POLAND

Submission of the Polish Drug Policy Network, Political Critique, the Jump 93 Association, Student Drug Policy Initiative, the Social AIDS Committee and Harm Reduction International to the UN Human Rights Council

Thirteenth session of the UPR Working Group of the Human Rights Council
Human rights violations associated with Poland's anti-drug laws

Executive Summary

This report highlights the human rights situation in Poland pertaining to drug use and Polish drug policy. The organizations submitting this report have found that Poland's severe drug laws result in human rights infringements, namely to the right to health and privacy. The government's abstinence-based policies risk acting as a barrier to effective, life-saving harm reduction and treatment services.

This report is organized into four sections.

I. Overview of Polish drug laws
II. Treatment, Harm Reduction Services and Human Rights in Poland
III. Recommendations

Drug laws in Poland

Poland has some of the harshest drug laws in the European Union. Anyone found with drugs on their person may face up to three years imprisonment, even if it is a first time offense. Even when alternative sanctions are imposed – such as heavy fines or restriction of liberty – the offender still receives a criminal record, which can have potentially severe consequences to the individual's ability to secure employment.

Poland's drug laws have not always been as severe as they are today. The Act on Prevention of Drug Abuse, passed in 1985, did not penalize the possession of narcotic drugs.[1] In 1997, an amendment to the law was introduced which criminalised possession of large amounts of narcotics. But these punishments did not apply to people caught in possession of small quantities intended for personal use.[2] Each case was assessed in court and guided by individualised consideration of the defendant and the circumstances. In practice, the Police and the Prosecutor's Office avoided prosecuting consumers and people in possession of small quantities.

In 2000, possession of any amount of drugs, for any purpose, was criminalized throughout the country, pursuant to Article 62 of the Act on Counteracting Drug Addiction (ACDA). Under ACDA, police officials are mandated to carry out "stop and frisk" procedures, based on arbitrary indicators of drug possession.

Under the new law drug use levels have continued unaffected. The number of arrests, however, has sharply increased. In 2009, for example, almost 30,000 people were arrested for possessing a small amount of illicit drugs.[3] Drug possession cases have increased by 1,500% since the law was introduced. Polish prisons are overcrowded and at the same time not free of drugs. Approximately 80 mln PLN (around 40 mln USD) is spent yearly from the state budget for the fulfilment of Article 62.[4]

Treatment, Harm Reduction Services and Human Rights in Poland

Blood-borne viruses present are a constant threat. Approximately 50% of the total registered HIV cases in Poland are related to injecting drug use. The National AIDS Centre reports that approximately 12,068 people have tested positive for the virus since 1985 – 5,476 of which were injecting drug users.[5] Hepatitis C prevalence among injecting drug users are 55-68%.[6] Despite these figures, spending on harm reduction, including OST, is extremely low. In 2007, just 1.5 million euro was allocated for methadone. Only 66% of this was spent.[7] Prevention and early-intervention programmes are not as adequate as they should be, as only 70% of regular drug users are tested for infectious diseases.[8]

Poland was the first the first country in Eastern and Central Europe to introduce methadone maintenance programmes, established in 1992 in the Institute of Psychiatry and Neurology (Warsaw).[9] Significant progress has been made in Poland in the past few decades with respect to increased access to treatment and harm reduction services, however, there is much work that needs to be done and laws that must be changed. Access to methadone (an essential medicine according to WHO[10]) is still limited. Out of approximately 25,000 opiate-addicted people in the country, only around 1,500 (6%) receive treatment. The European average is 20%.[11]

Two of the core HIV-related harm reduction interventions are needle and syringe programmes and opioid substitution therapy (e.g. with methadone or buprenorphine).[12] The UN Commission on Narcotic Drugs in a 2010 resolution recognised these measures as essential in the HIV response[13]

Needle and syringe exchange programmes are also not meeting need and are actually in decline. In 2002 there were 21 programmes, in 2008 only 13. The reduction is due to a combination of factors. First, municipalities, which are gradually becoming the main financing institution of drug prevention and treatment, do not allocate sufficient funds for harm reduction programmes. Second, the National Health Fund does not provide funds directly for needle and syringe exchange programmes. Third, the opening of new methadone maintenance programmes has redirected some clients from the exchange programmes to OST treatment. Fourth, elimination of open drug scenes so-called "bajzel", such as in Poznań, Szczecin and Gdańsk, has dispersed drug-using populations.[14] There are no exchange programmes in prisons. Finally, in 2004, Open Society Institute and United Nations Development Program stopped funding harm reduction services in Poland. At the time, 12 programmes were supported by these sources.

Guidelines from the World Health Organization, UNAIDS and the United Nations Office on Drugs and Crime emphasise the importance of harm reduction within a comprehensive package for people who inject drugs.[15] The commitment of UN member states to key harm reduction interventions as HIV prevention measures is enshrined in political declarations on HIV/AIDS adopted by the General Assembly in 2001 and 2006,[16] as well as most recently in the Millennium Development Goals summit outcome document.[17] In late 2009, the General Assembly also adopted a Political Declaration on drug control which yet again reaffirmed the importance of measures to address injection driven HIV epidemics.[18]

Current and former UN Special Rapporteurs on the right to health have stated that harm reduction is essential in realising the right to the highest attainable standard of health for people who use drugs.[19] The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health recommended that states, 'Ensure that all harm-reduction measures (as itemized by UNAIDS) and drug-dependence treatment services, particularly opioid substitution therapy, are available to people who use drugs, in particular those among incarcerated populations.'[20] This has been recognised time and again by the UN Committee on Economic Social and Cultural Rights,[21] and the Human Rights Council, in 2009, has also recognised harm reduction as an essential element of the right to health in the context of HIV/AIDS.[22]

There are regions in Poland including the northern coastal region of Pomorze, where there are a substantial number of people dependent on opiates, but no OST is available. Those who need treatment have to travel long distances to receive their medicine. If any of these patients are imprisoned (usually related to drug possession and sometimes for possession of methadone), they are refused their treatment and left with substandard medical assistance.

A lack of accessible treatment for opiate dependence has many serious social and health consequences. Those refused OST in prisons, for example, often undergo withdrawal without appropriate medical assistance, causing considerable physical and mental distress. Furthermore, people leave prison at considerable risk of overdose. Every year, 250-300 people die from overdose.[23] Lack of OST while in prison can contribute to that risk.

Poland is a party to the International Covenant on Economic Social and Cultural Rights – and the right to health is recognized in articles 68 and 69 of the Constitution of Poland.[24] In its Concluding Observations on Poland in 2009, the Committee on Economic, Social and Cultural Rights wrote:

> 'The Committee is concerned at reports that only a small number of drug users have access to substitute drug dependence treatment, and that such treatment is even more limited for those in detention (art. 12). The Committee calls on the State party to take measures to ensure that effective treatment of drug dependence is made accessible to all, including to those in detention.'[25]

Moreover, the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment has also noted that, "[W]ithdrawal symptoms can cause severe pain and suffering if not alleviated by appropriate medical treatment" and that "denial of medical treatment and/or absence of access to medical care in custodial situations may

constitute cruel, inhuman or degrading treatment or punishment and is therefore prohibited under international human rights law."[26]

Similar concerns were raised with respect to Poland by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The CPT wrote:

> 'Practically no progress had been made as regards the care of inmates with drug-related problems, the services offered to them, or the development of a prevention policy. Methadone substitution programmes were not available in the establishments visited, with the exception of Poznań Prison Hospital where a few prisoners were being treated with methadone. Further, none of the establishments visited had in place harm-prevention measures (such as, for instance, the provision of bleach and information on how to sterilise needles, needle-exchange programmes or the supply of condoms).
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> 'The CPT wishes to stress that the management of drug-addicted prisoners must be varied –combining detoxification, psychological support, socio-educational programmes, rehabilitation and substitution programmes – and linked to a real prevention policy. It goes without saying that health-care staff must play a key role in drawing up, implementing and monitoring the programmes concerned and co-operate closely with the other (psycho-socio-educational) staff involved.
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> 'The CPT reiterates the recommendation made in its 2004 visit report that the Polish authorities develop and implement a comprehensive policy for the provision of care to prisoners with drug-related problems.'[27]

The Helsinki Foundation for Human Rights has expressed concerns about the use of degrading practices such as strip searches carried out during admission to a number of drug treatment facilities. It also noted clients' limitations to contact with family and others of significance to clients.

A system of punishment - so called "dociążenia" – was confusing and not always clearly defined. Data about patients who fail to complete therapy (ca. 70-75%), then return to the centres of addiction treatment (even 11-12 times) are very disturbing in terms of both efficacy and costs incurred by the National Health Fund. There is a lack of standards and permanent mechanisms of assessing effectiveness of addiction treatment, but also the effectiveness of individual centres. All in-patient treatment facilities use one methodology - therapeutic community supplemented by limited individual and group therapy. There is no evidence that those who stay in therapeutic communities for a duration of 1.5 years to 2 years and were involved in various types of physical labour at these centres succeed in living a drug-free life after release.

Furthermore, there is no cooperation and the flow of information about patients between ambulatory and stationary centres. The Helsinki Foundation for Human Rights recommends that there is a great need to assess the Polish model of drug treatment. Undoubtedly, the therapeutic range should be more diverse.[28]

All of these factors risk putting health services to drug users in conflict with the normative content of Article 12 of the Covenant, which requires that health facilities be available, accessible and acceptable.[29]

To address many of these issues, and to promote policies that protect the health and human rights of drug users and non-users alike, the government should consider reforming laws that prescribe strict criminal penalties against people in possession of small amounts of drugs. Such reforms would allow resources to be directed to proven-effective methods of treatment instead of incarceration.[30] UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health wrote:

> 'National criminal laws need to complement harm reduction strategies and programmes. In this regard, criminal laws should not impede, but facilitate measures taken by States to reduce the transmission of HIV and to provide HIV-related care and treatment for people using drugs.' [31]

To this end the UN Special Rapporteur urged Poland in 2010 to:

> "Amend the National Law on Counteracting Drug Addiction to avoid penalization of the possession of minute quantities of drugs, in order to foster access to substitution therapy for people using drugs."[32]

Recommendations

- The government should scale up harm reduction services, including to people in detention, as a means of fulfilling its obligation under Article 12 of the Covenant on Economic Social and Cultural Rights – in particular to ensure that health facilities for people who use drugs are available, accessible and acceptable.

- The government should consider amending the National Law on Counteracting Drug Addiction to avoid penalization of the possession of minute quantities of drugs, in order to foster access to substitution therapy for people using drugs.

Notes

[1] E KuŸmicz, Z Mielecka-Kubieñ, J Stasiowski, D Wiszejko-Wierzbicka, The Institute of Public Affairs, 'Penalisation of drug possession – institutional action and costs', 11 Analysis and Opinions 104 [available at: http://www.idpc.net/sites/default/files/library/IPA%27s%20research%20in%20Analysis%20and%20Opinions.pdf]. Though the paper makes clear that the law did include penalties for acts associated with trafficking in drugs.
[2] ibid. The authors refer to Article 48 paragraph 4 of the 1997 law with respect to penalties pertaining to personal use.
[3] K. Krajewski, *Cases of drug possession in the practice of courts in Krakow*, Jagiellonian University, Kraków 2008
[4]Evaluation of the Act of 29 July 2005 on Counteracting Drug Addiction, The Institute of Public Affairs, 2009

[5]*Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*. UN Human Rights Council, 20 May 2010.
[6] International Harm Reduction Association, Global State of Harm Reduction 2008
[7]Fifth periodic report of Poland to the UN Committee on Economic Social and Cultural Rights Briefing by the Open Society Institute Global Drug Policy Program and the International Harm Reduction Association, 2009
[8]*Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*. UN Human Rights Council, 20 May 2010.
[9] H. BaranFurga, K.Chmielewska, *Methadone therapy*, Alcoholism and Drug Dependence, 1(15), 25-45, 1994
[10]"Who Model List of Essential Medicines." World Health Organization, Mar. 2011.
[11]Fifth periodic report of Poland to the UN Committee on Economic Social and Cultural Rights Briefing by the Open Society Institute Global Drug Policy Program and the International Harm Reduction Association, 2009
[12] http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/InjectDrugUsers/default.asp.
[13] Commission on Narcotic Drugs, Resolution 53/9, Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV
[14]Malczewski A., *Needle and syringe exchange programs in Poland and Europe*, National Bureau for Drug Prevention, Information Service Bulletin ADDICTION, nr 2(46)/2009
[15] WHO, UNAIDS & UNODC (2009) Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. World Health Organization, Geneva.
[16] See GA Special Session on AIDS Res S-26/2, adopting the Declaration of Commitment on HIV/AIDS (2001) A/RES/S-26/2 Para. 52, and GA Res 60/262, Political Declaration on HIV/AIDS, A/RES/60/262 (2006) Para. 22
[17] United Nations Development Programme, 2010 MDG Summit Outcome, A/65/L.1 (17 September 2010)
[18] UNGA res 64/182, 30 March 2010.
[19] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the General Assembly (main focus: the right to health and international drug control, compulsory treatment for drug dependence and access to controlled medicines), UN doc. A/65/255; Foreword, "Harm Reduction and Human Rights: The Global Response to Drug Related HIV Epidemics," http://www.ihra.net/GlobalResponse.
[20] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report to the General Assembly (main focus: the right to health and international drug control, compulsory treatment for drug dependence and access to controlled medicines), UN doc. A/65/255, para. 76.
[21] See for example, UN Doc No A/HRC/RES/12/27 (para 5)
[22] Human Rights Council resolution 27/12, " The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS),"
[23] Ibid
[24] UN Treaty Series [available at: http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en] Date of last access: 18 October 2011
[25] Concluding observations of the Committee on Economic, Social and Cultural Rights, Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant, Poland, E/C.12/POL/CO/5, para. 26
[26] UN Human Rights Council, Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak, 14 January 2009, A/HRC/10/44,
paras. 57, 71.
[27] Report to the Polish Government on the visit to Poland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 26 November to 8 December 2009, CPT/Inf (2011) 20, para. 125
[28] *Monitoring of respecting patients rights and access to the stationary treatment of addiction*, Helsinki Foundation for Human Rights, 2010
[29] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, para. 12
[30] Recently, an expert group commissioned by the Ministry of Justice and chaired by Professor Krzysztof Krajewski of the Jagiellonian University in Kraków, introduced a project to amend the bill, which would bring a small, yet crucial change to the Polish antidrug law: it would give prosecutors the option to drop legal proceedings if the social harm caused by the offense is minimal.

Though this is a miniscule change, seeing as prosecutors still have the option of penalizing minor drug offenses, it is a sign that people in Poland are beginning to realize the harmful consequences of current drug policies. We insist on further reforms so that Poland, a country of people equal in rights and obligations towards the common good, may have drug policies that advance the best interests of all.

[31]*Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*. UN Human Rights Council, 20 May 2010., para. 60

[32]*Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover*. UN Human Rights Council, 20 May 2010.