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Submission to the United Nations Working Group on Arbitrary Detention

On arbitrary detention in drug policies

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Submitting organisation:

The International Drug Policy Consortium is a global network of 198 non-governmental organisations that advocate for drug policies based on evidence, and on principles of public health, human rights, human security, development and civil society participation.

Executive summary

1. The International Drug Policy Consortium (IDPC, www.idpc.net) welcomes the opportunity to provide a submission to the United Nations Working Group on Arbitrary Detention (the Working Group) concerning cases of arbitrary detention as they relate to drug policies. This submission outlines the main global trends concerning arbitrary detention and connected human rights violations carried out in the name of the drug policies implemented by UN member states.

2. We respectfully urge the Working Group to include the following issues in their study:

    1. **The criminalisation of drug use and drug possession for personal use** remains a key driver of arrests and incarceration worldwide, with an estimated 470,000 individuals in prison for drug use only. Detention for drug possession or use is inherently arbitrary, as it is a manifestly inappropriate response to drug use and drug dependence, causes disproportionate harm, and is applied in a fundamentally discriminatory way, targeting certain populations on the basis of gender, race, ethnic origin and socio-economic status.

    2. **The disproportionate criminal punishment of drug offences**. Over 1.7 million people are in prison worldwide for drug trafficking offences. Mandatory pre-trial detention, minimum mandatory prison terms equal to those envisaged for serious and violent crimes, the wholesale exclusion of drug offenders from prison benefits, and legal regimes that do not allow for the consideration of the personal circumstances of the alleged offender, result in disproportionate penalties.

    3. **The continued use of compulsory drug detention centres,** in which over 400,000 people who use drugs are currently held worldwide. These centres constitute a manifest form of arbitrary detention, as they are not an appropriate response to drug use, in some cases operate without any form of fair trial protection, and they subject people who use drugs to serious ill-treatment, ranging from corporal punishment to the denial of appropriate care.

    4. **The proliferation of private drug 'rehabilitation' centres** in which people who use drugs are interned against their will and subjected to "rehabilitation" that is not supported by evidence, and that can sometimes amount to torture or ill-treatment, or result in death. Some member states have facilitated this development by failing to ensure the provision of evidence-based services and programmes in response to drug use and dependence, by failing to monitor, regulate and evaluate the effectiveness of such private centres, and in some cases by sustaining them with public funding and legal frameworks that effectively mandate the completion of treatment or rehabilitation programmes for people arrested for drug use.

    5. **The impact of COVID-19 on detentions and drug control.** A significant number of countries reduced their prison population to prevent the spread of the COVID-19 pandemic. While this is encouraging proof that it is possible to tackle the role of mass incarceration in drug policies, in some countries people charged with drug offences have been categorically excluded from these measures, showing the dehumanising power of punitive drug control.

For each of these issues, we provide an overview of the elements that lead to arbitrary deprivations of liberty, and we cite – where possible – good practice examples.

1. The criminalisation of drug use and drug possession for personal use

Working Group Questions 2 and 3

The criminalisation of drug use and of drug possession for personal use is a major driver of incarceration across the world. Approximately 2.17 million people, or one in five persons detained worldwide,[1] are in prison for drug offences. According to UN data, 21.65% of them, or a staggering 470,000 people, are incarcerated for drug use/possession for personal use as the principal offence.[2]

(a) Elements of arbitrariness

The UN Human Rights Committee has established that the notion of 'arbitrariness' cannot be equated with unlawfulness; instead, it should be interpreted broadly 'to include elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity and proportionality'.[3] This Working Group has similarly found that a detention, even if authorised by law, may still be considered arbitrary if 'based on arbitrary legislation or it is inherently unjust, relying for instance on discriminatory grounds'.[4] In that line, this Working Group has also noted that 'drug consumption or dependence is not sufficient justification for detention'.[5] We urge you to restate and expand that finding on the basis of the following considerations.

Detention for drug possession and use is inherently inappropriate. A plethora of UN bodies and human rights experts have made clear that detention is never an appropriate response to drug use or drug dependence, and that scientific evidence proves it is not an appropriate treatment for problematic drug use.[6] According to the International Guidelines on Human Rights and Drug Policy, which were developed by a coalition including Member States, the WHO, UNAIDS, the UNDP, and the OHCHR, 'States shall ensure that people are not detained solely on the basis of drug use or drug dependence'.[7]

Detention for drug possession and use is inherently disproportionate, as it has an extremely harmful impact on the rights and health of people who use drugs. In 2016, a group of UN human rights experts noted that criminalisation has contributed to a range of negative consequences for the health, security, and human rights of individuals and communities across the globe.[8] Criminalisation deters people who use drugs from accessing health care services, including life-saving HIV treatment and harm reduction services, exacerbates stigmatisation, and undermines health promotion initiatives to the detriment of all society.[9] This can be especially the case for women who use drugs, who are particularly at risk of contracting infectious diseases due to lack of access to gender-specific harm reduction services, high levels of drug-related stigma, and vulnerability to gender-based violence.[10]

Detention for drug possession and use can lead to the violation of the right to health in prison. Evidence shows that prisons are high risk environments for the spread of communicable diseases amongst people who use drugs, with a high prevalence of HIV and tuberculosis,[11] with high rates of drug use and high-risk injecting practices.[12] However, people who use drugs are rarely provided with adequate health and harm reduction services – in particular in women's prisons. For instance, a global systematic review of the literature and national surveys of 189 countries indicated that only 56 countries operated opioid substitution therapy in prison, while HIV testing and treatment were provided in only 79 and 88 countries, respectively.[13]

Detention for drug possession and use is discriminatory. This Working Group has recognised that, in conducting drug law enforcement activities, states disproportionately target women, minority groups, and people who use drugs.[14] For instance, research has shown that in the United Kingdom people identifying as black were found to be subject to court proceedings for drug possession at 4.5 times the rate of people identifying as white, while drug use prevalence among both groups is comparable.[15] Similarly, although rates of drug use are comparable across races in the United States, black and Hispanic people are systematically over-represented in arrests for drug possession, with black people being over five times more likely to be arrested for a drug offence.[16]

(b) An area of global concern: Drug courts

One specific area of concern regarding drug policies and arbitrary detention is the rapid expansion of drug courts, which have been promoted as an alternative to incarceration. While there is a wide diversity of drug court models, they tend to perpetuate the problematic elements of the criminalisation and prison model, while exacerbating stigmatisation. Drug courts aim to target people dependent on drugs who have committed other crimes, offering them treatment instead of incarceration.

However, in many contexts these courts exclusively target people for drug use or possession for personal use. This can be highly problematic given that drug courts are not an adequate public health response to drug use, as they put judges who generally know little about drug use and dependence in the position of doctors, giving them the power to prescribe medical treatment without the consent, or with the coerced consent, of people who use drugs.[17] As a result, treatment is frequently prescribed when there is no need for it, as most people who use drugs do not develop a dependence on drugs.[18] In countries like Brazil, Puerto Rico[19] and Russia,[20] drug courts compel people to enter treatment programmes that have no basis in scientific evidence, and proposed programmes are a one-size-fits-all which generally fails to include opioid agonist therapy.[21]

Lastly, drug courts are not a genuine alternative to incarceration.[22] In the United States, people failing their drug court programme may be incarcerated for longer than they would have if they had not entered the programme in the first place.[23]

(c) Good practice: The decriminalisation of drug use and drug possession

We recommend that the Working Group points to existing examples of decriminalisation of drug use and drug possession as good practices for member states to follow. The watershed UN System Common Position on Drugs endorses the decriminalisation of drug possession for personal use as a means to address prison overcrowding and over-incarceration.[24] The Common Position follows a significant number of UN agencies that had previously called for decriminalisation, including the OHCHR,[25] UNAIDS,[26] WHO,[27] the UNDP,[28] or the CESCR,[29] among others.

At the date of this submission, 49 jurisdictions in 29 countries across the world have decriminalised the possession of drugs for personal use, including countries such as Armenia, Ecuador, Israel, Jamaica or Switzerland, as well as various US states.[30] Countries that have adopted decriminalisation for decades (e.g. Portugal, the Czech Republic or Spain), have documented positive social and public health outcomes.[31] However, not all decriminalisation models have yielded positive results. Some member states do not impose criminal sanctions against drug use or drug possession *per se,* but

continue to use excessive and disproportionate administrative punishments, including administrative detention (see below), high fines, forced urine testing, and compulsory registration.[32]

We recommend that the Working Group makes a clear call for decriminalisation models that are fully consistent with principles of human rights, public health, harm reduction and social inclusion, thus substituting criminal or administrative punishments for drug use and drug possession for personal use, with voluntary access to health and social services, including harm reduction and drug treatment .

2. Disproportionate criminal punishment and lack of alternatives to incarceration

Working Group Questions 5 and 6

According to UN data, an estimated 1.7 million people were incarcerated in 2017 for drug trafficking offences, excluding drug use and possession for personal use.[33] A significant share of those incarcerated for drug trafficking were convicted of minor offences, with many countries imposing disproportionate criminal punishment for drug offences. Disproportionate punishment has contributed to prison overcrowding across the globe, from Brazil to the United States,[34] thus diverting law enforcement resources to the incarceration of low-level offenders.[35]

(a) Elements of arbitrariness

The 2016 UNGASS Outcome Document[36] calls on member states to ensure that criminal punishment for drug offences is proportionate. However, legal frameworks that envisage mandatory pre-trial detention for drug offences, that do not allow for the consideration of the perpetrator's role in the offence or for their personal circumstances, and that establish minimum mandatory prison sentences for drug offences, are manifestly disproportionate, and can lead to arbitrary detention.

Mandatory pre-trial detention. According to international human rights law, pre-trial detention must be an exceptional measure. It should be based on an individualised determination establishing that pre-trial detention is reasonable and necessary due to a substantial risk of flight, harm to others or interference with the evidence or investigation that cannot be allayed by other means.[37] The UN Human Rights Committee has further established that pre-trial detention should not be mandatory for any particular crime nor should it be ordered for a period based on the potential sentence.[38] However, many countries continue to impose mandatory pre-trial detention for all drug offences, without regard to any personal consideration. This is the case in the Philippines[39] or Mexico,[40] where mandatory pre-trial detention for drug offences often leads to periods of remand detention of several months to years. The disproportionate and prolonged use of pretrial detention undermines the principles of the presumption of innocence, legality, necessity and proportionality.

Mandatory minimum sentences. Many governments worldwide impose disproportionately high mandatory minimum prison sentences for drug offences, irrespective of the gravity of the offence. For instance, in Myanmar the minimum sentence for any drug offence is five years in prison;[41] in the Philippines the normal penalty for a drug offence ranges from 12 to 20 years in prison;[42] in Peru the highest minimum penalty envisioned for drug offences is 25 years of prison;[43] in the United States, the average prison term imposed on people convicted for drug offences subject to a mandatory minimum is 11 years.[44]

Equating all drug offences to violent and lethal offences. Several member states envisage minimum sentences for drug offences that are equal to, or even higher, than the minimum sentences for violent and even lethal crimes, such as murder or rape. For instance, in Bolivia and Peru, drug-related crimes are punished with the most severe penalties allowed by the legal system.[45] The same applies to countries that retain the death penalty for drug trafficking, including for people recognised by the courts as low-level drug couriers, such as Singapore, or Indonesia.[46] (It should be noted that the death penalty for drug offences is unlawful under international law,[47] and that IDPC strongly opposes the death penalty in all circumstances and for all crimes).

No consideration of mitigating factors. In many countries and jurisdictions, the punishment for drug offences depends exclusively on the type and quantity of trafficked substances, excluding any consideration of the personal circumstances of the offender (such as any situation of vulnerability including being coerced by their partners, being a head of household responsible for children or other dependents, poverty, etc.), and their role in the illegal drug market.[48] As a consequence, actors such as traditional farmers, drug couriers or low-level drug sellers can face the same penalties as major and violent drug traffickers with a leading role in the market. The Human Rights Committee has found that death sentences based solely on the category of the offence are inherently arbitrary because they fail to take into account the personal circumstances of the offender, and their role in the offence.[49] The same underlying principle should extend to prison sentences.

Blanket bans on parole, early release, pardons, etc. Some jurisdictions have put in place special legal frameworks that deprive people convicted of drug offences from accessing administrative and judicial mechanisms that could reduce the length of incarceration after sentencing, such as early release,[50] parole, the right to appeal or to seek pardons.[51] In Mexico, for instance, the law prevents people condemned for 'crimes against health' (which include drug offences) from benefiting from such measures. In the wake of the COVID-19 pandemic we have also seen how people convicted for drug offences have been excluded from early prison release schemes without an assessment of their personal circumstances in countries such as Algeria, Colombia, Senegal, or Turkey.[52]

(b) The specific impact of disproportionate sentencing on women

Although women continue to represent a minority of the total prison population (at 6.9%), it is estimated that about 35% of all women in prison worldwide are convicted of a drug offence – compared to 19% of men.[53] The proportion of women imprisoned for drug offences is even higher in Latin America and Asia, amounting to 82% in Thailand, 53% in the Philippines and Peru, 68% in Brazil and Costa Rica.[54] Women are also the fastest growing prison population in the world, with an estimated increase by 53% between 2010 and 2017, compared to 19.6% for male prisoners.[55]

Women are typically involved in low-level drug offences (e.g. as drug couriers), for activities that are high-risk, most visible and with a low financial reward. Most cases are linked to histories of poverty, trauma and abuse. For instance, in Colombia 76% of women in prison hadn't completed their secondary school education before being incarcerated, while in Costa Rica more than 95% of women incarcerated for bringing drugs into prison were single mothers.[56] In Mexico, an estimated 40% of women that had committed a drug offence were coerced by boyfriends or husbands.[57] In spite of this, countries generally fail to take account of the specific circumstances and roles of women involved with drugs, or to consider mitigating factors such as domestic violence, coercion and poverty.[58]

Because women constitute only 6.9% of the global prison population, in most cases prison facilities have not been adapted to their gender-specific needs.[59] In a male-dominated prison system, authorities rarely provide women with appropriate medical care, including mental health care, and they even fail to supply basic products for menstruation.[60] Because authorities do not invest in building adequate prison facilities, in very large countries such as Mexico or the Philippines[61] there are only one or two female prisons, leading to women very far away from their family, including their children.

(c) Good practices: Legislative reforms, reviews of sentencing guidelines, and alternatives to incarceration

Although they remain an exception, some member states have reformed their laws in order to introduce elements of proportionality in sentencing for drug offences, successfully reducing the average lengths of prison terms for drug supply offences. The Working Group might be interested in pointing to them as good practices.

In 2013, Costa Rica reformed Article 77 of the Narcotics and Substances Law, to reduce sentences from a range of eight to 20 years in prison, to a range of three to eight years for women smuggling drugs in prison (at the time, 150 out of the 750 women in prison were incarcerated for this offence). If the accused is found to be in situation of vulnerability (including being single mother head of household), a non-custodial sentence can now be introduced.[62] The adoption of the law led to the immediate release of more than 120 women. A particularly innovative aspect of this legislative change was that it was a gender-specific policy that took into account the particular ways in which women engage in drug activities, and are affected by drug control frameworks.[63]

The case of the United Kingdom shows the mixed results of half-hearted reform. In 2012, England and Wales introduced new sentencing guidelines that allow judges to reduce the length of sentences for people engaged in a lesser role in the illegal drug supply chain. Preliminary research showed that the average sentence for importing Class A drugs dropped from 90 to 72.3 months immediately after the reform.[64] However, the length of sentences slowly crept up after 2013, in part because offenders with a lesser role in the offence can still face long prison sentences when the quantities of transported drugs are large.[65] This is particularly unfair, as research has shown that those involved in lesser roles are in fact likely to transport larger quantities of drugs.[66]

Other countries have opted for alternatives to incarceration for low-level drug offences. This practice is aligned with international drug control treaties, which do not require incarceration for people who use drugs and persons convicted for drug offences of a minor nature, but provide for alternatives to conviction or punishment.[67] Alternatives to incarceration include a wide set of measures, from police cautioning to pre-trial diversion, sentence suspension, community service, etc.[68] Alternatives to incarceration are promoted in the 2016 UNGASS Outcome Document,[69] and by regional bodies such as the European Union,[70] the Organization of American States,[71] and the African Union.[72] The effectiveness of alternative measures to conviction and punishment, however, can vary considerably. A key factor in their effectiveness is ensuring that measures are targeted at individual needs, address the risk factors of offenders, and take steps to help retain people dependent on drugs in treatment programmes.[73] However, alternatives to incarceration should not include punitive measures like administrative detention and compulsory drug treatment, which are used in countries like China and Vietnam, are not backed by evidence, and constitute a serious rights violation.[74]

3. Administrative detention in Compulsory Drug Detention Centres

Working Group Question 7

Administrative detention and compulsory treatment for drug use and drug dependence in state-run facilities, generally known as 'compulsory drug detention centres' (CDDCs), is a major driver of arbitrary deprivation of liberty in the context of drug policies. CDDCs are prevalent across South East Asian countries, with reports of a total of over 400,000 people in administrative detention for drug use in 2017.[75] Countries with CDDCs include Cambodia, China, Lao PDR, Malaysia, the Philippines, Singapore, Thailand and Vietnam. This Working Group has previously found[76] that detention in CDDCs is not supported by the international drug control conventions, and is in contravention of international human rights law. In 2012[77] and again in June 2020[78], twelve UN bodies including the UNODC, WHO, UNAIDS and the OHCHR, called for their immediate closure. However, the number of people detained in these centres have in fact increased in the recent years, principally in Cambodia, Vietnam and Thailand.[79]

(a) Elements of arbitrariness

CDDCs should be regarded as an arbitrary deprivation of liberty, in all cases, due to the following well-documented factors.

Inappropriate response. Any detention for the purpose of providing involuntary drug treatment is inherently arbitrary, as detention is in no case an appropriate response to drug use or drug dependence. As noted in section one of this submission, the WHO and the UNODC have made clear that detention has no value as a treatment for problematic drug use.[80] In fact, existing research shows that CDDCs are not effective in reducing drug use and drug dependence.[81]

Lack of evidence-based drug treatment. Treatment for drug dependence in CDDCs is primarily abstinence-based,[82] and in many cases lacks any kind of scientific basis, as it revolves around involuntary seclusion and military-style physical discipline.[83] Even though most people detained in Asian CDDCs use opiates, very few countries are reported to provide opioid substitution therapy in CDDCs, with some exceptions in Iran.[84] In 2014, researchers compared[85] the effectiveness of drug dependence treatment in CDDCs with voluntary methadone treatment centres, which at the time coexisted in Malaysia; individuals 'treated' in CDDCs were significantly more likely to relapse after release, or sooner. Research in Thailand also shows that people who had gone through compulsory treatment in CDDCs had not reported any difference in the prevalence of drug use once they were released.[86]

Ill-treatment. In most cases, administrative detention in CDDCs involves various forms of administrative punishment that constitute torture or ill-treatment, sometimes in the guise of 'tough-love' treatment. These include corporal punishment such as beatings, flogging or whipping, which have been reported in Cambodia, China, Malaysia, Thailand and Vietnam;[87] forced and/or unpaid labour, which has been principally reported in Vietnam but also in China and Cambodia;[88] and the denial of appropriate medical care, including the denial of appropriate prevention and treatment of life-threatening diseases such as HIV. In 2010, the WHO reported that no ART treatment was provided to persons detained in CDDCs in Cambodia and in most CDDCs in Vietnam;[89] another study published in 2012 found a similar situation in Malaysia.[90]

(b) A dearth of good practices: Failed attempts to close down CDDCs

In Asia, the relationship between state authorities and people who use drugs has been characterised for decades by serious human rights violations that infringe the core of human dignity, from compulsory treatment to forced drug testing and compulsory registration of drug users. However, in the beginning of the last decade, countries like Vietnam and Malaysia announced that they would put in place policies departing from that paradigm. For instance, in 2013 Vietnam adopted a so-called Renovation Plan on Drug Treatment that aimed to transform 80 out of the 107 CDDCs in the country into voluntary community-based treatment, social and occupational services, including psychological support and aftercare services, OST and relapse prevention.[91] In a similar spirit, in 2012 China and eight Southeast Asian countries agreed to relocate resources from CDDCs to voluntary treatment services.[92]

In spite of these stated intentions, the regions has followed a completely opposite path. For instance, Vietnam has actually increased the number of detainees in administrative detention, from roughly 30,000 in 2012, to approximately 50,000 in 2017.[93] Similarly, while in 2010 Malaysia began to replace CDDCs with voluntary treatment services, political resistance limited the scope of this policy.[94] By the end of 2017, there were approximately 5,000 people still detained in Malaysian CDDCs -the same as in 2012.[95]

4. Arbitrary detention in private drug 'rehabilitation' centres

Working Group Questions 8 and 9

A concerning worldwide trend is the proliferation of privately-run 'rehabilitation centres', in which people who use drugs can be detained against their will, are provided with drug 'treatment' that lacks any scientific basis, and are in some cases subject to serious ill-treatment. Reports of this trend have been found in settings as diverse as Brazil, Cambodia, India, Iran, Mexico, Nepal and Puerto Rico, among others.[96]

(a) State obligations regarding private drug 'rehabilitation' centres

Under international human rights law, member states have the obligation to prevent, investigate, prosecute and punish any act of torture and ill-treatment committed by private actors.[97] When public officials fail to do so, they are considered to be authors, complicit or otherwise responsible for these acts.[98] In view of this, we respectfully urge the Working Group to stress member states' obligation to prevent, investigate, prosecute and punish arbitrary deprivations of liberty and other human rights violations that might take place in private drug treatment centres.

In some cases, member states are found to have a key role in promoting private drug treatment centres, either because they are failing to provide adequate public treatment facilities, or because they are directly funding private centres. For instance, in 2015 it was reported that in Mexico City alone there were approximately 2,000 residential drug treatment centres, but only 43 of them were state-run; less than a quarter of these private centres followed the relevant state regulations, resulting in 35,000 people who use drugs being 'treated' in centres not abiding by Mexican law.[99] In Brazil, federal, state-level and local authorities provide public funding to religious therapeutic communities.[100] When

the Brazilian National Prevention Mechanism visited several of these facilities, it found that some of them were operating outside any form of regulation, without oversight, and holding people who use drugs in conditions much worse than prison.[101]

(b) Elements of arbitrariness

The following elements should be considered when assessing whether the internment of a person in a private drug treatment centres constitutes a form of arbitrary detention.

Interment without consent. A common thread across regions is that people who use drugs are sent to these private centres against their will by families, public officials, irregular groups such as 'spiritual patrols', or simply by the centres themselves. Reports of police funnelling people who use drugs to private treatment centres are to be found across Central America[102] and in Asian states like Iran[103] and Nepal, sometimes for financial gain. In countries such as Mexico,[104] people who use drugs are not allowed to leave the centre unless they are considered sufficiently 'rehabilitated', or they are claimed by their families.

Lack of evidence-based treatment. As it was the case for CDDCs, many private centres run 'rehabilitation' treatment programmes that are abstinence-based only, and that discard scientific health interventions such as opioid substitution therapy.[105] Denying opioid substitution therapies to a person suffering withdrawal symptoms is commonly regarded as a form of cruel, inhuman or degrading treatment,[106] and can sometimes have lethal consequences. For instance, according to Iranian authorities, 39 individuals died in private rehabilitation centres during 2013, mostly during the first days of detention, in which prisoners were forced to go through opioid withdrawal without medical support.[107]

Ill-treatment. Reports of torture and ill-treatment in privately-run drug treatment centres are widespread, ranging from confinement in unhygienic conditions to painful or coercive rehabilitation techniques. In Nepal,[108] where there are no state-run drug treatment centres, private 'rehabilitation' facilities are plagued by reports of solitary confinement, forced labour, flogging, beatings and other inhuman and degrading 'punishments' to 'discipline' and 'cure' people who use drugs. In India, private 'de-addiction centres' have proliferated; some of them lack trained staff and proper infrastructures, giving rise to reports of torture under little to no government oversight.[109] Similarly, physical violence and humiliation are commonplace in the thousands of Mexican informal rehabilitation centres called '*anexos'*,[110] which regularly report deaths and abuse.[111]

(c) Good practice: Community-based drug treatment and minimum quality standards

As an alternative to CDDCs and to private 'rehabilitation centres' where people who use drugs are detained against their will, the Working Group could point to community-based drug dependence treatment and harm reduction services that are voluntary, rights-based, and grounded in scientific evidence. While each community-based programme is different, community-based treatments are commonly defined[112] as services that provide people with drug dependence with a continuum of care from outreach and low threshold services to aftercare and recovery; they are based in the community; they use to operate in outpatient settings; they are patient-centred, letting the client choose amongst a menu of interventions; and they involve the coordination of a number of health and social interventions.

Community-based programmes have begun to successfully operate in countries that have historically interned people who use drugs in CDDCs, and in private inpatient centres against their will, such as Malaysia, Cambodia or Vietnam.[113] In Malaysia, research on the network of voluntary out-patient centres created by the government in 2010 provided preliminary evidence of reduced drug use, and high levels of primary satisfaction amongst clients,[114] while average relapse periods where much shorter than for CDDCs.[115]

Even though community-based interventions will vary from context to context, some common principles can be established. In that regard, the European Union has adopted a set of minimum quality standards for interventions in the field of drug prevention, drug treatment, and harm reduction, that also apply to private actors.[116] These principles can be pointed to as an example of a basic framework for regulating the private provision of drug services whilst protecting basic human rights.

5. The impact of COVID-19 on arbitrary detention and drug policies

Working Group Questions 5 and 18

In response to the COVID-19 pandemic, a large number of member states have taken measures to reduce prison populations, as detention centres are regarded as a high-risk environment the transmission of the virus, especially when they are overcrowded, cannot maintain adequate standards of sanitation and hygiene, and are limited in their capacity to ensure access to medical treatment.

In doing so, states are acting in accordance with the guidance provided by many United Nations bodies, which urged national authorities to reduce prison populations by limiting deprivation of liberty, including pre-trial detention, to a measure of last resort, and through the early release of incarcerated people.[117]

It is important to note that some countries that have historically pursued punitive drug policies have released, or announced their intention to release, significant numbers of prisoners. For instance, Indonesian authorities have announced their intention to release of up to 50,000 people,[118] and Myanmar has announced the pardon of approximately 25,000 people deprived of liberty.[119]While these measures are still insufficient and too slow,[120] they also cast a serious doubt on the necessity of incarcerating these people in the first place.

However, for many of these countries it is very complicated to obtain reliable information on whether people convicted from drug offences are in fact being able to benefit from these measures,[121] which raises serious concerns. In a similar sense, there seems to be no public information available on any releases from CDDCs in response to the pandemic.

Even more concerningly, it is clear that some countries have in fact excluded all people convicted from drug offences from prison releases in response to COVID-19. This is the case of Turkey, which had announced the release of up to 100,000 people in response to COVID-19, but left out people sentenced for drug offences.[122] (It should also be noted that in Turkey buying, cultivating or possessing illegal drugs for personal use is punishable with up to two years in prison).[123] In Indonesia, people convicted to over 5 years in prison for a drug offence are also not eligible for release, which entails the exclusions of hundreds of people who use drugs or people convicted for minor drug

offences.[124] In the United Kingdom, children convicted of certain drug offences, including the possession of Class A drugs, have also been excluded from prison releases.[125]

In these life-threatening circumstances, denying access to a crucial prison benefit to all people convicted for a certain category of offences without an individualised consideration of their personal vulnerability to the virus, of the public safety concerns associated to their release, and of their personal role in the offence, could also constitute a form of arbitrary deprivation of liberty.

ENDNOTES

[1] According to Penal Reform International, approximately ten million people are incarcerated worldwide. See Peanl Reform International (2019), *Global Prison Trends 2019*. Available at: https://cdn.penalreform.org/wp-content/uploads/2019/05/PRI-Global-prison-trends-report-2019_WEB.pdf

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