



Observations with regard to December 2, 2014 responses of Russian Federation to the List of Issues.

February 20, 2015

This document consists of supplementary information to the Shadow Report to the UN Human Rights Committee in relation to the review of the 7th Periodic Report of the Russian Federation (CCPR/C/RUS/7) submitted by the Andrey Rylkov Foundation for Social Justice and Health, Moscow and the Canadian HIV/AIDS Legal Network, Toronto*. For the Committee's convenience we attach the Shadow report to this document (Annex I)

Contact person: Anya Sarang, Moscow. Email: anysarang@gmail.com

Background information.

1. On April 4, 2014 we submitted to the Committee a Shadow Report to the UN Human Rights Committee in relation to the review of the 7th Periodic Report of the Russian Federation (CCPR/C/RUS/7)¹. Some of issues, outlined in the Shadow Report were included in the Committee's List of issues². On December 2, 2014 the Russian Federation submitted to the Committee the Responses of the Russian Federation to the List of Issues (CCPR/C/RUS/Q/7/Add.1)³. In this document we provide very brief additional comments regarding some of the responses of the Russian Federation which are related to our shadow report. We ask the Committee to use this information together with the information provided in our Shadow report and address the Russian Federation with the following recommendations related to its obligations to respect, protect and fulfill the rights and freedoms guaranteed in the International Covenant on Civil and Political Rights.

2. Recommendations to the Russian Federation

- In order to ensure the **prohibition of torture and other cruel, inhuman or degrading treatment or punishment, the right to liberty and security of person, and humane treatment of persons deprived of their liberty (arts. 7, 9–10 and 16)**, the State-party should adopt a human rights-based approach in regulating drug-demand reduction and drug-related harm reduction through social and medical interventions, rather than law enforcement and punishment, and in particular take into account the special vulnerability of people who use drugs, especially drug-dependent people, to discrimination, ill treatment and other human rights violations, and ensure that evidence-based drug-dependence treatment, such as opioid substitution therapy, is available to all in need, particularly in places of detention, and no punishment is applicable for drug use and related actions, including the purchase and possession of drugs, where there is no intent to supply.⁴
- In order to **ensure the right to fair trial (art. 14)**, the State-party should observe international standards of fair trial on drug cases, including by avoiding evidence which have been received as a result of ill-treatment of people who use drugs, police provocation (entrapment), inappropriate use of medical data and a person's health status, or when purity of street drugs is not established. Promote the use of independent forensic and scientific research in drug cases.
- In order to improve the **legal framework within which the Covenant is implemented (art. 2)**, the State-party should amend procedural laws to provide for a reconsideration of legal cases if the UN Human Rights Bodies, including Special Procedures which observe adversarial rules when reviewing individual complaints (for example the UN Working Group on Arbitrary Detention), find human rights violations.

Observations with respect to the Russian Federation's responses to Issue No 1 "Constitutional and legal framework within which the Covenant is implemented".

¹ The shadow report is available at the OHCHR website

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCCPR%2fICO%2fRUS%2f17138&Lang=en

² The List of Issues is available at the OHCHR website <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G14/157/08/PDF/G1415708.pdf?OpenElement>

³ The Responses of the Russian Federation to the List of Issues are available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fRUS%2fQ%2f7%2fAdd.1&Lang=en

⁴ Report presented by Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health, in 2010 in accordance with Resolution 6/29 of the Human Rights Council; Vienna Declaration, 2010; *Report of the Global Commission on Drug Policy*, June 2011.

3. In paragraph 1 of its responses the Russian Federation informed the Committee that “Russian courts actively implement the International Covenant on Civil and Political Rights”. We would like to draw the attention of the Committee to the shadow report which we submitted to the Committee in 2014. In paragraph 4.1.5 of the shadow report we informed the Committee that the Supreme Court of the Russian Federation completely ignored an Opinion of the Working Group on Arbitrary Detention of the UN Human Rights Council (Working Group) on the case of Denis Matveev, where the Working Group established that Russian authorities, including courts, violated articles 14(1), 18(1) and 19(2) of the International Covenant on Civil and Political Rights when they considered a criminal case against Denis Matveev. The Supreme Court of the Russian Federation did not give respect to any of those documents which the Russian Federation referred to in paragraphs 1-4 of the Russian Federation’s Replies to the List of Issues, and rejected the application for reconsideration of Mr. Matveev’s case stating that Russian laws do not mention Opinions of the Working Group as possible grounds to trigger reconsideration of criminal cases. Such a decision of the Supreme Court demonstrates that Russian authorities shall enhance their laws and practices in order to give stronger considerations to decisions of the UN Human Rights Bodies which clearly identify violations of the International Covenant on Civil and Political Rights, including by way of reconsiderations of cases in line with recommendations of the UN Human Rights Bodies.

Observations with respect to the Russian Federation’s responses to Issue No 15 “Right to life and prohibition of torture and other cruel, inhuman or degrading treatment or punishment, liberty and security of persons, and treatment of persons deprived of their liberty”.

4. In paragraph 83 of its responses the Russian Federation informed the Committee that according to Russian laws, law enforcement agencies are prohibited from discriminating against people who use drugs. We would like to submit that it is exactly because of Russian laws and policy documents, that people who use drugs in Russia are singled out as a group of people against whom law enforcement agencies act based just on their social identity and health condition as people who use drugs. In addition to part 4.3 of our Shadow report we would like to provide the Committee with the following information:
5. Police Orders stipulate that police should obtain medical information about people who used drugs and drug dependent people registered as such with drug dependence treatment clinics, and use this information for law enforcement purposes⁵.
6. The review of criminal drug case files demonstrate that in more than 50% of the cases police arrested people for possession of drugs following information from unspecified source that the suspect was using drugs⁶. We believe that in many cases this information was received from the medical files. In more than 6% of the cases police stopped and search people who use drugs after approaching them because they “look intoxicated”. The official courts statistics demonstrate that annually police prosecute more than 90 thousand people for “non-medical use of drugs” (Article 6.9 of the Code of Administrative Violations)⁷. In more than half of those cases people are punished with custodial sentences. Article 6.9 of the Code of Administrative Violations stipulates that anyone who consumes narcotic drugs without medical prescription can be prosecuted for this, regardless when the consumption took place, and whether or not a person is actually intoxicated and/or pose any risk to public order at the time of arrest.
7. Russian law enforcement agencies use medical data about people with drug dependency in order to limit their rights. For example there are many reports on the website of the General Prosecutor’s Office which inform the public that prosecutor’s offices in many regions of the Russian Federation receive medical data from drug dependence clinics (dispensaries) and use this data in order to terminate driver’s licenses of thousands of people who are registered as a persons who use drugs or as a drug dependent persons⁸.

⁵ Para 63.2, 65.2, 67.2 of the Instruction for Community Policing Officers approved by the Ministry of the Interior Order No 1166 of December 31, 2012.

⁶ As part of the on-going legal research, in 2012-2013 the Andrey Rylkov Foundation and the Canadian HIV/AIDS Legal Network together with their partners in Russia reviewed 213 drug case files randomly selected from 6 district courts in Russia.

⁷ The official statistics is available of the website of the Administration of Justice Department of the Supreme Court of Russia www.cdep.ru

⁸ Here are the links of just a few such reports: “По искам прокуроров суды признали недействительными 42 тысячи водительских удостоверений, выданных лицам, страдающим алкоголизмом и наркоманией”. October 1, 2012. Available at <http://genproc.gov.ru/smi/news/archive/news-78208/>; “В Самарской области прокуроры направили в суды свыше 110 исков о лишении водительских прав лиц, страдающих наркоманией”. October 24, 2014. Available at <http://genproc.gov.ru/smi/news/archive/news-426064/>; “Органы прокуратуры

Most of those whose licenses were withdrawn based on the medical data received by Prosecutor's Service from drug dependence clinics, were never stopped on the road for impaired driving or committed any other traffic offence. The only reason for Prosecutors' actions was the medical data indicating that the person is registered as a person who use drugs or is a drug dependent person⁹. Apart from being a gross and systematic violation of the right to privacy, this inappropriate use of medical information by law enforcement severely undermines the trust of drug dependent people have in the health system and prevent them from seeking drug dependence treatment.

8. The use of medical information as a reason for arrest and other law enforcement activities against people who use drugs is a violation of the right to liberty and security of person, as well as the right to be free from discrimination. The laws which provide for persecution of people based on their health condition and social identity (drug dependence and drug use) are discriminatory contrary to Articles 2 and 9 of the International Covenant on Civil and Political Rights.
9. In paragraph 84 of its responses the Russian Federation asserts that there is a legal ban on Opioid Substitution Therapy (OST) and that this ban does not "provide for an opportunity to coerce people to make confessions". As indicated by the Russian authorities, there is no intention to lift the legal ban on OST in Russia, despite the fact that OST is recommended by the World Health Organization as the most effective methods of opioid dependence treatment¹⁰ and that methadone and buprenorphine are listed by WHO as the essential medicines to be used in substance dependence programmes.¹¹
10. In addition to information provided in parts 4.2 and 4.4 we request the Committee to take into account the following two major concerns: 1) misuse of withdrawal syndrome in custodial settings; 2) preventing access to essential medicines for people outside prisons but otherwise vulnerable and dependent on the state support.
11. Misuse of withdrawal syndrome in custodial settings.

Scope of a problem.

- 11.1 According to the official statistics, every year the Russian Federation prosecutes 220 000-230 000 people for drug crimes¹², of which about 110000 people are sentenced to different types of criminal punishment, including imprisonment¹³. The review of the official courts' statistics demonstrate that not less than 75% of drug crimes are crimes related to drug use, not drug trafficking¹⁴. This means that not less than 80 000 people who use drugs are arrested by police every year. Many of these people suffer from opioid withdrawal syndrome during arrest and detention.

Pain and suffering of opioid withdrawal.

- 11.2 In our shadow report to the Committee we referred to the WHO definition of opioid withdrawal as well as to reports of the UN Special Rapporteur on Torture where he stated that "there is no doubt that the withdrawal syndrome can cause severe pain and suffering if medical assistance is not provided accordingly, and the condition of withdrawal in prisoners creates strong potential for mistreatment".
- 11.3 Medical drug treatment interventions approved in Russia are not helpful in alleviating opioid withdrawal syndrome in conditions of police detention. In those rare cases when medical doctors attend to arrested people in police custody, the only help they can provide is giving some sedatives which act for a very short period of time so people would again return to the state of withdrawal. For this reason medical doctors usually refuse giving any medications to people suffering severe withdrawal. A case of Mr. Polushkin is a good example; here we provide an extract from the official complaint to Prosecutor's Service:

Ставропольского края принимают меры по изъятию водительских удостоверений у лиц, страдающих алкоголизмом и наркоманией". April 25, 2014. Available at <http://genproc.gov.ru/smi/news/archive/news-141512/> .

⁹ Andrey Rylkov Foundation thoroughly documented one of such cases when the withdrawal of driver's license was only based on the diagnosis whilst there was no single traffic violation done by a person whose driver's license was withdrawn. The information about the case is available at <http://rylkov-fond.org/blog/advocacy/national-level-advocacy/kurmanaevskiy/>

¹⁰ WHO, "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence," 2009. Page x-xii

¹¹ WHO Model List of Essential Medicines, 17th list (updated) March 2011 (WHO, 2011), http://whqlibdoc.who.int/hq/2011/a95053_eng.pdf

¹² According to information from the official website from the State Statistic Service http://www.gks.ru/free_doc/new_site/population/pravo/10-01.htm

¹³ According to the official courts' statistics <http://www.cdep.ru/index.php?id=79>

¹⁴ Ibid.

In response to Mr. Polushkin's complaints about his health condition due to opioid withdrawal, police officers sprayed tear gas into his cell. Mr. Polushkin's condition only worsened. The police called ambulance but when doctors arrived they did not provide Mr. P with any medical help. The doctors commented with a scornful smile: "We cannot cook a crocodile [homemade opioid] for you"¹⁵.

- 11.4 Unlike sedatives, OST medications act for much longer period of time (24 hours and longer), so people can have long relief from withdrawal. OST can be administered by any nurse once a day, something which is manageable in the conditions of police custody or pre-trial detention. It is easy to manage and very cost effective.

Evidence that law enforcement misuse opioid withdrawal

- 11.5 It is very difficult to document cases when the withdrawal syndrome was misused to extract confessions and other evidence from people with drug dependence, mostly because in such cases drug dependent people chose the simplified procedure with no trial and the right to appeal, according to chapter 40 of the Criminal Procedural Code. However there are rare cases when the misuse of withdrawal syndrome by police was documented.
- 11.6 In one case the withdrawal syndrome which an accused suffered was used by police to extract confession in committing of a crime of drug possession¹⁶.
- 11.7 In another case, in the judgment of 16 February 2010 No 1-180/10 (city court of Naberezhnye Chelny, the Republic of Tatarstan, Russia)¹⁷, the court established that police manipulated a person who suffered opioid withdrawal syndrome in order to coerce her to slander another person and to act as a police agent in a police provocation. There are many adjudicated and communicated cases at the European Court of Human Rights against the Russian Federation which consist of information that police use drug dependent people in order to conduct police entrapment (police provocation) against fellow drug addicts¹⁸.
- 11.8 There are media reports that police provide narcotic drugs to drug dependent persons accused in exchange of confessions and other evidences¹⁹.
- 11.9 Taking into account the information above, we cannot but agree with the UN Special Rapporteur on Torture, that the condition of withdrawal in prisoners [and detainees] creates a strong potential for mistreatment²⁰. In Russia this mistreatment is promoted by the lack of access to the most effective drug treatment method – OST – which is under a legal ban. As such the lack of access to OST for people in police custody, and the legal ban on OST in particular, run contrary to the state obligations to prevent torture and other forms of cruel and degrading treatment.
- 11.10 In paragraphs 85-89 of its responses the Russian Federation informed the Committee that drug dependence treatment is available in prisons. We would like to provide comments on paragraphs 85-89 altogether.
- 11.11 As we mentioned earlier in this document as well as in our shadow report to the Committee, the Russian Federation keeps under the legal ban the most effective method of drug treatment – OST. Drug treatment methods available in Russia are ineffective and even harmful. We submit that the Russian authorities act contrary to Article 10 of the Covenant when they subject a large number of inmates to knowingly ineffective and painful methods of drug treatment, and at the same time ban the type of treatment which is science based, cost effective, painless, and highly recommended by WHO.
- 11.12 In addition we would like to refer to a recent judgment of the European Court on a case of *Keller v. Russia*, where the Russian authorities admitted that Mr. Keller, who was addicted to drugs, committed suicide whilst suffering opioid withdrawal during arrest because he "feared pre-trial detention because of

¹⁵ All documents of this case are available and can be presented at the Committee's request.

¹⁶ Application No 25721/13 Anoshkin v Russia. All papers from the case are available and can be presented to the Committee if necessary.

¹⁷ The judgment is available and can be presented to the Committee if necessary.

¹⁸ For instance the recent cases of *Lagutin and others v. Russia*, No 6228/09 19678/07 52340/08, Judgment of 24/04/2014; Case of *Veselov and others v. Russia*, No 23200/10 24009/07 556/10, Judgment of 02/10/2012.

¹⁹ "The Chief Detective is accused of providing narcotic drugs to pre-trial detention in exchange of confession". March 23, 2012. Available at <http://pravo.ru/news/view/70241/>; "In the city of Kazan a police officer used to give narcotic drugs to accused people in exchange of evidence". May 11, 2011. Available at <http://kazan24.ru/news/71803.html>

²⁰ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, 14 January 2009, A/HRC/10/44, para. 57.

the difficulty of obtaining drugs in a detention center”²¹. This case is a yet another shocking example that people with drug dependence rather commit suicide than go to prison where no adequate medical help is available for them.

12. Preventing access to essential medicines for people outside prisons but otherwise vulnerable and dependent on the state support.
- 12.1 According to the Special Rapporteur on Torture the denial of methadone treatment in custodial settings is a violation of the right to be free from torture and ill-treatment in certain circumstances and “similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment”²². The Special Rapporteur further asserts that “[b]y denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures”²³
- 12.2. The position of the Special Rapporteur corresponds to the case law of the European Court of Human Rights regarding access to medical and other essential services for people outside prisons. For example, the European Court has found that a six week delay in providing access to genetic testing to a pregnant woman amounted to a violation of the prohibition of degrading treatment, because doctors did not take into account the special vulnerability of pregnant women when they failed to fulfill their positive legal obligations related to her right to health (*R.R. v. Poland*, Application No. 27617/04, Judgment of 26 May 2011, paras. 153-162). In another case Court concluded that the “authorities have not had due regard to the applicant’s vulnerability as an asylum seeker and must be held responsible, because of their inaction, for the situation in which he has found himself for several months, living in the street, with no resources or access to sanitary facilities, and without any means of providing for his essential needs. The Court considers that the applicant has been the victim of humiliating treatment showing a lack of respect for his dignity and that this situation has, without doubt, aroused in him feelings of fear, anguish or inferiority capable of inducing desperation. It considers that such living conditions, combined with the prolonged uncertainty in which he has remained and the total lack of any prospects of his situation improving, have attained the level of severity required to fall within the scope of Article 3 of the Convention” (*M.S.S. v. Belgium and Greece* [No 30696/09, Judgment of 21 January 2011, paras 251-263]).
- 12.4 The Russian Federation only accepts the so-called abstinence based drug treatment standards, which stipulate detoxification under heavy sedation. The World Health Organization (WHO) considers this type of treatment ineffective²⁴. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) also specifically notes that for treatment for opioid users, “detoxification under heavy sedation does not work and can actually be harmful.”²⁵ It is not a surprise that thousands of people with drug dependence undertake multiple unsuccessful attempts of drug treatment whilst their life and health deteriorates, which is accompanied with severe pain and suffering²⁶. Despite this the Russian authorities continue to maintain the legal ban on the most effective drug treatment – OST – in callous disregard to pain and suffering of drug dependent people, who can only receive drug treatment services from the state run clinics and only with methods approved by the state (art. 55 of the Federal Law No 3-FZ of 8.01.1998 “On Narcotic Drugs and Psychotropic Substances”). As such people living with drug dependence are totally dependent on state support and are very vulnerable to mistreatment, especially when the state ignores their needs related to their chronic health condition and withholds effective and most internationally recognized method of drug dependence treatment.

²¹ European Court case of *Keller v. Russia*, No 26824/04, Judgment of 17/10/2013

²² Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Applying the torture and ill-treatment protection framework in health-care settings*, A/HRC/22/53, Feb 1, 2013, para 73.

²³ *Ibid*, para 74.

²⁴ WHO/UNODC/UNAIDS position paper *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva, 2004. Page 8. Available online at http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

²⁵ EMCDDA. “Best practice in drug interventions”. Available at <http://www.emcdda.europa.eu/best-practice#view-answer9>

²⁶ Golichenko M., Sarang A. “Atmospheric pressure: Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic, Social and Cultural Rights.” *Health Hum Rights*. 2013 Jun 14;15(1):E135-43. Available online <http://www.hhrjournal.org/wp-content/uploads/sites/13/2013/06/Golichenko-FINAL.pdf>

- 12.5 We request the Committee to take into account the third parties interventions to the European Court of Human Rights by the UN Special Rapporteur on Torture, Human Rights Watch, the Canadian HIV/AIDS Legal Network, the Eurasian Harm Reduction Network, and Harm Reduction International which we attach to the this document (Annex II). The interventions were made with respect to three cases regarding access to OST in Russia which are currently under the considerations of the European Court of Human Rights. All the interveners provide thorough arguments that the denial of OST for people with opioid dependence is a violation of the right to be free from cruel, inhuman or degrading treatment.

Observations with respect to the Russian Federation's responses to Issue No 20 (right to fair trial, art. 14)

13. In paragraph 122 of its response the Russian Federation attributes the low rate of acquittals to the fact that "the significant number of criminal cases is considered by courts according to the special procedure when an accused pleads guilty". This statement is correct for drug crimes. Courts statistics for the year 2013 demonstrate that more than 84% of 90,649 persons, who were convicted for drug crimes punishable with up to 10 years imprisonment (eligible for the special procedure), were processed according to the special procedure when they plead guilty and the court proceeded directly to sentencing without a trial²⁷. The review of case files demonstrates similar proportion. Of 189 cases where people were charged with drug crimes punishable with up to 10 years imprisonment, 76% were cases adjudicated according with the special procedure²⁸. One of the main reasons why, on drug crimes, accused people plead guilty so often is the simplicity of a charge. Police has to establish two main facts: a) the fact that there is prohibited substance in the seized mixture; b) that an accused is a drug user/drug dependent person. All other evidence in drug case files are usually the derivatives from evidences which establish the two facts. As regards the fact that an accused is a drug user or a drug dependent person, in paragraphs 5-8 above we already discussed that using the social and health status of drug user and/or drug dependent person as ground for law enforcement activities runs contrary to arts. 2 and 9 of the Covenant. In this part we would like to draw the Committee's attention to the very low quality of the forensic examination of seized substances. Very often forensic experts, who always belong to the same law enforcement agency which prosecutes accused persons, do not even establish a purity of narcotic drug in seized substances²⁹. In other words people are prosecuted for possession of mixtures which composition is not properly established and the justice system accepts such evidences. On the other hand courts refuse to accept results of independent forensic and other scientific examinations. Moreover in some cases drug enforcement authorities prosecute scientists, who make independent scientific statements on criminal cases at the request of the defence, for adding and abetting drug crimes (please see paragraphs 4.5.5 and 4.5.6 of our Shadow Report for more details).
14. Most of accused people who use drugs know about these bogus justice standards and prefer to mitigate the consequences of their arrest by pleading guilty and reducing sentencing by this. The above facts demonstrate the false legitimacy of the simplified procedure and falsity of the alleged correspondence of the justice system in Russian to the right of a fair trial. The Russian Federation should observe international standards of fair trial on drug cases, including by avoiding evidence which have been received as a result of inappropriate use of medical data and a person's health status, or when purity of street drugs is not established. It should promote the use of independent forensic and scientific research in drug cases.

Observations with respect to the Russian Federation's responses to Issue No 29 Protection of Covenant rights of residents of the Autonomous Republic of Crimea and the city of Sevastopol

²⁷ According to the official courts' statistics <http://www.cdep.ru/index.php?id=79>

²⁸ Reference to the on-going legal research, supra note 6.

²⁹ As part of the on-going legal research (supra note 6) we found that in 73% of 213 reviewed cases opioids were the drug of choice, followed by cannabis and stimulants. Purity was not established in 90% of opioid possession cases.

15. In paragraph 184 of its responses the Russian Federation informed the Committee that the Republic Crimea is a part of the Russian Federation and that all anti-discrimination laws of the Russian Federation are effective on the territory of Crimea. We would like to refer to paragraph 4.2.5 of our shadow report which informs the Committee that since May 2014 the Russian Federation terminated essential drug treatment services – OST – for more than 800 OST patients in Crimea. According to different sources of information by now from 6 to 80 former OST patients died because of suicides or health complications related to the lack of access to OST³⁰. There is no doubt that the withdrawal of essential health service from such vulnerable people as people with drug dependence, in complete disregard of pain, suffering, and adverse health consequences of such an action, amounts to torture, contrary to Article 7 of the International Covenant on Civil and Political Rights.

³⁰ The UN Secretary-General's Special Envoy for HIV/AIDS in Eastern Europe and Central Asia, along with Ukrainian non-governmental organizations providing HIV prevention services, recently made statements reporting their knowledge of dozens of former OST patients in Crimea who died due to the discontinuation of the OST program in Crimea by the Russian Federal Drug Control Service following annexation ("ООН: наркоманы Крыма умирают без заместительной терапии". 22 January 2015. Available at http://www.bbc.co.uk/russian/society/2015/01/150122_crimea_drugs_crisis); data from Crimea OST patients are consistent with these reports (Video about OST termination in Crimea. Eurasian Network of People Who Use Drugs. January 2015. Available at <https://www.youtube.com/watch?v=G9zhiLK5AGY>). The Ministry of Health of the Russian Federation deny these data ("Минздрав: в Крыму снижается смертность наркозависимых, проходивших заместительную терапию". 21 January 2015. Available at <http://tass.ru/obschestvo/1713220>)

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TÉLÉCOPIÉ • FACSIMILE TRANSMISSION

DATE: 29 September 2014

TO: Madame Isabelle Berro-Lefèvre
President of the Chamber
Chamber I
European Court of Human Rights
Council of Europe
F-67075 Strasbourg-Cedex
France
Tel : +33 (0)3 88 41 20 18

CC: M. Soren Nilsen
Greffier de section

FAX: +33 (0)3 88 41 27 30

FROM: Karim Ghezraoui
Chief of Branch
Special Procedures Branch

FAX: 022 917 9006

E-MAIL: kghezraoui@ohchr.org

PAGES: 11 (including this page)

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SUBJECT: Submission of Intervenor Juan E. Méndez, United Nations Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment

Please find attached Submission of Intervenor Juan E. Méndez, United Nations Special Rapporteur on the question of torture and other cruel, inhuman or degrading treatment or punishment in the case of Kurmanayevskiy v. Russia, Application 62964/10, Abdyusheva v. Russia, Application 58502/11 and Anoshkin v. Russia, Application 55683/13 for the Court's consideration.

IN THE EUROPEAN COURT OF HUMAN RIGHTS
Application nos. 62964/10, 58502/11 & 55683/13

BETWEEN:

**ALEKSEY VLADIMIROVICH KURMANAYEVSKIY, IVAN VASILYEVICH ANOSHKIN AND IRINA
 NIKOLAYEVNA ABDYUSHEVA**

- and -

RUSSIA

Respondent Government

**SUBMISSION OF INTERVENOR JUAN E. MÉNDEZ
 UNITED NATIONS SPECIAL RAPPORTEUR ON TORTURE AND
 OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT**

Introduction

1. This written Intervention is submitted by the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment pursuant to leave granted by the Deputy Registrar of the Court 9 September 2014 in accordance with rule 44 § 3 of the Rules of the Court.¹
2. This case concerns three applicants who suffer from opioid drug dependence, a chronic, relapsing medical condition, with an effective medical treatment: opioid substitution therapy with methadone or buprenorphine. Russian law bans the use of methadone altogether. It allows the use of buprenorphine for all purposes except for drug dependence treatment.
3. These comments set forth international human rights standards on the issue of drug dependence treatment, particularly for individuals dependent on opioids, such as heroin. They demonstrate that opioid substitution therapy, in particular with methadone or buprenorphine, is a key component of opioid drug dependence treatment, and that it is a violation of international human rights protections against torture and cruel, inhuman and degrading treatment or punishment to deny this proven, medically effective treatment to people suffering from the health condition of opioid dependence. International and regional law standards discussed herein demonstrate that states have a positive obligation to take reasonable, effective measures to ensure access to and availability of methadone and buprenorphine treatment to meet their obligations to prevent torture and ill-treatment of opioid dependent persons.
4. These comments draw substantially on interpretations by United Nations treaty monitoring bodies (including the Committee on Economic, Social and Cultural Rights and the Committee against Torture) of relevant international treaty provisions and on jurisprudence from the European Court of Human Rights, with regard to discriminatory denial of essential medicines that foreseeably results in severe mental and physical consequences, including pain and suffering. The Special Rapporteur urges the Court to take these arguments into consideration in its

¹ Counsel of record for all parties have consented to the filing of this *written intervention*. No counsel for a party authored this intervention in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this intervention. No persons other than the *intervener* or his counsel made a monetary contribution to this intervention's preparation or submission.

determination of whether the facts of the current case amount to a violation of Article 3 rights to freedom from torture or inhuman or degrading treatment or punishment.

Interest of Intervener

5. Professor Juan E. Méndez is the current United Nations Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment (the Special Rapporteur), whose mandate covers all countries, irrespective of whether a state has ratified the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture or CAT). He was Co-Chair of the Human Rights Institute of the International Bar Association, London in 2010 and 2011, and Special Advisor on Crime Prevention to the Prosecutor, International Criminal Court, The Hague from mid-2009 to late 2010. Until May 2009, Méndez was the President of the International Center for Transitional Justice (ICTJ). Concurrently, he was Kofi Annan's Special Advisor on the Prevention of Genocide (2004 to 2007). Between 2000 and 2003 he was a member of the Inter-American Commission on Human Rights of the Organization of American States, and its President in 2002. He directed the Inter-American Institute on Human Rights in San Jose, Costa Rica (1996-1999) and worked for Human Rights Watch (1982-1996). He teaches human rights at American University in Washington D.C. and at Oxford University in the United Kingdom. He previously taught at Notre Dame Law School, Georgetown, and Johns Hopkins.

6. Pursuant to UN Human Rights Council Resolution 25/13 (A/HRC/RES/25/23), Méndez acts under the aegis of the Council without remuneration as an independent expert within the scope of his mandate, which enables him to seek, receive, examine and act on information from numerous sources, including individuals, regarding issues and alleged cases concerning torture or other cruel, inhuman or degrading treatment or punishment.

7. The Special Rapporteur has delivered several reports to the UN Human Rights Council and the UN General Assembly on issues related to drug policy, including questions of drug treatment standards. Those reports include the following:

- "Applying a human rights-based approach to drug policies." (2009). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak. Part IV. A/HRC/10/44.
- "Emerging recognition of different forms of abuses in health-care settings. Marginalized groups." (2013). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. Part IV(E). A/HRC/22/53.

8. This submission is drafted on a voluntary basis for consideration by the European Court of Human Rights in **KURMANAYEVSKIY et al. v. RUSSIA, Application Nos. 62964/10, 58502/11 & 55683/13**. It is submitted without prejudice to, and should not be considered as an express or implicit waiver of the privileges and immunities of the United Nations, its officials and experts on missions, pursuant to the 1946 Convention on the Privileges and Immunities of the United Nations.

Denial Of Opioid Substitution Therapy: Application of the Prohibition on Torture And Ill-Treatment

9. The prohibition against torture and cruel, inhuman and degrading treatment or punishment is enshrined in Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), Article 7 of the International Covenant on Civil and Political Rights (ICCPR), Articles 2 and 16 of the Convention against Torture (CAT), and in

numerous other international and regional treaties.² This prohibition is absolute and non-derogable.³ It is also a matter of *jus cogens*, a peremptory norm of customary international law binding on every State regardless of whether it has ratified any particular treaty provision prohibiting such ill-treatment.⁴

10. In interpreting the provisions of the ECHR and the scope of the States' obligations in specific cases, the European Court of Human Rights (ECtHR) looks "for any consensus and common values emerging from the practices of European States and specialised international instruments... as well as giving heed to the evolution of norms and principles in international law..."⁵ In recent years, international law has evolved to include abuses in the context of health care within the definition of torture and ill-treatment.⁶

11. The prohibition on torture includes positive and negative obligations: the obligation to prohibit torture; and the positive obligation to prevent, investigate, prosecute and punish acts of torture and ill-treatment by State, non-state, and private actors.⁷ The Committee against Torture has made clear that this obligation requires State Parties to "prohibit, prevent, and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm."⁸

12. In *da Silva Pimentel v. Brazil*, the Committee on the Elimination of Discrimination against Women observed that "the State is directly responsible for the action of private institutions when it outsources its medical services" and "always maintains the duty to regulate and monitor private health-care institutions."⁹ The Inter-American Court of Human Rights addressed State responsibility for actions of private actors in the context of health-care delivery in *Ximenes Lopes v. Brazil*.¹⁰ Previously, this Court has noted that the suffering associated with a relapse [to psychosis], due in part to restricted access to medicines, "could, in principle, fall within the scope of Article 3."¹¹

13. Ensuring special protection of minority and marginalized groups and individuals is a critical component of the obligation to prevent torture and ill-treatment. The Committee against Torture, the ECtHR, and the Inter-American Court of Human Rights have confirmed that States

² European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), 213 U.N.T.S. 222, entered into force Sept. 3, 1953, as amended by Protocols Nos. 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998 respectively, ratified by Russia on May 5, 1998; International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 999 U.N.T.S. 171 (entered into force March 23, 1976), ratified by Russia on March 23, 1976; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. Res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by Russia on March 3, 1987.

³ ICCPR, article 4(2); CAT, article 2(2).

⁴ Manfred Nowak & Elizabeth McArthur, *The United Nations Convention Against Torture: A Commentary* (2008), p. 8; Committee Against Torture, General Comment No. 2, Implementation of article 2 by States Parties, U.N. Doc. CAT/C/GC/2/CRP. 1/Rev.4 (2007), para. 1.

⁵ *Oyuz v. Turkey*, No. 33401/02, (2009), para. 164.

⁶ See U.N. General Assembly (2013), *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A-HRC-22-53 (2013) (by Juan Méndez).

⁷ Human Rights Committee, General Comment No. 20, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994), para. 8; Committee against Torture, General Comment No. 2, paras. 15-18; Committee against Torture, *Hajrizi Dzemajli et al. v. Yugoslavia*, Communication No. 181/2000, U.N. Doc. CAT/C/29/D/181/2000 (2002), paras. 8.12, 9.2; see also the judgment of the European Court of Human Rights in *Z and Others v. United Kingdom*, No. 29382/95, (2001), para. 73.

⁸ Committee Against Torture, General Comment No. 2, para. 15 (and see also para. 17).

⁹ Committee on the Elimination of Discrimination against Women, Views: Communication No 17/2008, 49th sess, U.N. Doc CEDAW/C/49/D/17/2008 (2011), para. 7.5

¹⁰ Inter-American Court of Human Rights. (Series C) No. 149 (2006), paras. 103, 150; see also Committee on the Elimination of Discrimination against Women, General Recommendation No. 19. Violence against Women, UN Doc A/47/38 (1992), para. 9.

¹¹ *Bensaid v. the United Kingdom*, No. 44599/98 (2001), para. 37.

have a heightened obligation to protect vulnerable and marginalized individuals from torture, as such individuals are generally more at risk of experiencing torture and ill-treatment.¹²

14. The CAT defines torture as: an act inflicting severe pain or suffering, whether physical or mental, that is intentionally inflicted on a person, for such purposes as obtaining information or a confession, punishing, intimidating or coercing someone, or for any reason based on discrimination of any kind, and at the instigation of, or with the consent or acquiescence of a public official or other person acting in an official capacity. All forms of cruel and inhuman treatment or punishment require the infliction of severe pain and suffering. The key criteria distinguishing torture from *cruel and inhuman* treatment are (i) whether the pain and suffering are inflicted intentionally or not, and (ii) the purpose of the conduct. In order to amount to torture under CAT (Article 1), pain and suffering must be intentionally inflicted; but in the absence of such intention, treatment causing severe pain and suffering may nonetheless still meet the lower threshold of being cruel and inhuman. Cruel and inhuman treatment also encompasses the infliction of severe pain or suffering even if not accompanied by a specific purpose. Treatment may qualify as *degrading* if it inflicts mental or physical pain or suffering that aims to humiliate the victim; the particular humiliation is sufficient, even where the pain or suffering is not so "severe" as to rise to the level of torture.¹³

15. The jurisprudence and authoritative interpretations of international human rights bodies provide useful guidance on how the four criteria of the definition of torture apply in the context of health-care settings. The ECtHR has noted that a violation of Article 3 may occur where the purpose or intention of the State's action or inaction was not to degrade, humiliate or punish the victim, but where this nevertheless was the result.¹⁴

16. The Russian government's ban on opioid substitution therapy clearly meets the elements of state involvement, intent, and severity, as well as the imposition of pain and suffering for an improper purpose, such that it constitutes a violation of the prohibition on torture or ill-treatment.

17. **State involvement:** Russia's ban on medications such as methadone and buprenorphine to assist with drug dependence detoxification or with maintenance therapy is a matter of law and official state policy (Article 31(6) of the Federal Law No 3-FZ of January 8, 1998 "On Narcotic Means and Psychotropic Substances" prohibits use of narcotic drugs and psychotropic substances such as methadone and buprenorphine for drug dependence treatment). State involvement in the harmful conduct is self-evident in such a case.

18. **Intentional infliction:** The intent to inflict pain and suffering is also clear. State policy explicitly seeks to coerce people with drug dependence into abstinence, including through the punishment of withholding evidence-based treatment for their health condition, in complete disregard of the chronic nature of dependence, of the scientific evidence pointing to the ineffectiveness of punitive measures and of repeated recommendations from a wide range of health experts and UN agencies to ensure access to opioid substitution treatment (The State Strategy of Antidrug Policy up to 2020 (para 4), adopted by the Decree of the President No 690 of June 9, 2010 lists "inadmissibility of substitutive addiction treatment [opioid substitution therapy]" among key principles of the state policy aimed at "substantial reduction of illicit trade and non-medical use of drugs." The State Strategy also lists "intensification of efforts to legalize

¹² Committee against Torture, General Comment No. 2, para. 21; *Ximenes Lopes v. Brazil*, para. 103; *Opuz v. Turkey*, para. 159.

¹³ Manfred Nowak & Elizabeth McArthur, *The United Nations Convention Against Torture: A Commentary*, (2008), pp. 558, 559. Treatment may be deemed degrading, in violation of ECHR Article 3, "because it was such as to arouse in the victim the feelings of fear, anguish and inferiority capable of humiliating and debasing them." *Kudła v. Poland*, No. 30210/96 (2000), para. 92.

¹⁴ See *Peers v. Greece*, No. 28524/95 (2001), paras. 68, 74; *Grorl v. Albania*, No. 25336/04 (2009), para. 125.

the substitutive addiction treatment using narcotic drug preparations" among the risks for the implementation of the Strategy (para 48).¹⁵

19. **Severity:** The physical and mental pain and suffering caused by Russia's denial of methadone and buprenorphine are severe and well documented.¹⁶

20. Opioid dependence is a chronic, relapsing health condition with major health consequences, including higher risk of premature death, and increased risk of HIV, hepatitis C, and other serious diseases. Untreated or forced, abrupt opioid withdrawal may cause profound physical pain (including convulsions, severe abdominal cramping, nausea, vomiting, diarrhea, and dehydration, which in extreme cases may lead to renal failure) and psychological suffering (including extreme agitation and/or anxiety) and can have serious medical consequences for pregnant women and their fetuses, immunocompromised people, and people suffering from comorbid medical disorders.¹⁷ By denying proven, effective drug treatment, the Russian government's drug policies intentionally subject thousands (2.29 per cent of the population 15-64 years old inject drugs in Russia, most of them opioids)¹⁸ of people to degrading humiliation and to severe mental and physical pain and suffering, including increased risk of premature death or serious disability as a result of overdose, as well as HIV, hepatitis C, and imprisonment – often in conditions that further damage their health or lead to premature death, including from tuberculosis that is highly prevalent in Russian prisons.

21. The cumulative effects of the Russia's denial of opioid substitution therapy for an opioid dependent individual are: extremely high risk of relapse to illicit drug use after leaving treatment and -- as a result - extremely high risk of contracting life-threatening diseases, such as HIV, hepatitis C, and tuberculosis; very high risk of serious disability or death due to overdose; extremely high risk of police arrest, imprisonment and constant state-sponsored humiliation through official government publications and campaigns that depict drug dependent people as repulsive, feeble-minded and degenerate. These effects exacerbate the harsh direct physical and psychological consequences of untreated opioid dependence.¹⁹

22. A substantial body of research has documented the effectiveness of opioid substitution therapy, in particular with methadone and buprenorphine, in reducing illicit drug use as well as criminal activity, overdose deaths, and behaviors such as syringe sharing that are associated with high risks of HIV prevention.²⁰ In light of this evidence, the World Health Organization (WHO), the United Nations Office of Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) all recommend that substitution maintenance therapy, in particular with methadone and buprenorphine, be integrated into national HIV/AIDS programs, both as an HIV prevention measure and to support adherence to antiretroviral HIV treatment and medical follow-up for opioid dependent drug users.²¹ According to WHO's *Guidelines for the*

¹⁵ Strategy for the Implementation of the National Anti-Drug Policy of the Russian Federation in the Period Until 2020 (available in English at <http://stratgap.ru/pages/strategy/3662/4434/4437/index.shtml>).

¹⁶ See, e.g., Mikhail Golichenko and Anya Sarang, *Atmospheric Pressure: Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic, Social and Cultural Rights*, Health and Human Rights Journal, June 14, 2013, vol. 15(1):E135-43; Human Rights Watch, *Rehabilitation Required: Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment*, (2007).

¹⁷ Center for Substance Abuse Treatment, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43, DHHS Publication No. (SMA) 05-4048, (2005), chs. 12, 13; WHO, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, (2009), pp. 5, 43, 51, 71; H.E. Jones, L.P. Finnegan and K. Kaltenbach, *Methadone and Buprenorphine for the Management of Opioid Dependence in Pregnancy*, *Drugs*, April 16, 2012, vol. 72, no. 6, pp. 747-57.

¹⁸ United Nations Office on Drugs and Crime (UNODC) 2014 World Drug Report. (2014), pp. 6, 17.

¹⁹ See Mikhail Golichenko and Anya Sarang, *Atmospheric Pressure: Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic, Social and Cultural Rights*, supra, note 16.

²⁰ World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS), *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention* (2004).

²¹ *Ibid.*

Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, providing methadone or buprenorphine is essential to meet *minimal* standards of health care provision.²²

23. **Improper purpose:** Finally, in order to constitute torture (pursuant to the definition in CAT Article 1), the ill-treatment must be imposed "for such purposes as obtaining information, punishing, intimidating or coercing someone, or for any reason based on discrimination of any kind." Russia's ban on opioid substitution therapy satisfies this requirement in several ways.

24. First, conduct may qualify as torture if applied with an improper purpose other than one explicitly stated in CAT. In the context of drug treatment, assisting "patients" in managing or overcoming drug dependence is the sole proper purpose – hence any other purpose, whether explicitly stated or determinable from the circumstances, is automatically suspect. As noted above, the refusal to permit access to opioid substitution treatment for opioid dependent persons fails to meet even minimal standards of care; these standards have been drawn to the attention of Russian officials at the highest levels repeatedly. Russian officials are also fully aware that their drug treatment system, deprived of a key, successful, evidence-based element of treatment (i.e., opioid substitution treatment), fails nearly all drug-dependent persons.²³ In this context, Russia cannot plausibly claim the purpose of its drug treatment for opioid dependent people, and of the practices to which they are subject, is treatment of a health condition.

25. The purpose element of CAT's definition of torture is also satisfied where it can be said that the treatment is carried out for "any reason based on any discrimination of any kind." The Committee Against Torture has declared that, as is the case with human rights law generally, the basic principle of nondiscrimination is "fundamental to the interpretation and application of the Convention," and has emphasized "that the discriminatory use of mental or physical violence or abuse is an important factor in determining whether an act constitutes torture."²⁴

26. Russia's denial of the use of buprenorphine to treat drug dependence, while permitting its use for other health conditions, and its complete ban on methadone, directly and needlessly causes severe mental and physical suffering to thousands of opioid dependent Russians. Where this treatment of people who use drugs is deliberate by the state (as is evidently the case with Russia), or even if it is simply tolerated in whole or in part because those who suffer the consequences are people who use illegal drugs, it amounts to "discrimination of any kind," meeting the "improper purpose" requirement under CAT's definition of torture. As noted by the Committee Against Torture: *The protection of certain minority or marginalized individuals or populations especially at risk of torture is a part of the obligation to prevent torture or ill treatment. States parties must ensure that, insofar as the obligations arising under the Convention are concerned, their laws are in practice applied to all persons, regardless of... mental or other disability, health status... or any other status or adverse distinction.*²⁵

27. In addition, the discriminatory ill-treatment of people who use drugs could be seen as discrimination based on "health status" or "other status" or based on "disability."²⁶ As the WHO

²² WHO, *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, (2009), p. xiv. These guidelines add, "A comprehensive package of interventions to prevent the transmission of HIV must include measures to reduce unsafe injecting of opioids, including the treatment of opioid dependence." *Ibid.*, p. x.

²³ According to Russian Federal Drug Control Agency data, more than 90 percent of drug treatment patients resume the use of illegal drugs within a year. FSKN RF Director Ivanov, Interview for RIA Novosti, September 16, 2009, www.ria.ru; Professor T. V. Klimenko, "On the Russian Drug Control Strategy," 2009. (Директор ФСН РФ Иванов (16 сентября 2009 года). Интервью РИА Новости. www.ria.ru; Профессор Т.В. Клеменко (2009). «О государственной антинаркотической стратегии. Российской Федерации».) <http://stratgap.ru/includes/periodics/comments/2009/1124/3841/detail.shtml>.

²⁴ Committee Against Torture, General Comment No. 2, para. 20.

²⁵ *Ibid.*, para. 21.

²⁶ Discrimination based on "other status" includes discrimination based on health status, as well as disability in international as well as European human rights instruments. See Committee on Economic, Social and Cultural Rights, General Comment No. 20, "Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)", E/C.12/GC/20 (2009), paras. 27, 28, 33; *Kyutin v. Russia*, No. 2700/10 (2011), para. 57. Some jurisdictions recognize drug dependence as a "disability" in anti-discrimination law including in Canada, the United States, and Australia. For a non-exhaustive list of cases, see Canadian HIV/AIDS Legal

and UNODC have affirmed: *Drug dependence is considered a multifactorial health disorder that often follows the course of a relapsing and remitting chronic disease. Unfortunately in many societies drug dependence is still not recognized as a health problem and many people suffering from it are stigmatized and have no access to treatment and rehabilitation . . . "Nothing less" must be provided for the treatment of drug dependence than a qualified, systematic, science based approach such as that developed to treat other chronic diseases considered untreatable some decades ago.*²⁷

28. Russian government officials tolerate (or themselves administer) "treatment" for drug dependence that substantially deviates from the requirements of evidence that are essential in treating other health conditions. To the extent that this is so because it is people who use drugs who are the subjects of this treatment, when non-evidence-based approaches are unacceptable in the treatment of other health conditions, then this substandard treatment amounts to discrimination, thereby satisfying this third element of the definition of torture.

Denial of opioid substitution therapy violates Russia's positive obligation to prevent torture and ill treatment

29. Opioid dependent individuals suffer from a chronic, relapsing disease, for which there is an effective, inexpensive, proven medical treatment: opioid substitution treatment with methadone or buprenorphine. The denial of this treatment forces opioid dependent persons to face serious physical and mental pain, and puts them at foreseeable high risk of life-threatening disease (including HIV and Hepatitis C), incarceration, and death by overdose. Russia's positive obligation to prevent severe pain and suffering due to opioid dependence requires it to take effective steps to ensure that opioid dependent individuals can gain access to adequate treatment. Its blanket ban on opioid substitution therapy with methadone and buprenorphine thus violates Russia's positive obligations to take effective, reasonable steps to protect opioid dependent individuals against torture and ill-treatment.

30. International law enjoins States not only to prohibit torture and ill-treatment but also requires them to take effective measures to ensure that individuals within their jurisdiction are not subjected to torture or cruel, inhuman or degrading treatment or punishment, including in cases where it is administered by private individuals.²⁸

31. Governments have an obligation under the Convention against Torture to take "effective legislative, administrative, judicial or other measures" to prevent torture and ill-treatment.²⁹ The Committee against Torture has found failure to take steps to prevent grave risks to physical and mental health, including denial of necessary medical treatment, to be a violation of the Convention, and recommended measures to remedy the problem. For example, in its 2006 review of Peru, the Committee expressed concern, *inter alia*, that "medical personnel employed by the State denie[d] medical treatment required to ensure that pregnant women do not resort to illegal abortions that put their lives at risk," and legislation that severely restricted access to voluntary abortion "leading to grave consequences, including the unnecessary deaths of women." The Committee found that the State's failure to prevent these acts put women's physical and mental health at risk, constituting cruel and inhuman treatment, and the Committee recommended that Peru take "whatever legal and other measures are necessary to effectively

Network, *Legislating for Health and Human Rights: Model Law on Drug Use and HIV/AIDS* at 14. (2006), www.aidslaw.ca/modelaw; see also F. Gibson, *Drugs, Discrimination And Disability*, 17 J. OF L. & MEDICINE 400-411 (2009).

²⁷ UNODC, *Principles of Drug Dependence Treatment: Discussion Paper* (2008), pp. 1-2; see also UNODC: Comm. On Narcotic Drugs, 53rd Sess., *Drug Control, Crime Prevention and Criminal Justice: A Human Rights Perspective— Note by the Executive Director*, para. 40 U.N. Doc. E/CN.7/2010/CRP.6 – E/CN.15/2010/CRP.1 (Mar. 3, 2010).

²⁸ *Opuz v Turkey*, para. 159.

²⁹ Convention Against Torture, articles 2,16.

prevent acts that put women's health at grave risk," including by providing the required medical treatment.³⁰

32. The Committee against Torture has made clear that States have a heightened obligation to protect vulnerable or marginalized individuals or populations especially at risk of torture by "by fully prosecuting and punishing all acts of violence and abuse against these individuals and ensuring implementation of other positive measures of prevention and protection."³¹ The Committee against Torture has cited the "protection of certain minority or marginalized individuals or populations especially at risk of torture" as part of the obligation to prevent torture or ill-treatment, and identified "mental or other disability, or health status" as factors that put individuals especially at risk of torture.³²

33. The ECtHR has likewise held that governments are required to take effective measures, in particular with regard to children and other vulnerable individuals, to prevent torture and ill-treatment.³³

34. It is well-established that drug dependence can cause or amount to disability.³⁴ As noted above, drug dependence is also recognized as a disability in the anti-discrimination statutes of some countries, which engages protections against torture guaranteed by the UN Convention on the Rights of Persons with Disabilities (CRPD).³⁵ The CRPD enjoins States to "take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment."³⁶ It also expressly requires States to take "all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse."³⁷ This includes the duty to investigate and prosecute those responsible for such actions.³⁸

Reasonable measures

35. The protection of the right to health under the International Covenant on Economic, Social and Cultural Rights (ICESCR), and even various provisions of the UN drug control conventions, offer guidance regarding reasonable measures that governments must take to prevent torture and ill-treatment of opioid dependent people.³⁹ Russia has a legal obligation under the 1961 Single Convention on Narcotic Drugs to ensure availability of narcotic drugs for medical and scientific use; there is no justification for excluding the use of methadone and buprenorphine for treatment of opioid dependence. The 1961 Single Convention, to which Russia is a party, declares the medical use of narcotic drugs indispensable for the relief of pain and

³⁰ Committee against Torture, Concluding Observations: Peru, U.N. Doc. CAT/C/PER/CO/4 (2006), para. 23.

³¹ Committee against Torture, General Comment No. 2, para. 21.

³² *Ibid.*

³³ *Opuz v Turkey*, para. 159.

³⁴ See WHO, *International Classification of Disease (ICD-10) Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines*, 2007; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Health Disorders*, 5th edition (2013); American Society of Addiction Medicine definition of addiction (online at <http://www.asam.org/for-the-public/definition-of-addiction>).

³⁵ See note 26, *supra*. In Canada, for example, federal and provincial/territorial anti-discrimination statutes have all been interpreted so as to recognize that drug dependence constitutes a "disability" (or "handicap" in the more antiquated terminology of some statutes). Since the early 1990s, courts and tribunals have repeatedly affirmed such interpretations. In some cases, this is explicit in the statute: e.g., the Canadian Human Rights (s. 25) defines disability as "any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug." Australian courts and tribunals have also recognized that opioid dependence may constitute a disability for purposes of anti-discrimination legislation.

³⁶ Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, entered into force May 3, 2008, ratified by Russia on September 25, 2012, article 15(2).

³⁷ CRPD, article 16(1).

³⁸ *Ibid.*, article 16(5).

³⁹ See Joseph Amon and Diederik Lohman, *Denial of Pain Treatment and the Prohibition of Torture and Cruel, Inhuman or Degrading Treatment and Punishment*, *Interrights Bulletin*, vol. 16 (11) (2011), pp. 172-184.

suffering and mandates states to ensure that adequate provision of narcotic drugs is available for such purposes.⁴⁰ According to the International Narcotics Control Board, the expert body charged with monitoring the implementation of the UN drug conventions, the 1961 Convention establishes a "control regime to serve a dual purpose: to ensure the availability of controlled substances for medical and scientific ends while preventing the illicit production of trafficking in and abuse of such substances."⁴¹

36. The ICESCR guarantees "the right of everyone to the highest attainable standard of physical and mental health," without discrimination on certain prohibited grounds (including physical or mental disability, health status, and any "other status" that has "the intention or the effect of nullifying or impairing the equal enjoyment or exercise of the right to health").⁴² Article 12 specifically obliges states to take all steps necessary for the "prevention, treatment and control of epidemic . . . diseases," and the "creation of conditions which would assure to all medical service and medical attention in the event of sickness."⁴³

37. According to the UN Committee on Economic, Social and Cultural Rights (CESCR), the ICESCR also requires states both to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health.⁴⁴ Laws and policies that "are likely to result in . . . unnecessary morbidity and preventable mortality" constitute specific breaches of the obligation to respect the right to health.⁴⁵

38. The CESCR has identified certain core obligations that are so fundamental that states must fulfill them regardless of resource constraints. The Committee has observed that states have a "special obligation to prevent any discrimination . . . in the provision of health care and health services, especially with respect to the core obligations of the right to health,"⁴⁶ and that states "cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations...which are non-derogable."⁴⁷ The Committee has identified, among others, the following core obligations: to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; to ensure the equitable distribution of all health facilities, goods and services; and to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.⁴⁸ The Committee considers the obligation to take measures to prevent, treat and control epidemic diseases to be an obligation of comparable priority.⁴⁹

39. WHO has included methadone and buprenorphine on its list of Model List of Essential Medicines for the treatment of drug dependence since 2005.⁵⁰ As noted above, WHO has also

⁴⁰ Single Convention on Narcotic Drugs, 30 March 1961, 520 UNTS as amended by 1972 Protocol amending the Single Convention on Narcotic Drugs, 25 March 1972, TIAS 8118, 976 UNTS, preamble, article 4. International Narcotics Control Board, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* (E/INCB/2010/1/Supp.1), para. 3.

⁴¹ INCB, *Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes* (2010), E/INCB/2010/1/Supp.1, para. 3.

⁴² International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, article 12; U.N. Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4 (2000), para. 18. The right to health is also guaranteed in numerous international and regional treaties, including the Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, entered into force September 2, 1990, ratified by Russia on August 16, 1990, article 24; Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, entered into force May 3, 2008, ratified by Russia on September 26, 2012, article 25.

⁴³ ICESCR, article 12(2)(c,d).

⁴⁴ CESCR, General Comment No. 14, paras. 30-37.

⁴⁵ *Ibid.*, para. 50.

⁴⁶ CESCR, para. 19.

⁴⁷ CESCR, para. 47.

⁴⁸ *Ibid.*, para. 43(a, d, e)

⁴⁹ *Ibid.*, para. 44(c).

⁵⁰ World Health Organization: WHO Model List of Essential Medicines: 18th List, April 2013, p. 32.

made clear that providing methadone or buprenorphine for the treatment of opioid drug dependence is essential to meet *minimal* standards of health care provision,⁵¹ and, together with the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), recommended that substitution maintenance therapy, in particular with methadone and buprenorphine, be integrated into national HIV/AIDS programs, both as an HIV prevention measure and to support adherence to antiretroviral treatment and medical follow-up for opioid dependent drug users.⁵²

40. The Committee on Economic, Social and Cultural Rights has interpreted the ICESCR to require, at a minimum, that states ensure access to effective drug dependence treatment, in particular, opioid substitution therapy with methadone and buprenorphine, in order to meet their obligations under Article 12 to ensure the rights to health.⁵³ In relation to Russia, it has stated its concern about the continued ban on the medical use of methadone and buprenorphine for treatment of drug dependence, and urged Russia to “to apply a human rights-based approach to drug users so that they do not forfeit their basic right to health,” and strongly recommended that Russia “provide clear legal grounds and other support for the internationally recognized measures for HIV prevention among injecting drug users, in particular the opioid substitution therapy with use of methadone and buprenorphine, as well as needle and syringe, and overdose prevention programmes.”⁵⁴

41. Russia’s denial of opioid substitution therapy, in violation of its obligations under the 1961 Single Convention on Narcotic Drugs and the ICESCR, Article 12, puts opiate dependent drug users – a marginalized, vulnerable population – at heightened risk of serious illness and premature death. This failure to prevent such serious risks to life and health results in pain and suffering associated with torture and inhuman and degrading treatment expressly and absolutely prohibited by Article 3 of the European Convention on Human Rights.

Conclusion

42. In summary, we submit that in evaluating the right of opioid dependent persons to have access to effective means to address their drug dependence, this Court should have regard to (1) the strong international consensus regarding the importance of ensuring access to opioid substitution therapy, in particular with methadone and buprenorphine, to address severe pain and suffering attendant to opioid withdrawal and other adverse consequences of illicit drug use, and to meet the minimal standards of health provision for opioid dependent persons; (2) the state’s heightened obligation to prevent torture and ill-treatment of vulnerable populations, such as drug-dependent persons; and (3) the cumulative effect of the many ways in which drug-dependent people in Russia experience severe pain, suffering and humiliation as a consequence of the Russian Federation’s intentional denial of access to opioid substitution treatment.

⁵¹ WHO. (2009). Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, p. xiv.

⁵² WHO, UNODC, UNAIDS, Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention.

⁵³ See, e.g., Committee on Economic, Social, and Cultural Rights (CESR), Concluding Observations: Indonesia, U.N. Doc. E/C.12/IDN/CO/1 (2014), para. 35; CESR, Concluding Observations: Lithuania, U.N. Doc. No. E/C.12/LTU/CO/2 (2014), para. 21; CESR, Concluding Observations: Ukraine, U.N. Doc. No. E/C.12/UKR/CO/6 (2014), para. 24; CESR, Concluding Observations: Russia, U.N. Doc. No. E/C.12/RUS/CO/5 (2011), para. 29; CESR, Concluding Observations: Uzbekistan, U.N. Doc. No. E/C.12/UZB/CO/2 (2014), para. 24; CESR, Concluding Observations: Tajikistan, E/C.12/TJK/CO/1 (2006), para. 70; CESR, Concluding Observations: Mauritius, U.N. Doc. E/C.12/MUS/CO/4 (2010), para. 27.

⁵⁴ Committee on Economic, Social and Cultural Rights, Concluding Observations: Russian Federation, E/C.12/RUS/CO/5 (2011), para. 29.



Application Nos. 62964/10, 58502/11, 55683/13

IN THE EUROPEAN COURT OF HUMAN RIGHTS

BETWEEN:

KURMANAYEVSKIY, ABDYUSHEVA, ANOSHKIN

Applicants

and

RUSSIA

Respondent

and

HUMAN RIGHTS WATCH

Interveners

SUBMISSIONS ON BEHALF OF THE INTERVENERS

Diederik Lohman, Aisling Reidy

Human Rights Watch

350 Fifth Avenue,

34th Floor New York,

New York 10118-3299

U.S.A.

lohmand@hrw.org, reidya@hrw.org

Fax: + 1 212 736 1300

1. These submissions are made by Human Rights Watch, pursuant to leave granted by the President of the Chamber on 9 September 2014, in accordance with Rule 44 § 3 of the Rules of Court. These submissions are divided into three parts:
 - I: Principles of drug control and access to controlled medicines
 - II: Human Rights Watch research on drug treatment on Russia
 - III: The human rights obligations of states with respect to ensuring the availability and accessibility of medicines under international control.

2. Over the past eight years, Human Rights Watch has conducted extensive research, covering more than a dozen countries, on the intersection of government regulation of controlled medicines, such as morphine and methadone, their availability and accessibility, and international human rights law.¹ Human Rights Watch submits that its analysis makes clear international law requires:
 - (i) States ensure the adequate availability of narcotic drugs for medical purposes
 - (ii) States regulate, *inter alia*, their production, transportation, prescription and dispensing
 - (iii) States strike a balance between, on the one hand, the obligation to protect against misuse of controlled substances, and on the other, the obligation to ensure access to medicines and treatment in compliance with the rights to life, health, bodily integrity and privacy of those within its jurisdiction.

3. In the course of its research Human Rights Watch has documented numerous examples of regulations on controlled substances, especially around opioids, that did not strike the appropriate balance and impeded medical access for patients in violation of respect for human rights. In some cases, the regulations did not seem to serve any useful purpose in terms of preventing non-medical use of controlled substances. In others, regulations did have the potential to prevent non-medical use but their impact on availability and accessibility for medical use was so disproportionate as to qualify as unjustifiable and inconsistent with respect for human rights.

4. Among all cases we have documented Russia's blanket ban on methadone and buprenorphine for substitution treatment stands out as exceptional. While in many countries ill-advised regulations that result in a lack of availability and accessibility of controlled medicines, nonetheless pursue the legitimate objective of preventing misuse of controlled substances, the predominant motivation of the Russian government's blanket ban on the use of two essential medicines for the treatment of opioid dependency is not to prevent their misuse but apparently ideological convictions that run counter to a preponderance of scientific evidence.

¹ See e.g. *Unbearable Pain: India's Obligation to Ensure Palliative Care* (2009); *Please Do Not Make Us Suffer Anymore: Access to Pain Treatment as a Human Right* (2009); *Needless Pain: Government Failure to Provide Palliative Care for Children in Kenya* (2010); *Global State of Pain Treatment: Access to Medicines and Palliative Care* (2011); *Uncontrolled Pain: Ukraine's Obligation to Ensure Evidence-Based Palliative Care* (2011); *Abandoned in Agony: Cancer and the Struggle for Pain Treatment in Senegal* (2013).

5. Russia's ban is disproportionate and unjustified in its impact on persons with opioid dependency and a violation of the state's obligations to ensure the availability of essential medicines for the purpose of medical and therapeutic treatment. As such it constitutes a violation of the state's international obligations to respect the rights to life, health, bodily integrity and privacy of those within its jurisdiction.

I: Principles of Drug Control and Access to Controlled Medicines

6. Human Rights Watch submits that Russia's blanket ban on substitution treatment for drug dependency is neither required by nor compatible with the international legal framework on regulation of controlled substances.
7. Both buprenorphine and methadone are considered 'controlled substances' under international law. That is their manufacture and use, *inter alia*, are subject to international legal controls set out in three United Nations drug conventions.² Substances controlled under international law are routinely used for treatment of conditions in such diverse fields of medicine as analgesia, anaesthesia, drug dependence, maternal health, mental health, neurology, and palliative care. Indeed, the World Health Organization's (WHO) Expert Committee on the Selection and Use of Essential Medicines, which periodically prepares the WHO Model List of Essential Medicines, considers eight medicines that contain internationally controlled substances, including buprenorphine and methadone, "essential", i.e. these medicines should be available to all who need them.³

The Principle of Balance in the UN Drug System

8. The goal of the UN drug system is explicitly not a ban on the use of substances but "limiting [controlled substances] to medical and scientific use" while recognizing the important role of controlled substances in medical care.⁴ The 1961 Single Convention on Narcotic Drugs (Single Convention) stipulates in its preamble:

The medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and adequate provision must be made to ensure the availability of narcotic drugs for such purposes.⁵

² The 1961 Single Convention on Narcotic Drugs, 1971 Convention on Psychotropic Substances, and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

³ Also codeine, diazepam, ephedrine, ergometrine, morphine, and phenobarbital.

⁴ http://www.who.int/medicines/arcas/quality_safety/Framework_ACMF_withcover.pdf?ua=1

⁴ Preamble of the 1961 Single Convention on Narcotic Drugs, <https://www.unodc.org/unodc/en/treaties/single-convention.html>.

⁵ *Ibid.*, preamble.

9. To achieve this, the UN drug conventions established a regulatory framework to determine what substances would be controlled internationally, ensure adequate but controlled production for medical and scientific use, and to guide countries on domestic regulatory systems. The Single Convention established a mechanism that allows the UN Commission on Narcotic Drugs (CND), on the recommendation of the WHO, to determine what substances should be placed under international control.⁶ It also set up a system to regulate the production, transportation and consumption of controlled substances for medical and scientific purposes, with the International Narcotics Control Board (INCB), a body set up by the Single Convention to oversee its implementation, playing a central role.⁷

10. According to the INCB, the Single Convention establishes a

...dual drug control obligation: to ensure adequate availability of narcotic drugs, including opiates, for medical and scientific purposes, while at the same time preventing illicit production of, trafficking in and use of such drugs.⁸

11. The Single Convention provides guidance on the minimum regulatory framework for the dispensing of controlled substances states must put in place, although under the Convention, governments may impose additional requirements if deemed necessary, such as requiring that all prescription be written on official forms provided by the government or authorized professional associations.⁹ The INCB and WHO have nevertheless warned against overregulation that would interfere with the obligation of states to ensure adequate availability of controlled substances for medical purposes. As WHO has observed, “this right must be continually balanced against the responsibility to ensure opioid availability for medical purposes.”¹⁰

12. The 2011 WHO guidelines on ensuring balance in national policies on controlled substances suggest a test for determining whether regulations are overly restrictive.¹¹ They provide the following definition of an “overly restrictive law or regulation”:

Overly restrictive law or regulation: In these guidelines, the term “overly restrictive law or regulation” refers to drug regulatory provisions that either:

⁶ Ibid., article 3.

⁷ Ibid., articles 12, 19, 21.

⁸ INCB, “Availability of Opiates for Medical Needs: Report of the International Narcotic Control Board for 1995,” <http://www.incb.org/pdf/e/ar/1995/suppl en.pdf>, p. 1.

⁹ 1961 Single Convention on Narcotic Drugs, Article 30(2bii).

¹⁰ WHO, *Cancer Pain Relief, Second Edition, With a guide to opioid availability*, 1996, p. 9.

¹¹ WHO, *Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines*, Geneva, 2011, p.8 available at: http://whqlibdoc.who.int/publications/2011/9789241564175_eng.pdf?ua=1.

- a) do not materially contribute to the prevention of misuse of the controlled medicines but do create an impediment to their availability and accessibility;
or
- b) have the potential to prevent the misuse of controlled medicines but disproportionately impede their availability and accessibility.

Whether a drug regulatory provision disproportionately impedes availability and accessibility of controlled medicines must be determined in each individual case and will depend on context, the extent of its contribution to preventing the misuse of the medicines, the extent to which it impedes the availability and accessibility of controlled medicines, and the availability of other control measures that could provide a similar prevention but interfere less with the availability and accessibility of the medicine.

The use of substitution maintenance treatment for drug dependency

13. Although substitution treatment with methadone or buprenorphine has not been without controversy, a huge body of scientific research illustrates beyond reasonable doubt that maintenance therapy is one of the most effective treatments for opioid drug dependence. Experts consider that, “even after 40 years, substitution therapies such as methadone are still the most promising method of reducing drug dependence, but getting access to treatment is a global problem.”¹² The WHO, UNAIDS, and UNODC all support substitution maintenance programs. In a joint position paper on maintenance therapy, the three organizations observed, “There is consistent evidence from numerous controlled trials, longitudinal studies and programme evaluations, that substitution maintenance therapy for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of HIV transmission.”¹³
14. The number of countries worldwide that use substitution treatment in drug dependence treatment programs has been increasing steadily over the past few decades, and it is considered a key evidence-based approach to drug treatment. Within the Council of Europe, Russian is the only member state in which substitution treatment is not available and indeed is subject to a ban.¹⁴

¹² See Bulletin of the World Health Organization, “The Methadone Fix”, Volume 86, Number 3, March 2008, 161-240 available at <http://www.who.int/bulletin/volumes/86/3/08-010308/en/>.

¹³ World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS), Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention (Geneva: 2004). p. 13. The paper also notes that studies have shown maintenance therapy can achieve “high rates of retention in treatment” and helps increase “the time and opportunity for individuals to tackle major health, psychological, family, housing, employment, financial, and legal issues while in contact with treatment services.” They have also shown that maintenance treatment is safe and cost-effective, and that diversion to the black market, though a real concern, can be minimized through proper implementation of national and international control procedures and other mechanisms, pp. 13, 20, 32.

¹⁴ According to figures from the European Monitoring Centre for Drugs and Drug Addiction based on 2009 data, over 60 countries worldwide, including all members of the European Union, have maintenance programs and at least one and

II. Human Rights Watch Research on Drug Dependency Treatment in Russia

15. In November 2007 Human Rights Watch published a report, entitled “*Rehabilitation Required: Russia’s Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment*”, the result of extensive research in 2006 and 2007 examining, amongst other things, how the ban impacts the availability and quality of drug dependency treatment in Russia, interviewing about sixty drug users, dozens of drug treatment doctors, NGOs, and government officials.¹⁵ Since 2007, we have been in regular touch with partners in Russia who inform us that the core findings of our report remain valid. Two issues we examined are particularly relevant for the Court’s deliberations on the present case including: 1) the Russian government’s justification for its ban on opiate substitution programs; and 2) the quality and effectiveness of the drug treatment services that are available in Russia’s public health system.

Justification for Ban on Opiate Substitution Treatment

16. In Russia, Article 31(6) of the Federal Law “On Narcotic Drugs and Psychoactive Substances” prohibits the use of narcotic drugs and psychoactive substances in treating drug dependence. For our report, we interviewed officials in Moscow, Kaliningrad and Kazan about this ban on substitution treatment. We also reviewed various articles published by government officials. Based on these, we concluded that “the policy decision not to make methadone and buprenorphine available for the treatment of drug-dependent persons, based on factors that ignore the best available medical evidence as to its effectiveness, can only be described as arbitrary and unreasonable, and as such is a violation of the right to health.”¹⁶ At pp. 47 -48 we note that:

Despite overwhelming evidence of its effectiveness in treating drug-dependent persons, top health and law enforcement officials as well as policy makers in Russia continue to vehemently oppose maintenance therapy, often on the basis of selective and inaccurate interpretation of research findings... The opponents of maintenance therapy in Russia, led by top officials, reject the vast body of solid scientific evidence compiled over decades through studies in numerous different countries that unequivocally confirms the effectiveness and cost-efficiency of maintenance treatment for drug users. ... They have variously maintained ... that maintenance therapy is dangerous for patients, ethically

half million opioid drug-dependent people are receiving maintenance therapy. This includes around 6950,000 in the European Union; 660,000 people in North America; 242,000 in China, 43,000 in Australia; and 22,000 in Canada. See European Monitoring Centre for Drugs and Drug Addiction, Annual Report 2011: the state of the drugs problem in Europe, table 10.

¹⁵ Available at <http://www.hrw.org/reports/2007/11/07/rehabilitation-required-0>.

¹⁶ Ibid., p. 47.

unacceptable, a ploy by drug companies to line their pockets, or has recently been shown to be ineffective as treatment.

17. As an example, we would point to a particularly egregious publication of this sort - a 2005 memorandum that appeared in *Meditsinskaja gazeta* (Medical Newspaper) and *Voprosy Narkologii* (Issues in Narcology) under the signature of top healthcare officials, including Russia's chief narcologist and the chair of the Russian Society of Psychiatrists. The memorandum selectively quotes a small number of research studies in support of their opposition to substitution therapy, ignoring the overwhelming majority that supports its efficacy, and many of the citations and references in the memorandum were inaccurate or misleading. For example:

- The suggestion that methadone substitution treatment poses a risk to the health of patients by causing a variety of serious side effects and because of a risk of methadone overdose without providing any references for some of these assertions, or references that are inaccurate and misleading.
- The suggestion that profit for pharmaceutical companies producing methadone is the driving factor behind the promotion of maintenance treatment. The memorandum ignores the fact that methadone is very cheap to produce and that numerous studies have shown its cost-effectiveness, as compared to providing patients with inpatient treatment.
- The dismissal of the connection between injection drug use and prevalence of HIV transmission. The memorandum stated that “[n]owadays lobbyists of methadone producers and methadone programs do not call attention to the problem of treating drug addiction, but try to represent methadone as a panacea for “saving” from AIDS... At the same time parenteral drug use is not the only, and nowadays, is not the primary way of HIV transmission. Only a low percentage of heroin addicts are HIV-positive, and this is definitely not justification enough to introduce the program of drug supply for all drug addicts.” This assertion is completely inaccurate and dangerously downplays the extent of the HIV epidemic in Russia. An estimated 80 percent of all people living with HIV in Russia are current or former drug users who were infected through sharing of injection equipment. In 2007, around 10 percent of injection drug users in Russia were infected with HIV, more than 10 times higher than in the general population.¹⁷
- Finally, the memorandum suggests that various different United Nations bodies have expressed concern about or opposition to maintenance treatment and that, therefore, the publication of the joint WHO, UNODC, UNAIDS position paper, which endorsed maintenance therapy as an effective method of drug dependence treatment and an effective instrument in preventing HIV transmission among drug users, was a surprise as it “was practically contrary to all previously held research and conventions and decisions of the

¹⁷ UNAIDS estimates that 940 000 people are HIV+ out of a population of 143 million, which is 0.656 percent, UNAIDS, “Russian Federation”, Country Page, 2006, http://www.unaids.org/en/Regions_Countries/Countries/russian_federation.asp (accessed October 1, 2007).

United Nations.” Again, this assertion is inaccurate as, in fact, the position paper simply reaffirms the findings of the majority of researchers who have examined maintenance therapy programs, as well as those of the various international organizations mentioned.¹⁸

Quality of Drug Treatment Services Available in Russia

18. Our research found that the absence of opiate substitution treatment was particularly problematic because of the poor quality of the drug treatment services that Russia’s public healthcare system offers. As a result, drug users are essentially condemned to a life with drug use, even when they are motivated to seek treatment, and exposure to drug use-related illnesses, such as HIV and hepatitis C.
19. After reviewing a number of studies of the effectiveness of Russia’s drug treatment system, we concluded, at p.6:

There is ample evidence that the state drug dependence treatment system in Russia is largely ineffective. In a 2006 survey of almost 1,000 injection drug users in 10 Russian regions conducted by the Penza Anti-AIDS Foundation, 59 percent of drug users who had made use of the state treatment system had gone back to using drugs within a month of finishing their treatment course; more than 90 percent had relapsed within a year. Various other studies also found that less than 10 percent of patients of state narcological clinics remain in remission a year after their treatment.¹⁹ ... Using other measures of treatment effectiveness, such as the treatment system’s ability to recruit patients and retain them for a length of time adequate for appropriate treatment, the Russian system fares equally poorly.

20. We found that Russia had failed to implement the findings of a “vast body of evidence on the effectiveness of various treatment approaches.” Although detoxification clinics are available, these offered very little benefit to drug users without subsequent rehabilitation. We also concluded that while research findings underscore the fundamental importance of beginning psychosocial interventions with patients during the detoxification stage to motivate them to stay in treatment after detoxification is over²⁰ this hardly happens in Russia’s drug dependence clinics because patients are generally heavily medicated with tranquilizers and antipsychotic medications,²¹ leaving patients in a reduced state of consciousness that makes counselling efforts difficult or even pointless. We also found that only very limited counselling took place.

¹⁸ World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS), *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention* (Geneva: 2004).

¹⁹ Draft report on the survey by the Penza Anti-AIDS Foundation, on file with Human Rights Watch.

²⁰ Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, “Detoxification and Substance Abuse Treatment,” Treatment Improvement Protocol (TIP) Series 45. DHHS Publication No. (SMA) 06-4131, Rockville, MD,, 2006, pp. 4 and 5.

²¹ *Ibid.*, p. 74.

III. The Human Rights Obligations of States with Respect to Ensuring the Availability and Accessibility of Medicines under International Control

21. Human Rights Watch notes that while the European Convention on Human Rights (ECHR) contains no explicit right to health, under the case law of this Court questions relating to the right to health may arise under Articles 2, 3 and 8.²²
22. The right to health is protected in international law, *inter alia*, by article 12 of the International Covenant on Economic Social and Cultural Rights (ICESCR), and the Committee on Economic, Social and Cultural Rights, which oversees compliance with the ICESCR, has identified certain core obligations within the right to health that are so fundamental states must fulfil them, irrespective of resources.²³ In relation to such obligations “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations..., which are non-derogable.”²⁴ Amongst those core obligations the Committee has identified the duty:
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs²⁵
23. Thus, under the right to health, countries must ensure the availability and accessibility of medicines included in WHO Model List of Essential Medicines, including those that are controlled under international law. Methadone and buprenorphine are two such controlled substances that therefore must be available for substitution therapy. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, has noted that ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the Single Convention on Narcotic Drugs, 1961.²⁶
24. The Committee on Economic, Social and Cultural Rights has also stipulated that the right to health requires states to “refrain from interfering directly or indirectly with the enjoyment of the right to health.”²⁷ States may not deny or limit equal access for all persons, enforce discriminatory health policies, arbitrarily impede existing health services, or unduly limit access to information about health. As the Court knows, the Committee has already expressed its

²² See for example, *Jolloh v Germany*, Judgement July 11, 2000; *Olay v Turkey*, Judgement of March 22 2010; *Haas v Switzerland*, January 20, 2011; *Hristozov and others v Bulgaria*, Judgement of November 13, 2012.

²³ International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 12. In general the right to health is considered a right of “progressive realization”, resource dependent, and states agree “to take steps... to the maximum of its available resources” to achieve the full realization of the right to health.

²⁴ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, November 8, 2000, para. 47.

²⁵ General Comment No. 14, *ibid.*, para. 43.

²⁶ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN Doc. A/HRC/22/53, February 1, 2013, para. 55.

²⁷ General Comment No. 14, *op.cit.*, para 33.

concerns over the ban on substitution treatment in Russia and strongly advised Russia to provide access to substitution treatment in order to fulfil its obligations under article 12 of the ICESCR.²⁸

25. Under the ECHR, this Court has noted that the compatibility of a state's decision to grant access to particular medical treatment under Article 8 may be examined in either, or both, of two ways: whether it is a justified or unjustified limitation on an individual's choice of medical treatment impacting their private life; or whether a state has failed in a positive duty to allow an individual access to particular treatment to ensure respect for their private life. In each case, the Court has held that the test is whether a fair balance has been struck between the competing interests of the individual and of the community as a whole (see *Hristozov and others v Bulgaria*, Judgment of November 13, 2012, para. 117).
26. The blanket ban in Russia on substitution treatment fails to balance the interests of individuals in need of appropriate and effective drug dependency treatment with the general interest in appropriate regulation of narcotics. It constitutes an unreasonable and arbitrary interference in the provision of evidence-based health-care services and in the ability of individuals to access what, by clear international consensus, is one of the most effective forms of treatment of opiate dependency. The WHO, UNODC and UNAIDS strongly recommend substitution therapy use in both the prevention and treatment of HIV, and the WHO includes both methadone and buprenorphine in their essential medicines list. Thus, banning methadone altogether and blocking the use of buprenorphine for drug treatment is an unreasonable and unjustified interference with the right of individuals to make decisions about their personal health and treatment options.
27. In so far as there is a positive duty on states to enable a person access to a particular type of medicine, both the preamble of the UN drug conventions and the INCB's interpretation of the conventions speak to an obligation to ensure the adequate availability of controlled medicines for medical purposes. Human Rights Watch submits that with reference to controlled medicines, governments have a particularly strong responsibility to ensure their availability and accessibility, because the production, distribution and dispensing of controlled medicines is under exclusive government control. With medications that are not controlled, private actors, including healthcare providers, pharmaceutical companies and nongovernmental organizations, can produce or import medications themselves with limited or no government facilitation. That is not the case with controlled medications—if a government does nothing to ensure an adequate supply and a functioning distribution system, they will simply not be legally available.
28. Human Rights Watch submits that Russia has a positive obligation to ensure access to and adequate availability of methadone and buprenorphine including for substitution treatment, which it has not met.

²⁸ UN Doc. E/C.12/RUS/CO/5, Concluding Observations: Russian Federation, June 2011, para. 29, available at: <http://www.refworld.org/docid/4efb0e492.html>.

29. The denial of access to substitution treatment for opioid addiction also raises issues under the prohibition on inhuman and degrading treatment. The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez issued a report focusing on forms of abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment.²⁹ The report specifically addresses violation of the rights of people who use drugs through non-provision of substitution treatment:

“The denial of methadone treatment in custodial settings has been declared to be a violation of the right to be free from torture and ill-treatment in certain circumstances (A/HRC/10/44 and Corr.1., para. 71). Similar reasoning should apply to the non-custodial context, particularly in instances where Governments impose a complete ban on substitution treatment and harm reduction measures.... By denying effective drug treatment, state drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures”.³⁰

30. The UN Special Rapporteur has also stated that “[w]hen the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment.³¹ He called on all States to

- Ensure that all harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations (A/65/255, para. 76).
- Establish an effective mechanism for monitoring dependence treatment practices and compliance with international norms.³²

31. Human Rights Watch submits that Russia’s ban on substitution treatment not only violates obligations with respect to the right to health, privacy and bodily integrity but causes those with drug dependency unnecessary suffering, placing their health and lives at unnecessary increased risk of infection of drug related illnesses such as HIV and hepatitis C.

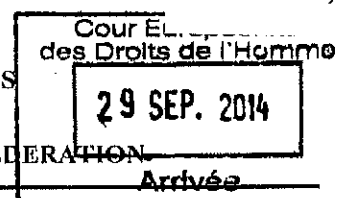
²⁹ UN Doc. A/HRC/22/53, February 1, 2013.

³⁰ Ibid. paras 73 – 74.

³¹ Ibid. para. 55.

³² Ibid. para. 87 (d) and (c) respectively.

IN THE EUROPEAN COURT OF HUMAN RIGHTS
Applications 62964/10, 58502/11, 55683/13
BETWEEN: KURMANAYEVSKIY et al. and the RUSSIAN FEDERATION



SUBMISSION OF THE INTERVENERS

Canadian HIV/AIDS Legal Network, Harm Reduction International and Eurasian Harm Reduction Network

This submission is made pursuant to Article 36(2) of the *Convention for the Protection of Human Rights and Fundamental Freedoms* ("European Convention on Human Rights") and Rule 44 of the Rules of the Court. The structure of this submission corresponds to the list of issues which was outlined in the request for leave to intervene. Accordingly the submission consists of four parts:

- Part I Drug treatment as an integral part of the Russian Federation's "zero tolerance" approach to drugs
- Part II Availability of opioid substitution therapy (OST) around the world,
- Part III The role of OST in improving the health and life of people with opioid dependence,
- Part IV Applicable international norms, including an overview of the European Court's standards

Part I. Drug treatment as an integral part of zero tolerance approach to drugs in Russian Federation

- 1.1 Russian laws provide for narcotic-free drug treatment, sometimes also known as abstinence-based treatment. This means that upon entering treatment, a drug-dependent person must immediately stop using any narcotic drug. Article 31 of the Federal Law of 08.01.1998 N 3-FZ, "On Narcotic Drugs and Psychotropic Substances" prohibits the use of narcotic drugs as part of drug treatment, including the medications methadone and buprenorphine, which are commonly used for opioid substitution therapy (OST). The same law establishes that only state and municipal clinics can provide drug treatment and only according to standards approved by the federal health authorities (Article 55). Therefore, prescribing these medications for drug treatment is treated as the criminal offence of drug trafficking (Article 228.1 of the Criminal Code), with a possible penalty of life imprisonment.
- 1.2 Russian drug treatment standards are based on repressive approaches practiced during Soviet times, when drug treatment was closely connected to law enforcement¹ and was underpinned with the notion of "treatment as edification - you suffer, and next time you won't do anything bad"². Medical protocols of drug dependence treatment³ provide for the use of "substances that suppress the craving, [and] behaviour correctors," including neuroleptics such as haloperidol that are not used in international practice to treat drug dependence. In the global literature, the use of neuroleptics is equated with torture, especially in cases when neuroleptics, including haloperidol, were used in Soviet psychiatry to suppress the will of political prisoners and dissidents⁴.
- 1.3 The Russian drug treatment system has a very low rate of effectiveness: over 90% of drug treatment patients relapse to illicit drug use within a year after treatment⁵.
- 1.4 The ineffectiveness of the government drug treatment system and the high demand for treatment in Russia have resulted in a large number of doubtful private practices, including flogging,⁶ beatings, punishment by starvation and long-term handcuffing to the bed frame,⁷ "coding" (i.e., hypnotherapy aimed at persuading the patient that drug use leads to death) and brain surgery,⁸ electric shock causing seizures, burying the patient in the ground for 15 minutes, putting electrodes into the patient's ears to cause electric shock,

¹ I Rhodes, A Sarang, P Vickerman, M Hickman (2010) *Policy resistance to harm reduction for drug users and potential effect of change* in *British Medical Journal* 2010; 341: c3439, V D Mendelovich *Bioethical differences between drug addiction treatment professionals inside and outside the Russian Federation* in *Harm Reduction Journal* 2011; 8: 15.

² A Zlobin, A Kovalevsky (2007) *Revolution of Doses* in *Newsweek* December 2, 2007 (А Злобин, А Ковалевский (2007) «Революция доз») Available at <http://www.narcom.ru/publ/info/738>

³ Order of the Ministry of Health April 28, 1998 No. 140, "On approving standards (model protocols) for diagnostics and treatment of drug dependent patients."

⁴ A Podrabinek (1980) *Punitive Medicine* Karoma Publishers Inc. 1st edition March 1980 pp. 15-20, R Gosden (2001) *Neuroleptics: Treatment or Torture?* in *Punishing the Patient: How Psychiatrists Misunderstand and Mistreat Schizophrenia*, Melbourne: Scribe Publications, 2001, J Langone, G Garelik "Medicine: A profession Under Stress," *Time Magazine* April 10, 1989 Available at <http://content.time.com/time/magazine/article/0,9171,957396,00.html>

⁵ V Ivanov, interview for RIA Novosti, September 16, 2009, [www.ria.ru](http://ria.ru); T V Klimentko (2009) "On the Russian Drug Control Strategy," 2009 Available in Russian at <http://stratgap.ru/includes/periodics/comments/2009/1124/3841/detail.shtml>

⁶ S V Speransky, MG Huchrova, NK Zhukov (2005), Method of pain impact in the treatment of addictions and other manifestations of avital activity," (С В Сперанский, МГ Чухрова, НК Жуков (2005) Метод болевого воздействия при лечении аддиктивного поведения и других проявлений авитальной активности) Available in Russian at <http://rozzamed.narod.ru/caust3.html>

⁷ A Sarang (2010) "Spas on Blood or the chronicles of anti-drug terror in Ekaterinburg" 2010 (Саранг А. (2010) Спас-на-крови, или хроники антинаркотического террора в Екатеринбурге) Available in Russian at <http://rykov-lond.ru/blog/2010/03/15/gbnnus/>

⁸ No to Drugs, an Informative-publishing resource (2010) 335 experimental operations on humans (Нет наркотикам (2010) 335 экспериментальных операций на людях) Available in Russian at http://www.narkotiki.ru/internet_5242.html

xenotransplantation of guinea pig brains, and other similar methods⁹

- 1.5 The drug treatment system, including the denial of OST, is part of the explicit State policy of “zero tolerance” of drug use, which *de facto* is a policy of zero tolerance towards people who use drugs¹⁰. The main drug policy document, the *Strategy of the Anti-Narcotic Policy of the Russian Federation until 2020*¹¹, emphasizes the promotion of this “zero tolerance” approach to drug use (paras 23(a), 48 of the Strategy), and the “inadmissibility of substitution therapy with use of narcotic drugs for drug treatment” (para 4 of the Strategy)
- 1.6 Law enforcement violence toward people who use drugs in Russia has been documented and referred to as omnipresent, “routine,” and “normalized”, not surprisingly, people with drug dependence live in constant fear of law enforcement; majority of them accept unlimited authority of police¹²
- 1.7 Penitentiary statistics demonstrate that every 5th adult inmate in Russian prison is imprisoned for drug crime¹³. Up to 65% of people who use drugs have experienced imprisonment¹⁴. In 2010 alone, more than 75% of drug related convictions were directed against those who use drugs rather than those who supply illicit drugs¹⁵. Considering the larger number of people who use drugs who are incarcerated, the lack of effective drug treatment in penitentiary facilities turns such facilities into incubators for HIV, since drugs are accessible in prisons while sterile syringes are not¹⁶
- 1.8 Russian state authorities and organs actively pursue the official “zero tolerance” approach though not only police violence and incarceration but also the public stigmatization and humiliation of people who use drugs, ostensibly to exercise “social pressure”¹⁷ on them and to deter others from taking drugs. Many misleading, sensationalized and often gruesome videos have surfaced on the Internet, including reports by journalists from the government broadcast channels, that purport to demonstrate the adverse consequences of drug use and show people rotting alive, as well as doctors’ claims regarding the severe consequences of using prohibited drugs, including loss of sight and limbs and quick death.¹⁸ Videos show doctors commenting that drug dependent people who continue to use drugs even after they lose their arms and legs “continue to kill themselves for a few minutes of doubtful happiness.”¹⁹ One of the videos shows how a doctor saws off the leg of a patient who is described as a 26-year-old “opiate addict,” the patient was conscious throughout the procedure and held his leg with his trembling hands over a waste bucket into which the sawed-off leg eventually dropped²⁰

Part II. Availability of OST around the world

Opioid substitution therapy (OST) is extensively used around the world for opioid dependence treatment. Currently, OST is used in 77 countries worldwide²¹. Currently, of 47 member states of the Council of Europe, only Russia prohibits OST.²² In Eastern Europe and Central Asia, OST programs have been implemented in all countries except Turkmenistan, Uzbekistan and Russia²³

Part III. The role of OST in improving the health and life of people with opioid dependence

⁹ S. Soshnikov (2011) *Patent-related activity in addiction treatment in Russia* – a presentation at the conference “Medical Science and Right in the 21st Century,” St. Petersburg, 2010 (С. Сошников (2011) «Патентная активность в области лечения аддитивных расстройств в России») Available in Russian at <http://www.youtube.com/watch?v=Hqsm7-XHVLk>

¹⁰ A. Sarang, M. Golichenko (2013) *Atmospheric Pressure: Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic, Social and Cultural Rights* in *Health and Human Rights Journal*, June 2013 14-15(1) 1135-43

¹¹ The Decree of the President of Russian Federation 2010 06 09 No. 690 “On the approval of Strategy of the Anti-Narcotic Policy of the Russian Federation until 2020”

¹² A. Sarang, T. Rhodes, N. Sheon, K. Page (2010) “*Policing drug users in Russia: Risk, fear and structural violence*” in *Substance Use and Misuse* 2010 45

¹³ Characteristics of Prisoners in Adult Penitentiary Institutions. Federal Penitentiary Service 2014. www.fsmn.su

¹⁴ A. Sarang, T. Rhodes, L. Platt, V. Kirzhanova, O. Shelkovich, V. Volnov, D. Blagovo, A. Rylkov (2006) *Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions* in *Addiction* 2006, 101 1787–1796

¹⁵ In 2010, there were 222,600 drug crimes registered in Russia. More than 75% of 104,000 convictions for drug crimes were for possession for personal use and for drug trafficking in “small amounts”. Small amount is set at 0.5 gram for heroin, opium or desomorphine. This amount of drugs in practice result in prosecution and detention of people who inject drugs carrying drugs for personal use. Information of Statistical data for 2010, “Trafficking in drugs, psychotropic substances and virulent substances” (www.mvd.ru) and Statistics on the website of the Department of Courts (www.cdep.ru)

¹⁶ HRW (2004) *Lessons not learned: human rights abuses and HIV/AIDS in the Russian Federation*. Human Rights Watch, April 2004. Vol. 16, No. 5 (D). Available at <http://www.hrw.org/sites/default/files/reports/rusia0404.pdf>

¹⁷ A. Kuzskaya (2011) “Public pressing against drug dependence” RIA Novosti, 16 May 2011 (Курская А (16 мая 2011) «Социальный прессинг против наркомании» РИА Новости)

¹⁸ A. Mamontov (2010) “The tragedy is called Coaxil” 2010 documentary, Rossiya TV Channel (А. Мамонтов (2010) «Трагедия зовут коаксил») http://www.rutv.ru/video.html?tvprog_id=123784&cid=125&d=0&mid=14

¹⁹ Selection of videos on this topic can be found at <http://www.youtube.com/watch?v=7K1WjhNT7U&feature=related>

²⁰ <http://www.youtube.com/watch?v=CDRrLA/uuPI&feature=related>

²¹ HRI (2012) *Global State of Harm Reduction: Towards Integrated Approach*. Harm Reduction International, London. Available at http://www.thra.net/files/2012/07/24/GlobalState2012_Web.pdf

²² According to most recent reports, OST is not delivered by public health services in the Principality of Monaco, but there is no prohibition on its use.

²³ HRI (2012), *Global State of Harm Reduction: Towards Integrated Approach*. Harm Reduction International, London, online http://www.thra.net/files/2012/07/24/GlobalState2012_Web.pdf

- 3 1 OST, especially with use of methadone and buprenorphine, is a highly researched intervention and the focus of thousands of scientific studies, many of which were reviewed under the auspices of the World Health Organization (WHO) by a large group of technical experts — international scientists with expertise in opioid dependence and clinical guidelines development. The result of the review was published in the WHO's 2009 Guidelines in which OST (referred to there as opioid agonist maintenance treatment) was defined as the administration of thoroughly evaluated opioid agonists by accredited professionals, in the framework of recognized medical practice, to people with opioid dependence, for achieving defined treatment aims. When combined with psychosocial assistance, it is considered by the World Health Organization (WHO) as the most effective method of treatment of opioid dependence²⁴.
- 3 2 Cochrane Reviews confirm that OST with methadone can keep people who are dependent on opioids in treatment programs and reduce their use of illicit drugs,²⁵ and that oral substitution treatment for injecting opioid users reduces drug-related behaviors that have a high risk of HIV transmission.²⁶ In addition, multiple publications report that OST improves the quality of life of recipients, including physical and mental health²⁷, is effective in managing physical pain and mental suffering in people with opioid dependence as part of withdrawal syndrome,²⁸ reduces individual risk of overdose death,²⁹ improves adherence to HIV treatment alone or in combination with treatment for hepatitis C,³⁰ and reduces the level of crimes committed by people with opioid dependence.³¹
- Adverse consequences of non-provision of OST
- 3 3 Unlike most countries of the Council of Europe, harm reduction approaches, including OST, were only developed in EECA in the late 1990s and still remain limited in scale.³² Around 3.7 million people inject drugs in this region, most of these people use opioids³³, and more than half of them live in Russia.³⁴ Russia also remains one of the biggest markets for opioids in the world.³⁵
- 3 4 Ukraine and Russia, account for over 85% of the people living with HIV in the region,³⁶ with eight out of every ten new HIV infections in the region occurring in Russia.³⁷ In Russia, the number of people living with HIV has reached an estimated 1.2 million people,³⁸ a staggering increase from only 170,000 cases a mere decade ago.³⁹ In contrast, in Ukraine in recent years the scale-up of OST, along with other harm reduction services, had a positive impact on the HIV epidemic: the proportion of all newly registered HIV

²⁴ World Health Organization (2009) Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. World Health Organization, Geneva. Available at http://whqlibdoc.who.int/publications/2009/9789241547543_eng.pdf?ua=1

²⁵ R P Mattick, C Breen, J Kimber, M Davoli (2009) *Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence*. In Cochrane Database of Systematic Reviews 2009 Issue 3. Art No. CD002209, doi: 10.1002/14651858.CD002209.pub2

²⁶ L Gowing, M F Farrell, R Bornemann, L E Sullivan, R Ali (2011) *Oral substitution treatment of injecting opioid users for prevention of HIV infection*. In Cochrane Database of Systematic Reviews 2011, Issue 8, Art No. CD004145, doi: 10.1002/14651858.CD004145.pub4

²⁷ M Connock, A Juarez-Garcia, S Jowell, E Frew, Z Liu, R J Taylor, A Fry-Smith, E Day, N Lintzeris, T Roberts, A Buris, RS Taylor (2007) *'Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation'*. Health Technology Assessment 2007 11(9): 1–171. Available at http://www.journalslibrary.nhr.ac.uk/data/assets/pdf_file/0020/65180/FullReporthta11090.pdf, S Giacomuzzi, G Kemmler, M Ertl, Y Richter (2006) *Opioid addicts at admission vs. slow release oral morphine, methadone, and sublingual buprenorphine maintenance treatment participants*. Substance Use and Misuse 2006, 41(2): 223–44.

²⁸ WHO describes withdrawal syndrome as "a group of symptoms of variable clustering and degree of severity which occur on cessation or reduction of use of a psychoactive substance that has been taken repeatedly, usually for a prolonged period and/or in high doses. The syndrome may be accompanied by signs of physiological disturbance. Opioid withdrawal is accompanied by rhinorrhoea (running nose), lacrimation (excessive tear formation), aching muscles, chills, gooseflesh, and after 24–48 hours, muscle and abdominal cramps. Drugseeking behaviour is prominent and continues after the physical symptoms have abated." For example: lexicon of alcohol and drug terms published by WHO: http://www.who.int/substance_abuse/terminology/who_lexicon/en/

²⁹ A Gibson, L Degenhardt, RP Mattick, R Ali, J White, S O'Brien (2008) *'Exposure to opioid maintenance treatment reduces long term mortality'*. In Addiction 2008, 103: 462–8, M F Brugal, A Domingo-Salvany, R Puig, G Barrio, P Garcia de Olalla, L de la Fuente (2005) *Evaluating the impact of methadone maintenance programmes on mortality due to overdose and AIDS in a cohort of heroin users in Spain*. Addiction 2005, 100: 981–9. C Nordt, R Stohler (2010) *'Combined effects of law enforcement and substitution treatment on heroin mortality'*. Drug and Alcohol Review, 2010, 29(5): 540–545.

³⁰ J Moatti, M Carrieri, B Spire, AJ Gastaut, JP Cassuto, J Moreau (2000) *Adherence to HAART in French HIV infected injecting drug users: the contribution of buprenorphine drug maintenance treatment. The Manifest 2000 study group*. AIDS 2000, 28: 14(2): 151–5, A Palepu, M Tyndall, R Joy, T Kerr, E Wood, N Press, RS Hogg, JS Montaner (2006) *Antiretroviral adherence and HIV treatment outcomes among HIV/HCV co-infected injection drug users: The role of methadone maintenance therapy*. Drug and Alcohol Dependence, Sep 15: 84(2): 188–94. G Lucas, B Mullen, P Weidle, S Hader, ME McCaul, R Moore (2006) *Directly administered antiretroviral therapy in methadone clinics is associated with improved HIV treatment outcomes compared with outcomes among concurrent comparison groups*. Clinical Infectious Diseases Jun; 42(11): 1628–35, S Meiknaite, W Knerr (2008) *Hepatitis C Among Injecting Drug Users in the New EU Member States and Neighboring Countries: Situation, Guidelines and Recommendations*. Central and Eastern European Harm Reduction Network, Vilnius.

³¹ UNODC/WHO/UNAIDS (2004) *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Position paper. World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS.

³² According to estimates, in the majority of former Soviet countries coverage of OST remains to be under 5% of estimated people who inject drugs. A Iatypov, A Bidordinova, A Khachatryan (2012) *Opioid Substitution Therapy in Eurasia: How to increase the access and improve the quality*, IDPC Briefing Series on Drug Dependence Treatment, No. 1. Available at http://idpc.net/sites/default/files/library/IDPC-briefing-paper_OST-in-Eurasia.pdf

³³ BM, Mathers, L Degenhardt, B Phillips, L Wiessing, M Hickman, SA Strathdee, A Wodak, S Panda, M Tyndall, A Toufik, RP Mattick for the Reference Group to the UN on HIV and Injecting Drug Use (2008) *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review* in the Lancet 372(9651): 1733–1745. Available at <http://www.thelancet.com/group.unsw.edu.au/results>

³⁴ UNAIDS (2014) *GAP Report*. Joint United Nations Programme on HIV/AIDS, Geneva.

³⁵ UNODC (2014) *World Drug Report*. United Nations Office on Drugs and Crime, Vienna. Available at

³⁶ Ibid.

³⁷ Ibid.

³⁸ UNAIDS (2013) *Report on Global AIDS Epidemic*. Joint United Nations Programme on HIV/AIDS, Geneva.

³⁹ Ibid.

infections in Ukraine attributed to injection drug use has declined significantly in just three years, from over 42% in 2010 to 33% in 2013.⁴⁰

- 3.5 Unsafe drug injection, fuelled by little or no access to effective treatment for opioid dependence, and a punitive environment that includes mass incarceration of people who use drugs, also fuel the spread of other infections. An estimated 90% of people who inject drugs in Russia have hepatitis C, and most patients co-infected with HIV and tuberculosis in Russia are people who inject drugs (with prison playing a significant role in the spread of TB).⁴¹
- 3.6 Drug-related overdose remains one of the leading causes of death in the region, as people lacking access to services are forced to keep injecting drugs in an unsafe manner and environment.⁴² An estimated 100,000 people die from drug overdoses in Russia every year. According to the Federal Drug Control Service, 28.7 out of 100,000 people have died from overdose and drug related diseases in 2013, which figures is 2.7 times higher than the mortality rate in 2012.⁴³

Part IV. Applicable international norms, including an overview of the European Court's standards
International norms governing access to OST in the context of HIV prevention and treatment

- 4.1 OST has been endorsed by UN member states in the General Assembly and the Commission on Narcotic Drugs (CND) (the chief policy-making forum among UN member states for drug policy),⁴⁴ as well as in the Economic and Social Council (ECOSOC),⁴⁵ and by the International Narcotics Control Board (INCB) (the quasi-judicial body monitoring States' compliance with the three UN drug control conventions).⁴⁶ The UN Office on Drugs and Crime (UNODC) and the UN Joint Programme on HIV/AIDS (UNAIDS) strongly recommend OST as a core intervention for HIV prevention among people who inject drugs.⁴⁷ Methadone and buprenorphine are listed by the WHO as the essential medicines to be used in substance dependence programs.⁴⁸ Ensuring the availability of essential medicines, as recommended by the WHO, has been emphasized by the UN Committee on Economic, Social and Cultural Rights (CESCR) as one of the underlying determinants of health.⁴⁹

OST in the context of international human rights norms, including European Convention on Human Rights

Violation of Article 3

- 4.2 In its jurisprudence on Article 3 of the Convention, the Court has tended to first examine whether or not Article 3 may be applicable to a specific situation; then whether the minimum level of severity has been established; the purpose of treatment; and finally, whether the respondent state is liable for the suffering experienced by the applicant. We address each of these below.

Applicability of Article 3 to a specific situation

- 4.3 According to the Court, the fundamental importance of the prohibition in Article 3 on torture or other inhuman or degrading treatment requires that the Court reserve to itself sufficient flexibility to address the application of that Article in different contexts. This includes contexts where the torture or other inhuman or degrading treatment is not directly inflicted by the action of public authorities, but arises out of the interplay between other factors and the failure or refusal of public authorities to take those other factors into account. Similarly, Article 3 is flexible enough to be applied in circumstances where any single act or omission by public authorities, taken alone, might not rise to the level of torture or other inhuman or degrading treatment, but the accumulation of factors amounts to such ill-treatment in breach of Article 3 (*D. v. The United Kingdom*, Application No. 30240/96, Judgment of 2 May 1997, para. 49).
- 4.4 Indeed, the Court has already demonstrated this more sophisticated understanding and application of Article 3 standards in cases regarding access to medicines and medical services. For example, the Court

⁴⁰ Ministry of Health of the Republic of Ukraine, Ukrainian centre for socially dangerous diseases, institute of epidemiology and infectious diseases (2014) HIV-infection in Ukraine. Information bulletin No. 41. Kyiv, CSDDC, March 2014.

⁴¹ "Russia's drug policy fuels infectious disease epidemics", www.thelancet.com/infection. Vol 12 April 2012

⁴² Ж. Атаянц, А. Литынов, Д. Очерет (2011) *Передозировка: Обзор ситуации и ответные меры в 12 странах Восточной Европы и Центральной Азии*. Вильнюс: Евразийская сеть снижения вреда. Available in Russian at: <http://www.harm-reduction.org/library/Peredozirovka-obzor-situacii-i-otvetnye-meru-v-12-stranah-Vostochnoj-Evropy-i-Centralnoj-Aziji>.

⁴³ Olga Mishina, deputy head of the Federal Drug Control Service, said, as quoted by Itar-Tass news agency. Available at: <http://rt.com/news/171348-russia-drugs-death-crime/>.

⁴⁴ CND (2009) Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. Commission on Narcotic Drugs, March 2009. Adopted by the UN General Assembly's Resolution 64/182 of December 18, 2009, para 20.

⁴⁵ ECOSOC (2004) Guidelines for psychosocially assisted pharmacological treatment of persons dependent on opioids. ECOSOC Resolution 2004/40.

⁴⁶ INCB (2009) Report of the International Narcotics Control Board for 2008. International Narcotics Control Board: New York, UN Doc. No. E/INCB/2008/1, paras 24 and 25.

⁴⁷ WHO, UNODC, UNAIDS (2009) Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva. Available at: <http://www.who.int/hiv/pub/idu/targetsetting/en/>.

⁴⁸ WHO Model List of Essential Medicines, 14th edition. Available at: http://whqlibdoc.who.int/hq/2005/a87017_eng.pdf?ua=1.

⁴⁹ CESCR, General Comments No.14 (2000). The right to the highest attainable standard of health. E/C.12/2000/4, para 12(a).

has found that 6 weeks' delay in providing access to genetic testing to a pregnant woman amounted to a violation of Article 3, including for reasons that doctors did not take into account the special vulnerability of pregnant women when they failed to fulfill their positive legal obligations related to her right to health (*R.R. v. Poland*, Application No., 27617/04, Judgment of 26 May 2011, paras. 153-162). We submit, therefore, that the Court's settled jurisprudence indicates that Article 3 standards may and should be applied in analyzing the impact of Russia's blanket prohibition on OST as medical treatment for persons with opioid dependence.

Minimum level of severity has been met (cumulative effect of treatment)

- 4.5 In determining whether the minimum level of severity of suffering has been established to constitute a breach of Article 3, the Court has held that "the assessment of this minimum is, in the nature of things, relative; it depends on all circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim" (*Ireland v. the United Kingdom*, Judgment of 18 January 1978, para. 162). Often the Court weighs in the cumulative effect of all elements of treatment to which a person has been subjected (*Husayn Abu Zubaydah v. Poland* No. 7511/13, Judgment of 24 July 2014, para 510; *Harakchiev and Tolunov v. Bulgaria*, No. 15018/11 61199/12, Judgment of 8 July 2014, para 213), including when someone is publicly humiliated and abused (*Svinarenko and Slyadnev v. Russia*, No. 32541/08 43441/08, Judgment of 17 July 2014, para 115). In accordance with this Court's jurisprudence, we respectfully submit that, in assessing the severity of the pain and suffering caused by Russia's denial of OST to people with opioid dependence, the correct approach is to take into account the circumstances of those who are victimized as a result and the multiple ways, including withholding of dependence treatment, in which this denial operates to systematically cause them severe pain and suffering.
- 4.6 The case of *M.S.S. v. Belgium and Greece* (No 30696/09, Judgment of 21 January 2011, paras 251-262) offers a striking and analogous example of such an assessment. In that case, the Court assessed whether or not the authorities violated Article 3 when their deliberate actions or omissions made it impossible in practice for the applicant to avail himself of his rights as an asylum-seeker and even to meet his basic needs. The Court took into consideration several important factors:
- the applicant's status as an asylum-seeker as a "member of a particularly underprivileged and vulnerable population group in need of special protection";
 - the higher level of responsibility of the State [under Article 3] in respect of treatment where an applicant, who was "wholly dependent on State support, found himself faced with official indifference in a situation of serious deprivation or want incompatible with human dignity";
 - the fact that the applicant spent months living in a state of the most extreme poverty, unable to cater for his most basic needs such as food, hygiene and a place to live, as well as the "ever-present fear of being attacked and robbed, and the total lack of any likelihood of his situation improving";
 - the fact that the applicant was forced by such circumstances to commit offences (i.e., to leave Greece with a falsified passport) in order to escape from that insecurity and of material and psychological deprivation;
 - the malfunctioning system for examining asylum applications, which exacerbated the applicant's suffering and uncertainty; and
 - the positive obligations of the authorities to meet minimum standards for the reception of asylum-seekers in the EU Member States as per the EU Directive.
- 4.7 After assessing these factors, the Court concluded that the "authorities have not had due regard to the applicant's vulnerability as an asylum seeker and must be held responsible, because of their inaction, for the situation in which he has found himself for several months, living in the street, with no resources or access to sanitary facilities, and without any means of providing for his essential needs. The Court considers that the applicant has been the victim of humiliating treatment showing a lack of respect for his dignity and that this situation has, without doubt, aroused in him feelings of fear, anguish or inferiority capable of inducing desperation. It considers that such living conditions, combined with the prolonged uncertainty in which he has remained and the total lack of any prospects of his situation improving, have attained the level of severity required to fall within the scope of Article 3 of the Convention" (*M.S.S. v. Belgium and Greece*, para 263).
- 4.8 We submit this same approach is equally applicable in assessing the severe pain and suffering caused to people with opioid dependence, in multiple, interlocking ways, by Russia's deliberate decision to deny access to medicine through a criminal prohibition on OST. The Court should consider the cumulative effect of the following factors:
- 4.9 Drug dependence is a multifactorial health disorder that often follows the course of a relapsing and

- remitting chronic disease, with key elements including the sense of compulsion to take opioids and persistence with opioid use despite clear evidence of overtly harmful consequences⁵⁰ It is a chronic relapsing brain disease⁵¹ Russia accepts that dependence syndrome persists even in long-term remission and often manifests itself as the irresistible desire to use a psychoactive substance⁵² It is not simply because of a lack of willpower that many people with strong opioid dependence continue using drugs despite the risk of harsh criminal penalties, potentially fatal overdose or other serious harms to health such as contracting blood-borne illnesses (e.g. HIV, viral hepatitis) through use of non-sterile injecting equipment The health condition of opioid dependence can dominate and often result in significant harm to a person's individual, family and community life
- 4 10 Under Russian drug law, virtually all aspects of life of an opioid-dependent person, especially in periods of relapses, are *de facto* and *de jure* affected by law enforcement and other punitive measures. Among other things, the non-medical use of drugs is an offence that can result in 15 days' administrative arrest (Article 6 9 of the Russian Code of Administrative Offences), while acquisition and possession of drugs is a crime (Article 228 of the Russian Criminal Code). Meanwhile, drug treatment may only include those methods approved by the State and drug treatment (especially detoxification) is only allowed in state and municipal clinics (Article 55 of the Federal Law No. 3-FZ of 8 January 1998)
- 4 11 Because of its nature and this legal framework surrounding it, opioid dependence makes people vulnerable to health, economic and legal risks, as well as institutional violence by police, health, and other actors who are positioned by the State in a position of power over those with opioid dependence Russia's official state policy of "zero tolerance" to drug use, and hence *de facto* zero tolerance of people who use drugs, drives this vulnerability further as it amounts to State approval for humiliating, abusing and debasing people with opioid dependence, deeming them unfit for society unless and until they stop using drugs.⁵³
- 4.12 In our submission, Russia's denial of access to medicine for people with opioid dependence is *per se* an intentional infliction of severe pain and suffering by the State, with an evident punitive and discriminatory purpose and effect, on a massive and widespread scale. However, in the alternative, we also submit that, in the context of such an environment as described above, Russia's prohibition of OST, one of the most effective types of opioid dependence treatment, puts people with opioid dependence into a multi-faceted situation of pain and suffering similar to that of the asylum-seeker applicant in *MSS v Belgium and Greece*, as set out in the paragraphs below
- 4 13 The available abstinence-based treatment in Russia, which is highly ineffective as indicated by the official data, is analogous to a pink card in *MSS* (the card issued by the Greek authorities to asylum-seekers which gives them no access to any practical benefits). People with opioid dependence cannot avail themselves of their rights to minimal health care standards The treatment ostensibly available in Russia does not meet their essential needs, as a result, they relapse soon after the treatment (with some experiencing 5-6 drug treatment attempts per year⁵⁴), and continue using illicit drugs and facing all the associated adverse consequences, including fear of arrest, prosecution, and imprisonment, and a very high risk of contracting HIV, hepatitis C, tuberculosis, etc. (as outlined in paras 1 6, 3 4-3 6 above)
- 4 14 Because of a lack of access to effective drug treatment, arising in part from Russia's ban on OST, many opioid-dependent people spend many years of their lives in a state of the most extreme poverty, unable to cater for their most basic needs such as food, hygiene and a place to live Often their life is a cycle of purchasing drugs, looking for funds to finance their dependence, withdrawal, police arrests and abuse, multiple bouts of incarceration, and multiple attempts at ineffective treatment For many, there is little or no likelihood of their situation improving, particularly as long as effective treatment, in the form of OST, is withheld by the Russian government, despite of extensive evidence of its benefits in helping to break this cycle.
- 4 15 Facing a lack of effective drug treatment, people with opioid dependence experience physical pain and mental suffering, combined with an often irresistible desire/compulsion to take opioids These factors push opioid dependent people to commit crimes of drug purchase, possession, and use; and often acquisitive

⁵⁰ Supra note 31

⁵¹ N D Volkow, L Chang, GJ Wang JS Fowler D Franceschi, M Sedler, SJ Gatley E Miller R Hitzemann, Yu-Shin Ding, J Logan (2001) "Loss of Dopamine Transporters in Methamphetamine Abusers Recovers with Protracted Abstinence" in Journal of Neuroscience 21 (2001), 9414-9418

⁵² Order of the Ministry of Health of the Russian Federation, October 22, 2003 Nr 500 "On approval of the protocol of managing rehabilitation of people with drug dependence" (Z50 3)

⁵³ A Sarang, M Golichenko (2013) "Atmospheric Pressure Russian drug policy as a driver for violations of the UN Convention against Torture and the International Covenant on Economic Social and Cultural Rights" in Health and Human Rights Journal 2013 Jun 14 15(1) E135-43

⁵⁴ V Ivanov, Interview for RIA Novosti, September 16, 2009, www.ria.ru, T V Klimentko (2009) "On the Russian Drug Control Strategy," 2009 A comment of the expert on the official website of the State Anti-Drug Committee of the Russian Federation Available in Russian at <http://statagp.ru/includes/periodics/comments/2009/1124/3841/detail.shtml>

crimes to finance their dependence. This is similar to the situation in *M.S.S.*, where the applicant was forced by circumstances to commit an offence (i.e., leaving Greece with a falsified passport) in order to escape from that situation of insecurity and of material and psychological deprivation.

- 4.16 Similar to the case of the applicant in *M.S.S.*, the malfunctioning system of drug treatment with no access to OST significantly exaggerates the suffering of people with opioid dependence and reinforces their uncertainty with respect to their health and even life.
- 4.17 Similar to the case of the applicant in *M.S.S.*, the Russian authorities have positive obligations to ensure minimum standards of health care, including pursuant to Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) to which Russia is a party. According to the UN Committee on Economic, Social and Cultural Rights, the monitoring body for the ICESCR, every State Party to the Covenant has core obligations which the authorities must satisfy regardless their possible financial constraints. Ensuring access to essential medicines, as defined from time to time by the WHO, is one such core obligation.⁵⁵ This includes methadone and buprenorphine for opioid dependence treatment.⁵⁶ Consequently, in 2011, after reviewing the country situation with regard to drug use and HIV among people who inject drugs, the Committee strongly recommended that Russia “provide clear legal grounds and other support for the opioid substitution therapy with use of methadone and buprenorphine.”⁵⁷
- 4.18 We respectfully submit that taking into account the cumulative effect of the factors noted above, the Court should find, as it did in *M.S.S. v. Belgium and Greece*, that Russian authorities do not demonstrate due regard to the vulnerability of those with opioid dependence and, because of their deliberate withholding of effective treatment, must be held at least partially responsible for the situations in which people with opioid dependence often find themselves for a long period of time, including (as cases may vary) being homeless and without any shelter, lacking access to sanitary facilities, and without any means of providing for essential needs. Because of lack of access to OST, many people with opioid dependence have unbearable living conditions, combined with endless uncertainty in which they remain and the total lack of any prospects of his situation improving. Taken together, these factors demonstrate that the ban on OST in Russia amounts to ill-treatment by public authorities whose severity falls within the scope of Article 3 of the Convention.

The purpose of treatment and the responsibility of the State

- 4.19 Finally, as these two considerations naturally go hand-in-hand, we consider jointly the *purpose of the treatment* in question and the *responsibility of the Russian State* for that harmful treatment of its citizens based on discriminative grounds due to their health condition.
- 4.20 We submit that Russia cannot escape responsibility for the pain and suffering caused by the inhuman and degrading treatment inherent in its blanket legal ban on OST, taking into account the factors outlined above (in paras 1.5, 1.9) suggesting that the *clear purpose of Russia's outright ban on OST is both punitive and discriminatory*, it is hard to avoid the conclusion that this infliction of pain and suffering, on a widespread scale against more than 1.8 million people,⁵⁸ is *intentional* on the part of the Russian government. Alternatively, at the very least, given the extensive evidence and recommendations repeatedly presented to the authorities, including by UN agencies and human rights bodies, it demonstrates a *willful blindness* with respect to the multi-faceted harm caused by the ban on evidence-based medical treatment for opioid dependence.
- 4.21 In this regard, we draw the Court's attention to the “callous disregard for vulnerability and distress” (*R.R. v. Poland*, No 27617/04, Judgment of 26 May 2011, para 151) of people with opioid dependence repeatedly and regularly demonstrated by Russian authorities in refusing to lift the legal ban on OST. In many instances, authorities refuse access to OST by simply referring to the legal ban and simply continue offering patients with severe opioid dependence abstinence-based treatment in complete disregard of the fact that these patients have already undertaken such treatment, often multiple times, with no positive results. Withholding effective treatment, and simply continuing to administer treatment already shown to be ineffective, thereby prolonging and contributing to further suffering, is profoundly unethical medical practice. When this is compelled by law, the State is responsible for what becomes state-sanctioned torture or other cruel or degrading treatment.

⁵⁵ Supra note 49, para 43(d)

⁵⁶ WHO Model List of Essential Medicines, 14th edition. Available at: http://whqlibdoc.who.int/hq/2005/a87017_eng.pdf?ua=1.

⁵⁷ Concluding Observations of the Committee on Economic, Social and Cultural Rights on Russia, E/C.12/RUS/CO/5, May 2011, para 29.

⁵⁸ The estimated number of people who inject drugs, as in UNAIDS (2014) GAP Report. Joint United Nations Programme on HIV/AIDS, Geneva.

- 4.22 The Court has established that “although the *purpose* of degrading treatment is a factor to be taken into account, in particular whether it was intended to humiliate or debase the victim, the absence of any such purpose does not inevitably lead to a finding that there has been no violation of Article 3” (*R.R. v. Poland*, No 27617/04, Judgment of 26 May 2011, para 151). The Court has found violations of Article 3 in many cases where the authorities “dealt with requests to provide information of crucial importance for the applicants, for example about the whereabouts and fate of their missing relatives, disclosing a callous disregard for their vulnerability and distress” (*R.R. v. Poland*, para 151). We also note that in addition to Federal Law No 3-FZ of January 8, 1998, the blanket legal ban on access to OST is at the core of the official *Strategy of the Anti-Narcotic Policy of the Russian Federation*. The inadmissibility of OST for drug treatment is among the key principles aimed at drug supply and demand reduction (para 4 of the Strategy). The “intensification” of attempts to legalize OST in Russia is listed among “threats” to the government’s Strategy (para 48 of the Strategy). With such a strong commitment to maintain the blanket legal ban on OST, as well as the fact that the Russian authorities are well aware of the pain and suffering attached to untreated opioid dependence, the “callous disregard for vulnerability and distress” of people with opioid dependence amounts to wilful blindness to all the adverse consequences that lack of access to OST entails for people with this health condition.
- 4.23 When reviewing the positive obligations of Russian authorities to prevent torture, inhuman or degrading treatment, the Court should take into account whether or not “all reasonable measures” have been undertaken in order to prevent degrading treatment of vulnerable groups (*Opuz v. Turkey*, No 33401/02, Judgment of 09/06/2009, para 162). We respectfully submit that, in light of the extensive evidence and authorities, including those of the UN, calling for introduction and expansion of OST as a progressive public health measure in countries where people use opioids, in refusing to permit access to OST, Russian authorities have failed to undertake reasonable steps to prevent cruel and degrading treatment of people with opioid dependence. The only alternative to OST that the Russian authorities continue offering to patients with opioid dependence is abstinence-based drug treatment, which is woefully ineffective (as outlined in para 1.3 above). Because of its ineffectiveness, it cannot be considered as a reasonable alternative. Furthermore, Russia has not presented a single credible research study that would disprove the effectiveness of OST, nor has clinical research been undertaken in Russia with respect to OST. Consequently, the legal ban on OST in Russia must also be considered arbitrary, and for this additional reasons, cannot be a “reasonable measure” with respect to Russia’s positive obligation to prevent torture, inhuman or degrading treatment against one of the most vulnerable groups of its population.

Violation of Article 14 and Article 8

- 4.24 We respectfully submit that when considering cases with respect to the lack of access to OST for people with opioid dependence in Russia, the Court should also follow the approach it has already adopted in the matter of *Kiyutin v. Russia*, No 2700/10, Judgment of 10 March 2011. In that case, the Court found that the policy of indiscriminate restriction of permanent residence based on HIV status amounted to discrimination contrary to Article 14, in conjunction with the protection of the right to private life under Article 8. We submit Russia’s blanket criminal prohibition amounts to a discriminatory violation of the right to private life, in breach of both these articles.

Whether the facts of the case fall “within the ambit” of Article 8

- 4.25 According to the Court, mental health must be regarded as a crucial part of a person’s private life. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is an indispensable precondition to effective enjoyment of this (*Bensaid v. The United Kingdom*, No 44599/98, Judgment of 06/02/2001, para 47). Opioid dependence is listed by the WHO among mental and behavioral disorders due to psychoactive substance use⁵⁹ and as such often seriously and negatively affects many aspects of a person’s individual, family and social life. An extensive body of evidence demonstrates that OST can significantly improve the quality of individual and family life of a person with opioid dependence. In our submission, it follows that denying access to this evidence-based treatment for this health condition – as Russia does with a blanket criminal prohibition on OST – falls “within the ambit” of the right protected under Article 8 of the Convention.

Protection of persons with opioid dependence against discrimination under Article 14

- 4.26 In *Kiyutin v. Russia* (paras 56, 57), the Court reaffirmed the well-settled proposition that “health status” falls within the term “other status” for the purpose of the protection against discrimination in Article 14 of

⁵⁹ WHO (2010) International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010, Chapter V “Mental and behavioural disorders”. World Health Organization: Geneva. Available at: <http://apps.who.int/classifications/icd10/browse/2010/en>.

the Convention. Unjustifiable differential, adverse treatment on the basis of health status is, therefore, a violation. This must necessarily include differential, adverse treatment on the basis of a chronic health condition such as opioid dependence. Medical professionals consider opioid dependence “similar to other chronic, relapsing diseases, such as diabetes, asthma, or heart disease.”⁶⁰ Many chronic health conditions are treatable by way of maintenance therapies (e.g., insulin in cases of diabetes). OST for people with opioid dependence is similar to pharmacological maintenance therapies for people with other health conditions. We therefore submit that people with opioid dependence can claim to be in a situation analogous to that of other people with chronic health conditions for the purpose of access to pharmacological maintenance therapy – and are similarly entitled to protection of Article 14 against discrimination on the basis of their health status.

The difference in treatment is not objectively and reasonably justified

- 4.27 We respectfully submit that a blanket legal ban on OST for people with opioid dependence cannot be objectively and reasonably justified. There is no reasonable relationship of proportionality between the blanket legal ban and the ostensible objective of promoting public health. We also submit that Russia can claim, at best, an extremely narrow margin of appreciation in imposing a blanket legal ban on an essential medical treatment.
- 4.28 According to the Court, “[i]f a restriction on fundamental rights applies to a particularly vulnerable group in society that has suffered considerable discrimination in the past, then the State’s margin of appreciation is substantially narrower and it must have very weighty reasons for the restrictions in question” (*Kiyutin*, para 63). According to the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, people who use drugs are often subjected to discrimination in medical settings, including in their access to antiretroviral medications and treatment for hepatitis C; they suffer stigma which is created or reinforced through punitive enforcement or treatment regimes; and policing practices ranging from surveillance to use of excessive force have been noted to target this vulnerable and marginalized populations⁶¹. The UN Special Rapporteur on Torture reports discrimination against people who use drugs in criminal justice system,⁶² as well as in health care settings where their experience of health-care “is often one of humiliation, punishment and cruelty.”⁶³ The Executive Director of the UNODC has asserted that one of the unintended consequences of drug control is that a “system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalized from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when they may be motivated to want it.”⁶⁴ In Russia such stigma and discrimination is actively promoted by public authorities (as outlined in paras 1.5 and 1.9 above). We therefore submit that people who use drugs, especially people with opioid dependence, are a vulnerable group with a history of prejudice and stigmatization and that the State is afforded at most a narrow margin of appreciation in choosing measures that single out this group for differential and adverse treatment on the basis of their health status (*Kiyutin*, para 64). This includes the deliberate decision by Russian authorities to deny access to evidence-based treatment.
- 4.29 In fact, we further submit that there is a very strong European consensus with respect to OST. Currently, out of 47 member states of the Council of Europe, only Russia prohibits OST. With such a strong European consensus, the Russian Federation is under an obligation to provide a particularly compelling justification for the differential treatment of people with opioid dependence, particularly in light of the severe adverse consequences that follow for those denied effective medical treatment for their health condition (*Kiyutin*, para 65).
- 4.30 According to the preamble to the Federal Law No 3-FZ of 8 January 1998, the aims of drug control measures, including the legal ban on using methadone and buprenorphine for drug dependence treatment, are “preserving [the] health of citizens, state and public safety.” Yet the law, which causes extensive suffering (as outlined above) that is grossly disproportionate to any purported benefit, is also arbitrary in that it does not advance its stated objectives.
- 4.31 We respectfully submit that for individuals who live with opioid dependence, the legal ban on OST does not serve the aim of preserving their health. On the contrary, it undermines it. Without access to OST,

⁶⁰ USA National Institute on Drug Abuse (2012) DrugFacts: Understanding Drug Abuse and Addiction. Available at: <http://www.drugabuse.gov>.

⁶¹ 2010 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/65/255, paras. 22-24.

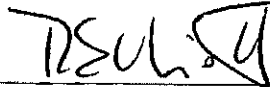
⁶² 2009 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. A/HRC/10/44, para 67.

⁶³ Human Rights Council (2013) Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. UN Doc. No. A/HRC/22/53, para 72. Available at: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

⁶⁴ UNODC (2008) Making drug control “fit for purpose”: Building on the UNGASS decade, A Report by UN Office on Drugs and Crime Executive Director Antonio Maria Costa, Vienna, 2008. UN Doc. No. E/CN.7/2008/CRP.17.

many people with opioid dependence continue using illicit drugs and face a real risk of potentially fatal overdose, infectious diseases such as HIV and hepatitis C, arrest, prosecution, imprisonment, and detention in prison settings causing further damage to their health, including high risk of infection with tuberculosis

- 4 32 Nor does the legal ban advance the protection of public health. On the contrary, the denial of access to OST, one of the key interventions for HIV prevention and treatment among people with opioid dependence, contributes significantly to the fact that Russia remains one of a few countries in the world where the HIV epidemic is expanding rapidly as a result of unsafe injecting drug use.
- 4 33 Finally, a ban on OST does not contribute to achieving the aims of state and public safety. On the contrary, OST is proven to be effective in reducing criminal behavior among people with opioid dependence.⁶⁵ Some legitimate concerns can arise regarding the diversion of methadone or buprenorphine to the illicit market. However, this is a matter of law enforcement and operational efficacy of OST programs, which operate successfully in virtually all other countries of the Council of Europe (and beyond), it is not a justification for a blanket ban on an essential medical treatment. The three UN Drug Conventions, to which Russia is a party, have at their core the obligation of States Parties to strike a correct balance between effective drug control and ensuring the accessibility of controlled substances for medical purposes.⁶⁶ A blanket ban makes no attempt to strike any such balance, ignoring the latter obligation, it is arbitrary (as it bears no rational connection to the stated objectives) and, worse, it results in gross, widespread pain and suffering on the part of those denied access to treatment.
- 4 34 Taking into account the above considerations, we submit that the Court should find in enforcing a blanket legal ban on OST, and thus indiscriminate denial of access to essential medical treatment for people with opioid dependence, the Russian Federation has overstepped any narrow margin of appreciation that may apply. It has, therefore, violated the right to private life protected by Article 8 and has done so in a discriminatory manner contrary to Article 14 of the Convention.



Richard Elliott, Executive Director, Canadian HIV/AIDS Legal Network

On behalf of the interveners Canadian HIV/AIDS Legal Network, Harm Reduction International and the Eurasian Harm Reduction Network

⁶⁵ Opioid Substitution Therapy: Research Review on Effectiveness in Crime Prevention. UNODC, Moscow, 2007. Available online: http://www.unodc.org/documents/russia/Reports/OST_crime_FINAL_RUS_www.pdf

⁶⁶ Single Convention on Narcotic Drugs, 1954, as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1954. Adopted at the United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, January 24 – March 25, 1954. Convention on Psychotropic Substances, 1971. Adopted at the United Nations Conference for the Adoption of a Protocol on Psychotropic Substances, January 11 – February 21, 1971. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. Adopted at the United Nations Conference for the Adoption of a Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, November 25 – December 10, 1988.