Drug use, drug dependence and the right to health under the UN Convention on the Rights of the Child

Submission to the UN Committee on the Rights of the Child: General Comment on Article 24

15 December 2011

Contents

About us

Harm Reduction International is a leading non-governmental organisation working to reduce the negative health, social and human rights impacts of drug use and drug policy – such as the increased vulnerability to HIV and hepatitis infection among people who inject drugs – by promoting evidence-based public health policies and practices, and human rights based approaches.[1] We are an influential global source of research, policy/legal analysis and advocacy on drug use, health and human rights issues. The organisation is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations. www.ihra.net

HRI's Senior Human Rights Analyst, Damon Barrett, is the lead author of this submission. He is the co-author of *A Commentary on the United Nations Convention on the Rights of the Child: Article 33, Protection from Narcotic Drugs and Psychotropic Substances* (forthcoming, Brill/Martinus Nijhoff 2012[2]) and editor of *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People* (IDEA, iDebate Press, New York and Amsterdam, 2011[3]).

Youth RISE (Resource. Information. Support. Education) is a youth led network promoting evidence based drug policies and harm reduction strategies with the involvement of young people who use drugs and are affected by drug polices. Youth RISE advocates for improvements to services for young people; delivers training on youth-focused harm reduction; supports the development of new youth-led organisations; and works to empower young people who use drugs. http://www.youthrise.org

The Eurasian Harm Reduction Network (EHRN) is a regional network promoting humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and protecting human rights at the individual, community, and societal level. In 2009, EHRN, support by Unicef, produced a comprehensive report entitled '*Young people and injecting drug use in selected countries of Central and Eastern Europe*' (Vilnius, EHRN, 2009) www.harm-reduction.org

Introduction

Harm Reduction International, Youth RISE and EHRN welcome the Committee's development of a General Comment on the right to health and the specific reference to substance use within the outline document.

The Convention on the Rights of the Child is the only core United Nations human rights treaty to specifically refer to drug use. Article 33 requires that '*States parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties...'*

The 'relevant international treaties' referred to in article 33 are not defined and open to change, but today include the three core UN drugs conventions of 1961, 1971 and 1988.[4] Only one of these, however, refers to 'minors' and children's needs are not specifically dealt with in them. Human rights considerations are all but absent and provisions for treatment and rehabilitation are limited. A criminal justice and 'supply reduction' approach dominates.[5] The WHO Framework Convention on Tobacco Control may also now be considered a 'relevant international treaty' for the purposes of article 33, and refers explicitly to article 24 of the CRC. Article 16 of the FCTC contains detailed provisions on minors.

The CRC, designed for children, must be considered the focal point for consideration of 'appropriate measures' to address drug use and dependence among them. A child rights based framework cannot be developed from the drugs conventions in isolation. Article 33 requires rights-based action for children in relation to drugs and, as the Committee has previously stated, must be read alongside article 24.[6] Through the development of normative guidance and specific obligations, 'appropriate measures' to protect children from narcotic drugs and psychotropic substances, from a child rights perspective, may be discerned. In turn, obligations under the drugs conventions as they relate to children may be clarified.

Our submission is divided into two main parts: normative content and specific obligations. We set out normative guidance in relation to drug use and dependence among children and young people as a health rather than a criminal matter; and a test for consideration of 'appropriate measures' to address this in the context of the CRC. This is vital given the dominant criminal law response to drug use in most countries.

We also discuss a number of specific obligations in relation to articles 24 and 33. Broadly, these relate to:

- Reduction of initiation into drugs use by children and young people
- Protection of children and young people who use drugs (with specific reference to the 3AQ framework)
- Protection of children from parental drug dependence (focusing on mothers and pregnancy in the context of pre and post natal care)

We do not consider drug use in the wider community and their impacts on child rights, including the right to health. We touch only briefly on parental drug use. Nor do we discuss children's involvement in the drug trade, the prevention of which is a second requirement of article 33 and, indeed, ILO Convention 182.[7] We do not address the interrelationship between the drugs conventions, the FCTC and the CRC, nor do we look in detail at the impacts of national, regional and international drugs policies and counter-narcotics efforts on the rights of the child.[8]

Given the complex and very serious nature of issues relating to drug use, the drug trade and drug policies, the relatively small space that can be allotted to this topic in a General Comment on the right to health will not be sufficient. There is a genuine lack of child rights guidance on drug use, the drug trade and drug policies, and many examples of abusive measures adopted in the name of protecting children from drugs. Sometimes in the name of the Convention on the Rights of the Child.

We therefore recommend a future General Comment on article 33.

Normative Content

Drug use and dependence as a health issue under the CRC

Article 33 of the CRC must be read alongside article 24. This is clear from the drafting history;[9] regular Concluding Observations of the Committee (where substance use is often dealt with under 'adolescent health')[10]; previous General Comments[11]; and the harmonised 'Treaty-specific guidelines regarding the form and content of periodic reports'.[12]

Since 1991, article 33 had been considered under the 'special protection measures' cluster of rights in the CRC, but the harmonised 2010 guidelines now split article 33 in two. The protection of children from the illicit use of drugs is now dealt with under 'disability, basic health and welfare', while prevention of the use of children in illicit production and trafficking remains a 'special protection measure'. This is a positive move, more reflective of the reality of drug use among young people, and connecting more closely drug use and dependence to the social and health-related rights in the treaty, in particular article 24.

The Committee on Economic Social and Cultural Rights has also addressed drug use under article 12 of the Covenant on Economic Social and Cultural Rights,[13] and both the present and former Special Rapporteurs on the Right to Health have addressed drug use as part of their mandate.[14]

The Committee has been consistent in its view that drug use among children should not be treated as a criminal issue and that children who use drugs should be provided with appropriate health and social assistance.[15]

'Appropriate measures'

The phrase 'appropriate measures' frames article 33 of the CRC. It also appears in article 24(2) on specific obligations relating to the right to health, and reflective of the 3AQ framework (available, accessible, acceptable and sufficient quality health services). It therefore provides an entry point for a normative discussion of State parties' responses to drug use and dependence in the context of child rights. The 3AQ framework is also essential for understanding obligations relating to health interventions for children and young people who use drugs (see further 'Specific Obligations' below).

'Appropriate' is an important qualifier, defending against arbitrariness, disproportionate measures and abuses of human rights in pursuit of protecting children from drugs, which are all too often seen in many countries. Importantly, though, it also guides a child rights based approach in a more positive sense.

We have identified five, interconnected, principles which form the core of our normative discussion, and which in our view are applicable beyond drug use/dependence to the right to health more broadly under the CRC:

Appropriate measures must be *read in the light of the remaining articles of the CRC,* in particular the General Principles and article 5 (evolving capacities). In the current context, of course, articles 24 and 33 must be read in conjunction. Conversely, measures that violate the rights of the child are impermissible. Additionally, in keeping with a child rights-based approach, policies and interventions should be holistic. This is reflected specifically in article 33, referring to administrative, legislative, social and educational measures.

Appropriate measures *must take into account other provisions more conducive to the realisation of the rights of the child*, brought into play explicitly by article 41(2). Here the highest standard applies. This, in turn, draws in other relevant human rights jurisprudence.[16]

Appropriate measures must address *patterns of vulnerability* including ensuring *gender sensitivity* in programmes and policy responses. As with many other issues, when it comes to drug use and dependence

the impacts on women and girls, socially marginalised groups, and different ethnic groups may be different or differently experienced. In addition, risks and harms as well as appropriate interventions may be related to the child's physical, social and psychological development. This supports the need for appropriately disaggregated data when it comes to patterns of drug use and drug related harms.

Appropriate measures must be *evidence-based* and *non-arbitrary*. In other words, they must be based on adequate data, targeted and effective. Patterns of drug use and drug related harms have changed significantly since the drafting of the CRC. Twenty years of research into drug use and dependence, prevention, treatment and harm reduction must be taken into account. The CRC and policies and programmes at State level must be able to adapt to such changing circumstances and incorporate scientific progress.[17]

Appropriate measures must be *proportionate*. In drug control some rights will inevitably be restricted. But the test for whether such restrictions are lawful is rooted in human rights law. Such measures must be prescribed by law, in pursuit of a legitimate aim, and no more than necessary for the achievement of that aim. Unfortunately, many abusive and disproportionate laws, policies and practices, are put in place around the world, often in the name of protecting children from drugs. Some rights of course, can never be so restricted.

Specific Obligations

1. Appropriate measures to reduce initiation into drug use

States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health
(f) To develop preventive health care

States parties must work to reduce initiation into drug use among children. This is a central component of protecting children from the illicit use of narcotic drugs, required by article 33, an obligation that must be read in the light of 'progressive realisation' for the purposes of article 4 (implementation of the rights in the Convention).[18]

It is not possible to prevent all drug use – either immediately or even in the long term. The State must, however, take measures to progressively reduce the numbers of young people initiating drug use. This is both measurable and outcome-driven.

Indicators and benchmarks and data collection are, as always, important, particularly if progress is to be measured. At a global level, however, limited surveillance from many of the world's most populous nations makes it impossible to accurately estimate the total number of drug-involved young people.[19] For the information we do have, data collection methods are imperfect. For the most part studies examining the prevalence of drug use among young people rely on self-reporting from an accessible group of young people, normally school students. However, the fear of a lack of anonymity, or of potential repercussions for an admittance of drug use may bias results due to under-reporting.

Appropriate disaggregation of data is a requirement if patterns of vulnerability and risk are to be identified and initiatives appropriately targeted.

Prevention measures themselves must be evidence based and effective if they are to be considered appropriate and not arbitrary. Random school drug testing is an example of an intervention that fails this test. Such interventions, though widely implemented, have shown to have no positive impact on prevalence rates in schools and have failed to demonstrate a working theory as to why they might work. Indeed, they may have negative side-effects such as encouraging truancy, while labelling a child as a 'drug user' can have negative

impacts on education and psychological wellbeing.[20] In addition, drug tests fail to distinguish between recreational drug use (which would not require treatment intervention) and problematic use or dependence.[21]

Drug prevention information and campaigns should be 'accurate and objective'. This is a consistent finding of the Committee.[22] They should also be targeted. Universal prevention programmes have not shown to be effective (though a lot of children may be reached by them). Indeed, many prevention programmes are not audited sufficiently to gauge effectiveness. On the other hand, a recent randomised controlled trial suggested that brief, personality-targeted interventions can prevent the onset and escalation of substance misuse in high-risk adolescents.[23]

It should be noted, however, that prevention is not solely about messaging and campaigns, but broader social and educational measures. Schools with a positive, inclusive ethos that foster positive teacher–student relationships and promote school engagement have the lowest rates of drug use.[24] Poverty, urban decay, income inequality and poor child wellbeing more broadly have all been linked to increased drug use and related harms within communities.

2. Appropriate measures to protect children who use drugs

1. States Parties recognize the right of the child to...facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
(b) To ensure the provision of necessary medical assistance and health care to all children
(c) To combat disease... through, inter alia, the application of readily available technology
(f) To develop preventive health care

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Some children and young people will experiment and use drugs. The majority of drug use among young people is recreational or experimental and most will transition out of these behaviours without significant health problems. There will, however, be those that experience problematic drug use or become dependent. Many factors come into play in this regard, including co-morbidity with mental health problems - another central consideration connecting drug use, dependence and the right to health.

The Committee is consistent on the need for treatment and rehabilitation services for children and young people who use drugs.[25] The 3AQ framework is directly applicable:

Availability*:* In many countries specialised services for young people who use drugs are non-existent. Specialised interventions for young people are multi-faceted – there should be a range of options depending on the kinds of drugs used, the related health risks, how problematic an individual's drug use is etc. As described by the UK organisation DrugScope, they can include residential rehabilitation, substitute prescribing and needle exchange for a small minority, through to services that offer a combination of motivational, psychosocial and harm reduction interventions for the majority.[26]

However, such interventions require adequate health infrastructure in order to be effectively delivered. As such, services for young people who use drugs must be visible and accounted for in budgets, and should be supported in international development aid.

Accessibility: Where services do exist there can be a number of factors impeding access for some children and young people.

Some are legal, such as age restrictions on certain services, or the need for parental consent (e.g. in the context of HIV prevention). Criminalising young people who use drugs is both harmful and counter-productive, driving them away from services that do exist and exposing them to unnecessary contact with the criminal justice system. The reform of criminal laws is required to ensure that children and young people who use drugs are not criminalised but offered the treatment and/or harm reduction services.[27] Age restrictions on specific health services should be lifted[28] to allow for clinical decisions to be made in the best interests of each child and consistent with their evolving capacities.

Other barriers relate to coverage and quality. Services may be available but there may be insufficient sites or services to meet need. Some young people have to travel long distances to attend drug services which can have knock-on effects, such as on school attendance. There may also be long waiting lists for certain treatment and harm reduction interventions during which time young people can be at significant risk and opportunities for early intervention are lost.

Stigma, of course is a considerable barrier, not helped by criminal laws and negative media coverage of drugs issues (article 17). This relates directly to the Committee's consistent recommendations for 'accurate and objective' drugs information.

***Acceptability*:** The Convention on the Rights of the Child imposes both positive and negative obligations on States parties. We have dealt with some of the positive obligations above. At the same time, States parties must of course refrain from practices that violate the rights of the child. Examples include arbitrary detention, and physical and psychological abuse in drug detention centres[29] and corporal punishment for drug use.[30]

Acceptable programmes must allow for the participation of the child in their treatment, in line with their evolving capacities. The Committee was clear in General Comment No. 12 that the right to be heard applies to healthcare settings and 'applies to individual health-care decisions, as well as to children's involvement in the development of health policy and services'.[31]

States should establish a clear test for assessing consent to treatment and for access to health services (the Gillick/Fraser Guidelines from the UK offer a roadmap[32]). Where treatment is deemed necessary without consent, clear legal and medical due process standards must be put in place. There must be a strong presumption in favour of voluntary, community-based services.

***Sufficient Quality*:** The mere existence of a service for young drug users says nothing of its quality. In keeping with the normative guidance outlined above, interventions must be evidence based and effective. In relation to injecting drug use, for example, needle and syringe programmes have proven effective in preventing the spread of HIV and other blood borne viruses while helping people to contact other health and social services. General Comment No. 3 on HIV/AIDS[33] addressed this problem directly as did the Committee's recent review of Ukraine.[34] Such programmes play a central role in combating disease, in line with Article 24(2)(c).

In relation to drug dependence treatment, there are various evidence based interventions available. Multidimensional Family Therapy (MDFT), for example, is now applied in many places in the world address adolescent drug use. [35] The MDFT therapist works separately with the adolescent and together with him or her, the parents and the school, with promising results.

It is important that the services are developed for young people's needs. Existing adult (and often male oriented) services may not be appropriate. Residential places in adult facilities may not be safe environments, for example, and adult services (whether in- or out-patient) may not address patterns of drug use among

younger people (i.e. type of drug and methods of consumption). In addition, many young people may not identify with older users. Treatment services should also recognise the different patterns of use and initiation among girls (e.g. initiation via sexual partners).[36]

But it is important to make a clear distinction between recreational drug use, problematic drug use and drug dependence (although the latter is a form of problematic use). Not all children who use drugs need treatment. Indeed, this is the case with the vast majority of young people who use drugs occasionally or recreationally. If the reality of the situation is not accepted, then the policies and interventions adopted will not be appropriately targeted and evidence based in order to protect these young people. Simply put, measures that focus on the worst case scenario fail to speak to the lived experiences of many recreational users. A young person using ecstasy on occasional weekends, for example, may not be in need of dependence treatment. And he or she may not be experiencing or have experienced any adverse consequences. But the risks are certainly there. He or she may be encouraged to cease use over time, but in the meantime, the possible health harms associated with ecstasy use can be mitigated.[37]

3. Appropriate measures to protect of children from parental drug dependence

States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (d) To ensure appropriate pre-natal and post-natal health care for mothers

The influence of stress, drinking, smoking and using drugs during pregnancy is becoming increasingly clear[38] as are the potentially irreversible effects on foetuses.[39] Many children suffer the first days of their life from neonatal abstinence syndrome. This raises many difficult ethical and practical questions.

It must be made very clear that many women who use drugs and are pregnant will often want to seek assistance. A major barrier to this is fear of coming into contact with law enforcement or stigma and discrimination about their drug use or dependence. The Irish Women's Health Council has noted that '[T]here is still a double standard that judges women's substance misuse more harshly than men's, particularly if the woman has children. This greater stigma can result in greater guilt and shame for women and for their families, and may lead to women being reluctant to seek treatment.'[40]

There is also the fear of losing their child. While parental drug use and dependence can have considerable impacts on children[41] it is not the case that removing a child from a parent who uses drugs is in each case an 'appropriate measure' to protect that child, nor is it always in the child's best interests. Not all people who use drugs are dependent, and not all people who are drug dependent are causing their children significant harm. Drug use or dependence alone is not sufficient as a reason to take children into care.

Each case must be taken on its own circumstances, and while removal from custody may be required in the child's best interests, and is sometimes requested by struggling parents, other options are available. For example, focused social work geared towards improving parenting skills and fostering family cohesion has shown to be promising.[42] This in turn could contribute towards the rendering of 'appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities' for the purposes of article 18(2). The Committee on the Rights of the Child has made clear the need to support families experiencing drug or alcohol dependence.[43]

In relation to pregnancy, consensual and supportive approaches are available in some countries, such as drug liaison midwives who can assist drug using women who are pregnant.[44] Voluntary, community-based drug treatment services also play an important role.[45] Substitution therapy (e.g. with methadone or buprenorphine) is also recommended for pregnant opiate users.[46] Studies have shown that methadone exposure is, however, associated with adverse perinatal outcomes[47] (though less than if the mother continued using street heroin). Specialised care for pregnant women who are prescribed methadone and their babies is therefore required. Some countries, however, allow for detention for the entirety of a pregnancy if the mother tests positive for drugs.[48] Such laws raise considerable human rights, medical ethics and due process concerns.

A recent UNICEF report puts the challenge succinctly: 'to change the attitude of both society and health-care professionals so that these women are treated as 'pregnant women who have a problem of drug use' and who need to be treated with dignity and respect, rather than just 'drug users who happen to be pregnant', with all that this implies'.[49]

Looking Ahead: The Need for a General Comment on Article 33

Since the CRC was drafted we know much more about risk factors for drug use, dependence and drug related harms. We know more about what is effective and ineffective in terms of prevention, treatment and harm reduction, and which groups of children are more at risk and why. We know more about children's involvement in the drug trade and the myriad factors contributing to this phenomenon. And we know much more about child-rights based approaches to multiple social issues. Still, not enough attention has been paid to articulating a child rights based approach to drug policies and to the many issues children face in relation to drugs and the drug trade.

This lack of analysis on child rights and drug control is unfortunate for many reasons. Firstly, drug dependence, drug related harms and the drug trade continue to affect a wide range of child rights. Secondly, article 33 requires using the Convention on the Rights of the Child as a framework for scrutiny of policies aimed at addressing these concerns and for policy formulation moving forward. At present there is little specific to go on. Thirdly, and conversely, excessively punitive drug control laws and policies are often put in place, and human rights abuses committed, in the name of protecting children from drugs. While protecting children from drugs is at the core of article 33, it should go without saying that abusive measures to pursue that aim are not legitimate. Fourthly, the CRC is increasingly seen as justifying or bolstering the punitive status quo in drug control, rather than as a check and balance against such policies. This is despite the fact that it is well known that drug control laws and policies have created an environment within which vulnerability to human rights abuse has increased for particular vulnerable groups including children.

Neither this short submission nor a General Comment on the right to health can fully address the complexity of issues relating to drug use and the drug trade, and engaging almost the entire spectrum of child rights, from health to juvenile justice to the worst forms of child labour to involvement in armed conflict. Other instruments of international law must be taken into account including the Optional Protocol on the Involvement of Children in Armed Conflict, the UN drugs conventions and ILO Convention No. 182. Indeed, the question of the interplay between the CRC and the drugs conventions is a complex one requiring specific attention.

There is a pressing need for a General Comment on article 33.

ENDNOTES

[1] 'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community. See also Committee on the Rights of the Child, *Concluding Observations: Ukraine*, (UN Doc No CRC/C/UKR/CO/4, 2011), paras 59 & 60.

[2] http://www.brill.nl/commentary-united-nations-convention-rights-child-article-33-protection-narcotic-drugs-and-psychotro#TOC_1

[3] Available for download at http://www.childrenofthedrugwar.org/

[4] Single Convention on Narcotic Drugs, 1961, March 30, 1961, 520 U.N.T.S. 204; Protocol Amending the Single Convention on Narcotic Drugs, 25 March 1972, T.I.A.S No 8118, 976 UNTS 3; Convention on Psychotropic Substances, 1971 32 U.S.T. 543, T.I.A.S. 9725, 1019 U.N.T.S. 175; Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, U.N. Doc. E/CONF.82/15 (1988), reprinted in 28 I.L.M. 493.

[5] See D. Barrett and M. Nowak 'The United Nations and Drug Policy: Towards a Human Rights-Based Approach' in *The Diversity Of International Law: Essays In Honour Of Professor Kalliopi K. Koufa*, Aristotle Constantinides and Nikos Zaikos, eds., (Amsterdam: Brill/Martinus Nijhoff), 2009

[6] Committee on the Rights of the Child, *General Comment No. 3 : HIV/AIDS and the Rights of the Child*, (UN Doc No CRC/GC/2003/3, 2003), para 39. 'Consistent with the rights of children under articles 33 and 24 of the Convention, States parties are obligated to ensure the implementation of programmes which aim to reduce the factors that expose children to the use of substances, as well as those that provide treatment and support to children who are abusing substances'

[7] Convention Concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour (ILO No. 182), 2133 U.N.T.S.161, *entered into force* Nov. 19, 2000, para 3(c).

[8] See further D. Barrett and P. Veerman, *A Commentary on the United Nations Convention on the Rights of the Child: Article 33, Protection from Narcotic Drugs and Psychotropic Substances* (forthcoming, Brill/Martinus Nijhoff 2012) and D. Barrett (ed) *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People* (IDEA, iDebate Press, New York and Amsterdam, 2011).

[9] The original formulation of article 33, submitted by China in 1984, was 'preventing and prohibiting the child from using drugs ' discussed in the context of then Article 12 on the right to health. Office of the High Commissioner for Human Rights, *Legislative History of the Convention on the Rights of the Child: Part II* (New York and Geneva, UN, 2007) pp. 709-710.

[10] On solvents (such as glue and petrol) see for example, Concluding Observations: Central African Republic (UN Doc No CRC/C/15/ADD.138, 2000) para 80; Greece, (UN Doc No CRC/C/15/ADD.170, 2002) para 74; Bangladesh (UN Doc No CRC/C/BGD/CO/4, 2009) para 65. On alcohol see *Belarus* (UN Doc No CRC/C/BLR/CO/3-4 2011), para 59; *Serbia* (UN Doc No CRC/C/SRB/CO/1, 2008) para 56; *Ireland* (UN Doc No CRC/C/IRL/CO/2, 2006) para 51.

[11] Committee on the Rights of the Child, *General Comment No. 3 : HIV/AIDS and the Rights of the Child*, (UN Doc No CRC/GC/2003/3, 2003); Committee on the Rights of the Child, *General Comment No.4: Adolescent health and development in the context of the Convention on the Rights of the Child*, (UN Doc No CRC/GC/2003/4, 2003).

[12] Committee on the Rights of the Child, *Treaty-specific guidelines regarding form and content of periodic reports to be submitted by States parties under article 44, paragraph 1 (b), of the Convention on the Rights of the Child* (CRC./C/58/Rev.2, 2010) paras 34(f) & 39(c)(ii).

[13] Committee on Economic Social and Cultural Rights, *Concluding Observations*: *Tajikistan* (UN Doc No E/C.12/TJK/CO/1, 2006) para 70; *Ukraine* (UN Doc No E/C.12/UKR/CO/5, 2007) para 28; *Poland* (UN Doc No E/C.12/POL/CO/5, 2009) para 26; *Kazakhstan* (UN Doc No E/C.12/KAZ/CO/1, 2010) para 34; *Mauritius* (UN Doc No E/C.12/MUS/CO/4, 2010) para 27. See also *List of Issues on the fifth periodic report of the Russian Federation* (UN Doc No E/C.12/RUS/Q/5, 2010) para, 36.

[14] For example, Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt, Mission to Sweden (UN Doc No A/HRC/4/28/Add.2, 2007) paras 60-62; Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Anand Grover, Mission to Poland (UN Doc No A/HRC/14/20/Add.3, 2009) paras 57-80; and the Special Rapporteur's Annual Thematic Report to the UN General Assembly, (UN Doc No A/65/255, 2010), focusing on drug control.

[15] For example: Committee on the Rights of the Child: *Concluding Observations: Armenia* (UN Doc No CRC/C/15/ADD.225, 2004) para 63; *Indonesia* (UN Doc No CRC/C/15/ADD.223, 2004) para 74; *Norway* (UN Doc No CRC/C/15/Add.263 , 2005) para 44; *Denmark* (UN Doc No CRC/C/DNK/CO/3 , 2005) para 55; *Russian Federation* (UN Doc No CRC/C/RUS/CO/3, 2005) para 77; *Maldives* (UN Doc No CRC/C/MDV/CO/3, 2007) para 88; *Marshall Islands* (UN Doc No CRC/C/MHL/CO/2, 2007) para 55; *Afghanistan* (UN Doc No CRC/C/AFG/CO/1, 2011) para 52(d).

[16] It also demands child rights scrutiny of the UN drug conventions of 1961, 1971, and 1988 and whether those conventions are conducive to the realisation of the rights of the child. That discussion is outside the scope of this submission but see D. Barrett and P. Veerman 'Children and drug use: the need for more clarity on State obligations in international law' *International Journal on Human Rights and Drug Policy*, Vol I (2010) pp. 63-81.

[17] Article 15(1)(b) of the International Covenant on Economic Social and Cultural Rights guarantees the right of everyone to benefit from scientific progress and its applications. See also Committee on Economic Social and Cultural Rights, *Concluding Observations: Mauritius* (UN Doc No E/C.12/MUS/CO/4, 2010), para 27.

[18] Committee on the Rights of the Child, General Comment No. 5 *General Measures of Implementation of the Convention on the Rights of the Child* (UN Doc No CRC/GC/2003/5, 2003), para7.

[19] C. Cook and A. Fletcher 'Youth drug use research and the missing pieces in the puzzle: How can researchers support the next generation of harm reduction approaches?' in: D. Barrett (ed.) *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People*, New York and Amsterdam, International Debate Education Association, iDebate Press, 2011.
[20] C. Bonell, A. Fletcher., 'Addressing the wider determinants of problematic drug use: advantages of whole-population over targeted interventions', *International Journal of Drug Policy*, (2008 (19)) 267-269.
[21] See A. Fletcher 'Drug testing in Schools: A case study in doing more harm than good' in D. Barrett (ed) *Children of the Drug War: Perspective on the impact of drug policies on young people* (2011)
[22] See for example, over the last decade: *Slovakia* (UN Doc No CRC/C/15/ADD.140, 2000) para 42; *Estonia* (UN Doc No CRC/C/15/ADD.196, 2003) para 50; *Pakistan* (UN Doc No CRC/C/15/ADD.217, 2003) para 73; *Indonesia* (UN Doc No CRC/C/15/ADD.223, 2004) para 74; *Norway* (UN Doc No CRC/C/15/Add.263 , 2005) para 44; *Denmark* (UN Doc No CRC/C/DNK/CO/3 , 2005) para 55; *Belize* (UN Doc No CRC/C/15/Add.252 , 2005) para 55; *Russian Federation* (UN Doc No CRC/C/RUS/CO/3, 2005) para 77; *Kiribati* (UN Doc No CRC/C/KIR/CO/1, 2006) para 49; *Sweden* (UN Doc No CRC/C/SWE/CO/4, 2009) para 49; *Tunisia* (UN Doc No CRC/C/TUN/CO/3, 2010) para 54.
[23] P. J. Conrod et al 'Brief, personality-targeted coping skills interventions and survival as a non-drug user over a 2-year period during adolescence' *Archives of General Psychiatry*, 2010 Jan;67(1):85-93.
[24] A. Fletcher 'Drug testing in Schools: A case study in doing more harm than good' in D. Barrett (ed) *Children of the Drug War: Perspective on the impact of drug policies on young people* (2011), citing C. Bonell et al., "Improving School Ethos May Reduce Substance Misuse and Teenage Pregnancy," British Medical Journal 334 (2007): 614–16
[25] See for example, Committee on the Rights of the Child, *Concluding Observations: South Africa* (UN Doc No CRC/C/15/ADD.122, 2000) para 38; *France* (UN Doc No CRC/C/15/ADD.240, 2004) para 57; *Germany* (UN Doc No CRC/C/15/ADD.226, 2004) para 43; *Thailand* (UN Doc No CRC/C/THA/CO/2, 2006) para 54; *Peru* (UN Doc No CRC/C/PER/CO/3, 2006) para 55; *Malaysia* (UN Doc No CRC/C/MYS/CO/1, 2007) para 98; *Bangladesh* (UN Doc No CRC/C/BGD/CO/4, 2009) para 66; *Cameroon* (UN Doc No CRC/C/CMR/CO/2, 2010) para 57; *Tajikistan* (UN Doc No CRC/C/TJK/CO/2, 2010) para 54; *Bahrain* (UN Doc No CRC/C/BHR/CO/2-3, 2011) paras 59 & 60.
[26] *Young people's drug and alcohol treatment and the crossroads: What it's for, where it's at and how to make it even better,* London, DrugScope, 2010, p.25.
[27] The Committee's most explicit statement in this regard came in February 2011 in relation to Ukraine. The Committee raised concerns that 'legal and attitudinal barriers' may impede access to services for children and that 'new regulations relating to personal possession of drugs may bring more at risk adolescents into contact with the criminal justice system'. It recommended the amendment of laws that 'criminalise children for possession or use of drugs'. Committee on the Rights of the Child, *Concluding Observations: Ukraine*, (UN Doc No CRC/C/UKR/CO/4, 2011), paras 59 & 60.
[28] See Committee on Economic Social and Cultural Rights, *Concluding Observations: Mauritius* (UN Doc No E/C.12/MUS/CO/4, 2010), para 27(c).
[29] See for example *Skin on the cable: The Illegal Arrest, Arbitrary Detention and Torture of People Who Use Drugs in Cambodia* (New York, Human Rights Watch, 2010). See also Committee on the Rights of the Child, *Concluding Observations: Cambodia* (UN Doc No CRC/C/KHM/CO/2, 2011) paras 55 & 56.
[30] E. Iakobishvili *Inflicting Harm: Judicial corporal punishment for drug and alcohol offences in selected countries*, Harm Reduction International (2011).
[31] Committee on the Rights of the Child, *General Comment No. 12: the right of the child to be heard*, (UN Doc No CRC/C/GC/12, 2009), para 98.
[32] Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL). Applied to access to needle and syringe programmes for minors see National Treatment Agency for Substance Misuse, *Assessing young people for substance misuse*, National Health Service (2007)
[33] Committee on theRights of the Child, *General Comment No. 3 : HIV/AIDS and the Rights of the Child*, (UN Doc No CRC/GC/2003/3, 2003), para 39. Injecting practices using unsterilized instruments further increase the risk of HIV transmission. The Committee notes that greater understanding of substance use behaviours among children is needed, including the impact that neglect and violation of the rights of the child has on these behaviours. In most countries, children have not benefited from pragmatic HIV prevention programmes related to substance use, which even when they do exist have largely targeted adults.
[34] Committee on the Rights of the Child, *Concluding Observations: Ukraine*, (UN Doc No CRC/C/UKR/CO/4, 2011), paras 59 & 60.
[35] H.A. Liddle, *Multidimensional Family Therapy for Adolescent Drug Abuse: Clinician's Manual*, (Center City, M.N. 2009, Hazelden Publishing Co.); H.A. Liddle, *Multidimensional; Family Therapy: A 12-weeks intensive outpatient treatment for adolescent cannabis users*, (Washington DC, Center for Substance Abuse Treatment, 2000).
[36] See *Young people and injecting drug use in selected countries of Central and Eastern Europe*, (Vilnius, Eurasian Harm Reduction Network, 2009).
[37] See for example www.drugscope.org.uk/resources/drugsearch/drugsearchpages/dancesafety.htm.
[38] For example, H. El Marroun, et al., Intrauterine Cannabis Exposure Affects Fetus growth Trajectories: The Generation R- Study, *Child and Adolescent Psychiatry* (2009 (48)) 12, 1173-1181.Maternal cannabis use, even for as short period, may be associated eith several adverse fetal growth trajectories, it was concluded.
[39] For example, S. L. Leech, et al., 'Prenatal substance exposure: Effects on atgention and impulsivity of 6 years olds', *Neurotoxcology and Teratology*, (1999 (21)) 2, 109-118.
[40] Women's Health Council, *Women & Substance Misuse in Ireland: Overview* (undated) p. 6
http://www.drugsandalcohol.ie/12439/1/womenSubstanceOverview.pdf

[41] M. Barnard and J. Barlow, 'Discovering Parental Drug Dependence: Silence and Disclosure', *Children's Society*, (2003(17)) 1, 45-46; D. Forester and J, Harwin, 'Parental substance misuse and child welfare: outcomes for children two years after referral', *British Journal of Social Work* (2009 (38)) 8, 1518-1538; D. Hogan and L. Higgins, *When parents use drugs; key findinds from a study of children in the care of drug-using parents* (Dublin, Trinity College, 1997); J.L. Johnson and M. Left, 'Children of substance abusers: overview of research findings', *Pediatrics* (1999 (103)) 5 Supplement, 1085-1099.

[42] See for example See D. Forrester et al *Happiness project working with resistance in families experiencing violence: Option 2 - Cardiff and Vale - Evaluation report 2008*, (Prepared for the Welsh Assembly Government, UK, 2009); and S. Dawe and P. Hartnett 'Reducing potential for child abuse among methadone-maintained parents: results from a randomized controlled trial' *Journal of Substance Abuse Treatment* 2007, 32(4):381-90

[43] See for example, Committee on the Rights of the Child, *Concluding Observations: New Zealand*, (UN Doc No CRC/C/NZL/CO/3-4, 2011) para 31.

[44] F. Macrory, 'The drug liaison midwife: developing a model of maternity service for drug-using women', in: Hilary Klee, Marcia Jackson and Suzan Lewis, editors, *Drug Misuse and Motherhood*, (London, Routledge, 2002) 234-249.

[45] S. Ruben and T. Fitzgerald, 'The role of drug services for pregnant users: the Liverpool approach', in: H. Klee, M. Jackson and S. Lewis, (eds), *Drug Misuse and Motherhood* (London, Roudledge, 2002) 224-238.

[46] United Nations Office on Drugs and Crime *Substance abuse treatment and care for women: case studies and lessons learned. United Nations*, New York, 2004.

[47] For example, B. Cleary et al 'Methadone and perinatal outcomes: a retrospective cohort study' *American Journal of Obstetrics and Gynacology*, 2011 Feb;204(2):139.e1-9

[48] For example, Section 6-2a of Norway's Social Services Act 1996.

[49] UNICEF, *Blame and Banishment: The Underground HIV epidemic affecting children in Eastern Europe and Central Asia* (New York, UNICEF, 2010) 46. See also: UNICEF, *Children at Risk of Contracting HIV/AIDS in Afghanistan* (New York, UNICEF December 2008). See further Eurasian Harm Reduction Network 'Women in Drug Policy' (Vilnius: EHRN, 2010) p.5.