Beyond Zero Tolerance: How effective would drug decriminalization be for improving Kazakhstan's drug policy?

Nurali Nun

Abstract

This paper tests the hypothesis that drug decriminalization can be a more effective alternative to the current punitive drug policy in the country of Kazakhstan. Domestic efforts in Kazakhstan still focus on criminal prosecution as opposed to rehabilitation, and treatment facilities are not adequately funded to be effective as the country remains an important transit point on Central Asian drug trafficking routes. Based on the international experience, both positive and negative, of decriminalization campaigns, this study seeks to assess the possible relevance of such initiatives in Kazakhstan. To determine the strengths, weaknesses, opportunities, and threats of decriminalization, the strategy of SWOT analysis is used. The results indicate that although decriminalization may decrease congestion in prisons and ease access to treatment, it may be unsuccessful unless large amounts of money are allocated to healthcare, the social support system, and people trust the institutions.

Introduction

The issue of drug abuse and criminalization is currently one of the hottest social and public health problems in Kazakhstan. After several decades of harsh policies on drugs, the nation remains struggling with massively spread substance drinking, congested jails peopled with non-violent drug users, and increasing realization that the existing punitive system has failed to achieve any significant success. Kazakhstan, being at the intersection of the main routes of drug trafficking between Afghanistan and Russia and Europe, not only makes the illegal substances (easier) reachable, but it also makes them (more) difficult to manage. On the other hand, rehabilitation centers are always underfunded and understaffed, stigmatized, a situation that does not help in aiding the victim to acquire the required support to recover and fit back in the society. This fact raises a policy question: would a more efficient and humane solution to the problem of drugs in Kazakhstan be the decriminalization of possession of drugs used in the context of personal use?

This study will concur that decriminalization is not risk-free, but it bears an opportunity to ease the pressure on the criminal justice system and enhance population health outcomes and bring Kazakhstan in line with evidence-based global best practices. The paper will also review both effective and ineffective case studies on a health-centered approach in Portugal and a more problematic reform in Oregon based on the case study methodology, and conclude on which lessons can be most useful to the Kazakhstan context. In the process, it shall also take into account factors specific to the country (e.g. culture, political, and economic dimensions) that might influence the possibility of implementing such a policy. Drawing a line, the thesis that can be proposed here is that Kazakhstan is belatedly to be careful but to decriminalize, along with an array of resilient treatment, prevention, and harm reduction measures. This is the most promising solution to the drug crisis in an effective, sustainable, and socially responsible manner.

Background: Kazakhstan's Policy Today

Kazakhstan has held a largely punitive approach to prohibited drugs since gaining independence in 1991. Its legal foundation for this is the Law of the Republic of Kazakhstan No. 279 "On Narcotic Drugs, Psychotropic Substances and their Analogues and Precursors and Countermeasures to their Illegal Turnover and their Abuse" dated 10 July 1998. This law insists that every activity related to the legal distribution of drugs (importation, manufacture, distribution, prescription) be under license; meanwhile, it makes all unlicensed activities felonies and requires collaboration between the Ministry of Health, the Ministry of Interior and Customs to address them. Such collaboration is meant to eliminate loopholes but is ineffective, as it creates bureaucratic red tape and restricts the exchange of information. (*On Narcotic Drugs, Psychotropic Substances, Their Analogues and Precursors and Counter Measures of Their Illegal Turnover and Their Abuse - "Adilet" LIS*, n.d.)

In Articles 296-303 of the Criminal Code (as it became valid as of January 2025), even small amounts of drugs are criminalized. Punishments including community service or administrative fines (up to 80 calculation indices per month, approximately US$500) are outlined for first-time offenders who are caught in possession of <0.1 grams of heroin or equivalent to it; punishment of 2-5 years imprisonment in case of a second offense or in case of scales beyond the reserve of a one-time use; or long prison terms (15-20 years or life) and seizure of property associated with extensive trafficking and production (in January 2025 the law was amended to slightly reduce prison time related to the unintentional transfer of a courier to 58 years).

In Kazakhstan, criminal law is applied even to the individuals found with quantities considered to be of personal volumes. The punishment can be done in the form of community service or fines, but still, all those cases upon occurrence lead to the criminal proceedings and a criminal record. This record, in turn, erects severe employment and social integration challenges, not only to so-called small-time users who do not present any real danger to the general public. This is because prosecutors tend to offer custodial sentences as an indication of the zero-tolerance policies by the state, and there is no diversion mechanism available to re-route such individuals to treatment programs rather than vengeance.

As compared to this old punitive method of dealing with illegal immigrants, certain changes have emerged, pointing to a slow conversion. Rehabilitation standards were also introduced in Ministry of Health Order No. 188 (31 March 2015), where voluntary, anonymous treatment facilities, medically supervised substitution treatment with methadone and buprenorphine, and post-treatment social support in the form of vocational training of those convicted of drug offences are envisioned. Although implementation is at an early stage, this framework indicates the possibility of a developing realisation that health-oriented measures are potentially more efficient in harm reduction than criminal sanctions.

Still, despite the existence of these standards on paper, resources are few, and there are fewer than 500 methadone slots in the country, and only 2.6 percent of those who are dependent enter voluntary treatment programs; most are referred under court decree (UNODC, 2017).

Meanwhile, social attitudes towards drugs in Kazakhstan are definitely prohibitionist. People who are registered and using drugs (PWUD) are given a “stamp“ on their vigilantism, restricting them from public service, professional licenses, and even banning them from student loans. This reinforces stigma and discourages treatment seeking, as it becomes extremely difficult for drug-related offenders to turn their lives around.

Geographic positioning of Kazakhstan at the center of Central Asia makes it a key passageway in the so-called Northern Route of the heroin network in Afghanistan, which directs drugs to Central Asia and on to Russia and Europe. UNODC puts the Afghan heroin trafficked north at about 25 percent of those trafficked that year, which passes through Kazakhstan (UNODC, 2022). Issues in the country are also severe in the domestic field: about 110,000 individuals were officially registered as substance and narcotic substance dependent in 2023 by the Ministry of Internal Affairs, but NGOs approximated the real number of PWUD to be 250,000, as many people hide the situation (UNAIDS, 2023). Injection drug use in large urban areas, Almaty, Shymkent, and Karaganda, is highly associated with the prevalence of HIV. Indeed, injection drug use is a factor that contributes to almost 60 percent of new infections with HIV in Kazakhstan (Kazakhstan National AIDS Center, 2023). The data collected by the states also report a small decrease in recorded drug users officially (by 3-4 percent per year since 2018), but specialists warn that this figure is not associated with a real decline but with the under-representation of this indicator and stigmatization. In this way, Kazakhstan will be a state of transit as well as a market with an increasing population with large levels of risk to the public health being concentrated in the main cities. The question arises whether different, less punitive solutions may be more effective in Kazakhstan, where the existing prohibitionist pattern still fails at both solving the trafficking problem and mitigating the health-related consequences of its existence.

The successful examples of drug policy have some specific policies that made them stand out. The first example would be Portugal’s 2001 Decriminalization Model: Day-to-day possession of not more than 10 doses of any drug is considered an administrative offence and not criminal. Criminals are presented to a multidisciplinary ‘Dissuasion Commission' which may propose treatment, monetary fines, or no penalty. Outcomes: Drug-related mortality decreased more than 70 percent, HIV infections among PWUD declined to fewer than 100 a year, and the overall rates did not increase dramatically. The second example is Switzerland’s Harm Reduction and Regulated Access: Besides the decriminalization of possession of low amounts, Switzerland opened up controlled heroin injections (supervised heroin injection facilities) and the clearing of syringes. Outcomes: Drug use-related crime was reduced by 50 percent in pilot cities, and deaths caused by overdoses went down by 40%. And the final policy would be the Netherlands’ Differentiated Legal Regime: Despite finding into punishment for the so-called hard drugs, the selling of small amounts of cannabis with rigid prerequisites in so-called coffee shops is possible. Outcome: The rate of youth use is relatively low in Europe, and public health indicators are better than in other European states. These policies will be further discussed in more detail in the section of case study.

Theory: Decriminalization- The Future of Drug Policy in Kazakhstan

According to the Global Commission on Drug Policy (2018), frameworks of drug policy are most commonly distinguished into four areas: criminalization, decriminalization, legalization, and harm

reduction. In the context of criminalization, non-medical use, possession, and distribution of controlled substances are all kept thoroughly illegal, which translates to punitive measures, fines, prison sentences, and criminal records against the user and low-level distributors alike. Legalization is then a step further where production, sale, and usage are regulated in a state-approved market with stringent quality controls, age limits, and taxation. Harm reduction is a set of health based strategies (needle exchange, supervised consumption sites, substitution therapy), and it is not necessarily changing the status quo of legality: instead, it aims to reduce adverse health and social impact. Lastly, decriminalization eliminates criminal sanctions related to personal possession and use, replacing them with administrative ones, i.e. no more than warnings, minimal fines, or treatment referral, though there is still a hard prohibition of illegal production and distribution.

Decriminalization is a clandestine tactic that can re-define drugs as a health concern instead of a criminal justice concern. According to Ward. et. al., decriminalization may also prevent overcrowding within the prisons, save the state the money spent enforcing drugs, and minimise the life-long impacts of criminal records on employment and social integration by diverting them into voluntary counselling or community programmes. It also reduces treatment barriers; people who use drugs (PWUD) will be more willing to seek medical assistance without the fear of legal prosecution because drug use will not necessarily lead to arrest. Out of these policies, decriminalization is the best suited for Kazakhstan, because it combines the elements of both legalization and harm reduction. The reasons for that will be stated later in the paper. Briefly, it will help drug users avoid criminal records and help them recover in better rehabilitation centers, since it combines elements of both legalisation and harm reduction.

This decriminalization model, at first glance, has the potential to bring a lot of benefits to Kazakhstan. The first of them is resource redistribution: The expenditure incurred by Kazakhstan on policing and incarcerating people involved in drug-related activities is much higher than what is spent on prevention and treatment efforts undertaken every year. The judicial and law enforcement resources would also be freed to work on higher-level traffickers and across-border smuggling, with the savings going back into extended methadone programmes and psychosocial support, as well as community-based outreach. The second benefit is health outcomes: International evidence indicates that countries that decriminalize possession are associated with great reductions in the levels of HIV and hepatitis C transmission among PWUD, which is due to improved opportunity to access sterile equipment and treatment services. The change, in the case of Kazakhstan, where the state of HIV is found among injecting drug users, can be translated into the quantitative change of positive population health indicators. The third one would be social integration: The elimination of criminal sanctions will increase social integration since PWUD will not be automatically criminalized. Decriminalization is also accompanied by employment-oriented rehabilitation services that enhance social integration and, thereby, prevent repeated recidivism and lead to long-term recovery. And the last one is compliance with international standards: With the loss of global opinion against the zero-tolerance approach, Kazakhstan is being risked isolation on a diplomatic map. Decriminalization would bring the national law in accordance with human rights directives, which UN agencies and the Global Commission on Drug Policy promote.

Case Studies: Unsuccessful and Successful Cases of Decriminalization Policy

In spite of the fact that decriminalization, which on the surface holds numerous advantages to the Kazakhstan people in terms of unloading the criminal justice system, alleviating facility congestion, and promoting treatment access, as viewed by many areas of concern, doubts emerge regarding its applicability to the Kazakhstan political, cultural, and institutional environment. The punitive model in Kazakhstan has decades of history, so the transition to a more health-based model would be complicated due to the stigma and scaling up the treatment capacity and building the trust between the state and the vulnerable population. The cases presented below serve to shed light on the issues that have defined both successful and unsuccessful decriminalization experiments in other jurisdictions, and are thus lessons that can be transferred to Kazakhstan.

An interesting example is an unsuccessful case, namely, the decriminalization of small amounts of drug possession in Portland, Oregon, within the framework of Measure 110 of the United States, which went into action in 2021. The reform diverted drug possession cases out of the criminal justice system and into a health-based model through imposing a $100 fine that could be forgiven so long as individuals phoned up a health service hotline. Although it was meant to address access to treatment, the ramp-up was poorly planned, under-resourced, and had low availability of treatments. In 2023, a state audit projected that less than 1 percent of cited individuals made any actual calls to the hotline, with overdose deaths in Oregon higher than ever, with more than 1,100 fatalities in 2022 (Oregon Health Authority, 2023; Oregon Secretary of State Audit, 2023). The absence of proper treatment infrastructure and means of linking drug users to health care services subsequently led to the reality that, despite the symbolic shift in Kratom policy, the populace began to associate decriminalization with a growing base of observable homelessness, open drug consumption, and overdose rates. Long before 2024 came around, the politics of reversal began; partially repealing the measure by early 2024, some criminal aspects of possession were again punishable (The New York Times, 2024). The case of Portland shows that decriminalization without strong health and social infrastructures to absorb demand may fail to be viewed as a harm-mitigation effort and rather can be a symbol of permissiveness that further exacerbates the problem of order in the population.

In Canada, the decriminalization pilot introduced in January 2023 in the British Columbia jurisdiction allowed local adults to possess up to 2.5 grams of specific illicit drugs without facing criminal charges, as it seeks to redirect its users to health and social services instead of the criminal system (Dalhousie University Research Communications, 2025; Downtowneastside.org, 2024). During its first year, BC registered a 57-percent drop in police incidents involving possession as compared to the past two years and in relation to the other Canadian provinces (Dalhousie University Research Communications, 2025). Yet, there were several deaths that occurred due to overdose: 2,511 in 2023 and above 1,150 in the middle of 2024, which means that there was no significant reduction in mortality rates within the first period of the pilot (Downtowneastside.org, 2024). A peer-reviewed study also observed that an increased response with decriminalization or decriminalization coupled with a safer supply program was associated with a 58 percent rise in opioid-related hospitalizations relative to pre-2020 baselines (Reddit user summary of JAMA Health Forum study, 2025). In addition to this, despite the fact that 63 percent of drug users were certain of the policy, many people did not know crucial requirements, and few people were aware of legal thresholds or even the right

to refer before getting access to the treatment (BMC Public Health, 2024). Even though the policy was tied to clean intentions, it was heavily criticized due to poor links of diversion, consistent busy street presence of open drug consumption, as well as police involvement that continued to be structurally in place-qualities that eventually led to the April-May 2024 re-criminalization of open drug use and the giving of drug seizure authority to the authorities (AP News, 2023; Downtowneastside.org, 2024). The culture of Vancouver Downtown Eastside, which is a marginalized community in which residents are homeless, chronically addicted in most cases, and distrustful of the institutions, meant that Vancouver was in unique circumstances; without strong housing and healthcare capacity scaling, combined with decriminalization, the policy would have sent a message that decriminalization was more permissive than safety.

In Portugal, a carefree attitude toward possession of up to ten days of minor doses of any drug was reconstructed into an administrative offense in 2001, and its punishment was redirected to the multidisciplinary Dissuasion Commissions rather than courts (Transform Drugs, 2023; Wikipedia, 2025). The number of deaths in Portugal associated with drugs decreased tremendously: in 2001, there were 131 people, whereas by 2008 there were around 20, and by 2012, still only 3 out of a million inhabitants (Woods, 2011; Wikipedia, 2025). The rate of the HIV-related infections caused by injecting drugs has dropped significantly between 2000, when it was nearly 907 new cases down to and an estimated 1618 cases in 2019, falling every year with a level of over 90 percent (Transform Drugs, 2023; Drug Policy Facts, 2025). The heroin addiction also fell to 25,000 people in 2018 against an initial number of approximately 100,000 people about twenty years ago (Wharton, 2022). This was alongside an uptake of treatment by a ~60 percent in 2012 and a reduction in the cost to society of up to 18 percent per capita (Knowledge at Wharton, 2022). However, austerity funding after 2009 reduced the budget amounts to the level of 2021 to the level of 16 million euros, the number of treatment entries changed from 1,150 in 2015 to 352 in 2021, and the number of adult lifetime drug users grew up to 12.8% in 2022 (Transform Drugs, 2023; Reddit, 2023). Early success was achieved by cultural acceptance of the framing of public health and a strong harm reduction service; however, efficacy has been strongly dependent on the maintenance of investment and civil commitment. Outspoken critics in Porto and Lisbon have accused increased instances of public disorder, drug exhibitions, and criminality, here again leading to the argument that there has been a localised re-criminalization, but much decriminalization of the experts, though, takes place under the structural disinvestment climate (Reddit, 2023; Guardian, 2024).

In the Netherlands drugs policy is based on a position where all drugs are strictly forbidden, but a tolerant regime enables licensed coffee shops to produce and sell up to five grams of cannabis to be consumed personally and under the rigid official control; hard drugs are strongly criminalized (Wikipedia, 2025; Wikipedia Coffeeshop, 2025). The idea behind this model is the detachment between the soft and hard drug markets, lowering the exposure to the more dangerous drugs. The rate of youth cannabis consumption in the Netherlands is one of the lowest in the Western European region, whereas the number of deaths related to cannabis overdose is also very low, which indicates the adequate efficiency of harm reduction facilities and regulated consumption places (Tonry, 2015). Some of the initiatives that have been involved are the heroin-assisted treatment as well as the exchange of a needle, which are said to have made high-risk groups socially stable. New policy reviews however have raised concern with

drug-related crime consumption of police resources, to the extent that up to 6080 percent of police capacity is used in drug cases, and harm reduction services have been hit with austerity driven budget cuts leading to understaffing, and increase in unmet need, especially among migratory or marginal users (PMC, 2025). There are structural inconsistencies between legal and policing policies because, at connection points, coffeeshops receive counterfeited cannabis from an illegal supply system, which has introduced legal inconsistencies; a 2023 pilot in Breda and Tilburg will first legalize supply under a state-run production scheme. In a cultural context, the Dutch are more tolerant and pragmatic, and this has long been observed to accommodate the use of soft drugs; however, policymakers are currently grappling with how to regulate potency, mass consumption of tourism, and sustainability of the system (FT, 2024).

Comparative Analysis

Metric	Portugal (2001 Decriminalization)	British Columbia, Canada (2023 Pilot)	Netherlands (Current Tolerance Model)	Kazakhstan (Current Context)	Portland, USA (Oregon Measure 110)
Illicit market	Black market reduced significantly; trafficking prosecutions target organized networks; illicit personal use estimated under 5% of total market volume (UNODC; Transform Drugs analysis) (IDPC, Transform).	BC's illicit opioid supply dominated by fentanyl (>75% of street samples); safe-supply pilots reached fewer than 10% of users through early 2025, leaving most users reliant on unregulated market (BCCDC, study) (PMC, downtowneastside.org).	Coffeeshops supply ~30% of cannabis demand; rest remains illicit; state-run regulated supply pilots launched in Breda and Tilburg December 2023 aim to shrink illegal distribution (Dutch policy reviews, RAND pilot) (BioMed Central).	Kazakhstan is a major transit hub on the Northern route; ~60% of Central Asia heroin seizures occur within its borders; rural homemade opiate use is widespread; no formal safe-supply or diversion systems exist (UNODC regional reports; PMC studies).	After M110, disruption in enforcement occurred; fentanyl-saturated markets continued; treatment access lagged though harm-reduction funds increased (Boulder Care; Atlantic; measure analysis reviews). (being.boulder.care, Atlantic).
Drug-related deaths (per 100 000)	Drug-related mortality dropped from ~3.2 per 100 000 in	BC recorded a record **2,511 overdose deaths in 2023** (~45.7	Netherlands drug mortality is around **2 per 100 000**, among the	Independent studies in Almaty found overdose accounted for	Fatal overdose numbers tripled from 280 (2019) to 956 (2022);

	2001 to ~0.3 by 2008 and stabilized through the mid-2000s (Transform Drugs, 2021; Wikipedia, 2025) (Transform).	per 100 000), up from ~2,383 in 2022; personal possession seizures dropped but mortality remained high (Guardian, 2024; BC Coroners) (bcruralhealth.org, theguardian.com).	lowest in EU, due to pragmatic harm reduction and market separation (EMCDDA, Harm Reduction Journal) (BioMed Central).	~2.1% mortality among surveyed PWID over one year (~11 deaths among 480 users), reflecting localized overdose burden (PMC, 2014) (PMC).	however, a cohort study adjusting for fentanyl found no statistical increase linked to M110 (JAMA Network Open, 2024; OPB, 2023) (jamanetwork.com).
Incarceration for possession (per 100 000)	Administrative model reduced incarceration for personal possession from ~60 per 100 000 to under 2 per 100 000 post-2001 (UNODC; World Prison Brief; Transform Drugs) (IDPC).	Possession-related charges fell by ~76% between Feb–June 2023; public-use arrests remain. Overall drug-possession incarceration estimated at ~35 per 100 000 (BC Govt reports, World Prison Brief) (downtowneastside.org, washingtonpost.com, theguardian.com).	Netherlands tolerates cannabis up to 5 g; hard-drug use remains criminal. Overall drug offense incarceration ~15 per 100 000 (Opium Law, EMCDDA profiles) (Википедия).	Kazakhstan's incarceration rate is **~156 per 100 000**, with ~18% of prisoners serving drug-related sentences and ~25% linked to personal-use offenses (World Prison Brief; Ministry of Justice Kazakhstan official estimates).	Measure 110 reclassified possession as a violation, reducing arrests; however, the criminal system was reinstated in 2024 for hard drugs (Hall Bill 4002), and treatment diversion effects were limited (Wikipedia Oregon Drug Policy; OPB, 2025).
HIV incidence among PWID	HIV cases among PWID fell from **~1,016 in 2001**	In Vancouver's Downtown Eastside, HIV diagnoses	Netherlands has maintained **very low HIV incidence** (~5	Kazakhstan's HIV prevalence among PWID is estimated at	Nearly 1 in 5 HIV diagnoses in Oregon (including

(new cases/year)	**to ~56 by 2010**, an estimated **90% reduction** following decriminalization and harm-reduction integration (IDPC, 2018) (IDPC).	among PWID declined from **42 in 2021 to 28 in 2023** after expansion of supervised injection services; rates remain elevated above provincial average (BCCDC, 2023) (downtowneastside.org).	cases/year, ~0.03 per 100 000), credited to long-standing needle-exchange and heroin maintenance programs since the 1990s (Harm Reduction Journal, 2024) (BioMed Central).	nearly **7%**, while general prevalence is ~0.3%; injection drug use drives a rising share of new infections (UNAIDS, 2023).	Portland) are linked to injection drug use; criminalization reduces syringe access and elevates HIV risk (Cascade AIDS Project Q&A, 2023) (https://www.capnw.org/news/2023/qa-drug-criminalization-hiv).
Public support for reform (favourable %)	Approximately **75% support** for decriminalization in early years; public trust maintained above 60% until 2010 (Eurobarometer, 2019 retrospective) (Transform).	Support began at ~66% in early 2023 but declined to ~52% by mid-2024 amid concerns over public drug use and overdose rise (Guardian, Angus Reid) (theguardian.com, downtowneastside.org).	Around **80% support** cannabis tolerance; only **~45% favour expanding decriminalization** beyond soft drugs (RIVM, EMCDDA surveys) (Википедия).	Public support in Kazakhstan remains low (~30%) due to conservative social norms, stigma against PWUD, and limited visibility of harm-reduction messaging (regional attitudes captured via UNAIDS/Eurasia Barometer).	M110 passed with 58 % voter approval in 2020, but by 2023–24, a poll showed 63 % favor recalling criminal penalties (Wikipedia Measure 110; OPB, 2023). (en.wikipedia.org, OPB).
Cultural & structural context	Portugal operates within collectivist welfare ethos, universal healthcare, and substantial civil society participation.	The Downtown Eastside is characterized by entrenched poverty, homelessness and institutional distrust;	Dutch policy embraces pragmatic tolerance and clear separation of soft and hard drugs; coffee-shop	Kazakhstan's structural context is conservative and state-centric with fragmented rural	Oregon's history includes public health ideals, but Measure 110 implementation suffered from lagging

	Dissuasion Commissions reframed drug use as public health challenge instead of criminal issue (UNODC; IDPC) (PMC, Transform).	without health and housing expansion, decriminalization was viewed by many as permissive and insufficient (Guardian, BC government statements) (theguardian.com, downtowneastside.org).	regulation reflects social stratification and continued emphasis on harm reduction, although supply chain inconsistencies persist (Harm Reduction Journal, EU) (BioMed Central).	healthcare, high PWUD stigma, negligible NGO involvement, and minimal substitution therapy access (<0.3% of PWID in treatment circa 2018) (PMC studies, Ministry of Health data) (PMC).	treatment infrastructure, rising street use visibility, and insufficient wraparound services, leading to mixed public perceptions (Atlantic; Washington Post).

As the Portuguese example shows, decriminalization in close collaboration with a large-scale health services presence can restore the health status of the population dramatically. Following the implementation of decriminalization in 2001, Portugal has seen a tremendous decrease in the number of people who inject drugs being infected with HIV: and an estimated 1,287 new infections in 2001 (over half of all infections in the country that year), to a mere 16 in 2019 (Hughes & Stevens, 2010; European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2020). Fatalities or problematic substance use linked to drugs also decreased to reach extremely low levels in comparison with the EU average. More importantly, this achievement was not because they were permissive but an effective combination of decriminalization and comprehensive health responses, including diversion commissions, substitution therapy, and mass harm reduction interventions. According to this model, decriminalization should not be perceived as legalization, but rather as a means of redirecting people out of the punishment and into the treatment and public assistance.

In contrast, the example of the Oregon Measure 110 (Portland, USA) pursues the dangers of decriminalizing without a functioning treatment system. In its operation, although the measure decriminalized small-scale possession and directed the taxation revenues of cannabis towards funding treatment, the measure was frustrated due to a lack of administrative efficiency and inefficiency in control. It was revealed that only 119 were reported having called the treatment hotline, totaling to more than 7,000 dollars per call, and only 27 people showed interest in obtaining services (Oregon Secretary of State Audit Division, 2023). In the meantime, the number of deaths caused by overdoses was still increasing, and much of the planned services were still not accessible or used intensively. The case in Oregon reaffirms that legal changes alone are insufficient to achieve good results unless an effective and well-funded treatment system is available; otherwise, decriminalization will turn into a discrete approach instead of being transformative.

In the case of Kazakhstan, the main lesson is that reforms are not only needed to drop criminal sanctions, but they are also required to broaden access to the avenues of care in parallel. This is an expansion of the substitution therapy provision to a scale where naloxone will be distributed, low-barrier clinics established, and to invest in community education to decrease the stigma. In a scenario lacking these elements, decriminalization may end up making things worse in regard to health and social outcomes instead of making them better. The Oregon and the Portuguese models present a detailed picture of what can be achieved in terms of health and the dire results that can lead when the right health-related infrastructures are not in place.

At that, the situation in Kazakhstan implies special difficulties in the context of cultural conditions. The political system of the country is characterized as centralized, there is a strong stigma affecting the perceptions of drug use among the population, and civil society institutions (primarily NGOs) are poorly involved in health policymaking. In contrast to Portugal, which had inherited the culture of collectivist welfare, Kazakhstan would have to, defined, develop a culturally sensitive model, which ensures harmony between the state-driven and gradual incorporation of programs based on treatment and reintegration. Decriminalization in Kazakhstan would hence have to be positioned not as permissiveness but as a means to safeguard the health of the citizens, fortify families, and ease the economic and social costs of drug-related injuries. Such framing, together with investing in the material infrastructure of treatment, has the potential to turn decriminalization into politically feasible and socially impactful.

Policy Recommendations

According to the above analysis and experiences in other countries, it is possible to say that there are certain policy options that are likely to work with Kazakhstan. Such policies will aim at alleviating the negative effects of drug misuse as well as solving the structural flaws surrounding the current punitive response to drug misuse in the country.

First, decriminalizing possession of small amounts of drugs that people use would indicate a crucial changeover. The main advantage of this policy is that it minimizes the rates of incarceration and precludes the stigmatization of people with addictions. This would also enable law enforcers to shift their scarce resources to break trafficking networks instead of prosecuting individual users. Nevertheless, the drawback is the threat of a misconception publicly- in case it is promoted ineffectively, decriminalization can be misunderstood as an outright legalization. In the conservative social environment of Kazakhstan, such a misunderstanding may create opposition among policymakers and individuals alike. Meanwhile, the opportunity presents itself in that, should they do this, the state can establish itself as an exemplar in evidence-based drug policy nationally and regionally, and the threat is the possibility that the decriminalization may lead to a sudden increase in visible street-level drug use should it be done without commensurate support systems.

Second, it is imperative that diversion and treatment programmes are established rather than incarceration. The most outstanding virtue of this policy is that it goes to the health issue of addiction and facilitates rehabilitation and decreases recidivism. On the other hand, the lack of good infrastructure in its current state is a weakness because most areas do not have good, cheap rehabilitation centers. The opportunity presents itself in the fact that it will be possible to enter partnership with international organizations and NGOs that will be capable of assisting Kazakhstan in expanding treatment capacity, and the threat is that the wrongly designed systems may not be engaging to work effectively if they are considered too bureaucratic or coercive.

Third, a larger scale of harm reduction interventions, including supervised consumption facilities, free testing kits, clean syringes, and the availability of overdose-reversal drugs, may reduce overdose deaths substantially. The power of this policy is its life-saving potential and the effectiveness of the policy in other situations. However, the weak point is that the political and cultural situation in Kazakhstan might not accept such measures readily, since harm reduction is considered as, in many cases, an approval of drug use. The opportunity is that, when framed adequately as a health measure, Kazakhstan can become an example of a clear and pragmatic, humane response that will reduce the long-term healthcare costs. Its danger however, is that when harm reduction is implemented in a vacuum of tight monitoring along with strong involvement of the community, it can lead to backlash by the public, being thus quickly phased out, as in Portland or Vancouver.

Fourth, to deal with the wider addictive socioeconomics, social reintegration systems, such as vocational training, placement, and housing, should be reinforced. Sustainability is the most significant advantage in this case: the rate of relapse among the people returned back to society is much lower. Its disadvantage is, however, that these programs take a long-term investment and inter-ministerial coordination that Kazakhstan has proven to be ineffective at sustaining over time. Conversely, the opportunity is using reintegration programmes to decrease unemployment and inequality, and the danger is that concerns over insufficient control might allow corruption or mismanagement to derail the implementation of these programmes, with the result that those who most need them receive them least.

Fifth, there is a need to enhance the level of public understanding and education on drug use and a renewed policy. This measure has the advantage of creating support in society and reducing stigma, thus other reforms become possible to sell politically. The weakness is that ill-designed campaigns risk going down into the use of fear messages since research has proved that messages using fear are ineffective. Nonetheless, the possibility exists that Kazakhstan can establish a new discourse on drugs, severing the idea that it presents a moral issue, but in the place a health problem instead, hence promoting intervention at an earlier phase. The danger is that unless there is uniformity in the message, public confusion may harm efforts to gain support for broader reform.

Sixth, the work of the police should be redesigned to go along with decriminalization. The advantage in this is that the police resources would be able to shift to trafficking and organized crime investigations instead of using them on petty possession cases. Nonetheless, one of its shortcomings is that the police force has traditionally been hostile to any change and lacks knowledge and expertise in community-based interventions within the context of Kazakhstan.

The opportunity is the building of trust towards the police whereas the threat is that unless the reform is deep-rooted, the confidence in the new policies could be swayed by further abuse of discretion.

Lastly, a pilot-based and evidence-based way would give Kazakhstan a rather conservative but innovative framework to follow. The advantage of a pilot program is that it allows flexibility: the state may experiment with reforms in a single city, say, Almaty or Astana, before including the unified application of the state. The limitation lies in the fact that pilot programs are subject to underfunding, or they are not narrow enough to have results that are generalizable. This opportunity is the possibility to produce data specific to Kazakhstan and, therefore, future policies may be more legitimate and customized. The risk, though, lies in that, when pilots are hurried or not assessed well enough, they may be confiscated by opponents in order to demonstrate that reform is not effective, and slow-improvement efforts.

Overall, this set of recommendations indicates that although Kazakhstan can shift toward a more humane and productive drug policy, the key to a successful reform is the cleverness of sequencing, institutional developments, and active public communication.

Limitations and Further Research

Although this paper has discussed how decriminalization could be effective in the case of Kazakhstan based on comparative case studies and analyses of policy, there are some limitations. There is a lack of reliable information regarding drug use, results of treatment, and recidivism in Kazakhstan that limits the possibility of drawing an accurate assessment. Second, the fact that culture and institutional factors in Kazakhstan are unique (e.g., level of confidence in law enforcement, access to healthcare infrastructure, or social shaming of drug use) might create difficulties with the direct applicability of lessons learned elsewhere. Third, it was assumed that decriminalization measures would exist in the larger body of available rehabilitation and social services; otherwise, the results may be quite different.

Further research would be aided by field investigations into the condition of Kazakhstan rehabilitation centers, opinion polls on social attitudes toward drug users, and longitudinal statistics on outcomes of decriminalization experiments in the other post-Soviet nations such as Russia. Moreover, an economic analysis of the costs and benefits of adopting a health-oriented rather than punitive approach to policy would give reform policymakers better evidence to use when attempting to implement change.

Conclusion

The international case studies analysis and its application to the situation of Kazakhstan prove that the process of decriminalization, even though not a panacea, provides a rather good alternative to the current Kazakh approach, which is based on punishment. The Portuguese case proves the possibilities of how decriminalization can minimize the harms caused by drugs

and change the policy to a health-related one, whereas the Oregon and Vancouver experiences show the dangers of enacting changes without proper treatment options, political determination, and dialogue with the population. In the case of Kazakhstan, these lessons are of extreme importance. It remains entrenched in high levels of incarceration due to petty possession cases, the lack of adequate rehabilitative services, and a persistent social stigma that has added to the inability of many people seeking assistance. In this regard, decriminalization would not in the first place resolve the task of drug misuse, but a compulsory initial step towards changing a vision of adding as a kind of illness rather than a criminal one.

The success of such a policy in Kazakhstan would eventually rely on the structure and implementation of the policy. Together with diversion, a larger treatment capacity, and selective harm reduction, decriminalization has the potential to significantly decrease social and economic consequences of drug misuse. Nevertheless, a rash or isolated implementation may make the policy counterproductive through popular or organizational inefficacy as has been the case in North America. However, the possible solutions are better than the dangers. Decriminalization not only would help take the pressure off the justice system but would provide people with a chance to reenter society and cut down the long-term healthcare expenses in relation to drug addiction.

Through this, a step-by-step and pilot-based decriminalization policy in Kazakhstan is worth undertaking. The introduction of restricted urban initiatives that would be closely examined in terms of effectiveness would provide policymakers with the opportunity to adjust the reform to the political, cultural, and social specifics of the country. In sum, decriminalization alone cannot solve the drug problems of Kazakhstan; nevertheless, it is a strategically good and ethically acceptable way of approaching to more humane, evidence-based, and effective drug policy. However, the results of this article can be positioned within some limitations because in Kazakhstan, data gaps and situational circumstances will make direct comparisons challenging. Future studies examining these blind spots are needed to come up with stronger evidence that policymakers could use.

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