

# DRUG POLICY AND HUMAN RIGHTS IN EUROPE: Managing tensions, maximising complementarities

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Abuse and Illicit trafficking in Drugs  
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French edition:  
*politiques en matière de drogues et droits  
de l'homme en europe : Gérer les tensions  
et maximiser les complémentarités*

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Cover and layout: Documents and  
Publications Production Department  
(SPDP), Council of Europe

This publication has not been copy-edited  
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Printed at the Council of Europe

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## 1. INTRODUCTION: FROM POLICY PRESCRIPTIONS TO HUMAN RIGHTS EVALUATION

■ Societal problems associated with drugs are complex and multifaceted. There is no perfect policy for all to follow. In some areas, for some interventions, the evidence is clear. In some the evidence is weaker. Situations vary considerably between States and what works in one may not be adequate for responses in another, it may be culturally inappropriate or presently unaffordable. Patterns of drug use, drug related harm and drug related crime also evolve. New transit routes develop, new drug related harms become apparent, and new substances come onto the market. As the evidence and situations develop, so too must drug policies constantly adapt. States have been struggling with these and other dilemmas nationally and internationally for decades.

■ Just as drug policies must be responsive to emerging situations and new evidence, so too must they take into account the human rights outcomes of laws, policies and practices, both positive and negative.

■ In recent years the human rights dimensions of drug policy have become increasingly prominent. This has been due in large part to at least three main developments. The first is the increasing attention to drug use and drug related harm in the context of positive obligations under the right to the highest attainable standard of health.<sup>1</sup> Second is the clear evidence in many countries of the negative human rights implications and consequences of drug enforcement, including issues of policing and sentencing, in particular

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1. See, for example, 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, UN Doc No. A/65/255, 6 August 2010.

the death penalty.<sup>2</sup> The third, which has received considerable political and media attention, is the funding of drug enforcement in those States with documented poor human rights records.<sup>3</sup>

■ The challenge for States is to ensure that their drug policies are *effective in the guaranteeing of rights*<sup>4</sup> and *effective in meeting their aims*. For many years the UN General Assembly has stated that ‘countering the world drug problem’ must be carried out ‘in full conformity’ with human rights. This has been repeated in the outcome document of the UN General Assembly Special Session held in April 2016<sup>5</sup>. In 2014 the Ministerial conference of the Pompidou Group mirrored this commitment as an objective moving forward. However, as the UN Special Rapporteur on the Right to Health has remarked, ‘While such language is welcome, it becomes meaningless unless underpinned by clear and explicit human rights standards and principles. Right now, this pledge only represents a consensus based commitment repeated in different fora that remains far from being realized.’<sup>6</sup> But moving from commitments to policy and practice is no easy task. There is little existing agreement on what a ‘human rights-based approach’ entails in this policy arena. Concrete efforts to incorporate human rights into drug policies are a relatively new

2. See, for example, Office of the High Commissioner for Human Rights, Study on the Impact of the World Drug Problem on the Enjoyment of Human Rights, UN Doc No. A/HRC/30/65, 4 September 2015; Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, UN Doc No. A/HRC/10/44, 14 January 2009; Joint Declaration issued on 9 October 2015 by Federica Mogherini, European Union High Representative for Foreign Affairs and Security Policy, on behalf of the EU, and Thorbjørn Jagland, Secretary General of the Council of Europe, on the European and World Day against the Death Penalty: “The death penalty is inhuman and degrading treatment” and “The Council of Europe and the European Union note with concern that the number of executions of persons for drug offences has increased during the last year in the few states that apply the death penalty to those offences. Both organisations are particularly alarmed when this involves the execution of minors, which is contrary to international law. It is all the closer to heart because some European citizens have been executed in 2015 and others are still on death row for drug-related offences.”
3. *European Parliament resolution of 8 October 2015 on the death penalty* (2015/2879(RSP)); ‘Using the death penalty to fight drug crimes violates international law, UN rights experts warn World Day Against the Death Penalty’ OHCHR Press Release, 10 October 2015.
4. *Golder v the United Kingdom*, No. 4451/70, 21 February 1975, paragraph 26; *Campbell v the United Kingdom*, No. 13590/88, 25 March 1992, paragraph 46.
5. See UN General Assembly, *Our joint commitment to effectively addressing and countering the world drug problem*, UN Doc No. A/RES/S-30/1, 4 May 2016, preamble and chapter 4.
6. Open Letter by the Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health, Dainius Pūras, in the context of the preparations for the UN General Assembly Special Session on the Drug Problem (UNGASS), which was to take place in New York in April 2016, 7 December 2015.

development, even if the commitment to do so is longer standing. Within the Council of Europe, States are provided a 'wide' margin of appreciation under the European Convention on Human Rights with regard to social policy, pursuant to the principle of subsidiarity. Internationally, there is significant room for policy development within the broad legal obligations set out under both international drug control and human rights law. It would therefore not be appropriate for a European or international mechanism to dictate *precisely* what to do in terms of domestic social policy.<sup>7</sup> This, however, does not mean there are no limits on the scope of State action.

■ Accepting States' margin of discretion, and without prejudice to the details of any policies that are developed or amendments made, human rights *standards* and *tests* may be brought to bear. Rather than attempting to set out detailed policy prescriptions, this paper explores this approach as an initial step towards incorporating human rights into drug policy development, monitoring and evaluation.

■ Two important points of departure should be borne in mind. First, as opposed to an external or adversarial approach, what is suggested is a process for States themselves, in collaboration with affected groups, civil society organisations and experts in the field. It is about asking questions to identify problems and help develop human rights-based responses, not setting out comprehensive answers from the outset. It requires political will and willingness for self-scrutiny. Second, such a process would not be easy, and may appear to be too large. But it need not be done in one single, overly burdensome and expensive review. Member States may begin with a newly proposed policy or service, a review that is already planned, or a pilot programme. Such manageable first steps can set the stage for wider incorporation of human rights into drug policy moving forward and the establishment of systems, tools and indicators for this purpose.

■ Following a discussion of proposed general principles a broad framework is set out for understanding the place of human rights in drug policy development, monitoring and evaluation. Three human rights tests are then explored: the principle of proportionality (applied to the criminalisation of personal possession and random school drug testing); the right to health

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7. *Handyside v the United Kingdom*, No. 5493/72, 7 December 1976, paragraphs 48-50; *Leander v. Sweden*, No. 9248/81, 26 March 1987; *Dudgeon v United Kingdom*, No. 7525/76, 22 October 1981; *W v. The United Kingdom*, No. 9749/82, 8 July 1987; *Campbell v the United Kingdom*, No. 13590/88, 25 March 1992; *Wenner v Germany*, No. 62303/13, 1 September 2016.

(applied to drug treatment and harm reduction); the principle of equivalence (applied to prison drug treatment and harm reduction). The human rights dimensions of funding decisions are also discussed, in particular with regard to initial risk assessment.

■ By way of an invitation for further research and analysis the paper concludes with an Appendix setting out an indicative list of issues in drug policy, the human rights engaged by them, and the tests that should be applied.

## 2. GENERAL PRINCIPLES

### 2.1. Precautionary principle

■ The precautionary principle is well known in European and international environmental law.<sup>8</sup> It aims to predict and prevent policy harms. By now the human rights risks associated with drug policies are well known. The question is whether and how these risks have been taken into account.

■ The precautionary principle suggests that it would be necessary to assess the human rights risk associated with a given law, policy or intervention. This is particularly important given the uncertainty about the best policy prescriptions for national dynamics. The principle requires that the best available evidence be used to assess the risk, alongside an assessment of uncertainty surrounding a given proposal. A possible negative human rights outcome requires that these risks be taken into account.

■ The precautionary principle itself contains various other principles, including non-discrimination, participation, proportionality and a requirement of evaluation (monitoring human rights outcomes).<sup>9</sup> All of these are incorporated in this paper.

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8. *European Commission Communication on the Precautionary Principle* COM(2001) 1final, available at <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:52000DC0001>

9. For a helpful summary of the European Commission Communication see EUR-Lex *The Precautionary Principle*, available at <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=URISERV%3A132042>



## 2.2. Accountability<sup>10</sup>

■ The precautionary principle also requires risk communication.<sup>11</sup> A human rights assessment undertaken behind closed doors loses part of its value. When developing or evaluating drug policies or a specific programme, it is important that affected groups, civil society organisations and others understand the bases for decisions made.

■ Accountability involves a commitment to the continuous, transparent evaluation of policy and, where needed, its amendment to resolve human rights problems or to better implement positive obligations. It also requires a commitment to examine the adverse effects on the enjoyment of human rights and, if necessary, a response to rights violations where they are identified and to provide a remedy for those affected.

## 2.3. Participation

■ Participation in policy development is an excellent example of human rights principles and good practice in drug policy coinciding. The involvement of affected communities, for example, is not only a core component of the realisation of their rights and the recognition of their agency, it is also essential for well-informed policy, and has been consistently supported by the Council of Europe<sup>12</sup> and the UN.<sup>13</sup> Human rights, meanwhile, are not merely abstract legal obligations. They are experienced on the ground. In order to adequately assess the human rights dimensions of a given issue, and to abide by the precautionary principle, speaking to those affected, including people who use drugs, families, young people<sup>14</sup> and the wider community can illuminate problems that may otherwise be missed.

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10. See for example *Human Rights, Health and Poverty Reduction Strategies*, World Health Organisation, HR/PUB/08/05, chapter 4.

11. *European Commission Communication on the Precautionary Principle* COM(2001) 1 final, available at <http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:52000DC0001>

12. See e.g. Pompidou Group, *Government Interaction with Civil Society*, P-PG (2015) 4 Final, 2015; *Code of Good Practice on Civil Participation in the Decision Making Process* (adopted by Conference of INGOs on 1 October 2009) and endorsed by the Committee of Ministers (Declaration by the Committee of Ministers on the Code of Good Practice for Civil Participation in the Decision Making Process, 21 October 2009); *Recommendation CM/Rec(2007)14 of the Committee of Ministers on the legal status of nongovernmental organisations in Europe*, adopted by the Committee of Ministers on 10 October 2007.

13. See, for example, UNGASS outcome document, preamble and paragraphs 1(j), 7(b) op. cit.

14. Article 12, Convention on the Rights of the Child 1989; Recommendation Rec(2004)13 of the Committee of Ministers to member states on the participation of young people in local and regional life (Adopted by the Committee of Ministers on 17 November 2004, at the 904th meeting of the Ministers' Deputies).

## 2.4. Non-discrimination<sup>15</sup>

As with other areas of human rights, non-discrimination involves both negative and positive obligations. States should of course refrain from actively discriminating against any person or group on the basis of their racial or ethnic group, their gender, or their health status.<sup>16</sup> The obligation, however, goes beyond this. Any de facto discriminatory effects of drug policies should also be monitored and remedied, even if this was not intended or enshrined in law or policy. This includes if certain services are inaccessible to some (e.g. structural barriers impeding women's access), or if law enforcement practices disproportionately focus on others (e.g. racial disparities in stop and search procedures).

It is also important to continuously improve our understanding patterns of vulnerability with regard to drug related harms. In this regard, as discussed below, disaggregated data are crucial and again we see important crossovers between existing good practice recommendations in drug policy, and human rights standards.

## 3. DRUG POLICY AND HUMAN RIGHTS: TENSIONS AND COMPLEMENTARITIES<sup>17</sup>

All Council of Europe Member States have ratified or acceded to the UN drug control conventions: the Single Convention on Narcotic Drugs, 1961 (as amended); the Convention on Psychotropic Substances, 1971; and the Convention Against Illicit Traffic in Narcotic Drug and Psychotropic Substances, 1988. While pursuing a declared health goal,<sup>18</sup> and while they contain some health elements, these are regulatory conventions, forming also a component

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15. Articles 2 and 7, Universal Declaration of Human Rights 1948; Articles 2 (1) and 26, International Covenant on Civil and Political Rights 1966; Articles 2(2) and 3, International Covenant on Economic, Social and Cultural Rights 1966; Article 2, Convention on the Elimination of All Forms of Discrimination Against Women 1979; Article 2, Convention on the Rights of the Child 1989.

16. *Kiyutin v Russia*, No. 2700/10, 10 March 2011, paragraph 57; *I.B. v Greece*, No. 552/10, 3 October 2013, paragraph 73; *Novruk and Others v Russia*, Nos. 31039/11, 48511/11, 76810/12, 14618/13 and 13817/14, 15 March 2016, paragraphs 111-112.

17. See generally R. Lines *Human Rights and Drug Control in International Law*, Cambridge University Press, 2017.

18. 'Concerned with the health and welfare of mankind...' Preamble, Single Convention on Narcotic Drugs, 1961.

of transnational criminal law.<sup>19</sup> Human rights provision within such conventions is known to be poor.<sup>20</sup> But at the same time all Member States are bound by the European Convention on Human Rights and almost all have also agreed to be bound by the European Social Charter. All have further ratified or acceded to the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination Against Women. These treaties all focus on the rights of individuals and groups, and are components of international human rights law. The two regimes – drug control and human rights – constitute different legal systems and may therefore approach the same problem differently because they begin from very different perspectives, have different end goals, and have a different overarching ethos.<sup>21</sup>

■ The international situation is thus a useful mirror for dilemmas at national level. States have dual aims to ensure the realisation of rights at the same time as achieving their drug policy objectives. But while drug control may pursue health goals, the measures taken to achieve those goals cannot be automatically equated with human rights gains. In some ways these two are complementary. But in many other ways they exhibit tensions that must be resolved.

■ A **complementarity** may be defined as a situation in which the goals or objectives of human rights and drug policy converge. A clear example is access to essential medicines under international human rights law,<sup>22</sup> and access to essential controlled medicines under the international drug control system.<sup>23</sup> The existence of complementarity, however, does not absolve the drug policy objective, or the means of achieving it, from human rights scrutiny. Clearly, for

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19. N. Boister, *An Introduction to Transnational Criminal Law*, Oxford University Press, 2012 pp. 50-62; N. Boister,

20. N. Boister 'Human Rights Protections in the Suppression Conventions' 2 *Human Rights Law Review* 2, 2002, pp. 199-227.

21. International Law Commission, *Fragmentation of International Law: Difficulties Arising From the Diversification and Expansion of International Law*. Report of the Study Group of the International Law Commission Finalized by Martti Koskenniemi UN Doc No. A/CN.4/L.682 13 April 2006, paragraphs 24 & 25.

22. Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12)*, UN Doc No. UN Doc No E/C.12/2000/4, 2000, paragraph 43(d).

23. International Narcotics Control Board, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* UN Doc No. E/INCB/2015/1/ Supp.1, 2016.

example, access to essential controlled medicines is poor. In such cases, human rights obligations may add further obligations, which strengthen those under the UN drugs conventions, or they may necessitate alternative methods to achieve the shared goal. *The policy challenge is to maximise complementarities by incorporating a stronger human rights focus.*

■ A **tension** is a situation where either a drug policy goal or means for achieving it can adversely affect the enjoyment of fundamental human rights. An example is the death penalty for drug offences. Here, States have international obligations to prosecute certain crimes as ‘particularly serious’<sup>24</sup> and permissive rights to adopt ‘more strict or severe’ measures than the treaties set out.<sup>25</sup> The tension here lies in the definitions of these terms, enforcement practices pursuant to them and the penalties ultimately applied. Another example is the criminalisation of possession for personal use and various rights, including privacy, religious freedom and cultural rights. There are also often tensions with economic and social rights due to certain laws and policies, including the right to health and the right to social security. Restrictions on certain harm reduction programmes and the connection of welfare receipt to drug testing are further examples. *The policy challenge in this case is to resolve tensions with a presumption in favour of human rights.*

■ The two categories are not entirely separate, however. Drug dependence treatment, for example, is a requirement of the UN drugs conventions and is widely recognised as being a requirement of the right to health. This is complementary in principle. But how drug treatment is implemented can create tensions. The same may be said for drug prevention and harm reduction interventions. Similarly, protecting children from drug use is, in principle, a complementarity between the drug control system and Article 33 of the Convention on the Rights of the Child. But how this is accomplished creates tensions (see random school drug testing below).<sup>26</sup> Thus, *a tension may be resolved in a way that maximises a complementarity.* But if accepted on face value, *an apparent complementarity can create tensions.*

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24. Article 3(5), Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

25. Article 39, Single Convention on Narcotic Drugs, 1961; Article 23, Convention on Psychotropic substances, 1971; and Article 24, Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

26. See also, for example, D. Barrett ‘International Child Rights Mechanisms and the Death Penalty for Drug Offences’, *Human Rights Law Review*, 2017; D. Barrett, *The Impacts of Drug Policies on Young People*, Open Society Foundations, 2016.

It is important to set out these relationships to dispense with overly simplistic characterisations of drug control being ‘against’ human rights.<sup>27</sup> Some practices certainly are (such as the death penalty) and some policies may generate widespread rights abuses (such as government sanctioned ‘crackdowns’). But in general, when considering the diversity of State approaches, the intersections are more nuanced. The human rights considerations relating to a law or policy, for example, may differ from those arising from the implementation of a particular intervention. In some countries the rights issues raised may differ from another. It is in this more nuanced view that a process of human rights evaluation of drug policy may be developed.

#### 4. LOCATING HUMAN RIGHTS IN DRUG POLICY DEVELOPMENT AND EVALUATION

Human rights tend to be associated with legal adversarial processes. However, over the decades the application of human rights to operational policy has developed considerably and across many areas, from poverty reduction to emergency healthcare.<sup>28</sup> Incorporating human rights into drug policy is therefore not merely about reacting to abuse, even if investigation and remedy of abuse remains vital. It is an ongoing process of applying human rights principles, legal standards and tests to policy development, implementation and evaluation.

Another way to put this is that human rights apply to at *structural, process and outcome* levels. In 2003, the UN Special Rapporteur on the Right to the Health, Professor Paul Hunt, presented to the General Assembly a new framework for a rights-based approach to health indicators. These were classified as structure, process and outcome indicators.<sup>29</sup> While this was intended to monitor progress in human rights, the framework may be applied to the incorporation of human rights into drug policy, thereby measuring progress on both and identifying complementarities and tensions between the two. In simple terms:

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27. UN Office on Drugs and Crime, *Drug Policy Provisions from the International Drug Control Conventions*, UN Doc No. E/CN.7/2014/CRP.5, 10 February 2014, p. 14.

28. See, for example, Northern Ireland Human Rights Commission, *Human Rights Inquiry: Emergency Healthcare*, 2016.

29. This has since been developed by the Office of the High Commissioner for Human Rights. See *Report on Indicators for Promoting and Monitoring the Implementation of Human Rights*, UN Doc No. HRI/MC/2008/3, 6 June 2008.

■ **Structural indicators relate to the broad legal and policy framework.**

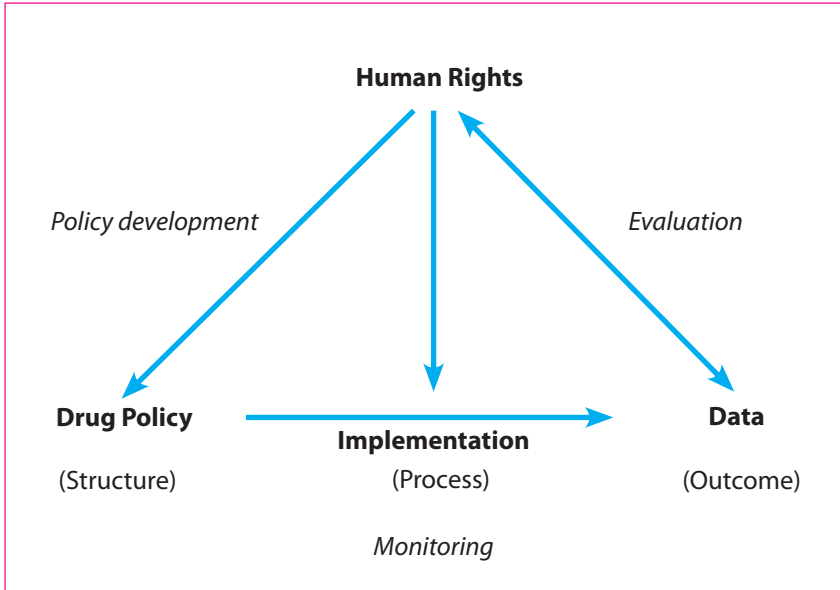
To apply a rights-based approach, the legal framework for drug control should include human rights obligations alongside drug laws. It requires an assessment of the compatibility of these structural dimensions.

■ **Process indicators are measure of state effort or, in other words, what is being done to achieve a given aim.**

A rights based approach involves scrutinising these efforts with regard to human rights standards and tests. Examples are international standards on the use of force by police or the application of human rights law to the provision of drug treatment. Many of the core indicators for drug enforcement (arrests, seizures, prosecutions etc.) are process indicators, and it is here that many tensions with human rights arise.

■ **Outcome indicators speak to the effects of the process indicators on the given problem.**

Applying human rights to outcome data has three main effects. First, outcomes can indicate human rights progress or adverse effects on the enjoyment of human rights. This involves incorporating further indicators into standard measurements. In other words, it is not only on a limited view of drug policy aims that the successes or failures of policy are assessed. Second, a rights based approach, pursuant to the principle of non-discrimination, requires better data disaggregation. This helps to uncover not only patterns of vulnerability with regard to drug dependency and drug related harm, but also patterns of human rights vulnerability with regard to enforcement efforts. Some communities are more affected than other. Third, outcome data can have an effect on whether a human rights test has been met.



**Fig 1:** Human rights standards and tests should be taken into account in the development, monitoring and evaluation of drug policy. Outcome data can indicate if human rights progress or adverse effects are evident, uncover patterns of vulnerability, and speak to whether a human rights test has been met, possibly requiring reassessment.

— The key issue is that human rights considerations are important at all stages of law, policy and intervention development, not only *after* a violation has been established. Human rights considerations should be brought to bear in the development (or revision) of drug policies, in the process of ongoing monitoring, and in the evaluation of outcomes. It is into this relationship that human rights standards and tests may be inserted. In the following sections three tests are presented relating to very different aspects of drug policy.

## 5. RIGHTS TESTS APPLIED

### 5.1 Proportionality

— Implementing concurrent drug control and human rights obligations involves what the European Court of Human Rights has referred to as ‘a search for a fair balance between the demands of the general interest of the community

and the protection of the individual's fundamental rights.<sup>30</sup> It is inevitable that drug control will engage fundamental rights and freedoms given that a range of behaviours will be banned and law enforcement measures will be taken. Such restrictions are not prima facie precluded, however. Some rights within the European Convention may be restricted if the measure is:

- Prescribed by law
- Pursuant to a legitimate aim
- Necessary in a democratic society for the achievement of that aim

■ In relation to drug control the measures are usually prescribed by law in some way and can easily be seen to pursue the legitimate aim of protecting health, public order or the rights of others. The European Court has indicated this more than once.<sup>31</sup> The key question is about whether the means in fact adopted pass the third step, and this, it is suggested, must become a core component of the drug policy development, monitoring and evaluation.

■ The Court has developed the test of proportionality for assessing whether restrictions have been 'necessary in a democratic society'.<sup>32</sup> There are varying iterations of the test, in particular depending on the nature of the right in question and the aim pursued (e.g. a stricter test would be applied to freedom of expression than to the right to property). Crucially, the burden is on the State to demonstrate the proportionality of the restriction.<sup>33</sup> Thus it should become central to policy development, monitoring and evaluation.

■ In this regard, States must investigate whether there were no less restrictive means available to achieve the aim in question.<sup>34</sup> This is necessary

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30. *Soering v the United Kingdom* No. 14038/88, 7 July 1989, paragraph 89; *Verein Gegen Tierfabriken Schweiz v Switzerland (No. 2)* No. 32772/02, 30 June 2009, paragraph 91; *Hutten-Czapska v Poland* No. 35014.97, 19 June 2006, paragraph 167.

31. *Air Canada v the United Kingdom*, No. 18465/91, 5 May 1995, paragraph 42; *Dalia v. France*, No. 154/1996/773/974, 19 February 1998, paragraph 54. See also *Prince v South Africa*, No. 1474/2006, 14 November 2007, UN Doc No. CCPR/C/91/D/1474/2006, paragraph 7.3.

32. *Handyside v the United Kingdom*, No. 5493/72, 7 December 1976, paragraph 49; *Mathieu-Mohin and Clerfayt v Belgium*, No. 9267/81, 2 March 1987, paragraph 52; *Rees v the United Kingdom*, No. 9532/81, 17 October 1986, paragraph 37. Versions of this, however, have also been applied by international human rights mechanisms and national courts for decades. On safe injection facilities in Canada, for example, see *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134.

33. *Novruk and Others v Russia*, Nos. 31039/11, 48511/11, 76810/12, 14618/13 and 13817/14, 15 March 2016, paragraph 99; *Chassagnou and Others v. France*, Nos. 25088/94, 28331/95 and 28443/95, paragraphs 91-92.

34. *Campbell v the United Kingdom*, No. 13590/88, 25 March 1992, paragraph 48.



both at policy level and at the time of implementation. This demands that alternatives to any given solution be considered at the decision-making and implementation stages. Without such alternatives, after all, how can a test of ‘no less restrictive means’ be passed in good faith?

■ Proportionality also speaks to the importance of evaluation and review. The question of outcomes is key. Even if a restriction is deemed proportionate to the legitimate aim in the development of an intervention, it still needs to remain under review if rights are to be fully respected. After some time it may transpire that the intervention in question is not achieving its aims. By definition, a measure that has not or cannot achieve its aim is disproportionate to any restrictions on human rights it may entail. It cannot be ‘necessary’ for the achievement of an aim. However, this does not mean that a failure to achieve aims would constitute an automatic rights *violation*.<sup>35</sup> The issue here is transparent re-evaluation on the basis of new evidence.

## Random school drug testing

■ The objective of keeping drugs out of schools is a legitimate aim of policy. Prevention is also a legitimate policy objective and so is, of course, seeking the early identification of young people who are using drugs in order to assist them. In some schools random drug testing has been adopted as a means to achieve these aims.

■ A first question is whether any rights are engaged. This demands an initial mapping. In this case the child’s right to privacy, protected under the ECHR and other treaties to which all Council of Europe Members are bound, is clearly engaged.<sup>36</sup> Any testing necessarily impinges on this right. Questions are also raised, *inter alia*, about the best interests of the child for the purposes of Article 3 of the Convention on the Rights of the Child.

■ Pursuant to the proportionality test, the authorities must demonstrate that there is a pressing social need for the restriction. There may be a pressing social need for prevention or early identification, but whether this requires a policy of random drug testing in schools is another matter. The State must therefore also show that there are no less restrictive means for the achievement of the aim. Many States and school authorities reject random school drug testing on various grounds, including child rights concerns. There are clearly

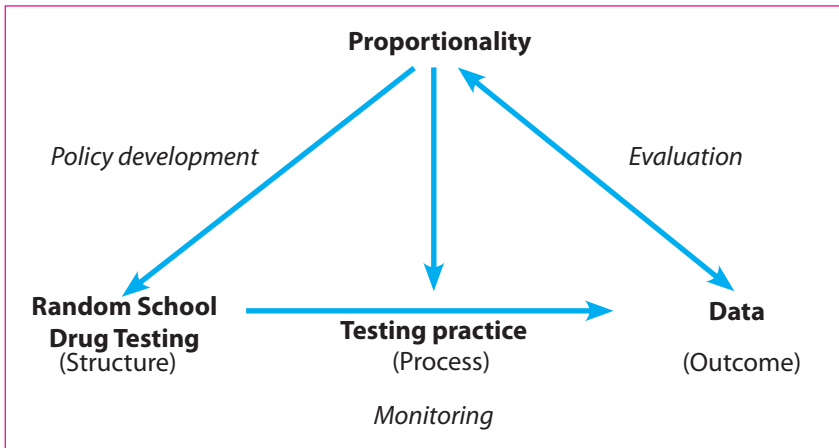
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35. Separate Judgment of Mosler J in *Handyside v United Kingdom*, paragraph 2.

36. Article 16, Convention on the Rights of the Child; Article 8, European Convention on Human Rights.

other methods available for the aims sought. The question is whether these are less restrictive and whether the issue was assessed at all.

■ The operation of the testing system is potentially important. For example, if the test is consensual only, rather than compulsory, then it might be more acceptable. More importantly, however, if a measure is to meet the test of necessity it must work to achieve the aim in question. It must, in other words, be fit for purpose. For example, the best available evidence suggests no positive effect of random school drug testing on levels of drug use.<sup>37</sup> The margin of appreciation, normally wide, is therefore narrowed as the restriction on the child's privacy has no evidence-based connection to a policy aim of prevention. In such circumstances, how the testing is conducted is not relevant, and the intervention fails a proportionality test. It may be that authorities are operating under the impression that these measures work but evidence later emerges to the contrary. A human rights based assessment necessitates a willingness to amend the policy when faced with restrictions on rights pursuant to a failed aim.



**Fig. 2.** The test of proportionality applies in the development of school drug testing policy and to its implementation. Absence of evidence or outcomes indicating ineffectiveness narrows the margin of appreciation.

37. See R. Yamaguchi et al 'Relationship between Student Illicit Drug Use and School Drug-Testing Policies' 73 *Journal of School Health* 159, 2003. The International Standards on Drug Use Prevention, 2013, developed by the UN Office on Drugs and Crime do not recommend random testing (p. 21).

## Criminalisation of possession for personal use outside of ‘medical and scientific purposes’

█ Laws criminalising the possession of illicit drugs for personal use have been in place all over the world for many decades. Drug use has also been widely criminalised. However, various Council of Europe States have now begun to amend these laws, or have done so long ago via *de jure* or *de facto* decriminalisation.<sup>38</sup> It is an approach that no longer enjoys full consensus and is eroding further. Indeed, recognising that this measure might cause human rights and constitutional concerns, the drafters of the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, included an important caveat. States need not criminalise such behaviour if to do so would be contrary to constitutional principles or the basic concepts of their legal system.<sup>39</sup> It is therefore not an international obligation to do so, even if there was a clear push towards such measures. The proportionality test is an important consideration in this regard. Whether or not States adopt such laws should be balanced against human rights considerations, which are often protected constitutionally or are central to the legal system in question. It is another obvious case of tension between the two systems of law.

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38. For example, in Spain, consistent case law over time excluded criminal punishment for drug use (e.g. Supreme Court judgements of 13 February 1966, 29 November 1968, 25 February 1971, 11 August 1971, 3 June 1972). This approach was confirmed following the adoption of the Law of 15 November 1971 which sought to enact the provisions of the UN drugs Conventions by introducing the notion of “possession” in Article 344 of the Criminal Code (Supreme Court Judgments of 12 June 1974, 24 September 1974, 18 February 1975, etc.). Subsequently, exclusion of criminal punishment was consolidated through the provision for administrative sanctions for drug use limited to consumption in public places (cf. Organic Law No. 1/1992, on public security [“seguridad ciudadana”]). Portugal decriminalised use, replacing criminal sanctions by administrative penalties by Law 30/2000 of 29 November 2000 (which entered into force in July 2001). Until 31 December 1998, only possession intended to supply was criminal in the Czech Republic. Subsequently, possession of “amount larger than small” was criminalised and the judiciary interpreted this to mean more than five to ten times (depending on drug) the usual single dose of an average consumer. Czech Regulation No. 467/2009 (which came into force on 1 January 2010) clarified the maximum amounts for possession to be treated as a misdemeanour punished by fine, effectively decriminalising possession of small amounts of drugs for own consumption.

39. Article 3(2).

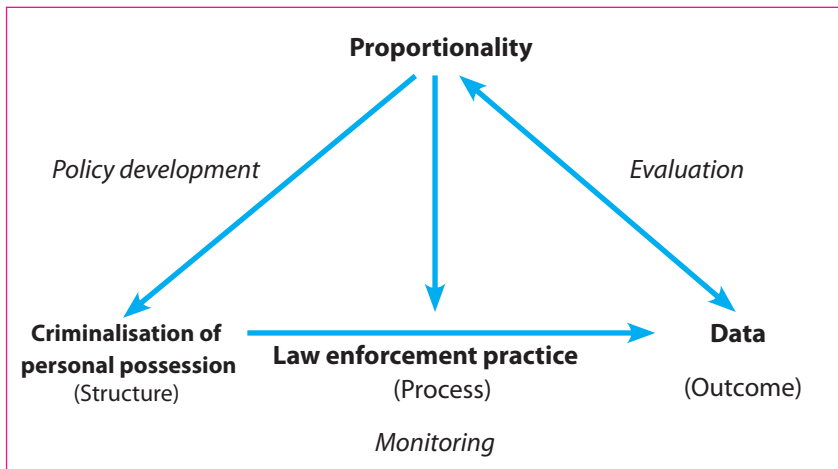
Again, a first step in this regard is mapping the potential human rights engaged. This certainly includes the right to privacy, which is inherently restricted by any broad behavioural ban. But it may also include the manifestation of religion or cultural or indigenous rights. Freedom of expression and freedom of thought may also be engaged. The question, then, is whether the criminalisation of possession for personal use is proportionate to the legitimate aim of protecting health, children, public order or other justifications. This of course will depend on the stated aim, but there must be a rational connection between these aims and indicators of success.

The burden is on the State to demonstrate the proportionality of the measure. It should not be merely assumed that a 'pressing social need' is there. This should be carefully considered based on the actual dynamics in the country. The current debates around whether to control ketamine are a serious example of why this is important. Similarly, the banning of khat in some European countries raises this question. Crucially, given that criminalising a behaviour bans it entirely, were any less restrictive means considered for the achievement of the same aim or aims? This requires the consideration of policy alternatives. Without this assessment, the burden of demonstrating that no less restrictive means were available cannot have been met.<sup>40</sup>

The issue of outcomes is again crucial. It may, for example, be decided by a given State that the criminalisation of non-medical uses of controlled substances is proportionate given a pressing social need due to the harms of drug dependence. But it may later begin to fail the test once its effects become apparent. It may on the other hand pass the test if it has proven successful. Has the measure, over the years, made progress in achieving its aims? The key issue is that the proportionality test is not a one-off when it comes to policy development but an on-going process of reflection.

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40. See the dissenting opinion of Sachs J in *Prince v President of the Law Society of the Cape of Good Hope*, 2002 (2) SA 794; 2002 (3) BCLR 231, 25 January 2002, asking why an exemption to cannabis prohibition for the Rastafari could not be considered.



**Fig. 3.** *The test of proportionality requires an assessment of criminal laws against human rights restrictions in the light of evidence of effectiveness in achieving the stated aims of those laws.*

There have now been a number of cases in Europe and internationally in which the courts have held that the criminalisation of possession for personal use represents a disproportionate restriction on rights.<sup>41</sup> However, the Courts are inconsistent on this question, as are human rights mechanisms.<sup>42</sup> It is a delicate area into which such bodies are reluctant to tread.

A final note is that investigation methods and the enforcement of criminal laws must of course be subject to consistent scrutiny. Even if a measure as a matter of policy is deemed acceptable from a human rights perspective, the means adopted to carry it out may fail. In some cases this too will engage the test of proportionality (e.g. sniffer dogs in railway stations, bodily searches). In others it may stray into absolute prohibitions such as cruel, inhuman or degrading treatment or punishment (e.g. beatings to extract information).

41. See case law referred to in footnote 37 above. Further examples include Georgia where the Constitutional Court ruled on 24 October 2015 that the severe criminal punishment in law for the possession of marijuana for own consumption was contrary to the right to human dignity protected by the Constitution. On 4 November 2015, the Supreme Court of Justice of Mexico ruled that the growing of marijuana plants by four applicants concerned a choice about their private life that could not be interfered with. For general application, this judgment requires consolidation through additional concurring case law.

42. See *Prince v South Africa* UN Doc No. CCPR/C/91/D/1474/2006, 31 October 2007.

## 5.2 The Right to Health and the 3AQ Framework

Proportionality applies not only to the legitimacy of restrictions on rights, but also on whether the State has taken measures proportionate to the realisation of positive obligations. The lack of fulfilment of a positive obligation in this regard may be proportionate when considered next to the effects on others, or the financial or other burden on the state compared with the harm suffered by the individual.<sup>43</sup> This does not mean that positive obligations may be avoided, as the case law shows.<sup>44</sup> However, all Council of Europe States have concurrent international obligations relating to economic, social and cultural rights. Some of these rights are also reflected in the European Social Charter, but standards and tests are better developed in international human rights law, and are well suited to policy development. Here, we move from tensions between human rights and drug control into (potential) complementarities.

Pursuant to the right to health, the '3AQ' framework requires that health services be Available, Accessible, Acceptable and of Sufficient Quality.<sup>45</sup>

**Availability** refers to the existence in sufficient quantity of health services. They must exist.

**Accessibility** refers to the ability of people to benefit from these services. This includes geographical and economic accessibility, as well the need to account for the specific needs of certain groups (non-discrimination).

**Acceptability** refers to the need for services to be ethically appropriate and human rights compliant. Abusive healthcare, simply put, fails the test. This engages a range of other rights related to the right to health, including freedom from torture and cruel, inhuman and degrading treatment. Acceptability also refers to the need to take into account cultural appropriateness and the gender considerations.

Finally, services must be of **sufficient quality**. This means that they must not be arbitrary, and based on medical and scientific evidence. This relates to

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43. *Rees v the United Kingdom*, No. 9532/81, 17 October 1986, paragraph 37; *Abdulaziz, Cabales and Balkandali v the United Kingdom*, Nos. 9214/80, 9473/81, 9474/81, 28 May 1985, paragraph 66; *Appleby and others v the United Kingdom*, No. 44306/98, 6 May 2003, paragraph 40.

44. *Gaskin v UK*, No. 10454/83, 7 July 1989, paragraph 49; *B. v France* No. 13343/87, 25 March 1992, paragraph 63; *Goodwin v the United Kingdom* No. 28957/95, 11 July 2002, paragraph 93; *Van Kück v Germany* No. 35968/97, 12 June 2003, paragraphs 84-85

45. Committee on Economic, Social and Cultural Rights, *General Comment No. 14*, op. cit. paragraph 12.

the right to benefit from scientific progress and its applications under Article 15 of the Covenant on Economic, Social and Cultural Rights.<sup>46</sup>

█ Critically, outside of certain core obligations, economic, social and cultural rights are subject to the principle of **progressive realisation**.<sup>47</sup> In other words, their implementation should be gradually improved. It is a process measure as well as an outcome. This therefore undergirds the 3AQ test. The idea of progressive realisation recognises resource constraints and the long-term project of implementing economic and social rights. But it contains also an important **presumption against retrograde measures**,<sup>48</sup> and it requires adequate **budgetary allocation** to the 'maximum' of 'available resources'<sup>49</sup> for the realisation of the right in question. This too is central to a human rights assessment. It is especially important given the very low proportion of drug policy funding dedicated to harm reduction and treatment compared with drug enforcement, and especially in times of austerity when health and social care can often face the brunt of cuts.<sup>50</sup>

█ The potential complementarity here is the shared aim of drug policy and human rights in securing improved health outcomes. Drug treatment obligations under international drug control law, however, are relatively weak. Moreover, harm reduction has been controversial in drug policy but is

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46. Committee on Economic, Social and Cultural Rights, Concluding Observations: Mauritius, 8 June 2010, UN Doc No. E/C.12/MUS/CO/4, paragraph 27. See also, The right to enjoy the benefits of scientific progress and its application, Report of the Special Rapporteur in the field of cultural rights, Farida Shaheed, UN Doc No. A/HRC/20/26, 14 May 2012.

47. Article 2(1), International Covenant on Economic Social and Cultural Rights 1966; Article 24(4), Convention on the Rights of the Child 1990; Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties' obligations*, UN Doc No. E/1991/23, 14 December 1990, paragraph 9; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc No. E/C.12/2000/4, paragraphs 30-31.

48. Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties' obligations* op. cit. paragraph 9; CESCR General Comment No. 14 op. cit., paragraph 32.

49. Article 2, ICESCR. Article 4, CRC.

50. Pompidou Group, *Athens Declaration on protecting public health by ensuring essential services in drug policy under austerity budgets*, adopted at the 73rd meeting of Permanent Correspondent, 26-27 November 2013. See also European Committee on Social Rights, General Introduction to Conclusions XIX-2 (2009) "the economic crisis should not have as a consequence the reduction of the protection of the rights recognised by the Charter. Hence, the governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when beneficiaries need the protection most." This was affirmed in *GENOP-DEI and ADEDY v. Greece*, Complaints No. 65/2011 and No. 66/2011, decisions on the merits of 23 May 2012, paragraph 16.

increasingly supported by human rights mechanisms. The human rights tests applied to this area may be incorporated into policy design from the outset. Through a 3AQ lens the objectives and priorities of the policy are focused in certain important ways.

■ Let us consider very briefly the 3AQ test applied to drug dependence treatment and harm reduction.<sup>51</sup> According to basic indicators a State may be able to say that drug treatment and harm reduction services are in place in the country. However, this speaks only to the availability part of the test and does not pass it alone. If there are only five treatment programmes in the entire country then they are not available to most. Nor are they geographically accessible. A needle and syringe programme may be available but only open for a few hours during the working day. This is also inaccessible to many that may need it. Opioid substitution therapy—or, in line with the emerging consensus, opioid agonist treatment (or OAT)—may be provided but only on a daily basis with no opportunity for take-home doses. This too is an accessibility issue as for some the daily trip to the clinic is simply too burdensome. It is argued, of course, that this could at the same time constitute a diversion problem, and it is a valid argument. This is a good example of the differing goals and perspectives of drug control and human rights at play.

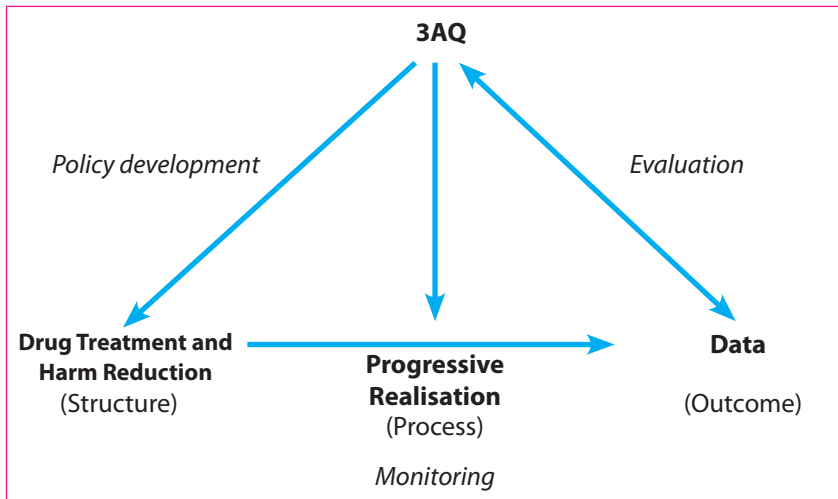
■ ‘Drug treatment’ may be provided, but in practice it takes the form of isolation. This raises acceptability problems. Methadone may be provided but subject to degrading practices (e.g. a requirement to urinate in front of staff) or disciplinary measures. A drug treatment programme may be available and acceptable for adults, but it may not be tailored for young people for whom the relevant programme is unsuitable.

■ This latter point speaks to the crossover between acceptability and quality. A programme may be of sufficient quality for some, but not for others, therefore unacceptable (e.g. minors in a residential programme for adults). But this is also a quality concern. Services must conform to best practice standards and the best available evidence. For example, if only one form of drug treatment is available, whatever this may be, this fails to recognise the variety of options necessary to address the needs of those experiencing dependency. Needle and syringe programmes may be in place all over the country, but may be underfunded, ill-equipped, understaffed, or may operate in ways that are contrary to the available evidence of effectiveness (e.g. the requirement to return used equipment to receive sterile equipment).

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51. European States have embraced harm reduction to varying degrees and one Council of Europe member state in particular—the Russian Federation—does not support harm reduction in its legislation and has paced a complete ban on opioid substitution treatment.





**Fig. 4.** Drug treatment and harm reduction services must be available, accessible, acceptable and of sufficient quality. This should form part of policy design, it should be monitored for 'progressive realisation', and progress in this regard should be incorporated into indicators of success.

### 5.3 Prisons and the Principle of Equivalence

Prisons present specific policy challenges and various human rights tests are applicable. Given the fact of imprisonment as punishment, for example, prison conditions are often addressed under the prohibition of cruel, inhuman or degrading treatment or punishment pursuant to Article 3 of the ECHR.<sup>52</sup> A specific test relating to the rights of prisoners, and of critical importance to drug policy, is the principle of equivalence. In essence, standards of healthcare in prisons should be equivalent to that in the community. The principle has been reaffirmed through many European Court cases, and is contained in various Council of Europe standards.<sup>53</sup> Detention is the punishment for the

52. E.g. *Kalashnikov v Russia*, No. 47095/99, 15 July 2002; *Modarca v Moldova*, No. 14437/05, 10 May 2007.

53. *European Prison Rules*, Committee of Ministers, Recommendation Rec(2006)2, 11 January 2006; *Ethical and organisational aspects of health care in prison*, Committee of Ministers Recommendation R (98)7, 1998; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the CPT standards, CPT/Inf/E 2002 1 – Rev. 2006; *Khudobin v. Russia*, No. 59696/00, 26 October 2006, paragraph 93.

crime committed, not the worsening of health. A person should not leave State custody in worse health than before he or she entered prison due to poor conditions or State neglect. This is a generally accepted principle in Europe and internationally, though its implementation falls far short for many reasons.

■ This, then, is a key test for the development, monitoring and evaluation of prison policy relating to drugs. Needle and syringe programmes and opioid agonist therapy serve as challenging examples. This is especially important given the disproportionate representation of people who use drugs in prisons, ongoing drug use in prisons, the increased risk of contracting communicable disease in closed settings, and the increased risk of overdose death upon release. In the community, both NSP and OAT (a.k.a. OST) are available in almost all Council of Europe States. OAT medications are on the WHO model list of essential medicines given their effectiveness in treating opioid dependency and reducing overdose death. The European Committee for the Prevention of Torture continuously recommends its scale up in prisons.<sup>54</sup> Needle and syringe programmes have long been central to the global response to HIV and are protective against a range of other health harms such as hepatitis C and wound abscesses. Both interventions are seen as requirements for the progressive realisation of the right to health.<sup>55</sup> Just as the 3AQ framework applies in the community, it is brought into prisons via the principle of equivalence. On this basis, where OAT and NSP are available in the community, both should be available, accessible, acceptable and of sufficient quality in prisons too, though prison environments require adaptation of services.

■ However, these services are often controversial in a prison context.<sup>56</sup> Some countries do not allow OAT in prisons at all. (In this regard it should be noted that discontinuing medication due to imprisonment may constitute cruel inhuman and degrading punishment<sup>57</sup>). In others OAT may be continued in prison, but not initiated. These are clearly different standards, and

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54. CPT, Report on the visit to Ireland from 25 January to 5 February 2010, CPT/Inf (2011) 3, paragraph 75; Report on the visit to Bosnia and Herzegovina from 29 September to 9 October 2015, 24 March 2016, paragraph 110. See also Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Mendez, UN Doc No. A/HRC/22/53, 1 February 2013, paragraph 73.

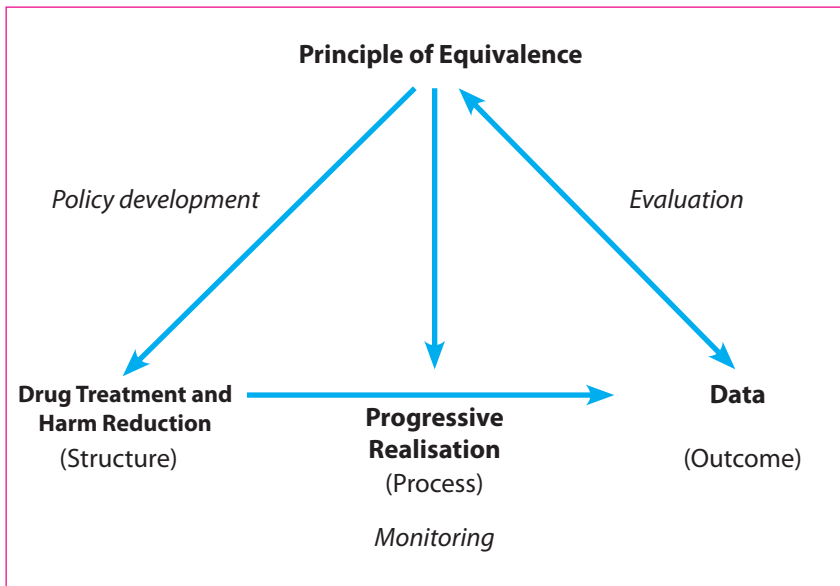
55. Report of the Special Rapporteur on the Right to Health 2010, op. cit. Committee on Economic Social and Cultural Rights, *Concluding Observations: Russian Federation*, 1 June 2011, UN Doc No. E/C.12/RUS/CO/5, paragraph 29.

56. *Shelley v the United Kingdom*, No. 23800/06, 4 January 2008.

57. See for example CPT Report on Bosnia and Herzegovina op. cit., paragraph 110 'In no case should substitution therapy be abruptly terminated'.

not equivalent to community entitlements. In other countries some prisons allow this treatment while others do not. This is an accessibility problem as the quality of healthcare depends on where one is imprisoned. In the majority of countries where needle and syringe programmes operate in the community for the purpose of health goals, they are not available in prisons.

Prison authorities may cite security concerns and goals of keeping drugs out of prisons, but these cannot prima facie override the human rights imperative to ensure equivalent healthcare. As with other areas the presumption should be in favour of this rights-based principle.



**Fig. 5.** The principle of equivalence requires standards of healthcare in prisons equivalent to that in the community, and should form a component of rights based assessment.

## 6. INTERNATIONAL FUNDING DECISIONS

International co-operation and assistance, including funding, is a central element of international drug control. It is imperative, however, that assistance and funding emanating from Council of Europe States do not fuel or worsen rights abuses elsewhere.

■ In the same way as the tests above, human rights standards may be brought to bear at the planning (decision-making), monitoring (e.g. mid-term evaluation) and final evaluation stages of any international assistance project. In this way the donor can assess whether funding is appropriate in the first place based on an initial risk assessment. From there, rights-based indicators may be employed to conduct ongoing impact assessments. Through this process drug policy objectives underpinning such funding are not divorced from human rights outcomes. Concerned with the death penalty for drug offences the European Parliament has called for the development of such a process by the European Commission.<sup>58</sup>

■ There are of course additional political and practical challenges in relation to funding relationships due to their inter-State nature. Politically, such assessments could be seen as interference with domestic issues or equated with conditionality. However, the focus here is on the donor's own responsibilities to do no human rights harm in the course of the programmes it funds. Additionally, the human rights considerations and objectives are explicit from the outset and part of the funding agreement. This in turn deflects from potential accusations of the later use of human rights as undue political influence.

■ Moreover, a human rights risk and impact assessment is not the same as conditionality. Where rights issues are raised there is a range of options to resolve them. The UN Office on Drugs and Crime has set out seven such measures relating to its own work. These range in severity from supportive programmes built into the project based on identified risks, to political interventions when later issues emerge. In certain circumstances funding may be refused, frozen or withdrawn where the human rights situation is too poor or where the recipient State refuses to address identified problems.<sup>59</sup> There have been concrete examples of this in drug control, in particular relating to the withdrawal of European funding from drug enforcement efforts in death penalty States. But there is a variety of other funding agreements that would benefit from such an assessment, including funding for drug treatment, harm reduction, prison building, border posts, sniffer dogs, airport detection, etc.

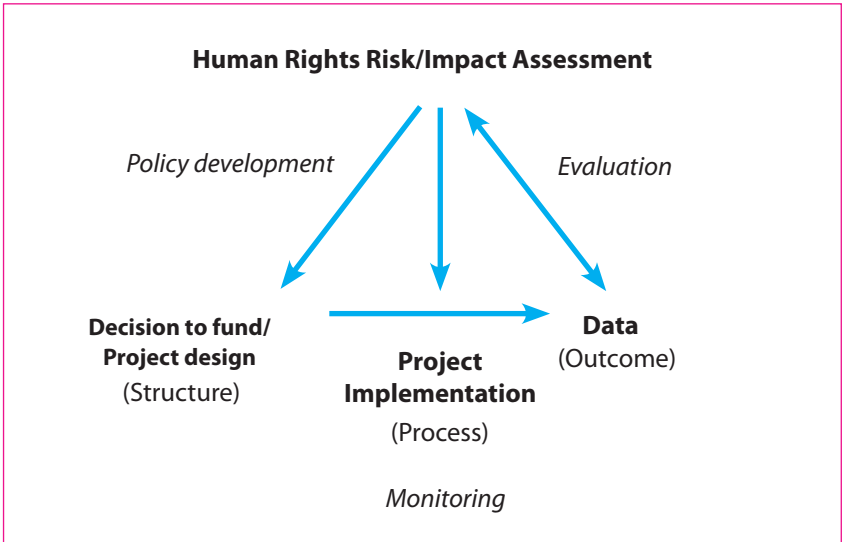
■ In a practical sense, desk officers within State agencies may not always have the requisite human rights expertise, or country knowledge, to carry

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58. European Parliament resolution of 8 October 2015 on the death penalty (2015/2879(RSP)), paragraph 16.

59. UN Office on Drugs and Crime, UNODC and the Promotion and Protection of Human Rights, 2012.

out a risk assessment or to oversee ongoing monitoring. Co-ordination across ministries is of course important. Recognising this problem, however, civil society organisations have created tools that may be adapted for this purpose. Harm Reduction International, for example, funded by the European Commission, has created a computer program specifically designed to meet this challenge. It may be downloaded and adapted to the relevant agency's systems, objectives and indicators. The tool covers the entire process from project design to final evaluation.<sup>60</sup>



**Fig. 6.** Human rights risk and impact assessments may be applied at the design, implementation and evaluation stages of international assistance projects.

60. Harm Reduction International, 'Human Rights Due Diligence in Drug Control: An Assessment Tool for Donors and Implementing Agencies', 2012. Available on a Creative Commons licence at: (Mac) <http://www.phoenixmediagroup.org/hri/hrtool-cd-mac.zip> (Windows) <http://www.phoenixmediagroup.org/hri/hrtool-windows-cd.zip>  
See also European Commission, 'Operational Human Rights Guidance for EU external cooperation actions addressing Terrorism, Organised Crime and Cybersecurity: Integrating the Rights-Based Approach', 2015.

## 7. CONCLUSION

■ The approach set out above is geared towards the improvement of drug policy through human rights, and the progressive realisation of human rights through drug policy. This short paper cannot set out the full range of rights engaged by drug control, nor set out a comprehensive set of indicators and legal standards or tests. It has instead attempted to set out a way of approaching human rights assessment across a range of aspects of drug control, from law to specific services, and taking into account the wide diversity of situations, issue areas and rights engaged.

■ By way of conclusion, it is worth reiterating the two points of departure set out in the introduction. The process set out above should not be seen as externally imposed or adversarial, but one of collaboration and joint ownership. And while incorporating human rights into drug policy is not easy—nor should it be if it is to be taken seriously—it need not begin with a comprehensive review of every aspect of this multifaceted issue area. There are many smaller ways to begin, and from which to move forward.

## APPENDIX:

### Indicative examples, rights and tests

■ This appendix sets out some indicative examples of the rights engaged by and tests applicable to demand reduction and supply reduction efforts. They are neither meant as recommendations nor are they exhaustive. Rather, they are set out to inspire further discussion and analysis among drug policy makers, implementers and evaluators when considering the human rights dimensions of drug policy.

■ The sources for the right and tests in question are included in brackets. In the case of tests, these all have treaty bases, but will have been developed further by monitoring mechanisms. The margin of appreciation should be borne in mind throughout. It is not set out in each case.

DEMAND REDUCTION	Rights Engaged	Tests and Sources	Examples and Comments
Prevention (Campaigns / Information)	Protection of children from drugs (Art. 33, CRC) Child's right to health (Art. 24, CRC) Child's right to receive and impart information (Art. 13, CRC)	'Appropriate measures' (Art. 33, CRC) 'Accurate and objective' information (Committee on the Rights of the Child)	<p><i>A mass media campaign is planned.</i></p> <p><i>School based drugs education is in development.</i></p> <p>While prevention efforts relate to positive obligations under child rights the content of prevention campaigns and drugs education must meet appropriate standards. The UN Committee on the Rights of the Child has consistently recommended that information be accurate and objective, conforming to UNODC and other expert warnings against 'scare tactics' and misinformation.</p>
Prevention (Random testing/sniffer dogs/searches)	Protection of children from drugs (Art. 33, CRC) Privacy (Art. 8, ECHR; Art. 16, CRC)	'Appropriate measures' (Art. 33, CRC) Proportionality (European Court of Human Rights)	<p><i>School policy allows for random searches of schoolbags and lockers.</i></p> <p><i>School policy allows for strip searches on suspicion of possession of drugs.</i></p> <p><i>Random school drug testing is employed.</i></p> <p>Safford Unified School District v. Redding (2009) was a US Supreme Court case involving strip searches in schools. Applying a test of 'reasonableness', similar to that of proportionality, the Court found a violation of the student's constitutional right to privacy.</p> <p>See also 'random school drug testing' above.</p>



DEMAND REDUCTION	Rights Engaged	Tests and Sources	Examples and Comments
<p>Prevention</p> <p>Addressing 'encouragement' to use drugs</p>	<p>Freedom of expression (Art. 10, ECHR)</p> <p>Protection of children from drugs (Art. 33, CRC)</p>	<p>Proportionality (European Court of Human Rights)</p>	<p><i>Inciting, inducing or encouraging drug use is criminalised.</i></p> <p><i>A website providing information on safer injection techniques is shut down.</i></p> <p>Handyside v UK (1976) dealt with a similar issue. In that case 'The Little Red Schoolbook' was banned in the UK for its frank depictions of sex and drug use. It was thought that the book could encourage risky and possibly illegal activity. Despite the accuracy of the information provided the European Court still found that the UK acted within its margin of appreciation. The book is now freely available indicating again the need for evaluation over time, and as norms change.</p>
<p>Prevention</p> <p>(Criminalisation of possession for personal use outside of medical and scientific purposes)</p>	<p>Right to privacy (Art. 8, ECHR)</p> <p>Freedom of thought, conscience and religion (Art. 9, ECHR)</p> <p>Freedom of expression (Art. 10, ECHR)</p> <p>Cultural and indigenous rights/expression (Art. 27, ICCPR)</p>	<p>Proportionality (European Court of Human Rights)</p>	<p><i>Drug use or possession for personal use is a crime.</i></p> <p>While common to almost all States, the criminalisation of possession for personal use has rarely undergone a rights-based proportionality assessment.</p> <p>See 'proportionality' above.</p>

<b>DEMAND REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Harm reduction <sup>1</sup>	<p>Right to health (Art. 12, ICESCR)</p> <p>Right to benefit from scientific progress and its application (Art. 15, ICESCR)</p>	<p>AAAQ (Special Rapporteur on the Right to Health; UN Committee on Economic, Social and Cultural Rights)</p>	<p><i>Each municipality may decide whether or not to put in place NSP.</i></p> <p><i>An age restriction of access to NSP is put in place.</i></p> <p>See 'AAAQ' above.</p>
Harm reduction (prisons)	<p>Right to health (Art. 12, ICESCR)</p> <p>Right to benefit from scientific progress and its application (Art. 15, ICESCR)</p> <p>Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)</p>	<p>AAAQ (Special Rapporteur on the Right to Health; UN Committee on Economic, Social and Cultural Rights)</p> <p>Principle of equivalence (European Court of Human Rights)</p>	<p><i>NSP is not permitted in prison.</i></p> <p>See 'AAAQ' and 'principle of equivalence' above.</p>

1. In many drug strategies harm reduction is a separate pillar. This is more appropriate as it is not geared towards demand reduction per se.

<b>DEMAND REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Drug dependence treatment	<p>Right to health (Art. 12, ICESCR)</p> <p>Right to benefit from scientific progress and its application (Art. 15, ICESCR)</p> <p>Right to privacy (Art. 8, ECHR)</p> <p>Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)</p> <p>Freedom from arbitrary detention (Art. 5, ECHR)</p>	<p>AAAQ (Special Rapporteur on the Right to Health; UN Committee on Economic, Social and Cultural Rights)</p> <p>Proportionality (European Court of Human Rights)</p> <p>Lawfulness of detention (Art. 5, ECHR)</p>	<p><i>There are no standards for privately run drug treatment clinics.</i></p> <p><i>Drug user registries are in place.</i></p> <p><i>Compulsory treatment is permissible.</i></p> <p><i>Monthly urine testing is required for OAT (or OST) access.</i></p> <p><i>OAT provision requires a new pilot project despite existing international evidence.</i></p> <p>Detention for reasons of drug addiction is complicated somewhat by Article 5(1) (e) of the ECHR, which allows for the 'lawful detention' of 'drug addicts'. Rather than being read as a licence to detain people who are drug dependent, however, this should require a careful analysis of the circumstances under which it is lawful and compliant with the Convention to do so.</p>

<b>DEMAND REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Drug dependence treatment (prisons)	<p>Right to health (Art. 12, ICESCR)</p> <p>Right to benefit from scientific progress and its application (Art. 15, ICESCR)</p> <p>Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)</p>	<p>AAAQ (Special Rapporteur on the Right to Health; UN Committee on Economic, Social and Cultural Rights)</p> <p>Principle of equivalence (European Court of Human Rights)</p>	<p><i>Drug dependence treatment is available in some prisons but not others.</i></p> <p><i>OAT (or OST) may be continued but not initiated in prison.</i></p> <p>See 'AAAQ' and 'principle of equivalence' above. There is of course an absolute prohibition on torture and cruel, inhuman or degrading treatment or punishment. The principle of equivalence can help determine whether such a violation has taken place.</p>

<b>SUPPLY REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Investigation and arrest	<p>Right to privacy (Art. 8, ECHR)</p> <p>Non-discrimination (Art. 14, ECHR)</p>	<p>Proportionality (European Court of Human Rights)</p> <p>De jure (structure) and de facto discrimination (outcome)</p> <p>(Jurisprudence of human rights bodies)</p>	<p><i>'Stop and search' is widely employed. Suspects may be made to vomit if it is suspected they have swallowed evidence.</i></p> <p>Stop and search procedures have been demonstrated in the UK and the US to have racially discriminatory effects. Even if not the intention, this evidence speaks to a de facto discriminatory outcome that must be addressed.</p> <p>In <i>Jalloh v Germany</i> the use of emetics to force a suspect to regurgitate a bag of cocaine he had swallowed was found to be a breach of Article 3, ECHR. In principle this was not an illegitimate practice for the investigation of a crime (though most Council of Europe States do not do it), but it was not in this case absolutely necessary, and was conducted in an abusive manner. As a result, using the evidence obtained in this way was also a breach of the applicant's right to a fair trial (Article 6, ECHR – see further below).</p>

<b>SUPPLY REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Prosecution	Right to fair trial (Art. 6, ECHR)	Standards set out in Art 6. ECHR and jurisprudence of European Court of Human Rights	<p><i>Drug trafficking cases are heard in special criminal courts designed for terrorism.</i></p> <p><i>Quantity levels bring a presumption of drug trafficking, reversing the burden of proof.</i></p> <p><i>Drug courts require admission of guilt for access to treatment.</i></p> <p>While the circumstances of each case will determine whether a fair trial has been provided, there are circumstances in which this may be undermined in law or policy from the outset.</p>

<b>SUPPLY REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
Penalties (Criminal and civil)	<p>Freedom from cruel, inhuman or degrading treatment or punishment (Art. 3, ECHR)</p> <p>Right to family life (Art. 8, ECHR)</p> <p>Best interests of the child (Art. 3, CRC)</p> <p>Right to social security (Art. 9, ICESCR)</p> <p>Protection of property (Art. 1, protocol 1, ECHR)</p> <p>Presumption of innocence (Art. 6, ECHR)</p>	<p>Absolute prohibition of cruel, inhuman or degrading treatment (circumstances will determine if there is a violation)</p> <p>Proportionality (European Court of Human Rights)</p> <p>Proportionality (European Court of Human Rights)</p> <p>Legality (European Court of Human Rights – civil actions are not seen to affect guilt in a criminal sense)</p>	<p><i>Prisons are overcrowded with a large proportion in prison for non-violent drug offences. Conviction for certain drug offences remove rights to social benefits.</i></p> <p>The issue here is not a challenge to penalties for drug offences, but the legitimacy, fairness and relation to the gravity of the offence of those penalties. (Civil) Asset forfeiture is undertaken.</p> <p>For an overview of ECHR jurisprudence on civil forfeiture see <a href="http://tinyurl.com/ggmncem">http://tinyurl.com/ggmncem</a>. By and large it has been found to be compatible with human rights law, but it can become disproportionate in certain circumstances. There also remains a controversy about forfeiture affecting innocent owners.</p>

<b>SUPPLY REDUCTION</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
<p>International assistance:</p> <p>Funding, joint operations, mutual legal assistance, extradition</p>	<p>Various rights are engaged</p> <p>e.g.</p> <p>Right to life (Art. 2, and protocol 13 ECHR)</p> <p>Freedom from cruel inhuman and degrading treatment or punishment (Art. 3, ECHR)</p>	<p>Various tests – robust risk and impact assessment system required</p>	<p><i>The death penalty is applied for drug offences in a country requesting extradition or mutual legal assistance.</i></p> <p><i>The death penalty is applied in a country in receipt of drug enforcement funding.</i></p> <p><i>During the lifetime of a funding agreement police violence in relation to drug enforcement escalates.</i></p> <p>There are many ways in which the donor/ requested State's human rights obligations may be engaged through international assistance and funding. It requires an ongoing system of risk and impact assessment based on core rights, tests and rights-based indicators for monitoring. See above and the tools referred to.</p>



<b>OBJECTIVES AND INDICATORS</b>	<b>Rights Engaged</b>	<b>Tests and Sources</b>	<b>Examples and Comments</b>
<p>International assistance:</p> <p>Funding, joint operations, mutual legal assistance, extradition</p>	<p>Various</p> <p>E.g.</p> <p>The right to health (Art. 12, ICESCR)</p> <p>Non-discrimination (Art. 14, ECHR)</p>	<p>Various</p> <p>AAAQ, progressive realisation</p> <p>De jure and de facto discrimination</p>	<p><i>Monitoring of scale up of services and statistics relating to access to those services over time.</i></p> <p><i>Disaggregation of outcome statistics to uncover patterns of discrimination if any, and to respond to needs of specific groups.</i></p> <p>The above issues relating to demand and supply reduction primarily speak to the means adopted. Drug strategies should, however, also incorporate human rights into the objectives and indicators of success of drug strategies.</p> <p>See for example <i>Report on Indicators for Promoting and Monitoring the Implementation of Human Rights</i>, UN Doc No. HRI/MC/2008/3, 6 June 2008</p>





## **“All policy areas must comply with human rights. This exigency applies equally to drug policy.”**

“The Pompidou Group encourages member states to conduct a comprehensive human rights-based review in their country”. The Permanent Correspondents of the Pompidou Group indicated that, in conducting such a review, states “can rely on a range of indicators, available in various sources issued by and with the help of organs such as the World Health Organisation (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the UN Office on Drugs and Crime (UNODC), the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, or the UN High Commissioner for Human Rights, as well as guidance adopted by the Pompidou Group” and also took note of this paper by Damon Barrett.

*Statement by the Permanent Correspondents of the Pompidou Group on bringing human rights into drug policy development, implementation, monitoring and evaluation (November 2017)*

### **The Pompidou Group**

The Pompidou Group provides a multidisciplinary forum at the wider European level where it is possible for policy-makers, professionals and researchers to exchange experiences and information on drug use and drug trafficking. Formed at the suggestion of the French President Georges Pompidou in 1971, it has become a Council of Europe partial agreement in 1980. In 2018, it gathers 39 countries: 36 among the 47th Member States of the Council of Europe and Morocco, Israel and Mexico.

[www.coe.int](http://www.coe.int)

The Council of Europe is the continent’s leading human rights organisation. It comprises 47 member states, 28 of which are members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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