Dependent on Rights:

Assessing Treatment of Drug Dependence from a Human Rights Perspective

Canadian HIV/AIDS Legal Network | Réseau juridique canadien VIH/sida

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July 2007

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Cataloguing in publication data

Csete J and R Pearshouse (2007). Dependent on Rights: Assessing Treatment of Drug Dependence from a Human Rights Perspective. Toronto: Canadian HIV/AIDS Legal Network.

ISBN 978-1-896735-88-7

Acknowledgements
The authors appreciate the financial support of the International Harm Reduction Development (IHRD) Program of the Open Society Institute for the preparation and publication of this report. Daniel Wolfe of IHRD provided useful comments on an earlier draft. From the Legal Network, we also thank Richard Elliott, Leon Mar and Leah Utyasheva for their comments, and Vajdon Sohaili and Leon Mar for overseeing the layout and design of the report.

Illustration by Conny Schwindel

About the Canadian HIV/AIDS Legal Network
The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

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Table of Contents

A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

— International Code of Medical Ethics,
World Medical Association, 1949

Executive summary

All people have the right to the enjoyment of the highest attainable standard of physical and mental health. For people who use addictive drugs, treatment for drug dependence is an essential element of this human right. Though such treatment may not always be 100 percent effective, an extensive body of research and practice demonstrates that it can dramatically improve the mental and physical health of those who are treated.

Treatment for drug dependence shares three of the principal conditions identified in international law as necessary for the full realization of the right to health:

- it is an important element of controlling epidemic illnesses because of its role in reducing the risk of HIV/AIDS and hepatitis C;
- it provides a health service to those who are ill; and
- treatment for parents and pregnant women can contribute to improved health and development of young children.

Each government has a margin of discretion in assessing which measures are most suitable, with respect to its specific circumstances, in ensuring the "highest attainable standard of physical and mental health." However, governments have an obligation to ensure that everyone has access to the level of health goods and services that enables them to enjoy, as soon as possible, the right to the highest attainable standard of health. This commitment requires that states adopt a publicly articulated plan for the realization of this right and show that they allocate resources and undertake actions to reach these goals. United Nations bodies suggest a number of criteria for assessing whether governments are meeting their obligations to respect, protect and fulfill this right. With respect to treatment of drug dependence, these criteria include the following:

- Services should be physically available; for drug dependence treatment, this necessarily means available in a timely way so as not to lose potential patients due to wait times, and available with sufficient variety to account for the fact that no single approach is effective for everyone.
- Services should be equally available to those with and without criminal records. Those with criminal records or other involvement with the justice system should not have to fear retribution when they seek treatment services.
- Treatment for drug dependence should not exclude those who cannot pay.

- Women should have access to services that are appropriate for their needs and situations.
- Services, especially those run by ministries of justice or other non-health authorities, should be compulsory only as a matter of last resort. Rarely will treatment without consent be ethical or justifiable in human rights terms.
- Drug dependence treatment must never involve torture or cruel, inhuman or degrading treatment or punishment.

Faced with this complex health service challenge, even a cursory review shows that many countries are not meeting their obligations toward progressive realization of this right. Proven treatments that are judged by international agencies to be essential health services, such as opioid substitution therapy (OST), remain unavailable to millions of people who need them. Higher-quality services in many countries are available only to the rich. In addition, in some countries, especially where drug offences are highly criminalized, treatment for drug dependence is managed by the criminal justice system, and it may be premised on punitive goals and be coercive in its implementation. Even in services run by health authorities, elements of coercion have become embedded in many forms of this treatment. Compulsory or otherwise inhumane elements of drug dependence treatment are not adequately monitored by health authorities, and means for patients to redress abuses or to file complaints are apparently non-existent in many places. There are no agreed international standards against which to hold governments accountable for these failures. International human rights norms can and should guide the formulation of such standards.

Social attitudes toward and criminalization of people who use illegal drugs have apparently influenced the practice and policy of treatment for drug dependence in many countries. The already precarious human rights situation of people who use drugs is compounded by the inability of a large percentage of them to receive humane, effective, timely and affordable treatment for their addiction.

There is an urgent need for the World Health Organization (WHO) to develop human rights-based standards of treatment for drug dependence. These standards should deal explicitly with compulsory elements of treatment and alternatives to them, involvement of criminal law authorities in treatment, and the relationship of this treatment to provisions of the UN drug conventions. WHO and the UN Office on Drugs and Crime (UNODC) should work with bilateral and multilateral donors to ensure the establishment of an effective system of monitoring compliance with these standards.

The already precarious human rights situation of people who use drugs is compounded by the inability of a large percentage of them to receive humane, effective, timely and affordable treatment for their addiction.

Introduction

This paper seeks to apply human rights law and principles to an assessment of practices and guidelines in the treatment of drug dependence. In many countries, people who use drugs are systematically and relentlessly subjected to a range of severe human rights abuses. Laws on illicit drugs in many countries are so repressive that it is impossible to enforce the law without violating the rights of people who use drugs.[1] They are often the first and easiest targets for police when arrest quotas need to be filled or when police engage in extortion. In some countries they are not tried promptly when they are detained and are often unable to have access to competent legal counsel. They may be detained by the state for long periods for minor offences.[2] In the intersection of the "war on terror" and the "war on drugs," they may be targets of anti-terrorism campaigns that are justified in the name of national security.[3] Beyond their treatment under the law, people who use drugs may be abandoned or ostracized by their families and communities. In short, people who use illegal drugs are often not recognized by law or society as full human beings deserving of human rights, particularly within the legal and health systems.

> [P]eople who use illegal drugs are often not recognized by law or society as full human beings deserving of human rights . . .

Providers of social or health services to people who use drugs must take into account the reality of the marginalization of these people by society and their criminalization under the law. Special sensitivity and diligence in addressing these factors are certainly required for the provision of effective services to treat drug dependence. These services should not only "do no harm" in the clinical sense, but should not contribute to or in any way exploit the marginalized status of people who use drugs.

United Nations declarations on drug use repeatedly call on member states to prioritize measures to reduce the demand for controlled drugs, including "early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration."[4] While an impressive body of published research on treatment of drug dependence has been amassed in the last decades, international and national standards on practices of drug dependence treatment are not as well developed as for treatment of other disorders that affect the health of millions of people. A few countries have developed standards of medical ethics for treatment of drug dependence.[5] Generally, however, national and international authorities have not attempted to analyze or set standards for drug dependence treatment using a human

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[1] A. Neier, "Focus on human rights," Harm Reduction News 2003; 4(1): 1.

[2] Human Rights Watch has argued that "otherwise legitimate punishment, such as imprisonment, can constitute cruel, inhuman or degrading punishment if its severity (i.e. length) is disproportionate to the crime for which it has been imposed". See Human Rights Watch, *Cruel and Unusual: Disproportionate sentences for New York drug offenders.* New York, 1997, chapter 6. Available at www.hrw.org.

[3] J. Csete, "AIDS and public security: the other side of the coin," *Lancet* 2007; 369(9563): 720–721.

[4] See, for example, UN General Assembly, Declaration on the Guiding Principles of Drug Demand Reduction, Resolution II adopted by the Ad Hoc Committee of the Whole based on draft in A/S-20/4, c. V, s. A, at the UN General Assembly Session on the World Drug Problem, 8–10 June 1998.

[5] See, e.g., a description of the efforts of some European countries in this regard in L Guggenbuhl et al. *Adequacy in drug abuse treatment and care in Europe (ADAT), Part I: Ethical aspects in the treatment and care of drug addicts.* Zurich: Addiction Research Institute, 2000.

rights framework.[6]

Medical ethics standards are essential, but they sometimes do not incorporate human rights norms as fully as they should. Human rights and medical ethics are overlapping but far from identical frameworks. Ethical concerns are fundamental underpinnings of human rights norms, but the field of human rights extends beyond the field of medical ethics. Human rights norms come from a body of laws that carry with them legal obligations on the part of national governments. In certain instances, human rights are legally enforceable in courts, and human rights violations can be remedied. Also distinguishing human rights and ethics is that human rights include a concern for justice and dignity of individuals beyond the clinical setting and beyond the elements of clinical practice. For example, a human rights-based assessment of drug dependence treatment would be centrally concerned with whether fear of arbitrary arrest or other human rights abuses might affect accessibility of treatment services, leading to conclusions about how laws and policies need to be reformed so as to address this barrier to the realization of the right to health. Medical ethics guidelines may not include such factors.

The purpose of this paper is to generate and contribute to a discussion about the application of human rights standards to the science and practice of treating drug dependence. It is an attempt to answer, in at least a preliminary way, the following questions:

- What criteria should be used in evaluating whether drug dependence treatment is consistent with human rights standards?
- What steps can be taken to ensure or increase the likelihood that drug dependence treatment is conducted in accordance with human rights standards?

[6] Exceptions are Guggenbulh (ibid.) and Pan American Health Organization and the Inter-American Drug Abuse Control Commission, *Standards of care in the treatment of drug dependence: Experience in the Americas*, 2000. Available at www.cicad.oas.org/Reduccion_Demanda/eng/DRprojects/Normas/standardsmain.asp. The latter document suggests a number of human rights indicators as elements of evaluating treatment programs for drug dependence, including confidentiality of medical records, informed consent for all procedures, and the right of patients to maintain contact with family members. The document mentions the Universal Declaration on Human Rights (1948), but it does not give guidance on the use of the principles in the Universal Declaration or on establishing grievance procedures for patients if their human rights are violated.

Background: the human right to health

Civil and political rights of people who use drugs are frequently violated in many countries, as noted above. In addition to civil and political rights, such as the right to due process and the right to be free from violence, all people, including those who use drugs, are entitled to economic, social and cultural rights, including the right to health. The International Covenant on Economic, Social and Cultural Rights ("the Covenant"), a widely ratified UN treaty, is a legally binding document that imposes both positive and negative obligations on those states that have ratified it — that is, the treaty obliges governments to take certain actions and to refrain from other actions.

The Covenant sets out a right to health, which is described as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[7] States must ensure that this right is exercised without discrimination of any kind.[8] The framers of the right to health in international law recognized that it is not reasonable to suppose that all governments can, in the short term, provide a full range of adequate health services to all people. Thus, the Covenant makes it clear that the right to health is subject to "progressive realization" by the state according to the "maximum of available resources".[9] Progressive realization means that states have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right.[10] That is, governments must demonstrate that they have a plan to move in this direction and that they are allocating resources and taking action toward the fulfillment of their plan.

[A]ll people, including those who use drugs, are entitled to economic, social and cultural rights, including the right to health.

The right to health is not the same as the right to be healthy. It is recognized in human rights law that there are factors beyond the control of governments that affect people's health, including genetic endowment or an individual's tendency to take certain kinds of risks.[11] Observance of the right to health requires states to respect, to protect and to fulfil the right. The UN Committee on Economic, Social and

[7] International Covenant on Economic, Social and Cultural Rights at article 12(1). Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The right to health is also recognised in the Convention on the Elimination of Racial Discrimination (1963), the Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (CROC) (1989). Regional human rights instruments also recognise the right to health, such as European Social Charter (1961), the African Charter on Peoples and Human Rights (1981) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988).

[8] International Covenant on Economic, Social and Cultural Rights. UN General Assembly Resolution 2200 A, 16 December 1966, at article 2(2).

[9] Ibid. at article 2(1).

[10] United Nations Committee on Economic, Social and Cultural Rights. General Comment no. 14: The right to the highest attainable standard of health. UN doc. D/C.12/2000/4, 4 July 2000 at para. 31.

[11] General Comment 14, at paras. 8 and 9.

Cultural Rights, the independent body of experts that monitors states' compliance with the Covenant, has specified that:

> [t]he obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 [i.e. the right to health] guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[12]

This human right is thus understood as including the obligation on governments to provide a certain level of health goods, services and information. Exactly which of these are essential and exactly what constitutes "progressive realization" of this right are matters of judgment, but both treaty law and important commentaries by UN bodies give important guidance on how progressive realization of this right is to be judged.

The Covenant identifies a number of areas that must be addressed to ensure the full realization of the right to health. Three of these essential areas are

1. "the prevention, treatment and control of epidemic, endemic, occupational and other diseases";
2. the "creation of conditions which would assure to all medical service and medical attention in the event of sickness"; and
3. reduction of infant mortality, and ensuring the healthy development of children.[13]

In addition, the UN Committee on Economic, Social and Cultural Rights has elaborated governments' obligations to work toward full realization of the right to health in a General Comment (no. 14) in 2000. The Committee identified the following as the core obligations on states under article 12:

- to ensure the right of physical and economic access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- to provide essential drugs, as from time to time defined under the World Health Organization Action Programme on Essential Drugs;
- to ensure equitable distribution of all health facilities, goods and services; and
- to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.[14]

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[12] Paragraph 33.

[13] International Covenant on Economic, Social and Cultural Rights at article 12 (2) (a), (c) and (d).

[14] General Comment no. 14, paragraph 43. Various versions of the right to health are also embodied in regional human rights instruments as well as numerous national constitutions. The African Charter on Human and Peoples' Rights (27 June 1981, OAU doc. CAB/LEG/67/3) in article 16 asserts the "right to enjoy the best attainable state of physical and

Treatment for drug dependence as an element of the right to health

Drug dependence treatment has received scant analysis in legal writings on the right to health. Thus, as a preliminary matter, it is important to consider whether drug dependence treatment is justifiably considered an element of the right to health.

The gamut of approaches to the treatment of drug dependence is enormous. Depending on the nature of the addiction, services may exist in the form of residential or non-residential detoxification and other services, psychosocial services or therapy, in-patient and outpatient services, services in a doctor's office or in a specialized facility or hospital, "12-step" programs and other support groups, therapeutic communities, long- and short-term strategies, and many forms of counselling, among others.[15] As noted above, opioid substitution therapy (OST) for people dependent on heroin or other opiates has a long record of effective use supported by a strong body of scientific research.[16] Evaluating the effectiveness of the various available methods of drug dependence treatment is beyond the scope of this paper.

For treatment of drug dependence to be considered an element of the right to health, it must demonstrably improve the physical or mental health of the individual concerned. OST has been judged by three UN bodies to meet that criterion very well. According to the WHO/UNODC/UNAIDS 2004 position paper, opioid substitution not only helps combat HIV/AIDS and hepatitis C, it can reduce heroin use over the long term, cut the death rate of people addicted to heroin, reduce complications of pregnancy and health problems of babies born to women who use drugs, reduce crime, and improve the capacity of people who use drugs to keep a job and earn a living.[17] In July 2005, WHO placed methadone and buprenorphine, another opioid substitute, on its Model List of Essential Medicines, which is meant to reflect "minimum medicine needs for basic health systems".[18] The UN Committee on Economic, Social and Cultural Rights has identified the provision of essential drugs as one of the "core obligations" of the right to health.[19]

Through extensive reviews of existing research, WHO has assessed evidence of the health-improving effects of medically assisted treatment methods for non-opiate addictions, including cocaine and amphetamines. WHO's review of treatment for cocaine dependence in 2000 concluded that various

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mental health". The American Declaration of the Rights of Duties of Man of the Conference of American States (1948) asserts the "right to the preservation of…health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources" (article 11). The European Social Charter of the Council of Europe (1961, revised in 1996) guarantees the right to "protection of health", noting that state parties to it will "as far as possible" remove the causes of ill health and prevent "epidemic, endemic and other diseases as well as accidents". The European Social Charter has been ratified by a numbr of states in the former Soviet bloc, including Lithuania, Moldova, Romania and Bulgaria, and signed but not ratified by Russia.

[15] World Health Organization, United Nations International Drug Control Programme, and European Monitoring Centre for Drugs and Drug Addiction. *International guidelines for the evaluation of treatment services and systems for psychoactive substance use disorders*. WHO doc. WHO/MSD/MSB/00.5, p. 7. Available via www.who.int.

[16] World Health Organization (WHO), UN Office on Drugs and Crime (UNODC) and UNAIDS. *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: WHO/UNODC/UNAIDS position paper*. Geneva: WHO, 2004.

[17] Ibid., pp. 18–19.

[18] See WHO, Essential Medicines: WHO Model List (15th edition). Geneva, 2007, section 24.5, "Medicines used in substance dependence programmes." Available at http://www.who.int/medicines/publications/EML15.pdf.

[19] General Comment no. 14, paragraph 43.

pharmacological agents that had been tried did not (then) show promise, but that research into agents that would be specific "blockers" of cocaine cravings was warranted.[20] It was suggested that psychotherapeutic support should be added to any pharmacological approach. With respect to amphetamines, the WHO reviewers concluded that certain medications seemed to have the effect of reducing cravings in the short term or increasing adherence to treatment programs in the medium term, but that no single pharmacological approach emerged as the treatment of choice for amphetamine dependence, psychosis or withdrawal.[21] Both these reviews and other WHO ublications[22] reinforce the widely held consensus that for drug dependence treatment, even for opiates, there is no single preferred method and no method with 100 percent effectiveness. It is thus essential to offer a range of services with the recognition that reactions to treatment will vary among individual people who use drugs.

The explosive epidemics of HIV/AIDS and hepatitis C linked to unsafe drug-injecting practices in some parts of the world have drawn unprecedented attention — and in some cases, resources — to health services for people who use drugs. The unanimous 2001 UN General Assembly declaration on HIV/AIDS recognizes the right of people who use drugs to a comprehensive range of HIV/AIDS prevention and treatment services, including access to sterile injecting equipment and harm reduction services.[23] The UNAIDS policy paper, "Intensifying HIV Prevention," which was approved by the countries on UNAIDS' governing board in 2005, makes explicit the right of people who use drugs to harm reduction programs, including "drug substitution treatment."[24] Opiate substitution therapy is regarded by both UN organizations and many national governments as a central element of HIV and hepatitis C prevention for people who inject opiates.[25] Others have argued on public health and human rights grounds for ensuring access to antiretroviral treatment for HIV-positive people who use drugs.[26]

As UN agencies have concluded, some methods of drug dependence treatment are clearly demonstrated to be of benefit to the physical or mental health (or both) of people who seek this treatment. The place of drug dependence treatment among the services to which people have a human right is bolstered by the overwhelming evidence of the importance of this treatment in the prevention of HIV/AIDS and in improving adherence to antiretroviral treatment.[27] In addition, drug treatment, at least OST, for pregnant women and for parents, contributes demonstrably to reducing health problems of babies born to drug-dependent women and to improving the health and development of young children.[28]

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[20] World Health Organization. Systematic review of pharmacological treatment of cocaine dependence. WHO doc. no. WHO/MSD/MSB00.1, 2000, at p.101.

[21] World Health Organization. Systematic review of treatment for amphetamine-related disorders. WHO doc. no. WHO/MSD/MSB/01.5, at p. 3.

[22] WHO/UNODC/UNAIDS, op.cit., p. 2.

[23] United Nations General Assembly. Declaration of Commitment on HIV/AIDS. UN doc. No. A/RES/S-26/2, 2 August 2001, at para. 52.

[24] Joint United Nations Programme on HIV/AIDS (UNAIDS). Intensifying HIV prevention: UNAIDS policy position paper. Geneva: UNAIDS, 2005 at p. 34.

[25] WHO/UNODC/UNAIDS position paper, at p. 2.

[26] See, e.g., the illustrative selection of case examples in Open Society Institute International Harm Reduction Development. *Breaking down barriers: lessons on providing HIV treatment to injection drug users*. New York: Open Society Institute, 2004.

[27] M. Farrell et al. Effectiveness of drug dependence treatment in HIV prevention. *International Journal of Drug Policy* 2005; 16S:S67-S75.

[28] WHO/UNODC/UNAIDS, *Position Paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, 2004, p 18; J McCarthy et al., "High-dose methadone maintenance in pregnancy: maternal and

Thus, drug dependence treatment shares three of the conditions identified in article 12 of the Convenant as necessary for the full realization of the right to health — it contributes to the control of epidemic or chronic disease, provides a service to someone who is ill, and contributes to good birth outcomes and child development.

General Comment 14 on the right to health

This paper uses some key elements of General Comment 14 to develop basic criteria for assessing whether drug dependence treatment is in accordance with human rights norms. The following paragraphs summarize some of the key ideas of the General Comment that are relevant to drug dependence treatment.

The General Comment reminds governments that there are several dimensions to ensuring people's right to a range of health goods, services and information. These are as follows:[29]

- Health services must be **available in adequate quantity** — including an adequate number of facilities where services are delivered and an adequate quantity of **essential drugs** as defined by the WHO Action Programme on Essential Drugs.
- Health services must be **accessible** to all. Accessibility has several components:
  - Services are delivered **without discrimination** based on sex, income, national origin, physical or mental disability, social class, religion or any other grounds for non-discrimination noted in international law. The **"most vulnerable or marginalized** sections of the population, in law and in fact," must be particularly protected from discrimination in access to health services. States must also take special care to ensure that **women and girls** have equal access to health services.
  - Services must be **of good quality,** meaning that they are **"scientifically and medically appropriate."** This means, among other things, that they are run by "skilled medical personnel" with scientifically approved medications, equipment and procedures. (If medical procedures that are not scientifically approved are characterized as experiments, people have a human right not to be subjected to medical experimentation without their consent.[30])
  - Services must be **acceptable culturally** and "must be **respectful of medical ethics."** They must be "designed to respect confidentiality and improve the health status of those concerned." People's right to **consent** in a specific and informed way to medical procedures is a central principle of human rights.

neonatal outcomes," *American Journal of Obstetrics and Gynecology* 2005; 193: 606–610.

[29] The following paragraphs are adapted from General Comment no. 14, paragraphs 12 (a) – (d), 17, 18, 20 and 28.

[30] International Covenant on Civil and Political Rights, article 7.

  - Services are **physically accessible,** meaning "within safe physical reach for all sections of the population," including "vulnerable or marginalized groups," "persons with disabilities and persons with HIV/AIDS."

  - Services are **economically accessible** or **affordable** for all who need them. "Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households," and particular attention to affordability must be paid with respect to "socially disadvantaged groups."

- If the state denies the provision of goods, services or information on the grounds of **"national security** or the preservation of public order," the onus is on the state to justify such action in a transparent manner. Furthermore, the denial or degree of hindrance must be in accordance with the law, in the pursuit of legitimate aims, and strictly necessary for the promotion of the general welfare.

- The right to health includes the **right to participate** in public decision-making related to the provision of health services, including "participation in political decisions relating to the right to health taken at both the community and national levels".

Assessing treatment of drug dependence from a human rights perspective

General Comment 14 emphasizes that even the best health services do not contribute to the progressive realization of anyone's right to health if they are not available and accessible. To assess any health program or intervention from a human rights perspective, it is important to understand the elements of availability and accessibility that are specific to that intervention. In the case of drug dependence treatment, the research literature suggests two essential aspects of the notion of overall quantitative access that should be central to any evaluation:

1. timeliness of availability is crucial, that is, availability of services at the opportune moment when they are sought by a person who uses drugs, and

2. availability should mean availability of a range of services since, as already noted, no single approach is sufficient.

Any further consideration of availability corresponding to General Comment 14 criteria should take into account these two essential features — timeliness and variety — of "available" treatment for drug dependence.

Access to services

It may take a long time for people who use drugs to come to the point where they are motivated to seek treatment on their own. Denying them services at that moment, for example, by requiring them to wait weeks or months for an opening in a treatment program may cause them to be lost to treatment entirely. Studies in the United States, for example, have concluded that 25 to 50 percent of people seeking dependence treatment may withdraw from waiting lists, and that, unsurprisingly, this percentage increases with the duration of the wait.[31]

Even in wealthy countries with well-developed public health services, the demand for the most basic drug treatment services seems greatly to exceed the supply. In the United States, for example, where an increasingly for-profit health system and poor health insurance coverage make access to many kinds of health services a challenge, drug dependence treatment is no exception. A 2002 national survey of outpatient service providers in the U.S. indicated that while the number of facilities providing "treatment on demand" increased in the 1990s, still by 2000, about one quarter of service providers could not provide treatment in this timely fashion.[32] In 2000, for-profit facilities turned away 31.3 percent of those who sought services, while private not-for-profit services had to turn away about 9 percent of patients.[33] The authors of the survey reported that most people turned away from U.S. outpatient facilities were excluded because of inability to pay.

In Europe, the illicit drug dependence for which treatment is most often sought is heroin dependence, though this is changing in some countries with increased cocaine and methamphetamine use.[34] It is

[31] Friedmann et al., op.cit., p.887.

[32] P.D. Friedmann et al. Accessibility of addiction treatment: results from a national survey of outpatient substance abuse treatment organizations. *Health Service Research* 2003; 38(3):887-903.

[33] Ibid.

[34] European Monitoring Centre for Drugs and Drug Addiction. *Annual report 2005: the state of the drugs problem in Europe*. Chapter 6: Heroin and injecting drug use, treatment demand data. Available at http://ar2005.emcdda.eu.int/en/page075-en.html.

therefore of interest to know how countries in this relatively well-off region have performed in availability of OST. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), performance is somewhat uneven in the region. In particular, the newer European Union (EU) member states of central and eastern Europe have been less successful than the previous 15 members. The newer members represent over 20 percent of the EU population but only 1.3 percent of the clients in substitution treatment.[35] Since the newer member states also have large populations at risk of HIV and hepatitis C, the EMCDDA regards the poor availability of methadone programs in particular to be a "cause for concern."[36]

Russia represents one of the most egregious cases of non-availability of OST in the world.

Although on-demand treatment is not analyzed as such by the EMCDDA, it is obvious from the very low numbers of methadone program participants that most of the newer EU members are not providing on-demand OST services. Poland, for example, a country that may have as many as 70 000 "problem drug users" (as the EMCDDA refers to them), of which most have opiate addictions, is estimated to be reaching less than 5 percent of them with OST.[37] The new EU member states of Slovakia, Estonia, Latvia, Bulgaria and Romania all list at most a few hundred people receiving medically assisted drug treatment, though each has thousands of heroin users. The EMCDDA estimated that in 2003 there were 332 people receiving methadone and none receiving buprenorphine, though it was technically available in Lithuania.[38] EMCDDA figures also indicate a troubling lack of data on numbers of people who use drugs and coverage of OST services in a number of member states.

On the matter of providing a variety of services, even just for opiate treatment, the European record is also uneven. Of the 26 countries monitored by the EMCDDA in 2005, six — Hungary, Poland, Romania, Lithuania, Latvia and Ireland — offered methadone as the only possibility for medically assisted opiate treatment. Fourteen countries reported some use of buprenorphine, though buprenorphine was theoretically available for use in 18 countries.[39] Of 23 countries for which information was available, 13 allowed prescription of opiate substitutes by general practitioners in their offices in addition to programs that required attendance at specialized facilities. Not surprisingly, countries that permitted this practice were generally among those with the highest estimated rates of coverage of OST services.[40]

The EMCDDA has generated an unusually rich collection of information on drug treatment availability

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[35] Ibid.

[36] Ibid.

[37] EMCDDA, *Annual report 2005*, Country reports, available at http://ar2005.emcdda.europa.eu/en/home-en.html.

[38] Lithuania, a country with thousands of heroin users, had an outbreak of 321 new HIV cases in a period of a few months in 2002. See UNAIDS. Report on outbreak of HIV infection in the Lithuanian prison system: assessment of the situation and the developing response. Vienna, 2002.

[39] European Monitoring Centre for Drugs and Drug Addiction. Responses to drug use: Drug treatment overviews [by country]. Available at www.emcdda.eu.int.

[40] Ibid.

in Europe. In other parts of the world, notably developing countries and countries in transition, it is often difficult to find any systematically gathered data on availability of treatment services for people with drug dependence. However, in the absence of more complete information, availability of OST is something of an indicator by which to assess the progressive realization of the right to health, particularly in countries where heroin use is significant.

Russia represents one of the most egregious cases of non-availability of OST in the world. With up to four million heroin users within its borders, the Russian Federation continues to ban by law any use of methadone or other opiate substitutes.[41] As reported in 2004 by Human Rights Watch, a high-level health official commented that methadone is a more dangerous drug than heroin and it should not be unleashed on the streets of Russia's cities.[42] It is likely that this policy is the result of pressure from officials outside the health system, including the narcotics police. Following WHO's addition of methadone and buprenorphine to the Model List of Essential Medicines in 2005, over 200 experts and organizations from around the world urged the directors of WHO, UNAIDS and UNODC to press Russia to legalize therapeutic use of methadone, to the benefit of what these experts suggested was the largest population of people who inject drugs in any country.[43]

Access to OST is limited in other former Soviet countries as well. As of November 2005, the estimated population of people who inject drugs in central and eastern Europe and the former Soviet Union was just under 3 million: just over 2000 people were receiving OST.[44] As of a 2004 WHO review of OST in central and eastern Europe, Belarus also banned methadone.[45] According to the same review, Ukraine, the country with the highest HIV prevalence in Europe, had registered methadone but had not authorized its use in organized programs.[46] In 2005, Ukraine started OST trials using buprenorphine, though at a level that is judged to be greatly inadequate to meet demand.[47] The Government of Kazakhstan proposed a first methadone therapy trial as part of its Global Fund-supported work in 2004, but as of the May 2006 regional AIDS conference in Moscow, there was still reportedly no methadone program in Kazakhstan in spite of evidence of rapid HIV transmission among people who inject drugs.[48]

In 2002, the WHO reviewed opioid substitution services in Southeast Asia and the Western Pacific Region

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[41] Wolfe and Malinowska-Sempruch, op. cit., p. 58. Under the Russian Federation's national drug legislation, methadone is prohibited by virtue of it's inclusion in List I. Buprenorphine is included in the less-restricted List II, although the use of substances in List II for the treatment of drug dependence is explicitly prohibited. See Russian Federation, Federal Act on Narcotic Drugs and Psychotropic Substances, 1997, Article 31.

[42] Human Rights Watch. *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation*. New York, 2004, p. 23.

[43] Making methadone accessible beyond the listing in the WHO EDL (letter), 19 August 2005, available at www.aidsinfonyc.org/tag/activism/methadoneAccess.html.

[44] International Harm Reduction Development. *Harm Reduction Developments 2005: Countries with Injection-driven HIV Epidemics.* 2006, p. 61.

[45] World Health Organization. The practices and context of pharmacotherapy of opioid dependence in central and eastern Europe. WHO doc. WHO/MSD/MSB/04.1, 2004, p. 10, 12.

[46] Ibid.

[47] Human Rights Watch. "Banning methadone would jeopardize HIV/AIDS fight" (letter to Ukrainian Prime Minister J. Timoshenko), July 15, 2005. Available at www.hrw.org.

[48] K. Alcorn. "Block on methadone for drug users in Eastern Europe biggest barrier to treatment," *Aidsmap News*, May 22, 2006. Available at www.aidsmap.com. See also "Kazakhstan: Fight against HIV/AIDS continues," *Irin News*, August 23, 2005. Available at www.irinnews.org.

(including China),[49] a region in which all countries report significant heroin use and most countries witnessed exponential increases in heroin use in the 1990s. With respect to OST availability in Southeast Asia and the Western Pacific Region, the WHO report notes:

> Opposition to developing substitution treatment programs is substantial. The majority of the public and general professionals are sceptical about the role of substitution treatment. There is a view that such treatments are regarded as being too soft on addicts and therefore not attractive from the harder perspective of the politician and policy maker.[50]

Among the important conclusions of this review is that a great many drug treatment programs in some countries of these regions are under the control of the criminal justice system.[51]

From a human rights point of view, government or popular opposition to a proven health intervention such as OST on the grounds that it is not punitive enough is of serious concern and at odds with states' obligations under international human rights law. The obligations to respect, protect and fulfil human rights are not vitiated by stigmatizing opinions of government officials or the general public. Indeed, the rights of those who are marginalized and most vulnerable — often precisely because of such attitudes — require particular attention.

Things have changed somewhat in Asia since the 2002 WHO report, with respect to OST availability. In 2004, China announced with some fanfare the establishment of 1000 methadone clinics that would include maintenance programs.[52] Dr. Wu Zunyou of China's National Center for AIDS Prevention and Control received an award from the International Harm Reduction Association for his efforts to establish methadone services.[53] It remains unclear, however, how available methadone treatment is to the most marginalized and criminalized opiate users, whether long-term methadone maintenance is offered or only short-term detoxification, and whether people who use drugs are aware of these services.[54]

In Thailand, the 2002 WHO report noted that short-term methadone detoxification was the main use of OST and that longer-term methadone maintenance was rarer and available only to those who had failed other treatment three times.[55] Since then, the government has developed new guidelines for OST.[56] In the bright light of the XV International AIDS Conference (AIDS 2004) in Bangkok, the then-prime minister pledged that Thailand would treat "drug abusers" as "patients, not criminals."[57] Nonetheless, it is still estimated that a very low percentage of heroin users have access to OST in Thailand, and methadone is

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[49] WHO's Western Pacific Region includes China, the Pacific Island countries, Australia, New Zealand, Papua New Guinea, Mongolia, Laos, Cambodia, Japan, Viet Nam, the Republic of Korea, Singapore and the Philippines. See www.wpro.who.int.

[50] Ibid., p. 16.

[51] World Health Organization. The practices and context of pharmacotherapy of opioid dependence in South-East Asia and Western Pacific regions. WHO doc. WHO/MSD/MSB/02.1, 2002, p. 14.

[52] Methadone clinics established to help addicts. *China Daily*, 18 November 2004, available at www.china.org.cn/english/government/112570.htm.

[53] See listing of winners of the International Rolleston Award administered by the International Harm Reduction Association at www.ihra.net/IHRAAwards.

[54] Wan Yanhai, Beijing Aizhixing Institute for Health Education, personal communication.

[55] WHO, Opioid dependence in SE Asia and Western Pacific, p. 74.

[56] S. Bezziccheri and P. Brenny. HIV/AIDS and drug abuse: looking forward in Thailand. *Eastern Horizons* (publication of the UNODC Regional Centre for E. Asia and the Pacific), no. 20, Spring 2005, p. 30.

[57] R. Walgate. Thailand ignores HIV epidemic in drug users. *British Medical Journal* 2004; 329:127 (17 July).

primarily provided as a detoxification technique.[58] Addressing an AIDS 2004 satellite meeting, Paisan Suwannawong, one of the founders of the Thai Drug Users' Network (TDN), said that many of TDN's members had no access to humane treatment for drug dependence. If someone wanted to try to get off drugs, members would help by finding the person a clean room and providing sleeping pills and a supportive presence.[59]

Some countries have rationalized limited or no access to OST by invoking the 1961 UN Single Convention on Narcotic Drugs ("the Single Convention"), which seeks to control the production, distribution, use and possession of a long list of narcotic drugs, including opiates such as methadone. Russia and several Asian countries have at various times claimed adherence to the Single Convention as a reason for limiting OST.[60] However, nothing in the Single Convention should prevent or threaten the continuation of OST programs. Article 4(c) limits the production, manufacture, export, import, distribution of, trade in, use and possession of drugs "exclusively to medical and scientific purposes."[61] Many policy-makers and practitioners regard substitution treatment as a legitimate form of treatment that corresponds to the obligation under Article 38 for states "to take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, aftercare, rehabilitation and social integration of the persons involved."[62]

WHO, UNODC and UNAIDS stated in 2004 that OST "in the framework of recognized medical practice approved by competent authorities is in line with" the UN drug conventions.[63] In reviewing the various types of harm reduction programs with respect to international treaties, the UN International Drug Control Programme (UNDCP), located within UNODC, concluded in 2002 that,

> In its more traditional approach substitution/maintenance treatment could hardly be perceived as contrary to the text or the spirit of the treaties. It is a commonly accepted addiction treatment, with several advantages and few drawbacks. Although results are mixed and dependent on many factors, its implementation along sound medical practice guidelines would not constitute a breach of treaty provisions.[64]

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[58] P. Kahn. Thai Drug Users Network, AIDS and human rights: A conversation with Karyn Kaplan. In P. Kahn, ed. *AIDS vaccine handbook: global perspectives* (2d ed.). New York: AIDS Vaccine Advocacy Coalition, 2005, chapter 27, p. 192; Human Rights Watch, *Not enough graves: The war on drugs, HIV/AIDS and violations of human rights.* New York, 2004, p. 34.

[59] P Suwannawong, presentation at Human Rights at the Margins: HIV/AIDS, Prisoners, Drug Users and the Law, a satellite of the XV International AIDS Conference, Bangkok, Thailand, 9 July 2004. One of the authors (JC) was present to hear this presentation.

[60] Wolfe and Malinowska-Sempruch, pp. 24–25.

[61] Single Convention on Narcotic Drugs, March 30, 1961, 520 UNTS 204, amended by the Protocol amending the Single Convention on Narcotic Drugs, March 25, 1972, 976 UNTS 3.

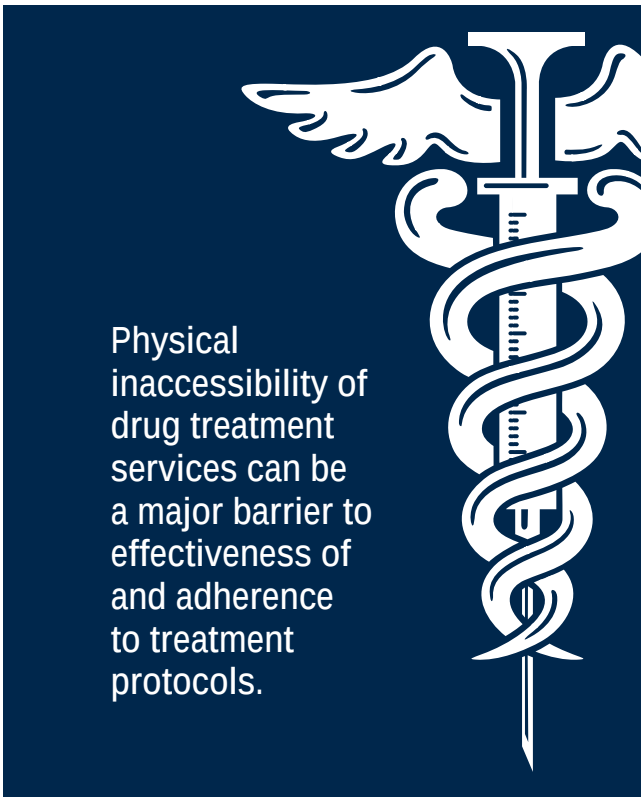
[62] Indeed, the *1972 Protocol Amending the Single Convention on Narcotic Drugs* clarifies that in the narrow sense "treatment" includes "the process of withdrawal of the abused narcotic drugs, or where necessary that of inducing the abuser to restrict his intake of narcotic drugs to such minimum quantities as might be medically justified in the light of his personal condition." UN General Assembly, *Protocol Amending the Single Convention on Narcotic Drugs (Schedules)*, 9 December 1975 A/RES/3444(XXX) (at www.incb.org/pdf/e/conv/convention_1961_en.pdf). Flowing from this definition, the official commentary to the convention acknowledges that "medically justified maintenance programmes" come within the definition of "treatment" under Article 38 of the Single Convention. UN, *Commentary on the Single Convention on Narcotic Drugs*, 1973, E/CN.7/588.

[63] WHO/UNODC/UNAIDS, op. cit., p. 13.

[64] UNDCP, Flexibility of Treaty Provisions as Regards Harm Reduction Approaches, para. 17. See also D. Wolfe et al., *Illicit drug policies and the global HIV epidemic: Effects of UN and national government approaches*, Open Society

The International Narcotics Control Board, the body responsible for overseeing compliance with the UN drug conventions, has noted that "drug substitution and maintenance treatment . . . does not constitute any breach of treaty provisions, whatever substance may be used for such treatment in line with established national sound medical practice."[65] Further, as noted above, methadone and buprenorphine are included on the WHO Model List of Essential Drugs.

Despite these factors, the invocation by certain countries of the Single Convention as an argument against OST signals the need for a policy that would send an unequivocal signal that the UN drug conventions can offer no justification for the failure to offer OST. WHO should work with member states to ensure that such a policy is introduced to its governing body.



Physical inaccessibility

Physical inaccessibility of drug treatment services can be a major barrier to effectiveness of and adherence to treatment protocols. In many countries, dependence treatment services are limited to bigger cities and towns. Non-residential dependence treatment programs may be in hard-to-reach places with restricted hours even though they may require frequent and regular attendance of those in treatment. The residents of more convenient neighbourhoods may have the political clout to keep drug programs out of their "backyard." People who care for children (disproportionately women) or people trying to hold down jobs may be disadvantaged by these factors.

In some jurisdictions, health authorities have attempted to address these concerns. With OST, for example, patients may be released from requirements of direct observation of their ingestion of an opioid substitute on a daily basis and may be entrusted with enough methadone or other substitute for a week, or be allowed to pick up methadone at a pharmacy rather than at a treatment facility. In its review of these requirements as part of the development of a model human rights-based policy,[66] the Canadian HIV/ AIDS Legal Network emphasized a number of points about "carry-homes" (i.e. take-away doses in OST programs), including the following:

- The determination of eligibility for take-away doses should be based on clinical factors and must not be applied in a way that discriminates on the basis of sex, criminal record, age, race or ethnicity, or any other such factor.[67]

Institute, p. 24–27.

[65] International Narcotics Control Board, *Report of the International Narcotics Control Board for 2003*, Vienna, 2004, para. 222.

[66] Canadian HIV AIDS Legal Network, *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/ AIDS — Module 2: Treatment for drug dependence*, 2006. Available via www.aidslaw.ca/modellaw.

[67] Health Canada suggests, "[p]rograms should balance the advantages of ensuring compliance and having regular contact with clients/patients with the need for flexible, client/patient-centred treatment that takes into account the realities of clients'/patients' lives." Research has shown that flexible take-home doses are an important factor in patient retention. See Health Canada. *Best practices: methadone maintenance treatment* p 44 and 58. 2002. Available via www.cds-sca.com. These requirements come from New Zealand Ministry of Health. *Opioid substitution treatment: New Zealand practice*

- The program should strive to allow take-away doses for patients who (1) have medical conditions or disabilities that limit their mobility, and (2) have to travel long distances or face other impediments to attending supervised consumption programs.[68]
- Program staff should give a clear explanation orally and in writing to patients on the use of take-away doses, and should ensure that copies are provided to the patient and the dispensing pharmacist.[69]

[E]very effort should be made to ensure that treatment facilities are in places where patients do not have to fear harassment or arrest by law enforcement authorities.

Another element of physical accessibility that may weigh on the minds of people who use drugs is whether treatment facilities are located in places that are under police surveillance or where police harassment is likely. While they are not a form of drug dependence treatment, the documented evidence with respect to sterile syringe programs is illustrative. Numerous studies and reports have identified police interaction with people who inject drugs as limiting the efficacy of sterile syringe programs and as creating an additional risk factor for HIV transmission.[70] To avoid undermining public health interventions, law enforcement agencies and syringe programs need to establish agreements between law enforcement officials and syringe program providers on policing practices in areas surrounding sterile-syringe program sites.[71]

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guidelines p. 27–28. February 2003. Available via www.moh.govt.nz. Regulations should specify how these requirements are to be judged. Examples of tools for assessment are listed in New Zealand Ministry of Health. *Opioid substitution treatment: New Zealand practice guidelines* p. 28. February 2003. Available via www.moh.govt.nz. See also "Carry Policy" guidelines in The College of Physicians of Ontario. *Methadone maintenance guidelines* p. 18–21. 2001. Available via www.cpso.on.ca.

[68] These guidelines come from The College of Physicians of Ontario. *Methadone maintenance guidelines*, p. 18–21. 2001. Available via www.cpso.on.ca.

[69] This requirement comes from New Zealand Ministry of Health. *Opioid substitution treatment: New Zealand practice guidelines*, p. 28. February 2003. Available via www.moh.govt.nz.

[70] S.R. Friedman et al., "Relationships of deterrence and law enforcement to drug related harms among drug injectors in U.S. metropolitan areas," *AIDS* 20(1) (2006): 93–99; R. Bluthenthal, et al., "Collateral damage in the war on drugs: HIV risk behaviours among injection drug users." See, also, L. Maher and D. Dixon, "Policing & public health: law enforcement in a street-level drug market," *British Journal of Criminology* 39(4) (1999): 488–512; L. Maher and D. Dixon, "The cost of crackdowns: Policing Cabramatta's Heroin Market," *Current Issues in Criminal Justice* 13(1) (2001): 5–22; T. Rhodes, L. Mikhailova, and A. Sarang, "Situational factors influencing drug injecting, risk reduction, and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment," *Social Science and Medicine* 57 (2003): 39–54; Human Rights Watch, *Abusing the User: Police Misconduct, Harm Reduction and HIV/AIDS in Vancouver,* 2003; Human Rights Watch, *Injecting Reason: Human Rights and HIV Prevention for Injection Drug Users (California),* 2005; International Harm Reduction Development Program, *Unintended Consequences: Drug Policies Fuel the HIV Epidemic in Russia and Ukraine,* 2003.

[71] Appropriate police liaisons and training are recommended by the UNAIDS, *Handbook for Legislators on HIV/AIDS, Law and Human Rights,* 1999, p. 54. See, also, Department of Health, Housing and Community Services (Australia), *The final report of the legal working party of the intergovernmental committee on AIDS,* 1992, Recommendation 8.4.

Similarly, every effort should be made to ensure that treatment facilities are in places where patients do not have to fear harassment or arrest by law enforcement authorities. Municipal statutes or policies — or regional or provincial statutes where they govern police actions — should protect clients of treatment facilities from any such abuse. In addition, service-providers should work with neighbourhood associations and other representatives of residents and business-owners in their localities to inform them of the importance of their service and of a non-hostile environment for people who seek treatment for drug dependence.

Affordability of drug dependence treatment

Affordability is another especially important aspect of access to dependence treatment, since drug use can often impoverish the user. Although there are few global or regional studies of affordability of drug treatment services, it is clear that in most countries there is a great divide between private services for those with money, and services (usually public) for others.[72] The guidelines developed with the support of WHO/Europe echo a key principle from UN documents:

> It must be possible to organise the financing of desired or suitable treatment within a useful period, and this should not represent a long-term burden for potential clients and their relatives. Each client has the right to receive health care on the basis of his/her clinical need, not his/her ability to pay. Financial consideration must not supersede expert criteria in the selection of a certain treatment.

One of the principal challenges to all countries in meeting this goal of affordable treatment is that there are not internationally agreed standards for what constitutes a core or minimum package of services to be provided by the public sector. Such standards are necessary to determine whether governments are fulfilling their responsibility to realize progressively the right to the highest attainable standard of health. They would also be indispensable for educating the tax-paying public about the costs and benefits of dependence treatment services, as well as for regulating health insurance providers. Private health insurance plans often do not provide coverage for drug dependence treatment, or, if they do, insurance policies may impose high payments, high deductibles and limitations to access.[73]

For both private and public health insurance, plans should be comprehensive — that is, they should cover the entire continuum of clinically effective and appropriate services provided by licensed professionals, and should provide coverage and funding identical to those benefits covering other physical illness.[74] The social and legal marginalization of people who use drugs, and the political unpopularity of services for them in many countries, make international standards all the more essential.

In summary, many countries maintain restrictions on access to drug dependence treatment, and cannot be said to be progressively realizing of the right of people who use drugs to the highest attainable standard of physical and mental health. OST, the best studied form of treatment for people who use opiates, is unavailable or insufficiently available in too many countries. In addition to countries such as Russia that ban opioid substitutes by law, others invest so little in OST that it is effectively unavailable. In the terms of General Comment 14, "[s]tate actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable

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[72] See, e.g., J.R.C. Wheeler and T.A. Nahra, "Private and public ownership in outpatient substance abuse treatment: Do we have a two-tiered system?" *Administration and Policy in Mental Health* 2000; 27(4):197–209.

[73] See [U.S.] National Mental Health Association, *Substance Abuse Insurance Parity: A guide for advocates*, Spring 2002, p. 1.

[74] See, for example, *An Act Relating to Health Insurance for Mental Health and Substance Abuse Disorders, Act No. 25 of 1997, Vermont (U.S.A.)*, s. (b).

mortality" are a violation of the obligation to respect the right to health. A legal prohibition on methadone and buprenorphine, classified by WHO as "essential drugs," is a clear example of such a violation. Similarly, the failure to provide sufficient OST to come anywhere remotely close to meeting demand is a clear violation of the obligation to fulfill the right to health.

Non-discrimination in treatment services, including attention to gender issues

As scarce as data are on the existence of drug treatment programs in some countries, data are even scarcer on the way in which these programs function. Discriminatory practices in the treatment of drug dependence are rarely discussed in the published literature. In its guidelines for evaluations of dependence treatment programs, WHO encourages service-providers to assess the ease with which "target groups" have access to the program. It lists "involvement with the justice system" as one of 20 characteristics that should be taken into account in evaluations of services.[75] It does not, however, give further guidance on addressing justice system "involvement" in treatment programs. The ethical guidelines for drug treatment drafted with the support of the WHO Regional Office for Europe in 2000 note as a "basic value" that services should be available to people who use drugs without discrimination on grounds of a criminal record, among other criteria.[76]

Given the harsh criminal environment in which people who use drugs live in many countries, it seems clear that making good on the obligation to non-discrimination requires serious attention to a number of key questions. For example:

- Does having a criminal record affect the availability of drug treatment services (as a matter of either perception or reality)?
- Do people who use drugs have grounds on which to fear that if they have a criminal record, they will receive harsher or in any way differential treatment compared to others, will be more likely to be reported to criminal authorities, or will be likely to be registered as having a criminal record or registered as a drug user for possible future prosecution?
- Are health workers asked to furnish information on the criminal records of their clients to law enforcement authorities, which compromises their integrity as health professionals?

Discrimination may also occur in treatment for addiction to one drug on the grounds of being found to be consuming another drug, as in OST programs that exclude people who are found to be using cannabis or cocaine. There is no scientific basis for such exclusion. Some studies have suggested that participation in OST can reduce consumption of cannabis and other drugs for some individuals and that OST can be a gateway to treatment for other addictions.[77] Some drug treatment programs, including OST programs, have also sought to exclude young people, again not on scientific grounds. The legal incapacity of young people to consent to medical procedures may pose a challenge in some jurisdictions. From the point of

[75] WHO, UNDCP, and EMCDDA. *International guidelines for the evaluation of treatment services and systems for psychoactive substance use disorders*. Geneva: WHO, 2000.

[76] L. Guggenbuhl et al. *Adequacy in Drug Abuse Treatment and Care in Europe (ADAT), Part I: Ethical aspects in the treatment and care of drug addicts – Country reports and ethical guidelines*. Zurich: Addiction Research Institute, 2000, p. 53.

[77] See, e.g., National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. Effective medical treatment of opiate addiction. *Journal of the American Medical Association* 1998; 280(22):1936–1943; and B.W. Fletcher and R.J. Battjes. Introduction to the special issue: treatment process in DATOS. *Drug and Alcohol Dependence* 1999; 57:81–87.

view of human rights law, however, states have an obligation to find ways to manage these problems since children and young people have the same human right as adults to services needed to achieve the highest attainable standard of health.[78] Exclusion on the grounds of positive HIV or hepatitis C status also has no basis in science and indeed is counterproductive from a public health point of view.

The perception on the part of people who use drugs of any of these forms of discrimination may discourage them from seeking services in the first place. Thus, the challenge of addressing non-discrimination in dependence treatment entails knowing who is excluded because of fear of discrimination or of being singled out as a criminal. People who use drugs may face multiple forms of discrimination — e.g., as members of racial, ethnic or sexual minorities,[79] as former prisoners, as people living in poverty, as people living without a stable home or family. Attention to all of these requires investment in establishing policies on non-discrimination that include training of health workers, informing people who use drugs of their right to treatment, monitoring discriminatory practices, and establishing accessible and effective mechanisms by which persons can seek redress in the case of discrimination.

In some countries, law or policy related to disabilities may be useful in this regard, particularly where the law prohibits discrimination specifically on the basis of a person's addiction. For example, Canada's federal human rights legislation prohibits discrimination on the basis of actual or perceived disability in "the provision of goods, services, facilities or accommodation customarily available to the general public", including health services.[80] The definition includes "any previous or existing mental or physical disability and includes . . . previous or existing dependence on alcohol or a drug." The Federal Court of Appeal in Canada has expressly confirmed that this provision should not be limited to dependence on a "legal" drug; therefore, dependence on illegal drugs also constitutes a disability under federal human rights legislation.[81] Courts in numerous Canadian provinces, and in Australia, have similarly held that drug dependence may constitute a disability for the purposes of anti-discrimination.[82]

[T]he challenge of addressing non-discrimination in dependence treatment entails knowing who is excluded because of fear of discrimination or of being singled out as a criminal.

[78] Convention on the Rights of the Child, United Nations General Assembly Resolution 44/25, November 20, 1989, art. 24.

[79] Evidence indicates homophobia contributes to higher rates of addiction by LGBT people, including among youth (both directly, and indirectly by forcing LGBT youth out of homes and families and onto streets) and homophobia can also be a barrier to health services, including addiction treatment. See, for example, National Association of Lesbian and Gay Addiction Professionals, "Alcohol, Tobacco and Other Drug Problems and Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals," July 2002. Available at http://www.nalgap.org/PDF/Resources/LGBT.pdf.

[80] See section 25 of the Canadian Human Rights Act. R.S. 1985, c H-6. The Federal Court of Appeal in Canada has expressly confirmed that this provision should not be limited to dependence on a "legal" drug; therefore, dependence on illegal drugs also constitutes a disability under federal human rights legislation. See *Canada (Human Rights Commission) v Toronto-Dominion Bank* , [1998] 4 FC 205 (CA). In addition, see *Entrop v Imperial Oil Ltd*, [1996] OHRBID No 30 (Ont Bd Inq) (QL) (alcoholism and substance abuse constitute handicap under Ontario statute), aff'd [1998] OJ No 422 (Div Ct) (QL), leave to appeal to Ont CA granted [1998] OJ No 1927, no Ont CA decision reported.

[81] See *Canada (Human Rights Commission*) *v Toronto-Dominion Bank* , [1998] 4 FC 205 (Federal Cour of Appeal).

[82] *Williams v. Elty Publications Ltd.*,(1992), 20 CHRR D/52 (B.C. Council on Human Rights); *Handfield v. North Thompson School District* (1995), 25 CHRR D/452, [1995] BCCHRD No 4 (QL) (BC Human Rights Tribunal); *Alberta (Human Rights Commission) v. Elizabeth Metis Settlement*, 2003 ABQB 342, [2003] AJ No 484 (QL) (Alberta Court of Queen's Bench); *Entrop* v. *Imperial Oil Ltd.*, (2000), 50 OR (3d) 18 (Ontario Court of Appeal); *Lapointe v. Doucet*,

[W]omen are underrepresented in dependence treatment programs in many countries.

Discrimination on other grounds may also inhibit accessibility of addiction treatment services, and particular attention to gender is needed in order to ensure equitable access for women. Discrimination on the basis of sex or gender is prohibited in many international human rights treaties and most countries' national laws. Sex discrimination is an important issue with respect to drug dependence treatment, as men's and women's clinical needs related to dependence may differ substantially. Women may become dependent on certain drugs more readily than men, and they may face a higher mortality risk from drug injection.[83] According to UNODC, women are underrepresented in dependence treatment programs in many countries. Women who use drugs are more likely than men to have a history of physical and sexual abuse and psychiatric disorders, including post-traumatic stress disorder.[84] In some countries, women who use drugs have been found to have little self-esteem and to be heavily influenced in their drug-using patterns by sexual partners or spouses.[85] Women may also avoid seeking drug dependence treatment for fear of losing custody of their children, rejection in the community, or reprisals or violence from their spouses or partners.[86]

Numerous studies have demonstrated that women, including pregnant women, can benefit greatly from drug dependence treatment. UNODC and other authorities recommend that governments give priority to admitting pregnant opiate users into substitution treatment, for example.[87] Experience and research show that, as with many health and social services, the effectiveness of dependence treatment for women is greatly enhanced by coupling it with child care, transportation assistance, social services and support (such as assistance with job and training opportunities, family therapy, and assistance with food, shelter and clothing).[88] UNODC concludes that programs that make any significant attempt to provide special services for women are associated with much better treatment outcomes for this population.[89] This includes involving women or women's groups in decision-making about program design and implementation.

Despite the evidence that drug treatment designed to meet the specific needs of women can improve the effectiveness of such treatment, such programs are rare. The EMCDDA has stated that in Europe, "coverage of gender-specific service provision appears to be low and is often limited to major urban

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[1999] JTDPQ No. 16 (Québec Human Rights Tribunal); *Carr v. Botany Bay Council & Anor* [2003] NSWADT 209 (New South Wales Administrative Appeals Tribunal); *Marsden* v. *Human Rights and Equal Opportunity Commission and Coffs Harbour & District Ex-Servicemen & Women's Memorial Club Ltd.*, [2000] FCA 1619 (Federal Court of Australia).

[83] UNODC. Substance abuse treatment and care for women (summary). Available at http://www.unodc.org/pdf/report_2004-08-30_1_summary.pdf.

[84] UNODC. Substance abuse treatment and care for women (long version), p.1.

[85] P. Zickler, "Childhood sex abuse increases risk of drug dependence in adult women." NIDA (National Institute on Drug Abuse) Notes 2002; 17(1). Available at http://www.nida.nih.gov/NIDA_Notes/NNVol17N1/Childhood.html.

[86] Ibid.

[87] UNODC, Substance abuse treatment and care for women (summary).

[88] NIDA, op. cit.

[89] UNODC, Substance abuse treatment and care for women (summary).

centres."[90] While a wide variety of women-friendly drug treatment services may not be possible for all countries in the immediate future, their progressive realization is an essential goal.

Acceptability: Scientific quality, ethics and cultural acceptability

With no widely accepted international standards and an apparent lack of national standards for dependence treatment in many countries, it is unsurprising that many forms of dependence treatment have flourished, even those that do not appear to be, in the terms of General Comment 14, "scientifically and medically appropriate." Indeed, reports from some countries point to drug dependence treatment that is cruel, inhuman or degrading and in some cases may amount to torture, violating one of the most fundamental human rights to freedom from such punishment or treatment.[91] It is worth noting here that the prohibition on torture and cruel, inhuman or degrading treatment or punishment is a fundamental and well-established precept of customary and conventional international law. The right to be protected from torture and cruel, inhuman or degrading treatment or punishment is non-derogable, meaning that it applies at all times, including during public emergencies.[92]

Some practices seem almost to be the stuff of science fiction. Emulating a procedure first established in Russia, Chinese doctors have offered drug dependence treatment in the form of surgically drilling into the head of patients, ostensibly to remove the part of the brain that governs addiction cravings. A British journalist witnessed one such operation in 2004 and interviewed another person who had survived the procedure.[93] He reported that two weeks after his visit, the Chinese Ministry of Health banned the procedure, but more recent reports indicate that it has been reinstituted.[94] A British medical doctor quoted in the earlier article, characterizing the procedure as "astonishing," noted: "There would be an outcry if you tried to do this in Britain."[95] According to one source, there have been more than 500 such operations in China.[96]

A more widespread practice in China (and commonly reported in other countries) is detention of people who use drugs during a period of forced detoxification, sometimes accompanied by "re-education" through forced labour. According to the WHO regional review of 2002, dependence treatment in China consisted by law of "compulsory detoxification institutions" run by the Ministry of Public Security, labour rehabilitation units run by departments of Justice, and detoxification institutions run by departments of Health.[97] The report notes: "According to the law, all drug abusers are forced to detoxify as soon as they are detected, and if they relapse after detoxification they will be sent for rehabilitation in labour camps."[98] In the WHO report, the relapse rate among those who had experienced detoxification centres of all kinds was reported to be 80 percent after two weeks and over 95 percent after six months,[99] signalling

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[90] See EMCDDA, *Annual Report 2006*, pp. 21–38.

[91] See Universal Declaration of Human Rights, art. 5; International Covenant on Civil and Political Rights, art. 7; Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984), art 16.

[92] Article 4(2) of the ICCPR.

[93] D. Adam. "Open your mind." *The Guardian*, 12 November 2004, p. 1 ff.

[94] P. Goff. "China resumes 'hole in head' surgery for addicts." *Vancouver Sun*, 20 November 2005, p. B12.

[95] Adam, op. cit.

[96] Goff, op. cit.

[97] WHO, Opioid dependence in SE Asia and Western Pacific, p. 30.

[98] Ibid.

[99] Ibid.

the dismal ineffectiveness of such "treatment." The use of forced (and unpaid) labour as a method of "rehabilitation" also raises the question of whether this method constitutes a form of slavery.

Human Rights Watch documented some effects of these policies in China in 2003, noting that "re-education" in this case included being required to shout slogans such as "drug use is bad" and "I am bad," as well as forced labour that was in many cases hazardous and always unpaid.[100] Interviewees in one compulsory detoxification centre said the only medication patients received in these periods of detention was an herbal mixture formulated at the centre itself. Observers who had visited many such centres said they were often lacking in sanitation facilities and overcrowded, particularly during festivals or other public events when police would clear the streets of "undesirable" persons.[101] Human Rights Watch's report notes that in some cases, people who use drugs could avoid this "treatment" if they could pay for voluntary dependence treatment in which conditions were generally much better.[102]

[R]eports from some countries point to drug dependence treatment that is cruel, inhuman or degrading and in some cases may amount to torture . . .

Reports from Thailand echo some of what has been documented in China. Investigating extrajudicial killings and other heinous abuses by the state during Thailand's 2003 "war on drugs," Human Rights Watch interviewed people who use drugs on their experiences of dependence treatment. In the heart of the 2003 crackdown, the government aimed to enrol some 300 000 methamphetamine users into drug rehabilitation programs. The violence of the war on drugs drew some people who use drugs into state-run rehabilitation centres simply because they feared they would be arrested or killed if they did not enrol.[103] In many cases, according to Human Rights Watch, people were forced to stay in these centres for long periods against their will. The rehabilitation in this case often consisted of military-style drills in a "boot camp" after which some patients would be declared "drug-free."

The end of the most violent phase of the Thai war on drugs has apparently not meant an end to abusive drug treatment practices. A media report from January 2006 recounted a drug "treatment" facility in Thailand's Mayo district, where "patients" were shackled to prevent their escape and the only medication used was a local herbal treatment not approved by the Ministry of Health.[104] The director of the facility in this case was quoted as saying: "People criticize us for chaining them, but it's our rule to confine them for three to six months depending on the severity of their condition."

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[100] Human Rights Watch. *Locked doors: The human rights of people living with HIV/AIDS in China*. New York: Human Rights Watch, Sept. 2003, pp. 46–48.

[101] Ibid., p. 45.

[102] Ibid.

[103] Human Rights Watch. *Not enough graves*, pp.32–33.

[104] W. Nanuam. "Unshackling the drug habit." *Bangkok Post*, 12 January 2006, p. 1 ff.

An estimated 2000 persons had been detained at this centre.[105] Experts from India have reported the practice in some Indian jurisdictions of enclosing patients in thorn-lined cages or shaving off half their hair so that they will be recognized as "drug offenders," as well as chaining people to beds in the name of treatment.[106]

Drug dependence treatment that is in any way compulsory must be regarded as potentially abusive of human rights and should be a measure of last resort, as well as requiring justification according to established principles for assessing permissible derogations of human rights.[107] As noted above, the right to be protected from torture, or cruel, inhuman or degrading treatment or punishment is non-derogable**.** At the very least, the justification for compulsory measures must be transparent and explained to the patient, and subject to a review, in accordance with human rights norms, by a competent, independent and impartial tribunal established by law.[108] The WHO-commissioned guidelines for drug treatment in Europe recommend that any compulsory element of treatment must be "clearly regulated in legal terms and its effectiveness evaluated. Compulsory treatment must be oriented towards the principle of facilitating the drug abuser's self-determination and towards the goal of social reintegration."[109] The authors of these guidelines note that voluntary treatment should always be attempted first, especially in the case of patients who are incarcerated. These principles should apply whether treatment services are run by health authorities or by the criminal justice system.

The 1991 General Assembly resolution on protecting the rights of persons with mental illness in health care provides some clear principles on coercive and potentially inhuman methods that could be applied to the treatment of drug addiction.[110] According to this resolution, a person's right to informed consent to undergo any medical procedure can be limited only after "a fair hearing by an independent and impartial tribunal established by domestic law."[111] In such a case, the person is entitled to be represented by counsel, and counsel should be provided by the state if the person cannot afford it. The resolution also contains the following pertinent elements:

- Everyone has the right "to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs…. [112]
- Physical restraint or involuntary seclusion of a patient "shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose….A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members

[105] Ibid.

[106] J Dorabjee. In the name of treatment – insights from India. Presentation at the 18th International Conference on the Reduction of Drug-related Harm (session C4-3), Warsaw, 15 May 2007.

[107] E.g., UN Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights*, UN Doc. E/CN.4/1985/4, Annex (1985).

[108] ICCPR, Article 14.

[109] Guggenbuhl et al., p. 55.

[110] United Nations General Assembly. Principles for the protection of persons with mental illness and the improvement of mental health care (resolution). UN doc. no. A/RES/46/119 17 December 1991.

[111] Ibid. at principle 1, para 6.

[112] Ibid. at principle 9, para 1.

of the staff."[113]

- "Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient" and must only be carried out where the patient has given informed consent "and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient."[114]
- "In no circumstances shall a patient be subject to forced labour."[115]
- A person may be admitted involuntarily to a health facility only in cases where there is "a serious likelihood of immediate or imminent harm to that person or to other persons" and when a person is deemed to have "impaired judgement" that would prevent the administration of treatment "that can only be given by admission to a mental health facility in accordance with the principle of the least restrctive alternative.[116]

The General Assembly resolution goes on to say that these principles should apply to "criminal offenders" as well as to other patients. While mental illness and drug addiction are far from the same thing, the main points of this resolution are directly relevant to treatment of drug dependence and should be consulted as international standards for drug dependence are developed.

Even in programs that are voluntary and appear to be based on scientifically sound practices, inhumane treatment may easily find its way into protocols. Both duration of treatment and dosage of opioid substitutes are important to the quality of OST, and both are sometimes limited in national protocols in arbitrary and scientifically unsound ways.[117] In their position paper on opioid substitution therapy, WHO, UNODC and UNAIDS state that an adequately high dose of methadone is an important determinant of the effectiveness of OST: "In programmes that use higher doses of methadone, a majority of patients are retained in treatment for at least 12 months."[118] The ideal dose is one that results in the absence of cravings without creating the ups and downs of euphoria and sedation.[119] It is generally impossible to determine the ideal dose without thorough and unthreatening consultation with the patient. According to a Health Canada document establishing "best practice" in methadone maintenance:

> Given that individuals vary in how they respond to doses of methadone, programs should have a flexible, individualized policy on dosage. Each individual needs to be carefully assessed by a clinician who is experienced with treating opioid dependence, and the initial dose should be assessed on an individualized basis. Client/patient input should be taken into account in determining the dosage.[120]

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[113] Ibid. at principle 11, para 11.

[114] Ibid. at principle 11, para 14.

[115] Ibid. at principle 13, para 3.

[116] Ibid. at principle 16, para 1.

[117] Methadone in Thailand, for example, remains limited to 90-day or 45-day "weaning" programs, and dosages are thought to be inadequate. See P. Kahn., *AIDS vaccine handbook,* op. cit., p. 192.

[118] WHO/UNODC/UNAIDS, op. cit., p. 20.

[119] H. Catania. *About methadone (2nd edition).* New York: Drug Policy Alliance, 2003, p. 10.

[120] Health Canada. *Best practices: methadone maintenance treatment,* 2002, p. 42. At www.hc-sc.gc.ca/ahc-asc/alt_formats/hecs-sesc/pdf/pubs/drugs-drogues/methadone-bp-mp/methadone-bp-mp_e.pdf; See also See S Maxwell and M Shinderman. Optimizing response to methadone maintenance treatment: use of higher-dose

Clinical research has indicated that when consulted respectfully, OST patients do not necessarily tend to seek higher or more intoxicating doses but reliably seek to consume stabilizing levels of opioid substitutes.[121] Nonetheless, some practitioners have used reduction of methadone doses as a means of punishment for non-compliance with the regimen or violation of other rules.[122] Instituting a health service on punitive grounds in this way is contrary to basic principles of both human rights and medical ethics. This practice, as one expert has noted, would be akin to taking away the insulin of diabetes patients who fail to control their blood sugar levels.[123]

[R]eduction of methadone doses as a means of punishment . . . is contrary to basic principles of both human rights and medical ethics.

In some countries, OST is used only for short-term detoxification. The 2004 statement by WHO, UNODC and UNAIDS emphasizes that adequate duration of treatment is "critical for treatment effectiveness":

> The appropriate duration of treatment for an individual depends on their problems and needs, but research indicates that for most people with drug dependence, the threshold of significant improvement is reached after about three months in treatment, with further gains as treatment is continued. . . . [P]remature departure is associated with high rates of relapse to drug use. . . . Many patients need several years in treatment.[124]

As with adjustment of dosages, curtailing the duration of treatment is a decision that should be taken in consultation with the patient, and it should never be used as punishment.[125] OST patients have a right to remain in treatment as long as the program is useful for them. As a review by Health Canada asserts: "For most people who are opioid-dependent, limiting the duration of treatment — either for financial reasons or because of program philosophy — results in serious negative consequences."[126]

The use of OST for short-term detoxification as opposed to maintenance treatment has been claimed in one legal case as a violation of the right to adequate medical care. In May 2006, some 200 prisoners and ex-prisoners who had been detained at prisons throughout England and Wales brought a group action against the United Kingdom's Home Office (which is responsible for HM Prison Service). All had drug dependence at the time of their imprisonment, mainly to heroin or other opiate drugs. When they entered prison, the maintenance treatment they had been receiving in the community was stopped and/or they were prescribed insufficient medication to treat their drug dependency. Each of the claimants suffered

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methadone. *Journal of Psychoactive Drugs* 1999; 31:95–102 at p. 99.

[121] E. Robles et al., Implementation of a clinic policy of client-regulated methadone dosing. *Journal of Substance Abuse Treatment* 2001; 20: 225–30 at 226: "[n]ot one patient continued to ask for increases in methadone after reaching clinical stabilization." See also S. Maxwell and M. Shinderman. Optimizing response to methadone maintenance treatment: use of higher-dose methadone. *Journal of Psychoactive Drugs* 1999; 31: 95–102 at 98.

[122] For example, one of us (JC) was a speaker in a course on methadone maintenance for physicians in eastern and central Europe in the Salzburg Medical Seminars series in 2003. A doctor from Serbia at this seminar described a regular system of reducing the dosages of methadone patients who missed sessions, were late to sessions, or otherwise did not obey the rules of the program.

[123] R. Newman (director, International Center for Advancement of Addiction Treatment), personal communication.

[124] WHO, UNODC, UNAIDS, op. cit., p. 9.

[125] S. Maxwell and M. Shinderman. Optimizing response to methadone maintenance treatment: use of higher-dose methadone. *Journal of Psychoactive Drugs* 1999; 31: 95–102 at 97.

[126] Health Canada. *Literature review: methadone maintenance treatment.* Ottawa, 2002, p. 37.

unpleasant and painful withdrawal symptoms.[127] Essentially, the claims were of medical negligence against the Home Office, alleging that the Prison Service failed to provide the minimum standard of treatment deemed reasonable to treat people with drug dependence. Claims were also brought under three articles of the U.K.'s *Human Rights Act* (1998).[128] The crime of assault was also alleged, since treatment was imposed without consent. The Home Office settled the claims out of court in November 2006 with payments to the claimants reportedly totalling £750,000.[129]

As noted above, international human rights law has strong prohibitions against torture and cruel, inhuman or degrading treatment or punishment in any context. While the definition of torture is well established, what constitutes cruel, inhuman or degrading treatment is not clearly laid out by international law.

In one notable case, the European Court of Human Rights held in 2003 that the failure of prison health facilities to provide adequate medical care to a prisoner undergoing heroin withdrawal, who subsequently died, constituted inhuman or degrading treatment in violation of article 3 of the European Convention on Human Rights.[130] Judith McGlinchey had been sentenced to four months in prison in the United Kingdom in 1998 for theft. Upon admission, she complained of heroin withdrawal symptoms and was vomiting heavily. About three weeks later, she was transferred to hospital after collapsing; she died a few days later. The Court deemed that the argument that McGlinchey was denied medication for heroin withdrawal as a form of punishment was unsubstantiated. However, it found that her suffering derived not from heroin withdrawal but "the failure of prison authorities to take more effective steps to combat her withdrawal symptoms and [that her] deteriorating condition must have contributed to her pain and distress." In particular, the Court found that better monitoring of her condition would have enabled earlier admission to hospital or more expert assistance to control her vomiting. Consequently, the Court found that the U.K. was responsible for inhuman or degrading treatment suffered by McGlinchey and ordered the British government to pay damages to her estate.

Treatment for drug dependence that entails compulsory detention . . . should be judged by human rights standards that apply to situations of detention.

Drug dependence treatment programs may have other rules that are unnecessarily punitive or otherwise cruel and degrading. Many programs, for example, require periodic screening of patients' urine. Urine tests should be conducted only as necessary to guide treatment and should never be used for punitive purposes[131] or to remove the individual from treatment. In addition, some programs require that a staff member observe the passage of urine for drug testing. Ward and colleagues, in their widely cited volume on methadone maintenance, recommend that the clinical advantages of urine testing be weighed against its unreliability as an indicator of current drug use, its cost, the humiliation patients undergo, and the atmosphere of distrust it may engender. Their 1998 review of available clinical evidence led them to conclude that urine testing is not an effective deterrent to drug

[127] See M. Scott, "Opiate Dependent Prisoner Litigation," Inside Time (via www.insidetime.org)

[128] Article 3 establishes "No one shall be subjected to torture or to inhuman or degrading treatment or punishment"; Article 8(1) establishes "Everyone has the right to respect for his private and family life, his home and his correspondence"; Article 14 establishes The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

[129] BBC news, "'Cold turkey' pay out of £750 000", November 14, 2006.

[130] Case of *McGlinchey and Others v The United Kingdom*, European Court of Human Rights, Application no 50390/99. Final Judgment, 29 April 2003.

[131] College of Physicians of Ontario (Canada). *Methadone maintenance guidelines*, 2001, p. 15.

use.[132] Some jurisdictions have established policies indicating that in these cases there should be a private place for taking urine samples and only staff of the same sex as the client should observe the taking of samples.[133]

Treatment for drug dependence that entails compulsory detention, which should be a measure of last resort, should be judged by human rights standards that apply to situations of detention. Patients in these services are, like prisoners and other detainees, completely dependent on the state (or other state-authorized provider of the service) for the satisfaction of their basic needs. The UN Standard Minimum Rules for the Treatment of Prisoners of 1957 state basic principles such as the need for valid commitment orders for each person detained and the obligation of the state to provide adequate food, shelter, sanitation, light, bedding, opportunity for exercise and sport, as well as medical care.[134]

There is an urgent need for WHO to develop standards for medical treatment that involves voluntary and involuntary detention. In so doing, WHO should consider the distinction drawn in the Minimum Rules between the rights and conditions of those in pre-trial detention, and rules for persons convicted of crimes. These norms specify that pre-trial detainees must not be required to work, should have easier means of communication with their families than convicted prisoners, may have their food procured at their own expense from outside the institution, may wear their own clothing rather than prison uniforms, and should be kept separate from convicted prisoners. The situation of persons detained in dependence treatment for reasons of treatment protocols, and not for reasons of having been convicted of a crime, is analogous to the situation of pre-trial detainees, rather than that of convicted persons. This would mean, among other things, that forced labour should be prohibited as a method of drug dependence treatment.

Consent and participation in decision-making

The human right to informed consent to medical procedures and the ethical requirement to secure informed consent are well established. The right to freedom from medical intervention with informed consent derives from the right to security of the person — that is, to have control over what happens to one's body[135] — and the right to full information about health and health procedures they may undergo.[136] According to international legal documents, informed consent requires that a person know and fully understand:

- the diagnostic assessment;

[132] J. Ward et al., The use of urinalysis during opioid replacement therapy. In J. Ward, R.P. Mattick and W. Hall, eds. *Methadone maintenance treatment and other opioid replacement therapies.* Amsterdam: Harwood Academic Publishers, 1998, pp. 242–243, 251.

[133] New Zealand Ministry of Health. *Opioid substitution treatment: New Zealand practice guidelines*, 2003, p. 31.

[134] United Nations Economic and Social Council. Standard Minimum Rules for the Treatment of Prisoners. ECOSOC Res. 663C, 1957.

[135] ICCPR, article 9. See one interpretation of "bodily security" as a foundational principle of informed consent at Canadian HIV/AIDS Legal Network, HIV Testing: Info Sheet 5 — Consent, available at www.aidslaw.ca/testing.

[136] General Comment no. 14, para. 34.

- the purpose, method, likely duration and expected benefit of the proposed treatment;
- alternative modes of treatment, including those less intrusive; and
- possible pain and discomfort, risks and side-effects of the proposed treatment.[137]

According to the guidelines on ethics of drug dependence treatment developed with WHO/Europe support, patients should be able to choose among the services available to them, but the patient's choice "should not run counter . . . to professionally sound indications."[138] The Italian government's drug treatment guidelines recommend "informed consensus" between the service provider and the patient.[139] Both these guidelines illustrate a central challenge of dependence treatment — that the patient may be perceived by the service-provider, rightly or wrongly, to be incompetent to make treatment decisions on his or her own behalf. (The same challenge presents itself in treatment of many mental disorders other than drug dependence, on which large bodies of research exist. Legal frameworks developed for those contexts may be of assistance in the context of addiction treatment.)

Human rights norms are no panacea for this challenge. They do, however, suggest that it is necessary at a minimum to

- respect patients' personal autonomy, right to information (including the information necessary to make a fully informed decision about the treatment, as well as information concerning the patient in his or her health records), and right to participate in decision-making about their care as they are able; and
- have in place transparent and fair procedures that allow for others to assist in their decision-making when they are unable, as well as measures for redress for human rights abuses.

The guidelines commissioned by WHO/Europe recommend that if a procedure is needed and the patient or his legal representative is unable to give informed consent, "appropriate measures should be taken to provide for a substitute decision-making process, taking into account what is known and, to the greatest extent possible, what may be presumed about the wishes of the patient."[140] The German national guidelines for treatment of drug dependence emphasize the importance of establishing with patients, at times when they are capable, a procedure for emergency measures to be taken without the patient's consent, if needed.[141]

In treatment of drug dependence, an essential principle is the patient's right to withdraw from treatment. This right may again be challenging to service providers if the patient chooses to withdraw at a time or in a way that is clinically counter-indicated. While there are no perfect solutions, treating patients with respect and providing them with information are more likely to yield sound decision-making on their part. As the German national guidelines suggest, a patient's right "to a relationship based on mutual trust, to be considered as an individual, and to absolutely confidentiality" is a minimum requirement for program

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[137] These criteria are taken from *Principles for the protection of persons with mental illness and the improvement of mental health care*, UN General Assembly, Res 46/119, December 17, 1981, Principle 11 (2).

[138] Guggenbuhl et al., p. 55.

[139] Ibid., p. 89.

[140] Ibid., p.74.

[141] Ibid., p.85.

effectiveness.[142]

Drug treatment courts

The involvement of the criminal law system in drug treatment decisions opens a dangerous door to seeing drug dependence treatment as part of punishment for a crime.

General Comment 14 asserts that the onus is on governments to provide transparent public justification for any denial of basic health services in the name of national security or public order. The establishment of health services under the aegis of security or law enforcement officials should similarly require careful and transparent decision-making and public justification by national governments. It should be a priority for WHO and UNODC to develop guidance to national governments for determining the role of criminal or drug control authorities in the provision of the medical service of dependence treatment. Any decision-making about drug dependence treatment that is directed or influenced by non-medical authorities should be subjected to close international and national scrutiny, including by both health authorities and human rights monitors.

One particular way in which the criminal law system is involved in the drug dependence treatment is the recent phenomenon of drug treatment courts. Drug treatment courts were first developed in the early 1990s in the United States and have also been implemented in Canada, Australia and the U.K. While there is a wide variety of models for drug treatment courts, the defining characteristic is court-imposed drug treatment as a part of sentencing.[143] There are a number of human rights concerns that have yet to be fully evaluated in the context of drug treatment courts, including the following:

- Drug treatment courts employ the weight of the criminal justice system to order people who use drugs to undergo treatment. The fact that participants enter treatment under the threat of incarceration, or abstain from drugs to avoid sanctions, has serious implications for the right to bodily integrity, the right to privacy and the right to equality.[144] The extent to which people can give their free and informed consent to such treatment is open to doubt.
- In most cases, drug treatment programs make no provision for reduced or moderated drug use as an end goal for treatment but rather aim exclusively for abstinence; any substance use can lead to termination of treatment and subsequent incarceration.[145]
- The U.S. and Australian drug court models confer broad authority upon judges to penalize drug offenders for breaching treatment conditions, which could result in

[142] Ibid., p.84.

[143] L. Harrison and F. Scarpitti. Progress and Issues in Drug Treatment Courts. *Substance Use and Misuse*. 2002, 37; 12, 13: 1441–1467.

[144] See Canadian HIV AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and ethical issues*. 1999, p A28; B Fischer et al., "Compulsory drug treatment in Canada: Historical origins and recent developments," *European Addiction Research* (2002); 8: 61–68.

[145] Canadian Centre on Substance Abuse, *Drug Treatment Courts FAQS*, 2007, p. 8.

incarceration. Thus, "drug court participants who fail to remain drug-free (which is not uncommon among drug-addicted individuals) may be incarcerated on the original charge without trial."[146] This practice violates basic human rights recognized in international law.[147] There is also the fear that in some cases, the drug court participant may not have gone to jail if he or she had been prosecuted through the regular system, given that many first-time and lesser offenders can be given non-custodial sentences.[148] Furthermore, drug courts ccasionally impose a greater sentence on the offender than the regular sentence would have imposed, leading to violations of due process.[149]

- A person accused of drug offences may enter treatment programs simply to avoid incarceration. (This could include some persons who are not drug-dependent, raising questions about the ethics of treatment that is not medically indicated.) In such circumstances, the decision by the accused to undergo treatment may not represent a genuine choice made with fully informed consent. Evidence has demonstrated that persons entering drug treatment programs without informed, voluntary consent may not benefit from the program and may be less likely to succeed, leaving them vulnerable to custodial penalties.[150] As the freedom of choice between incarceration and drug treatment may be elusive, the possibility of entering a treatment program under the threat of incarceration may also violate the right to security of the person.[151]

[P]roviders of drug dependence treatment should strive to involve organizations of people who use or have used drugs in planning, implementation and evaluation of these services.

[146] King County Bar Association Drug Policy Project. *Report of the Task Force on the Use of Criminal Sanctions*., p 41.

[147] Article 14(1) of the ICCPR states "...In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law..." . See also European Convention on Human Rights, Article 6.

[148] Smoyer et al. *Drug Policy: Definition, Discussion & State Variation*. Yale University Center for Interdisciplinary Research on AIDS Policy Update, 2004, p 8; S. Tremblay, "Illicit drugs and crime in Canada," *Juristat* 19 (1999) 1–14.

[149] T. Makkai. Drugs Courts: Issues and Prospects. *Australian Institute of Criminology: Trends and Issues in Crime and Criminal Justice* 95, September 1998, p. 7. See also Smoyer et al., p. 8.

[150] See D. James and E. Sawka, "Drug treatment courts: substance abuse intervention within the justice system", *Isuma* 2002; 3(1). See also C. Kirkby, "Drug treatment courts in Canada: who benefits?", in John Howard Society, *Perspectives on Canadian Drug Policy* 2004; 2: 63.

[151] Article 9.1 of the ICCPR and Article 5.1 of the *European Convention on Human Rights and Fundamental Freedoms* guarantee security of the person.

Greater involvement of people who use drugs

As part of respecting, protecting and fulfilling the right of people to participate in health decision-making that affects them, providers of drug dependence treatment should strive to involve organizations of people who use or have used drugs in planning, implementation and evaluation of these services. Greater involvement of people who use drugs is a specific expression of the right to participation exemplified by the right to "take part in the conduct of public affairs" and the right to "take part in cultural life."[152] Greater involvement of people vulnerable to HIV/AIDS in program and policy decision-making affecting them is a principle articulated in the Declaration of Commitment on HIV/AIDS approved unanimously by the UN General Assembly in 2001.[153] All member states have to report periodically on their implementation of the Declaration. This principle of greater involvement is also consistent with the UN International Guidelines on HIV/AIDS and Human Rights.[154] UNAIDS publications note that the participation of people living with and vulnerable to HIV/AIDS in program decision-making is a matter not just of human rights and ethics but of "best practice" for effective programs.[155]

At the community level, meaningful involvement sends a signal that people who use drugs have rights and can be effectively involved in the delivery of health care services and human rights advocacy.[156] While not directly a form of drug dependence treatment, various peer-driven interventions and drug users organizations have developed throughout the world with the goal of reducing drug-related harms.[157] Such initiatives have been particularly effective in expanding the reach and effectiveness of sterile syringe programs, educational and outreach programs.[158] In many settings, peer driven interventions have also focused on overdose prevention.[159]

Not all countries have welcomed or allowed the meaningful participation of people who use drugs in programs that affect them. For example, in 2004, the head of the Russian federal narcotics police issued a directive indicating that people who use or had used drugs should not be employees or volunteers in syringe exchange programs.[160] Had this directive been followed, it would have disabled the many programs in Russia where peer-based counselling and support were part of syringe exchange. In countries where drug dependence treatment is highly medicalized and hospital-based or where treatment

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[152] ICCPR, art. 25; ICESCR, art. 15.

[153] UN General Assembly. Declaration of Commitment on HIV/AIDS. UN doc. A/RES/S-26/2, 2 August 2001, para. 33.

[154] UNAIDS and Office of the UN High Commissioner for Human Rights. *HIV/AIDS and Human Rights: International Guidelines*. UN doc. HR/PUB/98/1, para. 24.

[155] See, for example, UNAIDS, *From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA)*, UNAIDS/99.43E, 1999.

[156] The Australian Injecting & Illicit Drug Users' League, *Policy Position: Drug User Organizations*; [UK] National Treatment Agency, *A Guide to Involving and Empowering Drug User*, s. 4.10; T. Kerr et al, *Responding to an Emergency: Education, Advocacy and Community Care by a Peer-Driven Organization of Drug Users — A Case Study of Vancouver Area Network of Drug Users (VANDU)*, Health Canada, 2001.

[157] R.S. Broadhead, D.D. Heckathorn et al., "Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention." *Public Health Reports* 1998; 113 Suppl 1: 42–57.

[158] J.P. Grund, P. Blanken et al. "Reaching the unreached: targeting hidden IDU populations with clean needles via known user groups," *Journal of Psychoactive Drugs* 1992; 24(1): 41–7.

[159] T. Kerr, W. Small et al. "Harm reduction by a 'user-run' organization: A case study of the Vancouver Area Network of Drug Users," *Intermantional Journal of Drug Policy* 2006; 17: 61–69.

[160] Human Rights Watch. *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation*. New York, 2004, p. 21.

is compulsory or managed by the criminal justice system, the value of peer-assisted programs is unlikely to be appreciated.

Confidentiality of health information

The requirement of confidentiality respects the right to privacy articulated under several international instruments.[161] As well, many countries and institutions, such as hospitals, have legislation or guidelines concerning patients' rights, including the right to confidentiality.[162] This protection is important in the context of drug dependence treatment because people may be discouraged from seeking assessment or treatment, disclosing accurate information, or participating in research for fear that information about their health status may be released. In particular, they may fear that information regarding their drug dependence may be passed on to police.

For people who use drugs, treatment for drug dependence is an essential element of the right to health.

In countries as diverse as the United States, Kazakhstan, Thailand, Russia, Canada and Bangladesh, Human Rights Watch has documented the fears of people who use drugs that they would be targeted for police harassment or arrest by using syringe exchange or drug treatment services.[163] It is difficult to find research on the sharing of data on people who use drugs with the police by health services, but it clear that this practice is feared by people who use drugs in many countries.

There is an urgent need for standards of and enforceable commitments to medical confidentiality with respect to people who use drugs, including those who have been charged with criminal acts. Information regarding a person's health status should be made available to that person and, beyond him or her, only to those for whom knowledge of the person's status is absolutely necessary, such as a health practitioner where that information is relevant to the treatment being sought from that practitioner.[164] The Pan American Health Organization standards on drug dependence treatment for the Americas region suggests that treatment programs should be judged by whether they have strict protections of the confidentiality of medical records, as well as protections for patients of any photographic images or recordings that may have been taken of them for research or training purposes.[165]

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[161] See, for instance, Article 12 of the *Universal Declaration of Human Rights*; Article 8(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms*; Article 17(1) of the ICCPR.

[162] See, for example, WHO Europe, *A Declaration on the Promotion of Patients' Rights in Europe*, p. 12; *Israel Patient's Rights Act 1996*, art. 19, 20 (at http://waml.haifa.ac.il/index/reference/legislation/israel/israel1.htm).

[163] See Human Rights Watch, *Fanning the flames — how human rights abuses are fueling the AIDS epidemic in Kazakhstan* (New York, 2003), pp. 32–33; Human Rights Watch, *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS* (New York, 2006), pp. 34–38; Human Rights Watch, *Injecting reason: Human rights and HIV prevention for injection drug users* (New York, 2003), pp. 20–24; Human Rights Watch. *Lessons not learned* (Russia report), pp. 33–35; Human Rights Watch. *Not enough graves: The war on drugs, HIV/AIDS, and violations of human rights* (New York, 2004), pp. 40–41.

[164] In *Smith v. Jones* ([1999] 1 S.C.R. 455) at para. 74 et seq., the Supreme Court of Canada considered situations in which release of confidential health information to parties other than immediately concerned health-care professionals may be justified. Confidentiality may be breached when there exists a clear risk to an identifiable person or group of persons; the risk is that serious bodily harm or death may occur; the danger is imminent; *and* the proposed disclosure will minimally impair the right to privacy of the person involved.

[165] PAHO/WHO and Inter-American Drug Abuse Control Commission, op. cit., pp. 59–60.

Conclusion and recommendations

For people who use drugs, treatment for drug dependence is an essential element of the right to health. Though treatment may not always be 100 percent effective, an extensive body of research and practice demonstrates that it can dramatically improve the mental and physical health of those who seek it. Treatment services, to be effective, should be available without delay when people who use drugs seek them. They should be varied and should allow clients the opportunity to choose among several approaches. They should be humane and ethical; coercion of any kind should be used only as a measure of last resort, and only subject to transparent justification, before a competent, independent and impartial tribunal, according to established standards regarding limitations on human rights. "Treatment" that amounts to torture or to other cruel, inhuman or degrading treatment is never permissible under international law.

Faced with this health service challenge, many countries are plainly not meeting their obligations toward progressive realization of the right to this essential service. Proven treatments that can be provided even in resource-poor settings and that are judged by international agencies to be essential health services, such as opioid substitution therapy, remain unavailable to millions who need them — and in some cases even outlawed, contrary to scientific evidence of best practice and the advice of international agencies with health expertise. In addition, in some countries, especially where drug offences are highly criminalized, addiction services are managed by the criminal justice system, and they may be premised on punitive goals or on limiting rather than respecting the human rights of people who use drugs. Even in services run by health ministries or authorities, elements of coercion are too often found in many forms of dependence treatment. Services that are compulsory or otherwise inhumane are not adequately monitored by health authorities, and means to redress abuses are non-existent in many places.

There is an urgent need for action at international and national levels to create a policy environment in which basic health services for people who use drugs will be valued, funded, and implemented in human rights-centred ways.

It is clear that social attitudes toward, and criminalization of, people who use drugs have influenced the practice and policy of drug dependence treatment. If governments failed to provide basic health services for a population in the social mainstream to the degree that they do for people who use drugs, there would be both a public outcry and action on the part of international health bodies. But for drug dependence treatment, there is no such outcry, and there are no international standards on which to rely. The already precarious human rights situation of people who use drugs is compounded by the inability of many of them to receive humane, effective, timely and affordable care.

It took over 20 years for the world to recognize the right of people living with HIV/AIDS to treatment for their disease, and even so, millions of people continue to die for lack of it. Drug addiction has been in the world much longer than HIV/AIDS. It is high time that it become a national and international public health and human rights priority. There is an urgent need for action at international and national levels to create a policy environment in which basic health services for people who use drugs will be valued, funded, and implemented in human rights-centred ways. The first steps should include the following:

- In consultation with recognized experts in the fields of health and human rights, the World Health Organization should develop human rights-based standards of drug dependence treatment. (These would complement WHO's existing guide to

evaluating drug treatment programs which, while helpful, does not constitute program guidance.) At a minimum, WHO should identify methods that should not be used and articulate useful parameters within which practices could evolve. It should pay particular attention to standards related to compulsory elements of treatment, including compulsory detention for the purposes of treatment, noting the principles of the 1991 UN General Assembly resolution 46/119 on protection of the rights of persons undergoing treatment for mental illness. WHO's new standards should be proposed to the WHO governing board as policy. In developing these standards, WHO should consider human rights-related questions such as those raised in this paper, which are summarized in Appendix 1, and the goal of protecting, respecting and fulfilling the human rights of people in drug treatment. An indicative list of key rights of people who use drugs in dependence treatment services is found in Appendix 2.

- WHO and the UN Office on Drugs and Crime (UNODC) should establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms. At a minimum, all national governments should be required to report on some basic indicators having to do with availability of timely and varied services, protection from discrimination, and justifications for and nature of compulsory treatment, and efforts to find alternatives to compulsory treatment. Relevant UN agencies, including the office of the High Commissioner on Human Rights, should put pressure on countries where abuses are committed in the name of treating drug dependence to cease such practices immediately. WHO and UNODC should work with bilateral donors and multilateral donors such as the Global Fund to fight HIV/ AIDS, Malaria and Tuberculosis to ensure adequate resource allocation to enable the development of a reporting system.

- WHO should make a particular effort using its existing Essential Drugs and Medicines Policy program to monitor national responses to its directive on methadone and buprenorphine as essential drugs. Moreover, WHO should urge the International Narcotics Control Board, a UN-supported body of ostensibly independent experts that monitors medical use of methadone, to improve its monitoring of opioid substitutes needed for OST, especially in AIDS-affected countries.[166]

- WHO and UNODC should commission a major global review of national practices and standards in drug dependence treatment, with particular attention to practices in services run by criminal law authorities and to compulsory practices. A human rights analysis should be included and should be presented formally to the UN High Commissioner on Human Rights, the new UN Human Rights Council, various of the expert committees that monitor states' compliance with their human rights treaty obligations (e.g., the Human Rights Committee; the Committee on Social, Economic and Cultural Rights; the Committee Against Torture) and other human rights mechanisms with relevant mandates (e.g., the Special Rapporteur on the right to health, the Special Rapporteur on torture).

- National governments should allocate resources to bolster existing health inspection and monitoring systems to comply with reporting requirements noted above. Health services for people who use drugs should also figure in country reports on the implementation of the International Covenant on Economic, Social and Cultural Rights. The Committee

[166] See J. Csete and D. Wolfe, *Closed to reason: The International Narcotics Control Board and HIV/AIDS* (Canadian HIV/AIDS Legal Network and Open Society Institute, 2007) for an explanation of the INCB's role in ensuring supplies for OST and recommendations for improvements of the Board's performance in this role.

on Economic, Social and Cultural Rights should request governments to include such information in their country reports, and should raise such concerns with states in its regular review of countries' compliance with their obligations under the Covenant.

- There is an urgent need for research and evaluation on drug dependence treatment from the perspective of patients. The published literature includes numerous assessments of the quality of this treatment without reference to first-hand experiences of patients. Such issues as fear of police interference or of breaches of confidentiality, as well as the quality of clinical practices, cannot be assessed adequately without learning from patients directly.

Appendix 1: Human rights assessment of drug dependence treatment methods and practices

The following questions might usefully be raised in conducting a human rights-centred assessment of dependence treatment methods and practices. This is not an exhaustive list but is meant to convey some important concerns derived from reviews of existing practices.

Timely availability: Are services available on demand? Do waiting lists or wait times cause some people who use drugs to be lost to treatment? Is there a mechanism for monitoring wait times or improving availability when wait times exceed a certain level?
Ethical guidelines or standards: Are there existing national standards on the practice or ethics of dependence treatment? Do they correspond to human rights norms?
Varied services: Are available services varied, or do they rely on one or very few approaches or methods? Is there a mechanism for monitoring variety of services on offer? Are dependence treatment services available from doctors' offices or only in specialized facilities?
Affordability: Are dependence treatment services affordable? Are some services available only to those who can pay fees for them? Is there a system to monitor the turning away of potential clients because of lack of ability to pay?
Legal basis of OST: Is opiate substitution therapy illegal or impeded by legal, regulatory or administrative barriers?
Discrimination based on criminal record: Are services equally available to those with and without a criminal record, a prison record, or any involvement with the criminal law system? Do those who have a criminal record enjoy the same degree of confidentiality of their medical records as those without a record? Do they have a reasonable fear of being reported to criminal authorities if they seek treatment? Is there a mechanism for assessing the self-exclusion of people with criminal records who fear entering treatment?
Discrimination on other grounds: Are services equally available (and of comparable quality) to people living in poverty and others, to people of all ethnic groups, to homeless people and those with stable shelter, to men, women and transgender people, to people in all occupations including sex work? Are there mechanisms for filing complaints in these areas that guarantee prompt and fair hearings of these complaints?
Treatment for women: Are there adequate services tailored to the needs and situations of women, including pregnant women? Are services designed for women adequately available with respect to hours of operation, location and child-care services? In making decisions about entering treatment, do women have a justified fear that treatment will lead to questions about their competence to retain custody of their children? Are pregnant women given priority in access to treatment services appropriate for them? Is dependence treatment for women linked to psychosocial services to address past abuses they may have faced, violence and abuse in their current situations, and related trauma? Is there a mechanism for assessing the self-exclusion of women who fear treatment or logistically cannot manage to enter it?

Compulsory practices: Are there compulsory dependence treatment services? Is compulsory treatment clearly a measure of last resort? Are there provisions for persons in compulsory forms of treatment to be represented in decision-making about treatment by others who can act in their interest? Is compulsory detention a feature of treatment programs? How is the treatment of persons in this form of detention monitored? Are there complaints mechanisms for those who wish to allege a violation of their rights?
Confidentiality of medical records: Is there an effective system in place to guarantee the confidentiality of medical records associated with drug dependence treatment, including all information related to the nature of treatment and the progress of the patient? Is there a complaint mechanism for those who want to allege a violation of their rights?
Treatment under non-health aegis: Are non-correctional dependence treatment services offered through non-health ministries, such as the ministry of justice or the ministry of the interior? Are these services meant to serve a punitive or correctional function in addition to a health function? Are decisions about the course of treatment made by health professionals?
Forced labour: Is forced, unpaid or inadequately compensated labour part of dependence treatment? Do national labour authorities monitor these practices?
OST standards: Are opiate substitution therapy programs based on scientifically sounds standards with respect to limits on dosages or duration of treatment? Are programs monitored with respect to internationally recognized treatment guidance?
Complaints mechanisms: Is there a functioning mechanism by which users of dependence treatment services can make formal complaints of violations of their human rights, including complaints about procedures that are cruel, inhuman or degrading? What is the record of actions of redress from this mechanism?
Meaningful involvement of people who use drugs: Are people who use drugs or users of treatment services meaningfully involved in decisions about the planning, design, implementation and evaluation of dependence treatment services? If so, in what ways? Is there peer-based counselling or other peer-based services in dependence treatment?

Appendix 2: The rights of people in drug dependence treatment[167]

Everyone who receives drug dependence treatment has the right:

(1) to a full course of high-quality treatment to be provided without delay and in accordance with accepted clinical practice;

(2) to treatment without discrimination and regardless of treatment goals;

(3) to help determine his/her own treatment goals, which may include, but are not limited to, abstinence or long-term maintenance; and

(4) to meaningful participation in all treatment decisions, including when and how treatment is initiated, determination of dosage, and withdrawal from treatment;

(5) to exercise his/her rights as a patient, including:

  (a) reporting, without retribution, any instances of suspected abuse, neglect, or exploitation of patients in the program;

  (b) a grievance and appeal process, in accordance with national laws and regulations;

  (c) input into program policies and services through patient satisfaction surveys;

  (d) voluntary withdrawal from treatment at any time;

(6) to be fully informed, including but not limited to, the right to receive information on:

  (a) his/her rights as a patient, as specified in this part and in applicable law;

  (b) the range of treatment options available;

  (c) his/her treatment plan, including a copy of the plan;

  (d) confidentiality of medical records and clinical test results;

  (e) the service's complaints procedure;

  (f) his/her obligations as a patient;

  (g) clinical test results; and

  (h) cost and payment conditions and the availability of medical insurance and other possible subsidies.

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[167] This list, compiled by the Canadian HIV/AIDS Legal Network, relies on consultations with a wide range of experts as well as ideas from several publications: see, for example, See, also, WHO Europe, *A Declaration on the Promotion of Patients' Rights in Europe*, ICP/HLE 121, 28, June 1994 (available via www.who.int/genomics/public/patientrights/en/index.html: documents on patients' rights for a variety of countries are also available via this site); New Zealand Ministry of Health. *Opioid substitution treatment: New Zealand practice guidelines.* February 2003. Available via www.moh.govt.nz; Macedonian Ministry of Health *Guidelines and Protocol for the Administration of Methadone in the Treatment of Opiate Addiction*, October 2001; Czech Republic Ministry of Health, *Czech Substitution Treatment Guidelines*, June 2000, adopted by a special Ministerial Decree in 2001.

(7) to withdraw voluntarily from treatment at any time:

(a) the health practitioner will fully inform the patient of the potential risks and benefits of withdrawal from treatment and shall work with the patient to ensure the patient's safety and comfort during the withdrawal process;

(b) the health practitioner will not discontinue services that are needed unless the patient requests the discontinuation, alternate services are arranged, or the patient is given a reasonable opportunity to arrange alternate services;

(c) the withdrawal from treatment with an explanation of likely consequences will be recorded or registered in medical documentation and signed by the patient and health practitioner;

(d) involuntary withdrawal from treatment will be avoided except where compelling reasons exist. Regulations governing grounds for involuntary withdrawal will be clearly communicated to patients at the outset of treatment.

(8) to confidentiality of their health care information:

(a) Records of the identity, diagnosis, prognosis or treatment of any patient which are created or obtained in the course of drug dependence treatment:

(i) are confidential;

(ii) are not open to public inspection or disclosure;

(iii) will not be shared with other individuals or agencies without the consent of the person to whom the record relates; and

(iv) will not be discoverable or admissible during legal proceedings.

(b) Program staff cannot be compelled under [relevant criminal procedure code] to provide evidence concerning the information that was entrusted to them or became known to them in this capacity.

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