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„Drug Treatment: Legality and Obligation under the
International Drug Conventions and Human Rights“

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Abbreviations

<i>AA</i>	Alcoholics Anonymous
<i>AAAQ</i>	availability, accessibility, acceptability, quality
<i>AIDS</i>	acquired immunodeficiency syndrome
<i>CND</i>	Commission on Narcotic Drugs
<i>CESCR</i>	Committee on Economic, Social and Cultural Rights
<i>ECOSOC</i>	Economic and Social Council
<i>ECtHR</i>	European Court of Human Rights
<i>HIV</i>	human immunodeficiency virus
<i>HRC</i>	Human Rights Council
<i>HRI</i>	Harm Reduction International
<i>HRW</i>	Human Rights Watch
<i>ICCPR</i>	International Covenant on Civil and Political Rights
<i>ICESCR</i>	International Covenant on Economic, Social and Cultural Rights
<i>INCB</i>	International Narcotics Control Board
<i>MDMA</i>	methylenedioxymethamphetamine
<i>MMT</i>	methadone maintenance therapy
<i>NA</i>	Narcotics Anonymous
<i>NGO</i>	non-governmental organisation
<i>NSE</i>	needle and syringe exchange
<i>OST</i>	opiate substitution therapy
<i>PWID</i>	people who inject drugs
<i>QCT</i>	quasi-compulsory treatment
<i>UN</i>	United Nations
<i>UNGA</i>	World Drug Report
<i>UDHR</i>	Universal Declaration of Human Rights
<i>UNODC</i>	United Nations Office on Drugs and Crime
<i>VCLT</i>	Vienna Convention on the Law of Treaties
<i>WDR</i>	World Drug Report
<i>WHO</i>	World Health Organization
<i>WHOEML</i>	World Health Organization Model List of Essential Medicines

1 Introduction

There currently remains a lack of consensus among States as to the standards that must be adhered to in the drug treatment articles of the three international drug control treaties. Although vague, both the international drug treaties and concurrent and applicable human rights documents, contain limitations on what these standards are. This paper will thus aim to develop these standards into a test which can be applied to any drug treatment initiative to ensure that State obligations are being met.

It is hypothesised that the test criteria identified will be *rights compliance* and *efficacy* of a given drug treatment approach. This hypothesis will be investigated through an analysis of the applicable human rights instruments, such as those surrounding the right to health, and a contemporary reading of the drug treatment sections of the international drug control treaties. This will further reveal how synchronous the two regimes are.

1.1 Constructive Treaty Interpretation

A 2010 paper by J. Tobin, published in the *Harvard Human Rights Journal*, discusses a constructive approach to human rights treaty interpretation. He describes human rights treaties as “invariably vague and ambiguous” and “not standards that have traditionally been renowned for their clarity”[129, p. 1]; a similar description could be applied to the three international drug control treaties, and particularly the drug treatment sections of those treaties¹. In fact, Tobin’s entire approach to human rights treaty interpretation provides useful principles upon which to base an interpretation of the drug treaties.

As with the human rights treaties, “non-judicial actors — academics, non-governmental organisations (NGOs), treaty monitoring bodies, special rapporteurs, and states — attempt to fill this interpretive void”[129, p. 2], that the drug treaties themselves do not provide. Tobin suggests, however, that the danger of such a system is that “advocates can be quick to offer interpretations that reflect personal preferences as to the nature of protection that the advocates think the right in question should accord”, but that this approach “may well persuade those who focus on what the law should be (*lex ferenda*) but its impact is limited for those who focus on what they perceive the law to be (*lex lata*)”[129, p. 2]. Tobin continues by stating that “Simply clothing an assertion about the content of an internationally recognized human right with the apparel of humanity may satisfy a moral or political urge, but it does not necessarily accord with the nature of the *legal* obligations

¹The broad nature of the drug control treaties is, however, deliberate and allows for the development of scientific approaches to drug treatment and contextual difference[69, p. 144].

actually assumed by a state under a human rights treaty”[129, p. 2]. Such observations could well be applied to the interpretation of the drug conventions; it would be easy to fall into the trap of advocating for a specific drug policy reform or drug treatment approach. Tobin, however, summarises a set of principles upon which treaty interpretation can be based in order to produce truly persuasive argument. Again, his words apply to human rights treaty interpretation but their further application to Drug Control Treaties is certainly useful.

Tobin first discusses the Vienna Convention on the Law of Treaties (VCLT), the natural starting point for a discussion of treaty interpretation. The VCLT ‘General rule of interpretation’, article 31, reads as follows:

1. A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose.
2. The context for the purpose of the interpretation of a treaty shall comprise, in addition to the text, including its preamble and annexes:
 - (a) any agreement relating to the treaty which was made between all the parties in connection with the conclusion of the treaty;
 - (b) any instrument which was made by one or more parties in connection with the conclusion of the treaty and accepted by the other parties as an instrument related to the treaty.
3. There shall be taken into account, together with the context:
 - (a) any subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions;
 - (b) any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation;
 - (c) any relevant rules of international law applicable in the relations between the parties.
4. A special meaning shall be given to a term if it is established that the parties so intended.[56, p. 12]

Tobin finds that “there is almost universal consensus, acknowledged even at the time of the VCLT’s adoption, that the inherent elasticity of the general rule makes it incapable of producing *the* determinate meaning of a treaty”[129, p. 3] and that although “[t]he VCLT’s general rule may frame the

interpretive process, ... it is ultimately unable to resolve the question of how to choose *a* meaning for the text of a treaty from among the inevitable range of potential meanings”[129, p. 3].

It is widely accepted that the Drug Control Treaties are “saturated with textual ambiguity”[69, p. 22], with this ambiguity being exemplified by the drug treatment articles. “[I]f there is a perceived controversy or uncertainty with respect to the meaning of a particular right, ... then there is a need to persuade states and the broader interpretive community to adopt a particular meaning of this right”[129, p. 14]. The principles that should thus be followed in order to ‘enhance the persuasiveness of the interpretation to be offered’ require that the proposed interpreted meaning be:

1. Principled
2. Clear and practical
3. Coherent in its reasoning and consistent with the system of international law
4. Sensitive to the nature of the socio-political context within individual states and throughout the international legal order[129, p. 14]

Drug treatment is an area that is not only ambiguous under the international drug treaties, but that is also attached to a certain amount of practical ambiguity. States are unable to reach consensus on the best approach or approaches to drug treatment, with much discussion of associated human rights norms and high levels of participation of human rights defenders. This thesis will thus apply the above principles to the international human rights law, specifically the right to health, and international drug law associated with drug treatment in order to attach limitations to these seemingly vague guidelines. Although it will not be possible to deliver *the* meaning of the drug treatment sections of the treaties and associated human rights law, *a* meaning will be found which conforms to the above principles and can thus act as a useful tool for States in their approach to drug treatment.

1.2 Research Question

This thesis will analyse what human rights law, and specifically the right to health, means for the interpretation of the international drug conventions, regarding drug treatment. Specifically, the following question will be addressed:

Considering the wide margin of discretion allowed for under the international drug conventions, how should a State implement the treatment provisions pro-

vided within, whilst fulfilling their human rights obligations?

In order to come to a conclusion on this subject, the following sub-questions will be investigated:

The Issues

What are currently the most controversial drug treatment issues, upon which no consensus has been reached?

International Human Rights Law

Which human rights norms and standards are relevant to the topic of drug treatment?

International Drug Law

Do the drug treatment sections of the three international drug control treaties provide limitations as to how States should implement drug treatment?

1.3 Methodology

To address this research question using Tobin's principles, outlined above, it will be necessary to identify current issues where no consensus has been found, regarding specific aspects of drug treatment. This will require research into the briefing reports and comments emerging from bodies directly related to the functioning and implementation of the international drug control treaties, such as the International Narcotics Control Board (INCB), United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO), along with other relevant commentary from other United Nations (UN) bodies, drug policy, health and human rights NGOs, States, and academics working in the field of drug treatment, drug policy and human rights.

An analysis of the areas of human rights, and specifically the right to health, which are most salient to the question of drug treatment will follow. Evidence will be drawn from academics, treaty monitoring bodies, Human Rights Council (HRC) Special Procedures and NGOs.

It will then be necessary to complete a thorough reading and analysis of the treatment sections of the three international drug control treaties and other relevant articles in order to assert what is expected of State Parties as regards their implementation of drug treatment programmes and to clarify how restrictive or flexible the drug conventions are in allowing States to choose the drug

treatment options that they feel are most appropriate to their domestic situation. This legal analysis will be based primarily on the 1961 Single Convention on Narcotic Drugs (as amended by its 1972 Protocol), the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The contemporary interpretation will be supported by the commentaries to the three conventions and protocol. The opinion of the Commission of Narcotic Drugs (CND), entrusted by the Economic and Social Council (ECOSOC) with the task of supervising the application of the international drug conventions, will be used to understand more recent interpretations of the conventions, following historical, medical and technological developments.

Following this, a number of the 'issues' identified in the earlier portion of the thesis will be taken as case studies to illustrate the practical application of the drug treatment sections of the international drug control treaties in light of their completed contemporary interpretation. For this section, core sources of human rights law will be utilised, such as the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), along with opinions from the human rights treaty bodies, HRC Special Procedures and academic opinions from NGOs and others.

2 The Issues

The 2014 World Drug Report (WDR) estimates that there are between 162 and 324 million global users of illicit substances (3.5 - 7%)²[130, p. 1]. Throughout history and across the world, drug users and the use of drugs have been approached in a wide variety of different ways. Many of the substances which are controlled today have historically been used both in spiritual and medicinal practice and are still considered vital for their medical, spiritual and traditional applications today[70]. Despite this, in the 19th Century, public and official sentiments towards psychoactive substances began to change, and the use of certain substances began, in some parts of the world, to be considered a moral failing or even a mental disorder. The first approach to reducing demand for these substances was heavily based on legislation and law enforcement, resulting in the prohibitive drug regime which remains today[67, pp. 2-3]. This was gradually supplemented with treatment options for those who used or were dependent upon drugs.

The INCB's most recent report suggests that worldwide only 1 in 6 of the individuals that require some form of treatment for drug dependence disorders has access to the treatment that they require. This figure sinks to 1 in 11 in Eastern and South-Eastern Europe and 1 in 18 in Africa[43, p. 2].

Approaches to drug treatment are varied, with a multitude of perspectives and approaches joining debates over which routes to treatment are appropriate and which not, over who requires treatment and which rights they hold, over ethics and effectiveness and even over how we measure that effectiveness; health, happiness, stability, longevity or abstinence?

A few of the core issues over which States, international bodies and NGOs debate are outlined below. The fact that no consensus has been reached over such issues exemplifies the continuing need for constructive analysis and interpretation of the drug treatment articles. Much of the discussion revolves around the human rights or ethics of different treatment options. This suggests that a human rights-based interpretation of the drug treatment articles in the drug conventions will likely be constructive. The aim here will be to clarify the legal obligation of States, under international law, as regards drug treatment.

2.1 Abstinence and Harm Reduction Models of Drug Treatment

Abstinence-based models of drug treatment

Abstinence-based models of drug treatment involve any treatment programme where abstinence is

²Sample of population aged between 15 and 64.

used as the measure of success. Total abstinence is often required for participation or is expected to be achieved within a short period of time.

There are numerous examples of abstinence-based approaches to drug dependency services; long-term and short-term inpatient and outpatient programmes, therapeutic communities, faith-based or secular, self-help or family supported, and with or without the aid of pharmaceuticals or prior detoxification[112, pp. 157-309], [120, p. 1]. Such initiatives overlap both with each other and with the temporal stages of treatment.

Furthermore, an abstinence-based approach to pharmacological drug treatment would include such programmes where maintenance drugs are prescribed at the lowest possible dosage and the goal of the therapy is to reduce and then eliminate the prescription relatively fast to achieve abstinence[134, p. 151]. Maintenance drugs are prescribed so that the drug user does not have to go through the suffering associated with withdrawal symptoms.

Drug detoxification is not a treatment as such but can be used to prepare drug users for an abstinence-based treatment programme. Detoxification is the removal of the drug from the body of the dependent drug user, necessarily resulting in the onset of withdrawal symptoms.

Abstinence-based programmes are highly popular and available across the world in their different forms, implemented by both States and private institutions. 12 Step Programmes, the most well-known and widespread abstinence-based therapy, for example has over 61,800 meeting groups in 129 different countries[113].

Harm reduction-based models of drug treatment

The second class of drug treatment is based on the harm reduction approach. According to Harm Reduction International (HRI)³, a global authority on harm reduction practices, “‘harm reduction’ refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community”[28, p. 1]; “The harm reduction approach to drugs is based on a strong commitment to public health and human rights”[28, p. 1]. Harm reduction approaches are ‘evidence based and cost effective’ and prioritise ‘dignity and compassion’, the ‘universality and interdependence of rights’, the development of harm minimising drug policies, ‘transparency, accountability and participation’[28, p. 2]. Some of the most well-known examples of harm reduction services in-

³formerly known as the International Harm Reduction Association

clude needle and syringe exchange (NSE) programmes, opiate substitution therapy (OST), such as methadone maintenance therapy (MMT) or heroin prescription programmes, supervised injection facilities and dissemination of the anti-overdose drug naloxone. These services apply mostly to the intravenous injection of opiates. However, the term harm reduction can also be applied to other forms of drug consumption. Additional harm reduction approaches thus include policy measures, such as the decriminalisation of possession of drugs for personal use, drug/ pill testing stands in nightclubs and, importantly, the dissemination of information to users of any recreational drugs, outlining best practices for reducing harms. This could include, for example, appropriate water consumption for users of MDMA, avoidance of tobacco for marijuana users, and avoidance of poly-drug use for all drug users. The efficacy of harm reduction is supported by evidence and advocated by the WHO[137][25, p. x-xi][102, pp. 9-36][48][71].

Harm reduction covers both drug treatment and generalised health services for drug users. For example, OST is a drug treatment, as it directly addresses a drug dependent user's drug use. Supervised injection facilities, however, are health services as an individual will continue to use drugs, as before, but the related harms will be reduced due to the safer environment. This thesis will focus on drug treatment rather than health services for drug users.

Associated Controversy

There is significant controversy over whether harm reduction-based drug treatment, abstinence-based drug treatment or a mixture of the two is the most appropriate approach to drug treatment.

Despite the popularity of abstinence-based approaches to drug treatment, their effectiveness is questionable. Some evidence suggests, for example, that they are only effective for a small minority of drug dependent users with a stable and supportive environment[131]. Thus, much of their criticism stems from accusations that these approaches are not based on scientific evidence but on misplaced morals and ideologies. Proponents of abstinence-based therapies would support abstinence as they believe that the use of drugs is 'wrong' and that cessation of drug use will produce positive outcomes for the individual and society, such as health benefits, social stability and reduced crime levels[102, pp. 7-9].

Furthermore, some consider the high relapse rates associated with abstinence-based therapies particularly worrying. If a heroin user, for example, relapses following a period of abstinence, their body will be unaccustomed to the substance and so the risk of overdose and fatal overdose will be higher. The focus on abstinence could also be dangerous as individuals who use drugs might not be encouraged to access harm reduction services, or to be provided with harm reducing and life

saving information on best practices when using drugs, as they are expected to abstain from drug use. Finally, the detoxification therapies mentioned above can be highly traumatic for physically dependent drug users and rapid, drug-assisted heroin detoxification under anaesthesia poses a great health risk and has resulted in deaths[100, pp. 63-68]. Even when a heroin user has gone through this suffering, the treatments are associated with little success[23, pp. 122-123].

Those who oppose the use of harm reduction approaches to drug treatment, alternatively, do so largely *because* harm reduction does not directly promote abstinence, but relies on other measures of success. This non-adherence to the goal of abstinence is seen by some bodies, such as the INCB, as condoning drug use and violating the international drug conventions[17, p. 5]. At the 2014 CND, on behalf of all harm reduction organisations, HRI stated to the plenary that “[h]arm reduction has saved lives, improved health and demonstrated cost-effectiveness at the same time that efforts to reduce overall demand have clearly failed and have cost billions of dollars”[7].

OST, the harm reduction-based drug treatment that will be focussed on in this paper, has faced specific controversy. This controversy is the same as that surrounding other non abstinence-based drug treatment. OST is sometimes considered to encourage drug dependent individuals to continue using drugs or to fail to take great enough steps to eliminate drug use. If someone believes that the use of drugs, per se, is wrong then that applies to heroin, methadone or any other narcotic drug or psychotropic substance. They would consider OST, such as MMT to merely constitute a subsidised continuation of the drug dependent individual’s ‘addiction’. A paper by Carmen Aceijas on the ethics of OST describes the “rivers of ink flowing against OST for years (as betraying the holy goal of making people “free from drugs”)”[58, p. 8] and discusses controversy surrounding OST, including their portrayal as “weak and evidence of a defeatist attitude towards drugs”[58, p. 7].

In 2007 V. Krasnov, Chair of the Russian Society of Psychiatrists, N. Ivanets, Director of the National Center on Addictions and other prominent Russian drug control figures, published and distributed a memorandum entitled ‘Say No to Methadone Programs in the Russian Federation (Use of methadone cannot be considered treatment)’. The memorandum firmly stated the Russian Federation’s position as regards OST, stating that “[a]n effective solution to the problem of drug addiction lies in an intensive search for new methods and approaches that focus on allowing for the complete cessation of drugs use by patients with addiction, the implementation of such methods, and the socialization of those suffering from addiction into a new life style free from drugs – not on the practise of substituting one drug for another”[106, p. 5]. Methadone is still prohibited in the Russian Federation and this ban has recently been spread to Crimea, following its March 2014 annexation.

2.2 Forced and Coerced Treatment

Drug detention centres, also known as drug rehabilitation centres, detoxification centres and education or re-education centres, operate in a number of countries and are widely considered to violate human rights standards, whilst providing little or no appropriate drug treatment or other medical care for their inmates. There are reports of such facilities operating in Vietnam, China, Cambodia, Lao PDR, Burma, Malaysia, Thailand, Mexico and Russia, among others[40][31][60, p. 1]. As reported in 2012, in East and South East Asia, where such approaches to drug ‘treatment’ appear to be the most common, “there are ... over 235,000 people detained in over 1,000 compulsory centres”[107, p. 3].

Human Rights Watch (HRW) and the Open Society Foundations have produced reports which outline, with the support of thorough field research and anecdotal evidence, the conditions within the numerous drug ‘treatment’ facilities where human rights violations have been uncovered. The approaches in question involve ‘treatment’ which, in reality, constitutes mandatory participation, arbitrary detention, lack of access to legal remedies, forced labour, forced physical exercise, physical, mental and sexual abuse, poor hygiene, insufficient nutrition and little access to appropriate medical care or drug treatment, all within the confines of an inescapable institutional setting[40, 31]. The inmates of these centres include men, women, children, the elderly and individuals without drug dependency problems[40, p. 15].

This issue is rather straightforward. It is well covered and accepted that such activities are gross violations of human rights standards and do not represent appropriate drug treatment methods. There have been numerous calls to close down such facilities from UN entities, HRW and many other groups[34][40, p. 21]. The majority of individuals in such treatment facilities are there involuntarily. Compulsory treatment violates international law and, again, this is well-established[59]. There is however a related practise, quasi-compulsory treatment (QCT), which operates in the United Kingdom, the United States, Canada, Australia and New Zealand, and is, understandably, far more accepted than compulsory treatment in drug detention centres, but still deserves discussion.

QCT operates in two main environments; in prisons and via drug courts. Here, we will focus on the second environment, drug courts. In this route to drug treatment the “prosecutor exercises wide discretion in determining who is actually referred to drug court. In most cases, participants must plead guilty as a prerequisite to entrance. Upon pleading guilty, they are mandated to treatment

or other social service programs. Abstinence is monitored through frequent drug testing. Positive drug tests and other program violations are punished with sanctions, including incarceration and removal from the program”[29, p. 5]. As the drug treatment is ‘chosen’ by the individual being sentenced, their only other option being imprisonment, this route to treatment is considered quasi-compulsory. The offender has a choice, but the choice is not as free as that of an individual acting without the threat of imprisonment if they refuse to enter treatment.

Although far less contended than mandatory drug treatment, human rights defenders maintain that QCT requires human rights analysis and that their appropriateness is not self-evident[115, p. 2]. The case against certain forms of QCT revolves around which individuals are eligible to be considered under these drug courts and certain aspects of the mode of treatment prescribed. The appropriateness of this route to drug treatment under both human rights and international drug law will be discussed in detail in section 5.2.

3 Human Rights and Drug Treatment

Alongside States' obligations under the drug control conventions, they have concurrent, applicable obligations under international human rights law. Drug treatment involves a vulnerable group, often subjected to discrimination and stigmatisation, who may require medical care and are subjected to punitive measures, such as deprivation of liberty, due to the criminalisation of their behaviours. It is thus no wonder that there already exists a cornucopia of human rights mechanisms which can be and have been applied to drug treatment questions. This section will thus investigate a number of components of the human rights system in order to identify what human rights law requires of drug treatment. Each instrument that is addressed will contribute to a catalogue of standards that States should apply to their drug treatment decisions.

3.1 The Right to Health

In a discussion of drug treatment and human rights, the right to health is naturally raised first. The right to the highest attainable standard of health is enshrined in a number of international human rights instruments including the Universal Declaration of Human Rights (UDHR) and ICESCR. Article 12 (1) of the ICESCR states that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) the improvement of all aspects of environmental and industrial hygiene;
 - (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) the creation of conditions which would assure to all medical services and medical attention in the event of sickness.[95, p. 52]

The provisions contained within this article of the CESCRC guarantee the right to health for *all* individuals, certainly including those who are dependent upon drugs.

State obligation under human rights law is threefold. States must *respect*, *protect* and *fulfil* each obligation to ensure that individuals are able to enjoy their human rights. Such principles can be

readily applied to drug treatment and States' related obligations under the right to health. Examples include:

Respect

A State should not limit or remove the opportunity for drug dependent users to access ethical and effective drug treatment services that they require, or to access medicines that they require. States should further not discriminate against drug users, both inside and outside prison settings, in regard to their access to treatment and the treatment options available to them. States should further respect the principle of informed consent and refrain from utilising compulsory drug detention approaches to drug treatment[32, p. 5].

Protect

A State should adopt legislation which sets minimum standards for drug treatment services to ensure that no third parties, such as private drug treatment facilities, can infringe the rights of an individual to enjoy their right to health. This would further include ensuring that privatisation of public services, such as prisons and medical facilities, would not reduce a dependent drug user's opportunities to access drug treatment that is appropriate under the AAAQ Framework, to be discussed shortly. States should further ensure that drug treatment facilities and programmes provide their services to dependent drug users only with their free and informed consent.

Fulfil

States should adopt national drug treatment action plans and policies to ensure the provision of drug treatment services and related medicines. They should further ensure that appropriate budgetary allowances are allocated to drug treatment services. In order to ensure the cost-effectiveness of drug treatment schemes and the availability of effective services for drug users, all approaches should be evidence-based. A State will further ensure that national policy on the provision of drug treatment does not discriminate against drug users, or between different drug users, e.g. no discrimination on the basis of race, religion, gender, age, etc.

General Comment No. 14 of ECOSOC outlines the AAAQ Framework - availability, accessibility, acceptability and quality - which clarifies the 'interrelated and essential elements' which make up the right to health[80, p. 3]. These can be applied to drug treatment as follows:

Availability

Availability requires that medical services are functioning and of sufficient quantity within

a given State. This requires that States make available enough drug treatment facilities and services as are required by the drug using population. In addition to this, the ‘availability’ criteria would include access to essential medicines, as listed in the WHO Model List of Essential Medicines (WHO EML)[52, p. 32]; this includes methadone, an opiate agonist used in maintenance programmes and would also proscribe that a drug such as naloxone, which can avoid overdose fatalities, is provided to all individuals who are in regular contact with individuals at risk of overdosing on heroin.

Accessibility

Accessibility guarantees that drug treatment services and programmes are as accessible to drug users as other medical care services are to other groups, and further that they are equally accessible to all drug users. This criterion obliges States to ensure that drug treatment is accessible to all, with no preference as to race, religion, ability or socio-economic status. It further raises the question of access outside normal working hours to ensure non-interference with financial stability and also the accessibility of information which is evidence-based and aims at reducing the potential harms associated with drug use.

Acceptability

The acceptability of facilities and services addresses their compliance with human rights and medical ethical standards. It is this criterion which would require States to ensure that individuals under their jurisdiction who use drugs have access to treatment services which are *rights compliant*, but also that they are not subjected to any non-rights compliant programmes against their will. The cases of drug detention centres in south-east Asia and other States, for example, where there are reports of torture and inhuman or degrading treatment or punishment, sexual abuse and non-adequate living conditions, are amongst the most obvious examples of a drug treatment approach where this criteria is not met.

Quality

This last element would require, assuming that a given drug treatment facility, programme or service was deemed rights compliant, that it would only be considered appropriate if it was effective at reducing or removing negative outcomes associated with an individual’s drug use. General Comment No. 14 suggests that this would “require, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation”[80, p. 5]. It would thus be necessary that any health-

care professionals or other individuals coming into contact with individuals who use drugs, and especially those working in emergency medicine, be trained to respond to specifically drug-related health issues. Furthermore, in order for the effectiveness of any given medical intervention to be proven it would need to be the subject of scientific, peer-reviewed research; thus, only evidence-based drug treatment approaches could be considered to be of a scientifically-proven level of quality.

A vital element of the right to health for drug treatment is the provision of essential medicines. General Comment No. 14 further outlines the provision of essential drugs as a core obligation under the right to health[80, p. 13] and HRC resolution 12/24 “[r]ecognizes that access to medicine is one of the fundamental elements in achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”[101, p. 2]. The 2013 WHO EML, the 18th List, includes methadone and buprenorphine, opiate agonists used in OST to replace the heroin used by dependent heroin users, and naloxone, used to reverse the effects of opiate overdose and thus avoid overdose fatalities[52, p. 32]. The appropriateness of OST programmes and heroin prescription programmes under both human rights law and the international drug control treaties will be discussed further in Section 5.1.

The Committee on Economic, Social and Cultural Rights (CESCR) has also addressed issues of drug treatment multiple times over the past years in its concluding observations of reports from State Parties to the ICESCR. These concluding observations have covered the topic of harm reduction services and OST, often emphasising the requirement under human rights law to ensure the availability of methadone for MMT[77, 78, 76, 74, 75, 79]. These observations will be described in detail in Section 5, ‘The Cases’.

This discussion of the right to health strongly supports both *rights compliance* and *efficacy* as the drug treatment limitations that States must adhere to. In particular, the AAAQ framework very concisely illustrates the different standards that are applicable here. Under rights compliance, ‘availability’, ‘accessibility’ and ‘acceptability’ cover non-discrimination, the prohibition of torture, access to essential medicines and other standards guaranteed under human rights; ‘acceptability’ relates specifically to the rights compliance of treatment options. The ‘quality’ criteria represents the *efficacy* limitation and suggests some of the factors needed to fulfil this - namely, that the approach is scientifically proven effective.

3.2 Rights in Prison

A relevant aspect of the right to health is also its operation in prisons. The right to health in prisons is particularly important as regards drug users due to their criminalisation across the globe. If a drug dependent user can be imprisoned for carrying the drugs he is dependent upon, then there will naturally be individuals requiring drug treatment in prisons⁴. According to the latest edition of the ‘World Prison Population List’, “more than 10.2 million people are held in penal institutions throughout the world”[135, p. 1]. Although there are no official global statistics on the matter, the UNODC asserts that “[m]any of those held are incarcerated for offences related to the use, possession or supply of drugs” and that “[d]rug use and injecting drug use are both highly prevalent among prison populations, often more so than among the general population”[130, p. 11].

Studies of the right to health suggest that it is “broadly protected under human rights norms”[108, p. 14], in Article 12 of the ICESCR for example, and that the right to health is universal and thus applies to all incarcerated individuals[108, p. 11]. “[T]he WHO defines the right to health as universal, and therefore entitled to all persons whether inside or outside of prison. In recent years, the WHO has explicitly applied this universal right to health as the basis for developing prison health guidelines”[108, p. 12]. General treatment guidelines for prisoners are codified in a number of UN instruments, all adopted by the United Nations General Assembly (UNGA). The ‘Standard Minimum Rules for the Treatment of Prisoners’, for example, outlines the rules and requirements related to medical services as follows:

- Availability of adequate psychiatric services
- Opportunity for transfer to specialist medical care facilities
- Adequate quality of ‘in-house’ medical services
- Availability of medical services to all prisoners
- Availability of reproductive health and childcare services
- Initial and thorough medical examination on arrival at detention centre to begin treatment, prevent infection and assess capacity for work
- Daily contact with and care of sick prisoners by the prison medical staff
- Medical staff will report to the prison director when they believe that imprisonment is endangering the health of a prisoner
- Medical staff will inspect the quality of health standards regularly and thoroughly e.g. food standards, hygiene, exercise availability

⁴This dissonance between the drug user or dependent user as both a criminal and a patient will be covered in the following section.

- Immediate steps will be taken by the director of the prison to correct any inadequate health standards reported by the medical staff[4, p. 3]

However, as described by R. Lines, of these “international resolutions and model standards, none enjoys the status of international law, and are rather non-binding “soft law” instruments”[108, p. 14]. Despite the non-binding nature of these instruments, Lines suggests that international case law “illustrates the influential position they enjoy with jurists” and that “far from articulating non-binding standards, in many cases these requirements have become accepted legal requirements for governments to meet”[108, p. 15]. This opinion is supported by the CESCR, who further stated in their General Comment No. 14 that “States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees . . . [to] preventive, curative and palliative health services”[80, p. 10]. The UN HRC, which is the committee overseeing the ICCPR has stated that the right to health for prisoners is also guaranteed under their covenant, under the right to life and the prohibition of torture; “the provision of adequate medical care during detention”[18, p. 53] is thus an obligation under the ICCPR as well as the ICESCR⁵.

Codes of medical ethics, discussed further below, also apply to the topic of the right to health for prisoners. The ‘UN Principles of Medical Ethics’, states that prisoners should receive medical treatment “of the same quality and standard as is afforded to those who are not imprisoned or detained” and that “[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation”[6]. This is the codification of the principle of ‘equivalence of care’, which obliges “prison health services... to provide prisoners with care of a quality equivalent to that provided for the general public in the same country”[114, p. 1]. This principle is further cited or enshrined in the WHO Health in Prisons Programme, the 8th amendment to the US Constitution, the Standards of Accreditation of Health Services in the USA, the European Committee of the Prevention of Torture’s ‘seven basic principles that must prevail in the organisation of care for prisoners’, Recommendation R (98) of the Committee of Ministers of the Council of Europe, along with domestic law[114, p. 1]. The evidence thus suggests that the principle of equivalence and the right to health of prisoners is indeed a principle of human rights law under the right to health and that States have an obligation to respect, protect and fulfil their obligations under this standard.

⁵See Rick Lines “The right to health of prisoners in international human rights law” in the *International Journal of Prisoner Health*, for an extensive analysis of this issue, including case law and discussion of the right to health of prisoners under the ICCPR.

It is made plain, through this analysis, that the right to health applies to incarcerated individuals and that they thus retain access to the same standards of care outlined above in the AAAQ framework. This supports *rights compliance* and *efficacy* as standards which can be applied to drug treatment for all drug dependent individuals, including those in detention. This section clarifies similar standards to the 3 A's and Q of the AAAQ Framework, only indicating how they would be tailored for incarcerated, drug-dependent populations.

3.3 Principles of Medical Ethics

Working hand in hand with the right to health and AAAQ Framework are principles of medical ethics. These ethical guidelines originated with the Hippocratic Oath's "first do no harm" and are now codified in such international documents as the WHO Declaration on the Promotion of Patients' Rights, the UN Principles of Medical Ethics and the World Medical Association International Code of Medical Ethics[127, p. 10].

According to these principles, a physician, "[s]hall respect a competent patient's right to accept or refuse treatment"[51, p. 1]. In drug treatment settings this would require informed consent from all prospective drug treatment patients. An interesting question that arises here is the competency of the patient and at which point a drug dependent individual might be considered incapable of providing informed consent. A UNODC CND 2014 preparatory document, clarifies that "[t]he legislation in many States Parties and international medical standards require that all medical treatment be provided with the free "consent" of the patient. Only in specific cases related to acute and dangerous conditions, including a patient at risk for life and security (psychotic crisis, overdose, risk of violence, suicide attempt), a treatment can be applied as mandatory for a few hours or at most a few days. After this short period, the patient will be in a condition to be autonomous and have the capacity to agree or refuse drug dependence treatment interventions"[42, p. 10]. This legal opinion is extrapolated from the 'United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care'[5].

There are also references throughout the codes to respecting the rights and dignity of *all* patients, here clarifying that a patient or prospective patient who uses drugs is entitled to the same respect and human rights as any other individual and should be treated accordingly[51]. The codes further outline the duty of all physicians to respect human life and thus avoid the infliction of harm. Therefore, not only is torture and inhuman or degrading treatment in drug treatment settings unacceptable, but so is any form of drug treatment as punishment, as well as the encouragement of undergoing dangerous, non evidence-based medical interventions as drug treatment.

A physician shall also “strive to use health care resources in the best way to benefit patients and their community”, “act in the patient’s best interest when providing medical care” and “owe his/her patients complete loyalty and all scientific resources available to him/her”[51, pp. 1-2]. As regards drug treatment, codes of medical ethics thus suggest that the patient should be both informed of and able to access the most potentially beneficial medical interventions available. Drug treatment approaches or specific treatments which are scientifically shown to produce positive medical outcomes should thus be readily available, notwithstanding any moral objections on behalf of the state or any medical practitioners. Such a discussion point is particularly salient when looking at the case of OST, for example, which some groups object to on moral or ideological grounds rather than for medical reasons. OST will be discussed further in Chapter 5.1.

These principles of medical ethics support both *rights compliance* and *efficacy* as appropriate tests to be applied to drug treatment approaches. Principles stemming from ‘first do no harm’ guarantee the rights of drug dependent individuals and uphold the primacy of respecting their dignity. Other principles, which suggest acting in the patient’s best interest and owing the patient all available scientific resources reflect the *efficacy* criteria and thus support evidence-based drug treatment approaches.

3.4 The Rights of the Child and Drug Treatment

The human rights of children must also be included in this discussion, as children around the world use drugs, both recreationally and due to dependence, and so it follows that questions of drug treatment must also be applied to them. The Convention on the Rights of the Child (CRC) is the only UN human rights treaty which directly mentions drug use and children, in its 33rd article, which states that:

33. States Parties shall take all appropriate measures, including legislative, administrative, social and educational measure, to protect children from illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances[95, p. 103].

A 2010 paper by Damon Barrett and Philip Veerman discussed the ‘need for more clarity on state obligation in international law’ as regards children who use drugs. They comment that the CRC was formulated around an image of children which omitted the child recreational user and focussed

on prevention of drug use, rather than aiding those children who already used or were dependent upon drugs[64, p. 64]. They assert, however, that “it can be relatively easily argued that the right to treatment is nevertheless an obligation in protecting the child from the illicit use of narcotic drugs and psychotropic substances”[64, p. 65]. Despite a general lack of comment on drug using and drug dependent children under article 33, General Comment No. 3 of the Committee on the Rights of the Child, which relates to HIV/AIDS, does emphasise that “State parties are obligated to ensure the implementation of programmes which aim to reduce the factors that expose children to the use of substances, as well as those that provide treatment and support to children who are abusing substances”[64, p. 70]. They thus clarify, as suggested by Barrett and Veerman, that article 33 does indeed include the obligation of States to provide drug treatment to children. This is further supported by the Committee on the Rights of the Child’s 2011 concluding observations on Ukraine, where it uses strong words to describe its concern about “the increasing practise of drug injection among children, affecting in particular children in prison, children left behind by migrating parents and children in street situations” and its deep concern at the “lack of specialized youth-friendly services aimed at treatment and rehabilitation for these at-risk children”[83, p. 14] in Ukraine. It recommended that both harm reduction services and drug treatment should be available to children, that the State’s laws should not impede young people’s access to such services, which they assert includes ending the criminalisation of children for drug possession, that HIV prevention is prioritised and that the “root causes of substance use and abuse among children and youth” are addressed[83, p. 15]. The above conclusions regarding drug treatment and the right to health are thus supported by the views of the Committee on the Rights of the Child, and it is clarified that the provisions of the right to health as regards drug treatment include drug dependent children and youth, as well as adults.

The CRC ensures that children are entitled to the same human rights as adults, and the above analysis clarifies that this extends to a specific right to appropriate drug treatment under article 33 of the CRC. In addition to this, the CRC can be used to clarify some of the standards which must be respected by States in implementing drug treatment for young people. Article 24, for example, outlines the right to health for children. CRC General Comment No. 15, on the child’s right to health, emphasises the principles outlined in the AAAQ Framework and further clarifies standards such as non-discrimination, and participation of children in decisions related to their healthcare and the healthcare of their age group, as necessary for the full realisation of the right to health for children[82]. Children are additionally entitled to freedom from torture and inhuman or degrading treatment or punishment, thus emphasising that drug treatment facilities or programmes which inflict such harm on a child would be in violation of the CRC as well as the ICCPR. It is made clear that “the treatment must not result in abuses of the rights of the child”[64, p. 75]. Article 25 further

obliges States to provide a periodic review of medical treatment for children[95, p. 101] and article 12 further outlines the necessity of child participation in decision-making which is relevant to them. General Comment No. 12 of the Committee on the Rights of the Child clarifies that this extends to healthcare settings. In a drug treatment scenario this would thus oblige states to provide confidential drug treatment consultations and advice to children, without parental consent. The comment suggests that “[t]he right to counselling and advice is distinct from the right to give medical consent and should not be subject to any age limit”[81, p. 20]. Regarding consent, the comment further suggests that where a child younger than the official age of consent “can demonstrate capacity to express an informed view on her or his treatment, this view is given due weight”[81, p. 21]. It should thus be ensured that children who are dependent on drugs participate in their drug treatment decision-making process and, where possible, consent freely to their inclusion in treatment.

Finally, the Committee on the Rights of the Child’s 2009 concluding observations on Sweden support the view that the provisions of the CRC include drug treatment for children, but also that this drug treatment should be evidence-based[84, p. 12].

As with the prison population, the opinions expressed above soundly conclude that children have the right to appropriate drug treatment services. Again, the *rights compliance* and *efficacy* standards identified in the AAAQ can thus be extended to children who are dependent on drugs. The use of these criteria in a test of the appropriateness of drug treatment services is then further supported by the CRC and the Committee on the Rights of the Child.

3.5 The Human Rights Council Special Procedures on Drug Treatment and Human Rights

The HRC Special Procedures, such as the thematic Special Rapporteurs, have also contributed to the discussion of human rights and drug treatment. Their task is to bring human rights violations and interferences to the attention of States and others and to report on such issues to the HRC, along with fulfilling their other duties. The topic of international drug control, drug treatment and human rights has been raised numerous times by these special procedures, which further illustrates that not only are human rights and drug treatment deeply intertwined issues, but also that drug treatment has been a source of human rights abuses.

Three Special Rapporteurs who have attributed significant time and effort to the topic of drug treatment are Manfred Nowak, former Special Rapporteur on Torture, Juan Méndez, current Special Rapporteur on Torture and Anand Grover, Special Rapporteur on the Right to Health. In December

2008 Nowak and Grover wrote a letter to the CND to offer guidance on the human rights law applicable to the international drug control regime, specifically in relation to the political declaration and its annex to be adopted at the 2009 CND. Regarding drug treatment, they emphasised the need to scale up harm reduction initiatives, such as OST, and to ensure access to evidence-based drug treatment programmes which are in conformity with human rights, which includes “encouraging States to ban non-evidence based strategies, both in state or non-state controlled institutions”[117].

Manfred Nowak, former Special Rapporteur on Torture, in his 2009 report to the HRC, discusses drug policy from a human rights perspective and raised a number of points that are particularly salient to the topic of drug treatment. He states that “the international drug control system has evolved practically detached from the United Nations human rights machinery”[116, p. 16]. Nowak further notes that withdrawal symptoms can “cause severe pain and suffering if not treated with appropriate medical treatment” and thus this failure to treat the symptoms of withdrawal could amount to a violation of the prohibition of inhuman or degrading treatment or punishment[116, p. 18], as supported by a 2003 European Court of Human Rights (ECtHR) case[54, para. 57]. Nowak further states that “Access to treatment and care services [need] to be ensured also for the patients not motivated to stop drug use or relapsing after treatment, as well as during detention periods in prison. The [WHO/United Nations Office on Drugs and Crime Principles of Drug Dependence Treatment of March 2008] also emphasize that drug dependence treatment should in general be voluntary and that, if it is part of State-imposed penal sanctions, the patient should have the possibility to reject treatment”[116, p. 19].

Regarding drug treatment, Juan Méndez focussed, in his 2013 report to the HRC, on ‘compulsory detention for medical conditions’, including drug dependence, and on drug users as a marginalised group. Méndez outlines some of the conditions and experiences of the victims of such centres. He states that: “Such detention - frequently without medical evaluation, judicial review or right of appeal - offers no evidence-based or effective treatment. Detention and forced labour programmes therefore violate international human rights law and are illegitimate substitutes for evidence-based measures, such as substitution therapy, psychological interventions and other forms of treatment given with full, informed consent”[111, pp. 9-10]. The topic of compulsory treatment will be revisited in Chapter 5.3. In Méndez’s communication to the HRC, he urges Member States to end the stigmatisation and discrimination of drug users, including the denial of emergency medical care, the denial of child custody, violations of patient confidentiality and denial of OST[111, p. 17]. The denial of OST will be discussed further in section 5.1.

Anand Grover’s, 2010 report to the UNGA was devoted to the relationship between the right to

health and controlled drugs. He first clarifies that “drug dependence is considered a chronic, relapsing disorder involving altered brain function that may require medical treatment, ideally utilizing a “biopsychosocial” approach. By contrast, drug use is not a medical condition and does not necessarily imply dependence. Indeed the majority of people who use drugs do not become dependent and do not require any treatment”[99, p. 5]. He states his view that “[w]hen the goals and approaches of the international drug control regime and international human rights regime conflict, it is clear that human rights obligations should prevail”[99, p. 6]. Specifically regarding drug treatment, Grover calls out those countries “where the “war on drugs” is zealously pursued”[99, p. 8] as deterring drug dependent users from accessing medical services, such as drug treatment, HIV/AIDS treatment and care, emergency medical care, and harm reduction services. He further remarks that “[s]ome of the most egregious violations of the right to health have occurred in the context of “treatment” for drug dependence” and that “[p]eople who use or are dependent on drugs do not automatically lack the capacity to consent to treatment”[99, p. 13]. Grover also covers access to controlled medicines, including for drug dependency, as being a core aspect of the enjoyment of the highest attainable standard of physical and mental health.

It becomes clear that the field of human rights has much to add to a discussion of drug treatment. There are many long-standing, and more recent, standards and mechanisms which can be utilised for the purpose of ensuring that drug users have access to the human rights that they are entitled to. These rights include, *available*, *accessible*, *acceptable* and appropriate *quality* treatment, whether an individual is incarcerated or free and, like all others, freedom from discrimination, torture and inhuman or degrading treatment or punishment.

The supreme importance of *rights compliance* and *efficacy* as criteria which illustrate the standards for drug treatment available in the human rights instrument is repeatedly emphasised by the HRC special procedures. They vilify States who employ treatment as punishment, or even torture, and bemoan the lack of evidence-based drug treatment approaches around the world.

Conclusion

The human rights framework and mechanisms make available myriad tools, capable of guiding States towards best practices for drug treatment. This regime has a clear and detailed network of limitations under which States should operate their drug treatment programmes. These can be summarised as *rights compliance* and *efficacy*, which supports the hypothesis outlined in the introduction, that these two criteria can comprise a test of appropriateness of drug treatment approaches. The next section will analyse whether the more broad drug treatment articles, in the international drug control treaties, will reflect these standards and limitations or allow States greater or total flex-

ibility. It will thus illustrate the compatibility of these two regimes which govern drug treatment from their seemingly opposing perspectives.

4 Treatment under the International Drug Conventions

The international drug control regime is comprised of three treaties: the 1961 Single Convention on Narcotic Drugs (as amended in 1972), the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. At the time of publication of the most recent INCB annual report only 16 states had not acceded to all of the Drug Control Conventions⁶[43, p. 7]. Although, pursuant to the 1969 VCLT, the drug conventions are legally binding, they are also non-self executing and so their implementation and, to a certain extent their interpretation, is left up to each State.

The official purpose of these three treaties was to establish an international framework aimed at limiting “exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs”[2, p. 4]. The 1961 Convention superseded all past international treaties related to drugs. Along with establishing this consolidated control system, the Single Convention focussed its attention on plant-based substances; specifically, coca leaf and cocaine, opium poppy and opiates, and cannabis. It obliged State Parties to eradicate opium within 15 years and coca and cannabis within 25 years.

The 1971 Convention went on to include a diversified drug culture in the control regime; a further 1000+ psychedelics, amphetamines, barbiturates and benzodiazepines. The control mechanisms outlined in this convention are weaker than in the former - often attributed to successful lobbying of the pharmaceutical industry who were not keen on their products being subject to the same stringent regulations as those substances in the 1961 Convention[65].

These first two treaties employed supply-side methods of drug control and so there was not an obligation for States to criminalise drug use or drug users. The final 1988 Convention, aimed at reducing illicit traffic in narcotic drugs and psychotropic substances, however, introduced a stricter approach that broadened the scope of the drug conventions to include demand-side suppression via requirements to criminalise possession of drugs for personal use, which amounts in fact to a required criminalisation of the personal consumption of these substances[3, p. 14].

There are a number of bodies which preside over these three Treaties; the UNGA and CND which hold “political-legislative power” over drug policy and decision making, the INCB as the “‘independent and quasi-judicial monitoring body” and the UNODC as the “executive body” providing

⁶Equatorial Guinea, South Sudan, Liberia, Somalia, Haiti, Timor-Leste, Cook Islands, Kiribati, Nauru, Niue, Samoa, Tuvalu, Vanuatu, Solomon Islands, Palau, Papua New Guinea.

administrative and technical support[70]. The INCB came into existence in 1968 and, with the addition of the 1972 Protocol amending the Single Convention, was strengthened. The INCB oversees the operation of the three conventions and their consolidation into domestic law, along with State Parties actual compliance with the Treaties[66, p. 173]. However, the INCB's only enforcement mechanism comprises of making recommendations to ECOSOC if it feels that a State has failed to comply with the drug control conventions.

4.1 The 1961 and 1971 Conventions

Originally, the 1961 Single Convention on Narcotic Drugs did not mention treatment anywhere in its 51 articles. However, its 1972 Amending Protocol contributed a number of additions which make reference to the 'treatment of drug addicts', mirroring the acceptance that a penal approach alone would not solve the 'world drug problem'[11, p. 330].

4.1.1 Measures Against the Abuse of Narcotic Drugs and Psychotropic Substances

Article 38 of the Single Convention, 'Measures against the Abuse of Drugs', and Article 20 of the 1971 Convention, 'Measures against the Abuse of Psychotropic Substances', are the same, *mutatis mutandis*, following the 1972 Amending Protocol. This means that their content and purpose remains the same but certain changes have been made for practical purposes; 'psychotropic substances' in the 1971 Convention in the place of the Single Convention's 'narcotic drugs', for example. Originally, article 38 of the Single Convention stated that 'The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts'[68, p. 6]⁷.

Following the 1972 amending protocol, article 38 (and article 20, *mutatis mutandis*) read as follows:

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

⁷Although it is not necessary to dwell on the unamended article 38 for too long, one paragraph of the relevant commentary is particularly poignant and acts as a good example of common misunderstandings of drug dependency. The article states that both "the terms "drug addicts" and "drug addiction" ... cover not only the abuse of narcotic drugs which cause physical dependence - i.e. of substances which are technically "addiction producing" but also the habitual abuse of other substances subject to the Single Convention but not producing physical dependence"[10, p. 446]. The purpose of this paragraph within the commentary of the unamended Single Convention was to clarify which individuals could be considered 'addicts' and thus required treatment. To use drug *abuse* as a synonym for drug *use*, and also to consider a habitual user of any drug - even one known not to be 'addictive' - as a 'drug addict' is incorrect.

2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.
3. The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.[2, p. 19]

It is best to tackle the first paragraph separately from the latter two. The first has a lengthy portion attributed to it in the commentaries, which is rather vague. It aims to define the time periods and applicability of all terms/ stages of treatment mentioned in the paragraph but fails to produce real clarity on such matters. A certain broadness was however intentional “so as to present guidelines for the policies to be adopted by Governments in the field, rather than mandatory rules requiring the adoption of specific measures”[11, p. 331].

The terms in need of discussion are ‘practicable’, ‘prevention’, ‘early identification’, ‘education’ and ‘treatment’ (in the broad sense), which covers ‘treatment’ (in the narrow sense), ‘aftercare’, ‘social rehabilitation’ and ‘social reintegration’. The existence of these provisions reflects the importance of supporting the ‘health and welfare of mankind’, which is emphasised in the preambles of the drug conventions. This suggests an alignment with principles of human rights law, such as the right to health, and supports *rights compliance* as an appropriate standard that States could use to test the appropriateness of drug treatment approaches.

The commentaries describe ‘practicable’ as “what can reasonably be expected of a Government in the light of its resources and the degree of seriousness of its problem of drug abuse”[12, p. 84]. However, the term ‘seriousness’ is itself ambiguous as, “all drug addiction, whatever its incidence, was always a serious problem” according to a 1959 WHO Expert Committee report[9, p. 12].

Having dealt with this first term, the commentaries then occupy their next six paragraphs with a ‘clarification’ of the terms treatment, aftercare, rehabilitation and social reintegration.

As already mentioned, ‘treatment’ under the drug conventions encompasses both a broad meaning (an umbrella term for treatment, aftercare, rehabilitation and social reintegration) and a narrow meaning. Under the narrow meaning the commentaries seem to promote an abstinence-based approach. However, an awareness of opiate-agonist maintenance programmes is exhibited via reference to an additional understanding of treatment as “inducing the abuser to restrict his intake of substances liable to be abused to such minimum quantities as are medically justified in the light of

his personal condition”[11, p. 332]. This would also include OST which does not prioritise abstinence. This subject will be covered thoroughly in section 5.1.

‘After-care’ is the “psychiatric, psychoanalytical or psychological measures as may be necessary after [a drug user] has been withdrawn from the substances which he abused or... after he has been induced to restrict the intake of such substances as required by the programme”[11, p. 332]. “ ‘Rehabilitation’ covers such measures as may be required to improve the personal qualities of the abuser”[11, p. 332]; to “make the former abuser of narcotic drugs or psychotropic substances physically, vocationally, morally and otherwise fit for living a normal life as a useful member of society (cure of diseases, physical rehabilitation of disabled persons, vocational training, supervision, accompanied by advice and encouragement, measures of gradual progress to a normal self-reliant life, etc.)”[11, p. 332]. Finally, social reintegration is defined as including “measures intended to make it possible for [the former drug user] to live in an environment more favourable to him... [and] may thus cover such measures as provision of a suitable job, appropriate housing and perhaps also an opportunity for the person to leave his former environment and to move to a social atmosphere less likely to produce such social evils as alcoholism or the abuse of narcotic drugs or psychotropic substances”[11, pp. 332-333].

The commentaries shed light on why there are no strictly prescribed treatment methods provided, which further illustrates the reasons behind the vagueness of all aspects of the drug treatment articles. In the third draft of the original, unamended Single Convention there was discussion as to whether to directly oblige states to “use their best endeavours to establish facilities for the compulsory treatment of drug addicts in closed institutions”[10, p. 447]. A decision was taken against this course of action “because [the Plenipotentiary Conference] considered that the differing causes of addiction and the divergent conditions in different countries, as well as the possibility of scientific progress in understanding of the problem and in the methods of treatment of addiction, made it advisable not to lay down in the treaty a particular method of treatment as being valid under all conditions, in all countries and for the whole period of the operation of the Convention”[10, p. 447]. In brief, they “objected to the specification of compulsory treatment in a closed institution that they regarded as restricting the use of other potentially effective methods”[69, p. 144]. This awareness that scientific progress might bring to light new and more effective treatment methods, health services or approaches to treatment suggests that the drafters felt that the conventions should be interpreted in light of future developments. This opinion is supported by numerous CND resolutions, which emphasise that there is a need for Member States to ‘promote, develop, review and strengthen’ “comprehensive drug demand reduction programmes, based on scientific evidence”[37, p. 1]. One example of this in practise can be found in the international response to HIV and AIDS.

The 1961 and 1971 Conventions both predated the HIV epidemic. However, the obligations of States as regards this new development and new developments in the treatment of blood-borne diseases mean that preventing the transmission of these diseases is now a primary State obligation. This is reflected in several CND resolutions and the UNODC's 2009 'Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem'[27][53, p. 20].

This illustrates the importance of evidence-based drug treatment to the drafters of the drug conventions, and thus supports *efficacy* as an appropriate limitation provided by the drug conventions that can be used by States to test the appropriateness of different drug treatment options.

Associated with this is another important issue; that of those individuals whom this article refers to. The articles use the term 'abuse of drugs' and 'abusers of drugs' to identify these behaviours and individuals. However, the 'definitions' articles of both the 1961 and 1971 Conventions do not define any of the terms 'drug use', 'drug abuse', 'drug user' or 'drug abuser'⁸. The term 'drug abuse' is in fact rather difficult to decipher. Child abuse and domestic abuse, for example, involve an act of 'abuse' committed against another person. The accepted meaning of drug abuse, however, does not entail an individual committing a violent act against a narcotic drug or psychotropic substance. Due to this and also to the stigma attached to the phrases 'drug abuse' and 'drug abuser', both individuals using drugs and those campaigning for non-discrimination and the prioritisation of the health of drug users tend to oppose the use of these phrases. Furthermore the tone of the language throughout the commentaries of article 38 of the Single Convention and article 20 of the 1971 Convention might be considered derogatory by drug users and those concerned with their stigmatisation and discrimination. The tone reflects an assumption that users of drugs are not 'normal' and cannot be 'socially useful' or 'self-reliant'; that they are not morally fit or need to be rehabilitated to improve their moral standards[11, pp. 331-332]. Overall, the tone could be considered patronising and stereotyping. Despite this, there has also been concerted action by the CND to encourage States to ensure that drug users are protected from stigmatisation and discrimination, especially when it might affect or be associated with drug treatment. In CND resolution 57/4 Member States are invited "to provide measures to ensure non-stigmatizing attitudes towards those seeking help or in recovery"[44] and in CND resolution 54/5 the CND stresses "the importance of avoiding the discrimination, including the stigmatization and social marginalization, of dependent drug users and ensuring respect for their human rights and human dignity"[30, p. 2]. Here we begin to see that another limitation is being put on States regarding their approach to drug treatment - *rights*

⁸Or indeed 'drug addiction' or 'drug addict' as used in the corresponding article of the unamended Single Convention on Narcotic Drugs

compliance.

The final three terms used in this first paragraph are ‘identification’, ‘education’ and ‘prevention’. ‘Identification’ is simply described as the “discovery of actual abusers”[11, p. 333] of narcotic drugs or psychotropic substances or of ““groups” whose members are specially prone to abuse them”[11, p. 333], presumably to steer them towards treatment or to *prevent* those ‘prone to abuse’ drugs from initiating such behaviours. The commentaries leave the interpretation of ‘prevention’ up to the State Parties, for the most part, stating that it includes “all practicable economic and social measures capable of changing a social atmosphere or subcultural conditions responsible for the development of personality traits finding expression in the abuse of narcotic drugs or psychotropic substances”[11, p. 334]. Interestingly the commentary also considers administrative control measures and penal sanctions as ‘preventative measures’. There is now a growing consensus and increasing body of scientific research suggesting that penal measures do not have an effect on drug users’, or potential drug users’, decisions to use drugs[122, pp. 25-26], nullifying it as a preventative measure.

In the articles themselves, education is not defined or restricted and so could include preventative campaigns, objective information about the potential harms and benefits of narcotic drugs and psychotropic substances and harm reduction information, delivered in a way that reduces discrimination and stigmatisation of drug users. This information could be available to children in schools, similar to sex education, as public health awareness raising schemes for the general public and for drug users, those close to them and those medical professionals working with them. The commentaries suggest that education here only applies to “education regarding the harmful consequences of the abuse of psychotropic substances”[11, p. 333](or narcotic drugs in the case of the Single Convention). Furthermore, the commentaries state that “Governments should not overlook the possibility that spreading of knowledge about narcotic drugs and psychotropic substances may in some situations lead to the spread of their abuse”[11, p. 333]. Neil Boister describes this reluctance to spread information to the public as “an irrational fear of education”[69, p. 158]. More recently the CND resolution on ‘Education and training on drug use disorders’ has stressed that drug-related education should reflect scientific evidence from medicinal, psychological, educational and social science sources[45, p. 3], possibly reflecting developments in the understanding of how to best prevent drug use and reduce drug-related harms.

Paragraphs 2 and 3 of article 38 of the 1961 Convention and article 20 of the 1971 Convention read as follows:

2. The Parties shall as far as possible promote the training of personnel in the treat-

ment, after-care, rehabilitation and social reintegration of abusers of psychotropic substances.

3. The Parties shall assist persons whose work so requires to gain an understanding of the problems of abuse of psychotropic substances and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of such substances will become widespread.[1, p. 12]

Paragraphs 2 and 3 suggest that States should ‘promote’ and ‘assist’ the implementation of such training and awareness raising initiatives; they are therefore not required to engage directly in such programmes. Although these paragraphs are relatively straight forward, the final phrase raises the same question as in paragraph 1 regarding the dissemination of information. Again, the CND resolution on ‘Education and drug use disorders’ also refers to the need for “evidence-based education and training programmes” and “[e]mphasizes the need to further promote the quality and availability of education and training”[45, p. 3]. It would thus need to be ensured that the decision as to the spread of information, and the nature of the training of individuals in contact with drug users, drug dependent users or undertaking preventative work, must be evidence-based so as to ensure its effectiveness in either reducing initial drug use, reducing drug use or reducing drug-related harms. This adds further support to *efficacy* as an important standard which the drug conventions provide for drug treatment and related activities.

Although some discussion can arise from a reading of this paragraph and its commentary, it is still only a “passing nod in the direction of the demand side of the drug issue”[68, p. 6]. The commentaries make it very clear that “a system of administrative controls and penal sanctions established for the purpose of keeping narcotic drugs from actual and potential victims however continues to be the essence of the Single Convention”[11, p. 330]. Despite this, the conventions do provide useful insight into what might be required of States when they implement drug treatment - although the limitations are broad and sparse, support for *efficacy* and *rights compliance* as tests of appropriateness is evident.

4.1.2 Penal Provisions

The next pair of articles of note - once again the same, *mutatis mutandis* - are articles 36 of the Single Convention and 22 of the 1971 Convention, which carry the title ‘Penal Provisions’. Their main purpose is to prescribe punishment, “particularly... imprisonment or other deprivations of liberty”, for the ‘cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this

Convention”[2, p. 18]. Although this criminal approach forms the foundation of these articles, the second paragraph, inserted in 1972 into the 1961 Convention, suggests an alternative approach that can be taken when dependent drug users are alleged to have committed a crime.

b) Notwithstanding the preceding subparagraph, when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration in conformity with paragraph 1 of article 38[2, p. 18].

The articles provide State Parties with the opportunity, under certain conditions, to provide treatment-based alternatives to conviction or punishment of drug-related crimes. Although the article does not specify any limitations to the type of crime eligible for such alternative measures, the commentaries on the conventions suggests that “it may however be expected that in accordance with the purpose of article 22 [and article 36 of the Single Convention] Parties will normally do so only in the case of relatively minor offences”[11, p. 353]. This refers to the first part of this first paragraph, which states that “serious offences shall be liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty”[1, p. 12]. This causes some confusion as the commentaries also state that “the measures of treatment substituted for conviction or punishment may also include civil commitment to an institution of treatment”[11, p. 354]. As this would of course constitute a deprivation of liberty it would possibly also be appropriate to substitute such a measure for the conviction or punishment of more serious drug-related offences. Neil Boister comments, in his book on the ‘Penal Aspects of the UN Drug Conventions’, that “[o]n its face, however, the provision allows substitution for a range of offences from the most serious case of drug trafficking to cases of simple possession”[69, p. 156].

In an attempt to clarify which individuals articles 22 and 36 concern, the commentaries go on to state that “subparagraph (b) may not be applied to offenders who abuse psychotropic substances occasionally, but only to those who abuse them frequently, i.e. are dependent on them”[11, p. 353] (and ‘those who abuse narcotic drugs occasionally’, in the case of the Single Convention). This guideline appears to sensibly suggest that only individuals dependent on drugs are eligible for treatment; non-dependent drug users could not be eligible for treatment due to an absence of a treatable condition. This adds further support for *rights compliance* as a test of the appropriateness of different drug treatment options as coercing a non-dependent drug user into drug treatment

would violate human rights norms (see section 5.2 for more).

Finally, the commentaries mention that “substitution of measures of treatment for conviction or punishment would under subparagraph (b) be justified only if it can reasonably be hoped that the abuser will not only be cured of his dependence, but also will not commit a serious penal offence again”[11, p. 354]. This comment expresses the importance of effective, and thus evidence-based drug treatment under the drug conventions. This further suggests support for *efficacy* as a standard to which States must adhere when implementing drug treatment.

CND resolution 55/12 covers alternatives to imprisonment and emphasises that “in addressing the world drug problem, the main objective is to ensure the health and welfare of individuals”[37, p. 2]. This reflects further the opinion that *rights compliance* may act as a limitation on States approaching the topic of drug treatment, and appears to specifically echo the obligations enshrined in the human right to health.

4.2 The 1988 Convention

The 1988 Convention takes a different approach to the subject of treatment. Whereas in the first two treaties, treatment was included both in its own article and alongside penal measures, in this final drug treaty, the two are combined into one, much stricter article. This article is the third in the convention, accentuating the importance of these new, tougher penal sanctions, whereas in the 1961 and 1971 Conventions, the penal and treatment articles could be found right towards the end of the documents.

The 1988 Convention Against Illicit Traffic in Narcotic Drugs was, as its title suggests, primarily intended to tackle illicit drug *trafficking* and this is very clearly reflected in the convention’s preamble. However, this mandate is taken very broadly by the drafters of this final international drug control treaty, possibly due to an “assumption that there is no supply of drugs without demand for them, and that, as a result, the latter should be subject to criminal policy measures as well”[105, p. 331]. One of the biggest changes brought by the 1988 Convention was the obligation of states to *criminalise* the demand side of the market in illicit drugs - the criminalisation of purchase, cultivation and possession for personal use of those drugs scheduled in the conventions. The penalisation of possession of drugs for personal use, according to the commentary on the 1961 Convention as referenced by the commentary on the 1988 Convention, “amounts in fact also to a penalization of personal consumption”[15, p. 80].

Article 3, ‘Offences and Sanctions’, covers two full pages of the convention and contains 11 paragraphs. The article first reaffirms the supply-side penal measures suggested by the amended 1961 Convention and 1971 Convention and then enumerates in detail those acts, considered either to be illicit traffic in drugs or to be involved in the illicit traffic of drugs, which must be criminalised. It is in the second paragraph that the article states, with the qualifier, “subject to its constitutional principles and the basic concepts of its legal system”[3, p. 3] that “possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption”[3, p. 3] must also be made criminal offences under the domestic law of State Parties. The phrase “Subject to [a State Party’s] constitutional principles and the basic concepts of its legal system” would include bills of rights and the rights protected under States’ constitutions, providing additional evidence of the intention of States to allow for a test of *rights compliance* under the drug treaties.

Paragraph 4 covers both sentencing options and the 1988 Convention’s most extensive reference to treatment. Paragraph 4 reads as follows:

4. (a) Each Party shall make the commission of the offences established in accordance with paragraph 1 of this article liable to sanctions which take into account the grave nature of these offences, such as imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation.
- (b) The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.
- (c) Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.
- (d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender[3, pp. 3-4].

Education, treatment, aftercare, rehabilitation and social reintegration are defined via reference to their definitions in the 1961 and 1971 Conventions. The understanding is however broadened to

include all individuals charged with drug-related offences and not only those who also use drugs. This means that some of the definitions would naturally be adapted to those definitions of rehabilitation, social reintegration etc., normally used when referring to individuals who have been prosecuted for an offence but who do not require medical treatment. For the purposes of this paper we will, however, only cover the application of these terms to users of drugs scheduled under the international drug conventions. Again, the mere existence of these provisions suggests concern for the health and welfare of drug dependent individuals.

An additional difference between this article and the corresponding articles entitled ‘Penal Provisions’ in the first treaties is that here different approaches to drug treatment, as an alternative or in addition to conviction or punishment, are designated based on the seriousness of the crime committed. In the first two conventions it was suggested that a State might assign treatment as an alternative or in addition to punishment, ‘no matter how serious’ the offence; although, as mentioned above, it was suggested in the commentaries that States should limit the use of such methods to more minor offences. The 1988 Convention, however, splits its paragraphs into ‘paragraph 1 offences’, ‘paragraph 1 offences, minor’ and ‘paragraph 2 offences’, a new subcategory. This means that conviction or punishment of non-minor supply-side offences *must* be bolstered by any or all of treatment, education, aftercare, rehabilitation or social integration and that conviction or punishment of minor supply-side drug offences *can* be traded for any of the above ‘treatment’ alternatives. The last sub-paragraph concerns the possession, cultivation or purchase of the scheduled drugs for personal use. Here, States *may* apply any of treatment, education, aftercare, rehabilitation or social reintegration in addition to *or* as an alternative to conviction or punishment. The CND resolution mentioned in the previous section applies here as well and encourages States to prioritise the health and welfare of individuals and society and to ensure that drug treatment approaches are evidence-based.

The commentary on the 1988 Convention also makes clear that treatment as an alternative is “not more lenient than imprisonment or much different in concept from punishment”[15, p. 88]. This raises pertinent questions surrounding treatment as punishment and the appropriateness of such forms of coerced or forced treatment under human rights law. This issue is dealt with in detail in section 5.2 - ‘Compulsory Drug Treatment’.

Article 3 of the 1988 Convention raises a major question. By criminalising drug purchase, cultivation and possession for personal use, and thus use itself, the drug user becomes a criminal. By suggesting that treatment is an appropriate alternative or addition to the conviction or punishment of offenders who use drugs, the same individual is considered a patient. This dissonance between

the criminal and the patient, the criminalising of an illness, is apparent throughout the three conventions but is most apparent here where the patient and criminal lie side by side on the first pages of the strictest international drug control treaty.

Drug treatment is also briefly mentioned in article 14(4) of the 1988 Convention. It reads as follows:

4. The Parties shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic. These measures may be based, *inter alia*, on the recommendations of the United Nations, specialized agencies of the United Nations such as the World Health Organization, and other competent international organizations, and on the Comprehensive Multidisciplinary Outline adopted by the International Conference on Drug Abuse and Illicit Trafficking, held in 1987, as it pertains to governmental and non-governmental agencies and private efforts in the field of prevention, treatment and rehabilitation. The Parties may enter into bilateral or multilateral agreements or arrangements aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances.

This passage provides strong support for *rights compliance* and efficacy as standards provided by the UN drug conventions which can be used to assess the appropriateness of different drug treatment approaches. The phrase ‘with a view to reducing human suffering’ certainly seems to suggest that States must respect the human rights of drug dependent individuals, particularly the right to health. Furthermore, reference to the recommendations of the UN, its specialised agencies and the WHO, all of whom advocate strongly for the increased availability of evidence-based and rights compliant drug treatment, further indicates an alignment between the drug treatment standards found under the international drug control and international human rights regimes.

4.2.1 Conclusion

The drug treatment sections of the international drug control treaties are indeed vague. They allow much space for the individuals situations and approaches of different States and for future developments in the drugs, drug-related health issues, medicine and technology. However, what is apparent is that States do face some limitations in their drug treatment approach. The first limitation is that of *rights compliance*. This is indicated first in the preambles of the conventions, where States are reminded of the importance of the ‘health and welfare of mankind’ and is further supported by

the encouragement of drug treatment and in numerous CND resolutions, the ‘Guiding Principles of Demand Reduction’, 1998, and the ‘Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem’, 2009. Resolution 55/3 “reaffirms [the CND’s] unwavering commitment to ensure that all aspects of demand reduction, supply reduction and international cooperation are addressed in full conformity with the purposes and principles of the Charter of the United Nations, international law and the Universal Declaration of Human Rights”[38, p. 2]. In resolution 57/4 the CND recognises “that efforts supporting recovery from substance use disorders need to be consistent with human rights obligations and be within the framework of the international drug control conventions”[44, p. 2]. Similarly, the introduction to the 1998 ‘Declaration on the guiding principles of demand reduction’ states that the “formulation of the demand reduction component of national and international drug control strategies, in accordance with the principles of the Charter of the United Nations and international law, in particular, respect for the sovereignty and territorial integrity of States, human rights and fundamental freedoms and the principles of the Universal Declaration of Human Rights”[57, p. 8]. Finally, the 2009 Political Declaration and Plan of Action, which evaluated the progress made since the 1998 Declaration, takes human rights as a core principle in the ongoing development of drug treatment approaches. It first states that “[t]here is an insufficient emphasis on human rights and dignity in the context of drug demand reduction efforts, in particular regarding access to the highest attainable standard of health services” and further that Member States should “Ensure that drug demand reduction measures respect human rights and the inherent dignity of all individuals”[53, p. 20].

The second limitation obliges States to base drug treatment measures on scientific evidence, thus obliging them to ensure the *efficacy* of available drug treatment approaches. This is best illustrated by the deliberately broad drafting of the conventions, done in large part to allow space for future scientific developments in the field, and is further clarified by the CND. In resolution 57/4 on ‘Supporting recovery from substance use disorders’, for example, the CND recognise that “substance use disorders ... requir[e], like other health conditions, treatment based on scientific evidence”[44, p. 1]. Here, as with the limitation as to rights compliance, the UNODC, in the 2009 Political Declaration and Plan of Action, also chose to emphasise the need for ‘measures based on scientific evidence’ as one of their central recommendations. They instruct Member States to “[i]nvest adequate resources in measures based on scientific evidence” and “[e]ncourage innovative measures and incorporate evaluation in order to respond to present and future challenges; and take into account the possibilities given by new media and technologies, including the Internet, with a view to developing the scientific evidence base”[53, p. 21]. Finally, UNGA resolution 66/183 “reiterates the commitment of Member States to promoting, developing, reviewing or strengthening effective,

comprehensive, integrated drug demand reduction programmes, based on scientific evidence”[33, p. 5].

It is thus clear that despite the widely recognised ambiguous nature of the drug treatment sections of the international drug conventions, limitations do exist for States and their decisions regarding drug treatment approaches; namely *rights compliance* and *efficacy*. These limitations are well-summarised in resolution 54/5 where the CND states their conviction “of the need to base programmes for the treatment and rehabilitation of drug use disorders on scientific evidence while respecting human rights and human dignity”[30, p. 1].

4.3 Tensions within the International Drug Control Regime: the Dependent Drug User as a Criminal and a Patient

This section further examines the dissonance in the international drug conventions, between the drug user as a *criminal* and the drug user as a *patient*, that became apparent through the above analysis of the three conventions, particularly the 1988 Treaty. The notion of the criminalisation of drug users involves the application of penal sanctions to the possession of drugs for personal use or the personal consumption of drugs. The medicalisation of a drug user could vary in its meaning. Although all groups of people should be able to access any and all specialist healthcare services that they require, this does not equate to them being *sick* or suffering from a *disorder*. However, at the time of the drafting of the drug conventions, treatment was certainly focussed on eliminating drug use, and thus drug dependence, or even habitual drug use, was considered a condition that could and should be treated. The current consensus from within the CND is consistent with “scientific evidence from the World Health Organization and the United Nations Office on Drugs and Crime [that] indicates that drug dependence is a preventable and treatable health disorder, resulting from a complex multifactorial interaction between repeated exposure to drugs and biological and environmental factors”[45, p. 1]. The following section will investigate the evidence for this medical/patient approach in the conventions, and the evidence for the criminalisation of drug users, and will seek to show how this dichotomous approach could be considered problematic for States that wish to uphold high standards of care for those within their territories.

4.3.1 Evidence from the International Drug Conventions

Although taking a more ‘supply-side’ approach than the final treaty, the 1961 and 1971 Conventions’ preambles, begin by expressing the importance of the ‘health and welfare of mankind’ for the State Parties to the conventions. The preambles then continue to state the shared goal of preventing and combatting the ‘evil of addiction’[2, p. 1], making clear that this ‘evil’ effects the individual

drug user him- or herself, *as well as* society in general. This suggests sympathy felt for individuals who use drugs and the primacy of health and welfare values in drug-related matters. This would appear to support the classification of drug users as individuals in need of access to necessary healthcare services and facilities.

However, the preambles of the 1961 and 1971 Conventions also provide the first mention of the “limiting [of] drugs to medical and scientific use”[2, p. 1]. This is then codified in the fourth article of both conventions, where States are obliged to limit, via ‘legislative and administrative measures’, a variety of activities including use and possession of drugs, to medical and scientific purposes[2, p. 4]. Although not expressly required to criminalise drug use, this is the first indication that by using drugs, an individual has *done something wrong*; the State must apply *measures* to try to end such behaviour. This marks the start of international criminalisation of drug users and drug use.

With the introduction of the second international drug convention, and the protocol amending the Single Convention, in 1971 and 1972 respectively, the drug user as a patient comes once more to the fore. The articles entitled ‘Penal Provisions’ and ‘Measures Against the Abuse of Drugs’ suggest that those ‘abusing’ drugs need treatment and that this treatment should be accessible to them. They also allow punishment to be substituted or supplemented with treatment[2, p. 18]. This suggests that drug use or drug dependency is considered, by the drafters of the conventions, to be a treatable condition. The articles, ‘limiting the use of drugs to medical and scientific purposes’, remain in the 1961 Convention and are included in the 1971 Convention, however. Thus, the drug user and drug use is simultaneously considered both a criminal and health concern.

With the coming into force of the 1988 Convention, the incongruity developed further. The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances bundles criminalisation and treatment for drug users into one article; the stricter, demand-oriented penal measures, including obliging states to criminalise the possession of drugs for personal use, and thus the use of drugs[3, p. 3], with the reinforcing of the treatment articles of the previous conventions and expansion on those referring to the addition or supplementation of penal measures with treatment. Following the coming into force of this final convention, the confusion had reached a peak; treatment was certainly still considered necessary under the drug conventions, but now States were obliged to “establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption”[3, p. 3].

4.3.2 Evidence from International Organisations and States

The tensions within the conventions are further reflected by tensions within and between other bodies, such as the UN, the INCB, the UNODC, the WHO and State Parties.

The INCB recognises that “a person’s health is greatly affected by drug abuse”[43, p. 1]; it bemoans the lack of access to treatment for problematic drug users[43, p. iv], encourages Indonesia to increase the capacity of its drug treatment facilities, Kenya to improve accessibility to drug treatment facilities for people who inject drugs (PWID) and makes similar recommendations regarding improving the accessibility and quality of services in the Lao People’s Democratic Republic, Malaysia, Croatia and Guatemala, whilst congratulating many other States on the improvement of their healthcare or treatment options for drug users⁹. Furthermore, the CND have illustrated their awareness of “the importance of addressing substance use disorders as a public health concern”[44, p. 1].

Alongside these recommendations and resolutions which treat drug use as a health issue, the opposite approach can be found. The Board noted its “long-standing concerns regarding certain drug control policies adopted by the Government of the Netherlands, in particular the policy that allows small amounts of cannabis to be sold and abused in so-called “coffee shops” ”[43, p. 8], which effectively ended the criminalisation of cannabis users in The Netherlands. The Board also expressed concern about supervised injection facilities as they are “facilities where drug addicts can abuse drugs”[43, p. 9]; it appears that the Board felt opposed to the possibility that drug users would receive sanctuary from the criminalisation of their activities in such places. The ultimate criminalisation of drug use must be the application of the death penalty to drug-related offences, which has even gone as far as to include the *possession* of controlled substances[93]. Only at the 2014 CND did the INCB officially urge countries to stop using the death penalty for drug offences[49]. Previously, an INCB Member had stated that the Board “neither supports nor objects to capital punishment for convicted offenders in drug-related court cases in any country”[62]; the official line was that “the determination of sanctions applicable to drug-related offences remains the exclusive prerogative of each State and therefore lie[s] beyond the mandate and powers which have been conferred upon the Board by the international community”[63].

Although other bodies, which fall under the umbrella of the UN do not directly promote an end to the criminalisation of drug use, they do prioritise a health-based approach more than the INCB.

⁹It should be noted here that this is under the guise of demand-reduction and so, as has been previously mentioned, does not necessarily allude to a full spectrum of treatment and healthcare services, that would include harm reduction.

The UNODC tends to lean much more towards a ‘public health issue’ approach to controlled substances, having made a concerted effort to mainstream human rights throughout its activities, particularly following resolution 51/12: ‘Strengthening cooperation between the United Nations Office on Drugs and Crime and other United Nations entities for the promotion of human rights in the implementation of the international drug control treaties’[24]. The UNODC has even released a discussion paper entitled, ‘From coercion to cohesion: Treating drug dependence through health care, not punishment’, which concludes that the criminalising policies adopted by many countries “for drug use and related crime,... have resulted in large numbers of people in prisons, compulsory treatment centres, or labour camps without significant long-term impact on drug use, drug dependence or drug-related crime in the community and are in contradiction with human rights”[94, p. 10]. They then encourage increased availability of “effective, affordable and humane treatment and care that meets the varied medical and social needs of people with drug use disorders ”[94, p. 10]. Further, following recent moves of several US States and Uruguay to legalise cannabis, the UNODC only stated that “it will take years of careful monitoring to understand the broader effects of those novel regulatory frameworks in order to inform future policy decisions”[130, p. xi], expressing neutrality on a policy decision that the INCB openly condemns.

The WHO naturally approaches the topic of drug use from a perspective that emphasises the primacy of access to the best standard of health and healthcare services possible, in line with the human right to health. For example, in the ‘Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence’ the WHO introduce the topic by stating that “substance dependence per se should be regarded as a health problem and not a legal one”[25, p. 8]. A further example of cross-body tensions include the classification by the WHO of methadone as an essential medicine[52, p. 32] and recognition of its indisputable worth by the UNODC[20, p. 14], but the disapproving tone of the reference in the INCB’s 2012 annual report to the exporting of Latvian produced methadone to Russia[36, p. 103] - there was no recognition in the report of the illegality of methadone in Russia and thus the inability of Russian dependent heroin users to access this essential medicine.

Moreover, examples of classifying drug users as both criminals and people in need of medical care can be found across States as well. All States of the world treat people who use drugs as criminals, as exhibited by the worldwide prohibition of the drugs scheduled in the international drug conventions. However, most also accept that drug users require health services or believe that they need access to or should even be encouraged to enter treatment programmes. The services offered range from harm reduction services to strict, even inhumane rehabilitation centres (see

section 5.2 - Compulsory Drug Treatment). Personal or human rights values aside, all of these initiatives at least prove that most countries across the world consider drug users to be both criminal and ailing. Of late there has been a small but significant move away from the criminalisation of drug users; Uruguay and 2 American states (Colorado and Washington) have legalised marijuana. Furthermore, a number of countries have decriminalised drugs - to lesser and greater extents - the most well-known examples being Portugal¹⁰ and The Netherlands¹¹[124, pp. 25-32] . It still remains, however, that no state has completely legalised all drug use and so prohibition and thus the criminalisation of drug users remains a global phenomenon.

4.3.3 Problems Resulting from this Approach

The international drug conventions, when requiring that States implement treatment plans for drug ‘abusers’ consider the drug user or ‘abuser’ as *one in need of treatment*. If one is in need of treatment it can be assumed that they are considered ill - the illness in question in this case being the use of or dependence upon controlled substances. If drug users are compelled by this ‘illness’ or ‘disease’ of drug dependence to use drugs, and this consequently results in real or potential health problems, then it makes sense that facilities and services providing information, services or ‘treatment’ be accessible to them. In criminalising drug use, as the 1988 Convention has, the drug dependent user commits a crime when they use the substance that they are dependent upon. The core symptom of this ‘illness’, as the conventions appear to see it, is the use of drugs and the inability to stop using drugs. Criminalising such a behaviour is criminalising the coughing or sneezing of a person with a cold or the scratching of a child with chicken pox.

These contrasting approaches may also lead to difficulties for States in deciding how to approach drug policy, enforcement and treatment. If drug use is to be criminalised, must only abstinence-based treatment be acceptable? If possession of drugs is against the law, how will the most effective health initiatives, such as NSE programmes and supervised injection facilities be justified? But, on the contrary, if a State finds that harm reduction services are the most effective in maintaining good health and stability, it would be equally difficult to justify denying a drug user access to such a facility or arresting them on their enrolment in an NSE programme.

¹⁰In Portugal, “if the police find an individual in possession of up to 10 days’ worth of an average daily dose of drugs for personal use, an officer issues that individual a citation referring him or her to a meeting with a ‘dissuasion commission’... The [commissions] have a wide range of sanctions at their disposal... For non-dependent, first-time offenders, the panels will almost always suspend the proceedings and impose no sanction”[124, p. 30].

¹¹The Netherlands technically continue “to criminalise drug possession and supply, but guidelines for prosecution... lay the foundation for the decriminalisation framework. These guidelines determined that cannabis supply and possession should be of the lowest priority to law enforcement and prosecutors. This was the system that led to the subsequent creation of the Netherlands’ famous ‘coffee shops,’ which are legally permitted to sell cannabis in limited amounts”[124, p. 27]

One negative impact that this double-pronged approach has is on the availability of drug treatment. It is well-documented that drug users and drug dependent users may avoid contacting drug treatment services, as well as emergency and harm reduction services, due to fear of arrest[21, 92]. For example, HRW's 2006 publication on Ukraine, entitled 'Rhetoric and Risk: Human Rights Abuses Impeding Ukraine's Fight against HIV/AIDS' reported that "[d]rug users said that they avoided seeking health care or drug treatment out of fear that health care workers would report their drug use to police or that information relayed to their employers would result in their dismissal"[21, p. 4].

Interestingly, a human rights approach might classify a drug user as neither patient nor criminal. Instead, considering them just a person, who happens to use drugs, they would naturally be entitled to the same rights as any other person. The criminalisation of drug use is, undoubtedly, the most harmful to the individual drug user, specifically when interacting with users who require medical care or who would benefit from access to health services. However, the medicalisation of all drug users does not seem appropriate either. Similarly to criminalisation, medicalisation can lead to stigma and discrimination. Additionally, many drug users, particularly those who are non-regular or non-dependent users, have no treatable condition and thus cannot be considered sick or suffering from any disease or disorder. They might require access to specialised medical services (e.g. sterile injecting equipment or harm reduction information), but this is the case for many groups; pregnant women, for example, require increased contact with medical professionals and specialised care, without pregnancy being labelled as a *disorder* and pregnant women being considered as *sick people*.

Despite not agreeing wholly with either the medicalisation or criminalisation of drug users, it is important to point out such incongruities in the drug conventions in order to illustrate potential difficulties for States in providing both effective treatment options *and* following the strictest obligations contained in the conventions. In this case however, the 1988 Convention's Article outlining the requirement to criminalise possession of drugs for personal use states that this is only necessary "[s]ubject to [a State Party's] constitutional principles and the basic concepts of its legal system"[3, p. 3]. It would thus be possible for a State to refuse "to establish as a criminal offence under its domestic law... the possession... of narcotic drugs or psychotropic substances for personal consumption" due to non-agreement of the article with aspects of a State's constitution. For example, in 2009 Argentina's Supreme Court upheld that criminalisation of drug possession for personal use and personal drug consumption was unconstitutional as "[c]riminalizing an individual [for drug use] is undeniably inhumane, subjecting the person to a criminal process that will stigmatize him for the rest of his life and subject him, in some cases, to prison time"[85]. Courts in other States

made similar decision. In Colombia in 1994, for example, the Colombian Constitutional Court ruled that “penalties for possession of a personal dose violated Article 49 of the 1991 Constitution guaranteeing the freedom of decision-making to affect one’s own health as long as it does not impact the rights of third parties”[124, p. 22].

5 The Cases: A Test of Rights Compliance and Effectiveness

Although the international drug control treaties take a very broad approach regarding drug treatment, limitations do exist. These are limitations of ethics and effectiveness, clarified and refined by human rights law. Thus, although a State is not under any direct obligation to implement or prohibit specific treatment modalities, they do need to ensure, under both drug and human rights law, that the treatment options available to drug using individuals are *first rights compliant and then effective*. International human rights law and international drug laws are aligned on this issue. The above analyses of both different regimes concluded that these same two criteria should be employed in order to ascertain the appropriateness of different drug treatment approaches.

The cases that will be covered will reflect the issues presented in the introduction to this paper. First, OST will be analysed, which will include the contentious issues of heroin prescription and the lack of availability of methadone for MMT. This drug treatment approach will undergo a test of compliance with the international drug control conventions, to dispel controversies over its legality and will then be analysed for rights compliance and efficacy.

Next, compulsory drug treatment will proceed through the same process; first a test of rights compliance and then a test of efficacy. This section will look at both compulsory and quasi-compulsory routes to drug treatment. The QCT section will cover court mandated 12 step programmes as a secondary topic.

First, the test of rights compliance will be applied to the cases. Only *if* the case proceeds successfully through this first test will the second test, *efficacy*, become relevant. A drug treatment approach which is effective, but not rights compliant is still not appropriate under human rights law or the international drug treaties.

5.1 Opiate Substitution Therapy

The case study that will be examined here is OST, including heroin prescription programmes, and with a specific focus on methadone for MMT and the standards which make its provision a State obligation.

Heroin (diacetylmorphine, diamorphine) is an opiate and induces an intense feeling of euphoria and relaxation[103]. The WDR 2014 estimates there to be between 12.8 and 20.2 million users of opiates (heroin and opium) globally[130, p. 22].

Some of the negative impacts associated with heroin use derive directly from use of the substance itself. However, what is less known is that a large number of the costs associated with drug use are attributable to or exacerbated by the prohibitive system under which they are used, rather than their use directly. All trade in opiates for recreational use is illegal throughout the world and therefore not subject to any regulations, or quality controls. Heroin can thus be purchased by anyone of any age, cut with any adulterants, bulking agents or other contaminants[73, pp. 17-24] and is sold without information regarding proper use, dosage, or purity. The risks associated with producing and trafficking illegal substances drive up the price of drugs and force users to resort to acquisitive crime and prostitution in order to fund their usage[123, p. 25]. The social stigma and criminalisation attached to drug use make it vastly more difficult for a user to find employment or to access life-saving information or health services[123, p. 89]. Specifically regarding fatal overdose among PWID, the prohibitionist approach tends to encourage the spread of information about the negative effects of drug use, both medical and penal, but not best practices for avoiding harm[123, p. 63]; it is to blame for fear of arrest or persecution resulting in failure to contact emergency health services[92, pp. 15-16]; and, it is responsible for the lack of accessibility of opiate users and their close friends and relatives to naloxone[89], due to fears that use might increase if PWID stopped fearing fatal overdose[138, p. 2].

OST is gaining ever more acceptance as a highly effective and ethical drug treatment option for individuals who are dependent on heroin. OST involves the provision of a dependent heroin user with a substance such as heroin, methadone, buprenorphine or naltrexone¹² (depending on the country and the preferred system). The drug provided is then either ingested under medical supervision in an appropriate facility or provided as a ‘take-home’ prescription to be consumed at the user’s own discretion. If the patient so chooses, and with the support of medical professionals, it is possible for the amount of the prescribed opiate to be reduced or eliminated. This process is called tapering and can be dangerous if implemented too fast, against medical advice or against the wishes of the patient[96, p. 1332][119, pp. 47-58]. It should further be noted that as methadone is ingested orally as part of OST, it eliminates the risk of transmitting blood-borne diseases via unsafe injecting practices.

Mathers et al. estimate that only 8% of individuals who require OST have access to it[110]. In March 2014, Crimea was annexed by the Russian Federation, leading to the extension of Russia’s

¹²Methadone is a synthetic opiate which mimics and, at high doses, blocks the effects of substances like heroin and morphine. Buprenorphine is a partial opioid agonist and opioid antagonist which functions similarly to methadone but with a milder, less euphoric effect on the user. Naltrexone is an opioid receptor antagonist and so blocks the pleasurable effects of opiates.

methadone ban and thus the discontinuation of MMT in the annexed region. This has resulted in over 700 MMT patients being refused further treatment, many leaving the country to continue with MMT elsewhere and, by the end of June 2014, at least 20 alleged deaths[61].

The legality of OST under the international drug treaties

Alongside other harm reducing approaches, such as supervised injection facilities, the legality of such programmes under the drug conventions has been a cause for some controversy. OST, and particularly heroin prescription programmes, can appear to oppose the aims of the international, prohibitionist drug control regime; particularly the most well-known goal, to ‘rid the world of drugs’. However, looking first to the preambles of the international drug conventions, which can provide guidance as to the purpose of a treaty, it is clear that a range of factors are prioritised; the importance of the health and welfare of mankind, the need to ensure the availability of narcotics for legitimate medical purposes, the ‘evil of addiction’, the limiting of narcotics to medical and scientific purposes and the need for states to come together to tackle the illicit market in narcotic substances[2, p. 1][1, p. 1][3, p. 1]. OST and medically prescribed heroin, which aim to reduce user dependence on the illicit market and improve the health and welfare of drug users, is not incongruous with any of these notions.

The international drug control regime uses a system of scheduling in order to categorise drugs via their relative riskiness and medical utility. Varying levels of control are then assigned accordingly. However, it must be stated that advocates for evidence-based drug policy criticise the scheduling system precisely because it lacks an evidence-based approach[118]. For example, cannabis and cannabis resin are included in Schedules I and IV, the schedule reserved for the most dangerous drugs with very limited or no therapeutic value. This is despite traditional medical uses of cannabis in many parts of the world[125] and more recent findings which recognise cannabis as a highly beneficial plant for the treatment or palliation of a range of ailments, including multiple sclerosis[121]. Heroin is also in Schedules I and IV; the Single Convention recommends that the use of Schedule IV drugs be limited to “medical and scientific research only, including clinical trials”[2, p. 3]. The requirements to justify programmes as experiments, the termination of programmes still beneficial to drug users and the additional bureaucracy that comes along with clinical trials on human subjects could hinder access to treatment for patients or ‘subjects’. However, heroin is still a legal pharmaceutical in many parts of the world and, as the conventions also require states to “ensure adequate availability of narcotic drugs, including opiates, for medical and scientific purposes” the limitation of heroin use to medical research applies only, “if in its opinion the prevailing conditions in [a state] render it the most appropriate means of protecting the public health and welfare”[1, p. 3]. Heroin prescription for heroin dependence is, therefore, legal under this article.

Another interesting passage, mentioned earlier, can be found in the 1988 Convention, which obliges parties to “adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic”[3, p. 14]. Read phrase-by-phrase, there appears to be a perfect alignment between this prohibitive piece and heroin prescription. Prescribing heroin for dependent drug use aims to reduce illicit demand for drugs by shifting the demand to legal, medical prescription. Evidence also seems to suggest that overall demand may also decrease as users of the service regain health and stability. Human suffering is no doubt reduced and, finally, prescriptions of heroin redirect funds from illicit to licit bodies. This article 14(4) continues by stating that “[t]hese measures may be based, *inter alia*, on the recommendations of the United Nations, specialized agencies of the United Nations such as the World Health Organization, and other competent international organizations”[3, p. 14]. As the WHO recommended treatment for drug dependency is OST[25, p. xi], this specifically supports the legality of OST under the drug conventions.

It should further be recalled that OST is one of the few drug treatment approaches which receives a direct mention in the drug convention commentaries, where it is stated that treatment includes eliminating drug use or “inducing the abuser to restrict his intake of substances liable to be abused to such minimum quantities as are medically justified in the light of his personal condition”[11, p. 332]. This recognition of the possibility that continuing drug use may be medically justified exhibits a crack in the abstinence-only approach and shows an appreciation for the medical usefulness of programmes such as OST and heroin prescription.

One aspect of the international drug conventions, which is appropriate to the topic of OST but doesn’t fall under the drug treatment sections, is the provision of essential medicines. One of the core purposes of the conventions is to ensure the adequate availability of narcotic drugs and psychotropic substances for the ‘relief of pain and suffering’. The mandate of the INCB is to limit “the use and distribution of drugs to an adequate amount required for medical and scientific purposes and to ensur[e] their availability for such purposes”[2, p. 7] or in the words of Raymond Yans, President of the INCB, to “set out the critical requirements for preventing and reducing drug-related suffering and for ensuring access to essential controlled medicines”. One of these ‘essential controlled medicines’ is methadone, and another is buprenorphine, one of the other maintenance drugs mentioned above. These substances are on the WHO EML due to their use in OST[52, p. 32]. CND resolution 54/6 ‘Promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse’ highlights the importance of this core purpose of the drug conventions and the INCB.

It makes specific reference to the WHO report ‘Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines’, which frequently refers to maintenance drugs and their status as essential medicines which should be made available across the world. The international drug conventions, the INCB and the CND not only condone the use of such substances, but they are mandated to actively ensure that these substances are available to those that require them.

Furthermore, the 2009 Political Declaration and Plan of Action on the ‘world drug problem’ states that a core challenge for Member States and area that urgently requires attention is the “availability of and accessibility to drug demand reduction services”[53, p. 21]. Through this document, the UNODC instructs Member States to “[e]nsure, where appropriate, the sufficient availability of substances for medication-assisted therapy, including those within the scope of control under the international drug control conventions”[53, p. 21]. Under such a recommendation, not only methadone and buprenorphine are considered, but also heroin for use in heroin prescription programmes.

The effectiveness of OST and heroin prescription programmes also contributes to their appropriateness under the drug conventions. As we have seen above, such programmes are grounded in scientific evidence and are proven to be effective at improving a number of health and social criteria[136, pp. 327-35][72][25, p. 29-32]. As concluded in the previous section, ‘Treatment under the International Drug Conventions’, the effectiveness of a drug treatment approach is one of the few limitations that States must comply with under the drug conventions. This is further supported by the 2009 Political Declaration and Plan of Action, in a section which directly refers to medication-assisted therapy, requiring States to “[e]nsure that access to drug treatment that is affordable, culturally appropriate and based on scientific evidence is available”[53, p. 21].

In general, however, the CND have refused to accept the term ‘harm reduction’ in their official discussions and publications and the INCB have notoriously opposed the implementation of such services, with a very slight change of heart only recently becoming apparent[46]. They have furthermore exhibited a lack of support for OST, stating in their 2011 annual report that “[w]ith regard to the existing methadone substitution programmes that are being conducted in Mauritius, the Board invites the Government to increase the provision of psychosocial support and to find ways of guiding drug abusers towards reducing their drug intake so that they may eventually stop abusing drugs”[35, p. 14]. The lack of appreciation of the potential benefits of OST programmes, such as MMT, and encouragement of a State to instead proceed with other options, alongside the description of OST as ‘drug abuse’ is indicative of the INCB’s lack of support for such initiatives. Instead,

as noted by J. Csete, “[g]iven its treaty-mandated status, the INCB should be the world’s most important promoter and protector of this use of controlled opioids. Unfortunately, this is far from the reality”[87, p. 2].

However, in the INCB’s 2003 annual report, almost a decade before the above opinion was released, the INCB asserted that:

“Many Governments have opted in favour of drug substitution and maintenance treatment as one of the forms of medical treatment of drug addicts, whereby a drug with similar action to the drug of dependence, but with a lower degree of risks, is prescribed by a medical doctor for a specific treatment aim. Although results are dependent on many factors, its implementation does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice”[19, pp. 36-37]

Here the INCB appear to find no fault in OST and instead appear to encourage the use of this approach among States.

The CND has released a number of resolutions which cover the topic ‘demand reduction’. As harm reduction approaches to drug treatment, including OST programmes do not prioritise reducing the demand for drugs it is not immediately clear that they should fall under this term, which is the term that is used by the CND to describe *all* matters related to the international drug conventions and drug treatment. However, the Commission has clarified this issue by stating that “demand reduction programmes should cover all areas of drug abuse prevention, ranging from discouraging the initial use of illicit drugs to reducing the negative health and social consequences of drug abuse”[39, p. 1]. This is very telling as it indicates that OST can fall under the umbrella term ‘demand reduction’ and that the CND supports certain harm reduction interventions and approaches to drug treatment, only resisting using the name harm reduction. As the aims of OST, and all other harm reduction programmes are to ‘reduce the negative health and social consequences of drug abuse’, there can be no question that the CND sees some merit in such approaches.

OST and heroin prescription programmes are not in conflict with the international drug control conventions, which in fact require Member States to ensure the availability of essential medicines, such as methadone, for those who require them.

5.1.1 The Rights Compliance of OST

Now that it has been ascertained that the international drug conventions do not provide any specific restrictions to States in their use of OST or heroin prescription programmes, the drug treatment approach must be passed through the tests of right compliance and efficacy, to judge whether it is an appropriate drug treatment options for States to implement.

OST and the right to health

The most obvious human right related to this topic is the right to ‘the highest attainable standard of physical and mental health’ [95, p. 52]. As relevant to drug treatment services, this means that every individual in a particular State should not be barred by that State from access to the most effective treatments.

The AAAQ framework can be used here to analyse how appropriate OST is under the right to health. Some aspects of drug treatment are decided by the State during implementation and are thus not directly related to the treatment approach itself. For example, it would be the State’s responsibility to ensure that OST programmes were sufficiently available. When it comes to the ‘accessibility’ criteria much of the responsibility falls again upon the State. However, it is important to note here that nothing about OST is inherently discriminatory. These programmes are equally as appropriate for all dependent opiate users, regardless of their race, religion, gender or socio-economic status. However, it should be ensured that drug dependent users are offered a full range of drug treatment approaches, including abstinence-based options, before beginning OST, to ensure that they feel that they have had sufficient opportunity to discontinue their drug use. OST programmes are further ‘acceptable’ under the AAAQ Framework - there is no aspect of them which poses a question of their incoherence with human rights standards and norms. As evidence for this, the WHO promotes OST as its recommended treatment approach to opiate dependency [25, p. xi]. The final criteria, ‘quality’ is again met by OST. There is a vast and growing amount of evidence in support of OST as the most effective approach to reducing negative health impacts and lowering health risks associated with dependence on opiates. These programmes can further reduce crime rates and improve life stability and wellbeing [136, pp. 327-35] [72] [25, p. 29-32].

According to General Comment No. 14, one of the core principles of the right to health is to “provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs” [80, p. 13]. This includes drugs, such as methadone, required for OST. As noted above, central to the INCB’s mandate is ensuring that adequate quantities of controlled substances are available for ‘scientific and medical uses’. Among the most important of these uses is treatment

of drug dependence itself, notably the use of opium-derived substances such as methadone and buprenorphine to treat opiate addiction.

The right to benefit from scientific progress and its applications

In March 2010, harm reduction NGOs, HRI and Collectif Urgence Toxida, submitted their briefing to the CESCR on the reports of Mauritius's implementation of the ICESCR. They focussed specifically on drug use, HIV/AIDS and harm reduction. The two groups brought together three articles enshrined in the Covenant to illustrate State obligation to implement harm reduction services, such as OST; "the realisation of the right to health in the context of injection driven HIV and harm reduction is further supported by Articles 15.1.b and 2. Together, these articles support the implementation of health systems for HIV prevention that are available, accessible, acceptable and of high quality"[26]. Article 2 of the ICESCR represents the concept of 'progressive realisation', whereby states must ensure that steps are taken continuously 'to the maximum of available resources' and including legislative reform. The cost-effectiveness of harm reduction services make them a perfect candidate for such progressive realisation and fulfilment of obligations would include legislative change which removed barriers to access for those in need of such vital services. Article 15.1.b. guarantees the 'right of everyone to benefit from scientific progress and its applications'. OST, including heroin prescription programmes, falls under this right as the evidence-base is considerable and growing in support of these options as improving health and quality of life, reducing harms and unsafe injection practices and even in diminishing drug use itself. The intentionally broad nature of the drug treatment articles of the international drug treaties allows for precisely such scientific development.

Following this briefing, the Committee recommended that, "in order to achieve the progressive realisation of the right to health for people who inject drugs and so that this group may benefit from scientific progress and its applications (article 15.1.b), the State party should implement in full the recommendations made by the WHO in 2009 designed to improve availability, accessibility and quality of harm reduction services, in particular needle and syringe exchange and opioid substitution therapy with methadone"[77, p. 6]; a huge success for those committed to improving access to harm reduction service and illustrating the coherence of the values underlying harm reduction with those of human rights.

The CESCR on the rights compliance of OST

The CESCR has released concluding observations on the reports of other State Parties to the ICESCR which are also applicable here. In 2008 it noted “the limited access by drug users to substitution therapy” in Ukraine and in 2010 the lack of access to methadone in Kazakhstan for MMT, recommending that the State “ensure that methadone as a substitute drug dependence therapy is made accessible to all drug dependents”[78, p. 8].

In 2011 it called upon Estonia to expand “the provision of drug substitution therapy” under article 12, the right to health, of the ICESCR[76, p. 6]. In the same year, the Committee emphasised its concern for Russia’s “continued ban on the medical use of methadone and buprenorphine for treatment of drug dependence and the fact that the Government does not support opioid substitution therapy (OST) and needle and syringe programmes which are strongly recommended by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Office on Drug and Crime and other international organizations as effective measures for prevention of HIV/AIDS among injecting drug users”[74].

Additionally, in 2013, the CESCR’s concluding observations on the ‘combined fourth to sixth periodic reports of Belarus’ supported the availability of OST as an essential aspect of the human right to health, recommending that “the State party apply a human rights-based approach to the treatment of ... drug users, and provide appropriate health care, psychological support services and rehabilitation to such persons, including effective drug dependence treatment such as opioid substitution therapy”[75, p. 8].

Finally, in May 2014 the CESCR criticised the Ukraine for its “existing regulations that restrict access to opioid substitution therapy (OST) and needle and syringe exchange (NSE) programmes”[79, p. 9], recommending that they “adopt a human rights-based approach in addressing the problem of drug use, including by... c) providing appropriate health-care, psychological support services and rehabilitation to such persons, including effective drug dependence treatment such as opioid substitution therapy (OST) ... [and] allocating financial resources for the proper operation of opioid substitution therapy (OST) and needle and syringe exchange (NSE) programmes and increasing their coverage, ensuring inter alia better access to such programmes in prison settings”. The same sentiments are reflected in the concluding observations for Uzbekistan, where the CESCR encourages the State to ensure the availability of OST. These comments echo an understanding of OST as a rights compliant drug treatment option that is a necessity under the right to health, and further that the right to access OST extends to prisoners. As noted in section 3, ‘Human Rights and Drug Treatment’, State obligation to provide OST further extends to children who are dependent upon

drugs; this opinion is supported both by academic opinion and by the Committee on the Rights of the Child[64, 83].

The HRC Special Procedures on the rights compliance of OST

As we have seen above, the HRC's Special Procedures have often taken on the cause of OST and support the availability of essential medicines, such as methadone and buprenorphine as a human right. Manfred Nowak, former Special Rapporteur on Torture is a key proponent of ensuring the availability of methadone and other opiates for use in drug dependency treatment. In his 2009 report to the HRC, Nowak states that "[o]ne of the questions in this context concerns withdrawal symptoms and to what extent they may qualify as torture or ill-treatment. There can be no doubt that withdrawal symptoms can cause severe pain and suffering if not alleviated by appropriate medical treatment, and the potential for abuse of withdrawal symptoms, in particular in custody situations, is evident"[116, p. 18]. He supports this opinion with reference to the 2003 ECtHR case *McGlinchey and others v. The United Kingdom* where "without specifically stating that the woman died from withdrawal, the [Court] found a violation of the prohibition of inhuman or degrading treatment or punishment"[116, p. 18]. Nowak also emphasises the proven effectiveness of OST and bemoans the lack of access to OST for drug dependent users who are in prisons, recalling that "in some developing and transitional countries, the most effective treatments for opiate addiction are available to fewer than 1 per cent of those in need"[116, pp. 18-19].

Nowak's successor, Juan Méndez, overtook the task of emphasising the importance of bringing attention to States abusing their obligations to provide essential medicines and effective drug treatment to dependent drug users. In his 2013 report, Méndez reasserts many of the former Rapporteur's opinions and emphasises that the issues raised in 2009 are yet to be resolved. As regards drug detention centres, which will be covered in an upcoming section, he notes that "users of illicit drugs who are detained in such centres undergo painful withdrawal from drug dependence without medical assistance"[111, p. 9]. He also clarifies to Member States that "[e]nsuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment". This includes OST medications such as methadone and buprenorphine and supports the opinion that the States' human rights commitments legally oblige them to make OST available, in line with the right to health and AAAQ Framework. In his report to the HRC, Méndez further refers to the restriction or denial of OST services as a "particular form of ill-treatment and possibly

torture of drug users”[111, p. 17] and asserts that “the denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances. Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures”[111, p. 17]. This is a reference to States such as Russia where legal methadone services are unavailable to all drug dependent users who require them. Russia recently extended this ban to cover Crimea, following its 2014 annexation. Méndez makes it clear that such active denial of health services amounts to a violation of international human rights standards, such as the right to health and the right to freedom from cruel inhuman and degrading treatment or punishment.

As mentioned in the earlier section on human rights and drug treatment, Anand Grover, Special Rapporteur on the Right to Health, has also covered drug treatment issues under his mandate. Two of his reports are particularly salient to the topic of OST. The first, already mentioned in this paper’s earlier human rights section, covers the right to health and drug control. Here, Anand Grover makes numerous references to the benefits of OST and urges, as his first recommendation, that “Member States should ensure that all harm-reduction measures (as itemized by UNAIDS) and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations”[99, p. 24]. The second report, Grover’s 2010 Report to the HRC focusses specifically on access to medicines. Grover notes that “[d]uring [his] consultations, concerns were raised about the lack of uptake by States of certain essential medicines listed on the WHO EML due to political, cultural and legal considerations... Criminalization of the activities of drug users in many States ... restricts the availability of opioid substitutes, buprenorphine and methadone, proven to be effective in treating drug dependence, despite the fact that they are listed on the WHO EML”[97, p. 14].

These Special Rapporteurs further mention the provision of OST under the specific conditions found in detention centres, such as prisons. As outlined in section 3, ‘Human Rights and Drug Treatment’, drug dependent users should have access to medical treatment “of the same quality and standard as is afforded to those who are not imprisoned or detained”[80, p. 10], in line with the principle of equivalence of care.

Further rights-related benefits of OST

Additionally, heroin prescription programmes and OST often enable or encourage individuals to access other harm reduction services which they may have otherwise bypassed. The increased access of those in heroin prescription programmes to information and additional harm reduction services, such as NSE programmes, could greatly reduce the risk of transmission of blood-borne

infections. Anand Grover, Special Rapporteur on the Right to Health, further defined steps to be taken as part of States' obligations under the ICESCR and included, "[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases"[98, p. 2]. This makes it a key technique for tackling the HIV epidemic and its implementation a human rights obligation. Furthermore, although the prescription of heroin, methadone or other substitution drugs can be in the form of a take-home prescription, it is most often provided to be taken under the supervision of medical professionals. This setting would emulate that of supervised injection facilities, where injecting drug users and other drug users can use drugs in a protected environment. Due to the availability of medical expertise and anti-overdose drugs like naloxone at such sites, overdose fatalities are enormously reduced. On the 10th anniversary of Vancouver, Canada's much-opposed injection facility, Insite, they were able to boast over 2 million visits and zero deaths. An article commemorating the event explained that, "life expectancy has gone up by a decade, the rate of HIV/AIDS has dropped in the neighbourhood and people that use Insite are more likely to enrol in detox programs"[104]. This is the effect of a supervised injection facility without the added bonus of quality-controlled heroin or other substitution drugs with accurate information on purity. The two harm reduction programmes combined, or either one alone, will protect the right to life of individuals dependent on heroin; increasingly as these services are introduced around the world.

Conclusion

The *rights compliance* of OST is clear. The greatest evidence for this is found in the fact that OST is considered so appropriate by human rights bodies that they stress that States have an *obligation* to ensure its availability for drug dependent individuals, under international human rights law.

5.1.2 The Efficacy of OST

As OST has successfully proceeded through a test of rights compliance, its *efficacy* now becomes relevant. Below, the evidence surrounding the efficacy of OST will be summarised.

All individuals requiring assistance with drug dependence are different from one another and so naturally will respond differently to the support programmes available to them. It is therefore of the utmost importance that any and all programmes proven to improve the health, stability and quality of life of an individual become an option available for their utilisation. OST, heroin prescription programmes, and other options often suggested to heroin users, such as abstinence-based treatment programmes or detoxification, have rather unimpressive results when it comes to eliminating dependency. In fact, some researchers claim that heroin dependency has a spontaneous remission rate of approximately 5%, regardless of which, if any, intervention is employed[126, p. 284]. As John

Marks wrote in his essay on the 'Paradox of Prohibition', "if the recession rate is spontaneous and impervious to external agency, medical intervention should try and ensure healthy survival"[109].

OST directly approaches these health criteria and seems to be very effective at doing so. Ideally, all users in OST programmes would withdraw entirely from the illicit market, would no longer need to resort to crime to fund their drug use, would gain increased stability in their working lives and would have the information, equipment and supervision to reduce the likelihood of fatal overdose and transmission of infection. They would be in regular contact with medical professionals, on hand to guide them towards other harm-reduction opportunities and to inform them of possibilities to reduce their drug consumption, only as and when the user felt interested in such a course of action. This would redirect funds from the illicit drug market to the licit, increase the health and quality of life of drug users, reduce crime levels, reduce the transmission of infectious disease, reduce overdose rates and fatal overdose rates and potentially even lead to a reduction in stigmatisation of drug use.

The evidence overwhelmingly suggests that OST programmes are concurrent with improved outcomes, including lower crime rates, health and social stability[136, pp. 327-35][72]. Heroin prescription programmes have particular efficacy when it comes to patient retention, which exacerbates other positive effects[132, p. 1]. It has even been found that, despite not actively seeking to reduce or eliminate drug use, OST, including heroin prescription, can reduce the use of illicit drugs[128, p. 35]. The WHO concluded that "[a]gonist maintenance treatment is indicated for all patients who are opioid dependent and are able to give informed consent, and for whom there are no specific contradictions... Staff should be cautious when excluding patients seeking opioid agonist maintenance treatment, because such patients often have poor clinical outcomes if they do not receive treatment"[25, p. 29] and recommended that "[e]ssential pharmacological treatment options should consist of opioid agonist maintenance treatment and services for the management of opioid withdrawal. At a minimum, this would include either methadone or buprenorphine for opioid agonist maintenance and outpatient withdrawal management"[25, p. xiv].

Conclusion

The provision of methadone and other substances for OST serves as a very interesting study of drug treatment under the international drug conventions and human rights law. Under the drug conventions Member States are obliged to ensure that those in need have access to essential controlled medicines, such as methadone and buprenorphine. Likewise, OST is appropriate under international human rights law. It is proven effective and does not present conflict with human rights norms under, for example, the right to health. This opinion is reflected in the numerous calls by

UN Special Procedures to Member States to ensure the availability of methadone for MMT, the inclusion of methadone on the WHO EML, and the selection of OST as the WHO's recommended treatment for opiate dependence disorders. Despite this, as we have seen, and despite support from all other related bodies, the INCB has sometimes been far less supportive of OST than is appropriate, considering its mandate to 'ensure the availability of controlled substances for their medical uses'. There has been much criticism of the INCB, for example, as regards Russia's ban on methadone. Despite consistently using strong words when berating countries who used less strict measures when criminalising aspects of the drug consumption chain[43, p. 8], the INCB has failed to comment on Russia's methadone ban, which causes huge amounts of suffering to Russian drug users.

Under the principles of *rights compliance* and *efficacy*, the core limitations to drug treatment approaches that can be found in the international drug conventions and human rights law, OST becomes a model treatment option. Additionally, a State that fails to provide methadone for OST is in contravention of both human rights and drug law standards. This shows that the international drug and human rights regimes can cofunction very successfully to inform States on the best drug treatment approaches to maintain high legal, ethical and medical standards.

5.2 Compulsory Drug Treatment

Compulsory drug treatment can be separated into two categories - that which is truly compulsory and that which is only quasi-compulsory. Drug detention centres will be used to illustrate truly compulsory drug treatment, while drug courts and court mandated 12 step programmes will be used to discuss QCT. These cases will proceed through a *rights compliance* test and then, if their rights compliance is verified, through a test of *efficacy*, in order to ascertain their appropriateness under international human rights law and international drug law.

As outlined in Section 2.2, drug detention centres, and other similar facilities, operate in a number of countries, including China, Vietnam and Cambodia. Alongside numerous other violations of human rights, participation in the drug 'treatment' programmes is usually compulsory, detention in the facilities is arbitrary and individuals face little or no access to legal remedy.

Drug courts exemplify a quasi-compulsory route to treatment, as an individual accused of a drug-related crime can choose drug treatment as their only alternative to punitive sanctions, such as imprisonment. Drug courts operate most widely in the United Kingdom, the United States, Canada,

Australia and New Zealand. The rights compliancy of drug courts themselves will be investigated below. But, in addition to this will be a discussion of 12 step programmes as drug court mandated, quasi-compulsory drug treatment.

12-step programmes fall into the category of self-help, faith-based, outpatient approaches to drug treatment and are adapted from the original ‘Alcoholics Anonymous’ or AA 12-Step programme for alcohol dependency. The programmes are based on a set of guiding ‘spiritual principles’[8, pp. 59-60] known as the twelve steps; and are summarised as follows by the American Psychological Association:

1. Admitting that one cannot control one’s addiction or compulsion;
2. recognizing a higher power that can give strength;
3. examining past errors with the help of a sponsor;
4. making amends for these errors;
5. learning to live a new life with a new code of behaviour;
6. helping others who suffer from the same addictions or compulsions.[133]

Normally, 12 step programmes are voluntary and privately run by the participants themselves and so it cannot be argued that they might interfere with international law. However, if prescribed via QCT, state obligation can be directly attributed and thus the tests of *rights compliance* and *efficacy* become relevant.

Compulsory drug treatment under the international drug control conventions

In preparation for the 2014 CND ‘high-level review on the implementation by Member States of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem’, the UNODC released a document wherein it responded to a number of the main criticisms of the current international drug control regime. One of these questions was, ‘Do the conventions support compulsory treatment?’, to which the UNODC responded “The Conventions do not mention and never support “compulsory treatment””[42, p. 9]. The document then continues to outline opinions which closely mirror the conclusions made above, regarding the legality of forced and coerced treatment. They suggest that, “[d]rug dependent patients found guilty of committing a crime should be given the possibility to attend treatment programs as an alternative to prison, or to serve their sentence in prison, on the basis of their free choice”[42, p. 10], which supports QCT. The use of the phrase *free choice* suggests that

the UNODC would expect that no measures (e.g. threat of strict penal sanction) be used which might bias the individual's decision to enter treatment. They also discourage the use of "social exclusion, segregation in detention centres or application of coercive measures"[42, p. 10], which also seems to echo a more human rights-based and harm reduction approach to drug treatment.

As stated in the UNODC document, there is indeed no explicit reference to compulsory treatment made in the conventions¹³. Article 36 of the 1961 Convention, article 22 of the 1971 Convention and article 3 of the 1988 Convention cover, in their paragraphs, treatment as an addition or alternative to punishment. The ambiguous wording states that "when *abusers* of drugs have committed such offences¹⁴ *the Parties may provide*, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers *shall* undergo measures of treatment, education, after-care, rehabilitation and social reintegration [emphasis added]"[2, p. 18]. The first ambiguity regards whether or not the drug user concerned would be given a free choice regarding whether or not they want to enter treatment in addition or as an alternative to any penal sanction that they would otherwise receive. The conventions do not make it clear whether the individual should be given a free choice in this matter or not. Considering the UNODC interpretation, as outlined above, and the commitment of the conventions to supporting the 'health and welfare of mankind', it can be assumed that a route into treatment devoid of this choice, and thus mandatory, would not be supported by the conventions.

Another question regards the word 'abuser'. If this word were to apply here to all users of drugs, infrequent, regular and dependent, then there would be cause for concern that the coerced treatment of non-dependent drug users was being condoned by the conventions. As we have seen, this would not be in concordance with either human rights or medical ethical principles. This point is somewhat clarified, however, in the commentaries. The definition of the word abuser is not clearly given and it still seems possible that it might refer to both non-dependent and dependent drug users. However, the statement that treatment as an alternative or addition to punishment "may not be applied to offenders who abuse narcotic drugs occasionally, but only to those who abuse them frequently, i.e. who are dependent on them"[12, p. 77] at least clarifies that the conventions would not condone the treating of an individual with no medical condition.

¹³However, as mentioned previously in this paper, Draft article 47(2) of the 1961 Single Convention did call "for 'the compulsory treatment of drug addicts in closed institutions' ", but "[o]thers objected to the specification of compulsory treatment in a closed institution that they regarded as restricting the use of other potentially effective methods"[69, p. 144].

¹⁴The cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs scheduled in the drug conventions.

This is further supported by CND resolutions and the 2009 Political Declaration and Plan of Action. In the Political Declaration, the UNODC, as with human rights, evidence-based drug treatment and available drug treatment, specifically raises the topic of ‘drug use and dependence care in the criminal justice system’. The document suggests that “when appropriate [Member States should] provid[e] treatment as an alternative to incarceration” and that this treatment should be ‘evidence-based and ethical’ [53, p. 23].

This interpretation suggests that the conventions would not encourage mandatory treatment and that they would discourage the forced or coerced treatment of non-dependent drug users. There is little evidence as to their stance on QCT but the second halves of articles 36, 22 and 3 of the three conventions, respectively, do seem to allow for such practices. It must then be assumed that, considering the importance placed by the conventions on the ‘health and welfare of mankind’ and the limitations on State practice, namely rights compliance and effectiveness, that QCT would be encouraged only in a way that is fully coherent with the principles of *rights compliance* and *efficacy*, to be determined below.

5.2.1 The Rights Compliance of Compulsory Drug Treatment

In most cases, compulsory drug treatment violates human rights as, whether an individual consents to the treatment programme or not, they would still be obliged to participate in the programme and thus the duty of the physician to “respect a competent patient’s right to accept or refuse treatment”[51], the principle of informed consent, enshrined in principles of medical ethics and the right to health, is violated. Former Executive Director of the UNODC, Antonio Maria Costa, commented that “[w]ith respect to drug treatment, in line with the right to informed consent to medical treatment (and its “logical corollary”, the right to refuse treatment), drug dependence treatment should not be forced on patients”[32, p. 5].

There are certain circumstances under which it might be appropriate that an individual be treated, even when consent is not provided. In the UNODC discussion paper ‘Principles of Drug Dependence Treatment’ it is first made clear that mandatory treatment is generally unacceptable; assumably for the reasons outlined above. However, the point is then made that “[o]nly in exceptional crisis situations of high risk to self or others, compulsory treatment should be mandated for specific conditions and periods of time as specified by the law”[22, p. 10]. This is further clarified by a UNODC CND 2014 preparatory document, to be discussed further shortly, which stated that “The legislation in many States Parties and international medical standards require that all medical

treatment be provided with the free “consent” of the patient. Only in specific cases related to acute and dangerous conditions, including a patient at risk for life and security (psychotic crisis, overdose, risk of violence, suicide attempt), a treatment can be applied as mandatory for a few hours or at most a few days. After this short period, the patient will be in a condition to be autonomous and have the capacity to agree or refuse drug dependence treatment interventions”[42, p. 10]. This legal opinion is extrapolated from the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care[5]. As stated above this would not constitute the inclusion of a patient in a treatment *programme* but only brief, emergency treatment, following which informed consent would be required in order for any, more extensive, treatment programme to continue.

As regards the capacity to consent, Anand Grover clarifies that “[p]eople who use or are dependent on drugs do not automatically lack the capacity to consent to treatment. A presumption of incapacity based on drug use or dependence creates significant potential for abuse. In many cases, a determination of individual incapacity merely is a pretext for the compulsory “treatment” of people who use drugs”[99, p. 13].

Informed consent as a necessary requirement of ethical medical practise, is most often discussed under the right to health. The CESCR for example, have interpreted Article 12, the right to health, to include “the right to be free from ... non-consensual medical treatment and experimentation”[80, p. 3]. However, both the Special Rapporteur for health and the current and previous Special Rapporteurs on Torture, Juan Méndez and Manfred Nowak have all emphasised the importance of informed consent in their reports.

As shown above, in the general human rights discussion of drug treatment, special procedures, such as Special Rapporteurs on Torture and the Right to Health have made it clear that their expert analysis of compulsory treatment in drug detention centres shows a clear violation of human rights standards. Manfred Nowak, former UN Special Rapporteur on Torture recalls, “[d]uring my six years as the United Nations’ Special Rapporteur on Torture, I often visited detention sites worldwide: police-holding cells, pretrial detention centers, and prisons. In such settings, too often what I found was that those most marginalized — including people who used drugs—were victims of torture and cruel, inhuman, or degrading treatment”[31, p. 2]. In 2013, Juan Méndez, the current UN Special Rapporteur on Torture, followed this up in his statement, that some ‘treatments’ for people who use drugs include “State-sanctioned beatings, caning or whipping, forced labour, sexual abuse and intentional humiliation”[111, p. 9] and recommends that Member States “[c]lose compulsory drug detention and “rehabilitation” centres without delay and implement voluntary, evidence-based

and rights-based health and social services in the community”[111, p. 22].

5.2.2 The Rights Compliance of Quasi-Compulsory Drug Treatment

In order to analyse QCT and thus drug courts under international law it is necessary to understand the different individuals facing such situations, and how their differences might affect a judgement of the appropriateness of their route to treatment. The first group are non-dependent drug using individuals who have been convicted of no crime beyond the use of drugs or possession of drugs for personal use. The second would be drug dependent individuals who have been convicted of no crime beyond the use of drugs or possession of drugs for personal use. The final group would thus be drug dependent individuals who have been convicted of a crime beyond the use of drugs or possession of drugs for personal use[127, p. 9].

Alex Stevens’ 2012 Article in *Human Rights and Drugs* analyses the ‘ethics and effectiveness of coerced treatment of people who use drugs’. When it comes to those who do not meet the criteria for drug dependence, and have committed no crime other than the possession of drugs for personal use, Stevens concludes that QCT would not be an appropriate route to treatment[127, p. 11]. If the drug user is not dependent on the drug, they have no condition which could be treated. “Ordering treatment for people who do not have a treatable condition can only be seen as the use of treatment as a form of punishment”[127, p. 11]. Under article 5 of the ‘UN Principles of Medical Ethics’, “[i]t is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria”[6]. It would not be possible to justify the treating of an individual with no medical condition in accordance with medical criteria and thus the forcing or coercing of that person into treatment would not be appropriate under any circumstance. This is further supported by the ICCPR. Article 9, paragraph 1 states that “Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law”[95, pp. 35-36]. As the treating of those with no treatable disorder is not legally justifiable, it cannot be considered an appropriate justification for the deprivation of an individual’s liberty if, for example, they were to be enrolled in a residential treatment programme. Furthermore, the use of treatment as punishment, as would be the case here, could interfere with article 7 of the ICCPR, where it is guaranteed that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”[95, p. 35]. This is because the use of treatment as a punishment is cruel and inhuman, especially where the ‘patient’ suffers from no medical

condition or when they have been charged with a crime where the only potential recipient of harm was themselves. Finally, article 11, which guarantees an individual's freedom of movement would also be interfered with if an individual was confined in a residential treatment institution, where the medical justification for his or her confinement there could not be proven.

The second group of individuals, those who *are* drug dependent but have still committed no crime beyond the possession of drugs for personal use, could be considered to benefit from treatment; thus, all problems associated with an individual entering treatment who does not suffer from any treatable disorder could not be applied here. In relation to this second group, Stevens concludes that "legal systems may provide for penal coercion of people possessing drugs", but that "[t]here are two ethical limits to the severity of penal sanctions: (1) they should be no more severe than is justified by the harm caused by the offence, and (2) they should be no more severe than is necessary to achieve their intended purpose. In the case of the offence of drug possession, any harm that is caused is primarily harm to the individual in possession, so it is disproportionate to impose a harmful penal sanction on him or her"[127, p. 12]. Stevens goes on to clarify that, as imprisonment is a disproportionately harsh punishment for the possession of drugs for personal use, using the "threat of penal sanction to encourage people who use drugs into treatment if the treatment is more restrictive of their liberty than would be the usual punishment for their offence"[127, p. 12] is unethical. If a State was to take such measures the principle of proportionality in sentencing would not be adhered to, as guaranteed by article 49 of the European Charter of Fundamental Rights, which states that "[t]he severity of penalties must not be disproportionate to the criminal offence"[95, pp. 352-359]. Disproportionate penalties imposed by a State, or the threat of such penalties in order to impose disproportionately strict treatment programmes on individuals could, similarly to non-dependent drug users, constitute a violation of the right to liberty and security of the person and freedom of movement, as prescribed in articles 9 and 11 of the ICCPR. It would thus only be in cases where a drug dependent individual was given the choice between an appropriate penal sanction and an equally or less restrictive treatment programme, where QCT for these drug dependent individuals could be considered *rights compliant*.

The final group consists of drug dependent individuals who *have* committed one or more offences beyond possession of personal drugs; acquisitive crime, for example. Here, professor Stevens concludes much the same as for the previous group - compulsory treatment is still unethical but QCT might be ethical under certain circumstances. The difference here is that "quasi-compulsory treatment is more likely to be ethical for drug dependent offenders who have committed more serious crimes than drug possession. This is because they may be facing penal sanctions for offences that cause direct harm to others, and so may be justifiably longer, in accordance with the principle of

proportionality”[127, p. 13].

The Drug Policy Alliance’s 2011 Report ‘Drug Courts Are Not the Answer: Towards a Health-Centred Approach to Drug Use’, describes a number of aspects of the current functioning of drug courts that do not appear to be rights compliant[29, p. 2]. The drug courts discussed in the report represent the real-life functioning of these systems and suggest that even if a drug court programme was rights compliant in theory it would have to be ensured that its real-life functioning also complied with human rights standards.

Overall, drug courts raise complex questions of rights compliance and effectiveness. Under international drug law it is suggested that their use be reserved for minor drug-related crime only. However, a human rights analysis finds that they are most likely to be rights compliant when applied to more major crimes where drug dependent individuals face long prison sentences.

It can be concluded that, under human rights law and international principles of medical ethics, QCT of non-dependent drug users is *never* appropriate. Furthermore, QCT of drug dependent offenders is only appropriate in very specific cases, where there has been no use of disproportionately strict penal measures as a device to threaten individuals into choosing treatment and where the treatment mode and deprivation of liberty is proportional to the crime committed and is equally or less restrictive than the penal alternative. Unfortunately it appears that, in the real world, drug courts do not function in accordance with these specific limitations. A similar conclusion is thus reached as that of the Drug Policy Alliance: that drug courts should be reserved only for more serious drug-related crime, and that “[w]orking toward removing criminal penalties for drug use to address the problem of mass drug arrest and incarceration; and [b]olstering public health systems, including harm reduction and treatment programmes [might] more effectively and cost-effectively address problematic drug use”[29, p. 2].

5.2.3 The Efficacy of Compulsory Drug Treatment

The *efficacy* or lack of efficacy of truly compulsory drug treatment is superseded by the human rights component, due to the failure of compulsory drug treatment to pass a test of rights compliance. It will thus not be discussed here.

Depending on the individuals involved, the crime committed and the drug treatment and the nature of the proposed penal sanction and alternative drug treatment, QCT can both pass and fail a test of

rights compliance. It is thus necessary to discuss its *efficacy*, only applicable in those few cases where QCT meets human rights standards.

The Drug Policy Alliance's 2011 report, mentioned above, states that "[a]lthough many individuals will benefit from drug courts each year, many others will ultimately be worse off than if they had received health services outside the criminal justice system, had been left alone, or even been conventionally sentenced"[29, p. 9]. Their three key findings are as follows:

"Drug courts have not demonstrated cost savings, reduced incarceration, or improved public safety"

- The evidence countering this claim was found to be unreliable
- In order to get better outcomes, drug courts "do not typically divert people from lengthy sentences"
- Incarceration is often used as a punishment for failing in treatment and thus "some drug court participants end up incarcerated for *more time* than if they had been conventionally sentenced in the first place"
- Due to the focus on low-level drug-crime, drug courts do not effect public safety

"Drug courts leave many people worse off for trying"

- Drug courts are beneficial for some people
- Many people, however, are left "worse off than if they had received drug treatment outside the criminal justice system, had been left alone, or even been conventionally sentenced"
- Drug courts have been associated with generalised "increased arrests and incarceration in some cases"

"Drug courts have made the criminal justice system more punitive toward addiction"

- Drug courts simultaneously treat drug dependent individuals as both patients and criminals
- Treatment outcomes other than abstinence, such as "improved health and stability, including reduced drug use and maintenance of relationships" are treated as secondary by the drug court system

- The participants who are most likely to succeed in drug courts are those who are not dependent on drugs; those most in need of drug treatment are the most likely to be redirected into prison
- Treatment options offered in the drug court system can be of insufficient quality and staff may be insufficiently trained[29, p. 2]

The findings of this comprehensive report suggest that, although drug courts can benefit certain individuals, they appear to also have a number of counterproductive aspects.

The original concept behind drug courts and their ‘real-life’ functioning are naturally disparate, but here it seems that the discrepancy is relatively large. Aspects of the above findings raise questions as to the *rights compliance* and *efficacy* of such systems and whether such problems result from the system itself or from its poor implementation.

If the rights compliance of a drug court was confirmed, and its real life implementation mirrored this compliance, then the rights compliance and efficacy of the resulting drug treatment would also become relevant. If any coercion to treatment, such as the use of a drug court, has been utilised then this will naturally constitute a limitation of the drug dependent user’s rights. In order for such a restriction of rights to be appropriate, there must be just cause to take such a course of action.

5.2.4 Drug Court Mandated 12 Step Programmes

12 step programmes form a compelling example of drug court mandated drug treatment. Under normal circumstances such programmes are private, voluntary and patient-run and so do not interfere with international law. However, they do attract controversy and for this reason form an interesting case to examine here.

12 step programmes under the international drug conventions

Firstly, the international drug treaties do not provide any barriers to the use of 12 step programmes as a specific drug treatment approach. The ‘limiting of the use of drugs to medical and scientific purposes’ found throughout the conventions[2, p. 4] and the second resolution of the Single Convention, which espouses abstinence-based treatment[2, p. IIX], for example, fall perfectly in line with the 12 step principle of complete abstinence. Furthermore, the demand reduction principle exhorted by the 1988 Convention favours approaches with the goal of abstinence over harm reduction approaches which aim to produce other positive outcomes for the individual and society, without

necessarily concerning themselves with reducing demand for illicit drugs. The INCB has made several statements related to the importance of not diverting funds towards harm reduction programmes at the expense of abstinence-oriented treatment approaches[16, para.446],[19][88, p. 8].

The goals and even the tone and language of 12 step programmes are in fact very similar to those of the international drug conventions. The concept that “addiction to narcotic drugs constitutes a serious evil for the individual” and that States have a duty “to prevent and combat this evil” can be found in the preamble of the Single Convention on Narcotic Drugs[2, p. 1]. Similarly, the NA White Booklet, the foundation of all subsequent NA literature, describes ‘addicts’ as “people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions, and death”[13, p. 1] and describes ‘addiction’ as a “cunning enemy of life”[13, p. 2]. At the core of both 12 step programmes and the international drug control regime is the belief that the use of drugs is morally wrong and that those who use drugs are either committing a sin, in the case of the 12 step programmes, or a crime, in the case of the drug conventions. However, alongside the either religious or legal ‘criminalisation’ of these individuals is the shared belief that they are sick or suffering from a mental disease; the second step exhibits the belief of the designers of the programme that the drug user needs to be ‘restored to sanity’, and thus, it can only be assumed, is considered ‘insane’ whilst using drugs[41]. Similarly, but less dramatically, in the first two drug conventions, the articles entitled ‘Measures Against the Abuse of Drugs’ exhibit a recognition for the need for ‘treatment’ of those ‘abusing’ drugs[2, p. 19]; the ambiguity over whether use of drugs is ‘abuse’, and ‘abuse’ is dependency illustrates that those drafting the conventions considered that, at least, all drug dependent users are in need of treatment and, at most, all drug *users* require treatment - presumably, in both groups, to achieve abstinence from illicit drugs.

The rights compliance of drug court mandated 12 step programmes

An analysis of quasi-compulsory 12 step programmes through a human rights lens focusses in quickly on their seemingly overt religious character. Religious references are made throughout the steps and are found throughout the literature; meetings end with the Lord’s Prayer or the Serenity Prayer¹⁵[90, p. 378].

The coercion of an individual into a programme where they are strongly encouraged to say prayers and follow principles that originate in or reference a religion that is not their own, or where success in the programme is based on spirituality and they choose to believe in no god or no ‘higher power’,

¹⁵“God, grant me the serenity
to accept the things I cannot change,
the courage to change the things I can,
and the wisdom to know the difference.”[13, p. 1]

might be difficult to reconcile with the diverse beliefs (or lack of belief) found in most prison populations.

Following criticism of the 12 step approach's religious nature, the movement began distancing itself, officially, from religion. The United Kingdom branch of NA, for example, state that "Narcotics Anonymous is a non-religious fellowship, encouraging each member to cultivate an individual understanding, religious or not, of a 'spiritual awakening'" [47]. This does not, however, clarify how a non-religious individual, who does not believe or want to believe in the existence of *any* higher power, might feel comfortable in such a setting. This additional comment notwithstanding, in 2007 the Ninth Circuit of the United States Courts of Appeal¹⁶ ruled, in *Inouye v. Kemna*, in favour of a buddhist parolee who objected to being offered participation in a 12 step programme as his only alternative to jail[50]. Not only did the Court rule that a parolee in such a situation would have the right to sue their parole officer for damages for violating the Establishment Clause of the First Amendment of the US Constitution¹⁷, it also concluded that, considering the decisions of 'virtually identical' cases that had passed before the Seventh¹⁸ and Second¹⁹ Circuit Courts of Appeal and the federal courts, a "unanimous conclusion" had been reached that 12 step programmes, such as AA and NA, have religious components[50]. States should bear such findings in mind when selecting the most appropriate drug treatment approaches.

The efficacy of drug court mandated 12 step programmes

Due to the anonymous nature of the majority of 12 step programmes, there is little research into their efficacy. However, the Cochrane Systematic Review found that, in terms of reduction in drug use, "no experimental studies unequivocally demonstrated the effectiveness of AA ... for reducing alcohol dependence or problems"[91, p. 1]. Additionally, leaked comments on the results of the Triennial Surveys of AA, the most well-known and widespread 12 step programme in operation, showed that even by AA's own estimations, their dropout rate at one year is 95%[55, pp. 11-13]. Even if there was evidence to suggest that such programmes might be useful in reducing dependencies, it seems that any positive outcomes would only be available to the very few participants who remained long enough to enjoy the benefits. There is far more reliable research into the efficacy of

¹⁶A United States Federal Court which hears appeals from cases from 9 western US States (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington) and 2 Pacific Island jurisdictions (Guam, Northern Mariana Islands).

¹⁷"Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances" - First Amendment to the Constitution of the United States of America[14, pp. 25-26].

¹⁸A United States Federal Court which hears appeals from cases from 3 US States (Illinois, Indiana, Wisconsin).

¹⁹A United States Federal Court which hears appeals from cases from 3 US States (New York, Connecticut, Vermont).

AA programmes than into those targeting dependency on illicit substances. However, a 1999 study by the National Institute of Drug Abuse, did find that 12 step programmes for cocaine dependency had a far higher dropout rate than other treatment approaches[86, p. 498].

If, via QCT, an individual's rights have been limited, it would be appropriate to ensure that the drug treatment chosen for them was effective in order to justify that limitation of rights.

Conclusion

As with other issues already discussed, there are some ambiguities and contradictions within the conventions which make can make clarity on such important issues as forced and coerced drug treatment difficult to identify. However, in this case it can be concluded that mandatory treatment is not appropriate; not under human rights law, nor principles of medical ethics, nor the international drug conventions, except in very rare and temporary cases, and in line with international law. Secondly, the forced or coerced treatment of individuals who are not dependent on drugs is never appropriate. This opinion is legally supported by human rights law, principles of medical ethics and the commentaries of the drug conventions. Finally, QCT could be appropriate under specific circumstances, as outlined above, where there has been no use of disproportionately strict penal measures as a device to threaten individuals into choosing treatment and where the treatment mode and deprivation of liberty is proportional to the crime committed and is equally or less restrictive than the penal alternative, and is further proven effective at producing health, wellbeing and/or social stability outcomes. This opinion is supported by human rights law, principles of medical ethics and the UNODC comments exhibited above. If the rights compliance of a QCT approach is confirmed, the chosen drug treatment should be effective in order to justify the restriction of the drug dependent individual's rights. For this reason, it is appropriate for States to ensure that 12 step programmes never comprise an individual's only alternative to punitive measures under QCT. It would be more appropriate as a supplementary and voluntary initiative.

6 Conclusion

The international drug conventions, including their articles relating to drug treatment, are relatively ambiguous and allow States considerable flexibility in their chosen approach to drug treatment implementation. Nevertheless, a lack of consensus over best practices, and evidence of inappropriate drug treatment approaches in some States, illustrates a need for further interpretation. Human rights emerges as a pertinent interpretive tool in carrying out a contemporary interpretation of these articles due to the entanglement of this field with the topic of drug treatment, an issue involving health, detention and a vulnerable group. The analyses above sought to avoid the manipulation of interpretation as a tool to progress a specific drug policy or drug treatment option, but rather aimed to provide useful and practical insight, with support of evidence from both the international human rights and drug regimes.

The key findings of this thesis are as follows:

- Harm reduction, abstinence-based treatments and forced and coerced drug treatment were identified as key drug treatment issues upon which no consensus has been found.
- Norms and standards related to the right to health contribute much to a discussion of drug treatment. Within the right to health, prisoners' rights and principles of medical ethics are also applicable. *Efficacy* and *rights compliance* were identified as tests of the appropriateness of drug treatment approaches under human rights law.
- The drug treatment sections of the international drug conventions are indeed ambiguous in part. However, they can be interpreted as providing *rights compliance* and *efficacy* as the limitations that States must abide by when selecting or reviewing drug treatment approaches. The international drug and international human rights regimes were aligned on this matter.

Thus, the research question - "Considering the wide margin of discretion allowed for under the international drug conventions, how should a State implement the treatment provisions provided within, whilst fulfilling their human rights obligations?" - was successfully resolved.

In order for a State to succeed in implementing the treaty provisions of the international drug conventions, whilst fulfilling their human rights obligations, they must apply a test of **rights compliance** and *then* a test of **efficacy** to all drug treatment programmes, facilities and routes to treatment currently in operation in their jurisdiction, and to all potential approaches that are being considered. They must then assure that rights compliant and effective drug treatment options are made available

to all that require them.

A test of *rights compliance* is composed of ensuring that a given drug treatment approach does not interfere with or violate any applicable human rights norms. These will most often be provisions under the right to health but will also extend to other standards, such as freedom from torture. Where vulnerable groups such as children and prisoners are concerned, instruments tailored to protect their human rights should be consulted. Concluding observations of the treaty bodies, such as the CESCR, alongside reports and comments from the HRC special procedures should be utilised to support an analysis of the rights compliance of a drug treatment approach.

A test of *efficacy* can be carried out by analysing all available peer-reviewed, scientific research on the effectiveness of a given drug treatment approach. Although reduction of a drug dependent individual's drug use can be used as a measure of effectiveness, other positive health and social outcomes should be attributed as much weight.

As this test of *rights compliance* and *efficacy* is not specific to any type of drug treatment, period in history or ideology it can be applied under changing policy regimes and is adaptable to advances in medical technology and scientific developments of drug dependence or habitual drug use.

The international drug conventions, specifically the earlier two, were developed before the HIV and AIDS epidemic, and thus the development and acceptance of the harm reduction approach, not only to drug treatment, but to medical services for drug users in general, such as NSE programmes and supervised injection facility, are not covered in the conventions. Although such 'medical services' are not mentioned in the drug conventions, they are now an integral part of many States' drug use-related health programmes and have further been accepted, in part, by the CND under its definition of 'demand reduction' when it recognises "the advantages of investing in the treatment of drug use disorders, including the reduction of adverse health and social consequences of drug use"[30, p. 2]. It may thus be useful for States to apply the tests of *rights compliance* and *efficacy* to such initiatives, and, if the initiatives prove compliant, to ensure that they too are implemented in a comprehensive drug treatment and drug health service programme.

A human rights perspective was able to add a great deal to the interpretation of the broad drug treatment articles and it is clear that it should be an integral part of drug treatment discussions. However, human rights is as deeply entwined with other aspects of international drug control as it is with drug treatment - thus, such an approach could be further applied to other sections of the international drug control treaties, and human rights acknowledged as a key contributor to efforts

to improve drug control.

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Abstract

Although the three international drug control treaties take a very broad approach to drug treatment, limitations do exist. These are limits of ethics and effectiveness, clarified and refined by human rights law. Thus, although States are not under any direct obligation to implement or prohibit specific treatment modalities, they do need to ensure, under both drug and human rights law, that the treatment options available to drug using individuals are *first rights compliant and then effective*.

Reaching this conclusion involved an analysis of human rights law related to drug treatment and constructive interpretation of the drug treatment articles in the three international drug control treaties. Many human rights standards, instruments and mechanisms are applicable to the topic of drug treatment. It is thus straightforward to identify State obligation, under human rights, as regards this topic. As expected, the human right to health is prominent, along with the rights of prisoners and children - particularly vulnerable groups in relation to drug treatment.

Although the drug conventions are broad when referring to treatment - to allow for future developments in medicine, among other things - standards could be identified which limit the flexibility of States regarding drug treatment approaches.

In both cases, international human rights and international drug law, *rights compliance* and *efficacy* emerged as the most appropriate tests of State obligation regarding drug treatment. These tests should be applied to all currently implemented and potential drug treatment options, in order to ensure that obligations under both human rights and drug law are respected.

A test of rights compliance should be applied first to a drug treatment approach, followed by a test of efficacy. A drug treatment programme which is effective but not rights compliant is still not appropriate under the human rights and drug control regimes.

The practicality of these tests, and thus the usefulness of human rights in drug policy discussions, is further demonstrated via their successful application to opiate substitution therapy (OST) and compulsory treatment. OST is found to be both rights compliant and effective under these tests, and thus also under human rights law and the international drug conventions. Compulsory drug treatment is only rights compliant in very rare and temporary circumstances, but quasi-compulsory treatment (QCT) - for example, drug courts where individuals choose drug treatment as their only alternative to penal sanctions - is rights compliant in more cases. It was thus concluded that only when these specific, rights respecting criteria were met would QCT be appropriate. Following that

assurance, the resulting drug treatment should be effective to justify the limitation of the individual's rights through coercion.

Drug Treatment, Human Rights, International Drug Control Treaties, Rights Compliance, Efficacy

Abstrakt

Obwohl die drei internationalen Abkommen zur Drogenkontrolle einen sehr breiten Ansatz zur medikamentösen Behandlung verfolgen, gibt es dennoch Einschränkungen. Diese betreffen die Einhaltung der Grundsätze von Wirksamkeit und ethischer Verantwortung, welche durch das internationale Menschenrechtssystem weiter präzisiert werden. Obwohl Nationalstaaten unter keiner direkten Verpflichtung zur Umsetzung oder dem Verbot gewisser Behandlungsmethoden stehen, müssen sie dennoch unter der Einhaltung der internationalen Abkommen zur Drogenkontrolle sowie der Menschenrechte gewährleisten, dass die Behandlungsmöglichkeiten für Drogenkonsumenten sowohl rechtskonform als auch effektiv sind.

Diese Schlussfolgerung basieren auf einer Analyse der Menschenrechte in Bezug auf medikamentöse Behandlung sowie eine konstruktive Auslegung der Artikel betreffend Drogentherapie in den drei internationalen Drogenkontrollabkommen. Viele verschiedene Menschenrechtsstandards, Menschenrechtsinstrumente und Mechanismen sind auf das Thema der medikamentösen Behandlung anwendbar. Es einfach staatliche Verpflichtungen im Hinblick auf dieses Thema zu identifizieren, welche im Einklang mit Menschenrechten sind. Wie erwartet steht hierbei das Menschenrecht auf Gesundheit im Vordergrund; zusammen mit den Rechten der Häftlinge und Kinder, diesen beiden besonders gefährdeten Gruppen im Bereich der medikamentösen Behandlung.

Obwohl die Drogenkonventionen breiten Interpretationsspielraum haben wenn es um Behandlung geht - unter anderem für zukünftige Entwicklungen in der Medizin - können Standards identifiziert werden, welche die Flexibilität der Staaten bezüglich Drogenbehandlungsansätze begrenzen.

Sowohl im Rahmen der internationalen Menschenrechte als auch des internationalen Drogenrechts haben sich die Rechtseinhaltung und die Wirksamkeit als die am besten geeigneten Tests der staatlichen Verpflichtung zur medikamentösen Behandlung erwiesen. Diese Tests sollten für alle aktuellen und potenziellen Drogenbehandlungsmöglichkeiten angewendet werden, um zu gewährleisten, dass die Verpflichtungen nach Menschenrechts- und Arzneimittelgesetzen eingehalten werden.

Bei der Kontrolle des Drogentherapie-Ansatzes sollte Test der Rechtseinhaltung zuerst angewendet werden, gefolgt von einem Test der Wirksamkeit. Ein medikamentöses Behandlungsprogramm, das wirksam ist, aber nicht Rechts-konform, ist somit nicht unter Anbetracht der Menschenrechte und Drogenkontrollregime geeignet.

Die Praktikabilität dieser Tests und der Nutzen der Menschenrechte in der Drogenpolitik wird weit-

ers durch die erfolgreiche Anwendung auf Opiat-Substitutionstherapien (OST) und Zwangsbehandlungen demonstriert. OST wird hierbei als rechtskonform und effektiv unter der Anwendung beider Tests angesehen, und somit auch im Rahmen der Menschenrechte und der internationalen Drogenkonventionen. Verpflichtende medikamentöse Behandlung ist nur in sehr seltenen Umständen und nur vorübergehend mit diesen Grundsätzen vereinbar, aber quasi-Zwangsbehandlung (QCT) - beispielsweise bei Drogengerichten, wo Menschen eine medikamentöse Behandlung als einzige Alternative zu strafrechtlichen Sanktionen wählen müssen - sind dabei in mehr Fällen rechtskonform. Es wurde somit festgestellt, dass nur dann, wenn diese spezifischen Rechte respektiert und die Kriterien erfüllt werden QCT angemessen sein kann. Auf Grundlage dieser Prinzipien sollte die resultierende medikamentöse Behandlung effektiv sein, um keine Beschränkung der Rechte des Einzelnen durch staatlichen Zwang zu ermöglichen.

Drogenbehandlung, Menschenrechte, Internationale Abkommen zur Drogenkontrolle, Rechtseinhaltung, Wirksamkeit.