

Submission to the UN Working Group on Arbitrary Detention on detention in the context of drug policies

31/03/2020

Submitting Organisation:



Harm Reduction International (HRI) is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. HRI promotes the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. HRI is a non-governmental organization in special consultative status with ECOSOC.

Introduction

Harm Reduction International (HRI) welcomes Human Rights Council resolution 42/22 renewing the mandate of the Working Group on Arbitrary Detention (WGAD); and requesting the WGAD to prepare and present a report on arbitrary detention related to drug policies. We also applaud the WGAD's sustained efforts to denounce violations of fundamental rights committed in the context of drug control.

In support to the drafting process, and as requested by the letter to stakeholders dated 4th February 2020, we submit information on:

1. Criminalisation of possession of drug consumption equipment and Opioid Agonist Therapy (Issue 2);
2. Harm reduction and drug treatment in custodial and pre-trial detention (Issues 6 and 14);
3. Torture and ill-treatment of people detained for drug offences through the imposition of corporal punishment (Issue 6);
4. Private drug treatment centres (Issue 8);
5. Services in detention settings in the context of migration (Issue 16).

1) Criminalisation of possession of drug consumption equipment and Opioid Agonist Therapy

People who use drugs, harm reduction services providers and human rights defenders are criminalised not only through criminalisation of drug use and possession for personal use, but also through the criminalisation of possession of paraphernalia and equipment for drug consumption. For example, possession of 'drug paraphernalia' is a crime in the Philippines, punished with imprisonment from six months to four years, and a fine.¹ This provision is a key challenge to the expansion of harm reduction services in the country as it exposes both service providers and people who use drugs to imprisonment. Similarly, some US state laws envisage penalties for the possession and distribution of drug paraphernalia; in Florida, for example, possession of drug paraphernalia can be punished with up to one year of jail, probation.²

¹ Philippines, Comprehensive Dangerous Drugs Act (2002), Section 12.

² Florida Statute, Chapter 893: Drug Abuse Prevention and Control, 145-147. Available at: <https://www.flsenate.gov/Laws/Statutes/2019/Chapter893/All>.

In 2018, UNAIDS reported that in ten countries the mere “possession of a needle or syringe without a prescription could be used as evidence of drug use or cause for arrest.”³

The provision of Opioid Agonist Therapy (OAT, also known as Opioid Substitution Therapy/OST) is prohibited in Russia since 1998, when the government prohibited the use of methadone and buprenorphine for the ‘treatment’ of drug dependence.⁴ ⁵ Similarly, Turkmenistan has OAT prohibitions in place. Illegal acquisition, storage and distribution of these substances is a criminal offence, punishable with imprisonment between three and fifteen years.⁶ Similarly in the Philippines, methadone and buprenorphine – the most commonly used medicines for OAT – are classified as dangerous drugs, thus their possession and use can be punished.⁷

2) Harm reduction and drug treatment in prison (Issues 6 and 14)⁸

A disproportionate number of people who use drugs are in prison: according to UNAIDS, between 56% and 90% of people who inject drugs globally will be incarcerated at some point in their lives;⁹ while in 2014 UNODC estimated that around 20% of the prison population is incarcerated for drug offences, overwhelmingly for possession offences.¹⁰ At the same time, drugs continue to be present in prisons around the world.¹¹

People in prison retain their fundamental rights, including the right to health, which in turn encompasses the right to access quality and evidence-based harm reduction services. Notably, states have an obligation to provide a standard of care in prison at least equivalent to that available in the community. We note in the questionnaire, Issue 14, a conflation between harm reduction and drug treatment. Harm reduction is not a form of drug treatment. OAT sits at the intersection of harm reduction and drug treatment – having the demonstrated effect of reducing the harms of drug use, and being the medically indicated treatment for opioid dependence. Harm reduction and drug treatment are often complementary, but should not be conflated.

As of 2019,¹² only 54 countries provided OAT in at least one prison. Notably, OAT reduces the risk of opioid overdose both during incarceration and on release; while an abrupt abstinence from opioid use without OAT can cause profound mental and physical pain, and have serious medical consequences. UN bodies have reiterated that the failure of States to ensure the availability and accessibility of essential medication – including methadone and buprenorphine – can constitute a violation not only of the right to health but also of the prohibition of torture and ill-treatment.

³ UNAIDS (2018), *Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices* (Geneva: Joint United Nations Programme on HIV/AIDS), 54. Available at: https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

⁴ Russian Federation, Government Decision No. 681 of 30 June 1998; Federal Act No. 3 of 8 January 1998

⁵ *Government Decision No. 681 of 30 June 1998; Federal Act No. 3 of 8 January 1998*

⁶ Kommersant (18 June 2019), ‘228th in Grams and Terms’, <https://www.kommersant.ru/doc/3999368>

⁷ NOBOX TRANSITIONS FOUNDATION, Inc (2018) Investment Into Harm Reduction In The Philippines. Report submitted to Harm Reduction International within Harm Reduction Advocacy in Asia Global Fund Regional Project (unpublished). Available upon request

⁸ Unless specified, the information in this paragraph has been extracted from Stone and Shirley-Beavan (2018), *The Global State of Harm Reduction 2018* (London: Harm Reduction International). Available at: <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf>

⁹ UNAIDS (2014), *The Gap Report* (Geneva: Joint United Nations Programme on HIV/AIDS).

¹⁰ UN Commission on Crime Prevention and Criminal Justice (2013), *World crime trends and emerging issues and responses in the field of crime prevention and criminal justice, note by the Secretariat*, E/CN.15/2013/9. Available at: http://www.unodc.org/documents/data-and-analysis/statistics/crime/World_Crime_Trends_2013.pdf

¹¹ Harm Reduction International (2020), ‘Global State of Harm Reduction: 2019 Updates’, <https://www.hri.global/global-state-of-harm-reduction-2019>

¹² Harm Reduction International (2018), *Harm Reduction and Prisons: Global State of Harm Reduction 2018 Briefing*. Available at: <https://www.hri.global/files/2019/03/29/prisons-harm-reduction-2018.pdf>

By 2019, only 10 countries had a needle and syringe programme in at least one prison.¹³ Condom distributions programmes are not in operation in many prisons, exposing prisoners to the risk of contracting communicable diseases. Virtually no country has harm reduction services in place in detention settings for new psychoactive substances, despite their use being increasingly reported in prisons; and naloxone – an effective overdose reversal medication – is often not available. For example, as of 2018 naloxone was reportedly available in prisons in only one country in Asia (Afghanistan).¹⁴ HIV and hepatitis C testing and treatment is often either absent, or available on a limited basis because of: stock-outs of medication; compounded stigma; or, delays in linkage to treatment where prison and health authorities are not integrated.

When in place, these services are often available in a limited number of facilities, and with varying degrees of availability, accessibility, and quality. For example, in several countries – such as Albania, Belgium, Bulgaria, Kenya, Latvia, Lithuania, Montenegro, New Zealand (with the exception of one prison) and Serbia – OAT is only provided in prison if the person was enrolled in an OAT programme before their incarceration. Even when OAT is available, there can be delays in provision once the person is arrested or put in detention. For example in Kenya, community paralegals report that when people who use drugs are arrested, OAT is not readily made available – which can result in the client experiencing severe withdrawal symptoms while at the police station. This has a particularly severe impact on people who use drugs who are arrested on Fridays, who are only presented to court on Mondays, sometimes while when experiencing severe withdrawal symptoms.

In many cases, health and harm reduction services are only available to certain groups of prisoners, and not others; for example, women in prison may have more limited access to health services than men, or be detained in worse conditions.

Recent research involving women who use drugs in Durban, South Africa, confirmed that OAT is unavailable in women’s prisons in South Africa, although being available in men’s prisons. This leaves women who use drugs in detention exposed to experiencing severe pain and suffering. As one woman described:

“You must suffer. You face the pain until the arosto is out [...]. Some of the girls kill themselves from the pain. The number of girls who kill themselves is really a lot. One of the girls with us, she hung herself from the pains and no one came. No one would help her. No methadone. They should have methadone or anything to help with the pain. It would save a lot of lives.”¹⁵

Similarly in Mexico – where no OAT nor NSP is available in prisons - civil society reports that “drug treatment programs for incarcerated women run on very little staff, little training, and no budget. As the incarcerated female population is much smaller than the male population, there are few specific detention centers for women in Mexico. Many spaces for incarcerated women are contiguous to prisons for men, and are very small; for this reason, when medical treatment is available in women's prisons, it is supplied in special spaces or cells in deplorable conditions, with little access to medicines and little access to health specialists.”¹⁶

When a woman requests treatment for drug dependence, it is reportedly the prison staff, and not a medical professional, who makes a first assessment of her request and then transmit it to the prison authorities, who refer her to the health services, if available. This is particularly concerning in light of the fact that some women may first develop drug dependence within prisons, due to the high availability of illicit substances in detention settings. Civil society organizations have denounced

¹³ Full list: Armenia, Canada, Germany, Kyrgyzstan (7 prisons), Luxembourg, Macedonia, Moldova, Spain, Switzerland and Tajikistan (1 prison)

¹⁴ Stone and Shirley-Beavan (2018), *The Global State of Harm Reduction 2018* (London: Harm Reduction International), 38

¹⁵ Harm Reduction International and South African Network of People who Use Drugs (2019), *Experiences of Barriers to Harm Reduction among Women who Use Drugs in Durban, South Africa* (Unpublished and available upon request)

¹⁶ EQUIS, Harm Reduction International and Mexico Unido Contra la Delinuencia, *Submission to the UN Human Rights Committee ahead of Mexico's sixth periodic review* (16 September 2019). Available at: https://www.hri.global/files/2019/09/18/HRctee_submission_Mexico_-_2019.pdf

unnecessary and forced medication of incarcerated women in the Federal Center for Women's Social Readaptation. Another problematic practice is the widespread use of antidepressants or medications for post-traumatic syndrome by prison – especially those that have little security personnel – as a control mechanism, with the aim of keeping a significant portion of the prison population sedated, rather than for health purposes.¹⁷

For a detailed review of the availability and quality of harm reduction services in prisons in different countries, please see [The Global State of Harm Reduction 2018](#) and its [2019 updates](#).

3) Torture and ill-treatment of people detained for drug offences: corporal punishment (Issue 6)¹⁸

International human rights law universally and absolutely prohibits judicial corporal punishment as a form of cruel, inhuman, or degrading treatment or punishment, if not torture.¹⁹ This prohibition has character of international customary law thus is binding on all states and without exception.²⁰

Nevertheless, at least 12 countries²¹ prescribe corporal punishment – including flogging, lashing, whipping, and amputation – as a penalty for drug offences; either in itself or as a complement to other forms of punishment. In at least one country – Singapore – corporal punishment is mandatorily imposed together with imprisonment for a range of drug offences.²²

This phenomenon is severely underreported, thus it is uncertain whether and how corporal punishment is implemented in these jurisdiction. The lack of transparency is problematic in itself and should be highlighted. Nevertheless, some information routinely emerges. For example, 121 flogging sentences and one hand amputation were confirmed in Iran in 2018.

4) Private treatment and rehabilitation centres

Private drug treatment and rehabilitation centres operate around the world, in addition to, or instead of public structures. These centres operate with varying degrees of concern for human dignity or quality of care, often with little recourse to evidence-based treatment, and with limited oversight by the state. Regardless, it is well-established that the final responsibility for protecting, respecting and promoting human rights falls with the state.²³ Lack of regulation, monitoring and assessment of these centres often leads to private centres detaining individuals in inhumane conditions and/or providing non-evidence based forms of treatment. While a comprehensive review of private 'treatment' centres exceeds the space of this report, some examples are provided below.

¹⁷ Ibid.

¹⁸ Unless specified, the information in this paragraph has been extracted from research conducted by the Essex Human Rights Law Clinic in partnership with Harm Reduction International in 2020 (unpublished, draft available upon request).

¹⁹ Among others, see United Nations General Assembly, 10 December 1948, 217 A (III), Article 5; International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976), 999 UNTS 171, Article 7; International Court of Justice, *Ahmadou Sadio Diallo (Republic of Guinea v Democratic Republic of the Congo)*, Judgment of 30 November 2010, para 87^o; International Court of Justice, *Questions relating to the Obligation to Prosecute or Extradite (Belgium v Switzerland)*, Judgment of 20 July 2012, para 99; Committee Against Torture in its General Comment No 2, 24 January 2008, CAT/C/GC/2, para 1, 3.

²⁰ Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 20 July 2017, A/72/178, para 18. See also: Human Rights Committee, General Comment No 20, 10 March 1992, para 3; Committee Against Torture, General Comment No 2, 24 January 2008, CAT/C/GC/2, particularly para 1, 3, 5, 26.

²¹ Botswana, Brunei, Grenada, Iran, Malaysia, Maldives, Nigeria, Qatar, Saudi Arabia, Singapore, United Arab Emirates, Yemen

²² Singapore, Misuse of Drugs Act (revised 2013), article 33(4)(A), 33(4)(B), 33(4)(C), 33(A)(2), 33(B) and Second Schedule. Available at: <https://sso.agc.gov.sg/Act/MDA1973#pr33->

²³ Among others, see UN Committee on Economic, Social and Cultural Rights, General Comment No 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities (10 August 2017). UN Doc. E/C.12/GC/24.

Dozens of private drug rehabilitation centres operate in **Bangladesh** (both licensed and non-licensed), which impose non-evidence based treatment amounting to ill-treatment, and in some cases leading to death.²⁴ Recent reports denounced the degrading, unhygienic conditions in which individuals are held in some of these centres and detailed the inhuman treatments imposed. Among others, these reports described severe overcrowding, lack of medical professionals, “clusters of cockroaches camped out in the clogged kitchen sink, hid out in the food and cutlery storage area and scurried away on the floor”, denial of information on the treatment imposed and forced feeding of medication, and abusive and intimidating behaviour by the part of the administrators.²⁵

Private treatment centres are also widespread in Central and Latin America. In **Brazil**, for example, there appears to be an increase in privately-managed but often publicly-funded centres. After its 2018 visit to Brazil, the Inter-American Commission on Human Rights denounced human rights violations in these centres, including “forced institutionalization, an arbitrary administration of psychotropic drugs, restricted family contact, limitations in access to personal documents and money, physical abuse, forced labour to replace staff and general services, violations of religious freedom and freedom of conscience, and the institutionalization of adolescents”. According to the Commission around 2,000 centres of this kind exist in Brazil, with the government recently granting them 24 million dollars.²⁶ **Ecuador** is also witnessing an increase in private ‘treatment’ centres imposing non-evidence based treatment, detaining individuals in inhumane conditions, and exposing them to outright ill-treatment. Abuses include sexual violence, forced medication, beatings, denial of essential hygiene products, forcing individuals to sleep on floors or swim in freezing water - among many others.²⁷ In 2018, 67 centres were closed by the authorities after investigations into allegations of abuse, but no support was provided to those who were in those centres, and many others remain open.²⁸

Iran Anti-Narcotics Law mandates that people identified as “addicts” seek treatment in government-run or private rehabilitation centers. Despite the existence of regulations and a licencing scheme for such centers (referred to as “camps”), lack of adequate oversight has resulted in the emergence of a large number of illegal camps. Individuals who use drugs are most commonly admitted by force to rehabilitation camps by the authorities - including law enforcement or judicial officials - or their families. There are no procedures for individuals detained in these camps to challenge the lawfulness of their detention and its continuity before a regular, independent, and impartial court. In practice, people who use drugs can be arbitrarily detained for indefinite periods of time.

Civil society reports of non-evidence based rehabilitation methods, incompatible with international human rights standards, as well as widespread torture and ill-treatment and punishment. For example, upon admission individuals are generally held in “withdrawal rooms”; in most cases, essential medications are discontinued following their admission to camps. While regulations prescribe the need for supervision by medical professionals, information received by civil society indicates that some camps are rarely or never supervised by doctors or psychiatrists. In 2014, an official from the State Welfare Organization reported that 39 individuals had died in rehabilitation camps between January 2013 and January 2014, referring to the severe suffering experienced during the first few days of

²⁴ For an example see Islam Z, ‘Rehabs in need of rehabilitation’ (The Daily Star, 1 February 2019). <https://www.thedailystar.net/star-weekend/spotlight/news/patients-not-criminals-1695820>;

²⁵ Islam Z, ‘Rehabs in need of rehabilitation’ (The Daily Star, 1 February 2019). <https://www.thedailystar.net/star-weekend/spotlight/news/patients-not-criminals-1695820>; Rabbi A H, ‘To rehab and back’ (Dhaka Tribune, 26 July 2018). <https://www.dhakatribune.com/magazine/weekend-tribune/2018/07/26/to-rehab-and-back>.

²⁶ Inter-American Commission on Human Rights, *Preliminary Observations of IACHR’s in Loco Visit to Brazil*, <https://www.oas.org/es/cidh/prensa/comunicados/2018/238OPeng.pdf>

²⁷ Among others see: Tessie Castillo (15 October 2019), ‘Drug Treatment Centres or Private Torture Clinics’, *Talking Drugs*, <https://www.talkingdrugs.org/drug-treatment-centres-or-private-torture-clinics>; Carlos E. Flores and Natalia Rivas, ‘La Tortura Como Terapia: El Riesgoso Camino a Los Centros de Adicciones’, <https://ojoaldata.ec/la-tortura-como-terapia/>

²⁸ Elena Paucar (15 January 2019), ‘67 centros para tartar adicciones fueron clausurados desde el 2018’, *El Comercio*, <https://www.elcomercio.com/actualidad/centros-tratamiento-adicciones-clausurados-ecuador.html>

'detoxification' as the main reason behind the deaths.²⁹ In some camps detainees are thrown in cold water pools during winter. Reports of beatings and denial of sufficient and adequate food resulting in reports of hunger are also rampant.³⁰

In 2019, 107 (legal) private 'de-addiction' centres were reported in **India**.³¹ Private centres – which may be run by NGOs, faith-based organisations, people who used drugs, or doctors - operate besides public and semi-public 'integrated' structures, with varying degrees of treatment quality, staffing, and infrastructure quality. Little official information is available on these centres, suggesting a lack of transparency, if not monitoring and oversight by the part of the government; indeed, civil society reports that most centres are "not regulated by any of the governmental agencies".³²

Reportedly, some of the centres are operated by unqualified individuals, and resort to violence and abuse as a form of 'treatment'.³³ Treatment seems to be predominantly focused on abstinence, with no harm reduction programmes in place. Some centres admit clients against their will, often upon request of the family and sometimes through forms of 'kidnapping'. Conditions in such centres are reportedly poor – when not outright abusive, including: overcrowding and inadequate sanitation; lack of healthcare professionals;³⁴ denial of adequate food or forced starvation;³⁵ verbal and physical abuse, including sexual violence;³⁶ forced labour as forms of treatment or punishment; and forced isolation.³⁷

In addition, illegal centres operate and are routinely denounced, which hold individuals against their will, often in inhuman conditions, and employ abusive methods of 'treatment'.³⁸

Reports from **Nepal** also suggest that several unregulated centres are in place in the country, in which individuals are forced to undergo inhuman and degrading forms of treatment in harrowing conditions of detention. In December 2018, individuals were rescued from a licenced – and costly - centre in which

*"More than 15 persons were found to have been kept in a single room with no adequate space to sleep. The owner of the rehab centre used to lock them up in the room most of the time without even allowing them to answer the nature's call. Ghimire and his staff would let patients leave the room to defecate only once a day, that too one by one and under strict supervision. The rooms were littered with faeces and urine"*³⁹

²⁹ ISNA (3 January 2014), 'Death of 39 people in rehabilitation camps in the past year', January 3, 2014, available at: <https://bit.ly/2JhmkL>.

³⁰ Abdorrahman Boroumand Center and Harm Reduction International (28 March 2019) *Joint Stakeholder Submission to the Working Group for The Universal Periodic Review, Third cycle*, 6-7. Available at: <https://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRIRStakeholdersInfoS34.aspx> (joint submission 11).

³¹ Navjeevan Gopal (18 March 2020), 'The Never Ending War on Drugs', *The Indian Express*, <https://indianexpress.com/article/cities/chandigarh/drug-menace-punjab-amarinder-singh-narcotics-drugs-and-psychotropic-substances-ndps-act-6319664/>.

³² Rao (2020), *Assessment of Standards of Care in Services for People Who Use Drugs in India* (new Delhi: Alliance India).

³³ Ibid.

³⁴ Newsclick (4 August 2019), 'Punjab Undertakes Drug Eradication in "Mission Mode"', <https://www.newsclick.in/Punjab-Undertakes-Drug-Eradication-Mission-Mode>

³⁵ Rakhi Bose (26 June 2018), 'Inmates Tortured, Starved and Sexually Abused Inside Drug Rehab Centres in Delhi, Study Reveals', *News 18*, <https://www.news18.com/news/buzz/study-reveals-inmates-tortured-starved-and-sexually-abused-inside-drug-de-addiction-centres-in-delhi-1791183.html>.

³⁶ Ibid.

³⁷ Aditya Dev (30 October 2019), 'Ghaziabad: Five Inmates held for rehab centre caretaker's murder', *Times of India*, <https://timesofindia.indiatimes.com/city/ghaziabad/ghaziabad-five-inmates-held-for-rehab-centre-caretakers-murder/articleshow/71826406.cms>. Also see Rao (2020), *Assessment of Standards of Care in Services for People Who Use Drugs in India* (new Delhi: Alliance India).

³⁸ The Tribune (25 June 2019), 'Machhiwara police raid illegal drug de-addiction centre', <https://www.tribuneindia.com/news/archive/ludhiana/machhiwara-police-raid-illegal-drug-de-addiction-centre-792795>; Fatehgarh Sahib (28 September 2019), 'Illegal drug de-addiction centre raided, 28 inmates rescued', *India Today*, <https://www.indiatoday.in/crime/story/illegal-drug-de-addiction-centre-raided-28-inmates-rescued-1604075-2019-09-28>

³⁹ The Himalayan Times (8 December 2018), '13 patients escape, 21 rescued from rehab centre', <https://thehimalayantimes.com/kathmandu/13-patients-escape-21-rescued-from-rehab-centre/>. The same month, a similar operation was conducted in a female-only rehabilitation centre: The Himalayan Times (28 December 2018), '49 patients rescued from rehab centre', <https://thehimalayantimes.com/kathmandu/49-patients-rescued-from-rehab-centre/>

A 2016 study assessing human rights violations of people who inject drugs and live with HIV in Nepal found the majority of respondents had experienced inhuman and degrading treatment in ‘rehab’ centres owned by non-governmental organisations, including: forced detention, lack of adequate space and light, physical violence, humiliation, being forced to bathe in freezing water, excessive medication. The centres are often very costly, thus weighing on the – often fragile – finances of the family.⁴⁰

Services in detention settings in the context of migration (16)

Despite there being little research on it, drug use and mobility is a real phenomenon;⁴¹ people who use drugs are represented in every mobile group, including migrants, asylum seekers, displaced people, refugees and others vulnerable to being detained in the context of migration. It is also known that drug use continues in detention, including in the context of migration, and drug-related harms pose a serious risk. For example, drug use has been reported at immigration detention estates in England and Wales,⁴² and three drug-related deaths were registered between 2016 and 2017;⁴³ drug use has also been reported in reception centres in Italy.⁴⁴

People who use drugs detained in the context of migration experience multiple and overlapping forms of social exclusion and stigma: as people who use drugs, as foreigners, and as people in detention. Their needs and vulnerabilities are therefore particularly important to consider. Nevertheless, there is limited information made publicly available by governments on drug in detention centres in the context of migration, nor on the provision of harm reduction and other essential services in these settings.

The little information that is available on access to and quality of health care services available to people detained in the context of migration strongly suggests that harm reduction and other essential services for people who use drugs are rare or non-existent. Indeed, a scan of the Committee for the Prevention of Torture’s (CPT) reports following visits to these types of detention centres reveals that health care provision is generally restricted and poor.⁴⁵ Many facilities do not even keep personal medical files, or provide access to specialised healthcare staff. Psychosocial support is often not provided. If these basic and uncontroversial services are not being provided, even in countries like Norway,⁴⁶ it is difficult to imagine the provision of harm reduction and other essential services to meet the needs and respect the rights of people who use drugs being detained. The only mention of services for people who use drugs was at a Closed Removal Centre (CPR) in Italy, where personnel from the drug rehabilitation service are reported to visit regularly.⁴⁷ No further information, however, was provided, and ‘drug rehabilitation’, while an important option, remains different from harm reduction.

In an effort to address some of these challenges, in December 2019 the Pompidou Group, the Council of Europe’s drug policy experts, organised a Preparatory Working Group Meeting “Responding to Drug-Related Challenges for Refugees, Migrants & IDPs” in Strasbourg, where it was decided that a handbook for professionals, guidelines and policy paper would be developed by 2021. Hopefully these will shed more light on and draw more attention to the nature of the problem, the unique needs of the population and the availability and coverage of harm reduction and other essential services.

⁴⁰ Human Rights Count (2016), *Speaking Out: personal testimonies of rights violations experienced by people who use drugs in Nepal* (Global Network of People Living with HIV), https://www.gnpplus.net/assets/wbb_file_updown/5666/Human%20Rights%20Count_KPLHIV_Nepal.pdf

⁴¹ Correlation, *Drug Use and Mobility in Central Europe*. Available at: http://fileserv.idpc.net/library/CORR_RP_DrugsAndMobility_EN.pdf

⁴² Independent Monitoring Boards (2019), *IMB National Annual Report for the Immigration Detention Estate 2018*.

⁴³ HM Chief Inspector of Prisons for England and Wales (2018), *Annual Report 2017-2018*.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/761589/hmi-prisons-annual-report-2017-18-revised-web.pdf

⁴⁴ Ronconi and Vecchio, ed. (2019), *I Migranti e le Sostanze Psicoattive*, 48. Available at: <https://www.fuoriluogo.it/formazione/summer-school-2019/i-migranti-e-le-sostanze-psicoattive-la-documentazione-on-line/#.XoG6r4hKg2w>.

⁴⁵ See, for example, the following CPT report: 2017 report on Greece (<https://rm.coe.int/pdf/168074f85d>); 2019 report on Georgia (<https://rm.coe.int/1680945eca>); 2019 report on Germany (<https://rm.coe.int/0900001680945a2d>); 2018 report on Bulgaria (<https://rm.coe.int/09000016807c4b74>);

⁴⁶ European Committee for the Prevention of Torture (17 January 2019) *Report to the Norwegian Government on the visit to Norway carried out by the European Committee for the Prevention of Torture*, CPT/Inf (2019) 1. Available from: <https://rm.coe.int/1680909713>

⁴⁷ European Committee for the Prevention of Torture (10 April 2018), *Report to the Italian Government on the visit to Italy carried out by the European Committee for the Prevention of Torture*, CPT/Inf (2018) 13, para 52. Available from: <https://rm.coe.int/16807b6d56>