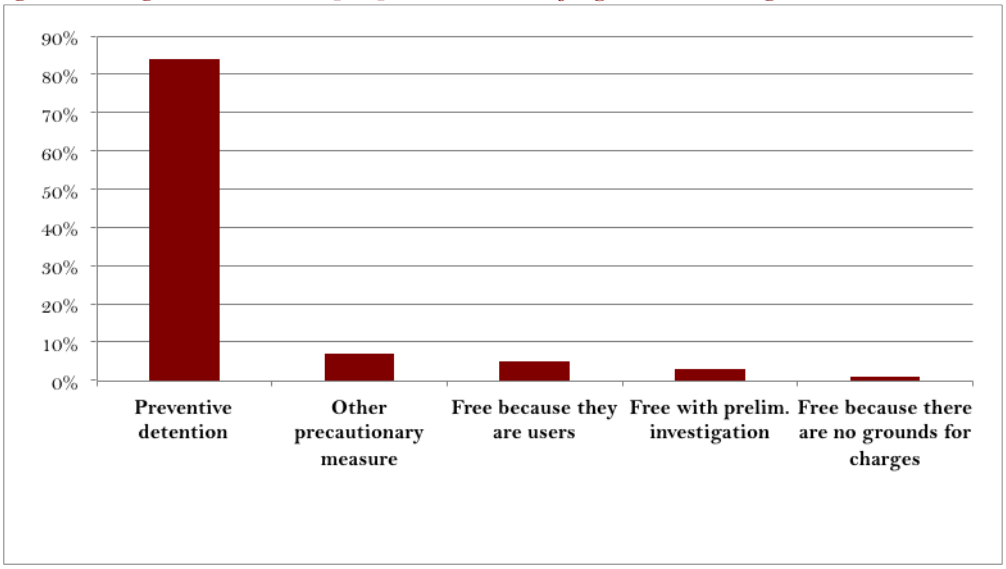
Although CONSEP issued regulations with a similar intent (Resolution 028-CD) in 2008, to date the Ministry of Public Health has had sole jurisdiction as the government agency that approves the procedures and programs of therapeutic communities. The ministry's directives are clearly in line with some rights and guarantees of dependent users. The regulations mentioned above, however, are ambivalent, as they legitimize the State's continuing absence from the provision of this service,[12] recognizing that private therapeutic communities can continue to exist and allowing them to provide compulsory or involuntary treatment (Article 12).

4. Quaternary prevention and chronic dependence to stay out of the criminal justice system

Although according to Article 364 of the Constitution, the use or consumption of drugs is not a crime--in fact mere possession for use is a crime. So after the flagrant offenses units were launched in October 2012, of 2,505 people arrested for alleged drug crimes, 84 percent were sent to preventive detention.

[12] Article 12 of the Law of Patient Rights and Protection, however, states: *"For no reason can a health service refuse care to a patient in an emergency. The health service that refuses to care for a patient in an emergency will be responsible for that patient's health and will assume, with the professional or person who was remiss in fulfilling their duty, the legal obligation to indemnify the patient for harm or damages caused by the refusal."*

Figure 4. Legal situation of people arrested *in flagrante* for drug crimes nationwide



Source: Compiled by author with information from Fiscalía General del Estado (*Delitoscopio*), 2013

In addition, there are frequent proposals to associate rehabilitation or therapeutic treatment with the criminal justice system through so-called "drug courts." The organization Justicia Penal-Ecuador (American Bar Association of the United States and Rule of Law Initiative) has lobbied for establishment of drug courts in Ecuador, sponsoring several conferences with what was then the Transitional Judiciary Council (*Consejo de la Judicatura de Transición*) and the National Assembly. Its proposal stated:

> These 'Courts' are administrative bodies characterized by the intensive treatment of users, judicial supervision of that treatment, which could include mandatory drug testing and periodic meetings with the judge to monitor progress, and consequences for non-compliance or violations.[13]

Although for the moment implementation of drug courts has not gained traction among the country's political decision makers, *de facto* criminalization of drug use remains latent. The Ministry of Public Health and the CONSEP Executive Secretariat issued Resolution 001-CONSEP-CO-2013, specifically to address the contradiction between the constitution and the law,[14] such that possession of specific amounts of drugs below an established threshold clearly

[13] Amado, A. (2012). *Oficio No. 95069 dirigido al Arquitecto Fernando Cordero.* Quito: Asamblea Nacional.
[14] Unfortunately, prejudices about thresholds have taken hold among the judges of the National Court of Justice. One is National Judge Jorge Blum Carcelén, who ends his article ("*Las Adicciones, un problema de salud pública*") with the phrase, "*Not a single gram for my children and my grandchildren.*" See Blum (2013, p.13).

indicate personal use; in other words, the resolution seeks to create a boundary between personal use and drug trafficking.[15]

Table 2. Thresholds for possession of illicitly used drugs in Ecuador

Substance	Quantity
Marijuana	10 grams
Cocaine Base	2 grams
Cocaine Hydrochloride	1 gram
Heroin	0,01 grams
MDA	0,15 grams
MDMA	0,015 grams
Amphetamines	0,040 grams

Source: Compiled by author with information from Resolution 001-CONSEP-CO-2013

Judges, however, are reluctant to apply thresholds as a reference, and instead prefer to criminalize simple possession, regardless of whether the person charged is a dependent user. One example is the case of Daniel Lennstrom, in which judges of the criminal chamber of the Provincial Court of Justice of Azuay rejected evidence that the defendant was a chronic user of marijuana and cocaine, stating:

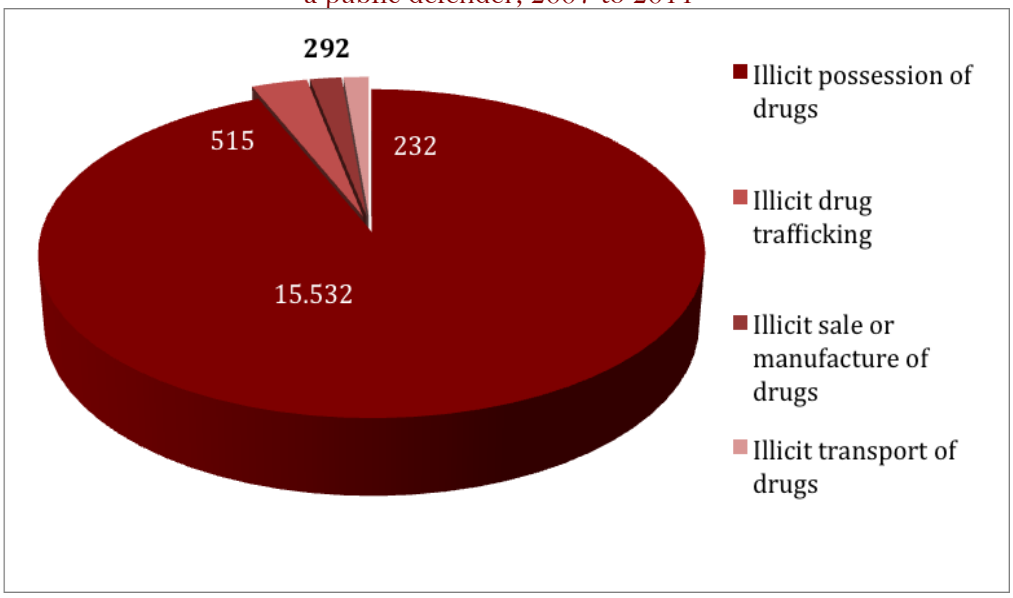
> … that the amount found in the defendant's possession [90 grams of marijuana] is excessive for his personal use; we also know that drugs such as marijuana cause physical and psychological dependence, the former being defined by the WHO in report 551/74 as 'an adaptive state characterized by intense physical disturbances when administration of the drug is suspended' and the latter as the 'condition in which the drug produces a feeling of satisfaction and a psychic drive that requires periodic or chronic administration of the drug for pleasure or to avoid discomfort;' but in addition, the ingestion of controlled substances by a drug-dependent person causes disturbances in their mental, physical and cognitive functions …. (Case 01121-2013-0267).

[15] The CONSEP resolution was not well received in some sectors of the government. One was the Ministry of Education, where Minister Augusto Espinoza publicly expressed his opposition, saying it would affect the educational community under his direction. See: http://www.lahora.com.ec/index.php/noticias/show/1101533600 (retrieved 19/07/13).

One clear result of Article 62 of Law 108 is that people convicted of possession of narcotic or psychotropic substances may be users and not traffickers. This is demonstrated qualitatively in the cases of Mónica Mejía, who was arrested with 15 grams of cocaine (Fourth Criminal Court of Pichincha Case 037-2013) and Daniel Lennstrom, who, as described above, was arrested with 90 grams of marijuana. These are two *false positives*—cases of people who were arrested and charged as traffickers, although they were later shown to be innocent. These cases are cause for concern, because they show how likely it is that a large number, if not the majority, of people sentenced for trafficking are, in fact, users.

Between 2007 and 2014, the Ecuadorian Public Defender's Office reported that among the cases it handled of people arrested for drug crimes, 232 were for transportation, 292 for sale or manufacturing, 515 for illicit traffic and 15,532 for possession.

Figure 5. Number of people arrested for drug crimes who needed a public defender, 2007 to 2014



Source: Compiled by author with information from the *Defensoría Pública General* (*Dirección de Investigaciones Aplicadas*): 2007 al 2014

Conclusions and recommendations

An abstinence-based message underlies the information about prevention of illicit use of drugs that is disseminated through the major media and is used to "justify" the government's failure

to recognize harm reduction as a means of treating dependent drug use. Information campaigns should diversify and expand the message that is disseminated, acknowledging the existence of people who use drugs. The Ministry of Education, meanwhile, has established police-style education plans with DINAPEN and the National Anti-Drug Office to detain anyone carrying or possessing narcotic or psychotropic substances in schools. The ministry groups information programs with school punishments and diversion to the criminal justice system for students who possess drugs illegally.

The identification of segments of the population at risk of illicit use of drugs is biased. The state must recognize that problems related to illicit use are also found among people over age 18. More in-depth research is needed to better develop the information needed in order to measure the causes of mortality associated with illicit use of drugs. Currently significant suspicion exists that this is more closely related to the legal consumption of alcohol than to the illicit use of other drugs.

Harm–and risk–reduction services are in the hands of therapeutic communities, most of which are religious, rather than governmental. Added to that are problems related to the conditions for patients, who are subjected to treatment based on methodologies that lack scientific rigor, and which have been categorized as abusive in joint operations carried out by the Ministry of Health and the Attorney General's Office. The government should regain control of health services to treat dependencies using methods and techniques that also avoid approaches that are excessively arbitrary or subjective in the neurosciences.

Finally, the American Bar Association is engaged in ongoing lobbying for the establishment of drug courts. Although this effort has not been successful, illicit possession of drugs is the most frequent crime in the national criminal system. The most common characteristic is the judges' unwillingness to believe that the case involves drug use, despite evidence to the contrary.

The prohibitionist spirit not only distorts policies and social norms, but it also affects government reform efforts underway. This is evident in the tendency not to provide information to people who use drugs illicitly; the incorrect identification of the groups most affected by real, rather than assumed, use of substances; diversion of treatment for dependency to religious congregations; and the tendency to incarcerate people stigmatized because of their "addiction."

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ILLICIT USE OF DRUGS AND DRUG USERS IN MEXICO[1]

Catalina Pérez Correa
Karen Silva Mora

According to data from the National Survey of Addictions in 2011, about 1.2 million people had used some drug in the 12 months prior to the survey. Although there are various branches of law that regulate drug use, it is criminal law that is most prominent in the relationship between users and the state. As this text shows, for many drug users, consumption has meant falling under the direct purview of criminal justice institutions, with all of the costs this implies.

Drug consumption in Mexico is not a crime, although nearly all behaviors prior to use-such as possession, acquisition, distribution, cultivation, production, planting, harvesting, etc.–are crimes. It is noteworthy, therefore, that between 2009 (when the Small-Scale Drug Trafficking Law was approved[2]) and May 2013, 140,860 people nationwide were arrested for drug use, leading to the initiation of 53,769 criminal investigations in the federal system.[3] In addition, 90,000 non-prosecution rulings[4] were issued for the same cause.[5] Although the latter number reflects people who were not in the end criminally punished, all took part in criminal proceedings–that is, they were arrested and appeared before the Public Ministry. Also of significance, while Mexican law does not include criminal punishment for drug use, it assumes that all use is problem use, leaving no room for recreational use.

The next section analyzes Mexican legislation on drug use, including a description of the Small-Scale Drug Trafficking Law. The third section presents a brief summary of the main sources of information about drug use and provides data useful for understanding the scope of the phenomenon in Mexico. Section four presents data related to the government's

[1] This chapter is an abridged version of Pérez Correa, C. and Silva, K. (2014), *El Estado frente al consumo y los consumidores de drogas ilícitas en México*, Cuadernos de Trabajo, Programa de Política de Drogas, Mexico: PPD-CIDE.
[2] The Small-Scale Drug Trafficking Law (*Ley de Narcomenudeo*) is analyzed in Section IV.2.
[3] Public information provided by the Attorney General's Office (*Procuradoría General de la República*, PGR), pages 0001700136313 and 0001700169413.
[4] "Criminal proceedings" here refers to the Public Ministry's power to "inform" a criminal judge of a crime so that the judge can open a criminal case. That power is conferred on the Public Ministry in Article 21 of the Constitution. The non-prosecution ruling refers to the Public Ministry's decision, after a pre-trial investigation, not to file criminal charges before the courts.
[5] Public information provided by the Attorney General's Office, pages 0001700136313 and 0001700169413.

response to drug use, to show how criminal justice and health institutions actually address illicit use of drugs.

1. Legislation on drug use in Mexico

In 2009, the Small-Scale Drug Trafficking Law was approved, reforming the Federal Criminal Code, the General Health Law and the Federal Criminal Procedures Code in the chapter on crimes against health. The modifications made by of the Small-Scale Drug Trafficking Law included the incorporation of a table of guidelines (hereafter referred to as Table) for maximum quantities for personal use into the General Health Law (Article 479). The Table establishes the threshold amount that can be considered for personal use, below which use is not punishable with a prison sentence. Above those amounts -and without exceeding them by 1,000 times- possession of illicitly used drugs is considered dealing or small-scale trafficking and is left to the jurisdiction of the states (with some exceptions[6]). When possession of those substances is 1,000 times the amount established in the guidelines, it is considered drug trafficking and falls under federal jurisdiction. With this provision, the Small-Scale Drug Trafficking Law was intended to eliminate discretional determination by police, Public Ministry officials and judges of the amounts that constitute use, small-scale dealing and drug trafficking (Pérez Correa *et al.*, 2013).[7] Possession of illicitly used drugs is not punishable by incarceration, as long as it is within the amounts established for personal use in the Table.

The main problem with the Small-Scale Drug Trafficking Law, however, is that it continues to criminalize users. This occurs in two ways: *de jure* (by law) and *de facto* (in practice). *De jure* criminalization occurs in cases of use in which the law orders the intervention of criminal justice institutions. According to current legislation, the Public Ministry will not file criminal charges before a judge for the crime of possession without intent to sell or distribute "against anyone, whether dependent or a user, who possesses any of

[6] There are three exceptions in which crimes of small-scale drug trafficking can become federal jurisdiction -and be prosecuted by the Attorney General's Office. These are: a) when the federal government opens the investigation and does not remand it to the state prosecutor's office; b) when the crime is committed as organized crime; and c) when the Attorney General's Office so determines.

[7] Specifically regarding use, the General Health Law included an administrative prohibition against the planting, cultivation, harvesting, manufacture, preparation, accommodation, acquisition, possession, sale, transportation in any form, medical prescription, provision, employment, use, consumption of opium prepared, for smoking; diacetylmorphine or heroin, its salts or prepared forms; cannabis sativa, india and americana or marijuana; *papaversomniferum* or poppy; *papaverbactreatum* and *erythroxilon novogratense* or coca, in any of their forms, derivatives or preparations. Violation of that provision would be punishable with a "fine equivalent to 12,000 to 16,000 times the daily general minimum wage in effect in the economic zone concerned," which is no small sum, given the income level of the average Mexican. See General Health Law, Articles 235, 237 and 421 bis.

the narcotics listed in the Table, in an amount equal to or less than the amount in the Table, strictly for personal use and outside of specified places indicated in the Law."[8] That, however, does not mean that no criminal investigation is opened. It is opened, but it concludes with a non-prosecution ruling (hereafter sometimes referred to as NEAP, *No Ejercicio de la Acción Penal*). In other words, in cases of drug use, the criminal justice apparatus goes to work: the police arrest the user and bring him or her before the Public Ministry. Users therefore continue to be immersed in the criminal justice system, with all of the risks and costs this implies–from being subject to detention by institutions that have often been linked to due process violations and corruption[9] to the costs incurred by the institutions in handling each case.[10]

There is *de facto* criminalization because the thresholds set in the Table are so low that their implementation implies, *de facto*, that users will be accused of possession and punished as if they were drug dealers. For example, the threshold for cocaine is 0.5 grams. Yet various activists have noted that in the market, cocaine is sold by the gram. A user who buys the minimum dose of cocaine available in the market will therefore be assumed of being a dealer, with the penalties that implies. This is a key point for understanding the large number of possession cases that are processed and underscores the fact that it is not known for certain how many cases of drug dealing actually involve people who had no intention of selling drugs, but who were merely users who were equated with drug dealers.

The issue of *de facto* criminalization of users is aggravated by Article 477 of the General Health Law, which sanctions **simple possession,** allowing punishment of possession without intent to sell and includes almost any user in possession of more than the small amounts established in the Table or in possession of any amount of drugs not contemplated in the Table. According to that article, simple possession occurs when someone possesses any of the "narcotics indicated in the Table in an amount smaller than that resulting from multiplying the quantities listed in the Table by 1,000" and "when because of circumstances possession cannot be considered to be for sale or provision, even if it is free." In other words, possession is punished even when there is no intent to sell.

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[8] These are "educational, assistance, police or detention centers or within a space contained within a radius of at least 300 meters from their boundaries." See General Health Law, Article 475-II.

[9] See, for example, Silva *et al*., (2012) and Human Rights Watch (2011).

[10] According to Guillermo Zepeda (2010: 55), an average of 4,181 Mexican pesos (US$380) is spent on the investigation of state crimes, and federal criminal cases cost more than local cases, so the estimates are even higher for cases sent to federal courts.

Regarding health-related institutions, the General Health Law requires Public Ministry agents to inform the user of the location of "institutions or centers for medical treatment or orientation for the prevention of drug dependence" and inform NEAP health institutions. Once the health center or institution is aware of the NEAP report, it must contact the user to provide "orientation and encourage him or her to take part in programs to combat drug dependence."[11]

In the health arena, a chapter was also added regarding the prevention and treatment of drug dependence. States were given a year, from the time the law took effect, to adapt the state laws and regulations necessary to implement the reform and three years to issue the necessary directives so that the institutions involved (such as local prosecutors' offices and health centers that offer treatment) could implement it. Although the deadline for states to begin handling crimes related to small-scale drug trafficking passed on August 21, 2012, not all states had made the necessary modifications to their local legal frameworks by that date. At the end of the Felipe Calderón Administration, nearly one-third of the states still had not approved criminal justice reforms and nearly 60 percent of the states still had not done so in the area of health.[12] Although data shows a gradual increase in the number of cases of this type that prosecutors are handling,[13] the delay is a serious problem in terms of legal security, as uncertainty about the applicable norms makes it difficult to know who is responsible for prosecuting drug-related crimes--including drug use cases--at the local level and how it should be done.

2. Drug users and the extent of use in Mexico

Five sources of information about drug users in the country were reviewed for this study: a) the National Survey of Addictions (*Encuesta Nacional de Adicciones*, ENA); b) the Survey of Drug Use among Students in Mexico City, 2012; c) the Epidemiological Surveillance System for Addictions (*Sistema de Vigilancia Epidemiológica de las Adicciones*, SISVEA) and; d) the Drug Information Reporting System (individual report about drug use).[14]

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[11] See General Health Law, Article 193 bis. The law also established that in cases of drug dependence, "upon the third report of a non-prosecution ruling by the Public Ministry, treatment will be obligatory." General Health Law, Article 478.

[12] Pérez Correa, C. Alonso, F. and Silva K. (2013). *La reforma en materia de narcomenudeo: seguimiento de los cambios legislativos e institucionales*. Mexico: CIDE. Available at: http://www.cide.mx/dts.php?d=4

[13] See Pérez Correa, C. and Meneses, R. (2014), La guerra contra las drogas y el procesamiento penal de los delitos de drogas 2006-2012, Cuadernos de Trabajo, Programa de Política de Drogas, Mexico: CIDE.

[14] For a complete description of these sources, see Pérez Correa and Silva (2014).

A review of these sources shows that there is a marked lack of information about drug use and points to a lack of interest in developing a more comprehensive understanding of the phenomenon. Two of the four main sources (SISVEA and the Drug Information Reporting System) report use by patients in health centers or people in minimum-security detention centers. This results in a serious bias in the information about use and users, as it is taken from cases where there is problem use or in extreme situations (where crimes were committed). In addition, the ENA has been criticized for using extremely broad definitions of drug dependency, which tend to exaggerate the phenomenon of illicit use of drugs in the country.

Taking this into account, these sources of information show that drug users--of both licitly and illicitly used substances--represent a heterogeneous population, although young men report the most drug use. The data also indicate that the drug most frequently used in the country, with the most problem use and the most negative effects, is alcohol. It is followed, in order of preference, by tobacco and marijuana.

The ENA–conducted six times by federal health agencies–maintains that the annual prevalence[15] of use of any drug is 1.8 percent of the total surveyed population (compared to 1.6 percent in 2008, the year of the previous survey). In other words, about 1.5 million people had used some drug in the past year.[16] Use of "illegal drugs"[17] in the past year was 1.5 percent of all respondents, very similar to the 2008 rate (1.4 percent) (SSA-INP, 2012: 26). Men show a higher prevalence of use of illegal drugs (2.6 percent) than women (0.4 percent). The average age of first drug use is 18.8, with men starting nearly two years earlier than women (SSA-INP, 2012: 29). The age group with the highest drug use prevalence is 18 to 34 years.

Despite the significant number of users reported by health facilities, however, existing information about drug users and drug use lacks uniformity, is not comprehensive and contributes little to knowledge of patterns of use, forms of obtaining drugs, relationships with authorities, users' perceptions of their own use, etc. As a result, it is impossible to address the phenomenon from the users' standpoint. Moreover, although alcohol and tobacco are the most

[15] This refers to people who have used substances or have shown symptoms of or been diagnosed with dependence in the 12 months preceding the survey.

[16] According to INEGI, in 2010, the year in which the 2011 ENA was conducted, there were 77,988,555 people between ages 12 and 65 (INEGI, 2010). According to data from the 2011 ENA, annual prevalence of use is 1.8 percent of all survey respondents (SSA-INP, 2012).

[17] ENA includes the following substances in this group: marijuana, cocaine, cocaine paste, crack, hallucinogens, inhalants, heroin and amphetamine-like stimulants (methamphetamines).

used substances, resources are mainly allocated for criminal prosecution or compulsory treatment of consumers of illicitly used drugs, whether or not they show problem use.

3. State responses in statistics: criminal and healthcare institutions

This section presents data about the way in which the State interacts with drug users and responds to the issue of drug use. It is divided into three parts. The first two provide information about detention, prosecution and sentencing for "use" and "possession" in the federal and local systems, respectively. Data is included about possession because, as noted above, the low doses established in the General Health Law's Table lead to the assumption that some of the people prosecuted and punished for possession are users and not dealers, although more information is needed to determine the type of possession-related crimes that are prosecuted in order to draw that conclusion with certainty. The third part presents information about the behavior of healthcare institutions regarding drug use.

The data collected for this study show that although the law does not consider the use of illicit substances as a crime, authorities continue to prosecute and criminally punish users, not only for possession, but also for use itself. Even without considering data about possession, the information about cases of drug use show that a significant number of users are arrested, tried and a small number is even sentenced for using drugs.

3.1. Drug use and the response of federal institutions

In response to a request for information,[18] the Attorney General's Office indicated that between 2009 and May 2013, a total of 140,860 people nationwide were arrested for drug use (see Table 1). The states in which the highest number of people were arrested by the Attorney General's Office between 2010 and 2013 were Jalisco (32,373 arrests), Mexico City (27,295), Baja California (23,195) and Guanajuato (18,551). Nayarit, Durango and Campeche had the fewest arrests between 2009 and 2013 (80, 55 and 54 people, respectively). Although there has been a steady decrease in the number of federal arrests for use of illicit substances, the number of arrests for drug use by the Attorney General's Office is notable, even though, apart from the exceptional circumstances mentioned, this does not fall under federal jurisdiction.

[18] Request for information with file number (*folio*) no. 0001700136313.

Table 1. People arrested for drug use

2009	2010	2011	2012	Mayo 2013	Total
46,951	38,000	30,361	21,162	4,386	140,860

Source: Public information provided by the Attorney General's Office, file number (*folio*) 0001700136313.

Data from the Executive Secretariat of the National Public Security System (2012), an agency within the Office of the President of Mexico, also shows that a significant number of pre-trial investigations opened in federal agencies between 2006 and 2012 were for drug use (see Table 2).[19] Another important figure is the number of cases of possession reported by the Secretariat. As Table 2 shows, between 2006 and 2012, these cases constituted 75 percent of the drug-related cases, as compared to 71 percent in 2012. As noted above, the low doses for personal use established in the General Health Law Table leads to the assumption that some percentage of those cases involves users who are criminalized *de facto* and treated as small-scale drug dealers. Without a detailed study of the case files, however, it is impossible to determine the percentage of possession cases that were brought against users.

Table 2. National incidence of crime[20]

Year	Federal crimes	All crimes against health	Possession/1	Use	Crimes against health as percentage (%) of federal crimes	Possession as percentage (%) of crimes against health
2006	109,629	58,066	49,255	27,629	53%	85%
2007	137,289	81,491	71,511	44,170	59%	88%
2008	136,091	73,222	47,535	26,475	54%	65%
2009	131,582	63,404	43,326	24,203	48%	68%
2010	132,227	55,122	39,189	14,577	42%	71%
2011	133,045	42,747	31,665	9,926	32%	74%
2012	125,328	27,870	19,643	-*	22%	70%
2013	98,189	8,836	5,009	-*	9%	57%
Total	**1,003,380**	**410,758**	**307,133**	**146,980**	**41%**	**75%**

Source: *Secretariado Ejecutivo del Sistema Nacional de Seguridad Pública* (2014).
1/ Possession figures include drug use.

[19] Until 2012, three years after the Small-Scale Drug Trafficking Law was approved, the Secretariat reported prior investigations of drug use separately. In 2012, the Secretariat stopped reporting drug use separately—although it clarifies that possession data includes cases of drug use. In other words, among the cases of possession (which are expressly treated as criminal cases) reported there are cases of simple use.

[20] According to the Executive Secretariat of the National Public Security System, data of incidence of crime at the state level "correspond to pre-trial investigations or files of investigations initiated for crimes against victims, which may involve one or more victims or more than one legal principle." See SESNSP (2012).

* Drug use and possession data for 2012 are not broken down separately.

Surprisingly, crimes against health (which include those involving illicitly used drugs) do not appear among the seven crimes reported by the Secretariat of the State system (which refers to local jurisdiction and which should include small-scale drug trafficking crimes). This could be because they represent only a small percentage of local prosecutors' caseloads, although it could also point to what other data seem to indicate: that States are still not taking responsibility for small-scale drug trafficking crimes.

Information from the Attorney General's Office[21] about pre-trail investigations of "narcotic drug use"[22] initiated and sent before a judge since 2006 shows that investigations decreased substantially after 2009, when the Small-Scale Drug Trafficking Law was issued (Table 3). It also indicates, as is common in the Mexican criminal justice system, that the number of pre-trial investigations submitted to a judge (that is, cases in which the Public Ministry decides to present the case before a court) is a relatively small fraction of all pre-trial investigations initiated.[23] It should also be noted that the office responsible for prosecuting and punishing crimes at the federal level appears to assume that "narcotic drug use" is a crime, when it is not.

[21] Via request for public information, file number (*folio*) no. 0001700169413.

[22] The term "narcotic" is used because it appears in legislation and is the term we used to request official information, although the legal term also includes other types of psychoactive substances. We prefer the term illicitly used drugs, but for clarity we used the terms used in the law.

[23] Mexico's criminal proceedings are a linear process consisting of three phases: pre-trial investigation, instruction and conclusions or sentencing. During the pre-trial investigation phase, the police and prosecutors, under the direction of the Public Ministry, conduct investigations to determine whether a crime has been committed. If it is determined that a crime was committed, an effort is made to find those responsible and/or to find evidence for filing formal charges against those arrested. If a person has been arrested, prosecutors have 48 hours (72 hours for certain crimes) to gather sufficient evidence to charge the detainee. If a suspect is found, or if enough evidence is gathered to file charges against a person who has already been arrested, the case is sent to the judiciary, for a judge to decide whether to issue an arrest warrant, and the instruction phase begins. At this point, it is understood that the pre-trial investigation has been turned over to a judge. If sufficient evidence is not found, or if it is determined that the behavior does not constitute a crime, the case is closed.

Table 3. Pre-trial investigations opened and brought before a court for use of narcotic drugs at the federal level

	Opened	Submitted to a judge		
Year		With detainee	Without detainee	Total
2006	27,629	1,225	802	2,027
2007	28,156	1,304	803	2,107
2008	26,475	1,216	641	1,857
2009	24,203	1,402	902	2,304
2010	14,577	794	1,486	2,280
2011	9,926	975	1,042	2,017
2012	3,368	458	419	877
abr-13	1,695	52	41	93
Total	**136,029**	**7,426**	**6,136**	**13,562**

Source: Public information provided by the Attorney General's, File number 0001700169413

Information was requested from the Attorney General's Office related to the "non-prosecution rulings issued in the period from 2009 to 2012 benefiting drug users or drug-dependent persons,"[24] as well as regarding the number of users who were informed of the location of drug-dependence treatment or prevention centers or institutions and how many had begun compulsory treatment under Article 193 bis of the General Health Law.

Between 2009 and 2012, at the federal level, 89,086 non-prosecution rulings were issued for "drug-dependent persons or drug users."[25] The largest number of non-prosecution rulings (36,926) was issued in 2009, although the figure has been decreasing gradually each year. By 2012, the number of non-prosecution rulings had decreased by 70 percent (11,011) as compared to 2009. The same was true in the case of "drug-dependent persons who have begun compulsory treatment," with a 43 percent decrease in the number of people from 2009 (12,977 with compulsory treatment) to 2012 (7,420 with compulsory treatment). Overall, during that period, compulsory treatment was begun for 29,867 persons and concluded for 20,646. As with the data mentioned above, these numbers are still very high, especially considering that this matter is no longer one of federal jurisdiction and that the resources that are employed could be used to investigate and prosecute crimes that have a greater impact on society.

[24] We believe the term drug dependent is problematic because it tends to discredit the person. Because that is the term used in the General Health Law, however, we use it here to report the data reported by authorities.

[25] Attorney General's Office response to request for public information with file number (*folio*) no. 0001700095613.

3.2. Drug use and local institutions

Although information was requested about people arrested for "narcotic drug use" from all states (32), responses were only received from 28. Sixteen provided the requested information, while six[26] provided information about small-scale drug trafficking and four others[27] said they did not have the requested information. According to the information obtained, a total of 4,708 persons were arrested for drug use.

State prosecutors' offices in 29 states responded to inquiries requesting the number of pre-trial investigations opened in cases of drug use since the Small-Scale Drug Trafficking Law was approved. Of these, thirteen provided the information requested, while nine[28] provided data about small-scale drug trafficking, without distinguishing between drug use and dealing or small-scale trafficking. Tabasco provided even broader information regarding "crimes against health" in general. Only Mexico City, Guanajuato and Sinaloa responded that they did not have the information, as "drug use" is not a crime.[29]

The data indicate that since 2009, local prosecutors' offices have opened 889 pre-trial investigations against drug users, with Quintana Roo having the most (34 percent of all investigations reported), followed by Campeche (22 percent of all investigations reported). Of the investigations opened in all states, 47 percent (416) were submitted to a judge; Quintana Roo also had the most investigations turned over to judges.

Requests were also filed with institutions in each state for information about drug users who had been tried and sentenced. Two states (Sonora and Morelos) reported information about verdicts–acquittals and convictions–for drug use. Although drug use is not a crime, we found 34 convictions against drug users, for drug use, in those states. In those cases, ministerial and judicial inertia appear to have blocked implementation of the reforms approved nearly three years ago.

Local judiciary officials were also asked for information regarding non-prosecution rulings issued between 2009 and 2012 in drug users' favor, the number of people who were informed of the location of "institutions or centers for treatment or for the prevention of drug

[26] Nuevo León, Puebla, Sonora, Guerrero and San Luis Potosí.
[27] Veracruz, Tlaxcala, Aguascalientes and the state of Mexico.
[28] Jalisco, Chihuahua, Yucatán, Sonora, Chiapas, Nuevo León, Puebla, Tamaulipas, Michoacán.
[29] Guerrero, the state of Mexico and Veracruz had no information; Tlaxcala did not respond to the request.

dependence" and how many people had begun compulsory treatment under Article 193 *bis* of the General Health Law.[30]

The information obtained from the states was not uniform, because local authorities were inconsistent in their responses.[31] The information obtained showed that between 2009 and 2012, 1,639 non-prosecution rulings were issued at the local level, with the majority (98 percent) in 2012; 36 percent were in the state of Jalisco, 26 percent in Baja California and 9 percent in Guanajuato (see Table 4).

Local officials reported a total of 3,931 cases of people with "drug dependence" who were informed of the location of treatment centers, the majority (99 percent) in 2012. In addition, 7,797 forced treatments of people with "drug dependence" began between 2009 and 2012; 82 percent of those people finished the treatment. The state with the most users who began compulsory treatment was Baja California, with 5,270 (68 percent of the total), all of whom finished the treatment; it was followed by Nayarit (with 752 treatments begun and 355 completed) and Morelos (with 343 begun and 40 percent completed).

Table 4. Non-prosecution rulings and forced treatment at the local level

Año	Non-prosecution rulings in cases of drug dependence	Users and dependent users who were informed of location of institutions or centers for medical treatment or prevention of drug dependence	Users and dependent users who began compulsory treatment	Users and dependent users who completed compulsory treatment
2009	0	0	976	885
2010	0	0	1,937	1,800
2011	7	0	2,084	1,710
2012	1,611	3,911	2,333	1,775
Unspecified	21	20	467	199
Total	**1,639**	**3,931**	**7,797**	**6,369**

Source: Compiled from public information provided by local prosecutors' offices in response to various requests for information.

The inconsistency of the information provided by state agencies indicates a certain lack of transparency and/or omission in the treatment of illicit use of drugs and drug users. The variation in responses from one agency to another could be due to a lack of institutional

[30]Article 193 *bis*, General Health Law: When the center or institution receives the non-prosecution report, under the terms of Article 478 of this law, health authorities must summon the user or dependent user to provide orientation and encourage the person to participate in programs against drug dependence or prevention programs. After the third such report from the Public Ministry, treatment of the drug-dependent person will be mandatory.

[31] Some did not respond to requests for information. Others said they did not have or were unaware of the information. Others provided information about or small-scale dealing or trafficking.

systematization and/or a lack of clarity about duties. Some states may also still depend on the Attorney General's Office to handle cases of drug use and small-scale drug trafficking. In any event, there seems to be a lack of interest in documenting the work done by prosecutors and police officials on the issue, or an inability to do so, or a lack of transparency.

In conclusion, the data presented above show that a significant number of people are arrested, tried and sentenced for drug use, at both the state and federal levels, even though drug use in Mexico is not classified as a crime.

3.3. Health care institutions

As noted above, the Small-Scale Drug Trafficking Law establishes that in cases of drug use, the Public Ministry should inform health authorities of the non-prosecution ruling so the health agency can encourage the user or dependent user to receive medical or preventive guidance. After a third non-prosecution report from the Public Ministry, treatment is mandatory.

The information obtained through this study indicates that there is little clarity on the part of either ministerial or health officials about how healthcare authorities carry out their duties with regard to drug use. Information was requested from healthcare institutions to determine the number of institutions that had received non-prosecution reports from local public ministries and how many times compulsory treatment had been ordered. In response to the request, the Federal Health Secretariat, through the National Center for Addiction Prevention and Control (*Centro Nacional para la Prevención y el Control de las Adicciones*, CENADIC), indicated that since 2011, the year CENADIC[32] was established, 97 requests for assistance (50 in 2011 and 47 in 2012) in cases of drug addiction were handled.[33] The agency also indicated that it summoned no drug users or dependent users for orientation, as CENADIC does not provide treatment.

The state secretariats, meanwhile, reported that "8,325 non-prosecution rulings have been received by prosecutorial authorities, of which 42 percent were in the state of Baja California and 11 percent in Guanajuato."[34] This information, however, does not coincide with

[32] Created by the decree that reforms, adds to and repeals various provisions of the internal regulations of the Secretariat of Health, dated January 6, 2011. It is CENADIC'S responsibility to exercise the functions assigned by law to the Secretariat of Health for prevention and control of addictions as a health problem (Article 45 bis).

[33] Response to request for public information, page (*folio*) no. 0001200111213.

[34] Campeche, Hidalgo, Tabasco and Tamaulipas do not have or are unaware of the information. Guerrero, the state of Mexico, Morelos, Nuevo León, Quintana Roo, Yucatán and Colima did not respond to the request.

that of the local prosecutors' offices. As indicated previously, information provided by local prosecutors' offices showed that between 2009 and 2012, a total of 1,639 non-prosecution rulings were issued. The Attorney General's Office stated that between 2009 and 2012, at the federal level, 89,086 "non-prosecution rulings were issued in cases of drug users or dependent users." In the case of both the local prosecutors' offices and the federal office, the health authorities should have received the non-prosecution ruling, but that does not appear to be the case.

Including information about health care institutions makes even more obvious the uncertainty under which various authorities operate in the area of drug use. It also shows the disproportionate handling of cases in the criminal justice system, as opposed to the health system, as the former reports more cases of drug use and "drug dependence." This highlights the punitive approach taken in the country's drug policies.

Once again, the data show that three years after the Small-Scale Drug Trafficking Law was passed, federal authorities -not just in the criminal justice system, but also in the health system- still have the main responsibility for handing cases involving drug treatment and prevention.

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DRUG USERS IN PERU: POLICIES, RIGHTS AND PROBLEMS

Ricardo Soberón Garrido

This study recognizes the limitations of the current political and legal paradigm based on abstinence for addressing and containing the problem use of drugs in the world, society and among individuals. Four issues are reviewed: i) the evolution of policies; ii) the drug problem in Peru; iii) the rights and duties involved; and iv) problems related to individual rights and services. The study takes as its starting point the need for drug policy to protect human rights and public health as an essential government service.

Peru is one of the few countries in the Andean Region in which a conservative attitude and therefore reluctance to make any reforms to drug policy or regulations prevails. Despite formal recognition of the existence of multiple forms of and contexts for the use of psychoactive substances—including cultural practices[1] in the Andean and Amazonian world that use San Pedro, ayahuasca and coca—the official response, from the president, the church the media, the National Commission for a Drug-Free Life (*Comisión Nacional de una Vida sin Drogas*, DEVIDA), judiciary officials and others, is extremely conservative, restrictive and limited with regard to uses, users and government responses.

This chapter ends with a series of conclusions and recommendations that should contribute to more appropriate decisions by future administrations in Peru, which should evaluate, review and correct domestic policies, as well as public management tools, to better define and delimit concepts associated with health, mental health and substance use.

1. The evolution of policies

Peru's institutional policy response can be divided into four stages: (i) customs; (ii) criminal justice; (iii) inclusion of health aspects; and (iv) increased emphasis on the criminal justice response.

In Peru, unlike in other countries, the drug issue was first addressed as a Customs issue, rather than a public health concern. This was because during the 19th century, there was active trade among members of Chinese communities on the Peruvian coast who

[1]Escohotado, Antonio (2002). *Historia General de las Drogas*, Madrid.

consumed and smoked opium produced in the regions of Amazonas and Cajamarca. In addition, after 1870, a complex international market developed for legal products made from coca from the regions of Huánuco and Cusco, such as cocaine sulfate and other salts.

The Customs Code of March 11, 1920 established the first administrative criteria for the export of substances derived from coca or other psychoactive substances, which had to be followed by Peruvian businesspeople who owned farms, laboratories or shops that produced or sold coca or derivative products.

In the second stage, Decree Law 11005 of March 28, 1949 became the first strictly criminal law to address the issue of drugs, their traffic and use. This second stage, according to Rubio, was characterized by the inclusion of health issues. Decree Law 17505 of March 18, 1969, also known as the Health Code, recognizes addiction as a public health problem, *"not only because of the harm suffered by the addict, but because contagion by suggestion makes it endemic"*[2] – in other words, astonishingly, it refers to mental contagion by suggestion.

The third stage in the evolution of Peruvian legislation came with Decree Law 19505, of August 22, 1972, which was the first to differentiate profit from use; decriminalize personal use and acquisition for personal use; and dictate measures for protecting the user, treating problem use as a social problem. The final stage began around 1978 with the launching of the so-called "War on Drugs" in the Andean Region. This was reflected in Decree Law 22095 of 1978, the country's first comprehensive anti-drug law and in the signing of bilateral agreements with the United States, which brought U.S. drug control cooperation to Peru. A punitive approach was established and a significant number of substantive and procedural laws were issued in Peru aimed at combating the problem in the courts and through military and police action.

The health reform of the 1990s, during the Alberto Fujimori government, was aimed at more selective targeting of public spending, sharing administrative programs with the public sector, strengthening reform of social security services and other mechanisms that reflected the paternalistic approach favored by that government, in a context that made it difficult to demand and/or insist on legal support for economic and social rights. The situation was even more difficult for an issue such as drug use, which is still plagued by many questions, prejudices and gray areas.

[2] Rubio Correa, Marcial. (1998). *Legislación Peruana sobre Drogas a partir de 1920*, Research Monograph of the Centro de Información y Educación para la Prevención del Abuso de Drogas, Lima, Peru, p. 12.

2. Illicit use of drugs in Peru

The first references to drug use mentioned cases of dependence in the 1960s and 1970s, as well as the first public initiatives such as the Rehabilitation Center in Ñaña, Health Ministry programs and other private initiatives, such as Alcoholics Anonymous and Narcotics Anonymous.[3]. Some analysts estimate that more than 100,000 Peruvians have problems related to use and problem use of cocaine-based drugs.[4]

The current National Drug Control Strategy for 2012-2016, developed and presented by DEVIDA and approved by the Peruvian government in February 2012, notes that 5.1 percent of the Peruvian population has used drugs at some time. The most recent poll was the Fourth National Survey of Drug Use in the General Population (DEVIDA, 2011), which estimates the number of people who used drugs in the past year at 249,974; of those, 168,245 used marijuana; 75,506 used cocaine base and 49,927 used cocaine.

Official figures from DEVIDA usually reflect information from three groups: (i) the general population; (ii) university students; and (iii) younger students; the latter being the most vulnerable and/or targeted sectors. Little capacity exists for detailed monitoring of particular situations, and there is a tendency toward generalization of statistics and the information from the surveys.

Another source of information is the Fourth National Survey of Drug Use in the General Population of Peru, 2010,[5] which surveyed people between the ages of 12 and 65 in 21,628 households in 40 cities in the country. The purpose was to understand the magnitude, characteristics, connections and factors associated with illicitly used drugs among Peru's urban population.

[3] "Programa de Intervención en Personas con Abuso y Dependencia de Sustancias Psicoactivas recluidas en Establecimientos Penitenciarios Peruanos," DEVIDA, INPE, OAS, 2008, p. 9.
[4] GARCIA DIAZ Jaime, "Narcotráfico: La Nueva Amenaza a la Seguridad y el Clima de los Negocios," in: Narcotráfico: Amenaza al Crecimiento Sostenible del Perú, MACROCONSULT, 2008.
[5] http://www.opd.gob.pe/cdoc/_cdocumentacion/Informe_Ejecutivo_Población_General_2010.pdf

Table 1. Prevalence of use (at least once in lifetime), general population

	Lifetime	Year	Month
All legal drugs	77.77	54.7	34
Alcohol	75.4	52.4	30.5
Tobacco	49.8	21.1	13.3
All illegal drugs	4.8	1.5	0.9
Marijuana	3.8	1	0.5
Cocaine	1.7	0.4	0.3
Cocaine base	1.5	0.5	0.3

Source: http://www.opd.gob.pe/cdoc/_cdocumentacion/Informe_Ejecutivo_Población_General_2010.pdf

Analysis of the results shows the great difference between the use of legal and illegal drugs: 34 compared to 0.9. The survey estimates that 180,000 people *"could be experiencing some harm to their physical and mental health and a greater psychosocial risk due to recent and current use of illegal drugs."*[6] More specifically, it delimits the universe of illegal drug users in the country to 180,700 people, including 124,364 marijuana users, 49,927 cocaine users and 55,813 PBC users.

3. Approaching use from the standpoint of rights and duties

There is no question about the constitutional status of public health in Peru; it is included in the 1993 Constitution[7] and all international human rights treaties signed and ratified by the country.[8] Article 7, which recognizes *"the right to protection of health for persons with physical and mental disabilities,"* should be analyzed along with Article 8, which states, *"The State combats and sanctions illicit traffic of drugs. It also regulates the use of social toxics."* These two articles also reflect a major constitutional contradiction in a country that benefits from commercial trade

[6] Survey of the General Population, p. 20.

[7] Article 7: "Everyone has the right to protection of their health, in the family and in the community, as well as the duty to contribute to its promotion and defense. Those who cannot care for themselves because of a physical or mental disability have the right to respect for their dignity and to a legal regime of protection, assistance, readaptation and security."

[8] Article 17, American Convention; Article 25.1, Universal Declaration of Human Rights; Article 12 of the International Convention on Economic, Social and Cultural Rights; Article 11 of the American Convention on Human Rights.

in licitly used drugs (alcohol and tobacco) while attempting to prohibit the trade of illicitly used drugs.

Advances in the concept of a social market economy in the 1993 Constitution and the rare Constitutional Tribunal rulings in favor of protecting the right to health have had insufficient impact on the Ministry of Economy and Finance to truly guarantee access to high-quality health services in Peru. The profound impact of neoliberal economic policies and the privatization of public services on Peru's public health system have been duly documented in recent years. In addition, only seven petitions related in any way to mental health appear to have been presented before Peru's Constitutional Tribunal.

Table 2. Legal cases related to mental health: year, judicial action and case number

Year	Prosecution	Folio
2005	**Injunction, payment of pensions to a patient with a mental illness**	**03593**
2006	Habeas Corpus	05842
2007	Injunction	03081
2008	Injunction	02480
2008	Habeas Corpus	03426
2009	Habeas Corpus	02313
2009	Habeas Corpus	05003

Source: *Tribunal Constitucional del Perú*, www.tc.gob.pe/tc_jurisprudencia_sis_05.php

4. Principal problems of drug users in Peru

What forms does non-compliance with human rights take with regard to substance use in Peru? Violations of freedoms and omissions on the part of the government, in relation to users, occur at various levels:

First problem: Personal freedom and autonomy, the problem of thresholds and the lack of free will in cases of compulsory treatment.

One key aspect that fully reflects the Peruvian government's attitude toward the mental health issues related to problem drug use is the police response, which has had a severe impact

on the fundamental rights of drug users. The harsh police response to users is also seen in the courts, where judges also often take a very hard line in cases related to illicit drug trafficking. One example is the Constitutional Tribunal, which, in response to actions seeking guarantees in cases of excessive detention or the granting of sentence reduction benefits for people convicted of crimes related to drug trafficking has upheld the continuation of an illegal action, on the grounds of security (*Sentence 0003-2007-PI/TC, rejecting the claim of unconstitutionality with regard to an article of Law 27765 on Money Laundering, which prohibits sentence-reduction benefits).*[9]

The main problem, however, arises with norms related to the Criminal Code, which establish that personal use is not punishable (Article 299). In response, legislation was passed to create a system based on the amount of drugs that can be considered possession for personal use, or a minimum dose. The establishment of such amounts began in July 2002 with Law 27817, which set thresholds for possession of cocaine base (50 grams), cocaine hydrochloride (25 grams) and marijuana (80 grams).

Those amounts were later reduced under Law 28002, published on June 16, 2003. The current thresholds for personal possession to be considered for the person's own immediate consumption are up to 8 grams of marijuana, 5 grams of cocaine base and 2 grams of cocaine hydrochloride. This means, *de facto*, that users are arrested and treated as if they were dealers of illicitly used drugs when they are detained with amounts exceeding the threshold. When looking at data about possession, therefore, it must be assumed that some of the people are actually users.

The following table shows police arrests by type of drug crime.

Table 3. Police arrests, by type of drug crime

	Traffic	Small-scale dealing	Use	Minors	Total	Arrests for use, as a % of total
2008	2372	2494	7466	366	12698	58.7
2009	2504	2974	7276	488	13242	54.9
2010	3557	3597	5402	124	12680	42.6
2011	3338	2835	6505	561	13239	49.1
2012	3120	2496	9107	620	15343	59.3

Source: DINANDRO, *Observatorio Peruano de Drogas*

[9] http://www.tc.gob.pe/jurisprudencia/2009/00033-2007-AI.html

The first thing to note (and criticize) in Table 3 is that every year, Peruvian police detain a significant number of minors for alleged drug crimes, and that, in itself, constitutes a flagrant violation of human rights and the general principles of Peruvian criminal law.

According to information gathered by the team that provides daily support to the "Green Line," an assistance and protection hotline set up by the Drugs and Human Rights Research Center (*Centro de Investigación Drogas y Derechos Humanos*, CIDDH) for cannabis users who are detained illegally by the police in Lima. In more than 50 percent of the requests, arrests for personal use or possession are followed by attempted abuse (such as planting of other drugs), physical violence and/or corruption (requesting money) before the prosecutor arrives at the police station. Table 4 shows in greater detail the data obtained by the "Green Line." As noted, Peruvian criminal law allows possession of up to 8 grams of marijuana; larger amounts can lead to arrest and prosecution for dealing.

Table 4. Cases recorded by "Green Line" ("Línea Verde")

Year	Resolution in street (coordinator – by telephone)	Resolution at police station (coordinator - by telephone)	Resolution at police station (lawyer – by telephone)	Resolution at police station (lawyer - in person)	Resolution at prosecutor's office (lawyer - in person)	Resolution in court (lawyer - in person)	Total arrests	Number of people assisted
2011	5	2	0	5	3	0	15	21
2012	12	14	2	7	2	0	37	53
2013	9	7	1	1	3	1	21	28
TOTAL	**26**	**23**	**3**	**13**	**8**	**1**	**73**	**102**

Source: Compiled by author with information from CIDDH, *Línea Verde*

On February 15, 2013, when the author was invited to speak at a Specialization Course at the DIRANDRO headquarters, the CIDDH team conducted an anonymous survey of 42 police officers in the specialized anti-drug unit about various aspects of their professional activity. One question asked how they thought drug use should be addressed. As reported by CIDDH:

> *In the minds of anti-drug police in Peru, drug use should be considered an illicit activity. The main reason for that statement is that drug use is strongly accompanied by other social and economic problems both for the individual who uses psychoactive substances and for society. Contrary to expectations,* ***only 26% said drug use***

should not be considered an illicit activity. *One of the noteworthy rationales was that use is basically a public health issue.*[10]

The last part of the complex problem involving drug use, health and the criminal justice system is drug use in Peruvian prisons, where approximately 67,000 people are currently incarcerated. Official information from INPE shows that the Peruvian prison population consists mainly of young men of working age, most of whom have been tried. Infrastructure and services are deficient to non-existent, making rehabilitation difficult. For several years, INPE's monthly reports[11] have referred to the problem of drug use as one of the issues of greatest concern in control of the country's penitentiaries. It is also related to the serious problem of corruption of INPE and National Police personnel. One figure that illustrates the degree of prisoners' vulnerability to drug use comes from a survey of 51 women incarcerated in the Chorrillos Annex, conducted by lawyers from the CIDDH Law Clinic in August 2011. When asked, "Have you suffered from psychological problems (depression, panic, anxiety, stress) since you entered the prison?" Forty-eight said yes and only three said no,[12] which could demonstrate a degree of vulnerability to drug use.

In February 2009, the Ombudsman's Office published Report 140, which states, "*The majority of Regional Governments do not make mental health a priority.*"[13] Regarding the voluntary nature of treatment, the report emphasizes the need for legislative regulation of voluntary and involuntary treatment, as well as the need for periodic review of orders for internment for drug treatment.

Second problem: Lack of access to and quality of services

Institutional leadership in the government is sorely lacking. The Ministry of Health, DEVIDA, other agencies and local governments avoid their responsibilities in the areas of prevention and treatment. There are approximately 500 informal treatment, or rehabilitation, centers, which are privately operated with no oversight by government authorities. An Executive Summary by the DEVIDA Prevention Area, dated August 16, 2011, refers to 219 formal treatment centers in the country for dependent drug users.

[10] Internal CIDDH paper analyzing the cited survey.
[11] http://www.inpe.gob.pe/menu/
[12] CIDDH, Drogas y Políticas Carcelarias en el Perú, Bulletin No. 5. December 2012.
[13] http://www.defensoria.gob.pe/modules/Downloads/resoluciones/2009/RD-010-2009.pdf (p. 5).

The unfortunate events in 2011 and 2012 in two informal rehabilitation centers in Lima demonstrate the chaos and lack of order and control in the operation of this system, which has been left in the hands of people of good will but who often lack even minimal technical, professional or even ethical standards. Two fires set during fights between people in the centers caused a total of 46 deaths from smoke inhalation and burns, as they were locked in the buildings and could not escape the flames. The director of the center called *"Cristo es Amor,"* in the district of San Juan de Lurigancho, where 29 people died, was recently sentenced to 18 years in prison by the 24th Court for Prisoners in Detention.

In July 2011, Law 29765 was passed to regulate the establishment and operation of treatment centers for dependent drug users. Although implementing regulations for the law were published, they have had little effect, as only three existing rehabilitation centers reportedly met the 17 requirements established by the regulations.[14] Analysis of that law, which regulates the establishment and operation of Treatment Centers for Dependent Drug Users in the Form of Therapeutic Communities in Peru, shows that it consists of just six articles, approved on July 14, 2011, in the last days of the government of Alan García (2006-2011), with little political and technical debate to build consensus on the goals and mechanisms to be included. It currently leaves operation of therapeutic centers in the hands of private third parties, with little government oversight. It also allows for various forms of treatment, which are not always evaluated or verified by health authorities.

A review of government budget allocations shows the scant funding–and hence lack of importance–placed on mental health and problem drug use. The following table shows Peruvian government budget allocations, in millions of Peruvian *soles*, for prevention and treatment programs supported by DEVIDA as compared to total resources allocated to all other drug control programs from 2002 to 2010. It shows that only 8.53 percent of all drug-related budget resources were allocated to prevention or treatment.

[14] Conversation between the CIDDH team and Eduardo Vega, acting Peruvian ombudsman, Monday, November 25, 2013.

Table5.
Direct government spending, 2002 - 2010, by intervention strategy
(in millions of *soles*)

Millions of soles	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total
Alternative development	1	3	6.3	6	6.7	4.9	12.5	5.5	16.9	62.8
Interdicction	8.8	16.4	14.2	12	14.2	22.5	46.5	75.2	74.2	284
Prevention and treatment	1.1	0.5	0.6	1.4	2.2	3.3	9.7	4.1	11.8	34.7
Institutional planning	2.5	2.7	2.6	3.4	2.4	2.8	2.9	2.7	3.1	25.1

Source: National Drug Control Strategy 2012-2016,
http://www.devida.gob.pe/images/documentosdisponibles/ENLCD_esp_21-08-12.pdf

Conclusions and recommendations

The following summarizes the principle conclusions of this study and subsequent recommendations that should be implemented in the near future:

1. In recent years, the Peruvian health system has suffered the consequences of deregulation, government downsizing and privatization, resulting in a reduction in the quality and coverage of services, to the detriment of the most vulnerable sectors of the Peruvian population.
2. A serious distortion can be found in how drug users are handled by the Peruvian police, the Public Ministry and the Peruvian criminal justice system in general. Although users are not formally criminalized, in practice police stations channel scarce resources into the detention of users, making them the main victims of corruption and abuse by the police, who, ironically, are the ones responsible for law enforcement.
3. According to the official information available, the problem of the licit and illicit use of drugs in Peru is completely distorted, poorly focused, exaggerated and generalized, and suffers from partial and biased information. Actions taken in the area of prevention have not met either the needs or the expectations of the population or new generations of young Peruvians, who are at risk of problem use. The roles of the Peruvian state must be completely redefined when it comes to conceptualizing, assessing and

addressing the issues of drugs and mental health, taking into account both licitly and illicitly used drugs and differentiating between the substances used and types of users.

4. In the coming years, Peru should take a new approach to mental health problems, particularly those related to problem drug use, with better definition of public and private roles, maintaining the government's responsibility to provide services or, at least, to monitor the quality of services that are provided, without a commercial or patronizing approach, and with policies and actions that emphasize human rights, harm reduction and proportionality in the detection and treatment of the problem.

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STATE RESPONSES TO USERS OF PSYCHOACTIVE SUBSTANCES IN URUGUAY: BETWEEN ALTERNATIVES AND AN ENTRENCHMENT OF THE "WAR ON DRUGS"

Gianella Bardazano[1]

This chapter analyzes the legal situation of users of psychoactive substances in Uruguay, describing the regulations and public policies on use of psychoactive substances, with special reference to the period since the 1970s, but also noting how norms approved in the 1930s and 1940s still influence the stigmatization of users. The main argument is that Uruguay's legislation on drugs reflects a double standard. On the one hand, there has been progress on the rights of cannabis users, with the implementation of a separate market for that substance (Law 19,172), reflecting the need for an alternative to the dominant drug war paradigm. At the same time, however, the drug war model has become more entrenched with regard to consumers of other psychoactive substances, both through their criminalization – because of the restrictive legal interpretation of *"reasonable quantity for personal use"*–and in initiatives for reforming the legal framework for compulsory treatment. Changes in drug-related regulations and public policies reflect contradictions in both conceptualization and approach. On the one hand, reforms are justified on grounds related to the integration of international human rights treaties, while on the other, the rationale is that there is a need to safeguard security and public order.

According to available data, young people are the main targets of drug-related legislation and those most affected by related institutional practices. More specifically, the main targets of the state's most intense, punitive actions are young people with little formal education. Data on drug use are gathered from users in general, users in treatment centers and people in the prison system.[2] Important conclusions from that data are: a) 21 of every 100 Uruguayans say they used an illegal drug at least once in their lives; b) young people are most likely to have used some illegal drug at least once; c) those who have more formal education are more likely to say that they used an illegal drug at some time in their lives; d) between 2006 and 2011, the proportion of Uruguayans who said they had experimented with an illegal drug at

[1] With the collaboration of Ignacio Salamano.

[2] This chapter includes data from national and regional sources, as well as a characterization of users and their relationship with illegal drugs. Three general profiles of users (people in prison, users in treatment centers and consumers in general in the country) are analyzed. Finally, a comparative analysis is made of those three groups, considering their main socio-demographic characteristics and their different patterns of use.

least once increased; e) in 2011, the age at which Uruguayans said they had first experimented with marijuana, cocaine or cocaine base (*pasta base)* ranged from 18 to 19 years; f) the (previously) illegal drug most frequently used among Uruguayans is marijuana, regardless of educational level; and g) in 2011, 29 out of every 1,000 Uruguayans said they had used marijuana at least once a week during the past year, two said they had used cocaine with that frequency and one had used cocaine base that often.

1. The regulatory environment for individual autonomy of drug users

National legislation on drugs consists basically of Decree Law 14,294 and Laws 17,016, 17,835, 18,494, 19,007 and 19,172. Specifically regarding drug use, Article 10 of the Constitution establishes that *"private actions by individuals that in no way affect the public order or harm a third party are exempt from the authority of the courts. No inhabitant of the Republic will be required to do what the law does not mandate or forbidden to do what the law does not prohibit."* The second section of Article 31 of Decree Law 14,294 (in the version cited by Law 17.016) exempts from penalty the possession of an amount of a substance that is meant exclusively for personal use. That provision states, *"Anyone possessing a reasonable amount exclusively for personal use will be exempted from penalty, in accordance with the moral conviction of the judge, who must explain in the ruling the rationale on which it is based."* Use of psychoactive substances therefore is clearly not prohibited, although possession of amounts that a judge does not deem reasonable for personal use is punishable.

Decree Law 14,294 of 1974, with modifications introduced by Law 17,016 of 1998, implies that drug use is a private act that does not affect the public order or harm third parties (Article 10 of the Constitution). Users, however, find themselves on uncertain legal ground regarding the extent of their individual autonomy because of contradictions between the legislation and its enforcement by the country's courts. Although drug use is not criminally prosecuted, behaviors involved in obtaining substances for consumption are subject to prosecution. Because the amounts of substances considered to be for personal use are not established, that determination is left to the discretion of the courts, and specifically to the judge's "free moral conviction" (*libre convicción moral*), as explained below. This undermines the principle of equality and places citizens who want to use drugs in the situation of engaging in a behavior that could violate criminal law, given the lack of legal means of access to substances.

In recent years, Uruguay has promoted extensive debate about drug policies, and it has become clear that there is a need to modify legislation based on the following guiding principles of the National Strategy of the National Drug Commission (*Estrategia Nacional de la Junta Nacional de Drogas*[3], JND) for 2011 to 2015: a) human rights (ensure consistency between human rights principles and conventions and drug policy, with respect for individual and collective rights and guarantees in all areas); b) equity (commitment to human dignity and equity, including socio-economic, gender, generational and territorial equity); c) democracy (promotion of robust and inclusive debate that integrates different views, as a democratic means of strengthening the strategy on drugs); d) cooperation, equitably shared mutual responsibility (defense of multilateralism as a hemispheric heritage and unity in diversity); e) an integral, balanced and cross-cutting approach (need for a complex, inter-agency approach that promotes cooperation with civil society); f) participation (shared management of risks); and g) scientific evidence and best practices (design and implementation of drug policies based on information, scientific knowledge and critically assessed best practices).

This debate under way in the country has raised questions about means of control and oversight, as well as the principles underlying the prohibitionist model, which are based on international treaties such as the 1961 Single Convention on Narcotic Drugs and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

2. Users and the criminal justice system: criminalization of drug use through interpretation of the law and punishment of all forms of access to psychoactive substances

The legal interpretation of the current categorization of crimes related to drug possession calls for a closer look at the legal discourse justifying decisions, the discretionality allowed (which results from lack of clarity in existing norms), as well as the way these norms operate and their legal interpretation within a prohibitionist model. One key issue is the regulatory definition of the phrase *reasonable quantity exclusively for personal use.* In practice, the legal interpretation of this phrase has led to punishment of possession for personal use despite the constitutional recognition of personal freedom, which is enshrined in the principal of individual autonomy (Article 10 of the Constitution). When the court interpreted Article 31 of

[3] The general guidelines of the National Strategy are also described in the explanations of the rationale for the law regulating cannabis and draft legislation for the regulation of alcohol.

DL 14,294, as cited in Law 17,016, it defined which cases of possession should be considered possession for personal use and which should not. The legislature intentionally avoided a precise definition by including the words *reasonable quantity*, which is determined in each case in accordance with the free moral conviction of the judge.[4] Whose ruling must include the rationale for that moral conviction.

2.1. The "free moral conviction of the judge" in the distinction between punishable and non-punishable possession

The following is an excerpt from the rationale for court decisions;[5] it explains the reasons for not applying the second section of Article 31 in a case and illustrates the criminalization of possession for personal use:

> *National legislation does not mean to criminally punish the drug addict as such, because it considers him ill; there is therefore a need to avoid prosecution in some situations in which there is no question that the only person harmed is the individual and not the 'public health' (protected legal principle) (…). Naturally, establishing when an amount is reasonable for personal use always requires a subjective judgment by the observer, but what cannot be subjective is the criterion or measuring stick by which the possible impact on the communal safeguarding of health is measured (…) Anyone who has the vice of smoking tobacco surely carries a pack of cigarettes (20 units) when traveling, even though they will use just 10 or 12; similarly, they can buy by the carton and keep some at home, for whatever reason (more economical, too lazy to purchase every day, etc.), because the law does not prohibit this. The question, therefore, is the following: Is it is possible for* [the defendant] *to consume 44 grams*[6] *of marijuana in two or three days? The answer is obvious; no one could consume that amount of drugs without dying. So this must be acknowledged as an amount that, for personal use, would be sufficient to drug oneself for at least a month. (…), the*

[4] Law 19,172 of cannabis regulation replaced the free moral conviction of the judge with the rule of "rational analysis of the evidence" (*sana crítica*) as the criterion for judgment, in cases of possession or cultivation for personal use. For other drugs, the free moral conviction of the judge remains the criterion for judgment.

[5] This illustrates the "moral conviction" of Uruguayan judges and is repeated almost verbatim in rationales for decisions. The argument not only criminalizes drug use, but also stigmatizes the users.

[6] Depending on the case, the amount considered is: 25.56 grams of marijuana and 28 doses of cocaine base for two persons, 13 grams of cocaine, "21 prepared marijuana cigarettes and substance sufficient for two more," "17 doses of cocaine and one additional rock, which could be divided into another 10," 35 grams of marijuana, 44 grams of marijuana, 42 grams of marijuana, 13.79 grams of marijuana, 31 grams of cocaine and 11 grams of marijuana, 70 grams of marijuana, 10 grams of cocaine, (TAP first session 235/2008, 134/2009, 312/2009 with dissent, 330/2010).

> *defendant could purchase the drug and store the excess, as he used 44 grams of marijuana to make 90 or 100 cigarettes (…) is that a reasonable amount exclusively for his own use? In the opinion of the Court, no, because it would be a cumulative amount that would tend to encourage the vice in the long term, leading to social risks for the person and others, and it therefore falls outside the legal exception to punishment for possession of the drug, which is limited to a reasonable amount for immediate personal use.*

According to the courts' reasoning, although use of illicit substances is not prohibited, possession of relatively small amounts tends to be considered punishable possession, because of the judge's possible stereotypes and prejudices. However, when the judges consider the defendants to be "addicts," in that case the exemption will apply. The prejudices that the system of "free moral conviction" facilitates occur at the two ends of the spectrum, in both application of the exemption (reserved for "addicts", according to the legal rhetoric) and establishment of the penalty. The court's interpretation of the law implies an assumption contrary to the criminal irrelevance of a series of behaviors connected with drug use–in other words, an assumption contrary to freedom. That assumption is reflected in the arguments used to justify decisions about the scope of the exemption in the second section of Article 31. In crimes of abstract danger, such as those analyzed in these decisions, priority is placed on "anticipatory protection," which translates into the punishment of behaviors that are far from causing harm to a protected legal principle. An assumption of danger *iuris et de iure* comes into play here, implying that the agent is not allowed to demonstrate that in the specific case, there was no risk of harm.

2.2. Assumptions established in Law 19,172 of December 10, 2013

The recently approved Law 19,172 raises the possibility of a reversal in prohibitionist practices, exclusively in the case of cannabis, as it exempts from responsibility anyone who transports, has in their power, keeps, stores or possesses an amount of cannabis for personal use, to be determined according to "the rules of rational analysis of the evidence" (*las reglas de sana crítica*). This is an improvement in the criteria for judgment, which shifts from the "free moral conviction of the judge" to the system of "rational analysis of the evidence." The law establishes that possession of up to 40 grams of marijuana is considered possession for personal use, and a person is exempt from punishment if they have in their home or in their

possession, or keep, store or possess the harvest of up to six cannabis plants with psychotropic effects or the product of the collection of such a planting up to a maximum of 480 grams a year, or in the case of a cannabis club's harvest.[7] The rationale for the law appears to attempt to stop punishing drug use indirectly, by establishing that *"it is not in the spirit* [of the law] *that people cannot have amounts larger than those established, as long as the purpose is personal or social use (…). Nevertheless, the judge can consider that possession is for other purposes, according to rational analysis of the evidence…."* Resorting to these "assumptions of freedom" appears to capture the minimalist idea (in criminal law) that there are always good reasons not to punish behavior under criminal law, insofar as doing so reduces the options for freedom of action and freedom of choice. This assumption of freedom demands that the legislature offer good reasons if it seeks to punish behaviors under criminal law; in other words, the importance of the principle of individual autonomy demands that the legislature justify a political decision involving the use of criminal law. The new cannabis legislation excludes from criminal punishment an entire group of behaviors that were being treated as crimes by the courts, as explained above. Law 19,172 helps define, with greater democratic legitimacy[8] (to the extent that the definition is specified in the law and is not delegated to the courts, or, at least, the latter is not done with the same intensity as with the current law), behaviors linked exclusively with cannabis that do not impact the public order or cause harm to third parties. As noted above, it establishes as a reasonable amount for personal use the possession of up to 40 grams of marijuana, and also exempts from punishment anyone who in their home and in their power keeps, stores or possesses the harvest of up to six cannabis plants with psychoactive properties or the corresponding harvest for members of a cannabis club as defined in the law.

2.3. Regulation of cocaine base[9]

Law 19,007, passed in November 2012,[10] increased the minimum penalties (establishing minimum prison terms[11]) for categories of crimes established in DL 14,294, as cited in Law

[7] At the time of this writing, the implementing regulations for this aspect of Law 19,172 had not yet been approved. Paragraph F of Article 5 of the law establishes that they will be authorized by the Executive Branch, that they can have 15 to 45 members and plant a maximum of 99 cannabis plants for psychoactive use.

[8] The assumptions are established in the law and the definition of a "reasonable" amount is not left to the judge's moral conviction.

[9] As noted previously, *pasta base de cocaína* (PBC) is translated as cocaine base. In the case of Uruguay, this is also called *paco*.

17,016, in an effort to respond to *"the alleged public demand for stiffer punishment for criminal behaviors related to cocaine base, which some political leaders and sectors even referred to as 'poison,' demanding that charges of homicide be brought in cases of provision and sale"* (Negro, 2013). In the case of possession of cocaine base, the legal judgment of a "reasonable amount for personal use" uses extremely small quantities (between one and two grams, according to judges) to distinguish between punishable behaviors and those exempt from punishment (Negro, 2013). The distinction between punishable and non-punishable possession lies in whether the subject's health is affected; if the judge, by virtue of his or her "free moral conviction," considers that the amount confiscated is harmful to health, then the behavior is not considered possession for personal use. Although Law 19,007 allows the judge to dictate measures other than preventive detention, this requires that three conditions be met: 1) the defendant must not have a criminal record of crimes involving willful misconduct; 2) the judge must consider the amount of the substance confiscated to be small; and 3) the defendant must not have sold the substance to minors.

3. Drug users and the government's health response

The goals of Law 19,172 on regulation of the cannabis market include the protection, promotion and improvement of public health through a policy of risk reduction and harm reduction for cannabis use, aimed at promoting information, education and prevention of the harmful consequences of drug use, as well as the treatment, rehabilitation and reintegration of dependent drug users (Article 1).

Meanwhile, Article 40 of Decree Law 14,294 notes that national criminal justice doctrine understands "*non-criminal addict*" as a legal state (Ottati, 2005: 119-120). The 1974 measure establishes (for all illicitly used drugs) that "*anyone caught consuming narcotic substances or abusing psychopharmaceuticals or in circumstances leading to the assumption that they just did so, or in possession of narcotic drugs for personal use*" will be taken before the corresponding criminal

[10] The law addresses behaviors included in legislation on narcotic drugs when "they have as their material object all forms of cocaine in their freebase or smokeable state, including cocaine base." Given the reference to cocaine in its freebase or smokeable state, it is clear that the provision refers to crack and cocaine base; the inclusion of the reference to cocaine base is therefore redundant, and it seems that its only purpose is to "reaffirm the reference to the legal *nomen juris*" (Negro, 2013).

[11] The prison sentence is a minimum of two years and is regulated, along with other penalties, in the Criminal Code (Articles 66 to 84). The result of the majority interpretation of Article 27 of the Constitution ("in any stage of a criminal case that does not have to result in a prison sentence, the judges can free the defendant...") is that when the category of crime has a minimum prison sentence, incarceration is the rule.

judge, who will order a medical examination under the auspices of the National Commission for Combating Addiction (*Comisión Nacional de Lucha contra las Toxicomanías*). Article 40 continues by stating that "if the examination determines that the person is a drug addict," the judge will order compulsory medical treatment (at either an in-patient establishment or ambulatory center). For compliance and termination of the measure, DL 14,294 refers to the provisions of Law 9,581 of 1936 (law on assistance to psychopaths). In addition, Law 10,071 of 1941 (Law on vagrancy, begging and similar situations) orders curative security measures for *"habitual alcoholics and drug addicts who become drunk or take drugs in public places or even in private places when they alter the public order and constitute a danger to others."* With regard to prosecution, Law 19,120 of August 28, 2013, which modified Article 361 of the Criminal Code, establishes a penalty of seven to 30 days of community labor for anyone *"in a serious state of emotional or physical alteration produced by alcohol or drugs, in a public place or a place accessible to the public, or anyone who provokes that state in another by the same means."* Legislation therefore reflects two punitive responses: one with a hygienist approach dating from 1941 and the other based on a rationale that combines peaceful coexistence and public security, presented by the executive branch in the *Strategy for Life and Peaceful Coexistence* (*Estrategia por la Vida y la Convivencia).*

On December 23, 2013, the Senate approved draft legislation creating the "Public Health Consortium for immediate assistance to persons affected by problem use of drugs in a crisis situation." At the time of this writing, the House of Representatives has not yet debated the measure, although it was announced that it would do so in early February 2014. The bill proposes creating a Public Health Consortium as part of the National Secretariat on Drugs to provide *"immediate health assistance to problem drug users in a crisis situation who constitute a risk to themselves or others,"* and would include participation by the National Secretariat on Drugs (*Secretaría Nacional de Drogas*, SND), Ministry of Public Health, State Health Services Administration (*Administración de los Servicios Sanitarios del Estado*, ASSE), Ministry of Social Development, Institute of Children and Adolescents of Uruguay (*Instituto del Niño y el Adolescente del Uruguay*, INAU) and Ministry of the Interior. The rationale in the original draft legislation submitted to Congress by the executive branch[12] notes that the purpose of the

[12] The text approved by the Senate has undergone variations in editing. It is interesting to note some passages of the version submitted by the executive branch, which maintained almost word for word the language of Article 40 of DL 14.294 for compulsory treatment, which says that persons *"found in the public thoroughfare or in uninhabited public or private places in circumstances leading to the assumption that they have used narcotic substances or that they just did so, or possess them for their personal use, when such circumstances pose a danger to themselves or to third parties, can be taken immediately to the*

measure is to preserve the physical and mental integrity of drug users, achieve the recovery of drug users and safeguard security and the public order. In the editing of the text, references to the "dangerousness" of the person or the use of the term "compulsory in-patient treatment" have been eliminated. Yet while explicit references to the paradigm of social defense and dangerous states that appear in legislation from the 1930s and 1940s have been replaced by less hygienist language, the spirit of the text is maintained. By appealing to the need to protect drug users' health, the draft legislation aims to create a harsh and punitive social control mechanism that targets people who use illegal drugs (Sbrocca, 2013). Or, at least, people who the team of doctors and police who make up the consortium consider to be included within the highly indeterminate language of Article 1: "problem users in a crisis situation who constitute a risk to themselves or others." The draft legislation allows for "involuntary in-patient treatment" for adults and refers to the Code for Children and Adolescents (*Código de la Niñez y la Adolescencia*, CNA) for those under age 18, which allows the judge to order "compulsory in-patient treatment" with a medical request. The legislation on children and adolescents uses the term "compulsory in-patient treatment" to refer to in-patient treatment ordered by a judge on the basis of a medical report, while the draft legislation approved by the Senate uses the term "involuntary treatment" to refer to the medical action authorized by a judge after a person is detained in a public or private place in circumstances that are considered to merit the intervention of the Public Health Consortium. The legal guarantees included in the draft legislation are more symbolic than real, because the measure does not describe the criteria for determining inclusion in the category of persons established in Article 1;[13] does not specifically refer to the existence of risk to life or the imminent nature of such risk; does not ensure that the judge has the ability to see that other therapeutic alternatives are evaluated before ordering in-patient treatment; does not require a mandatory hearing, but designs a procedure based on communiqués and reports; and does not make the court responsible for monitoring in-patient treatment, but merely gives it the power

Assistance Center designated by the Executive Branch for this purpose. The person can only be taken by personnel responsible for the System for Assistance to Victims of Narcotic Drug Use." The text approved by the Senate repeals Article 40 of that law.

[13] In enforcing the law, the determination of problem users can be made using the definition provided in some documents of the National Secretariat on Drugs, in whose sphere the Public Health Consortium will operate. That provision states: "abuse is understood as that form of relationship with drugs in which, because of the quantity, frequency and/or the subject's physical, mental and social state, there are negative consequences for the user and/or his surroundings (...) During a relatively prolonged period, at least one of the following manifestations: physical and/or mental complications related to use of the substance; repeated use of a substance that leads to an inability to fulfill obligations; repeated use of substances in situations in which use can constitute a hazard; legal problems related to use of a substance; persistent or recurring interpersonal or social problems caused or aggravated by use of the substance" (Glossary of the National Assistance Program for Problem Drug Users, 2007). The complexity of the evaluation and the need to quickly justify detention for health reasons would be likely to result in arbitrary procedures by the consortium.

to request reports. For situations not covered by this law, the text refers to Law 9,581 of 1936 (law on assistance to psychopaths).

With regard to treatment centers, on September 3, 2013, the Executive Branch approved a new decree, replacing the one approved in 2007, establishing *"general norms for assistance to and treatment of problem drug users."* Chapter IX of the decree establishes users' rights. In effect, Article 39 establishes that respect for the human rights of users of services will be guaranteed, and Article 40 establishes the obligation to treat users, their relatives, friends and legal representatives with the dignity inherent to human beings. It also specifies a guarantee for the right not to be subjected to torture or to cruel, inhumane or degrading treatment or punishment; not to be subjected to abusive and arbitrary intrusion into one's private life or illegal attacks on one's honor or reputation; not to be subjected to measures that undermine freedom of conscience or religious freedom; and not to suffer restrictions on freedom of thought or expression. For people under age 15, it establishes that their treatment must take into account their stage of development and conform to specific legislation for children and adolescents. Article 40 also provides for the patient's informed consent regarding the content and conditions of therapeutic treatment. Because they were approved very recently, it is not yet possible to evaluate the impact of these assistance-related norms on users' rights.

4. Incarcerated persons and use of illegal drugs

The most recent data about the use of illegal drugs among prisoners in Uruguay come from the "First National Census of Prisoners" conducted between June and October 2010 by the University of the Republic School of Social Sciences and the Ministry of the Interior; the second Survey of Drug Use among Recently Detained Persons, conducted in 2004 by the National Drug Council (*Junta Nacional de Drogas*, JND) and CICAD; and statistical summaries of the control of supply prepared periodically by the JND. This section examines those reports, indicating key trends and general characteristics of patterns of use in that population. It includes a review of supply-related trends between 2008 and 2012, establishing the number of people arrested and tried during that period.

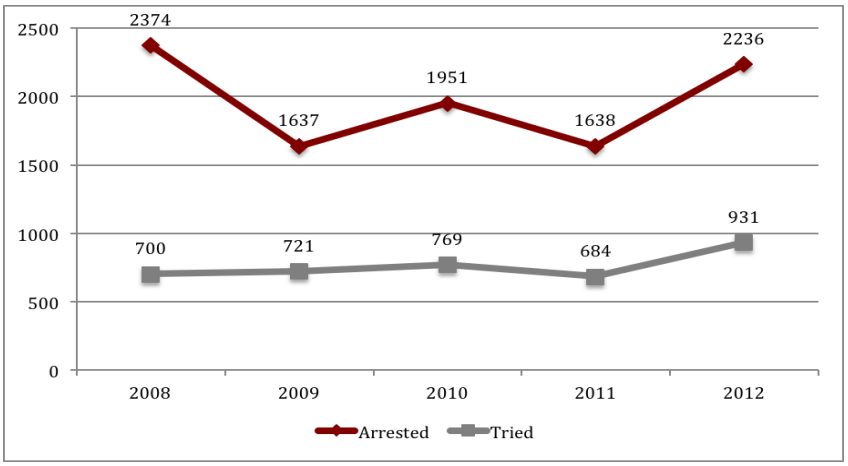
The First National Census of Prisoners (FCS-Interior Ministry) was designed to gather data about the basic characteristics of all prisoners, to understand incarceration conditions and determine the social, cultural and economic situation of the prison population. The universe consisted of all people incarcerated in any prison in the country at the time of

the survey (June to October 2010). A total of 8,492 prisoners were registered; of these, 5,831 provided all information requested, incomplete information was obtained from 2,338, and no information is available about 323, who refused to be interviewed. In socio-demographic terms, the population is mainly male, with nine men for every woman. It is also mainly young: 7 out of every 10 prisoners are between ages 18 and 35. Within this age group, the proportion between ages 18 and 25 (35 percent) is similar to the proportion between ages 26 and 35 (34.5 percent). The proportion that has completed primary school is 26.6 percent, but six out of every 10 people surveyed said their highest educational level completed was incomplete basic education.

The Second Survey of Drug Use among Recently Detained Persons (JND and CICAD) included all people over age 18 who were arrested during one month in the second half of 2004 -for any cause- and sent to different police stations in Montevideo. A total of 914 interviews were conducted and urine samples were analyzed. Another recent study of drug use in Uruguayan prisons was published in 2010 in the sub-regional report on drug use among the prison population and the relationship between drugs and crime (ONUDD-UNODC, CICAD/OAS, Inter-American Observatory on Drugs and JND), based on the Study of Drug Use and Associated Factors among the Penitentiary Population in Uruguay (*Estudio sobre Consumo de Drogas y Factores Asociados en Población Privada de Libertad en Centros Carcelarios de Uruguay*) (2008). There has been a considerable increase in the number of people incarcerated in recent years. The crime for which the largest number of people are incarcerated is robbery or attempted robbery. One out of every 10 people in the total population surveyed said they were incarcerated for drug-related crimes, which would add up to 800 people, according to the census parameters.

The JND's reports on supply control show a large proportion of men among those arrested and tried during the study period (2008-2012): 7 out of every 10 are men, while 3 out of every 10 are women. There are also various changes in the number of people arrested and tried during the study period.

Figure 1. Number of people arrested and tried on drug-related charges



Source: Compiled by author based on data from report on control of supply, JND (2012).

The graph shows that between 2009 and 2011, the number of people arrested held relatively steady at between 1,638 and 1,951. In 2012, the figure increased to 2,236 people, a level similar to that of 2008 (2,374 people). Despite some variation in the number of people arrested over this period, the number of people tried on drug charges remained fairly steady until 2011, at between 684 and 769 cases (over the period, the proportion fluctuated between 30 percent and 50 percent of all arrests). In 2012, there was a significant increase in the number of cases in which charges were filed: from 684 in 2011 to 931 in 2012.

Another relatively recent source of data about prisoners and drug use in Uruguay is the Second Survey of Drug Use among Recently Detained Persons by the National Drug Commission (JND) and CICAD. That report shows that the prevalence of marijuana use in the past year and past month was 31.5 percent and 24.8 percent of the prison population. It also shows that those figures were seven times the level in the rest of the Uruguayan population.

According to the results of the laboratory analysis, prevalence of annual and monthly use of cocaine base was 16.7 percent and 12.6 percent of the surveyed population, respectively; those rates are 23 and 46 times the level for the rest of the population. Annual and monthly rates of cocaine use were 9.7 percent and 4.5 percent of prisoners, respectively, six times the levels in the rest of the Uruguayan population.

Finally, the sub-regional report on *Drug use in the prison population and the relationship between crime and drugs* (ONUDD-UNODC, CICAD/OAS, Inter-American Observatory on

Drugs and Junta Nacional de Drogas, 2010) states that in 2008, 8 out of every 10 prisoners had used an illegal drug at least once in their lives. For comparison, that was four times the lifetime prevalence figure for the rest of the Uruguayan population, according to data reported in the 2006 Household Census. This trend held true for use of all illegal drugs, and the age at first use was significantly lower than for the population surveyed in the Household Census. Besides the high prevalence of use at least once in one's life, use of multiple illegal drugs is another strong characteristic of that population: on average, the prison population has used between two and three types of drugs. The substance with the greatest lifetime prevalence is marijuana (74.1 percent), followed by cocaine (51.4 percent), then cocaine base (46.3 percent) and finally hallucinogens (22 percent).

Conclusions and recommendations

The Uruguayan state's responses to users of psychoactive substances, with regard to recreational use and supply, as well as the prevention and treatment of health risks associated with the use of those substances, reflect contradictions in national legislation. While some laws reflect a hygienist approach (such as the law on assistance to psychopaths and the law on vagrancy, begging and similar states), others encourage the criminalization of users by leaving the decision about criminal punishment to the "free moral conviction" of judges (Narcotic Drug Law 14.294, as cited by Law 17.016 and Law 19.007). At the same time, responses that offer an alternative to the prohibitionist approach are limited exclusively to cannabis (Law 19.172). In other words, the contradictions in conceptualization and approach that can be seen in the State's responses to users of psychoactive substances must be considered in relation to a dual discourse that supports reforms based on the integration of international human rights norms on the one hand and arguments that emphasize the safeguarding of security and the public order through punitive measures on the other.

In recent years, national drug policy guidelines outlined in the JND's National Strategy have centered on human rights and the need to promote and implement regulatory solutions that provide an alternative to the prohibitionist model. These guidelines are reflected in the recently approved Law 19,172, which regulates the cannabis market. This alternative to the prohibitionist model was approved in parallel with the promotion, also through executive branch initiatives, of specific regulations for behaviors related to cocaine base, including stiffer penalties and increased criminalization of users. Except in the case of cannabis, the "free moral conviction of the judge" has been maintained as the means of

determining whether possession is treated as a crime or a behavior that is not punishable because it involves an amount considered reasonable for personal use.

Meanwhile, the draft legislation reforming the regulatory framework for compulsory treatment, which is part way through the approval process in Congress, merits serious criticism from the standpoint of the rights of users of psychoactive substances, as do the provisions of the draft legislation on the regulation of alcohol regarding non-compliance with the prohibition against consuming alcohol in public. For the proposed legislation to be consistent with the principles of the JND's National Strategy for 2011 to 2015, it would be necessary to ensure that dependent drug users have free, informed and autonomous access to appropriate and safe treatment, thus guaranteeing respect for human rights.

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CONCLUSIONS AND RECOMMENDATIONS[1]

The CEDD country studies of drug users and government responses reveal persistent criminalization of people who use these substances and point to the need to rethink drug policies in Latin America, shifting toward a focus on health promotion and harm reduction, instead of the current punitive, criminalizing approach.

The CEDD studies summarized in this report analyze each country's response to drug use in two basic areas: health and criminal justice. The studies begin with a review of legislation, regulations and public policies related to illicit use of drugs in each country, followed by an analysis of the way in which laws and public policies are actually implemented and enforced. The results show that most drug-related public policies adopted by the countries studied are based on a punitive, prohibitionist approach that does not distinguish among different types of use, substances or consumers and are therefore inadequate for addressing the harm caused by problem drug use. In practice, those policies also violate a series of fundamental rights of drug users. The studies reveal the need to redirect current drug use policies toward an approach that emphasizes public health, human rights and harm reduction and is based on scientific evidence.

Based on the information and analysis presented in these eight country studies, we have developed 14 principal conclusions, which are grouped in three parts. The first are related to general aspects of public policies on drug use, while the second and third groups are related specifically to public health and the criminal justice system's response to users of controlled substances. Based on these conclusions, we present a series of recommendations that we hope will contribute to the development of more realistic, effective and humane drug policies.

[1] This chapter was written by Coletta Youngers, Catalina Pérez Correa and Diana Guzman, using the individual country studies summarized in the present report.

CONCLUSIONS

A) GENERAL PUBLIC POLICIES

Conclusion 1

The design of national policies and legislation related to drug use is often the result of a strict interpretation of international drug control treaties that is not necessarily in line with those conventions and which conflicts with international human rights law. The result is the violation of users' fundamental rights and discrimination against and stigmatization of users. Governments often base punitive laws and practices on a strict interpretation of international legal norms on drugs–a tendency promoted by international bodies related to drugs, such as the International Narcotics Control Board (INCB) and the United Nations Commission on Narcotic Drugs–while ignoring other international responsibilities in the area of human rights.

International legal instruments for control of illicitly used drugs present at least two basic problems with regard to drug use.[2] First, the Single Convention on Narcotic Drugs of 1961 recognizes only two legal forms of drug use–medicinal or scientific–as well as abuse or addiction. The Single Convention does not recognize other uses as legitimate, including recreational use, even though that use represents the largest part of the drug market and does not cause significant problems for the vast majority of users, their families or their communities. Meanwhile, the 1972 Protocol (to the Single Convention of 1961) highlights the need to provide access to treatment and rehabilitation for drug users, along with or as an alternative to incarceration.

Second, although the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances does not make drug use a crime, all actions related to it–such as possession, purchase and cultivation–are included in the list of criminal behaviors, along with trafficking and inciting or inducing use. However, the convention contains an escape clause, as it states that the provisions are "subject to [the] constitutional principles and the basic concepts of [the] legal system" of each country. Despite this clause, the 1988 convention forms the basis for the criminalization of users, which leads to stigmatization of and

[2] As is analyzed in detail in the CEDD study, *Systems Overload: Drug Laws and Prisons in Latin America*, the laws in most of the countries studied were revised and made stricter after the international treaties were adopted. In fact, the 1988 convention required the countries that ratified it to adjust their national legislation to the international norms.

discrimination against users and leaves open the option of punishing them with compulsory treatment.

Although it is clear that within the framework of the drug control treaties, countries are not required to punish drug use, in practice most of the countries analyzed in this report treat drug users as criminals. This highly punitive tendency, which stems from a strict interpretation that is not necessarily consistent with the actual provisions of the international drug control treaties, threatens and violates fundamental rights enshrined in the constitutions of the countries analyzed. It also contravenes international human rights treaties that are at the heart of the universal and Inter-American human rights protection systems. Among the outcomes of such an interpretation are policies that ignore the existence of non-problem recreational use and threaten users' rights.

Yet according to guidelines issued by the UN General Assembly, drug control should comply with international human rights norms and standards. According to the UN Charter, United Nations member states are required to promote "universal respect for, and observance of, human rights and fundamental freedoms," and human rights treaties take precedence over any other treaty, including those of the international drug-control system. As this report illustrates, however, the implementation of drug control policies in the region results in various violations of the human rights of drug users.

Conclusion 2

Governments in the region emphasize controlling the supply of illicitly used drugs over drug use, or demand, resulting in a lack of social and health-oriented responses to the latter and leading to the violation of (present and future) users' right to health. For decades, the U.S. government has implemented a "war on drugs" strategy in Latin America aimed at disrupting cannabis, cocaine and heroin markets at the "point of origin," in countries where the drugs are produced. That supply-oriented strategy, however, has had little effect on reducing the size of the illicit drug market or use of those drugs. The emphasis on supply-reduction has also undermined health policies, because resources are allocated to the armed forces and justice sectors instead of efforts aimed at prevention and promoting public health. A similar argument can be made with regards to prioritizing resources for law enforcement to the detriment of promoting sustainable economic development in rural areas where people are involved in growing illicitly used crops.

This tendency is evident both in the economic assistance provided by the U.S. government to countries in the region and in domestic spending in those countries. Several of the country studies show the lack of balance between resources allocated to supply reduction and those earmarked for demand reduction. In Argentina, for example, the proportion of spending is approximately 82 percent for reducing supply and 18 percent for reducing demand. In Peru, the study reveals that between 2002 and 2010, most emphasis was on interdiction, while only 8.53 percent of government drug-related budget allocations went to prevention and treatment. In Colombia, the proportion is even worse: only 4.1 percent of all spending on drug-related programs went to prevention and treatment. In Bolivia, although the amounts of annual funding for police interdiction efforts are made public, it is not known how much funding is available for prevention, treatment and rehabilitation. The CICAD Evaluation Report on Bolivia's Progress on Drug Control 2007-2009 notes that the Ministry of Health and Sports, responsible for designing and implementing public policies related to drug abuse, did not have a budget for treatment programs during the evaluation period. In Brazil, limited healthcare resources are diverted to coercive measures (such as compulsory treatment) in private therapeutic communities in which flagrant human rights violations have been reported.

Overall, these figures suggest that governments have shirked their responsibility to strengthen and expand social and health-related public policies and have focused resource allocations on punitive policies. Some might argue that this disproportionate investment is justified because the problem of violence associated with criminal drug trafficking networks is larger and more serious than drug use. Similarly, it could be argued that in countries such as Colombia or Mexico, which have high levels of drug trafficking-related violence, investing less in demand-side policies is reasonable because those policies would have a less dramatic impact. These arguments are contradictory, however, for at least two reasons: First, the resources are actually invested in combating supply, not organized crime; and second, the disproportionate resource allocation exists in all countries, not just in those with high levels of violence or production. The studies also show that governments have failed to sufficiently address problems that can result from drug use.

In contrast to current practice, governments should design and implement inclusive, evidence-based policies on illicit use of drugs that respect human rights, increase budgets and provide high-quality, accessible public services. Governments should also develop the ability to periodically monitor and evaluate enforcement of policies and their outcomes. The focus on

supply is also reflected in the tendency to give the criminal justice system precedence over the health system, as explained in greater detail below.

Conclusion 3

Most of the studies report a lack of information about drug use, lack of systematization of that information, and methodological and conceptual problems in gathering information about drug use. This has a negative impact on government responses to drug use and the development of informed, evidence-based policies.

The lack of reliable information–even of indicators on basic issues such as mortality from drug use, harm caused, etc.–make it impossible to determine the true scope of the phenomenon. In addition, when countries produce information, they use prevalence of drug use (often in the past year) as the main indicator, which provides a distorted picture of the use of controlled substances and makes it impossible to distinguish between problem and non-problem use; it also contributes to an exaggeration of the magnitude of problem use. As a result, rhetoric about drug use and users is based on prejudices, creates fear and does not reflect the real experiences of young people. The tendency to present information about drug use linked to crime, along with the lack of research on the issue, has encouraged official rhetoric in which drug users are labeled "criminals" or "sick." Ultimately, it is not just a matter of having reliable data, but also of how those data are interpreted and used to create public policies.

In Mexico, for example, there is a clear lack of information about the use of illicit substances and official approaches to the issue. Although the country could have a significant number of users, existing information about users and use lacks uniformity, is not comprehensive or is focused on groups with problem use. Little information is available about patterns of use or how users obtain drugs. Moreover, measurement tools appear to be based on the assumption that all use is problem use, without recognizing that most use is recreational (a tendency encountered in nearly all the countries studied).

Bolivia also has little systematic information about use; monitoring tools that are essential for demand-reduction policies, such as the Bolivian Observatory on Drugs (*Observatorio Boliviano de Drogas*), are not yet in operation. Available information about drug use comes from isolated studies that use methodologies that are biased or based on zero-tolerance ideologies, are not repeated over time and use different population samples.

In recent years, some governments have improved the gathering of information about drug use. In Ecuador, for example, although previous reports on nationwide drug use were based on unreliable methodologies, the most recent CONSEP report presents the results of a national survey of drug use by students in 2012, which corrects the methodological flaws of earlier studies. The new approach uses categories that allow measurement over time, frequency and quantity of use of certain drugs. Similarly, in Uruguay a similar effort has been under way for several years to develop an information system with indicators and methodologies that provide a base-line for describing the evolution of certain characteristics of drug use over time, thus yielding reliable information that can provide input for public policy.

In Brazil, new research methodologies have also been implemented to better understand drug use. The Fiocruz Foundation, for example, uses a different methodology (*scale up method*) to obtain information about users of cocaine base, or crack, and other substances. That methodology generates more reliable data than those obtained by traditional methods, such as household surveys, though the two data sets cannot be compared.

Conclusion 4

In all of the countries studied, we found strong discrimination against and stigmatization of drug users; even in countries where use of those substances is not a crime, users are often treated as criminals. The 1961 Single Convention on Narcotic Drugs equates all use other than medical or scientific use with addiction. In addition, illicit use of drugs is often associated with high-risk behaviors, such as sexually transmitted diseases and, more recently, with public insecurity, violence and crime. The country studies show that in the region, users are often perceived and treated as criminals and/or as being sick.

This characterization is still reflected in the legislation of some of the countries studied. In Argentina, for example, the rationale for the 1974 drug law identified the user as a person who succumbed to a "vice that not only destroys himself, but which ... causes harm to those around him." It also maintains that "every drug addict is potentially a drug trafficker," thus justifying a punitive approach. Though manifest in different ways, these ideas persisted in legislation and jurisprudence in the 1990s. The current situation contrasts with that view, however, since, as the study shows, most users arrested in Argentina are young people without criminal records who were arrested on the street with small amounts of drugs, and who were not committing another crime or carrying weapons.

In Ecuador, the Civil Code also maintains provisions that discriminate arbitrarily against drug users. For example, being a "drug addict" can be grounds for divorce, and any drug user can be turned over to a custodian who will manage his or her property. In other words, it reaffirms the social sentiment that drug use violates generally accepted rules of behavior. In all of the countries studied, we found that drug use is seen as an unacceptable deviation from those rules.

Even in Uruguay, which has the most progressive drug policies of all the cases analyzed, judges' comments in their court decisions contribute to the stigmatization of users, often referring to them as ill.

Peru–where drug use or possession of small amounts is not a crime–presents an interesting case. Because of prejudices about use, the majority of the population views any type of use as illicit. According to one survey cited in the study, only 26 percent of Peruvian police say that drug use should not be considered an illegal activity. This shows that even in countries where drug use is not a crime, drug users are not considered subjects of full rights.

In Colombia, although drug use itself is not illegal, police officers tend to associate substance use with a security threat. According to surveys and other documents cited in the Colombia study, many citizen complaints identify drug use as a security problem in neighborhoods. According to interviews, police tend to reproduce that stereotype, particularly in the case of users with certain racial and socioeconomic class profiles.

Finally, the use of certain substances leads to greater stigmatization and criminalization than others. This is true of users of different kinds of smokeable cocaine, as is particularly evident in Uruguay, where the government is creating regulated cannabis markets, but where there are high rates of criminal charges against users of the cocaine base known as *paco*. Judges also use very low thresholds (between one and two grams) for determining whether the amount confiscated is for personal use or for sale. In Brazil, in response to publicity about crack users in the streets, whom the media labeled "zombies" or non-human, the government has adopted punitive policies that violate rights, such as compulsory treatment. Although users in Brazil are not sent to prison, users of certain substances, such as crack, are arrested by police so tourists will not see them.

Conclusion 5

Largely as a result of the stigmatization of drug use, users suffer constant violation of their fundamental rights. Several international human rights treaties are relevant for cases of users of controlled drugs. These include the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Despite governments' obligations, however, users suffer a series of violations of their basic rights, including:

- **Right to autonomy and to free personal development**

This right implies the freedom to make decisions about what one puts into one's body. Most users of drugs do so because they decide to do so and because it gives them pleasure, not because they have a problem with compulsive behavior.

- **Right not to suffer discrimination**

Users of illicit substances are often stigmatized, resulting in unequal treatment in society and before the law.

- **Right to health**

For drug users, the right to health implies the availability of public health centers, goods and services; that they be accessible (economically and physically) to the entire population; and that treatments comply with objective and scientific criteria. The lack of development and funding of prevention and treatment policies, as well as the inadequate oversight of treatments offered by the private sector in the countries studied, threaten and violate this right to which users are entitled.

- **Right to information**

As noted in most of the country studies, governments have the duty to provide information to users about potential harm from the use of legal and illegal drugs. In the case of problem use, the state also has the duty to provide information about available treatments. In practice, however, the information provided is scant and is based on stereotypical and erroneous ideas about drug use, its consequences and its scope.

- **Right to due process**

The authors of the report on Mexico explain that this right is often violated because of the criminalization suffered by users of illicit substances. Like other marginalized groups, because of the stigma related to drug use, they are more vulnerable before authorities, making enforcement of this right even more important for them.

It is important to acknowledge that some countries have made significant progress in recognizing users' rights in their laws and policies. Argentina's 2010 Mental Health Law establishes that "Persons with problem use of drugs, legal and illegal, have all the rights and guarantees established in this law with regard to health services," and includes a list of those rights. In Uruguay, a decree issued in 2013 mandates respect for the human rights of users and establishes the obligation to treat users and their families with the dignity inherent to the human person, along with other rights recognized in the decree. Ecuador's Constitution enshrines the right to health for occasional, habitual or problem users, as stated in Article 364.

Approval of laws and policies, however, is only the first step, as their impact depends on effective implementation. The case of Colombia exemplifies this. The reform of Article 49 of the Constitution recognizes that users have the right to treatment and that this should be voluntary. In 2012, a law was also approved recognizing this right and requiring the General System of Social Security in Health to offer treatment services. As the study shows, however, in practice various constraints seriously restrict these rights.

B) PUBLIC HEALTH POLICIES

Conclusion 6

A common trend in the countries studied is the failure to distinguish among the different forms of use and the substances themselves, as well as a lack of appropriate government response to each. The country studies use different categories to distinguish forms of use, but in general, these can be classified as: infrequent non-problem use, frequent problem use, frequent non-problem use and infrequent problem use. This classification shows that not all drug use is problematic or justifies government intervention. In several of the countries studied, however, legislation recognizes only problem use. And as noted above, in

several countries there is a tendency to categorize all users having a dependency, resulting in policies aimed at eliminating all types of use.

In Bolivia, for example, legislation and official rhetoric do not distinguish among different types of users (considered a homogeneous population in policies and plans) or types of drugs. In the case of Peru, the law does not distinguish between recreational and problem use. The National Drug Control Strategy 2012-2016 also fails to distinguish among different types of users. As a result, many users are detained, although neither drug use nor possession for personal use is a crime in Peru.

One overall conclusion of the studies is the importance of distinguishing among different types of substances and the possible harm they can cause in order to develop more proportional policies; this is at the heart of the current debate over cannabis. Earlier studies by CEDD show that throughout the region, cannabis users face stigmatization and harassment by local police and are often detained for growing plants or for simple possession of the substance. In several of the countries studied, cannabis consumers make up a significant percentage of people incarcerated on drug-related charges. This is true even though various countries around the world have new ways of regulating the cannabis market (for example, Uruguay or the U.S. states of Colorado and Washington).

Conclusion 7

In general, states have adopted a narrow interpretation of their responsibilities related to the right to health, especially for drug users, allowing the private sector to become the main provider of rehabilitation and treatment services. Governments have also abdicated their responsibility in the regulation and oversight of those centers, many of which function as therapeutic communities operated informally by religious groups. As explained above, this situation results from the disproportionate attention given to supply over demand and is reflected in the lack of investment in public health and in programs targeting illicit use of drugs, as well as in the privatization of health services in general. In the countries studied, public health institutions also lack appropriate services for people with drug dependencies. That has alarming implications given the increase in drug use in various countries in the region.

One particularly worrisome problem is the failure to regulate private rehabilitation and treatment centers. Some countries, such as Colombia, have tried to regulate these establishments, but have run into many difficulties in implementation. In that country,

rehabilitation treatment has been included in the Mandatory Health Plan. The availability of health services for dependent drug users, however, mainly depends on private initiatives, which implies a lack of access for many people who request assistance. In addition, although the government has a list of such establishments and strict requirements for granting them official authorization, the use of clandestine centers is widespread. At the same time, there is insufficient institutional capacity to determine how many such centers are operating in the country or to ensure that they meet minimum legal requirements. These centers therefore escape government control and can pose a risk to users' human rights. Even those that are officially registered receive inconsistent government oversight. The Colombia study concludes that although criteria for establishing a treatment center for dependent drug users are demanding and consistent, the government lacks the ability to verify compliance with those requirements in the treatment centers that operate in the country, which affects the quality of treatment services available.

Another interesting example is Ecuador, where the lack of government services resulted in abandonment of oversight of rehabilitation techniques and methods and the appearance of hundreds of private rehabilitation centers or therapeutic communities, many of which are based on a "spiritual," rather than scientific, approach to "treating" drug dependence. There have even been reports of practices that could be described as torture. In response, the current government recently adopted guidelines for "Regulation of Treatment Centers for People with Addiction to or Dependence on Psychoactive Substances" and launched a process of registering and accrediting the private centers operating in the country. By the end of 2013, the government had closed down 20 rehabilitation clinics and freed more than 500 people from compulsory treatment centers nationwide. The Ministry of Health is also expanding its services to include people with problem use, with particular emphasis on ambulatory centers located so as to ensure that those who need the services have access to them.

Conclusion 8

Abstinence-based treatment models predominate in both public and private services offered to drug users. Little emphasis is placed on programs with a harm reduction approach, which have proven more effective in mitigating the negative effects of illicit use of drugs.

The harm reduction[3] model is used in more than 70 countries around the world, has been rigorously evaluated and has proven effective, among other things, in reducing the spread of blood-transmitted infections, as well as morbidity and mortality rates related to drug use. Harm reduction has been traditionally associated with interventions aimed at reducing risks related to drug use, and not necessarily at reducing overall use. Some governments, therefore, have not wanted to adopt harm reduction policies for fear of being seen as "soft on crime" and not doing enough to "combat" drug trafficking, and have maintained an abstinence-based approach, with disastrous and avoidable results. One example is Argentina in the 1980s and 1990s and the expansion of the AIDS epidemic, related to injecting drug use. During those years, the government took a "prohibitionist-abstentionist" approach, and preventive messages focused on exhorting those who had never used drugs not to start and on those who were already using drugs to give up the practice (all under the threat of criminal punishment). There were no systematic HIV-prevention programs targeting those who continued to inject drugs. Only in the late 1990s was some action taken–mainly by non-governmental organizations, universities and some local or municipal officials–largely with international funding. In that case, the lack of an appropriate government response had fatal consequences for many injecting drug users.

Conclusion 9

Throughout the region, drug users–even when their use is not problematic–can be subjected to involuntary, compulsory or semi-compulsory treatment, which can violate their rights. All of the country studies express concern about compulsory treatment and several include unfortunate accounts of people who have been confined–often with the consent of relatives–in centers where flagrant human rights violations are committed. Some studies also warn of the use of compulsory treatment in the cases of recreational drug users, where use is not problematic. Mexico's Small-Scale Drug Trafficking Law, for example, establishes that a person who is arrested more than twice with amounts of drugs that are below the thresholds for personal use can be subjected to compulsory treatment. Similarly, Bolivia's Law 1008 establishes that even a non-habitual user detained with small amounts of controlled substances that presumably are for immediate personal use be admitted to a public or private

[3] According to the International Drug Policy Consortium (IDPC), harm reduction refers to public health interventions that seek to reduce the negative consequences stemming from drug use, as well as from drug policies.

drug addiction institute for treatment until officials are convinced that he or she has been rehabilitated.

As explained above, treatment centers tend to lack government regulation and oversight and tend to emphasize discipline, isolation, prayer and unpaid work as treatment, instead of evidence-based programs. In addition to being an unethical alternative that undermines individual freedom and self-determination, compulsory treatment is ineffective. The therapeutic outcomes associated with compulsory treatment centers are poor, with reported relapse rates as high as 90 percent in some cases. Several of the studies found that this mechanism operates more as one of extrajudicial incarceration than as treatment. Even in extreme cases in which in-patient treatment may be advisable, individual guarantees must be respected, with particular emphasis on: 1) the user's informed consent, and 2) the use of this measure as a last resort, always with the strictest legal guarantees.

In 2011 and 2012, two events drew international attention to the situation of people in compulsory treatment centers in Peru, where a total of 46 people died of smoke inhalation and burns in fires in two centers; they were unable to escape because they were locked in the buildings. According to the Peruvian government, 81.53 percent of the private centers identified currently operate informally. Despite new regulations providing for government control over the establishment and operation of centers for dependent drug users, little improvement has been seen, and most of the centers identified have not complied with the regulations, leaving open the possibility of similar tragedies in the future.

Over the past year, intense discussion has also taken place in Brazil regarding a proposed law aimed at making compulsory treatment part of the country's drug policy. In Uruguay, a proposed law, "Health Assistance for Addicts in High-Risk Situations," includes articles providing for involuntary in-patient treatment in exceptional cases.

Conclusion 10

In all the countries studied, the extent of the illicit use of drugs is exaggerated, in contrast to the assessment of harm done to health by legal drugs such as alcohol and tobacco. The studies generally find that the image of illicit use of drugs that is presented is exaggerated compared to the levels of use reflected in surveys. Each of the country studies presents data about the use of various drugs. In all, the percentage of people who use or have tried alcohol is far greater than those who have tried a drug classified as illicit. Problem use also tends to be higher with alcohol than with any other substance.

This could lead to the conclusion that alcohol's legal status is at the root of problem use of that substance. The case of tobacco, however, indicates that prohibiting a substance is not what leads to reduced use. In that case, intensive education campaigns about the risks of smoking have resulted in a significant decrease–and in some countries, such as Uruguay, a dramatic decrease–in the number of smokers and have had an impact on the incidence of tobacco-related diseases and death. In other words, it was not the substance's status as legal or illegal that affected levels of use, but effective information and education campaigns.

This does not mean that governments and societies should not address problem drug use. On the contrary, the state has an obligation to offer education and health programs to all citizens about licitly and illicitly used drugs. But public policies related to drug use should be based on reliable, systematized information and scientific evidence and should avoid exaggerating the problem. They also should always be part of the health sector, not the criminal justice system.

Ecuador offers an example of the contradictions that can arise when policies are not based on empirical evidence. In that country, the sale of alcohol to children and adolescents is prohibited and there are restrictions on sale to adults. Sports organizations, however, are sponsored by beer companies. In fact, Pilsener beer is advertised with banners in stadiums, as well as on radio and television. So on the one hand, the government launches prevention campaigns based on abstinence (from all drugs, legal and illegal), but on the other, it allows beer companies to promote beer drinking to the entire population. It is not surprising, therefore, that in Ecuador, university students prefer alcohol to illicitly used drugs or that beer is the drink of choice.

C) CRIMINAL JUSTICE POLICIES

Conclusion 11

In all of the countries studied, the criminal justice system takes precedence over the health system. This can be seen in the criminalization of drug use and/or possession for personal use and the number of users and people who grow crops for their personal use who are arrested, tried, sentenced and even incarcerated. For a significant number of drug users, under current drug laws, use has meant entering the criminal justice system, with all the costs that implies. The prohibition of substances has also forced users to turn to the illicit market, which exposes them to organized crime networks and substances of unknown

origin and quality. Current drug laws also make drug users vulnerable in their contact with authorities, exposing them to corruption, extortion, physical abuse, arbitrary detention and other violations of their fundamental rights.

In Argentina, possession for personal use remains a crime despite the 2009 "Arriola" ruling, in which the Supreme Court declared unconstitutional the article of the drug law that punishes possession for personal use, as long as this occurs "under conditions that do not result in a concrete threat or harm to the rights or property of third parties." A 2011 survey found that nearly 75 percent of cases of drug law violations submitted by security forces to the Federal Criminal Court in the city of Buenos Aires were for possession of drugs for personal use. And although most of those cases end up being closed for various reasons, coming into contact with criminal justice system agencies even for a short period of detention at a police station, or because of having criminal proceedings opened, tends to interfere with the exercise of other rights, such as obtaining a job or official documents. Treating drug users as criminals may therefore do more harm than the drug use itself.

In Ecuador, 5,103 people are presently incarcerated for possession of narcotic drugs or psychotropic substances, of a total of 6,467 of those convicted on drug-related charges. These data indicate that users are the main target of law enforcement efforts.

Each country in this study has its own criminal regulations regarding the drug market. In Argentina, possession for personal use is criminalized. In Bolivia, although drug use and possession for personal use are not crimes, if the amount of the drug that the user is carrying exceeds the amount considered the threshold for immediate personal use, the user will be classified as a drug trafficker, a crime punishable by between 10 and 25 years in prison. In Brazil and Mexico, drug use is depenalized, but in both cases, that has resulted in an increase in the number of users incarcerated for small-scale dealing. Colombia and Peru allow possession for personal use, with established thresholds, and Ecuador is in the process of adopting a similar legal regime. Uruguay does not classify possession for personal consumption as a crime and leaves each case to the judge's discretion. Despite these differences, however, in all of the countries studied, users are criminalized and tend to have more contact with the criminal justice system than with the health system, as explained in more detail below.

Conclusion 12

In several of the countries studied, there is confusion–or at least there are gray areas–about legislation that results in users being treated as criminals. Lack of precision in the law facilitates police abuse. Even in countries where drug use is not a criminal offense, users may be detained and receive harsh prison sentences. The studies show that even in countries in which possession for personal use is not a crime, users can be detained by police. In those cases, police make the first decision about whether the drugs found are for personal use or not. At that moment, there is a significant risk that the person detained will be subjected to extortion.

If the case goes to a prosecutor and/or judge, and the law is ambiguous, the handling of the case depends on who is interpreting the law and the facts; some judges may be more tolerant, while others may be stricter. In other words, police, prosecutors and judges enjoy significant discretionality in their handling of cases involving drug users.

The report on Colombia notes that police have two incentives for arresting drug users. First, one of the main objectives of their work is to seize the largest possible amount of controlled substances and that objective can be met by accumulating small amounts. Second, another performance indicator is the number of arrests, which means police often must also meet arrest quotas. These objectives create a perverse incentive that prompts police to pursue users. Although Colombia's Attorney General has made a significant effort to keep users and people in the lowest echelons of drug trafficking out of the court system, those efforts are often undermined by prosecutors at various levels who do not share the same legal criteria, which can also lead to unequal enforcement of the law.

In Peru, corruption drives the detention of users, even though possession for personal use is not a crime in that country. The CIDDH has a "Green Line" that users who have been detained can call for legal assistance. In more than 50 percent of the cases it has handled, there has been attempted abuse (planting of other drugs), physical violence and/or corruption (asking for money). Notably, according to Peru's Public Ministry, less than 5 percent of police arrests for possession for personal use are brought to the ministry's attention; instead, they are resolved at the police station. Several other country studies also report that corruption is a key factor in explaining the number of arrests for possession for personal use.

In Mexico, despite the adoption in 2009 of the Small-Scale Drug Trafficking Law that supposedly depenalizes possession for personal use, 140,860 people nationwide were detained by the Attorney General's Office for drug use between 2009 and May 2013. During that

period, 53,769 pre-trial investigations for drug use were opened in the federal system. These data show the ongoing criminalization of a behavior that is not considered a crime under Mexican law. Even in Uruguay, information shows an alarming number of users arrested, charged and incarcerated.

Conclusion 13

Thresholds are a two-edged sword. They limit criminal sanctions, but they also allow the criminalization of users when the allowable amounts are very low and when penalties are increased for amounts exceeding the threshold. The threshold system defines a certain quantity of illicit substances that is assumed to be for personal use. Because those thresholds often do not reflect the reality of the market and because they operate in a prohibitionist environment, however, they tend to blur the distinction between possession of drugs for personal use and possession for sale or dealing. They therefore result in prosecution of users who are arrested as small-scale traffickers because they were carrying more than the allowable amount.

At the same time, a total lack of thresholds leaves a great deal to the discretion of members of the criminal justice system, including police, prosecutors and judges. In Latin America, where criminal justice institutions have often been linked to corruption, leaving so much to the discretion of police, prosecutors or judges also is not optimal. In Uruguay, for example, there are no thresholds–except, recently, for cannabis–and that has led to inconsistent and contradictory criteria. While in some cases a judge determines that a certain amount is reasonable for personal use, in others a similar amount is ruled to be for sale. Mexico, meanwhile, has definitions for the maximum amount for personal use, but the thresholds are so low that some users are charged as small-scale traffickers.

However, even where they accurately reflect the real amounts used, thresholds alone do not ensure that users will not be criminalized. Peru illustrates the limitations of this approach. Although the thresholds there are more reasonable and reflect the amounts actually used by consumers, the existence of thresholds has not prevented the criminalization of users. Police frequently extort users, taking advantage of people who participate in the illicit market.

Another problem with thresholds is that they do not consider users who purchase as a group to limit contact with the illicit market, or those who, for the same or other reasons, acquire a larger supply at one time. The fact that the model is based on a presumption of guilt of trafficking for those possessing amounts above the threshold also violates the principle of

presumption of innocence. This translates into the criminalization of users, as seen in some court cases in Ecuador.

For these reasons, thresholds alone are not enough; judicial authorities must prove that possession is linked to trafficking rather than personal use. It is crucial that judges and prosecutors take into account the circumstances of the case and of the person involved, the circumstances of the arrest and other relevant factors in cases of possession of amounts larger than the amount for personal use. In addition, when they possess less than the threshold amount, users must be protected from extortion by police.

Conclusion 14

Drug courts are proposed as an alternative to incarceration and as an alternative mechanism for resolving criminal proceedings. One concern, however, is that drug courts are perceived as a response related to public health, when its components are still of a criminal justice nature and they risk reproducing all of the problems within the criminal justice system regarding drug use. It is also important to recognize that while the U.S. drug court model is being promoted in Latin America and the Caribbean, there are different models for these courts in other parts of the world; in other words, drug courts have different characteristics in each country and must be evaluated accordingly.

In the U.S. drug court model, people who are arrested for drug use or minor non-violent, drug-related offenses are offered the possibility of entering a treatment program as an alternative to continuing with the criminal proceedings. If the treatment program is completed successfully, the sentence could be reduced significantly or expunged. In the case of non-compliance with the treatment program, the criminal proceedings continue. Although supporters of this measure claim that these people have the option of deciding which path to take, the fact that the alternative is prison shows that ultimately, these courts are a form of compulsory (or semi-compulsory) treatment. Moreover, a person who does not comply with the treatment program requirements can end up spending more time in the criminal justice system than they would have if the case had followed its normal course.

Studies of the implementation of drug courts in the United States show that they have increased the number of people entering the criminal justice system. This is because drug courts frequently handle cases of people who would not have been tried in the ordinary system. Presenting drug courts as an alternative model is therefore questionable, especially in Latin America, where their implementation is moving forward.

In Latin America, another cause for concern is that the model depends on sufficient resource allocations for implementation; judicial and health systems capable of implementing it; and, in particular, the ability to ensure access to appropriate, evidence-based treatment (which, as noted, does not currently exist). Given these serious constraints, countries in the region should explore other alternatives to incarceration and, more importantly, reform their drug laws to reduce the number of people imprisoned for simple possession or for minor, non-violent drug-related crimes.

Despite the serious limitations of the model and its implementation in Latin America, the U.S. government and OAS's CICAD are strongly promoting the establishment of drug courts, which already exist or are set to begin in at least 14 countries in the region. There are some variations. In Mexico, for example, Addiction Treatment Courts target licitly and illicitly used drugs and appear to be aimed more at first-time offenders who commit a crime under the influence of drugs or alcohol. As in the United States, if the person does not complete the treatment program successfully, the criminal case is resumed.

RECOMMENDATIONS

1. Users or consumers of illicit substances must be recognized as being subjects of rights. These include the right to self-determination and free personal development, the right not to suffer discrimination, the right to health and the right to due process.

2. Drug use is a social and health issue that requires non-punitive public policies. Criminal law should never be applied in cases of drug use and simple possession or as an excuse to protect health. Possession and cultivation for personal use should therefore be effectively decriminalized by changing criminal laws and/or by correcting the practices of law-enforcement agencies and judicial authorities.

3. States should redirect the priorities of their drug policies, placing much more emphasis on demand and doing so through health services and education programs.

4. Governments should establish and implement inclusive, evidence-based social and health policies that respect human rights, with increased budgets; accessible, high-quality public services; monitoring capacity; and periodic evaluation of the implementation of policies and their impact.

5. Drug policies should not be based on prejudices or stereotypes, but on reliable scientific information. Governments should make a greater effort to identify, gather, systematize and disseminate relevant information about types of use, users, the supply of services, and the production and distribution of substances.

6. Governments should also provide users with information about potential harm from the use of legal and illegal drugs, measures for mitigating the risks related to their use, and treatments that are available if needed.

7. Drug policies, including education and prevention programs, should distinguish among different forms of use–infrequent non-problem use, frequent problem use, frequent non-problem use, and infrequent problem use–and differences in the substances themselves. Governments should also recognize that not all drug use is problematic or implies dependence that justifies state intervention.

8. Uruguay's initiative to create legal, regulated cannabis markets, including cannabis clubs, deserves international and regional support. Similar initiatives to promote legal, regulated cannabis markets should be promoted in other countries and localities (like those in the U.S. states of Colorado and Washington).

9. Governments should design and implement treatment and rehabilitation programs based on scientific evidence and with harm reduction approaches to mitigate the negative consequences and risks that can result from drug use.

10. Governments should oversee treatment and rehabilitation services provided by the private sector. Therapeutic centers that emphasize isolation or forced or unpaid labor should be replaced by evidence-based programs.

11. The State, as a rule, cannot force treatment. In extreme cases where internment may be advisable, State intervention must be based on two principles: informed consent and compulsory rehabilitation as a last resort, always with strict observance of individual guarantees.

12. Thresholds of legal quantities for personal use should be used to set minimum quantities below which a person cannot be considered a dealer; nevertheless, it should not be assumed that a person possessing an amount exceeding the threshold can be punished for distribution and trafficking, because the State must prove intent to sell or distribute. Thresholds must also be based on users' practices and not set arbitrarily, always ensuring that users are protected.

13. Although promoted as an alternative to incarceration, drug courts remain primarily a criminal justice response, rather than a social or health-oriented response. Instead of replicating the U.S. drug court model, Latin American countries should explore other alternatives to incarceration and the decriminalization of possession for personal use in order to reduce the number of people incarcerated for possession for personal use and for minor, non-violent drug offenses.

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