

'Treatment in Liberty'

Human Rights and Compulsory Detention for Drug Use

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Abstract: This is the first detailed examination of compulsory detention for 'drug treatment' through the lens of a rapidly evolving international legal framework. It is estimated that as many as half a million people worldwide are detained for the purpose of 'drug treatment', many held for months or years at a time without being charged criminally or being able to challenge the legality of their detention. This is therefore a key issue sitting at the intersection of human rights, drug policy and medical ethics. The article explores arbitrary detention and involuntary committal on medical grounds within international human rights law, as well as the historical-legal evolution of drug 'treatment' as the term is understood within international drug control law. It assesses whether drug use or drug dependency constitute a reasonable limitation of the right to liberty, and concludes that this type of detention represents a violation of international law.

KEYWORDS: drug control, drug policy, detention, drug treatment, human rights, arbitrary detention, compulsory treatment

'Treatment in liberty has failed wherever it has been tried'.¹

Hon. H. Ellenbogen
Representative of the United States
United Nations Conference for the Adoption
of a Single Convention on Narcotic Drugs (1961)

'Some of the most egregious violations of the right to health have
occurred in the context of "treatment" for drug dependence'.²

Anand Grover
UN Special Rapporteur on the Right to Health
Annual Report 2010

1. INTRODUCTION

In June 2020, a group of thirteen United Nations agencies – including the Office of the High Commissioner for Human Rights, the World Health Organization, the UN Office on Drugs and Crime and UNICEF – released a joint statement calling for the closure of all compulsory drug detention and rehabilitation centres in the Asia Pacific region.³ This statement, issued in the context of the COVID-19 pandemic, echoed a similar 2012 joint statement released by twelve United Nations organisations in 2012.⁴ That earlier statement emerged following a series of investigations by non-governmental organisations and human rights monitors detailing the involuntary detention of perhaps half a million people worldwide for the purpose of compulsory 'drug treatment'.⁵ It states:

¹ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. I (1964) A/CONF.24/24 at 103.

² Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, A/65/255, 6 August 2010 at 11.

³ International Labour Organisation; United Nations Development Programme; United Nations Population Fund; Office of the High Commissioner for Human Rights; Joint United Nations Programme on HIV/AIDS; United Nations High Commissioner for Refugees; United Nations Children's Fund; United Nations Office on Drugs and Crime; United Nations Entity for Gender Equality and the Empowerment of Women; World Food Programme; World Health Organization; United Nations Educational, Scientific and Cultural Organisation; International Organization for Migration, 'Joint Statement: Compulsory drug detention and rehabilitation centres in Asia and the Pacific in the context of COVID-19', 1 June 2020.

⁴ International Labour Organisation; Office of the High Commissioner for Human Rights; United Nations Development Programme; United Nations Educational, Scientific and Cultural Organisation; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; United Nations Office on Drugs and Crime; United Nations Entity for Gender Equality and the Empowerment of Women; World Food Programme; World Health Organization; and Joint United Nations Programme on HIV/AIDS, 'Joint Statement: Compulsory drug detention and rehabilitation centres', March 2012.

⁵ See, for example, International Harm Reduction Development Program, *Human Rights Abuses in the Name of Drug Treatment: Reports From the Field* (March 2009).; Human Rights Watch, *The Rehab Archipelago Forced Labor and Other Abuses in Drug Detention Centers in Southern Vietnam* (2011).; Human Rights Watch, 'Skin on the Cable': *The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia* (2010).; Thompson, *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and*

The continued existence of compulsory drug detention and rehabilitation centres, where people who are suspected of using drugs or being dependent on drugs...are detained without due process in the name of “treatment” or “rehabilitation”, is a serious concern....The UN entities which have signed on to this statement call on States that operate compulsory drug detention and rehabilitation centres to close them without delay and to release the individuals detained.⁶

The situation of mass detention of persons using, or suspected of using, illicit drugs represents the latest development in a debate that has been ongoing for decades. Indeed, in the evolution of the international drug control regime, underpinned by the three UN drug conventions,⁷ the question of the detention or involuntary committal of people who use illicit substances has been a recurring theme. In some cases, the impetus for this discussion has been from a humanitarian (albeit paternalistic) concern to address some people’s legitimate medical needs.⁸ In others, it has been driven by a conception of drug use as a social ‘evil’,⁹ and the people who use them as threats of ‘contagion’ to broader society and morality.¹⁰ Indeed the interplay between these two driving rationales makes the issue of involuntary detention and treatment for drugs an area in which abusive practices have been pursued, and even legitimised, by claims of noble intent.¹¹

Thailand, International Harm Reduction Development Program (2010).; Elliott, Lines, Schleifer and Symington, *Treatment as Torture: Applying International Human Rights Standards to Drug Detention Centres*, Open Society Foundations (2011).; Pearshouse, *Compulsory Drug Treatment in Thailand*, Canadian HIV/AIDS Legal Network (2009).; World Health Organization Western Pacific Region, *Assessment of Compulsory Treatment of People Who Use Drugs in Cambodia, China, Malaysia and Viet Nam: An Application of Selected Human Rights Principles*, 2009, available at: <https://apps.who.int/iris/handle/10665/207014> [last accessed 15 November 2020].

⁶ International Labour Organisation, *et al*, supra n 4 at 1.

⁷ Single Convention on Narcotic Drugs 1961, 520 UNTS 204 (as amended by the Protocol Amending the Single Convention on Narcotic Drugs 1972, 976 UNTS 3); Convention on Psychotropic Substances 1971, 1019 UNTS 175; Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, 28 ILM 493.

⁸ See, for example, the statement of the representative of Ghana during the drafting of the 1961 Single Convention on Narcotic Drugs that ‘[N]o sincere humanitarian could fail to agree with the provisions of article 47 concerning the treatment of addicts.’ United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, supra n 1 at 109.

⁹ See generally, Lines, *Drug Control and Human Rights in International Law* (2017) at chap 3.; Lines, “‘Deliver us from evil’? – The Single Convention on Narcotic Drugs, 50 years on” (2010) *International Journal on Human Rights and Drug Policy* 1 at 3—13.; United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, supra n 1 at 103.

¹⁰ See, for example, the arguments of the United States in support of compulsory detention during the drafting of the 1961 Single Convention on Narcotic Drugs. United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, supra n 1 at 103.

¹¹ *Ibid*.

Yet whatever the justification, arbitrary detention violates basic principles of international law.¹² Article 9 of the Universal Declaration of Human Rights states that, 'No one shall be subjected to arbitrary arrest, detention or exile.'¹³ The right to be free from arbitrary arrest or detention is also enshrined in other international treaties, including Article 9 of the International Covenant on Civil and Political Rights,¹⁴ the Articles 37 and 40 of the Convention on the Rights of the Child¹⁵ and Article 14 of the Convention on the Rights of Persons with Disabilities.¹⁶ It is also enshrined within the regional human rights instruments.¹⁷

The issue of compulsory drug detention raises significant concerns about the use of arbitrary detention in the name of drug control, as well as engaging the related issue of the right to consent to, or refuse, treatment. However, despite the clear guidance on these matters within international human rights law, some argue that the nature of drug use or 'addiction' means that such norms do not apply, and drug dependency represents a legitimate basis for limitation on the right to liberty. Takahashi, for example, advances the position that 'drug addiction...destroys—or at least suspends—the free will of the addict',¹⁸ and therefore that 'It is disingenuous to pretend that the "decision" not to undergo treatment is an entirely free one...[as] Decisions made under the influence of drugs are not decisions of free will.'¹⁹

This article offers the first detailed examination of the issue of compulsory detention for drug treatment through the lenses of both international human rights law and international drug control law. It explores the definition of arbitrary detention, and using various legal frameworks considers the conditions under which involuntary committal on medical grounds is consistent with current human rights norms. In doing so, this paper reveals a significant fragmentation within the international human rights architecture in scrutinising the legitimacy

¹² See generally, Rodley and Pollard, *The Treatment of Prisoners under International Law*, 3rd edn' (2009) at chap 11.

¹³ Article 9 Universal Declaration of Human Rights 1948, UNGA Res 217 A(III).

¹⁴ Article 9 International Covenant on Civil and Political Rights 1966, 999 UNTS 171.

¹⁵ Articles 37 and 40, Convention on the Rights of the Child 1989, 1577 UNTS 3.

¹⁶ Article 14 Convention on the Rights of Persons with Disabilities 2007, A/RES/61/106.

¹⁷ Article 4 Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) 1950, ETS 5.; Article 14 Arab Charter on Human Rights 2004.; Article 7 American Convention on Human Rights 1978, 36 ILM 1144 UNTS 123.; Article 6 African Charter on Human and Peoples' Rights 1981, 21 ILM 58.; Article XXV American Declaration of the Rights and Duties of Man 1948, OAS Res XXX.

¹⁸ Takahashi, 'Drug Control, Human Rights, and the Right to the Highest Attainable Standard of Health: By No Means Straightforward Issues' (2009) *Human Rights Quarterly* 31 at 775.

¹⁹ *Ibid.*

of detention on such grounds. At the foundation of this divergence lie important discussions around paternalism, colonialism and medical power for social control, which fall outside of the scope of this paper.²⁰ However, this article highlights the significance of this fragmentation as it reflects an expansion of the normative space within which to consider the legitimacy of detention. It builds upon the most recent work of United Nations human rights mechanisms on the specific question of detention based on mental health grounds and offers an original analysis of this work in the context of detention for the purposes of drug treatment. It also explores, for the first time, the historical-legal evolution of 'drug treatment' as the term is understood within international drug control law. Through this process, the article considers whether drug use or drug dependency constitute a reasonable limitation on the right to liberty under international human rights law and international drug control law, and engages directly with arguments that justify drug 'addiction' as such a legitimate limitation. In doing so, the article offers guidance to law and policy makers, practitioners and multi-lateral agencies on a quickly evolving issue that sits at the intersection of human rights, drug policy and medical ethics.

2. COMPULSORY DETENTION IN THE NAME OF 'DRUG TREATMENT'

In recent years, the issue of the forcible detention and compulsory 'drug treatment' of people who use (or who are suspected of using) illegal drugs has become one of increasing concern among non-governmental organisations and United Nations human rights bodies. As described by the UN Special Rapporteur on Torture in 2013,

Compulsory detention for drug users is common in so-called rehabilitation centres. Sometimes referred to as drug treatment centres or "reeducation through labor" centres or camps, these are institutions commonly run by military or paramilitary, police or security forces, or private companies. Persons who use, or are suspected of using, drugs and who do not voluntarily opt for drug treatment and rehabilitation are confined in such centres and compelled to undergo diverse interventions.²¹

This practice has been documented in numerous States including China, Vietnam, Cambodia, Thailand, Russia, Malaysia, Myanmar, Lao PDR, Indonesia, the Philippines, Brunei Darussalam, and Singapore. In total, it is estimated that more than half a million

²⁰ See Schenwar and Law, *Prison by Any Other Name: The Harmful Consequences of Popular Reforms* (2020).

²¹ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, A/HRC/22/53, 1 February 2013 at 40.

people worldwide could be arbitrarily detained for the purpose of 'drug treatment', many of them held for months or even years at a time, without being charged with any criminal offence, being brought before a court or otherwise allowed to challenge the legality of their detention.²² In China alone in 2018, there were 370 compulsory isolation drug rehabilitation centres and 73 drug rehabilitation centres housing nearly 270,000 people. It is estimated that 1.4 million people passed through these centres between 2008 and 2018.²³ Police have the authority to commit a person who uses drugs to three years of 'community-based' treatment, with repeat offenders and those 'failing' such treatment liable to be detained in a compulsory isolation centre for up to three years.²⁴ In Malaysia,²⁵ over 5,000 people were involuntarily committed to drug treatment centres pursuant to a court order in 2018.²⁶ The Government of Thailand reported over 200,000 people 'registered in treatment and rehabilitation programmes' in 2018.²⁷

More recent research has also revealed the troubling scale of compulsory drug detention in private rehabilitation facilities, particularly in Latin America, often run by religious groups.²⁸ Concerns have also been raised about privately run treatment centres in countries including Bangladesh, Brazil, Ecuador, Iran and India. These private facilities exist instead of or in addition to State-run programmes, and have been criticised for operating with 'varying degrees of concern for human dignity or quality of care, often with little recourse to

²² The real number is likely to be much higher, but cannot be accurately estimated because of poor transparency and the secrecy in which many of the private rehabilitation centres operate. See Open Society Foundations, *supra* n 22.; Jürgens and Csete, 'In the name of treatment: ending abuses in compulsory drug detention centers' (April 2012) 107 *Addiction* 4.

²³ China Government Network – Central People's Government Portal, *Ministry of Justice releases "Report on the development of China's Judicial Administration of Drug Detoxification"*, 26 June 2019; Dirks, *The China Drug, Crime and Detention Database*, International Drug Policy Unit: The London School of Economics and Political Science, 2019.

²⁴ International Drug Policy Consortium, *Drug Dependence Treatment in China: A policy analysis*, February 2017, available at: http://fileserv.idpc.net/library/IDPC-briefing-paper_China-drug-treatment.pdf [last accessed 1 November 2020].

²⁵ Malaysia National Anti-Drug Agency, *Maklumat Dadah 2018*.

²⁶ Human Rights Watch, *supra* n 5 at 3–4.

²⁷ ASEAN Narcotics Cooperation Center, *ASEAN Drug Monitoring Report 2018 – Second Edition*, August 2019 at 74.

²⁸ See Open Society Foundations, *No Health, No Help: Abuse as Drug Rehabilitation in Latin America & the Caribbean* (2016).; Conselho Federal de Psicologia Mecanismo Nacional de Prevenção e Combate à Tortura Conselho Nacional do Ministério Público Ministério Público do Trabalho, *Hospitais Psiquiátricos No Brasil: Relatório De Inspeção Nacional* (December 2019).; O'Neill, 'On Liberation: Crack, Christianity, and Captivity in Postwar Guatemala City' (2014) *Social Text* 32(3).

evidence-based treatment, and with limited oversight by to the state'.²⁹ In Mexico, it is estimated that 35,000 people are held in such unregulated 'treatment' centres.³⁰

In many cases, these centres are run by religious, military or police personnel rather than competently trained social or medical staff, and numerous investigations into the conditions of these centres include reports of physical and sexual abuse and humiliation, beatings, forced labour and denial of medical services.³¹ Human rights monitors identify various processes through which people may be sent to compulsory drug detention. In many cases, people are detained following arrest by police, militia or other State authority for drug use/possession or vagrancy, and detention takes place without access to legal counsel or formal hearing. As described by one former detainee in Vietnam, 'I was caught by police in a roundup of drug users. They saw me with other users. They took me to the police station in the morning and by that evening I was in the drug center.... I saw no lawyer, no judge.'³² In other cases, people are committed by police at the request of the person's parents or other family members.³³ As described by a former detainee in Cambodia, 'My parents called the police to arrest me. [My parents] said I am a drug user and I caused trouble to them. The military police arrested me inside the house while I was sleeping'.³⁴ Research in several countries has documented failure to inform people of their length of sentence when first detained, and/or having sentences extended without reason or due process.³⁵

After a sharp increase in the use of detention centres in the name of 'drug treatment' between 2000 and 2010,³⁶ some countries in Asia have taken steps to reform this system, due in part to international pressure. For example, with the adoption of the 2016 New Strategic Plan on Drug Control, Cambodia committed to adopt a more health-centred approach to drug policy, and to prioritise community-based treatment programmes.³⁷ As of October 2018,

²⁹ Harm Reduction International, *Submission to the UN Working Group on Arbitrary Detention on detention in the context of drug policies* (31 March 2020) at 4.

³⁰ Open Society Foundations, *supra* n 28 at 6.

³¹ ASEAN Narcotics Cooperation Center, *supra* n 27.; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, *supra* n 21 at 40–44.

³² Amon, Pearshouse, Cohen and Schleifer, 'Compulsory Drug Detention Centers in China, Cambodia, Vietnam, and Laos: Health and Human Rights Abuses' (2013) 15 *Health and Human Rights* 2 at 126.

³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *Ibid* at 127.

³⁶ Among others, Thompson, *supra* n 5 at 18; Human Rights Watch, *supra* n 5 at 2.

³⁷ Council of the European Union, Dublin Group – Regional Report on South Asia: September 2018, 7 November 2018, 13784/18 at 46.; Marazzi Sassoon, 'Study calls for closure of compulsory drug centres', *The Phnom Penh Post*, 19 January 2017.

however, seven compulsory drug treatment centres remained in operation (alongside ten privately-run centres).³⁸ The 'Decision on the Drug Rehabilitation Renovation Plan' adopted by Vietnam in 2013 included a commitment to scale up community-based and voluntary drug treatment while reducing the number of people detained in compulsory treatment centres. As of April 2019, six compulsory drug rehabilitation centres were present in the country (alongside 79 mixed compulsory and voluntary centres) hosting over 26,000 people.³⁹ Forced labour remains a central part of the 'treatment', was also denounced by the Human Rights Committee in 2019.⁴⁰ According to a report from Human Rights Watch, detainees in the centres 'are forced to work in other forms of agricultural production (either for outside sale, such as potato or coffee farming, or for consumption by detainees), garment manufacturing, other forms of manufacturing (such as making bamboo and rattan products), and construction work'.⁴¹ Those who fail to meet the expected work quotas are subject to punishments including denial of baths for up to a month, beatings and chaining and being forced to stand on their toes for more than 24 hours.⁴² The national legislation allows for the incarceration in these centres of people as young as twelve for up to two years.⁴³

A 2009 report of the Western Pacific Regional Office of the World Health Organization documenting the practice of detention *en masse* of people who use drugs in four Asian States provides another glimpse of the scale of the problem.⁴⁴ According to the report,

In countries such as Cambodia, China, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, Thailand and Viet Nam, [people who use drugs] are arrested and sent to compulsory drug treatment centres, which are supervised by custodial staff, often with little involvement of trained staff or outside health agencies. One problem related to this type of response is that it does not differentiate between people who use drugs occasionally and those who are drug dependent. As a result, some [people who use drugs] are sent to such centres though they may not need drug treatment therapy. In addition... the treatment and rehabilitation services provided to those who need it is of poor quality and

³⁸ Marazzi Sassoon, *supra* n 37.; Amnesty International, *Substance Abuses: The Human Cost of Cambodia's Anti-Drug Campaign*, AI ASA 23/2220/2020, 12 May 2020, available at : <https://www.amnesty.org/en/documents/ASA23/2220/2020/en/> [last accessed 15 November 2020].

³⁹ Council of the European Union, *supra* n 37 at 25.

⁴⁰ Human Rights Committee, Concluding Observations on the third periodic report of Vietnam, 28 March 2019, CCPR/C/VNM/CO/3 at 31.

⁴¹ *Ibid* at 3.

⁴² International Harm Reduction Development Program, *supra* n 5 at 2.

⁴³ Articles 28 and 29, Socialist Republic of Vietnam, Law on Preventing and Combating Narcotic Drugs, 9 December 2000, available at: https://www.unodc.org/res/cld/document/vnm/law-on-preventing-and-combating-narcotics_html/Law_preventnarcoticsdrugs-viet2000.pdf [last accessed 15 November 2020].

⁴⁴ World Health Organization Western Pacific Region, *supra* n 5.

neither in accordance with human rights' principles nor with evidence-based drug treatment...The treatment of [people who use drugs], therefore, tends to take the form of sanction rather than of therapy and the relapse rate after release from the centres is very high.⁴⁵

The conditions documented in these 'drug treatment' centres raise multiple human rights concerns, including the right to health and the prohibition of torture, and cruel, inhuman or degrading treatment or punishment, to name but two. This article will focus, however, on the issue of the right to liberty, and consider whether committal of people to these centres on the basis of drug use or drug dependency constitutes arbitrary detention or a form of involuntary treatment.

3. WHEN IS DETENTION ARBITRARY?

The prohibition of arbitrary detention is integrally linked to the broader right to liberty.⁴⁶ As stated by the European Court of Human Rights in reference to Article 5 of the European Convention on Human Rights, 'it enshrines a fundamental human right, namely the protection of the individual against arbitrary interferences by the State with his right to liberty'.⁴⁷ As described by de Londras, 'international law focuses on preventing arbitrariness in detention; it does not attempt to prevent detention per se'.⁴⁸ These approaches necessarily focus on the individual's experience of detention and emphasise safeguards to prevent arbitrariness. Implicit in this perspective is an acceptance of the legitimacy of detention, which can have the effect of shifting the legal gaze away from problematic regimes that give rise to the widespread phenomenon of arbitrary detention.

This approach characterises the traditional understanding of arbitrary detention as expressed by a number of international human rights mechanisms and instruments. However, it is also important to acknowledge that the international legal machinery is undergoing an evolution on this question. In recent years, international human rights mechanisms have begun to structurally interrogate the legitimacy of detention regimes including immigration

⁴⁵ Ibid at 3.

⁴⁶ de Londras, 'The Right to Challenge the Lawfulness of Detention: An International Perspective on US Detention of Suspected Terrorists' (2007) 12 *Journal of Conflict & Security Law* 2007 at 238.

⁴⁷ *Case of Brogan and Others*, Ser A, vol 145, 29 November 1988, at 58.

⁴⁸ de Londras, supra n 46 at 224.

detention,⁴⁹ the detention of children,⁵⁰ security or administrative detention⁵¹ and, for the purposes of this paper, mental health detention as well as compulsory drug detention.⁵² Understanding these trends is important for considering the arbitrary nature of the regime of compulsory drug detention and will be returned to throughout this paper.

The legal safeguards established by treaties in order to avoid arrest or detention that is arbitrary in nature include:

- (a) The arrest or detention must be prescribed by law.⁵³
- (b) The individual must be informed promptly of the reasons for his or her arrest or detention, and the charges made against them.⁵⁴
- (c) The individual must be brought promptly before a judge or other judicial body, and is entitled to a trial within a reasonable period of time.⁵⁵

⁴⁹ Joint general comment No. 4 (2017) of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and No. 23 (2017) of the Committee on the Rights of the Child on State obligations regarding the human rights of children in the context of international migration in countries of origin, transit, destination and return, CMW/C/GC/4-CRC/C/GC/23, 16 November 2017 at 5-11.

⁵⁰ In his 2018 report on the right to health and deprivation of liberty, the Special Rapporteur on the right to health reflected on the detention of children by stating 'There can be no hesitation in concluding that the act of detaining children is a form of violence. The Convention on the Rights of the Child prohibits the use of detention as a default strategy. Looking forward, a child rights-based strategy must strengthen even further the presumption against detention of children with a view to abolition.' A/HRC/38/36, 10 April 2018 at 59.

⁵¹ See Neuman, 'Arbitrary Detention and the Human Rights Committee's General Comment 35' in Decaux, Motoc and Gillibert (eds) *Mélanges in tribute to Judge Christine Chanut* (in press).; Human Rights Council, Joint Study on Global Practices in relation to Secret Detention in the Context of Terrorism of the Special Rapporteur on the Promotion and Protection of Human Rights and Fundamental Freedoms while Countering Terrorism, A/HRC/13/42, 20 May 2010.

⁵² Report of the UN Special Rapporteur on the Rights of Persons with Disabilities, A/HRC/40/54, 11 January 2019 at 57-63.

⁵³ See, for example, Article 9(1) International Covenant on Civil and Political Rights, supra n 14; Article 5(1) European Convention on Human Rights, supra n 17.; Article 7(2) American Convention on Human Rights, supra n 17.; Article 6 African Charter, supra n 17.; Article 16 Arab Charter on Human Rights, supra n 17.; Art. XXV American Declaration on the Rights and Duties of Man, supra n 17.

⁵⁴ See, for example, Article 9(2) International Covenant on Civil and Political Rights, supra n 14.; Article 5(2) European Convention on Human Rights, supra n 17.; Article 7(4) American Convention on Human Rights, supra n 17.; Article 16(1) Arab Charter on Human Rights, supra n 17.

⁵⁵ See, for example, Article 9(3) International Covenant on Civil and Political Rights, supra n 14.; Article 5(3) European Convention, supra n 17.; Article 7(1)(d) African Charter, supra n 17.; Article 16(3) Arab Charter, supra n 17.; Article XXVI American Declaration on the Rights and Duties of Man, supra n 17.; See also, Principle 11(1) Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, 9 December 1988, A/RES/43/173 which requires that persons 'not be kept in detention without being given effective opportunity to be heard promptly by a judicial or other authority. A detained person shall have the right to defend himself or to be assisted by counsel as prescribed by law.'

(d) The individual must be allowed the opportunity to challenge the lawfulness of their arrest or detention in court, and to be released if their detention is deemed unlawful.⁵⁶

The *travaux préparatoires* to Article 9 of the International Covenant on Civil and Political Rights offers further guidance on the question of the circumstances under which detention is arbitrary in nature. It notes that the notion of 'arbitrariness' also includes 'incompatibility with the principles of justice or with the dignity of the human person'.⁵⁷ During the Third Committee debates on retaining the word 'arbitrary' in draft Article 9, many States acknowledged its significance as a means to protect against unjust laws.⁵⁸ The Brazilian representative at the time stating "“arbitrary” referred in part to matters of conscience...it was not inconceivable that arbitrary laws might be adopted in certain countries'.⁵⁹ The UN Human Rights Committee in General Comment No. 35 on Article 9, as well as in individual communications,⁶⁰ has confirmed that

the notion of 'arbitrariness' is not to be equated with 'against the law', but must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity, and proportionality.⁶¹

The jurisprudence of various human rights bodies further details safeguards that are necessary to ensure that a person's arrest or detention are not arbitrary in nature. For example, the European Court affirms that arrest or detention must be based on 'reasonable suspicion', which it defines as 'facts or information which would satisfy an objective observer that the person concerned may have committed the offence'.⁶² The Court has affirmed that 'the requirement that the suspicion must be based on reasonable grounds forms an essential part of the safeguard against arbitrary arrest and detention'.⁶³

⁵⁶ See, for example, Article 9(4) International Covenant on Civil and Political Rights, *supra* n 14; Article 5(4) European Convention on Human Rights, *supra* n 17.; Article 7(6) American Convention on Human Rights, *supra* n 17.; Article XXV American Declaration on the Rights and Duties of Man, *supra* n 17.

⁵⁷ Bossuyt, *Guide to the 'Travaux Préparatoires' of the International Covenant on Civil and Political Rights* (1987).; also *A v. Australia* (560/1993), CCPR/C/59/D/560/1993 at 7.6.

⁵⁸ Marcoux, 'Protection from Arbitrary Arrest and Detention under International Law' (1982) 5 *Boston College International and Comparative Law Review* 2 at 354.

⁵⁹ *Ibid* at fn 54.

⁶⁰ Among others: *Hugo van Alphen v The Netherlands* (305/19880), CCPR/C/39/D/305/1988 at 5.8.; *T.V. and A.G. v Uzbekistan* (2044/2011), CCPR/C/116/D/2044/2011 at 7.3.; *Hadji Hamid Japalali v Philippines* (2536/2015), CCPR/C/125/D/2536/2015 at 7.3.

⁶¹ Human Rights Committee, General Comment No 35: Article 9 (Liberty and security of person), (16 December 2014, CCPR/C/GC/35 at 12.

⁶² *Nechiporuk and Yonkalo v Ukraine* Application Number 42310/04, Judgment 21 April 2011 at 175.

⁶³ *Ibid*.

The Court has further stated that detention must be officially recorded, with information including name, date, location of detention and reasons for detention. It has characterised the absence of such record keeping as a 'complete negation' and 'grave violation' of the rights enshrined in Article 5, and 'must be seen as incompatible with the requirement of lawfulness' of the detention.⁶⁴ The European Court has also affirmed that detention cannot be prolonged or extended without the provision of reasons for such that extension.⁶⁵ Furthermore, any reasons provided by the State must be credible and based on evidence in order to be 'regarded as free from arbitrariness'.⁶⁶

4. DOES DRUG USE CONSTITUTE A REASONABLE LIMITATION ON THE RIGHT TO LIBERTY?

Does drug use or dependency constitute a legitimate or legal limitation on the right to liberty and security? Some make the case that the use of involuntary detention and compulsory treatment are both justified and human rights compliant given the nature of drug use and 'addiction'. Takahashi, as noted above, argues that 'drug addiction...destroys—or at least suspends—the free will of the addict', making more difficult considerations of when true consent, or lack thereof, exists.⁶⁷ Wu also questions the ability of people who are drug dependent 'to make rational decisions, provide informed consent for treatment or participate completely in their own due process'.⁶⁸ Wu, in effect, suggests that any human rights violations involved in drug treatment are either minimal or justified as being done in the best interests of the individual. The Director of the US National Institute on Drug Abuse, Dr Nora Volkow, has supported these same arguments. Although not discussing compulsory treatment *per se*, Volkow takes the position that, 'because of drug use, a person's brain is no longer able to produce something needed for our functioning and that healthy people take for granted, free will'.⁶⁹ Wu further argues that 'the rights of entire communities'

⁶⁴ *Ibid* at 176. ; see also, *Kurt v Turkey* Application Number 5/1997/799/1002, Judgment 25 May 1998) at 125.

⁶⁵ *Nechiporuk and Yonkalo v Ukraine*, supra n 62 at 187—189.; see also, *Yeloyev v Ukraine* Application Number 17283/02, Judgment 6 February 2009) at 52—55.; *Solovey and Zozulya v Ukraine* Application Number 40774/02 and 4048/03, Judgment 27 February 2009 at 59.

⁶⁶ *Nechiporuk and Yonkalo v Ukraine*, supra n 62 at 197-199.

⁶⁷ Takahashi, supra n 18 at 775.

⁶⁸ Wu, 'Arguments in favour of compulsory treatment of opioid dependence' (2013) 91 *Bulletin of the World Health Organization* 2 at 142.

⁶⁹ Volkow, 'Addiction is a Disease of Free Will', *The Huffington Post*, 12 June 2015.

[presumably to be drug free] need to be balanced with, or even take priority over, the rights of the individual in question.⁷⁰ Takahashi makes a similar argument. 'Society has a strong interest in ensuring that persons who are addicted to drugs undergo treatment for their condition and... 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.'⁷¹ A case can also be made that the State has a positive obligation to intervene to protect the well-being of a vulnerable person whose condition or behaviour constitutes an imminent threat of harm to themselves or to others.⁷² It is therefore useful when examining the question of compulsory drug detention to address whether drug use or drug dependency provides a legal justification for the type of compulsory detention or involuntary treatment described above.

A. When is Involuntary Detention and Treatment for Drug Use Legal?

Under international human rights law, the involuntary detention and compulsory treatment of an individual is a matter of significant debate, and the norms in this area have been evolving rapidly since the adoption of the Convention on the Rights of Persons with Disabilities in 2006.⁷³ The first question is whether there are medical grounds to support the use of detention for the purpose of drug treatment. The existing public health evidence suggests that no form of coerced treatment (including detention) is any more effective than voluntary treatment in the community.⁷⁴ According to the World Health Organization and the United Nations Office on Drugs and Crime, '[n]either detention nor forced labor have been recognized by science as treatment for drug use disorders'.⁷⁵

Much of the existing human rights guidance for involuntary detention on medical grounds has focused on safeguards, which extend beyond criminal justice settings to ensure

⁷⁰ Wu, *supra* n 68 at 142.

⁷¹ Takahashi, *supra* n 18 at 775.

⁷² See, for example, *Witold Litwa v Poland* Application Number 26629/95, Judgment 4 April 2000 at 65.

⁷³ Much of this debate forms around the broader issue of forced treatment for mental health conditions, which includes the widespread use of detention on mental health grounds for persons with psycho-social disabilities. See Report of the Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52. ; O'Mahony, 'Legal capacity and detention: implications of the UN disability convention for the inspection standards of human rights monitoring bodies' (2012) 16 *International Journal of Human Rights* 883.

⁷⁴ Stevens, 'The Ethics and Effectiveness of Coerced Treatment of People who use Drugs, Human Rights and Drugs' (2011) *Human Rights and Drugs* 2 at 7.

⁷⁵ UN Office on Drugs and Crime and World Health Organization, *Principles of Drug Dependence Treatment. Discussion Paper*, 2008 at 15.

such rights are 'equally respected in cases of administrative detention'.⁷⁶ Most of these safeguards were and are linked to the broader phenomenon of mental health detention or involuntary hospitalisation. While not analogous to the specifics of compulsory detention for drug treatment, these rapidly evolving norms provide important instructive guidance on matters of health-related detention, including for drug treatment.

Around the world, most jurisdictions permit the use of detention on the basis of a real or perceived impairment as an exception to the right to liberty.⁷⁷ The international human rights jurisprudence has historically supported such exceptions, legitimising the widespread use of detention for 'mental health' reasons and the disproportionate capture of people with real or perceived impairments at risk for arbitrary detention. Importantly, none of the core international human rights instruments explicitly state that 'disability', 'impairment' or 'drug use/dependence' are grounds for a deprivation of liberty.⁷⁸

The adoption of the Convention on the Rights of Persons with Disabilities in 2006, and its entry into force in 2008, introduced a seismic shift in the normative protections for those at risk of arbitrary detention on the basis of a real or perceived impairment.⁷⁹ Whether people who use drugs or are drug dependent should be recognised as people with disabilities is highly contested, and is a debate that goes beyond the scope of this article.⁸⁰ However, whichever perspective one adopts, an analysis of the normative framework provided by the Convention offers useful guidance on the issue of compulsory detention and treatment.

In some countries drug dependence is either regulated or perceived as a disability, and the rights and autonomy of people who use drugs are restricted on this basis.⁸¹ Deprivation of liberty and institutionalisation of people who use drugs and people with disabilities often follow the same paternalistic rationale, such as 'caring' for persons whose legal capacity is perceived to be diminished, based on what an external party determines to be their best interests. The Committee on the Rights of Persons with Disabilities has provided extensive

⁷⁶ UN Commission on Human Rights, Question of arbitrary detention, 5 March 1991, E/CN.4/RES/1991/42, 4(e).

⁷⁷ Report of the Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52 at 41.

⁷⁸ The exception being Article 5(e) of the European Convention on Human Rights, discussed later in the article.

⁷⁹ Convention on the Rights of Persons with Disabilities, *supra* n 16.

⁸⁰ See, for example, Flacks, 'Deviant Disabilities: The Exclusion of Drug and Alcohol Addiction from the Equality Act 2010' (2012) 21 *Social & Legal Studies* 3.

⁸¹ *Ibid*; Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by State parties under article 35 of the Convention – Peru, 16 May 2012, CRPD/C/PER/CO/1.

guidance on issues of forced treatment and institutionalisation on the basis of an actual or perceived impairment, as well as on concepts such as autonomy, legal capacity, consent, and substitute decision-making, all of which are central to the discussion of compulsory treatment.⁸² As a consequence, regardless of whether people who use drugs should be recognised as people with disabilities, the Convention provides a robust blueprint for a human rights approach to drug use and drug treatment, which imposes an absolute ban on using detention for the purposes of medical treatment.

Most notably, a key overarching principle the Committee derived from the right to equality before the law is that 'legal capacity is a universal attribute inherent in all persons by virtue of their humanity'.⁸³ As a consequence, the existence of an impairment, or 'perceived or actual deficits in mental capacity', can never be a ground for denying legal capacity, and thus (among others) restricting the right to give consent to medical treatment.⁸⁴ In line with this reasoning, the Committee has reiterated that involuntary detention (such as detention without consent or with consent of a substitute decision-maker) on the basis of an actual or perceived disability or impairment in itself constitutes an arbitrary deprivation of liberty, while forced treatment by health professionals violates the right to personal integrity and the prohibition of torture.⁸⁵

In 2015, at the request of the Human Rights Council, the Working Group on Arbitrary Detention presented the 'United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court'.⁸⁶ Principle 21 and Guideline 20 on specific measures for people with disabilities explicitly note that States have an 'obligation to prohibit involuntary committal or internment

⁸² Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: the right to liberty and security of persons with disabilities (2015).

⁸³ Committee on the Rights of Persons with Disabilities, General Comment No. 1: Article 12: Equal recognition before the law, 19 May 2014, CRPD/C/GC/1 at 8.

⁸⁴ *Ibid* at 13.; Committee on the Rights of Persons with Disabilities, General Comment No. 6 on equality and non-discrimination, 26 April 2018, CRPD/C/GC/6 at 9, 30.

⁸⁵ Among others: Committee on the Rights of Persons with Disabilities, *supra* n 83 at 40.; Committee on the Rights of Persons with Disabilities, *supra* n 81.; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Mauritius, 30 September 2015, CRPD/C/MUS/CO/1 at 25.; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Montenegro, 22 September 2017, CRPD/C/MNE/CO/1 at 31.; Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Armenia, 8 May 2017, CRPD/C/ARM/CO/1 at 23-24.

⁸⁶ UN Working Group on Arbitrary Detention, United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court, 6 July 2015, A/HRC/30/37.

on the grounds of the existence of an impairment or perceived impairment, particularly on the basis of psychosocial or intellectual disability or perceived psychosocial or intellectual disability'.⁸⁷

Prior to this, the Working Group had produced several relevant 'Deliberations', essentially commentaries 'on matters of a general nature involving a position of principle in order to develop a consistent set of precedents and assist States, for purposes of prevention, to guard against the practice of arbitrary deprivation of liberty'.⁸⁸ These are documents similar to General Comments produced by UN human rights treaty bodies. In 2005, prior to the adoption of the Convention on the Rights of Persons with Disabilities, 'Deliberation No. 7 on Issues Related to Psychiatric Detention' described the safeguards necessary to ensure that detention based upon mental health grounds does not fall into the category of arbitrariness. While now superseded by the more recent set of Basic Principles and Guidelines, it is instructive to see the important procedural safeguards established, such as regular reviews of the person's detention 'at reasonable intervals by a court or a competent independent and impartial organ',⁸⁹ and adversarial processes through which the person or his/her legal representative may challenge the reasons for detention.⁹⁰

The Human Rights Committee has also repeatedly deliberated (in General Comment 35, Concluding Observations and Individual Communications) upon administrative detention, involuntary hospitalisation (and treatment) and institutionalisation of persons with psychosocial disabilities. Although not specifically analogous to drug use or dependency, the substantive safeguards outlined by the Committee to ensure detention is not arbitrary are relevant to consider.

- a) It must be necessary and proportionate for the purpose of protecting the individual from serious harm, or prevent injury to others. From the 'necessity' requirement it

⁸⁷ Ibid at 38, 103.

⁸⁸ Office of the United Nations High Commissioner for Human Rights, Working Group on Arbitrary Detention: Individual Complaints, Urgent Appeals, Deliberations, available at: <http://www.ohchr.org/EN/Issues/Detention/Pages/Complaints.aspx> [last accessed 15 November 2020].

⁸⁹ UN Working Group on Arbitrary Detention, Report of the Working Group on Arbitrary Detention, 1 December 2004, E/CN.4/2005/6 at 58(e).

⁹⁰ Ibid at 58(f).

also follows that it must be employed as a measure of last resort, and for the shortest possible time.⁹¹

- b) It must be 'accompanied by adequate procedural and substantive safeguards established by law',⁹² including access to effective legal representation⁹³ and to judicial review.⁹⁴
- c) Its necessity must be re-evaluated periodically by a judicial body,⁹⁵ and independent monitoring mechanisms should be in place.⁹⁶
- d) Adequate remedies must be available and accessible in case of a rights violation.⁹⁷

In decisions concerning the institutionalisation of persons with disabilities, the Committee further clarified that deprivation of liberty must be preceded by a comprehensive medical assessment (also implying that such assessment must be evidence-based and carried out by a qualified professional) to determine its necessity and proportionality.⁹⁸ This again is not to equate drug use or dependency with a disability, but rather to illustrate the procedural safeguards that underpin how the Committee views human rights compliant detention on medical grounds. General Comment No. 35 captures an increasingly restrictive approach to involuntary hospitalisation that developed from the Committee's more recent Concluding Observations,⁹⁹ but falls short of an absolute ban as supported by the Committee on the Rights of Persons with Disabilities and the Working Group on Arbitrary Detention. It is important to note the development of this element of General Comment 35 emerged within a highly contentious public discussion and remains sharply criticised by disability rights

⁹¹ Human Rights Committee, supra n 61 at 19; Human Rights Committee, Concluding Observations on the fourth periodic report of Paraguay, 20 August 2019, CCPR/C/PRY/CO/4 at 30-31. Also, among others: Human Rights Committee, Concluding Observations on the fourth periodic report of Lithuania, 29 August 2018, CCPR/C/LTU/CO/4 at 13-14.; Human Rights Committee, Concluding Observations on the seventh periodic report of El Salvador, 9 May 2018, CCPR/C/SLV/CO/7 at 30.; UN Human Rights Committee, *T.V. and A.G. v Uzbekistan*, supra n 60 at 7.7.

⁹² Human Rights Committee, supra n 61 at 19.

⁹³ For example, Human Rights Committee, Concluding Observations Paraguay, supra n 91 at 31.

⁹⁴ Human Rights Committee, Concluding Observations on the fourth periodic report of Bulgaria, 15 November 2018, CCPR/C/BGR/CO/4 at 18.

⁹⁵ Human Rights Committee, supra n 61 at 19, 32-38.

⁹⁶ Human Rights Committee, Concluding Observations on the third periodic report of Latvia, 11 April 2014, CCPR/C/LVA/CO/3.; Human Rights Committee, Concluding Observations on the third periodic report of Croatia, 30 April 2015, CCPR/C/HRV/CO/3.

⁹⁷ Human Rights Committee, supra n 47 at 19.

⁹⁸ For example: Human Rights Committee, Concluding Observations on the fourth periodic report of Guatemala, 7 May 2018, CCPR/C/GTM/CO/4 at 27.

⁹⁹ Human Rights Committee, Concluding observations on the fourth periodic report of the United States of America, CCPR/C/CO/USA/4, 23 April 2014 at 18.; Human Rights Committee, Concluding observations on the third periodic report of Latvia, CCPR/C/CO/LVA/3, 11 April 2014 at 16.

advocates, including survivors of involuntary hospitalisation, and the Committee on the Rights of Persons with Disabilities.¹⁰⁰

In short, fundamental rights and dignity must be respected, access to justice must always be guaranteed and the decision on whether to detain a person must be taken on a case-by-case basis. *En masse* detention on the basis of drug use or drug dependence alone based on a court, administrative or police decision without a thorough medical assessment to indicate imminent risk of harm to oneself or others – such as in the case of compulsory drug detention – is not acceptable within the framework of the Covenant on Civil and Political Rights. This was explicitly recognised in *F.K.A.G. et al v. Australia*, a case concerning immigration detention, where the Human Rights Committee concluded that ‘The decision must consider relevant factors case-by-case, and not be based on a mandatory rule for a broad category; must take into account less invasive means of achieving the same ends, [...] must be subject to periodic re-evaluation and judicial review’.¹⁰¹

Within the international human rights case law, issues of consent to treatment have also been considered under the right to health and the prohibition of cruel, inhuman or degrading treatment. The previous consensus was that while people, including those in detention, have a right to consent and a right to refuse treatment, these rights are subject to some specific limitations. In its General Comment 14, issued in 2000, the Committee on Economic, Social and Cultural Rights stated the right to health includes the ‘right to be free from...non-consensual medical treatment’.¹⁰² At the time, the Committee articulated a limited qualification to this right, specifically in the case of mental illness and disease control. It describes the

State's obligation to refrain from...applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.¹⁰³

¹⁰⁰ Neuman, *supra* n 51.

¹⁰¹ Human Rights Committee, *F.K.A.G. et al. v. Australia* (2094/2011), CCPR/C/108/D/2094/2011 at 9.3.

¹⁰² Committee on Economic Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, 11 August 2000, E/C.12/2000/4 at 8.

¹⁰³ *Ibid* at 34.

The Convention on the Rights of Persons with Disabilities has since replaced the 'Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care' as the standard to guide any limitations on the basis of mental health conditions. In 2017, the UN Special Rapporteur on the Right to Health stated '[c]onsidering that the right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities, immediate action is required to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement'.¹⁰⁴

In an earlier Annual Report in 2004, the Special Rapporteur specifically highlighted concerns over 'non-consensual medical treatment'.¹⁰⁵ The UN Special Rapporteurs investigating conditions at Guantanamo Bay take a position consistent with that of the Committee on Economic, Social and Cultural Rights. In their joint report, the Rapporteurs state that

From the perspective of the right to health, informed consent to medical treatment is essential, as is its 'logical corollary' the right to refuse treatment. A competent detainee, no less than any other individual, has the right to refuse treatment. In summary, treating a competent detainee without his or her consent - including force-feeding - is a violation of the right to health, as well as international ethics for health professionals.¹⁰⁶

The Committee Against Torture has not yet published specific and dedicated guidance on involuntary hospitalisation and treatment. This has resulted in a piecemeal approach to the issue, which has mainly been considered in State monitoring. In many cases, primary attention has been placed on the need for legal and procedural safeguards as well as independent monitoring and oversight, rather than on the arbitrary nature of the detention. Nevertheless, some overarching principles emerge from Concluding Observations, in which the Committee has clarified that involuntary hospitalisation and institutionalisation are only acceptable in cases clearly defined by law and on the basis of a legal decision,¹⁰⁷ open to

¹⁰⁴ Report of the Special Rapporteur on the right to health, A/HRC/35/21, 28 March 2017 at 65.

¹⁰⁵ The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt, E/CN.4/2004/49, 16 February 2004 at 5.

¹⁰⁶ UN Commission on Human Rights, Situation of detainees at Guantánamo Bay, 27 February 2006, E/CN.4/2006/120 at 82.

¹⁰⁷ Among others: Committee Against Torture, Concluding Observations on the third periodic report of Kazakhstan, 12 December 2014, CAT/C/KAZ/CO/3 at 19.; Committee Against Torture, Concluding Observations on the second periodic report of Serbia, 3 June 2015, CAT/C/SRB/CO/2 at 18.

appeal,¹⁰⁸ subject to a periodic judicial review¹⁰⁹ and for medical reasons alone.¹¹⁰ Accordingly, the Committee has stressed the right of all persons 'not to be arbitrarily detained on the basis of their social status'.¹¹¹

Even when purported medical reasons exist, the Committee has reiterated that free and informed consent to hospitalisation and treatment is paramount,¹¹² thus can only be derogated from in situations of necessity and pursuant to an individualised assessment by an independent medical professional.¹¹³ In a recent Concluding Observation, the Committee expressed concern at the involuntary hospitalisation of persons with mental and psychological disabilities 'who do not present a threat to themselves or others',¹¹⁴ further aligning its definition of 'necessity' with that of the Human Rights Committee. In 2016, the Sub-Committee on the Prevention of Torture released its approach to deprivation of liberty, which also aligned itself with the Human Rights Committee approach.¹¹⁵

The position of the Committee Against Torture on this topic may be best summarised in its 2016 Concluding Observations on China, where forms of administrative detention were reviewed, including legal education centres, compulsory isolation in drug treatment centres, and compulsory psychiatric institutionalisation. The Committee urged the country to:

¹⁰⁸ Committee Against Torture, Concluding Observations on the third periodic report on Moldova, 21 December 2017, CAT/C/MDA/CO/3 at 32.

¹⁰⁹ Committee Against Torture, Concluding Observations on Serbia, supra n 107 at 18.; Committee Against Torture, Concluding Observations on the second periodic report of Romania, 5 June 2015, CAT/C/ROU/CO/2.

¹¹⁰ Among others: Committee Against Torture, Concluding Observations on Kazakhstan, supra n 107 at 19.; Committee Against Torture, Concluding Observations on Moldova, supra n 108 at 32.; Committee Against Torture, Concluding Observations on the second periodic report of Turkmenistan, 23 January 2017, CAT/C/KTM/CO/2 at 36.

¹¹¹ Committee Against Torture, Consideration of reports submitted by State parties under article 19 of the Convention: Cambodia, 20 January 2011, CAT/C/KHM/CO/2 at 20.

¹¹² Among others: Committee Against Torture, Concluding Observations on Turkmenistan, supra n 110 at 36.; Committee Against Torture, Concluding Observations on the sixth periodic report of Bulgaria, 15 December 2017, CAT/C/BGR/CO/6 at 15-16.; Committee Against Torture, Concluding Observations on the seventh periodic report of Finland, 20 January 2017, CAT/C/FIN/CO/7 at 23.; Committee Against Torture, Concluding Observations on the fourth periodic report of Azerbaijan, 27 January 2016, CAT/C/AZE/CO/4 at 27.

¹¹³ Among others, Committee Against Torture, Concluding Observations on Bulgaria, supra n 112 at 15-16.; Committee Against Torture, Concluding Observations on the combined third to fifth periodic reports of the Republic of Korea, 30 May 2017, CAT/C/KOR/CO/3-5 at 32.; Committee Against Torture, Concluding Observations on the third periodic report of Lithuania, 17 June 2014, CAT/C/LTU/CO/3 at 23.

¹¹⁴ Committee Against Torture, Concluding Observations on the Republic of Korea, supra n 113 at 31.

¹¹⁵ Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent, CAT/OP/27/2, 26 January 2016 at 5-1.

- (b) Abolish all forms of administrative detention, which confine individuals without due process and make them vulnerable to abuse;
- (c) Prioritize the use of community-based or alternative social-care services for persons with psychosocial disabilities or drug addiction;
- (d) Avoid forced hospitalization or confinement for medical reasons, unless it is imposed as a last resort, for the minimum period required and only when accompanied by adequate procedural and substantive safeguards, such as prompt initial and periodic judicial review, unrestricted access to counsel and complaints mechanisms and an effective and independent monitoring and reporting system.¹¹⁶

The approaches of the Treaty Bodies and Special Procedures in this regard undermine arguments that compulsory detention and treatment for drug use is human rights compliant. Even if one were to accept his position that ‘drug addiction...destroys—or at least suspends—the free will of the addict’,¹¹⁷ such a situation would not mean that the individual in question had surrendered his or her right against being arbitrarily detained. Clearly the fact that the Committee on the Rights of Persons with Disabilities, the Working Group on Arbitrary Detention and the Human Rights Committee have enunciated safeguards, even universal legal capacity, for people with psychosocial disabilities presupposes that human rights safeguards apply specifically for those whose mental state makes it difficult for them to articulate their own choices regarding treatment intervention. Furthermore, even if one accepts the proposition that a person’s right to consent is compromised as a result of intoxication, surely that situation fundamentally reverses itself when the effects of the intoxicants inevitably wear off, hours or a day later. It must also be pointed out that Takahashi’s position turns a traditional principle of human rights protections on its head, as his assertion suggests that the *more vulnerable* a person is (i.e. a person with a psychosocial disability) the *less* the State has an obligation to ensure the protection of his or her rights. This is clearly the opposite of established principles that increased vulnerability of an individual places increased obligations on the State to protect them from human rights violations.

¹¹⁶ Committee Against Torture, Concluding Observations on the fifth periodic report of China, 3 February 2015, /C/CHN/CO/5 at 43.

¹¹⁷ Takahashi, *supra* n 18 at 775.

The Article 3 jurisprudence of the European Court of Human Rights contains the most detailed examination of the issue of consent to treatment, though its jurisprudence has been criticised as articulated protections that fall well below the international standards established above.¹¹⁸ The European Court adopts the approach that 'a measure which is of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading'.¹¹⁹ Therefore, if a physician can sufficiently justify that the treatment is both necessary and in conformity with established medical practice, it can be administered without consent. According to the Court in *Herczegfalvy v Austria*,

[I]t is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible.¹²⁰

However, the method by which the compulsory treatment takes place must be consistent with Article 3 protections against torture and inhuman or degrading treatment.¹²¹

This is also the Court's approach to force-feeding of prisoners, as the practice 'is aimed at saving the life of a particular detainee who consciously refuses to take food'.¹²² However, like medical treatments, the State has an obligation to show that the force-feeding is 'medically necessary' otherwise it can amount to torture under Article 3.¹²³ Indeed, in *Nevmerzhitsky v. Ukraine* the State was found guilty of torture for force-feeding the applicant without proving medical necessity.¹²⁴ This raises the possibility that non-consensual treatment, particularly if administered in a forceful or violent manner, could be found to reach the threshold of torture. This point has indeed been argued by non-governmental organisations that have reviewed this issue.¹²⁵

¹¹⁸ Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52 at 60.

¹¹⁹ *Nevmerzhitsky v Ukraine* Application Number 54825/00, Judgment 5 April 2005 at 94.

¹²⁰ *Herczegfalvy v Austria* Application Number 10533/83, Judgment 24 September 1992 at 82.

¹²¹ *Ibid* at 80-82.

¹²² *Nevmerzhitsky v Ukraine*, *supra* n 119 at 94.

¹²³ *Ibid* at 97.

¹²⁴ *Ibid* at 98-99.

¹²⁵ See, for example, Elliott, Lines, Schleifer and Symington, *supra* n 5.

The Working Group on Arbitrary Detention's 'Deliberation No. 4 on Rehabilitation through Forced Labour' is also of interest to the question of compulsory or coercive treatment. The Deliberation specifically pertains to the use of detention and forced labour as a means of coercing a person to renounce his/her political or religious opinions or beliefs. Of possible relevance to the question of compulsory or coercive treatment is that the Working Group specifies that 'Where the main purpose of the measure is political and/or cultural rehabilitation through self-criticism, the deprivation of freedom is, by reason of its very purpose, inherently arbitrary.'¹²⁶ Although this comment is made within the context of the protection of freedom of thought, it does suggest that 'rehabilitation through self-criticism' as part of coercive or compulsory treatment may be an issue that could be raised with the Working Group. As described above, similar practices are employed in the drug detention centres in a number of countries as a means of 'drug treatment'.¹²⁷

Based upon the above, while international human rights law does not provide a clear consensus regarding the permissibility of an involuntary detention for medical grounds, it is clear that no detention is justified on the basis of a real or perceived 'impairment' alone. If one were to accept that an involuntary commitment is permissible, there exists a highly restrictive set of safeguards that any detention must follow, including:

- a) The decision to involuntarily commit an individual must be made on a case-by-case basis and by an independent person medically qualified to make that judgment.
- b) The committal must not be on the basis of a real or perceived impairment.
- c) The committal must be necessary and proportionate for the purpose of protecting oneself or others from imminent harm.
- d) The committal must be only for the shortest period of time that above risk is imminent.
- e) Regular independent reviews of the person's detention must be made to determine whether involuntary committal is still warranted.

¹²⁶ UN Working Group on Arbitrary Detention, Report of the Working Group on Arbitrary Detention, 12 January 1993, E/CN.4/1993/3 at 19.

¹²⁷ See, for example, Wolfe and Saucier, 'In rehabilitation's name? Ending institutionalized cruelty and degrading treatment of people who use drugs' (May 2010) 21 *International Journal of Drug Policy* 3.; Human Rights Watch, 'The Rehab Archipelago Forced Labor and Other Abuses in Drug Detention Centers in Southern Vietnam'. *Supra* n 5.; Human Rights Watch, "'Skin on the Cable" The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia', *supra* n 5.

- f) There must be an opportunity for the individual to immediately meaningfully challenge the lawfulness of the committal in court.
- g) The conditions of detention and the method(s) of treatment must not in themselves be inhuman or degrading.

Absent one or more of these safeguards, involuntary detention for drug treatment – even assuming it is necessary to protect from imminent risk of harm – fails to comply with international human rights standards, and falls into the category of arbitrariness. It is clear, therefore, that the types of detention *en masse* described above meet few, and in some cases none, of these thresholds. In most cases, the decision to commit a person to a drug detention centre has no legal basis,¹²⁸ is not made by appropriately qualified medical personnel, is of dubious (or at least untested or unproven) medical necessity, the detentions themselves are not subject to regular periodic review and the detainees have no recourse to the courts as a basis to challenge the legality of their detention. There is also an established and growing body of evidence documenting conditions within many of these detention centres that clearly meet the threshold of inhuman or degrading treatment or punishment, sometimes even meeting the threshold for torture.¹²⁹ Therefore, the kinds of blanket (and often secret) detention of people on the basis of drug use documented above clearly fall far short of the essential safeguards, and therefore constitute a violation of international human rights law.

B. Is Drug Use or Drug Dependency Governed by Different Standards of Consent?

Is there anything unique about drug use or drug dependency as a condition that sets it apart from the standard safeguards that apply to the general rules of detention and/or consent to medical treatment outlined above? International human rights law offers significant guidance on this question, none of it supportive of the notion that people who use drugs or are drug dependent surrender the right to liberty or security of the person, or the right to informed consent.

In its General Comment No. 35 on Article 9 of the International Covenant on Civil and Political Rights, the Human Rights Committee notes that the protections enshrined in the

¹²⁸ See Amnesty International, *supra* n 38.

¹²⁹ *Ibid.*; see also Elliott, Lines, Schleifer and Symington, *supra* n 5.

treaty should not be narrowly interpreted to apply only to arrest and detention in the context of criminal cases. Rather, Article 9 ‘applies to all detention by official action or pursuant to official authorization, including detention in connection with criminal proceedings, [...] detention for vagrancy or drug addiction’.¹³⁰ Rather than excluding people who use drugs from the protections offered under Article 9, the Committee has specifically included them as rights holders in this context.

The Human Rights Committee has also reviewed the compatibility of drug detention centres with Article 9. The position of the Committee is less progressive than that of other bodies, such as the Working Group on Arbitrary Detention, in that it does not find detention on the ground of drug use or dependence to be arbitrary per se (although in its 2015 Concluding Observations it urged Cambodia to ‘take all necessary measures to put an end to the arbitrary arrest and detention of [...] people who use drugs’).¹³¹ Nevertheless, the Committee urged States to review their policies to ensure drug rehabilitation is in full compliance with the Covenant, ensure that everyone detained enjoys fundamental legal safeguards and due process rights, including access to counsel and review of the lawfulness of the detention by a court, ensure strict compliance with the principles of legality and proportionality and guarantee that prisoners are treated with respect for their humanity and dignity.¹³²

As mentioned above, the Working Group on Arbitrary Detention has engaged Article 9 protections to consider questions related to drugs. For example, in its 2003 Report, the Working Group noted that it had been

[I]nformed by several sources that, in some countries, the disabled, drug addicts and people suffering from AIDS are detained in places that are

¹³⁰ Human Rights Committee, *supra* n 61 at 40. The Committee on the Rights of the Child has similarly noted that the rights of children deprived of their liberty apply with respect to children in conflict with the law and “to children placed in institutions for the purposes of care, protection or treatment, including mental health, educational, drug treatment, child protection or immigration institutions.” See UN Committee on the Rights of the Child, General Comment No. 10 – Children’s rights in juvenile justice, 9 February 2007, CRC/C/GC/10 at fn 1.

¹³¹ Human Rights Committee, Concluding Observations on the second periodic report of Cambodia, 27 April 2015, CCPR/C/KHM/CO/2 at 17.

¹³² Human Rights Committee, *supra* n 40 at 32.; Human Rights Committee, Concluding Observations on the initial report of Lao, 23 November 2018, CCPR/C/LAO/CO/1 at 27-28.; Human Rights Committee, Concluding Observations on the fifth periodic report of Belarus, 22 November 2018, CCPR/C/BLR/CO/5 at 37-38.; Human Rights Committee, Concluding Observations on the second periodic report of Cambodia, 27 April 2015, CCPR/C/KHM/CO/2 at 16.

incompatible with their state of health, sometimes without treatment and without it having been established that their detention is justified on medical or public health grounds. The Group is concerned because it is vulnerable persons that are involved, people who are often stigmatized by social stereotypes; but it is concerned above all because often such administrative detention is not subject to judicial supervision.¹³³

The Working Group continues on to state that, 'With regard to persons deprived of their liberty on health grounds, the Working Group considers that in any event all persons affected by such measures must have judicial means of challenging their detention.'¹³⁴ Here again, rather than limiting the rights of persons who use drugs, the Working Group has specifically identified them as a group whose rights in this regard are often violated.

In its 2015 annual report, the Working Group provided its most detailed and unequivocal analysis of the legality of detention for drug use and drug dependence. After acknowledging the disproportionate impact of criminal and administrative detention for drug control on vulnerable groups, the Working Group turned to compulsory drug detention and treatment. The Working Group concluded that 'compulsory detention regimes for purposes of drug "rehabilitation" through confinement or forced labour are contrary to scientific evidence and *inherently arbitrary*',¹³⁵ unsupported by either international human rights law and international drug control law,¹³⁶ and reiterated that 'drug consumption or dependence is not sufficient justification for detention'.¹³⁷ In finding compulsory drug detention and treatment to be arbitrary *per se*, the Working Group has adopted a more progressive position than that of the treaty bodies described above, one that acknowledges that this form of detention would never meet the standards of necessity, reasonableness and proportionality (nor pass an independent and qualified medical assessment) because it is based on a faulty and non-scientific understanding of drug use and drug dependence. At the time of writing, the Working Group on Arbitrary Detention is conducting a new study on arbitrary detention relating to drug policies, upon request by the Human Rights Council.¹³⁸

¹³³ UN Working Group on Arbitrary Detention, Report of the Working Group on Arbitrary Detention, 15 December 2003, E/CN.4/2004/3 at 74.

¹³⁴ *Ibid* at 87.

¹³⁵ Human Rights Council, Report of the Working Group on Arbitrary Detention, 10 July 2015, A/HRC/30/36 at 59 (emphasis added).

¹³⁶ *Ibid*.

¹³⁷ *Ibid* at 60.

¹³⁸ Human Rights Council, Arbitrary detention, 25 September 2019, A/HRC/42/L.34/Rev.1 at 14.

In his 2009 report to the General Assembly, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health specifically addressed the question of informed consent to treatment, noting that 'fundamental to achieving the enjoyment of 'the right to health through practices, policies and research that are respectful of autonomy, self-determination and human dignity'.¹³⁹ In that report, the Special Rapporteur raised specific concerns about consent to treatment for people who use drugs, noting they 'are often perceived as being dangerous to themselves and unable to make the "right" decision. Prohibitions against their behaviour threaten their ability to refuse testing and treatment'.¹⁴⁰ The Special Rapporteur's report in 2010 was entirely dedicated to exploring issues of drug use and drug policy as they affect the right to health, and the report addressed the question of compulsory detention and treatment.¹⁴¹ He concluded, 'People who use or are dependent on drugs do not automatically lack the capacity to consent to treatment. A presumption of incapacity based on drug use or dependence creates significant potential for abuse.'¹⁴²

The Special Rapporteur also found that the type of mass detention and treatment described above were inconsistent with established human rights safeguards governing when such committal is legal. According to the report, 'Decisions regarding capacity and competence, and the need to obtain informed consent, must be made on a case-by-case basis. Treatment *en masse* prima facie fails to meet this requirement.'¹⁴³

Among the regional human rights instruments, the issue of drugs and arbitrary detention is specifically engaged under Article 5 of the European Convention on Human Rights, which enshrines the right to liberty and security.¹⁴⁴ This is the only international or regional human rights instrument that explicitly imagines a limitation of the right to liberty on the basis of an impairment. Under Article 5(1)(e), 'drug addiction' is specifically identified as a lawful limitation on the right to liberty and security. Apart from being outdated, the provision has been criticised as contradicting Article 14 of the Convention on the Rights of Persons with Disabilities.¹⁴⁵ According to Article 5 of the European Convention

¹³⁹ Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 10 August 2009, A/64/272 at 2.

¹⁴⁰ *Ibid* at 88.

¹⁴¹ Right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 6 August 2010, A/65/255.

¹⁴² *Ibid* at 39

¹⁴³ *Ibid* at 38.

¹⁴⁴ Article 5, Convention for the Protection of Human Rights and Fundamental Freedoms, *supra* n 17.

¹⁴⁵ Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52 at 60.

1. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

...

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants¹⁴⁶

The European Convention is the only one of the international human rights treaties that includes a limitation on the right to liberty specifically on the basis of drug dependency. It is therefore worthy of further attention in considering the question of compulsory detention for drug use and human rights.

According to the drafting history of the Convention, the language of Article 5 is drawn upon that found in Articles 3, 5 and 8 (security of the person) as well as Articles 9, 10 and 11 (immunity from arrest, detention or arbitrary exile) of the Universal Declaration of Human Rights,¹⁴⁷ none of which make reference to 'drug addiction' as a specific limitation on the rights enumerated. The limitation that eventually became Article 5(1)(e) was initially introduced by Sweden during the first meeting of the Committee of Experts on Human Rights, which proposed that the provision 'should not exclude the right to take necessary measures to fight vagrancy and alcoholism'.¹⁴⁸ The Swedish proposal made its way into the official draft text through via a drafting committee comprised of the United Kingdom, Sweden and Denmark. This committee expanded upon the alcoholism and vagrancy to include the longer list of limitations including 'drug addiction'.¹⁴⁹ The language as proposed by this committee is identical to that found in the treaty as ratified.

To date there have been no judgments from the European Court that engage this article in the specific context of drug use. However, guidance on the Court's possible approach to this question may be found in the April 2000 judgment in the case of *Witold*

¹⁴⁶ Article 5(1)(e), Convention for the Protection of Human Rights and Fundamental Freedoms, *supra* n 17.

¹⁴⁷ European Commission of Human Rights, Preparatory Work on Article 5 of the European Convention on Human Rights, 8 August 1956, Council of Europe DH (56) 10 at 3.

¹⁴⁸ *Ibid* at 9.

¹⁴⁹ *Ibid* at 15—16.

Litwa v. Poland.¹⁵⁰ In this case, the applicant was arrested for public alcohol intoxication and detained in a 'sobering up centre' for a period of six and a half hours. He argued that this detention was in violation of his rights under Article 5. In its defense, the government argued that Mr Witold's detention had been lawful under Article 5(1)(e), which allows for the 'lawful detention of...alcoholics of drug addicts'.

The Court found against the State. In its judgment that the applicant's detention was unlawful, and violated his rights under Article 5, the Court came to two conclusions of relevance to the issue of drug use. The first was that 'alcohol intake' in and of itself was insufficient grounds to engage the limitation prescribed in Article 5(1)(e). Rather, the Court found that the purpose of the limitation was to allow scope 'to limit the harm caused by alcohol to himself and the public, or to prevent dangerous behaviour after drinking'.¹⁵¹ In other words, the limitation prescribed in Article 5(1)(e) must be linked to dangerous, or potentially dangerous, behaviour of a person in the context of alcohol use, rather than the alcohol use itself. The second key element of the judgment was that deprivation of liberty, for whatever reason, 'must be compatible with the purpose of Article 5, namely to protect the individual from arbitrariness'.¹⁵² Therefore, in order to be 'lawful' within the meaning of the article, the measures must show 'the absence of arbitrariness'.¹⁵³ According to the Court,

The detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained. That means that it does not suffice that the deprivation of liberty is executed in conformity with national law but it must also be necessary in the circumstances.'¹⁵⁴

Therefore the Court found that lawfulness alone is not sufficient grounds for deprivation of liberty under Article 5(1)(e), and that the test of necessity must also be satisfied. The Court in *Witold Litwa* found a violation of Article 5 because the police took the most restrictive measure possible of committing the applicant to custody, rather than considering less restrictive measures that would have accomplished the objective of preventing injury to himself or others, such as taking him to a health centre or merely escorting him home.¹⁵⁵ The

¹⁵⁰ *Witold Litwa v Poland*, supra n 72.

¹⁵¹ *Ibid* at 62.

¹⁵² *Ibid* at 73.

¹⁵³ *Ibid* at 78.

¹⁵⁴ *Ibid*.

¹⁵⁵ *Ibid* at 79.

fact that the person was intoxicated or considered an alcoholic did not give the State *carte blanche* to detain him, as the State had not demonstrated that detention was a necessary sanction, even though it may in the narrow sense have been legal under domestic legislation.

The principles elaborated by the European Court in this case are of direct relevance to the question of mass detention and compulsory treatment on the basis of drug use or dependency. Indeed, rather than suggesting that drug use *per se* is a unique exception to broader human rights safeguards put in place in the context of involuntary treatment, it instead suggests two additional safeguards that further undermine the legality of the detention of people on the basis of drug use.

- a) Drug use, or even intoxication, in and of itself is not sufficient grounds for deprivation of liberty, absent the reasonable presumption that the individual poses a threat to him or herself or others due to the intoxication.
- b) Deprivation of liberty for drug use, even if it is prescribed in law, must meet the test of necessity, and may only be used as a final option when other, less restrictive or coercive options, have been considered and found insufficient to meet the objective of protecting the health and safety of the individual and the broader public.

In the cases of the types of mass drug detention documented above, it is difficult to see that either of these tests is met. Further, given a modern understanding of the pharmacology of drug use, it is difficult to imagine meeting these thresholds in any individual case assessed. Clearly from the perspective of international human rights law, drug use or dependency does not constitute a legitimate basis to limit or remove established protections against arbitrary detention or involuntary treatment. This normative position is affirmed in the International Guidelines on Human Rights and Drug Policy, which is the most current reflection of international law as it relates to drug policy. In Guideline 7 on freedom from arbitrary arrest and detention the Guideline reads that States “shall...ensure people are not detained solely on the basis of drug use or drug dependence” and that States “should...take immediate measures to close compulsory drug detention centres where they exist, release people detained in such centres, and replace such facilities with voluntary, evidence-based care and support in the

community'.¹⁵⁶ As expressed in a 2009 statement to the UN High Level Meeting on Drugs, the High Commissioner for Human Rights specifically stated that 'Individuals who use drugs do not forfeit their human rights. These include the right...not to be tortured or arbitrarily detained'.¹⁵⁷

C. The Approach of the International Drug Control Treaties

While mass detention in the name of 'drug treatment' is clearly unacceptable under international human rights law, is there anything within the international drug control treaties that would suggest a legal authority for such compulsory detention and treatment? Article 38 of the 1961 Single Convention on Narcotic Drugs does contain a specific article on drug treatment. The inclusion of this article was novel at the time of the drafting, as it was the first time that provision of drug treatment and rehabilitation services formed part of State obligations under a multilateral drug control instrument, although the Official Commentary notes that its inclusion in the treaty represented the codification of a pre-existing international consensus on the need to provide such services within a broader approach to narcotics control.¹⁵⁸ Article 38 of the 1961 Convention, entitled 'Treatment of Drug Addicts', stated that

1. The Parties shall give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts.
2. If a Party has a serious problem of drug addiction and its economic resources permit, it is desirable that it establish adequate facilities for the effective treatment of drug addicts.

The question of whether involuntary or compulsory drug treatment should be explicitly included within Article 38 was the source of significant debate during the plenipotentiary conference that finalised the draft treaty. The Third Draft of the 1961 Single Convention, which was the version reviewed at the plenipotentiary conference, contained draft Article 47

¹⁵⁶ Guideline (7), International Guidelines on Human Rights and Drug Policy (2019) available at: www.humanrights-drugpolicy.org [last accessed 1 March 2021].

¹⁵⁷ Office of the UN High Commissioner for Human Rights, High Commissioner calls for focus on human rights and harm reduction in international drug policy, 10 March 2009.

¹⁵⁸ *Commentary on the Single Convention on Narcotic Drugs, 1961* (1973) at 446.

(which was to become Article 38 in the final text) on the issue 'Treatment for Drug Addicts'. Draft Article 47(2) stated that.

If they [a State party] have a serious problem of drug addiction and their economic resources permit, they shall use their best endeavours to establish facilities for the compulsory treatment of drug addicts in closed institutions.¹⁵⁹

The United States was the primary advocate of the inclusion of compulsory detention and treatment within the treaty, expressing that its delegation 'unreservedly supported' the proposed text and arguing that 'Treatment in liberty had failed wherever it had been tried'.¹⁶⁰ The statement of the US representative, Mr Ellenbogen, reflected the concept that people who use drugs must be detained in order to prevent a threat of 'contagion' to the broader society.

The isolation of susceptible persons from pathogenic agents was one of the most time-honoured in public health. Drug addiction was contagious in the sense that the addict tended to convert others to his morbid habit, and it was therefore essential in his case to use the recognized public health method of quarantine.¹⁶¹

A number of States shared the US's enthusiasm for the inclusion of compulsory detention and treatment. India described the importance of 'isolat[ing] the addict so that he would not corrupt others'.¹⁶² The Indian delegation considered that 'The idea of compulsory treatment was excellent' and that 'the government intended to apply it as soon as it was able'.¹⁶³ Iran stated that 'if the drug habit was really to be eradicated, compulsory treatment was necessary'.¹⁶⁴ Others supporting this position included Canada, the United Arab Republic and China.¹⁶⁵

The States speaking against the inclusion of compulsory treatment in closed institutions within draft Article 47 were not opposed on explicit human rights grounds. For some States, their concern was based on the underdevelopment of the national infrastructure,

¹⁵⁹ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. II (1964) E/CONF.34/24/Add.1 at 18. This article eventually became Article 38 of the final treaty.

¹⁶⁰ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. I, supra n 1 at 103.

¹⁶¹ Ibid.

¹⁶² Ibid at 106.

¹⁶³ Ibid.

¹⁶⁴ Ibid.

¹⁶⁵ Ibid at 103, 106.

and their inability to provide such resource-intensive facilities.¹⁶⁶ For others, there was reluctance to enshrine a specific medical intervention in an international treaty, decisions which they thought better left to national governments, or individual medical practitioners. From a human rights perspective, it is interesting that some of the concerns in this regard raised by States touched upon questions of the right to enjoy the benefits of scientific progress, originally enshrined under Article 27 of the Universal Declaration of Human Rights.¹⁶⁷ The Netherlands, for example, questioned the wisdom of enshrining a specific treatment modality within the convention. As 'better methods of treatment might be devised in the future; it was, therefore, inadvisable to make the provision compulsory'.¹⁶⁸ Uruguay noted that 'the Conference was not asked to indicate the method of treating drug addicts, as modern techniques were being improved every day'.¹⁶⁹ More explicitly, Israel argued for more 'flexibility' in the language of Article 47 'to allow...for eventual scientific progress',¹⁷⁰ while Peru suggested 'that it would be better to adopt a wording which was not as likely to become outdated by scientific progress'.¹⁷¹ Greece proposed that the wording 'in closed institutions' be replaced with 'by efficient, scientific, special methods'.¹⁷²

In the end, draft Article 47 was amended to remove reference to compulsory treatment in closed facilities, and instead the term 'adequate facilities' was agreed. Given the content of these drafting debates, and the specific and deliberate decision to delete reference to 'compulsory treatment of drug addicts in closed institutions' from the final treaty, it is difficult to make the case that the drafters of the 1961 Convention agreed that drug use or 'drug addiction' constituted a unique exception to the general rules on involuntary detention or consent to treatment.

Following its failure to achieve the desired language in the treaty itself, the United States delegation proposed a separate resolution declaring 'that one of the most effective methods of civil commitment in a hospital institution having a drug free atmosphere' and urging 'Parties having serious drug addiction problem, and the economic facilities to do so, to

¹⁶⁶ For example, India, Brazil, Cambodia, Ghana. See *ibid* at 106—110.

¹⁶⁷ Article 27, Universal Declaration of Human Rights, *supra* n 13.

¹⁶⁸ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. I, *supra* n 1 at 109.

¹⁶⁹ *Ibid* at 113.

¹⁷⁰ *Ibid*.

¹⁷¹ *Ibid*.

¹⁷² *Ibid* at 105

provide such facilities'.¹⁷³ This resolution prompted the only specific human rights debate in the entire plenipotentiary conference when the Holy See expressed concern 'that "civil commitment" might possibly involve the infringement of a basic human right', and went on to seek 'some assurance that the necessary limitations would be placed upon the power of civil commitment to ensure the protection of human rights'.¹⁷⁴ The United States responded that the Vatican's concerns 'were completely fallacious' and that there 'would be no question of any impairment of human rights' as such commitments would be subject to legislative control and oversight.¹⁷⁵ The Holy See responded that, while it was aware of the protections observed in the United States in these matters, 'the Convention was intended for application not merely in the United States, but throughout the world'.¹⁷⁶

In the end, the US resolution was adopted by the plenipotentiary conference. However, as is clear from the exchange between the Holy See and the US delegation on the human rights implications of this resolution, the US was not proposing that drug use or addiction be unique limitations on the right to liberty and security. Just the opposite, the US delegation was clear that any 'civil commitment' order made on the basis of drug use should be subject to legislative control and oversight. This would suggest that the process of ordering individual detention for drug issues should reflect the safeguards established in other areas of the law and of health policy, rather than create an exception or exemption. This undermines any suggestion that the drug conventions create a special limitation on rights in the context of drug use or dependency, as does the fact that the language of Article 38 was amended by the 1972 Protocol to the 1961 Single Convention. The 1972 Protocol changed the name of Article 38 from 'Treatment of Drug Addicts' to 'Measures Against the Abuse of Drugs', therefore moving away from a strict focus on treatment and its various modalities. It also eliminated all specific references to types of treatment facilities found in the original Single Convention text, changing the language instead to one directing States to 'take all practicable measures for the prevention of abuse of drugs and for the early identification,

¹⁷³ United States of America: draft resolution on the treatment of drug addicts, 13 March 1961, E/CONF.34/L.27, United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. II, *supra* n 159 at 295.

¹⁷⁴ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. I, *supra* n 1 at 197.

¹⁷⁵ *Ibid.*

¹⁷⁶ *Ibid.*

treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends'.¹⁷⁷

The international drug control treaties further identify deprivation of liberty as an appropriate penal sanction for certain categories of drug offences. For example, Article 36(1) of the Single Convention on 'Penal Provisions' allows that 'serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty'.¹⁷⁸ Imprisonment or other deprivation of liberty is also named as appropriate and 'adequate' punishment for serious offences in Article 22 of the 1971 Convention,¹⁷⁹ and Article 3 of the 1988 Convention.¹⁸⁰ The Official Commentary on the Single Convention suggests that, through its use of this language, the Plenipotentiary Conference 'appears to have made it clearer' that confinement in a prison is not the only acceptable option in this regard, but also that 'other places such as labour or "re-education" camps, constitutes an "adequate" penalty' for the purposes of Article 36(1).¹⁸¹ This raises some concern, as Barrett and Nowak point out, as it is exactly these sorts 'of labour and re-education camps in which people who use drugs are often confined, without trial, and in which the abuses...have been systematic'.¹⁸²

However, it is difficult to argue that Article 36 of the Single Convention allows for the types of arbitrary detention and forced treatment described above. The Official Commentary's observation that the Plenipotentiary Conference's choice of the term 'adequate punishment' reflects its support for labour or re-education camps as appropriate places of detention appears to be wholly invented by the Commentary's author, as there is absolutely no discussion of labour or re-education camps contained in the Official Records of the drafting of Article 36.¹⁸³ Compare this against the lengthy debate that resulted in the dropping of the reference to compulsory treatment and detention under draft Article 47, and it is clear that there was not sufficient political support for these types of measures to have them

¹⁷⁷ Article 38, Single Convention, supra n 7.

¹⁷⁸ Ibid at Article 36(1)(a).

¹⁷⁹ Article 22(1)(a), 1971 Convention, supra n 7.

¹⁸⁰ Article 3(4)(b), 1988 Convention, supra n 7.

¹⁸¹ *Commentary on the Single Convention on Narcotic Drugs, 1961*, supra n 158 at 429, para 10.

¹⁸² Barrett and Nowak, 'The United Nations and Drug Policy: Towards a Human Rights-Based Approach' in Constantinides and Zaikos (eds) *The Diversity of International Law: Essays in Honour of Professor Kalliopi K. Koufa*, Martinus Nijhoff (2009) at 465.

¹⁸³ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. II, supra n 159 at 145—147.

included in the final text. It is also noteworthy that when reviewing the drafting history, the term 'adequate punishment' was agreed as compromise language replacing the term 'severe punishment' found in the Convention of 1936 for the Suppression of the Illicit Traffic in Dangerous Drugs,¹⁸⁴ this to allay concerns from many countries that the enshrining penalties of 'severe punishment' within the treaty would compromise judicial independence. In other words, in the context of Article 36, 'adequate punishment' refers to sentencing options, not guidance on what does or does not constitute 'adequate' detention facilities, regimes or conditions.¹⁸⁵

Finally, by definition Article 36 of the 1961 Convention – like Article 22 of the 1971 Convention and Article 3 of the 1988 Convention – specifically describe *penal sanctions*, that is sanctions arrived at through the process of criminal charge, trial and conviction. In short, via a system of due process that is subject to all the legal safeguards provided by international human rights law in the context of criminal law. For example, Article 3(4)(b) of the 1988 Convention allows that 'The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.'¹⁸⁶ This is exactly the opposite of the systems of mass compulsory detention and treatment without due process documented in the countries above. Articles 3(4)(c) and 3(4)(d) also allow for the use of treatment as an alternative to conviction or punishment. However, there is nothing to indicate from the text that the treaty allows such treatment to be imposed involuntarily.¹⁸⁷

Supporting this interpretation is the fact that in recent years, the UN Office on Drugs and Crime has made increasingly clear statements against the compulsory detention *en masse* of people who use drugs, as well as in support of the right to consent to treatment. The Office stated in a 2008 report that,

¹⁸⁴ Convention of 1936 for the Suppression of the Illicit Traffic in Dangerous Drugs 1936, LNTS, vol 198 at 301.

¹⁸⁵ United Nations Conference for the adoption of a Single Convention on Narcotic Drugs: Official Records Vol. I, supra n 1 at 145—146.

¹⁸⁶ Article 3(4)(b), 1988 Convention, supra n 7.

¹⁸⁷ Ibid at Article 3(4)(b-d). Unlike the text of Article 3(4)(b) which states that the 'offender shall undergo measures such as treatment', Articles 3(4)(c-d) state that States 'may provide...treatment', which does not imply the imposition of treatment on an involuntary basis.

In the context of drug control, this means that the drug Conventions must be implemented in line with the obligations inscribed in the Charter. Among those obligations are the commitments of signatories to protect human rights and fundamental freedoms.¹⁸⁸

This clearly suggests that from the perspective of the Office on Drugs and Crime, the drug control treaties may not be used as a legal justification to limit the human rights obligations of States. On the specific question of arbitrary detention in the name of drug treatment, the former Executive Director Antonio Maria Costa has stated that

Drug dependence treatment without the consent of the patient should only be considered a short-term option of last resort in some acute emergency situations and needs to follow the same ethical and scientific standards as voluntary-based treatment. Human rights violations carried out in the name of “treatment” are not compliant with this approach.¹⁸⁹

4. CONCLUSION

Compulsory drug detention is an issue that engages multiple areas of human rights law – including the right to liberty, the right to health, the right to consent to treatment and the prohibition of inhuman and degrading treatment – as well as obligations in international drug control law to suppress use of illicit drugs and provide treatment to people who are drug users. Having reviewed this question from all these perspectives, it is clear that the mass detention of up to half a million people worldwide under the guise of ‘drug treatment’ constitutes a grave violation of human rights, and any claim that the nature of drug use or ‘drug addiction’ itself constitutes a reasonable limitation on the right to liberty fails when tested.

Beginning in 1990, multiple resolutions of the UN General Assembly have affirmed that international drug control efforts must ‘be pursued in full conformity with the principles enshrined in the Charter of the United Nations, and the principles of international law’.¹⁹⁰ In more recent years, this General Assembly language has expanded to include specific

¹⁸⁸ Making drug control ‘fit for purpose’: Building on the UNGASS decade - Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly, 7 March 2008, E/CN.7/2008/CRP.17 at 19.

¹⁸⁹ Antonio Maria Costa in the foreword to United Nations Office on Drugs and Crime, *From coercion to cohesion: Treating drug dependence through health care, not punishment*, 2010 at iii.

¹⁹⁰ UN General Assembly, *Respect for the principles enshrined in the Charter of the United Nations and international law in the fight against drug abuse and illicit trafficking*, 18 December 1990, A/RES/45/147 at 3.

reference to the Universal Declaration of Human Rights. These resolutions assert that the national and international drug control activities of Member States can and should be subjected to scrutiny in international law, beyond merely that of the international drug conventions. The question of the compulsory drug detention of people who use, or who are suspected of using, illicit drugs offers a useful case study in testing the commitments made in these resolutions, and in assessing national drug control treaty obligations within a broader context of public international law; in effect, testing the legal validity of a domestic drug control approach using international legal instruments.

Beyond the matter of *en masse* detention for drug use, involuntary detention for treatment in any circumstance is a subject on which human rights standards are evolving quickly, particularly in light of the adoption of the Convention on the Rights of Persons with Disabilities and its expansive understanding of legal capacity and the inherently arbitrary nature of involuntary detention. While this approach is now supported by the interpretation of the Working Group on Arbitrary Detention, the Committee on the Elimination of Discrimination against Women and both the Special Rapporteurs on the Right to Health and on the Rights of Persons with Disabilities, some aspects remain divergent from the jurisprudence of the Committee Against Torture, Sub-Committee on the Prevention of Torture, the Human Rights Committee and the European Court of Human Rights.¹⁹¹

While the safeguards enumerated by these mechanisms continue to evolve and place increasing restrictions on the use of exceptions, the divergence is most stark in relation to the subjective concepts of 'medical necessity' and 'dangerousness' as grounds for which involuntary confinement can be deemed acceptable. In its 2015 Concluding Observations on Mauritius, the Committee on the Rights of Persons with Disabilities found involuntary hospitalisation and institutionalisation of persons with disabilities arbitrary even in cases where a person 'represents a danger to themselves or others'.¹⁹² These concepts have also been heavily criticised as 'subjective' and 'unjust' by UN Special Procedures.¹⁹³ In his 2017 report, the Special Rapporteur on the right to health stated that '[t]hese subjective principles are not supported by research and their application is open to broad interpretation, raising

¹⁹¹ Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52 at 58.
Committee on the Rights of Persons with Disabilities, *supra* n 85 at 25.

¹⁹³ Special Rapporteur on the Rights of Persons with Disabilities, *supra* n 52 at 62.; Report of the Special Rapporteur on Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, A/HRC/35/21, 28 March 2017 at 64.

questions of arbitrariness that has come under increasing legal scrutiny'.¹⁹⁴ He further reflected that “‘dangerousness’ is often based on inappropriate prejudice, rather than evidence’. While the Subcommittee Against Torture and the Human Rights Committee’s work no longer accepts ‘medical necessity’ as justification for mental health detention, they retain the concept of ‘dangerousness’ as legitimate grounds.

To fully understand these divergences, a broader piece of research is required using methods that are beyond the scope of this article. Such research would engage important socio-political questions about global human rights governance and mental health as well as an exploration of the path dependencies of human rights bodies. It is certainly not a surprise that a treaty drafted and adopted in this millennium, the Convention on the Rights of Persons with Disabilities, using a robust participatory approach, has produced a different body of work than those drafted fifty years ago or more. This temporal consideration is important as the institutional memory of the treaty bodies themselves forms part of that path dependency. More reflection is needed as these important normative institutions advance and harmonise their respective positions on this vitally important human rights matter.

¹⁹⁴ Special Rapporteur on Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *supra* n 193 at 64.