Drug Control, Human Rights, and the Right to the Highest Attainable Standard of Health: By No Means Straightforward Issues

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HUMAN RIGHTS QUARTERLY

Drug Control, Human Rights, and the Right to the Highest Attainable Standard of Health: By No Means Straightforward Issues

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ABSTRACT

There has been increasing attention to the importance of respecting the human rights of addicts with regard to illicit drug trafficking and abuse. The debate is multifaceted, encompassing issues involving drug control as it relates to criminal justice, the death penalty, mandated treatment, and, most prominently, the right to the highest attainable standard of health. This article addresses each of these issues, focusing on the right to the highest attainable standard of health, including the ongoing international debate surrounding controversial "harm reduction" measures. The applicability of this right to drug control is not as straightforward as is often presented, and some of the arguments put forward come dangerously close to stating that there is a "right to abuse drugs," which the author disputes.

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The opinions expressed in this article are those of the author alone, and do not necessarily represent the views of the International Narcotics Control Board, the United Nations Office on Drugs and Crime, or of any other organization or body of the United Nations.

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I. INTRODUCTION

There has been wide-ranging attention in recent months regarding the importance of ensuring respect for human rights in international efforts against illicit drug trafficking and abuse, with some arguing for a "human rights framework" in drug control. While human rights must be taken into account when dealing with illicit drug issues, the conceptual framework for many of these issues is too simplistic. In addition, many of the points raised are not specific to drug control, but they instead apply to all areas of law enforcement and criminal justice. A more creative framework to deal specifically with drug control issues in a human rights context is needed.

This article reviews discussion addressing the right to the highest attainable standard of health as it relates to drug control, in particular, the debate surrounding "harm reduction." The article concludes that the applicability of this right to drug control is not as straightforward as is often presented. This author disputes the notion that mandated treatment for drug addiction should be looked upon as a human rights violation and argues that, as a practical matter, this position is not based on the reality of drug addiction.

II. THE INTERNATIONAL DRUG CONTROL REGIME—AN OVERVIEW

The international drug control regime is based on the three international drug control conventions, namely the 1961 Single Convention on Narcotic Drugs as amended by the 1972 Protocol (1961 Convention), the 1971 Convention on Psychotropic Substances (1971 Convention), and the 1988 United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances (1988 Convention).[1] These conventions have nearly achieved universal ratification, with, as of 1 November 2008, at least 182 state parties to each of the three.[2]

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1. Single Convention on Narcotic Drugs, 1961, as amended by the Protocol amending the Single Convention on Narcotic Drugs, 1961 [hereinafter Single Convention on Narcotic Drugs], *adopted* 8 Aug. 1975, 976 U.N.T.S. 105 (*entered into force* 8 Aug. 1975), *available at* http://www.unodc.org/pdf/convention_1961_en.pdf; Convention on Psychotropic Substances, *adopted* 21 Feb. 1971, 1019 U.N.T.S. 175 (*entered into force* 16 Aug. 1976), *available at* http://www.unodc.org/pdf/convention_1971_en.pdf; United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, *adopted* 20 Dec. 1988, U.N. Doc. E/CONF.82/14 (*entered into force* 11 Nov. 1990), *available at* http://www.unodc.org/pdf/convention_1988_en.pdf.
2. As of 1 November 2008, there were 186 state parties to the 1961 Convention on Narcotic Drugs, 183 state parties to the 1971 Convention on Psychotropic Substances, and 182 state parties to the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. International Narcotics Control Board, *Report of the International Narcotics Board on Follow-up to the Twentieth Special Session of the General Assembly*, ¶56, U.N. Doc. E/INCB/2008/1/Supp.1 (Feb. 19, 2009), *available at* http://www.incb.org/pdf/ungass/en/UNGASS_INCB_Report-English.pdf.

The primary goal of the international drug control conventions, as stated in Article 4 of the 1961 Convention, is to "limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs."[3] The provisions of the conventions concentrate mainly on controls that state parties are to introduce on the licit movement and trade of controlled substances so as to ensure that there is no diversion of these substances into the illicit market.

Some organizations have argued that there is a heavy slant in these conventions towards prohibition and law enforcement.[4] For example, the Beckley Foundation has stated that the conventions are "overwhelmingly prohibitionist in their approach, and, as such, in favor of punishment."[5] Similarly, Human Rights Watch has argued that the conventions "contain weak language on the treatment and prevention of drug use while obliging states to adopt strict law enforcement measures."[6] These points have merit—when the first two conventions were drafted and adopted, there was wide-ranging international consensus that reducing the supply of drugs would be sufficient to solve the drug abuse problem. Recently, states have come to realize that supply reduction alone cannot be the answer and that equal measures must be taken to reduce the demand for drugs as well.[7]

Despite arguments to the contrary, there are provisions in the international drug control conventions obligating states to provide adequate treatment facilities for drug addiction and abuse. Article 38 of the 1961 Convention, for example, states that "[t]he Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends."[8] Similarly, the 1988 Convention states that "in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment [for the possession of illicit drugs], measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare."[9]

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3. Single Convention on Narcotic Drugs, *supra* note 1, at art. 4.
4. *See* Jonathan Cohen, Human Rights Watch, Injecting Reason: Human Rights and HIV Prevention for Injecting Drug Users (Sept. 2003), *available at* http://www.hrw.org/sites/default/files/reports/usa0903full.pdf.
5. Damon Barrett et al., Beckley Foundation Drug Policy Programme, Recalibrating the Regime: The Need for a Human Rights-Based Approach to International Drug Policy 19 (Mar. 2008), *available at* http://www.internationaldrugpolicy.net/reports/BFDPP_RP_13_Recal_Regime_EN.pdf.
6. Cohen, Human Rights Watch *supra* note 4, at 51.
7. For a general history of drug control and the developments of policy approaches, *see* Richard Davenport-Hines, The Pursuit of Oblivion: A Global History of Narcotics, 1500–2000, at 254 (2001); UN International Drug Control Programme, World Drug Report (1997).
8. Single Convention on Narcotic Drugs, *supra* note 1, art. 8 § 1.
9. United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, *supra* note 1, art. 3 § 4.

The main policy making body of the international drug control regime is the United Nations (UN) Commission on Narcotic Drugs (CND), an intergovernmental commission of the Economic and Social Council with fifty three members. The UN Office on Drugs and Crime (UNODC) serves as the secretariat of the CND (as well as the UN Crime Commission) and provides assistance to governments in strengthening drug control. UNODC's strategy for 2008–2011 states that the organization's mission is to "contribute to the achievement of security and justice for all by making the world safer from drugs, crime and terrorism."[10]

UNODC is part of the UN Secretariat, and the organization is heavily reliant on voluntary contributions, many of which are earmarked. A report submitted to CND by UNODC states that only twelve percent (USD 16.1 million) of the organization's annual budget of US$ 135.9 million comes from the regular budget of the UN.[11]

This reliance on earmarked funds has made UNODC vulnerable to accusations that it is susceptible to political pressure by wealthy, powerful states. UNODC's neutrality was questioned in 2004 when a letter written by the Executive Director (ED) to the United States Government seemed to bend certain policies of the organization to conform to US policies as a response to pressure from the government.[12] The letter was pursuant to a meeting between the ED and a representative of the US government during which the US government had apparently expressed concern over the use of the controversial term "harm reduction" in UNODC documents.[13]

In the letter, which was leaked to a nongovernmental organization (NGO) and posted on its website, the ED stated that UNODC shared the concern of the US government that "there are people working disingenuously to alter the world's opposition to drugs. These people can misuse our well-intentioned statements for their own agenda, and this we cannot allow . . . we are reviewing all our statements, both printed and electronic, and will even be more vigilant in the future."[14] Although no change of any UNODC position was expressed in this letter, many NGOs widely characterized the

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10. *UNODC Strategy 2008–2011: Towards Security and Justice for all: Making the World Safer From Crime, Drugs and Terrorism,* U.N. Office on Drugs and Crime, at 7, U.N. Doc. E/CN.7/2007/14–E/CN.15/2007/5 (Jun. 2008), *available at* http://www.unodc.org/documents/about-unodc/UNODC-strategy-July08.pdf.
11. *Id.* at 8. This paper states, "Although the increase in earmarked contributions represents a vote of confidence in UNODC by Member States, it creates an unstable and unpredictable funding situation, making it difficult to plan even one year ahead." *Id.*
12. Letter from Antonio Maria Costa, Executive Director, United Nations Office on Drugs and Crime, to Robert Charles, Assistant Secretary, International Narcotics and Law Enforcement Affairs (11 Nov. 2004), *available at* http://www.encod.org/info/IMG/pdf/LETCOSTA2004.pdf.
13. *Id.* Section IV of this article explains the meaning of "harm reduction" and its connotations in the drug control field.
14. *Id.*

letter as indicative of a UN organization buckling under pressure: "UNODC has shown the organization is not capable of defending the interests of citizens. Not only does it possess extremely poor knowledge of facts, it also operates as an agency that is more faithful to financial and political pressure than to scientific evidence."[15]

The international drug control regime has established a treaty body of independent experts to monitor states' application of the regime's obligations, and this treaty body, at least at first glance, bears a striking similarity to the treaty bodies of human rights. The 1961 Convention established the International Narcotics Control Board (INCB) as an independent committee charged with monitoring application of the provisions of the Convention by state parties. INCB consists of thirteen members, each of whom are elected by states at the Economic and Social Council but who serve on INCB in their independent capacities.[16]

INCB meets three times a year in Vienna and is provided secretariat services by the Secretary General; in the case of INCB, the UNODC provides these services.[17] However, one significant difference between INCB and the human rights treaty bodies is the relationship INCB has with the UN Secretariat (specifically, with UNODC). Article 16 of the 1961 Convention states, "The secretariat services of the Commission and the Board shall be furnished by the Secretary-General [of the UN]. In particular, *the Secretary*

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15. Joep Oomen, European Coalition for Just and Effective Drug Policies, *UN Does not Support Harm Reduction*, UNCOD Online, 19 May 2001, *available at* http://www.encod.org/info/UN-DOES-NOT-SUPPORT-HARM-REDUCTION.html. *See, e.g.*, Press Release, Transnational Institute, US Pressure Against Harm Reduction Backfires at CND (9 Mar. 2005), *available at* http://www.tni.org/detail_page.phtml?page=drugs-docs_pr090305.
16. Single Convention on Narcotic Drugs, *supra* note 1, art. 9 § 1. The Convention states that members of INCB shall be "persons who, by their competence, impartiality and disinterestedness, will command general confidence. During their term of office they shall not hold any position or engage in any activity which would be liable to impair their impartiality in the exercise of their functions." *Id.* art. 9 § 2. The Convention also states that at least three of its thirteen members should be elected from a list submitted by the World Health Organization, thereby ensuring that there is a base of "medical, pharmaceutical, or pharmacological experience" in INCB. *Id.* art. 9 § 2.
17. Joanne Csete & Daniel Wolfe, Canadian HIV/AIDS Legal Network & Open Society Institute, Closed to Reason: The International Narcotics Control Board and HIV/AIDS 6 (2007), *available at* http://www.ahrn.net/library_upload/uploadfile/file3077.pdf. INCB is mandated under Article 15 of the Single Convention on Narcotic Drugs to publish an annual report of its activities. Single Convention on Narcotic Drugs, *supra* note 1, art. 15. Unlike the human rights treaty bodies, the deliberations of INCB are not open to the public, and INCB generally does not publish its evaluations on country's performance under the conventions. Csete & Wolfe, *supra* note 17, at 6. As such, the Annual Report is essentially the only avenue through which outside parties can see the views of the INCB on particular countries or issues. This lack of transparency, which is based on the rules of procedures of INCB and not on any treaty provision, has been the subject of considerable criticism in recent years. *See* Damon Barrett, International Harm Reduction Association, "Unique in International Relations?": A Comparison of the International Narcotics Control Board and the UN Human Rights Treaty Bodies (2008).

of the Board shall be appointed by the Secretary-General in consultation with the Board."[18] This provision appears to intend to guard the INCB's independence and shield the INCB from political interference from the UN.

The Commentary on the 1961 Convention, prepared by the UN pursuant to a resolution of ECOSOC in 1962, states that

> the existence of two separate, mutually independent secretariat units in the field of international narcotics control within the [UN] has been the subject of controversy. On the one hand, the opinion has been expressed that such a secretariat arrangement is unsound from an administrative viewpoint, hampers co-ordination of work and facilitates duplication of effort . . . It has, on the other hand, been asserted that [INCB] needs a separate secretariat for the independent performance of its tasks, which include judicial functions.[19]

The Commentary goes on to note that while "the majority of the delegates [that drafted the 1961 Convention] was in favour of establishing a single secretariat for [INCB and CND], the Convention adopted Article 16."[20]

Staff members at the INCB Secretariat are trained to receive substantive instructions only from INCB and not from the Executive Director of UNODC. Indeed, though the INCB Secretariat is physically located in the same building in Vienna as UNODC, it is separated by special security doors to which only INCB staff are allowed to have access. Whether there are good reasons for maintaining this distance from UNODC is debatable, but such compartmentalization would be unthinkable in the human rights field.[21] Perhaps more important, however, is the fact that, unlike UNODC, the INCB secretariat is funded almost entirely with funds from the UN regular budget and therefore is not vulnerable to pressure in the same way as UNODC.[22]

III. DRUG CONTROL IN LAW ENFORCEMENT

There have been a number of reports in recent months regarding human rights as it relates to drug control that raise issue with international efforts against drug abuse and illicit drug trafficking. The Beckley Foundation, for example, in a joint paper with the International Harm Reduction Associa-

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18. Single Convention on Narcotic Drugs, *supra* note 1, art. 16 (emphasis added).
19. *Commentary on the Single Convention on Narcotic* Drugs, *1961, Prepared by the Secretary-General*, at 204, U.N. Sales No. E.73.XI.1 (1973).
20. *Id.* at 205.
21. This is not to suggest that cooperation between treaty bodies and charter based procedures in human rights does not require improvement. *See, e.g.*, Nigel Rodley, *United Nations Human Rights Treaty Bodies and Special Procedures of the Commission on Human Rights: Complementarity or Competition?,* 25 Hum. Rts. Q. 882 (2003).
22. *See Consolidated Budget for the Biennium 2006–2007 for the United Nations Office on Drugs and Crime*, U.N. ESCOR, Comm'n on Narcotic Drugs, 48th Sess., Agenda item 10, U.N. Doc. E/CN.7/2005/12 (2005).

tion, Human Rights Watch, and the Canadian HIV/AIDS Legal Network, raises concerns regarding the conduct of law enforcement officials in several countries towards drug abusers:

> People who use drugs make especially easy targets for arrest or ill-treatment by police needing to fulfill arrest quotas, as Human Rights Watch has documented in reports on Russia, Kazakhstan, and Ukraine. . . . Police also use drug addiction as a tool to coerce incriminating testimony from drug users. A former senior detective specializing in drug enforcement cases, and attorneys and social workers to drug users in Ukraine have reported, for example, that police intentionally use withdrawal as an investigative tool to coerce incriminating testimony from drug users, extort money from drug users by threatening to detain them, forcing them to suffer withdrawal and deny medical assistance to drug users.[23]

In addition, Human Rights Watch has "documented numerous cases of unnecessary use of force and illegal search and seizure by the police [in Vancouver, Canada] directed against persons, mostly injection drug users, who were not charged with dealing drugs."[24]

Academics have also made similar points. Tom Obokata, for example, has examined numerous issues related to drug control and human rights, including the death penalty and human rights violations in the course of law enforcement operations against drug traffickers and abusers. He rightly notes that

> law enforcement practices against traffickers and narcotics users also raise a series of human rights concerns. Instances of physical and verbal abuse during search, seizure, and arrest of those suspected of narcotics related offences have been reported. The war on drugs in some parts of the world also has resulted in the extrajudicial killing not only of traffickers, but also of innocent civilians.[25]

While all of these concerns are valid, they are not necessarily specific to the field of drug control. Nearly all of the human rights concerns pointed out by Obokata apply equally to other areas of law enforcement and criminal justice. Combating the presence of illegal drugs may act as a justification for governments to engage in overzealous policing operations, and being a drug abuser may make one more vulnerable to abuse by police officers. Because of this, human rights considerations must be taken into account in antidrug operations. Nevertheless, most countries where such violations take place are countries with equally poor records in other areas of law enforcement.

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23. Damon Barrett et al., Beckley Foundation, Drug Policy Programme, *supra* note 5, at 26.
24. Human Rights Watch, Abusing the User 1 (2003), *available at* http://www.hrw.org/en/reports/2003/05/06/abusing-user.
25. Tom Obokata, *Illicit Cycle of Narcotics from a Human Rights Perspective*, 25 Neth. Q. Hum. Rts. 159, at 170 (2007).

One country in which the antidrug law enforcement efforts resulted in gross human rights violations is Thailand. In early 2003, the government announced a national campaign known as the "war on drugs," which, by all accounts, led to widespread gross human rights violations by law enforcement officials.[26] The prevalence of drug use in Thailand was admittedly serious; the country suffered from the world's highest abuse rate of methamphetamine. In fact, as much as 5.6 percent of the population over fifteen years of age abused methamphetamine tablets known as "ya ba," the Thai word for "crazy,"[27] and, according to information provided by the Thai government to UNODC, "the total number of methamphetamine users rose 6-10 fold between 1993 and 2001."[28]

Against this backdrop, the government launched a national antidrug campaign on 1 February 2003, stating its goal to eradicate methamphetamine from the country by 30 April 2003, exactly three months later.[29] Each province drew up "blacklists" containing a total of over 46,000 suspected drug traffickers (including over 1,000 state officials), and the central government established numerical targets for "elimination."[30] As noted by Amnesty International, there was "widespread concern about the methodology used to draw up these blacklists, and it [appeared] that authorities [had] no obligation to notify suspects that their names [were] on the blacklist. In addition, . . . there [was] no judicial mechanism for appeals to be made to challenge inclusion in the blacklist."[31]

The results of the campaign were to be assessed at 9:00 P.M. on 30 April, and provincial governors and local police and military officials who failed to achieve their targets would be severely punished. In fact, upon announcing the plan to high-ranking officials on 14 January, the Prime Minister stated, "You are finished if you do not do your job."[32] Officers were also offered financial incentives to seize illicit drugs.[33]

From its earliest stages, large numbers of killings marked the subsequent law enforcement drive. Suspicious circumstances surrounded many of these killings. One media report cites the case of a suspected drug trafficker who

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26. HUMAN RIGHTS WATCH, THAILAND: NOT ENOUGH GRAVES: THE WAR ON DRUGS, HIV/AIDS, AND VIOLATIONS OF HUMAN RIGHTS 7 (2004), *available at* http://www.hrw.org/sites/default/files/reports/thailand0704.pdf.
27. UNITED NATIONS OFFICE ON DRUGS AND CRIME, 2004 WORLD DRUG REPORT 175 (2004), *available at* http://www.unodc.org/unodc/en/data-and-analysis/WDR-2004.html.
28. *Id.* at 182.
29. AMNESTY INT'L (AI), THAILAND: GRAVE DEVELOPMENTS—KILLINGS AND OTHER ABUSES 7 (2003), *available at* http://www.amnesty.org/en/library/asset/ASA39/008/2003/en/dom-ASA390082003en.html.
30. Surath Jinakul, *Tightening the Screws on Drug Traders,* BANGKOK POST, 19 Jan. 2003.
31. AI, *supra* note 29, at 4.
32. *Drug-free Thailand Deadline Criticized,* CNN, 16 Jan. 2003, *available at* http://edition.cnn.com/2003/WORLD/asiapcf/southeast/01/15/thailand.drugs/.
33. Thongbai Thongpao, *Wage War on Drugs by the Rules,* BANGKOK POST, 9 Feb. 2003.

had been found dead in his car with methamphetamine tablets carelessly splattered across the seat. The person had been shot through the chest, but there was no sign of damage on the car seat.[34] Other media reports cite cases where suspected drug traffickers were found dead with plastic bags of drugs neatly by their side; reports also point to police assertions that there were rarely any witnesses to the killings.[35] Both Amnesty International and Human Rights Watch documented additional cases of suspicious killings.[36]

In a statement issued on 24 February 2003, the Special Rapporteur of the Commission on Human Rights noted her "deep concern" about the situation and urged the Thai government to ensure that law enforcement officers comply with international standards limiting the lethal use of force. The Special Rapporteur also urged the Thai government to conduct independent investigations into each individual death so that officials who had used excessive force could be held accountable.[37]

At the end of the three month period, over 2,800 people had been killed.[38] Human Rights Watch stated, "the government crackdown has resulted in the unexplained killing of more than 2,000 persons, the arbitrary arrest or blacklisting of several thousand more, and the endorsement of extreme violence by government officials at the highest levels."[39] In January 2008, a new committee formed by the government to investigate government conduct during the "war on drugs" concluded that over half of those killed had no links to the drug trade and called the killings a "crime against humanity." [40] However, the committee stated that there was insufficient evidence to hold any particular person responsible for any of the killings.[41] Though the com-

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34. Tony Cheng, *Thai Drugs War "Settling Old Scores,"* BBC News, 4 Mar. 2003, *available at* http://news.bbc.co.uk/1/hi/world/asia-pacific/2815307.stm.
35. Seth Mydans, *A Wave of Drug Killings is Linked to Thai Police,* N.Y. Times, 8 Apr. 2003, at A3.
36. *See* AI, *supra* note 29; *see also* Human Rights Watch, Thailand: Not Enough Graves, *supra* note 26.
37. Press Release, UN Expert on Extrajudicial Executions Expresses Concern Over Recent Killings in Thailand, U.N. Doc. HR/4645 (24 Feb. 2003).
38. The independent committee appointed by the interim Thai government to investigate the killings reported that there were "2,559 cases with 2,819 deaths." Piyanuch Thammakasetchai, *"War on Drugs" Probe Draws a Blank*, The Nation, 16 Jan. 2008, *available at* http://www.nationmultimedia.com/2008/01/16/national/national_30062378.php.
39. Human Rights Watch, Thailand: Not Enough Graves, *supra* note 26, at 2. On 6 July 2003, the Thai PM reportedly stated in his weekly radio address that police should shoot to kill drug traffickers who resist arrest: "I would like to tell all police to take a stringent approach towards drug traffickers. . . . If [traffickers] resist arrest, there is nothing we can do. They will die prematurely if necessary." *PM Warns Drug Dealers: Surrender or You'll be Shot*, The Nation, 6 July 2003.
40. Human Rights Watch is cited as having stated that the original report named the politicians that created the incentives for the killings; however, the names were omitted after the election. *Back on the Offensive: Thailand's Drug Wars,* The Economist, 24 Jan. 2008.
41. *Id.*

mittee recommended compensation to the victims' families, these recommendations do not appear to have been carried out or even considered.[42]

The national antidrug campaign, therefore, was clearly marked by gross and wide scale violations of human rights. Again, however, this campaign was symbolic of the deprivation of human rights, corruption in the criminal justice system, and the longstanding problem of impunity for violators of human rights in Thailand—it is not solely a drug control issue.[43] The problem of drugs in the country certainly provided the government with the impetus to take violative measures. However, law enforcement officials should have complied with human rights standards, regardless of the subject matter; to characterize the campaign as a drug control issue is to disregard the broader human rights issues that existed in Thailand. Had widespread human rights offenses taken place in a national campaign against traffic offenses, observers probably would not have called for a human rights framework in traffic control.

IV. THE DEATH PENALTY

The issue of the death penalty being imposed on drug offenders is also a relevant issue. The Second Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR) provides for the abolition of the death penalty; though, this international instrument still only has seventy-one parties and therefore arguably on its own cannot be evidence of an international consensus.[44] Nevertheless, according to Amnesty International, 137 countries—over two thirds of the countries of the world—have now abolished the death penalty, either in law or in practice.[45]

Perhaps more reflective of an international consensus to abolish the death penalty is the fact that in December 2007 the UN General Assembly (GA)

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42. Marwaan Marcan-Markar, *War on Drugs Massacre—Officials Scot-Free*, Inter Press Service News Agency, 24 Jan. 2008, *available at* http://www.ipsnews.net/news.asp?idnews=40896.
43. *See, e.g.*, AI, Thailand: If you Want Peace, Work for Justice (2006), *available at* http://www.amnesty.org/en/library/asset/ASA39/001/2006/en/08ee0ded-d46f-11dd-8743-d305bea2b2c7/asa390012006en.html. HRC expressed concern regarding impunity for law enforcement officials over the excessive use of force, ill treatment, and torture, as evidenced by the fact that "only a few of the investigations into cases of ill treatment have resulted in prosecutions, and, fewer in convictions." *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant,* Hum. Rts. Comm., 84th Sess., ¶ 15, U.N. Doc. CCPR/CO/84/THA (2005), *available at* http://www.unhchr.ch/tbs/doc.nsf/0/e860ca7730edc51ec125706900453a28/$FILE/G0543504.pdf
44. Second Optional Protocol to the International Covenant on Civil and Political Rights, *adopted* 15 Dec. 1989, GA Res. 44/128, U.N. GAOR, 44th Sess. (*entered into force* 11 July 1991).
45. AI, Abolitionist and Retentionist Countries, *available at* http://www.amnesty.org/en/death-penalty/abolitionist-and-retentionist-countries.

adopted a resolution titled "Moratorium on the use of the death penalty," which highlights the GA's opinion that all states should be moving toward abolishing the death penalty:[46]

> [R]ecalling the Universal Declaration of Human Rights, the [ICCPR] and the Convention on the Rights of the Child . . . Considering that the use of the death penalty undermines human dignity, and convinced that a moratorium on the use of the death penalty contributes to the enhancement and progressive development of human rights, that there is no conclusive evidence of the death penalty's deterrent value and that any miscarriage or failure of justice in the death penalty's implementation is irreversible and irreparable . . . Expresses its deep concern about the continued application of the death penalty. . . . Calls upon all States that still maintain the death penalty. . . . To progressively restrict the use of the death penalty and reduce the number of offences for which it may be imposed; To establish a moratorium on executions with a view to abolishing the death penalty.[47]

Amnesty International stated that the adoption of this resolution "clearly demonstrates how world opinion has moved further against the death penalty since the issue was last discussed by the General Assembly in 1999."[48]

Article 6(2) of the International Covenant on Civil and Political Rights states: "In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes."[49] The Human Rights Committee (HRC), the treaty body charged with monitoring application of the ICCPR, has noted in its General Comment on Article 6 that "the article . . . strongly [suggests] that abolition is desirable" and that the term "most serious crimes" indicates that "the death penalty should be a quite exceptional measure."[50]

The jurisprudence of the HRC indicates that only crimes which directly result in death could be considered as "most serious," and, as pointed out by Manfred Nowak, "in no event was the death penalty to be provided for crimes of property, economic crimes, political crimes or in general for offences not involving the use of force."[51] The HRC has explicitly stated

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46. *Moratorium on the Use of the Death Penalty*, *adopted* 18 Dec. 2007, G.A. Res. 62/149, U.N. GAOR, 62nd Sess., U.N. Doc. A/Res/62/149 (2008).
47. *Id.*
48. Press Release, AI, UN overwhelmingly backs call to suspend executions (18 Dec. 2007), *available at* http://www.amnesty.ca/resource_centre/news/view.php?load=arcview&article=4149&c=Resource+Centre+News.
49. International Covenant on Civil and Political Rights, *adopted* 16 Dec. 1966, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, art. 6 § 2, U.N. Doc. A/6316 (1996), 999 U.N.T.S. 171 (*entered into force* 23 Mar. 1976).
50. *General Comment No. 06: The Right to Life (art.6)*, U.N. GAOR, Hum. Rts. Comm., 16th Sess., ¶ ¶ 6–7 (1982), *available at* http://www.unhchr.ch/tbs/doc.nsf/0/84ab9690ccd81fc7c12563ed0046fae3.
51. Manfred Nowak, UN Covenant on Civil and Political Rights: CCPR Commentary 141 (2d. ed. 2005).

on several occasions that drug related offenses would not fall into this category; for example, in reviewing the state report of Kuwait in 2000, HRC expressed "serious concern over the large number of offences for which the death penalty can be imposed, including . . . drug-related crimes."[52] More recently, in reviewing the initial report of Thailand, HRC noted "with concern that the death penalty is not restricted to the 'most serious crimes' . . . and is applicable to drug trafficking . . . [Thailand] should review the imposition of the death penalty for offences related to drug trafficking in order to reduce the categories of crime punishable by death."[53] Thus, regardless of the general legality of the death penalty under international human rights law, to impose the death penalty for drug related offenses is certainly not lawful under international human rights law.

However, many countries still impose the death penalty for drug related offenses. According to information compiled by the UN in 2001, at the end of 2000, at least thirty-four countries provided for the death penalty for such offenses.[54] Additionally, the UN noted that this number had increased from twenty-two countries in 1985.[55] The UN expressed concern that "many retentionist countries have exhibited a tendency in the opposite direction. They have increased the range of crimes for which capital punishment may be imposed, rather than followed the expressed United Nations policy of progressively restricting the number of offences."[56] The UN went on to state:

> In a few of these countries and areas, the death penalty can be imposed for possession of quite small amounts of an illegal drug with intent to supply. For example, it is a mandatory capital offence in Singapore to illegally traffic in, import or export heroin of more than 15 grams, morphine of more than 30 grams, cannabis resin of more than 200 grams and cannabis of more than 500 grams. In 1998, Singapore made the death penalty mandatory for trafficking in more than 250 grams of crystal methamphetamine. . . . Under Malaysian law anyone found in possession of more than 15 grams of heroin is presumed, unless the contrary can be proven, to be trafficking in that drug and therefore liable to a mandatory death sentence.[57]

The UN Special Rapporteur on extrajudicial, summary or arbitrary executions has also expressed "concern that certain countries, namely China, the

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52. *Concluding observations of the Human Rights Committee: Kuwait,* Hum. Rts. Comm., ¶ 13, U.N. Doc. CCPR/CO/69/KWT (2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/0/ab637770e26e7fa8c12569490042d1d2?Opendocument.
53. *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, supra* note 43, ¶ 14.
54. *Capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty, Report of the Secretary-General,* U.N. ESCOR, ¶ 90, U.N. Doc. E/2005/3 (2001).
55. *Id.*
56. *Id.* ¶ 89.
57. *Id.* ¶ 90.

Islamic Republic of Iran, Malaysia, Singapore, Thailand and the United States of America, maintain in their national legislation the option to impose the death penalty for economic and/or drug-related offences."[58]

Of course, many NGOs have raised similar concerns. As the International Harm Reduction Association aptly noted, "If the progress towards the abolition of capital punishment is indeed a dramatic example of the success of human rights law, then the expansion of capital punishment for narcotics is a dramatic illustration of failure."[59]

China has, for many years, been the worst offender, holding large scale public executions of persons convicted of drug trafficking to coincide with International Day against Drug Abuse and Illicit Drug Trafficking (International Antidrug Day). According to Amnesty International, on International Antidrug Day 2001, over fifty people were convicted of drug related crimes at mass sentencing rallies in China and were executed.[60] State television did a nationwide broadcast of at least one of these rallies.[61] In 2002, China once again held public sentencing rallies, which led to sixty-four people being "convicted" of drug related offenses and being executed immediately afterwards.[62] One hundred eighty-eight other people, also accused of drug crimes, were sentenced to life in prison.[63] Though there is no information regarding public rallies, Amnesty International also compiled data indicating that at least fifty-five persons were executed in China for drug related offenses during the two weeks prior to International Antidrug Day in 2006.[64] More recently, Amnesty International issued a statement condemning the execution on International Drug Day 2008 of two men in Indonesia who had been convicted of heroin smuggling in 2001.[65]

In March 2008, The Executive Director (ED) of UNODC delivered his regular opening address at the CND, stating his views on human rights and in particular, his views on the death penalty. In the most comprehensive

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58. *Civil and Political Rights, including the Questions of Disappearances and Summary Executions, Report of the Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Mr. Philip Alston*, U.N. GAOR, Hum. Rts. Council, 5th Sess., Agenda Item 2, at n.57, U.N. Doc. A/HRC/4/20 (2007).
59. International Harm Reduction Association, The Death Penalty for Drug Offences: A Violation of International Human Rights Law 25 (2007).
60. Drug Scope, New IHRA Report Calls for End to Death Penalty for Drug Offenses (10 Dec. 2007), *available at* http://www.drugscope.org.uk/newsandevents/currentnewspages/IHRA-death-penalty.htm.
61. AI, The Death Penalty Worldwide: Development in 2001 33 (2002), *available at* http://www.amnesty.org.ru/library/pdf/ACT500012002ENGLISH/$File/ACT5000102.pdf.
62. *China Executed 64 to Mark Anti-Drug Day*, CBC News, 26 Jun. 2002, *available at* http://www.cbc.ca/world/story/2002/06/26/china020626.html.
63. *Id.*
64. AI, UN Anti-Drugs Day: Death Sentences for Drug-Crimes Rise in the Asia Pacific – Action 3 (2007), *available at* http://www.amnesty.org/en/library/info/ASA01/002/2007/en.
65. AI, Amnesty International Condemns Executions for Drug Trafficking, 30 Jun. 2008, *available at* http://www.amnesty.ie/amnesty/live/irish/news-events/article.asp?id=21718&page=9009.

reference on the subject at the CND by any ED of UNODC or member state of the body, the ED listed human rights as one of the key issues that he believed member states should discuss:

> Our work is guided first and foremost by *the UN Charter* that commits signatories to fundamental freedoms, and by the *Universal Declaration of Human Rights*. . . . In Article 25 of the *Universal Declaration*, health is listed as a basic human right. As we emphasize the health aspects of drug control, it stands to reason that implementation of the drug Conventions must proceed with due regard to human rights. Thus far, there has been little attention paid to this aspect of our work. This definitely needs to be amended.[66]

Even more surprisingly, the ED made clear his opposition to the death penalty being imposed for drug related offenses. He stated:

> Although drugs kill, I don't believe we need to kill because of drugs . . . today I propose that Member States . . . give serious consideration to whether the imposition of capital punishment for drug-related crimes is a best practice. The recent General Assembly moratorium [on the death penalty] suggests a way forward.[67]

That the head of a UN organization who is specifically charged with combating crime would make this statement is clearly an important step forward in the mainstreaming of human rights, in UNODC, and in the UN system as whole. Imposing the death penalty for drug related offenses clearly is against international human rights standards, and the UNODC must take this into account in providing assistance to states.

However, the death penalty issue is not so much of a drug control issue as much as it is an issue of human rights. That the death penalty should not be imposed for drug related offenses in no way means that international efforts against illicit drugs are themselves illegitimate and should be terminated. Simply, the death penalty should not be imposed for non-serious crimes, of which drug related offenses are just one category.

The INCB has not made any pronouncements specifically on the death penalty. The first chapter of INCB's Annual Report 2007 is "The Principle of Proportionality and Drug Related Offences," but the report is oddly silent on the subject of the death penalty, focusing mainly on recommending to states that they should "better balance law enforcement efforts, so that lower level offenders do not bear the brunt of justice while higher level offenders are not brought to trial."[68] The report makes the first reference to human rights ever made by INCB:

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66. Antonio Maria Costa, Executive Director, UNODC, Address to the 51st session of the Commission on Narcotic Drugs (10 Mar. 2008), *available at* http://www.unodc.org/unodc/en/about-unodc/speeches/2008-03-10.html.
67. *Id.*
68. International Narcotics Control Board (INCB), Annual Report 2007 ¶ 59 (2007) *available at* http://www.incb.org/incb/en/annual-report-2007.html.

> Due respect for universal human rights, human duties and the rule of law is important for effective implementation of the international drug control conventions. Non-respect for them can prejudice the ability of the criminal justice system to enforce the law, can lead to discriminatory disproportionate responses to drug offending and can undermine the [international drug control] conventions.[69]

Especially given the emphasis on human rights, that the rest of the report does not refer to the death penalty is puzzling.

Subsequent to this opening address of the ED, a draft resolution was submitted for the first time to the CND on ensuring respect for human rights standards in drug control policy.[70] The draft resolution, submitted by the governments of Argentina, Bolivia, and Uruguay, stated that the CND:

> 1. *Reaffirms* that international drug control must be conducted in conformity with international human rights law, as defined in the Universal Declaration of Human Rights and the international human rights conventions;
>
> 2. *Requests* the United Nations Office on Drugs and Crime to work closely towards those ends with the Office of the United Nations High Commissioner for Human Rights and the special procedures of the Human Rights Council;
>
> 3. *Requests* the Executive Director of the United Nations Office on Drugs and Crime to report to the Commission . . . on progress in that cooperation.[71]

The draft resolution was the subject of intense debate and much of the original language was changed. The committee eventually adopted the resolution as Resolution 51/12 and titled it "Strengthening co-operation between UNODC and other UN bodies for the promotion of human rights and the implementation of the international drug control treaties." The resolution states that the CND:

> 1. *Reaffirms* that countering the world drug problem . . . requires an integrated and balanced approach and that it must be carried out in full conformity with the purposes and principles of the Charter of the United Nations and other provisions of international law and, in particular, with full respect for the sovereignty and territorial integrity of States, the principle of non-intervention in the internal affairs of States and all human rights and fundamental freedoms and on the basis of the principles of equal rights and mutual respect;
>
> 2. *Requests* the United Nations Office on Drugs and Crime to continue, within its existing mandate, to work closely with the competent United Nations entities, including the United Nations human rights agencies;

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69. *Id.* at 9 ¶ 38.
70. *Proper Integration of the United Nations Human Rights System With International Drug Control Policy, Revised draft resolution from Argentina, Bolivia and Uruguay,* U.N. ESCOR, Comm'n on Narcotic Drugs, 51st Sess., Agenda Item 6(d), U.N. Doc. E/CN.7/2008/L.16/Rev.1 (2008).
71. *Id.* at 2.

> 3. *Requests* the Executive Director of the United Nations Office on Drugs and Crime to report to the Commission . . . on the implementation of the present resolution.[72]

One of the reasons that the draft resolution sparked such debate was the fact that the resolution had been submitted by Bolivia, which had been vocal in its condemnation of INCB and the INCB's criticisms of Bolivian policies regarding the cultivation of the country's coca bush for traditional purposes. In one of its preambular paragraphs, the draft resolution included a brief reference to the UN Declaration on the Rights of Indigenous Peoples, adopted in September 2007, which the Bolivian government had attempted to invoke to justify coca bush cultivation by the country's indigenous population.[73] The Bolivian government has not minced words in its criticism of INCB; in a letter to the UN Secretary General in March 2008, complaining about the INCB's condemnation of the government's policies regarding coca bush, the president of Bolivia called the "attitude of the INCB . . . colonial, and accused [INCB] members of lacking the necessary scientific background."[74]

INCB is justified in being concerned about the possible implications of remaining silent on the Bolivia issue, in particular given the media attention on the activities of Bolivian President Morales. On the other hand, Bolivia could conceivably be successful in convincing enough countries that indigenous rights should take precedence over the drug control conventions in this instance—in particular, because Bolivian cultivation of coca bush has been taking place for many decades, without discernable negative effects internationally.[75]

V. RIGHT TO HEALTH AND HARM REDUCTION

The right to the highest attainable standard of health is an even more salient issue in drug control than the issue of criminal justice and the death penalty. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states that "States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard

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72. *Report on the Fifty-first Session,* U.N. ESCOR, Comm'n on Narcotic Drugs, 51st Sess., Supp. No 8, at 32, U.N. Doc. E/CN.7/2008/15 (2008).
73. Declaration on the Rights of Indigenous Peoples, *adopted* 13 Sept. 2007, G.A. Res. 61/295, U.N. GAOR, 61st Sess., U.N. Doc. A/Res/61/295 (2007).
74. Tom Blickman, *Blessing In Disguise?*, TransNational Institute, 9 Mar. 2008, *available at* http://www.ungassondrugs.org/index.php?option=com_content&task=view&id=167&Itemid=6
75. Although this article does not include an in depth examination of this issue, it is important to note that the development of this debate will be of considerable interest to practitioners in both international human rights and drug control.

of physical and mental health," and, as shall be examined, this article has been cited to justify various approaches in drug control often categorized as "harm reduction."[76]

There is no single, internationally agreed upon definition of the term "harm reduction."[77] Broadly speaking, the term signifies measures taken to reduce the harm caused by the abuse of drugs, as opposed to measures aimed at eliminating the abuse itself. For example, the distribution of clean needles to drug addicts—usually referred to as "needle exchange"—is one of the main harm reduction measures. In the late 1980s, governments became aware that HIV was being spread through the sharing of needles amongst drug (mainly heroin) addicts.[78] Countries therefore introduced programs whereby drug addicts could exchange dirty needles for, or receive free of charge, clean needles, so as to prevent the sharing of infected needles. Even in countries where drug abuse or possession is criminalized, governments took measures to ensure that addicts who received these needles were not prosecuted so that the addicts would not be discouraged from using the service.[79]

According to a 2007 joint publication of the World Health Organization (WHO), UNODC, and the Joint UN Programme against AIDS (UNAIDS), over sixty countries worldwide have introduced such programs.[80] As support for the premise that these programs have been effective, the WHO states that there is "compelling evidence that increasing the availability and utilisation of sterile injecting equipment . . . reduced HIV infection substantially" and that "there is no convincing evidence" that such programs lead to an increase of drug abuse.[81]

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76. *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mr. Paul Hunt*, U.N. ESCOR, Comm'n on Hum. Rts, 59th Sess., Agenda Item 10, U.N. Doc. E/CN.4/2003/58 (2003).
77. *See, e.g.*, United Kingdom Department for International Development, Harm Reduction: tackling Drug Use and HIV in the Developing World (2005), *available at* http://www.eldis.org/vfile/upload/1/document/0708/DOC23859.pdf. The Canadian Centre on Substance Abuse has argued for a definition of harm reduction that would require that the program in question be proven to reduce harm. *See* Douglas J. Beirness, Rebecca Jesseman, Rita Notarandrea & Michel Perron, Canadian Centre on Substance Abuse, Harm Reduction: What's in a Name? (2008) *available at* http://www.ccsa.ca/2008%20CCSA%20Documents2/ccsa0115302008e.pdf.
78. Various strands of Hepatitis are also transmitted through the sharing of infected needles amongst drug addicts in many countries. *See, e.g.*, Hamid Ghodse, Drugs and Addictive Behaviour: a Guide to Treatment 295 (3d ed. 2002).
79. *See, e.g.*, World Health Organization (WHO), Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users (2004).
80. WHO, United Nations Office on Drugs and Crime (UNODC), & Joint United Nations Programme on HIV/AIDS (UNAIDS), Guide to Starting and Managing Needle and Syringe Programmes 5 (2007).
81. WHO, Effectiveness of Sterile Needle and Syringe Programme in Reducing HIV/AIDS, *supra* note 79, at 28.

Another prominent harm reduction measure is the operation of what has been variously termed as "drug injection rooms,"[82] "supervised injecting sites,"[83] or "drug consumption rooms."[84] These are facilities that allow drug addicts to come with drugs that they have acquired on the illicit market and engage in drug abuse with clean equipment provided by the facility under the watch of social workers and/or medical professionals. Though, as the name "injection room" suggests, most of these facilities are geared for addicts who inject heroin, some facilities also have special rooms for the inhaling of heroin.[85] Such facilities operate in a relatively small but growing number of countries, predominantly in Europe.

Such facilities may be a logical consequence of the harm reduction philosophy and from the needle distribution equation. Though needles may be clean when they are distributed, they soon become "dirty." They are shared amongst groups of addicts or at the very least often discarded in public spaces, causing nuisance and even danger to the general public.[86] In addition, drug addicts can overdose with clean or dirty needles, so there remains an immediate danger that mere needle distribution does not address. It is therefore somewhat difficult to draw a clear line between the distribution of needles, on the one hand, and the establishment of injection rooms, on the other. Both measures recognize that there are people who abuse drugs and provide a certain amount of facilitation for their drug abuse while at

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82. INCB uses this term. *See, e.g.*, INCB, Annual Report 2006 ¶ 175 (2006), *available at* http://www.incb.org/pdf/e/ar/2006/annual-report-2006-en.pdf.
83. The one facility in operation in Canada, in Vancouver, is known as a "supervised injecting site." *See, e.g.*,Vancouver Coastal Health, Insite—Supervised Injection Site, *available at* http://www.vch.ca/sis/.
84. The European Monitoring Centre for Drugs and Drug Addiction, a decentralized agency of the European Union, refers to such facilities as "drug consumption rooms." *See, e.g.,* European Monitoring Center for Drugs and Drug Addiction, European Report on Drug Consumption Rooms (2004), *available at* http://www.emcdda.europa.eu/attachements.cfm/att_2944_EN_consumption_rooms_report.pdf. Harm reduction measures are hardly confined to needle exchange and drug injection rooms, and include a much wider range of approaches, which shall not be examined in this article. *See, e.g.*, Open Society Institute Public Health Program, Harm Reduction Developments 2008: Countries with Injection-Driven HIV Epidemics (2008), *available at* http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/developments_20080304/developments_20080304.pdf.
85. *See, e.g.*, European Monitoring Centre for Drugs and Drug Addiction, *supra* note 84, at 20.
86. *See, e.g., Ottawa's Needle-Exchange Policy Too Dangerous, Shelter Says*, CBC News, 13 Mar. 2008, *available at* http://www.cbc.ca/canada/ottawa/story/2008/03/13/needle-exchange.html (reporting that residents of an area where a needle exchange program was being implemented collected over 1,000 discarded needles in public spaces over a six-week period, prompting a review of the program by the NGO running it. This review showed that, over a twenty-five day period, only 500 of over 2,000 needles distributed were returned to the outreach facility, and concluded that the program, insofar as it does not require addicts to return their used needles to obtain new ones, does not provide enough of an incentive to return used needles.)

the same time trying to make sure that the spread of communicable diseases through the sharing of needles is prevented.

Nevertheless, both UNODC and INCB have drawn a distinction between these two harm reduction measures. The INCB has indicated that it is not against needle exchange: "Governments need to adopt measures that may decrease the sharing of hypodermic needles among injecting drug abusers in order to limit the spread of HIV/AIDS. At the same time, the Board has been stressing that any prophylactic measures should not promote and/or facilitate drug abuse."[87] UNODC, together with WHO and UNAIDS, published a manual for government officials and practitioners on starting needle exchange programs.[88]

However, both organizations, in particular INCB, express opposition to injection rooms, arguing that they are in violation of the international drug control conventions. INCB regularly engages in public condemnation of the countries that allow such facilities. For example, in a very strong passage in its Annual Report 2006, INCB

> [noted] with concern that, despite its ongoing dialogue with the Governments concerned, drug injection rooms, where drug abusers can abuse with impunity drugs acquired on the illicit market, remain in operation in a number of countries, including Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland. [INCB] regrets that no measures have been taken to terminate the operation of such facilities in the countries concerned, and, in some cases, the number of such rooms has increased. . . . [INCB] wishes to reiterate that the provision of rooms for the abuse of drugs . . . are contrary to the international drug control treaties . . . [INCB] believes that any national, state or local authority that permits the establishment and operation of rooms or any outlet to facilitate the abuse of drugs, by injection or any other route of administration, also provides an opportunity for illicit drug distribution. The Board would like to emphasize that Governments have an obligation to combat illicit drug trafficking in all its forms.[89]

Several NGOs have harshly criticized INCB for these positions and for what they characterize as being against harm reduction in general. The

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87. INCB, Annual Report 2003 ¶ 221 (2003), *available at* http://www.incb.org/incb/annual_report_2003.html.
88. WHO/UNODC/UNAIDS, Guide to Starting and Managing Needle and Syringe Programmes, *supra* note 80.
89. INCB, Annual Report 2006, *supra* note 82, ¶¶ 175, 176, 177. *See, e.g.,* Ghodse *supra* note 78, at 277:

> The simplicity of this approach is appealing, but it has certain inbuilt disadvantages. There is a very real risk, for example, that the easy availability of sterile syringes and needles may make the transition to injecting easier and more acceptable and might encourage more young drug abusers to start injecting and to do so sooner: equally there may be less incentive for others to give up injecting. . . . Perhaps the best way forward is to judge each case on its merits, rather than to adopt a stereotyped response.

International Drug Policy Consortium states that INCB has "consistently [positioned] itself as opposed to the harm reduction discourse in general, and in its reticence to speak out in favor of specific harm reduction measures, the INCB is in many ways stifling the development of a system-wide response to the problem."[90] The Canadian Legal Network for HIV/AIDS states that INCB, "rather than acknowledging the urgent need for harm reduction to counter accelerating HIV epidemics, has repeatedly emphasized what it sees as the negative potential of the approach."[91] Though not all of these criticisms are necessarily accurate—as noted above, INCB is not against needle exchange—INCB does hold diametrically opposing views from these organizations on some of the issues.

The concept of harm reduction and the specific measures described above remain controversial. Harm reduction does nothing to address the abuse of the drugs itself; that is not its objective. To those who are against needle exchange programs and injection rooms, these measures amount to condoning and facilitating drug abuse and to discarding the goal of eradicating drug abuse altogether. The United States in particular is vehemently opposed to harm reduction and regularly makes statements at the CND that such practices "assist people in using or abusing drugs" and contribute to "undermining global counter drug efforts."[92] Advocates of harm reduction see things very differently; to them, harm reduction measures are pragmatic tools that take into account the reality of drug abuse and try at least to help drug addicts protect themselves from communicable diseases or overdose. The debate in international drug control circles is polarized and acrimonious and shows little sign of abating.[93]

Some have focused the debate on the concept of the right to the highest attainable standard of health, arguing, broadly, as follows: drug addicts, as much as any other member of society, enjoy the right to health, and as such, states should take measures to ensure that this right is realized. In the context of a person abusing drugs, this would mean that the harm caused by the abuse should be alleviated, hence, the necessity for adequate harm reduction measures.

For example, in his report on his mission to Sweden, the Special Rapporteur on the Right to Health of the Human Rights Council elaborates on a needle exchange program he had visited:

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90. International Drug Policy Consortium, The International Narcotics Control Board: Current Tensions and Options for Reform 6 (2008) *available at* http://www.ungassondrugs.org/images/stories/IDPC_BP_07_INCB_TensionsAndOptions_EN.pdf.
91. Csete & Wolfe, *supra* note 17, at 8.
92. Open Society Institute Public Health Program, *supra* note 84, at 17.
93. *See, e.g.*, Martin Jelsma, Transnational Institute, The Current State of Drug Policy Debate: Trends in the Last Decade in the European Union and United Nations (2008), *available at* http://www.ungassondrugs.org/images/stories/currentstate-e.pdf.

> Not only has this project proven to be highly effective in terms of public health objectives (i.e. it prevents the spread of disease), but it also enhances the realisation of the right to health, including sexual and reproductive health, for intravenous drug users. These results are in line with the worldwide experience that harm-reduction programmes, including needle exchange programmes and associated health care, promote and protect the health of drug users and reduce transmission of communicable diseases such as hepatitis B and C and HIV, including vertical transmission to newborn children from pregnant intravenous drug users or their partners. These programmes are highly cost-effective. . . . The Special Rapporteur emphasizes that the Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm-reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes.[94]

The Committee on Economic, Cultural and Social Rights (CESCR), the treaty body charged with monitoring application of the ICESCR, has made similar statements. In reviewing the implementation of the ICESCR by Tajikistan in November 2006, the Committee stated that it

> recommends to the State party to conduct education campaigns on HIV/AIDS through the media, school curricula and other means, aimed at (1) ensuring that individuals (particularly those belonging to high-risk groups) have the necessary information to protect themselves from the disease, and (2) reducing the stigma and discrimination surrounding the disease and the groups most affected by it, such as injection drug users. . . . The Committee also recommends that the State party establish time-bound targets for extending the provision of free testing services, free treatment for HIV and harm reduction services to all parts of the country.[95]

At the domestic level, a recent judgment of the Supreme Court of British Columbia, Canada, also touches on these issues.[96] The operators of the sole injection room in Canada, known as Insite, which had been established initially as a pilot project under an exemption from federal law prohibiting the possession of illicit drugs, sued for relief from the federal government's efforts to terminate the exemption and consequently, close down the site. The court found in favor of the plaintiffs, stating:

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94. *Implementation of General Assembly Resolution 60/251 of 15 March 2006, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mr. Paul Hunt,* Hum. Rts. Council, 4th Sess., Provisional Agenda Item 2, ¶ 60–62, U.N. Doc. A/HRC/4/28/Add.2 (2007).
95. *Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant, Concluding Observations of the Committee on Economic, Social and Cultural Rights,* U.N. ECSOR, 37th Sess., ¶ 70, U.N. Doc. E/C.12/TJK/CO/1 (2006).
96. *Appeal of B.C. Injection Site Ruling Begins*, The Star, 29 May 2008, *available at* http://www.thestar.com/article/625047.

> While users do not use Insite to directly treat their addiction, they receive services and assistance at Insite which reduce the risk of overdose that is a feature of their illness, they avoid the risk of being infected or of infecting others by injection, and they gain access to counselling and consultation that may lead to abstinence and rehabilitation. All of this is health care. . . . failure to manage the addiction in all of its aspects may lead to death, whether from overdose or other illness resulting from unsafe injection practices. If the root cause of death derives from the illness of addiction, then a law that prevents access to health care services that can prevent death clearly engages the right to life. . . . Denial of access to Insite and safe injection . . . amounts to a condemnation of the consumption that led to addiction in the first place, while ignoring the resulting illness. Though not a ruling on the right to health as such, it is clearly relevant for the matter at hand. The federal government has appealed this ruling, and the case is now with the Supreme Court of that country. [97]

NGOs have put forward similar arguments. Human Rights Watch, for example, has criticized the United States policy prohibiting the distribution of clean needles to drug addicts:

> The government's penalizing people for attempting to protect themselves from [HIV] is blatant interference with the right to the highest attainable standard of health. . . . In reality, the scarcity of treatment programs and the very nature of drug use guarantee that there will always be people who either cannot or will not stop using drugs. Penalizing this population for using sterile syringes amounts to prescribing death as a punishment for illicit drug use.[98]

Some organizations have gone so far as to state that there is a fundamental conflict between the prohibition of drugs and the right to health. The Beckley Foundation argues that there is an inherent "tension between prohibition on the one hand, and health and human rights concerns on the other."[99] Similar assessments are made by Canada HIV/AIDS Legal Network, which states that "the criminalisation of people who use drugs is undermining public health efforts, including the response to HIV . . . among people who use drugs [and] stigmatising people who use drugs through criminalising them undermines their human rights."[100] Human Rights Watch argues that "the ideology of the 'war on drugs' has trumped both reason and reality . . . and violated the human right of injection drug users to take steps to protect their health."[101] Even WHO, UNODC, and UNAIDS stated in a joint publication promoting needle exchange programs that the "[p]rotection of

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97. PHS Community Services Society v. Attorney General of Canada, [2008] 293 D.L.R. (4th) 392, ¶ ¶ 135, 141, 144 (Can.).
98. Cohen, Human Rights Watch, *supra* note 4.
99. Damon Barrett et al., Beckley Foundation, Drug Policy Programme, *supra* note 5, at 34.
100. Ralf Jürgens "Nothing about us without us" Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative 57 (Int'l Ed. 2008)
101. Cohen, Human Rights Watch, *supra* note 4.

human rights is critical for preventing HIV as people are more vulnerable to infection when their economic, health, social or cultural rights are not respected. Equally, a punitive approach, based overtly on criminal justice measures, succeeds only in driving underground those people most in need of prevention and care services."[102]

Indeed, these arguments seem to be supported by the aforementioned Canadian court judgment, which states that Canadian legislation outlawing the possession of drugs

> for every purpose without discrimination or differentiation in its effect, is arbitrary. In particular it prohibits the management of addiction and its associated risks at [the injection room]. It treats all consumption of controlled substances, whether addictive or not, and whether by an addict or not, in the same manner. Instead of being rationally connected to a reasonable apprehension of harm, the blanket prohibition contributes to the very harm it seeks to prevent. It is inconsistent with the state's interest in fostering individual and community health, and preventing death and disease. That is enough to compel the conclusion that [this provision] . . . is arbitrary and not in accord with the principles of fundamental justice.[103]

The human right to the highest attainable standard of health, therefore, appears to be used as one of the pillars of harm reduction.

VI. MANDATED DRUG TREATMENT—REALLY A HUMAN RIGHTS VIOLATION?

One of the unstated, but fundamental, tenets of the harm reduction philosophy is that undergoing treatment for drug addiction must always be a *choice* on the part of the addict. In other words, no person should be forced into drug addiction treatment against their will, and, insofar as the addict has not yet made the choice to undergo treatment, the state must provide facilities so that he can attain the highest possible standard of health, taking into account the fact of his addiction. As stated by the Canadian Centre on Substance Abuse:

> Mandatory treatment strategies run contrary to . . . harm reduction approaches. Harm reduction is founded on the notion of offering participants choices and options for their treatment, while recognising that many individuals with substance abuse problems may not be willing or able to stop using drugs. In such cases, it is important to "meet them where they are" in order to gradually reduce

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102. WHO/UNODC/UNAIDS, GUIDE, *supra* note 84, at 5.
103. PHS Community Services Society v. Attorney General of Canada, *supra* note 97, ¶ 152.

> high-risk and harmful behaviours. . . . Forcing individuals to undergo treatment for substance abuse may be seen as violating their civil liberties.[104]

Furthermore, the right to the highest attainable standard of health includes the right to be free from involuntary medical treatment of any kind. Article 12 of the ICESR has been the subject of a General Comment by CESCR that states:

> The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.[105]

There is little elaboration on the right to be free from involuntary treatment, and the concept may be so obvious as not to require further explanation. Certainly, involuntary "medical" treatment has been the cause of a litany of human rights abuses in the world, including incarceration for "mental illness" in the Soviet Union[106] and forced sterilization of mentally ill people in Sweden.[107] Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation. Entitlements include the right to a system of health protection (e.g., health care and the underlying determinants of health) that provides equality of opportunity for people to enjoy the highest attainable standard of health.[108]

Other organizations have also argued that, if imposed, treatment for drug addiction is a violation of human rights. The Beckley Foundation, for

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104. Canadian Center on Substance Abuse, Fact Sheet on Mandatory and Coerced Treatment 2 (2006), *available at* http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-003648-2006.pdf.
105. *Substantive Issues Arising in the Implementation of the International Covenant of Economic, Social and Cultural Rights,* General Comment No. 14, U.N. Econ., & Soc. Council, 22nd Sess., U.N. Doc. E/C.12/2000/4 (2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument. (emphasis in original).
106. Robert van Voran, *The Soviet Case: Prelude to a Global Consensus on Psychiatry and Human Rights, in* Dangerous Minds: Political Psychiatry in China Today and its Origins in the Mao Era 31, 31 (2000), *available* at http://www.hrw.org/legacy/reports/2002/china02/china0802.pdf. Some reports indicate that psychiatry is still being used to oppress dissidents in Russia; see, e.g., Peter Finn, *In Russia, Psychiatry Is Again a Tool Against Dissent,* Wash. Post, 30 Sept. 2006, at A01; Association of American Physicians and Surgeons, *Psychiatry Used as a Tool Against Dissent* (2 Oct. 2006); Adolf Ratzka, *Eradication of "Deviants": The Dark Side of the Swedish Model,* Independent Living Institute (Oct. 1997).
107. Adolf Ratzka, *Eradication of "Deviants": The Dark Side of the Swedish Model,* Independent Living Institute (Oct. 1997).
108. *Special Rapporteur, Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health,* ¶ 24, Comm'n on Hum. Rts., U.N. Doc. E/CN.4/2003/58 (13 Feb. 2003).

example, includes "coercive drug treatment" amongst the litany of human rights abuses that take place within the context of efforts against drugs. They state:

> In many countries people who use drugs can face coerced "treatment" and "rehabilitation." Rather than being discouraged, such mandatory treatment is specifically permitted in the 1961 Single Convention on Narcotic Drugs. . . . The law in China, for example, dictates that "drug users must be rehabilitated." Those arrested for drug possession and use can be consigned to forced detoxification centres without any trial or other semblance of due process. . . . Throughout its 2003 "war on drugs," the government in Thailand took a number of coercive steps to force people to enroll in drug treatment programs. Initially, the Thai government mandated that all drug users attend drug treatment. Those that did not "volunteer" for treatment during the first few months of the war on drugs were subject to arrest and compulsory treatment, and placed on blacklists that were widely publicized throughout local communities and shared with local police.[109]

While the practices in China and Thailand are indeed violations of human rights, it is submitted that it is not the mandated treatment that is the issue, but rather the lack of due process as well as the conditions of detention that violate human rights norms.

Many countries with criminal justice procedures far more compliant with international human rights standards than China or Thailand do implement a level of coercion pursuant to procedures which adhere to standards of human rights in ensuring that drug addicts undergo treatment. In particular, a number of countries use specialized procedures to deal with non-violent drug offenders, including what are generally known as "drug courts."[110] According to UNODC, these are in operation in Australia, New Zealand, Barbados, Bermuda, Brazil, Canada, the Cayman Islands, Chile, Jamaica, Trinidad and Tobago, the United States, Norway, Scotland, and Ireland.[111]

Though drug courts vary considerably from jurisdiction to jurisdiction, the general model is the same; non-violent drug offenders (those found guilty of simple possession or abuse as opposed to trafficking) are directed to specialized courts that usually provide the offender with a choice of undergoing treatment or incarceration.[112] The offender undergoes treatment while being closely supervised by the drug court, and, generally, more spe-

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109. Barrett et al., Beckley Foundation Drug Policy Programme, *supra* note 5, at 29.
110. UNODC, Drug Treatment Courts Work! 3 (2005), *available at* http://www.unodc.org/pdf/drug_treatment_courts_flyer.pdf. Drug courts are a major programme in the United States of America, where "there are more than 2,140 drug courts in operation with another 284 being planned or developed." Office of National Drug Control Policy, Drug Courts, *available at* http://www.whitehousedrugpolicy.gov/enforce/drugcourt.html.
111. Drug Treatment Courts Work!, *supra* note 110.
112. UNODC, UNODC and Drug Treatment Courts ("Drug Courts"), *available at* http://www.unodc.org/unodc/en/legal-tools/Drug-Treatment-Courts.html.

cifically by multi-disciplinary teams that provide offenders with assistance in other areas. Successful completion of the treatment leads to suspension or dismissal of the criminal case.

Some practitioners and academics disagree about the effectiveness of the drug court approach.[113] However, countries where this approach exists agree that it is a useful tool to direct drug addicts into treatment, and the approach appears to be growing internationally.[114] The Department of Justice of the United States has concluded that drug courts

> quickly identify substance abusing offenders and place them under ongoing judicial monitoring and community supervision, coupled with effective, long-term treatment services. . . . Research verifies that no other justice intervention can rival the results produced by drug courts. . . . According to over a decade of research, drug courts significantly improve substance abuse treatment outcomes, substantially reduce crime, and produce greater cost benefits than any other justice strategy.[115]

One study conducted by the United States Accountability Office has found "a lower level of recidivism for persons who have underwent treatment through drug court supervision."[116] In addition, the INCB has advocated for the use of specialized drug courts:

> The Board notes, for example, the positive impact of "drug treatment courts," as specialist courts for drug offenders, that have been established in a small but growing number of countries where, inter alia, lower-level violent offenders can be taken care of using a multidisciplinary approach. The Board sees potential in these courts contributing more to dealing with the underlying individual, public safety, public health and community problems of drug-related crime and violence.[117]

Other countries have comparable approaches with similar goals as drug courts to promote treatment and rehabilitation. In the United Kingdom, courts can issue orders for drug rehabilitation, requiring treatment and

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113. *See, e.g.*, Douglas Marlowe, Drug Court Efficacy vs Effectiveness (2004), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/DCEfficacyvsEffectiveness.pdf.
114. *See, e.g.*, Drug Courts, *supra* note 112.
115. C. West Huddleston, III, Douglass B. Marlowe & Rachel Casebolt, National Drug Court Institute, *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem-Solving Court Programs in the United States*, 1 Nat'l Drug Ct. Inst. 1, 2 (2008)
116. United States Government Accountability Office, Adult Drug Courts: Evidence Indicates Recidivism Reduction and Mixed Results for Other Outcomes: Report to Congressional Committees 1 (2005), *available at* http://www.gao.gov/new.items/d05219.pdf.
117. INCB, Drugs, Crime and Violence: The Microlevel Impact ¶ 55 (2003), *available at* http://www.incb.org/pdf/e/ar/2003/incb_report_2003_1.pdf.

regular drug testing under the supervision of the probation service.[118] In Portugal, persons apprehended in possession of a small quantity of drugs—not over the threshold to create a legal presumption that they are engaged in trafficking—are brought before Commissions for the Dissuasion of Drug Abuse. These commissions consist of legal professionals and persons with medical, psychological, or pharmacological experience who make an assessment as to whether the person is a drug addict and, if so, refers the person to treatment.[119] The Dissuasion Commissions have reportedly been successful in encouraging increasing numbers of addicts to undergo treatment.[120]

In March 2008, UNODC and WHO published a joint paper entitled "Principles of Drug Dependence Treatment."[121] Though termed as a "discussion paper," the paper clearly outlines the joint position of both organizations on issues surrounding treatment for drug addiction and takes a middle ground on these issues. The paper highlights that one of the main principles of treatment should be "human rights and patient dignity" and states that

> drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination. . . [a]s any other medical procedure, in general conditions drug dependence treatment, be it psychosocial or pharmacological, should not be forced on patients. Only in exceptional crisis situations of high risk to self or others, compulsory treatment should be mandated for specific conditions and periods of time as specified by the law.[122]

At the same time, the paper goes on to underscore that "[w]hen the use and possession of drugs results in state-imposed penal sanctions, the offer of treatment as an alternative to imprisonment or other penal sanction presents a choice to the patient/offender, and although it entails a degree of coercion to treatment, the patient is entitled to reject treatment and choose the penal sanction instead."[123] The two organizations therefore recognize the

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118. *See, e.g.,* U.K. Government Home Office, Drug Interventions Programme, *available at* http://drugs.homeoffice.gov.uk/drug-interventions-programme/strategy/interventions/DRR/. The Home Office of the United Kingdom states that "such orders have succeeded in engaging people in treatment for more than 12 weeks, which is regarded as a key milestone for many drug misusers in making real progress towards a drug-free lifestyle." *Id.*
119. *See, e.g.*, Reitox National Focal Point, Portugal's 2006 National Report to the European Monitoring Centre for Drugs and Drug Addiction (2006), *available at* http://www.emcdda.europa.eu/attachements.cfm/att_44976_EN_NR2006pt.pdf.
120. *Id.*
121. UNODC & WHO, Principles of Drug Dependence Treatment (2008), *available at* http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf.
122. *Id.* at 10.
123. *Id.*

drug court approach as legitimate, even though the process does involve coercing addicts into undergoing treatment.

Clearly, the decision to undergo treatment in the drug court context is not strictly voluntary. Given that the alternative would be criminal sanctions, including imprisonment in some cases, the offenders certainly have a strong incentive to undergo treatment. For example, HIV/AIDS Law Canada has argued that

> there are a number of human rights concerns that have yet to be fully evaluated in the context of drug treatment courts. . . . 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.[124]

However, it is submitted that not every level of involuntariness in this area is in violation of the individual's rights. Society has a strong interest in ensuring that persons who are addicted to drugs undergo treatment for their condition and, hopefully, overcome their addiction. Even at the individual level, one could certainly sustain the argument that ensuring that a person undergoes treatment for drug addiction, even with a level of coercion, would be the most effective way to guarantee that he is able to attain the highest possible standard of health. To exclude completely the possibility of any level of coercion would be in many cases to exclude the possibility of the addict overcoming his addiction.

The reality of drug addiction is that it destroys—or at least suspends—the free will of the addict. While taking into account the varying individual degrees of addiction, the general situation of the addict is one who is, to some extent, consistently under the influence of drugs. It is disingenuous to pretend that the "decision" not to undergo treatment is an entirely free one. The situation is fundamentally different from the individual who, for religious reasons, chooses not to undergo a particular treatment for a life threatening disease. Decisions made under the influence of drugs are not decisions of free will, and to base one's argument on the premise that it is so is to come dangerously close to arguing that there is a right to abuse drugs.

Of course, this is not to state that all persons who abuse drugs have lost their capacity to make reasoned decisions. The question of whether consent on the part of the addict is a necessary prerequisite for drug addic-

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124. Canadian HIV/AIDS Legal Network, Dependent on RigHts: Assessing Treatment of Drug Dependence from a Human Rights Perspective 30 (2007), *available at* http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1124. Ghodse also states that there are "important implications for civil rights" with drug courts, but does not have objections in principle to the approach; rather, he states "it is essential that confidentiality is guaranteed and that effective and ethical treatment is provided when individuals may have little choice but to co-operate." Ghodse, *supra* note 78, at 238.

tion treatment to be effective is one which remains a subject of debate.[125] At least some degree of motivation is desirable, if only because, as a practical matter, it usually leads to better results.[126] However, much has to do with the individual's specific circumstances, and the issue defies sweeping generalizations either way. Blanket statements that any kind of mandated treatment is a violation of the addict's human rights are neither helpful nor practical and, at the end of the day, are not grounded in the reality of drug addiction.

Harm reduction certainly has an important part to play, but rather as a "stop gap" measure until the addict undergoes treatment and, hopefully, overcomes his addiction—not as an end in itself. Many seem to have lost sight of this, putting forward an approach summarized succinctly in one paper issued by Transnational Institute: "a world without drugs will never exist. The ideology of 'zero tolerance' needs to be replaced by the principle of harm reduction, which offers a more pragmatic approach that favors policies capable of reducing drug related harms as far as possible, for the consumer and for society in general."[127] One wonders how this argument would develop in the area of human rights. While a world without human rights violations will arguably never exist either, that is certainly no excuse to discard the ideal and to continue to strive for that goal. The same should apply to drug control.

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125. *See, e.g.*, Robert Newman, *Involuntary Treatment of Drug Addiction*, 3 Yale Rev. L. & Soc. Action 246 (1973); Canadian Centre on Substance Abuse, Mandatory and Coerced Treatment Fact Sheet (2006), *available at* http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-003648-2006.pdf; National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Reseach-Based Guide (1999); Caryl M. Beynon, Mark A. Bellis & Jim McVeigh, *Trends in Drop Out, Drug Free Discharge and Rates of Representation: A Retrospective Cohort Study of Drug Treatment Clients in the North West of England*, BMC Public Health (Aug. 2006); RAND Corporation, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States (2001), *available at* http://www.rand.org/pubs/monograph_reports/2007/MR1340.pdf.

126. *See, e.g.*, Ghodse, *supra* note 78, at 211: "A person's level of motivation for change is an important factor in determining the likely success of any intervention."

127. Transnational Institute, Rewriting History: A Response to the 2008 World Drug Report 3 (2008), *available at* http://www.tni.org/reports/drugs/brief26.pdf?.