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INTERNATIONAL TREATMENT STANDARDS. A BACKGROUND BRIEFING FROM TRANSFORM & MUCD.

Treatment standards and best practice principles have been elucidated by a number of international agencies and regional bodies. These include the European Monitoring Center for Drugs and Drugs Addiction[1], the European Union[2], the Africa Union[3], OAS/CICAD, and the United Nations. These documents are variously reflected in treatment standards adopted formally and informally at a national level where specific policy documents are produced.[4]

The three UN Drug Treaties (1961, 1971, and 1988[5]) provide the foundation for drug treatment provision under international law. Of particular relevance are Article 38 of the 1961 Single Convention, and article 20 of the 1971 Convention, that require Member States to give special attention to, and take all practicable measures for, the prevention of the use of substances as well as 'early identification, treatment, education, after-care, rehabilitation and social reintegration' of the persons involved.

The drug treaty mandated agencies - The UN Office on Drugs and Crime, The World Health Organisation, and the International Narcotics Control Board also have various roles in ensuring good practice in provision of drug treatment - supported by other expertise from other UN agencies including but not limited to UNAIDS (with regards HIV prevention and treatment and harm reduction for people who inject drugs), and UN OHCHR (with regards to human rights).

In 2009 the UNODC and WHO published a set treatment principles (produced with input from regional bodies including EMCDDA and CICAD, as well as national member state drug agencies, including NIDA). These principles were described as constituting 'overarching policy and guidance'. In 2016 these were expanded to include standards alongside each of the principles[6];

'Standards include a description of specific practices and procedures that help establish, maintain and support the Principles. Standards provide rules or minimum requirements for clinical practice, generally accepted principles of patient management in the healthcare system that should be always followed."

"The International Standards on the Treatment of Drug Use Disorders defines a set of requirements and attributes (standards) that must be in place to initiate any form of outreach, treatment, rehabilitation, or recovery services, regardless of the treatment philosophy that is used and the setting it is used in. This is critically important, because individuals with drug use disorders deserve nothing less than ethical and science-based standards of care that are available similar to the standards used in treatment of other chronic diseases."

The text of these standards has been strongly criticised from some civil society groups, including the International Network of People who use Drugs, for containing stigmatising language around people who use drugs[7], for avoiding the phrase 'harm reduction' (see below), and for its prioritisation of certain abstinence based approaches over proven harm reduction interventions.

As well as this overarching statement of principles and standards, more detailed guidance for a number specialised policy areas have been produced, including for treatment in criminal justice settings[8], treatment for girls and women[9], management of substance use disorders in pregnant women[10], overdose reduction[11], and treatment in rural settings.[12]

The key overarching treatment standards document was endorsed by consensus in the UN General Assembly Special Session Outcome document[13] which called on member states to:

"Promote and implement the standards on the treatment of drug use disorders developed by the United Nations Office on Drugs and Crime and the World Health Organization and other relevant international standards, as appropriate and in accordance with national legislation and the international drug control conventions"

The key principles and standards from this document are summarised below:

Principle 1. Treatment must be available, accessible, attractive, and appropriate for needs.

"All barriers that limit their accessibility to appropriate treatment services should be minimized".

"Services should not only offer addiction treatment, but also provide social support and protection and general medical care".

"The legal framework should not discourage the people affected from attending treatment programs."

"The treatment environment should be friendly, culturally sensitive and focus on the specific needs and level of preparedness of each patient, the environment that encourages rather than deters individuals from attending the program."

Standards detailed relating to this principle include; the range of service provision; availability of services at all levels of healthcare; geographical accessibility of services (for example in rural areas); accessibility regarding opening hours; affordability; provision of gender sensitive services; access to wider health and social care services; access to information about services

Principle 2: Ensuring ethical standards in treatment services.

"Treatment of drug use disorders should be based on the universal ethical standards – respect for human rights and dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma."

"Treatment should not be forced or against the will and autonomy of the patient. The

consent of the patient should be obtained before any treatment intervention."

"The individual affected should be recognized as a person suffering with a health problem and deserving treatment similar to patients with other psychiatric or medical problems."

Standards detailed relating to this principle include; Avoidance of humiliating or degrading interventions; Informed consent; Patient confidentiality; human rights training for service providers; ethical patient research practices

Principle 3: Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services.

"Drug use disorders should be seen primarily as a health problem rather than a criminal behavior and wherever possible, drug users should be treated in the health care system rather than in the criminal justice system. "

"In all justice related cases people should be provided treatment and care of equal standards to treatment offered to anyone else in the general population."

Standards detailed relating to this principle include; availability of treatment as an alternative to punishment or incarceration; equal access to treatment and harm reduction in criminal justice settings; consent to receive treatment in criminal justice settings; appropriate training of criminal justice staff; continuity of treatment for those entering or leaving criminal justice settings

Principle 4: Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders.

"The same high quality of standards required for the approval and implementation of pharmacological or psychosocial interventions in other medical disciplines should be applied to the treatment of drug use disorders."

"Multidisciplinary teams should integrate different interventions tailored to each patient."
"Existing interventions should be adapted to the cultural and financial situation of the country without undermining the core elements identified by science as crucial for effective outcome."

Standards detailed relating to this principle include; availability of specialised evidence based services and training; non-imposition of time limits on treatment provision; regular updating of guidance on good practice in light of new evidence.

Principle 5: Responding to the needs of special subgroups and conditions.

"Groups with specific needs include but are not limited to adolescents, elderly, women, pregnant women, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with criminal justice system and individuals that are socially marginalized."

"Working with those special groups requires differentiated and individualized treatment planning that considers their unique vulnerabilities and needs."

"Women may require women-focus treatment in a safe single-sex setting to obtain maximum benefit."

"Treatment programs should be able to accommodate children needs to allow parents caring for children to receive treatment, and support good parenting and child care practices."

"Women may need training and support on issues such as sexual health, contraception."

Standards detailed relating to this principle include; provision of tailored specialist services for adolescents, women and pregnant women, and

minority groups; provision of outreach to engage vulnerable populations with service provision

Principle 6: Ensuring good clinical governance of treatment services and programs for drug use disorders.

"Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance that facilitates the achievement of treatment goals and objectives. "

"Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and target population"

Standards detailed relating to this principle include; development of policies based on evidence and stakeholder participation; adequately trained and supported staff; sustainable and properly managed funding; appropriate record keeping; monitoring and evaluation of service provision

Principle 7. Integrated treatment policies, services, procedures, approaches and linkages must be constantly monitored and evaluated.

"The treatment system must be constantly monitored evaluated and adapted."

"This requires planning and implementation of services in a logical, step-by-step sequence that insures the strength of links between (a) policy, (b) needs assessment, (c) treatment planning, (d)implementation of services, (e) monitoring of services (f) evaluation of outcomes and (g)quality improvements."

Standards detailed relating to this principle include; development of policies based on evidence and stakeholder participation; accreditation of service providers linked to quality standards; monitoring and evaluation of clinical accountability and patient health and wellbeing.

Treatment standards and international human rights law.

The guidance document on principles and standards provided by the UNODC/WHO does not have formal legal standing for member states - being presented as guidance, a 'draft for field testing'. However, it is important to emphasise that, as noted throughout the guidance and in principle 2 specifically, there are many areas where the treatment standards directly intersects with international human rights law that all member states are party to, and have obligations to uphold, (and for some members states - which may be directly incorporated into domestic law).

A 2016 letter[14] published by the UN Office of the High Commissioner for Human Rights from key UN human rights authorities, makes this point clearly;

"...we would like to remind States that they remain legally bound by their obligations to respect, protect, and fulfil human rights including while developing and implementing their responses to drugs."

Many of these human rights obligations are well understood, and have obvious intersections with drug service provisions. These include rights to freedom from arbitrary detention, and the freedom from torture and cruel, inhuman, and degrading treatment (both of which have often been been violated in the name of 'drug treatment').[15]

Less well understood, but equally important within international human rights law, are obligations regarding the right to health[16] (or 'the right to the enjoyment of the highest attainable standard of physical and mental health', to give it its full name) which underpins much of the UNODC/WHO treatment standards. Concepts such as informed consent to treatment, and availability and non discriminatory access to quality treatment, are core elements of the right to health[17] and explicitly apply to treatment for drug use disorders. The UN OHCHR[18] notes that:

"The right to health is provided for in article 12 of the International Covenant on Economic Social and Cultural Rights.Under articles 2 (2) and 3 of the Covenant, States are required to implement the right to health on a non-discriminatory basis, which includes extending that right to drug users."

The UN OHCHR joint letter to UNGASS makes a specific link between the right to health and UN treatment standards:

"The right to health requires that drug dependence treatment be available, accessible, acceptable (culturally, for women, for children and other key populations), and of sufficient quality, meaning voluntary and based on the best available evidence. We welcome the commitment in the [UNGASS] outcome document to ensuring international treatment standards are integrated into national drug treatment strategies."

It also makes the link between decriminalisation (ending the criminalisation of people who use drugs) and fulfilment of the right to health;

"In recent years, States have explored decriminalisation regimes as a means to improve the safety and wellbeing of their communities, with documented, positive outcomes for health and public safety. In keeping with these domestic policy successes, and with the recommendations of United Nations agencies[19] and as a step towards the fulfilment of the right to health, drug use and possession should be decriminalized and depenalized. This should be accompanied with increased investment in treatment, education, and other interventions as discussed further below."

A 2015 UNODC discussion paper[20] makes a more explicit case that criminalisation constitutes a violation of obligations under the right to health; first detailing the significant negative health impacts of criminalisation of at-risk populations who use drugs, before noting that;

"According to the UN Committee on Social and Economic Rights, laws and policies that "are likely to result in... unnecessary morbidity and preventable mortality"[21] constitute specific breaches of the obligation to respect the right to health".

The UN special rapporteur on the right to health has made similar arguments[22], endorsed by the UN High Commissioner for Human Rights.[23]

Harm Reduction.

The term 'harm reduction' has often proved contentious in the high level drug policy and treatment debate (as it does not mandate abstinence), but is now at least clearly defined within UN best practice and international human rights obligations. It is described by UN OHCHR as follows[24]:

"Harm reduction interventions aim to reduce the harms associated with the use of psychoactive drugs, without necessarily discouraging use. They include needle and syringe programmes, prescription of substitute medications, drug-consumption rooms, promotion of non-injecting routes for the administration of drugs, overdose prevention practices, and outreach and education programmes"

Some member states include harm reduction under the wider drug treatment banner (ie it is one of a range of treatment options), whilst others it is seperated, to varying degrees, from other treatment modalities. The UN agencies have correspondingly provided overarching guidance and standards, as well as more detailed guidance for a number specialised policy areas, including harm reduction in different settings and for different populations. The 'WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users'[25] (first published in 2009, and updated in 2012) provides the current 'gold standard' international best practice guidance and standards for harm reduction provision (specifically in the context of injecting drug use and the HIV response), and is also explicitly endorsed in the 2016 UNGASS outcome document. It includes a set of indicators to monitor and evaluate the implementation and impact of these interventions.

The 2016 UN OHCHR joint letter makes clear that provision of harm reduction, like drug treatment more broadly, is part of members states obligations to realize the right to health;

"The provision of harm reduction is not merely a policy option for States. Rather, the provision of these programmes for people who use drugs, including but not limited to the core UNODC/WHO/UNAIDS interventions, constitute a legal obligation as part of State obligations to progressively realize the right to health and to guard against inhuman or degrading treatment".[26]

Furthermore, The Special Rapporteur on the right to health has stated that if harm reduction programmes and evidence-based treatments are made available to the general public, but not to

persons in detention, this contravenes the right to health.

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