HUMAN RIGHTS WATCH

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Rehabilitation Required

Russia's Human Rights Obligation to Provide Evidence-based Drug Dependence Treatment

I. Summary

> I'm not going back there. There's no point, they don't cure you. I would go to the detoxification clinic if they actually helped [me] there. I'm sick and tired of injecting. But I can't do it [withdraw] at home… I would like to live to 30 at least...[1]
> —Svetlana S., 25 years old

Illicit drug use is a serious problem in Russia today, with estimates of the numbers of users ranging between 3 and 6 million people.[2] Many of these people—though by no means all—have developed drug dependence, a serious chronic, and often relapsing, disease as a result of prolonged drug use.[3] As is the case with people affected by other diseases, persons dependent on drugs have a right to medical care for their condition, both under Russian and international law. Indeed, Russia has an extensive system of state substance abuse clinics that offer services for alcohol and drug dependence and has, in the past few years, invested considerable funds into the development of rehabilitation centers for people dependent on drugs.

Yet, despite the recognition by the Russian government of the importance of drug dependence treatment, research by Human Rights Watch in Russia, including detailed field studies in Kazan (Republic of Tatarstan), Kaliningrad, and Penza, shows that the vast majority of individuals addicted to drugs in Russia do not have access to evidence-based medical care to treat their dependence. Russia has made policy decisions relating to the provision of medical treatment for drug dependents that are inconsistent with and in violation of its obligation to provide, within available resources, health care that meets the criteria of available, accessible, and appropriate. While detoxification treatment is widely available throughout Russia, rehabilitation treatment remains unavailable in many parts of the country. Private drug dependence clinics, some of which offer evidence-based rehabilitation

[1] Human Rights Watch interview with Svetlana S., Kazan, January 25, 2007.

[2] These figures are estimates of the total number of people in Russia who use illicit drugs, including both regular and occasional users, and cover all types of illicit drugs. Russia's total population is about 143 million.

[3] While Human Rights Watch is aware that there is some debate among experts about how to characterize drug dependence, we follow the American Medical Association and the US National Institute on Drug Abuse in using the term "disease."

treatment, are often unaffordable for drug users. Various obstacles keep drug users away from seeking treatment at state clinics, including the risk of restrictions on civil rights by being registered as a drug user, breaches of confidentiality associated with treatment, and a widespread distrust of drug treatment services that also undermines take-up rates. The treatment offered at detoxification clinics does not follow lessons learned from decades of research on effective drug dependence treatment modalities. On the contrary, policy decisions relating to what drug treatment programs can be offered deliberately ignore the best available medical evidence and recommendations, and as such arbitrarily restrict drug users' access to appropriate health care.

Despite these important failings of the drug dependence treatment system in Russia, healthcare institutions, policy makers, and the Russian public routinely blame drug users for the failure to overcome their drug dependence. In its research, Human Rights Watch was repeatedly told that drug users simply lack the motivation, character, or perseverance to stop using drugs. Various officials are currently advocating new laws and policies that would enable the state to force drug users to undergo treatment. Undoubtedly, some drug users do not want to end their drug habit. But various studies show that almost all drug users in Russia who have used drugs for more than one year have made multiple attempts to stop using, either at healthcare facilities or on their own. Every single one of the around 60 drug users Human Rights Watch interviewed for this report had made at least one attempt to stop, and many had made multiple attempts.

Studies repeatedly demonstrate, however, that, no matter how strong a drug-dependent person's motivation to address his or her drug use, the odds are that he or she will not succeed without access to an evidence-based drug dependence treatment program. Drug dependence is a chronic disease that often relapses, even for drug users who participate in proven treatment programs and are committed to their treatment. For many people affected by the disease, there are biological and psychological reasons why will power does not suffice to overcome the disease—just as people who suffer from depression cannot overcome their condition on will power alone but need medications, therapy, or a combination of the two.

A considerable part of the blame for the drug dependence treatment gap thus lies with the Russian government and Russia's healthcare system, which leave most drug users who wish to stop using drugs or to gain control over their addiction to their own devices in the face of a serious chronic disease. As a result, many drug users who might otherwise have successfully entered into treatment programs are condemned to a life of continued drug use with its increased risk of HIV infection, other drug-related health conditions, and death by overdose. But Russian society also pays a price for the state's failure to provide easily accessible and evidence-based drug dependence treatment services. In other countries, evidence-based treatment of drug users has been shown to lead to considerable savings on drug-use-related law enforcement efforts, incarcerations of drug users, and healthcare costs due to HIV, hepatitis C and other drug-related health conditions.

The right to health, which Russia has explicitly recognized in its constitution and by becoming party to various international human rights conventions, requires states to make healthcare services **available** for people affected by disease, including by drug dependence. These services must be **accessible**—without discrimination—for people who need them, and have to be **culturally and ethically acceptable**, **scientifically and medically appropriate**, and of **good quality**. Although the right to health, in recognition of the great variation in resource availability in different countries, is not prescriptive about a specific standard of care that has to be provided, states are obliged to work toward full realization of the right and to progressively improve the care offered. A rights-based health policy also requires states to ensure that policy decisions and choices are objective and evidence-based, directed towards maximizing the right to health of individuals, and not made on criteria that are discriminatory, arbitrary, or have an unjustifiably restrictive or negative impact on the enjoyment of the right to health, in comparison to other available policy options.

Availability of drug dependence treatment is mixed in Russia. While there are narcological clinics in all major towns of Russia, most of these clinics offer only detoxification, which, on its own, does little to help a drug user achieve a lasting remission.[4] State-run rehabilitation or relapse prevention centers, which provide the

[4] See, for example, Russian Ministry of Health Treatment Protocol for rehabilitation of persons dependent on drugs of 2003 (on file with Human Rights Watch); and US National Institute for Drug Abuse (NIDA), "Principles of Drug Addiction Treatment: A

crucial second phase of drug dependence treatment by helping drug users manage psychological craving for drugs, exist in only 26 of Russia's 85 regions. In some regions commercial or faith-based rehabilitation centers exist, but treatment at the former is often too expensive for drug users while many drug users do not feel comfortable using the latter.

One of the most effective and best researched drug dependence treatment modalities for opiate dependence known today, methadone or buprenorphine maintenance treatment, is altogether unavailable in Russia. Although dozens of countries have successfully used these medications in the treatment of drug-dependent persons for several decades and the World Health Organization and the United Nations Office on Drugs and Crime have strongly endorsed them, their use is explicitly prohibited by law in Russia. Top officials in Russia, including in the healthcare sector, oppose their use on the mostly ideological ground that it substitutes one drug for another. The policy decision not to make methadone and buprenorphine available for the treatment of drug-dependent persons, based on factors that ignore medical evidence, can only be described as arbitrary and unreasonable, and as such is a failure of Russia's obligation to fulfill the right to health.

Accessibility of treatment, the second requirement under the right to health, is highly problematic in Russia. Whereas research indicates that drug treatment services should be easily accessible so as to ensure that as many drug users make use of them as possible,[5] in Russia numerous barriers exist that keep drug users away from these services. Most drug users distrust state narcological clinics; they do not believe that the treatment offered is effective, and see the clinic staff as corrupt and uninterested in their recovery. State narcological clinics in the regions we visited have done little to counter this distrust. A central, and easily remedied, obstacle to treatment seeking is the fact that clinics in all three regions tell drug-dependent persons who voluntarily seek help—behavior that states should clearly encourage—that unless they pay for their own treatment, their names will be entered into a

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Research-Based Guide," NIH Publication No. 99-4180, October 1999, http://www.nida.nih.gov/PODAT/PODATindex.html (accessed August 27, 2007), principle 9.

[5] See for example NIDA, "Principles of Drug Addiction Treatment," principle 2.

database of people considered to be drug dependent—under Russian law, all drug users who seek free treatment at state narcological clinics are placed on this state drug user registry—and that consequently certain restrictions will be imposed on their rights. Other factors that keep drug users away from state narcological clinics are the cost of paid treatment, including out-of-pocket charges for medications patients are supposed to receive for free, the requirement to collect paperwork on various health conditions prior to admission, and poor conditions in the clinics. Most drug users therefore do not believe that the treatment offered is effective, and they see the clinic staff as corrupt and uninterested in their recovery. State narcological clinics in the regions we visited have done little to counter this distrust.

Russia also fails to meet the requirement that treatment services offered be **"scientifically and medically appropriate, and of good quality."** Decades of research into drug dependence treatment have created a vast body of evidence on the effectiveness of various treatment approaches. These findings have been summarized, among others, in the United Nations Office on Drugs and Crime's "Drug Dependence Treatment Toolkit." Yet, Russia has made little effort to incorporate lessons learned into its drug dependence treatment services.

Research findings, for example, underscore the fundamental importance of beginning psychosocial interventions with patients during the detoxification stage to motivate them to stay in treatment after detoxification is over.[6] However, we found that this hardly happens in Russia's drug dependence clinics. First of all, patients are generally heavily medicated with tranquillizers and antipsychotic medications, even if research shows that this is not necessary for most patients.[7] As a result, patients are often in a reduced state of consciousness, making counseling efforts difficult or even pointless. Secondly, we found that only very limited counseling took place. Most drug users said that a psychologist or peer counselor from a rehabilitation center had talked to them about the possibility of continuing treatment but that that was the extent of psychosocial interventions. Various drug users mentioned extreme

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

[7] Ibid., p. 74.

boredom while in the detoxification clinic. Patients are also generally not counseled on HIV while in the detoxification clinics, although best practice standards for drug dependence treatment recommend that such counseling take place.[8] Research also demonstrates the high effectiveness of methadone and buprenorphine maintenance programs, which, as mentioned above, are prohibited in Russia.

There is ample evidence that the state drug dependence treatment system in Russia is largely ineffective. In a 2006 survey of almost 1,000 injection drug users in 10 Russian regions conducted by the Penza Anti-AIDS Foundation, 59 percent of drug users who had made use of the state treatment system had gone back to using drugs within a month of finishing their treatment course; more than 90 percent had relapsed within a year. Various other studies also found that less than 10 percent of patients of state narcological clinics remain in remission a year after their treatment.[9] Indeed, Human Rights Watch interviewed drug users in each of the regions visited for this report who told us that they had gone back to using drugs within days of their release from the detoxification clinic. Using other measures of treatment effectiveness, such as the treatment system's ability to recruit patients and retain them for a length of time adequate for appropriate treatment, the Russian system fares equally poorly.

Some narcological clinics in Russia also appear to routinely violate the privacy rights of those who try to access them. Governments and their agents are required to observe confidentiality of medical information. It appears, however, that some state narcological clinics in Russia share information on patients who are on the state drug user registry with law enforcement and other government agencies. The Penza Anti-AIDS Foundation survey found that respondents in many of the 10 regions surveyed believed that narcological clinics had shared information on them with others, mostly law enforcement agencies.[10] The routine sharing of medical information of drug users violates the acceptability component of the right to health, and the right to privacy protected under the European Convention on Human Rights, to which Russia is a party.

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[8] Ibid., p. 23.

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

[10] Ibid.

Human Rights Watch also found that Russia imposes unnecessary restrictions on the rights of people on the drug user registry, such as the right to obtain a driver's license or hold certain jobs, and thereby violates the principle of non-discrimination. While the rationale behind these restrictions—public safety—may in principle appear to be legitimate, the restrictions are imposed selectively only on those drug users who have to avail of free treatment at state clinics because they cannot afford to pay for treatment services. Whether a patient can pay for services is not a legitimate criterion on which to determine that private information about them should be retained on a registry and be used to restrict certain civil rights. Furthermore, the restrictions are disproportionate as they are imposed for a five-year period without any assessment whether there is a need to impose them on the individual in question or any periodic review to determine whether that need continues to exist.

The close links between injection drug use and HIV infection add extra urgency to the need for effective drug dependence treatment. Injection drug users make up an estimated 65 to 80 percent of all persons living with HIV in Russia and around 10 percent of injection drug users in Russia are HIV-positive. Effective drug dependence treatment has been shown to help reduce HIV infections as patients may either stop using drugs altogether or may adopt less risky injection behavior. Today, as Russia is rapidly expanding access to antiretroviral (ARV) treatment for people living with HIV, effective drug treatment programs, including methadone maintenance therapy and drug-free programs, could play an important role in aiding drug users in accessing and adhering to ARV treatment. If Russia does not take steps to address the problems of its drug dependence treatment system, it runs the risk of continued and increasing spread of HIV, and even drug resistant HIV strains, due to lack of access by drug users to ARV and their suboptimal adherence due to poor quality drug dependence treatment programs.

Russia needs to take urgent steps to address the various failings identified in this report, and reform its drug dependence treatment system in accordance with the findings of scientific evidence. Human Rights Watch makes the following key recommendations (detailed recommendations are set out in Chapter V):

Key Recommendations to the Government of Russia

- Immediately lift the ban on the medical use of methadone and buprenorphine in the treatment of drug dependence and introduce maintenance therapy programs.
- Integrate evidence-based drug treatment policies into the drug treatment system.
- Adopt and fund a federal plan aimed at increasing the availability of rehabilitation treatment by opening new rehabilitation programs and centers in regions that do not currently have any. This plan should have a clear timeline and benchmarks for implementation, and should prioritize regions and towns on the basis of need.
- Take steps to ensure drug users can enter treatment without delay. This should include measures to remove arbitrary requirements to present certificates on various health conditions upon admission, and steps to minimize, to the extent possible, waiting lists for admission.
- Provide adequate funding to narcological clinics and cease out-of-pocket charges for medications that should be provided free of charge.
- Reform the detoxification treatment protocol to end overmedication of patients and introduce clear guidance on psychosocial interventions aimed at patient retention.
- Take steps to ensure all patients in detoxification receive proper counseling on HIV and other diseases that are prevalent among drug users.
- Take active steps to counter distrust toward state narcological clinics among drug users. These should include the adoption of a patient bill of rights, clear guidelines on treatment options and costs, and steps to root out corrupt practices by clinic doctors.
- Reform the drug user registry to remove blanket restrictions on rights of people on the registry.
- Take steps to ensure respect for confidentiality of medical information.

Methods

This report is based on information collected during several field visits to Russia between January and April 2007. Over the course of a total of four weeks in the field, a Human Rights Watch researcher and a consultant conducted detailed interviews with about 60 injection drug users, at least a dozen of whom were living with HIV/AIDS. Almost all were between 20 and 40 years of age, and a quarter were women. These interviews took place in Kazan (Republic of Tatarstan), Kaliningrad, Penza, and Kuznetsk (Penza province). In July 2007 the consultant conducted a number of interviews with drug users in St. Petersburg. These cities were chosen because they all have a serious illicit drug use problem but have varying levels of HIV prevalence among drug users and of harm reduction services availability.

Interviews were conducted in private, were semi-structured and covered a number of topics related to illicit drug use, drug dependence treatment experiences, and care and treatment for HIV (where relevant). Interviews were conducted predominantly in nongovernmental organization (NGO) and government offices, at harm reduction worksites, and at hospitals. Interviewees were identified largely with the assistance of Russian NGOs providing services to injecting drug users and people living with HIV/AIDS. Some were specifically asked by NGOs to speak to the researchers while others happened to visit the site where the researchers were at work. These interviewees may therefore have had greater access to drug dependence treatment, harm reduction, and HIV/AIDS services than the general population of injecting drug users. The identity of these interviewees has been disguised with pseudonyms, and in some cases certain other identifying information has been withheld, to protect their privacy and safety. Before the interview, interviewees were told of the purpose of the interview, informed what kinds of issues would be covered, and asked if they wanted to proceed. No incentives were offered or provided to persons interviewed.

The Human Rights Watch researcher is a fluent Russian speaker with years of experience working in Russia. The consultant is an HIV treatment peer counselor in St. Petersburg and a native Russian speaker.

Human Rights Watch also interviewed Russia's chief narcologist, and the chief narcologists for the Republic of Tatarstan and Kaliningrad region; the chief

narcologist in Penza declined to meet with Human Rights Watch. In Kuznetsk, Human Rights Watch interviewed the head doctor and the psychologist of the local narcological clinic. Human Rights Watch also interviewed doctors at the AIDS centers and representatives of NGOs in each of the cities visited. We also interviewed more than a dozen representatives of NGOs in Moscow and other cities in Russia, as well as several international experts, about Russia's drug dependence treatment system. We also conducted extensive literature study on the topic of drug dependence treatment, and consulted with various international experts on it.

All documents cited in the report are either publicly available or on file with Human Rights Watch.

II. Background

Illicit Drug Use and Drug Policy in Russia

Illicit drugs, which had been fairly rare in the Soviet Union, made a decisive entry onto the Russian scene in the 1990s. At a time of opening international borders and widespread social upheaval caused by political and economic transformation, rapidly increasing numbers of people, mostly young, began using drugs. Today, estimates for the number of drug users range from 3 to 6 million people,[11] in Russia's total population of about 143 million. In 2004 the head of the Federal Narcotics Control Service (FNCS) stated that between 4 and 5 million people regularly use drugs.[12] A 2003 country profile by the United Nations Office for Drugs and Crime (UNODC) estimated that about 2.4 percent of the total adult population uses drugs.[13]

The vast majority of drug users in Russia use drugs intravenously.[14] Most people use heroin, although *khanka,* an opiate produced from poppy straw, and *vint*, a home-made amphetamine, are also used.[15] According to the International Narcotics Control Board (INCB), Russia is becoming the largest heroin market in Europe—the INCB estimated the number of heroin users at close to one million people in 2004—with that number continuing to increase.[16] Although the number of drug users appears to have stabilized somewhat in recent years, Russia's National Research Institute for Substance Abuse reported a considerable increase (16.3 percent) in the number of

[11] United Nations Office on Drugs and Crime (UNODC), "Illicit Drug Trends in the Russian Federation 2005," 2006, www.unodc.org/pdf/russia/Publications/drug%20trends%202005_eng.pdf (accessed August 28, 2007), p. 11.

[12] US Bureau for International Narcotics and Law Enforcement Affairs, "International Narcotics Control Strategy Report 2006," March 2006, http://www.state.gov/p/inl/rls/nrcrpt/2006/ (accessed August 28, 2007).

[13] UNODC, "Russian Federation: Country profile," 2003, as cited in Natalie Bobrova, Tim Rhodes, Robert Power, Ron Alcorn, Elena Neifeld, Nikolai Krasiukov, Natalia Latyshevskaya, and Svetlana Maksimova, "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities." *Drug and Alcohol Dependence,* 82 Supplement 1 (2006), S57-63.

[14] UNODC, "Illicit Drug Trends in the Russian Federation 2005," p. 11.

[15] Eighty-five percent of the 343,500 drug-dependent people registered with Russia's alcohol and drug treatment services in 2005 were addicted to heroin. Nikolai Ivanets, "Drug Addiction Today, Prevention, Treatment, Rehabilitation" (powerpoint presentation), undated. A copy of the presentation was provided to Human Rights Watch on March 7, 2007, by Mr. Ivanets.

[16] International Narcotics Control Board (INCB), "Annual Report 2004," E/INCB/2004/1, http://www.incb.org/incb/annual_report_2004.html (accessed August 28, 2007), p. 72.

people newly diagnosed with drug dependence in 2005, for the first time in five years.[17]

The drug use explosion of the late 1990s was accompanied by a rapid increase in the number of HIV infections. Due to poor knowledge of HIV and the frequent joint use of injecting equipment, HIV spread rapidly. In the years between 1995 and 2001 the rate of new infection doubled every six to twelve months.[18] By mid-2006 almost one million people were believed to be HIV-positive, the vast majority of them infected through drug use.[19] Rates of HIV infection among drug users vary considerably across Russia. According to National Research Institute for Substance Abuse studies, 9.3 percent of injection drug users who are registered with state narcological clinics were HIV-positive in 2005.[20] In some Russian cities studies have found considerably higher prevalence rates. For example, UNAIDS cites studies that found that 30 percent of injection drug users in St. Petersburg were HIV-positive and 12 to 15 percent in Cherepovets and Veliky Novgorod.[21]

In response to the illicit drug use problem, Russian policy makers and law enforcement agencies have enacted various measures aimed at interrupting drug trafficking, bringing drug traffickers and dealers to justice, incarcerating drug users, and preventing the onset of drug use. Although a concept for illicit drug policies adopted in 1993 by the Supreme Soviet, the parliament at that time, had called for an approach that carefully balanced law enforcement action with public health and prevention measures, the policies that were enacted have often strongly emphasized law enforcement,[22] at the expense of public health responses.

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[17] E.A. Koshkina and V.V. Kirzhanova, "Specifics of the spread of substance abuse disorders in the Russian Federation in 2005" ("Osobennosti rasprostranennosti narkologicheskikh rasstroistv v Rossiiskoi Federatsii v 2005 g."), *Psykhiatria i psykhofarmokoterapia* (Psychiatry and psychopharmacotherapy), vol. 9/N1/2007, http://www.consilium-medicum.com/media/psycho/07_01/18.shtml (accessed July 9, 2007).

[18] United Nations Development Programme (UNDP), "Reversing the Epidemic: Facts and Policy Options (HIV/AIDS in Eastern Europe and the Commonwealth of Independent States)," ISBN 92-1-126162-7, February 17, 2004, http://rbec.undp.org/hiv/?english (accessed October 1, 2007).

[19] United Nations Joint Programme on HIV/AIDS (UNAIDS), "AIDS Epidemic Update: Eastern Europe and Central Asia," Geneva, 2006, www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/Epi05_07_en.pdf (accessed October 1, 2007), p. 39.

[20] Ivanets, "Drug Addiction Today, Prevention, Treatment, Rehabilitation."

[21] UNAIDS, "AIDS Epidemic Update: Eastern Europe and Central Asia," p. 35.

[22] Concept of state policy on the control of narcotics in the Russian Federation, as adopted by ruling No. 5494-1 of the Supreme Soviet of the Russian Federation of July 22, 1993.

Up until 2004, the criminalization of possession of very small amounts of drugs led to widespread preying by police on drug users rather than on dealers, driving drug users underground and away from healthcare services. Law enforcement agencies' efforts to counter "incitement of drug use"—a criminal offense under Russian law—has interfered with attempts to introduce harm reduction and needle exchange programs aimed at educating drug users on HIV, hepatitis, and other health risks related to drug use and helping them protect their health.

Over-incarceration of Drug Users

From 1996 to 2004, possession of very small amounts of heroin—as little as 0.005 gram (about one hundredth of an average daily dose)—was a criminal offense punishable by imprisonment for five to seven years.[23] Absurdly, a drug-dependent person apprehended at the time in possession of one dose of heroin and a drug dealer caught with 100 kilograms could both be charged under the provision of the criminal code for "possession of especially large amounts" of illicit drugs. During this period, many drug users were prosecuted for possession of small amounts of drugs that were meant for personal use. Many ended up going to jail for lengthy prison terms. In its 2004 book on illicit drug policies and the global HIV epidemic, the International Harm Reduction Development Program of the Open Society Institute concluded,

> There were 100,000 drug-related convictions in Russia in the first year following passage of harsher penalties for drug possession, and the number of those imprisoned for drugs increased five-fold between 1997 and 2000. Even after amnesties and sharp restriction of pretrial detention, as many as 850,000 remain imprisoned in Russia, with as many as 20 percent—and 40 percent of women prisoners—detained on drug charges.[24]

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[23] Daniel Wolfe and Kasia Malinowska-Sempruch, Open Society Institute, "Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches," 2004, http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/cnd_20040316 (accessed October 1, 2007), p. 39.

[24] Ibid., p. 46.

The widespread practice of targeting drug users for possession of small amounts of drugs has been harmful to public health efforts. As Human Rights Watch concluded in a 2004 study on HIV in Russia, the practice had created "a climate of fear for drug users":

> …numerous drug users told Human Rights Watch that police patrol drug stores, especially at night, and target those who purchase syringes for harassment or detainment. Fear of encountering police around syringe exchange points similarly deters some drug users from utilizing these services. Drug injectors are detained because of possession of syringes, which is not illegal in Russia. Drug users in Saint Petersburg recounted stories of having been forced by police on the street to show their arms and if they have needle marks to be subjected to extortion and threats of detention or to having narcotics planted on them. For police, drug users represent an easy and welcome target for filling arrest quotas and extortion of money—and society is unlikely to raise a voice objecting to these abuses.[25]

In recent years there have been some attempts to move away from pursuing drug users. In May 2004 the Russian government decriminalized possession of small amount of drugs; for example, possession of a gram of heroin or less became a misdemeanor rather than a criminal offense. This resulted in some 40,000 drug users being released from prison or having their sentences reduced.[26] Lev Levinson of the Institute for Human Rights and the Public Expertise Institute estimates that in 2004 and 2005 at least 60,000 drug users were spared criminal prosecution and possible prison time due to these changes.[27]

In February 2006 the Russian government partially reversed the reforms of May 2004. Possession of more than one-half of a gram of heroin is now considered a criminal

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[25] Human Rights Watch, *Lessons Not Learned: Human Rights Abuses and HIV/AIDS in the Russian Federation*, vol. 16, no. 5 (D), April 2004, http://hrw.org/reports/2004/russia0404/.

[26] Lev Levinson, "Half a gram and thousands of lives," *Russian Harm Reduction Network Newsletter 2006-2007*, http://www.harmreduction.ru/files/harm_reduction_russia_2006-2007_eng.pdf (accessed June 27, 2007), pp. 9-11.

[27] Ibid.

offense. According to Levinson, the number of criminal prosecutions for possession of illicit drugs has risen sharply since February 2006, with 30,000 more people facing prosecution for the crime in 2006 than in 2005.[28]

Harm Reduction Programs

Despite their proven effectiveness at slowing the spread of HIV, and their other health benefits to drug users, harm reduction programs—and needle exchange in particular—continue to be controversial in Russia. Their exact legal position will remain unclear until a joint position of the Ministry of Health and Social Development and the FNCS, which has been in the making for years, is adopted. The lack of a clear official position in support of harm reduction programs leads to continuous insecurity for those programs that exist, and widely varying views on harm reduction programs by regional administrations, some of which refuse to allow them to work on their territory.

When harm reduction programs were first introduced in Russia in the mid-1990s, law enforcement agencies generally regarded them with suspicion. As Lev Levinson points out in an article about the legal status of harm reduction programs, law enforcement agencies regularly expressed the opinion that syringes "ought to be confiscated rather than distributed since they represent paraphernalia for illegal activity" and that "an invitation to use sterile syringes may be considered an act of encouraging someone to use drugs or promoting drugs," which constitutes a criminal offense under article 230 of the Russian criminal code.[29]

In 2003 the Russian State Duma (parliament) adopted a series of amendments to the Russian criminal code that included an annotation to article 230 that specified that "promotion of the use of relevant tools and equipment necessary for the use of narcotic and psychoactive substances, aimed at prevention of HIV infection and

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[28] Human Rights Watch telephone interview with Lev Levinson, Moscow, July 9, 2007.

[29] Article 230 of the Russian Criminal Code (Criminal Code of the Russian Federation, June 13, 1996, as amended on December 28, 2004, Chapter 25, Crimes Against Health of the Populace and Social Morality) prohibits the incitement of drug use. Lev Levinson, "How to Properly Exchange Needles: The story of how not to develop a methodological guideline," http://www.harmreduction.ru/files/harm_reduction_russia_2006-2007_eng.pdf (accessed June 22, 2007), pp. 12-13.

other dangerous diseases" did not violate the article provided that it is implemented with the consent of relevant health and law enforcement authorities.[30]

The government requested the Ministry of Health and Social Development and the Federal Narcotics Control Service to develop regulations for harm reduction programs. Initially it appeared that the authorities would adopt these regulations swiftly. In 2004 the Ministry of Health and Social Development developed a draft with input from the FNCS and various nongovernmental organizations. However, the FNCS then stalled on approving the draft and, in late 2006, produced its own draft, which, if adopted, would effectively make it impossible to operate needle exchange programs.[31] At this writing, the government had not approved either draft.

Due to this official wrangling over harm reduction programs, considerable discrepancies in policies toward harm reduction services across Russia persist. In some regions, harm reduction programs cannot operate syringe exchange points at all as local authorities and the narcotics control services oppose them, while in others local authorities actively support them. The discrepancies were clear in the cities visited for research for this report. While Kazan has a strong needle exchange program that enjoys support of the local authorities, Kaliningrad has no harm reduction program at all. A spokesperson for the narcotics control service in Kaliningrad left no doubt in a meeting with Human Rights Watch that his agency would not tolerate any attempt to operate a needle exchange program in the city.[32] In Penza, the operation of the local harm reduction program was disrupted in 2006 because local authorities, apparently under pressure of the narcotics control service, were unwilling to provide it with office space.[33]

The shifting position of narcotics control services on needle exchange programs in several of the regions participating in the Globus project also illustrates the

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[30] Federal Law no. 162, About amendments and additions to the Criminal Code of the Russian Federation, December 2003.

[31] Some of the major problems of the draft include: a ban on mobile needle exchange points; a provision that all needle exchange programs must operate out of state or municipal medical facilities; highly burdensome and expensive procedures for disposing of used needles; and a requirement to use syringes that have been shown to be ineffective in needle exchange programs.

[32] Human Rights Watch interview with Mikhail Nechushkin, Kaliningrad, January 29, 2007.

[33] Human Rights Watch interview with Sergei Oleinik, Penza, April 11, 2007.

insecurity that harm reduction programs in Russia face. The Global Fund to Fight HIV, Tuberculosis and Malaria awarded a large grant to a coalition of nongovernmental organizations, led by the Open Health Institute, to implement a project—the Globus project—on HIV prevention, care, and treatment between 2004 and 2009. As a condition for participation in the project, regional narcotics control services in the 10 regions had to provide support letters for harm reduction programs, including needle exchange. In several of the regions that participate in the project, narcotic drug control services have since withdrawn their letters of support, apparently under pressure of the FNCS.[34] Although the withdrawal of these letters has not had an impact on the operation of the harm reduction programs in those regions, it did sent a clear signal of ambivalence.[35]

Despite such official ambivalence, about 60 harm reduction programs were active in Russia at this writing. In 2006 the Global Fund awarded a €10.1 million (approximately US$13 million) grant to the Russian Harm Reduction Network to support and expand harm reduction services in 33 cities in Russia. Two other Global Fund grants, one to the Globus project and one to the Russian Health Care Foundation, also support harm reduction programs. In 2006 the Russian federal government also funded some harm reduction programs through the national health project.

Russia's Drug Dependence Treatment System

Russia has a predominantly state-run drug dependence treatment system that has traditionally been highly centralized. As a result, the basic drug dependence healthcare infrastructure and treatment approach a drug user encounters when he or she seeks treatment today look very much the same whether the user is in Kazan, Kaliningrad, or Penza. The basic elements of this system go back to the now defunct Soviet-era alcohol and drug dependence "treatment" system, even if some of the defining features of that system no longer exist. There is, however, increasing regional differentiation now that Russia is in the process of decentralizing its

[34] The regions covered by the Globus project are: the Republic of Tatarstan, Tver province, the Republic of Buriatia, the city of St. Petersburg, Pskov province, Vologda province, Nizhnii Novgorod province, Tomsk province, Orenburg province, and Krasnoyarsk region.

[35] Human Rights Watch email correspondence with Aleksei Bobrik of the Open Health Institute, July 31, 2007.

healthcare system. As the healthcare infrastructure is now largely paid for from local budgets, regional wealth and commitment to drug dependence treatment are becoming key determinants in the availability and accessibility of various treatment services.

The Soviet Alcohol and Drug Dependence Treatment System

The Soviet authorities treated drug dependence, a fairly rare condition, the same way as alcoholism, which was far more widespread. The response to both problems was centered on the notion that "citizens of the Soviet Union must treat their health with care," and that alcoholism and drug dependence were "diseases posing a threat to surrounding people."[36]

People who were diagnosed with either condition were expected to undergo treatment and then refrain from further use of illicit drugs or abuse of alcohol. Treatment consisted of a detoxification course followed by regular outpatient observation with a narcologist for a period of five years. Those drug- or alcohol-dependent people who refused treatment or continued to abuse illicit drugs or alcohol risked being committed to special work camps for drug users and alcoholics, known in Russia as LTPs (*lechebno-trudovye profilaktorii*), for a period of six months to two years, where they were subjected to "reeducation through labor."[37] More than two million people, the vast majority of them alcoholics, went through these camps in the 1970s and 1980s.[38]

In order to ensure that individuals dependent on drugs or alcohol were indeed refraining from further use of illicit drugs or abuse of alcohol, they were essentially placed under surveillance by state substance abuse clinics. Doctors at these clinics

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[36] V. Pelipas and I. Solomonidina, "The rights of persons addicted to psychoactive substances," in Moscow Helsinki Group, "Human Rights and Psychiatry in the Russian Federation," 2004, http://www.mhg.ru/english/3959925 (accessed August 28, 2007).

[37] Initially, drug- and alcohol-dependent people could be sent to LTPs only if, in addition to refusing treatment or continuing to abuse substances, they also violated "public order, work discipline, and the rules of socialist life." In 1985, however, as part of an anti-alcohol campaign launched by USSR leader Mikhail Gorbachev, refusal to undergo treatment or continued abuse of substances alone became sufficient ground for committing drug- and alcohol-dependent persons to LTPs. See Conclusion of the Committee for Constitutional Supervision of the USSR of 25 October 1990 No. 8 (2-10).

[38] V.E. Pelipas, I.O. Solomonidina, M.G. Tsetlin, "Forced and Mandatory Treatment of Patients with Substance Abuse Profile. Experience and Perspectives" ("Prinuditelnoe I obyazatelnoe lechenie bolnykh narkologicheskogo profilia. Opyt I perpsektivy"), Moscow, 2005.

entered them into a special registry. People on this registry were expected to make regular follow-up visits to narcologists over the course of five years (three years for alcohol-dependent persons). After five years of abstinence—and at least 30 visits—doctors would take a drug user off the registry.[39] As explained below, a single relapse, however, could reset the follow-up procedure. The registry also served as the basis for restricting certain rights of drug- and alcohol-dependent persons, including the right to obtain a driver's license and the right to hold certain jobs.

Doctors at substance abuse clinics cooperated with other state bodies, including law enforcement agencies, in enforcing state policies toward drug users. Laws on confidentiality of medical information explicitly stipulated that information on drug- and alcohol-dependent persons should only be treated confidentially if the persons involved were "taking a critical attitude to their condition, were firmly committed to medical treatment and diligently carried out all medical prescriptions."[40] Information on persons on the registry was routinely shared with law enforcement agencies.

Drug- and alcohol-dependent persons who refused treatment or continued to use drugs or alcohol were essentially treated as criminal offenders. In fact, during proceedings to commit them to LTPs their legal position was considerably worse than that of criminal defendants: Soviet law provided for simplified proceedings in such cases and court rulings were not subject to appeal. The legal regime at LTPs, which were run by the ministry that also ran the prison system, resembled that in penal colonies.[41] Escapes from LTPs were criminal offenses and carried a punishment of up to one year's imprisonment.[42] In 1987, during an anti-alcohol campaign, the Soviet Union made the use of illicit drugs a criminal offense and misdemeanor.[43]

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[39] Order N. 704 of the Ministry of Health of the USSR of 12 September 1988 "On the periods of follow-up observation of persons affected by the diseases alcoholism, drug dependence, dependence on toxic substances."

[40] Pelipas and Solomonidina, "The rights of persons addicted to psychoactive substances."

[41] Conclusion of the Committee for Constitutional Supervision of the USSR of 25 October 1990 No. 8 (2-10), on file with Human Rights Watch.

[42] Pelipas and Solomonidina, "The rights of persons addicted to psychoactive substances."

[43] Decree of the Presidium of the Supreme Soviet of the USSR of 22 June 1987 "On the introduction of amendments and additions to some legislative acts of the USSR."

Changes in early 1990s

In the early 1990s, as the Soviet Union fell apart and the new Russian leadership embarked on a new course, policies toward drug dependence underwent a number of important changes. In 1990 the Committee for Constitutional Supervision of the USSR, a body with Constitutional Court-like functions, declared the LTPs and criminal liability for illicit drug use unconstitutional. It observed that committing drug- and alcohol-dependent persons to LTPs constituted "isolation of the person from society for a considerable period of time, which makes this measure similar to that of the criminal punishment deprivation of freedom" and that "treatment of people who are ill with alcohol or drug dependence who have not committed offenses should be conducted on a voluntary basis in medical, not penal institutions."[44]

In 1993 Russia adopted a law that set out the fundamental principles of legislation in the field of health care. This law guaranteed confidentiality of medical information for all patients, established the principle of voluntary treatment based on informed consent, and banned all forms of discrimination on the ground of a health condition.[45] A 1992 law on psychiatric care, which has also been applied to drug dependence, also enumerates these rights.[46]

Also in 1993, as mentioned above, Russia's Supreme Soviet adopted a new concept policy on illicit drug use that proposed a significant shift away from the Soviet-era approach in favor of an approach that balanced law enforcement and public health interventions. It called for a mixture of law enforcement and educational measures, emphasizing prevention and efforts to change social and cultural stereotypes. It also called for the establishment of a state-run institution that would provide social support and rehabilitation for drug-dependent persons. It further recommended that the persons who had committed minor drug-related offences be subjected to medical treatment, rather than to punishment.[47] The document was not a law but

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[44] Conclusion of the Committee for Constitutional Supervision of the USSR of 25 October 1990 No. 8 (2-10).

[45] Fundamental Principles of Legislation of the Russian Federation on Public Health of 22 July 1993, Chapters 4 and 6.

[46] Law on Psychiatric Care and Guarantees of the Rights of Citizens in its Application of 2 July 1992.

[47] Citation in: Natalia Bobrova, Ron Alcorn, Tim Rhodes, Iurii Rughnikov, Elena Neifeld and Robert Power, "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities," *Journal of Substance Abuse Treatment*, available online 17 May 2007 [http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=PubMed&list_uids=17499960&dopt=Citation].

served as a declaration of intentions. Illicit drug policies have in practice not followed the spirit of this concept policy; this is best illustrated with the criminalization of possession of very small doses of drugs, discussed above.

Russia's Contemporary Drug Dependence Treatment System

Drug users in Russia who wish to seek medical treatment can do so through the state drug dependence treatment system, which offers them detoxification services and, in some regions, rehabilitation treatment. Today, treatment is mostly voluntary, although in certain, limited circumstances drug users can also be forcibly committed to treatment.[48]

System of state clinics

The state is the primary provider of drug dependence treatment in Russia, although some private treatment facilities do exist (see below). In 2005 the state treatment infrastructure consisted of 192 so-called narcological dispensaries, inpatient facilities with a cumulative total of 28,200 beds for alcohol and drug detoxification and care for complications arising from the misuse of alcohol and drugs, and 1,975 "narcological cabinets," outpatient facilities that mostly cater to alcohol-dependent patients. That year, the system provided services to 717,000 patients, including approximately 70,000 drug users.[49]

State rehabilitation programs are a relatively new phenomenon; a government program to create such centers began only in 2000. In 2006 rehabilitation centers existed in 26 regions.[50] The state narcological services currently offer about 1,100

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[48] These exceptions include: courts can commit people to treatment who have a psychiatric disorder and form a danger to themselves or others; parents are authorized to commit children under 16 years of age to treatment (legislation is currently under discussion about raising that age to 18); a judge who finds a drug-dependent person guilty of a criminal offense but sentences him or her to a non-custodial punishment may order him or her to enter drug dependence treatment (Article 73 of the Criminal Code of the Russian Federation); and prison administrations may require a drug-dependent person who is convicted of a criminal offense and sentenced to a prison term to undergo treatment if a medical commission of the prison system considers that necessary.

[49] Bobrova et al., "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities," *Journal of Substance Abuse Treatment*.

[50] E.A.Koshkina, V.V. Kirzhanova, and O.V.Sidoriuk, "Prevalence of substance-related disorders in the Russian Federation in 2004-2005" ("Rasprostranennost narkologicheskikh rasstroistv v Rossijskoi Federatsii v 2004-2005"), Moscow, 2006, cited in Bobrova et al., "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities," *Journal of Substance Abuse Treatment.*

beds for free rehabilitation treatment across Russia, according to Russia's chief narcologist, Nikolai Ivanets.[51] In a meeting with Human Rights Watch Dr. Ivanets, who is also the head of the National Research Center for Substance Abuse, said that great importance is accorded to the further development and improvement of rehabilitation programs.[52]

Treatment modalities

State clinics offer drug-free treatment programs for opioid dependence that are aimed at immediate and complete abstinence. Official treatment protocols identify three phases of treatment: the detoxification phase, a "post-abstinent" phase that immediately follows detoxification, and the remission phase.[53]

The detoxification phase involves inpatient treatment ranging from 3 to 12 days, depending on the level of drug dependence of the patient. The treatment protocols recommend the use of a range of medications including pharmacotherapy to suppress withdrawal symptoms, tranquillizers and sleeping pills, antipsychotics, anticonvulsants, and others. Treatment heavily relies on these medications, with most patients getting a cocktail of drugs. People interviewed for this report who went through detoxification treatment remarked that they were in a coma-like sleep for the first half of their treatment and remained heavily tranquillized for the remainder of it. Outpatient detoxification services for drug users do not formally exist, although doctors at narcological clinics in many regions do offer such care unofficially (and for payment). The treatment protocol for the lightest form of dependence also recommends "suggestive psychotherapy."[54]

The treatment protocol for the second phase recommends a further 21 days of inpatient treatment, although it states that outpatient treatment is also a possibility. The protocol recommends a variety of medications for symptoms related to feelings

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[51] Ivanets, "Drug Addiction Today, Prevention, Treatment, Rehabilitation."

[52] Human Rights Watch interview with Nikolai Ivanets, Moscow, March 7, 2007.

[53] Order N. 140 of the Ministry of Health of the Russian Federation of 28 April 1998 "On the confirmation of standards (model protocols) for the diagnosis and treatment of the narcologically ill."

[54] Suggestive or directive psychotherapy utilizes the authority of the therapist to direct the course of the patient's therapy, as contrasted with nondirective psychotherapy.

of depression, related behavior, and urges to use narcotics. It also recommends psychotherapy, massage, and acupuncture.

For the final remission phase, the treatment protocol recommends six to eight months of outpatient treatment, during which the patient continues to receive antidepressants, antipsychotics, and stimulants, and undergoes blood and urine tests every three to four weeks. The protocol also recommends psychotherapy for this period but does not provide any detail on the type of psychotherapy or its frequency.

Narcological clinics do not offer opioid maintenance therapy for drug users. As already noted, the use of methadone or buprenorphine for treating drug-dependent persons is prohibited by law.[55]

Some narcological clinics host drug user self-help groups on their premises. However, Natalia Bobrova of the Department of Epidemiology and Public Health at University College London and several colleagues who have conducted extensive research on drug use, drug dependence, and HIV in Russia, observe that Narcotics Anonymous meetings "are generally available in cities only."[56] Of the regions visited for this report, several strong Narcotics Anonymous groups exist in Kazan, one hosted by a narcological clinic and one by a local NGO, with meetings most days of the week and attendance varying from 30 to 70 people per meeting; a much smaller one exists in Kaliningrad. No such groups exist in Penza and Kuznetsk although one had existed in the latter city when it hosted a now-defunct drug dependence rehabilitation program a number of years ago.

Drug user registration and confidentiality

The drug user registry continues to exist as in Soviet times, with some modifications. Drug-dependent persons who seek treatment at state clinics are, in principle, put on

[55] Article 31(6) of the Federal Law "On Narcotic Drugs and Psychoactive Substances" prohibits the use of narcotic drugs and psychoactive substances in treating drug dependence.

[56] Bobrova et al., "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities," *Journal of Substance Abuse Treatment.*

the registry.[57] In many regions, however, drug users can pay for services they receive at state clinics in order to avoid the registry (see also below). Some individual narcologists will also give patients free outpatient treatment without registering them.

Registered drug users are expected to pay regular follow-up visits with their treating doctor over the course of at least five years, generally making no less than 30 such visits.[58] During these follow-up visits, narcologists may require urine or other tests to establish whether the patient remains abstinent. A patient can be taken off the registry after five years if he or she "carried out all orders [*naznacheni*] of the treating doctor, appeared at substance abuse institutions in time, and has achieved, after treatment, a firm, objectively confirmed remission."[59] In case a drug user relapses at any point in this period, the five-year period may be reset. Most drug users interviewed for this report who were on the drug user registry said that they do not go to the narcological clinic for follow-up appointments, meaning that they will never be taken off the registry. Not surprisingly, therefore, the number of people taken off the registry every year due to completion of five years of observation is small. Nikolai Ivanets, Russia's chief narcologist, told Human Rights Watch that more people are taken off the registry because they die than because of recovery.[60] In 2005 a total of 343,500 drug-dependent persons were on the drug user registry, with 24,390 people being newly registered that year.[61]

Legal provisions on confidentiality of information in the registry have improved considerably since Soviet years, but some state clinics and doctors still appear to routinely share such information on patients with law enforcement agencies. Legislation on health care now recognizes the confidentiality of medical information and allows for its disclosure only in certain cases. However, among others, it

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[57] Order N. 704 of the Ministry of Health of the Union of Soviet Socialist Republics (USSR) of 12 September 1988 "About period of follow-up supervision for those affected by alcoholism, drug dependence, or toxicomania." The order also provides for a "risk" category for people who use drugs but who are not currently considered to be drug dependent.

[58] During the first year they are supposed to visit their narcologist once a month; during the second year once every two months; and during the third, fourth, and fifth years three or four times per year.

[59] Order N. 704 of the USSR Ministry of Health "About period of follow-up supervision for those affected by alcoholism, drug dependence, or toxicomania"

[60] Human Rights Watch interview with Nikolai Ivanets, Moscow, March 7, 2007.

[61] Ivanets, "Drug Addiction Today, Prevention, Treatment, Rehabilitation."

stipulates that medical doctors may disclose medical information if "there is ground to believe that the damage to the health of a citizen was inflicted as a result of unlawful activity."[62] As the use of illicit drugs is a misdemeanor under Russian law and thus "unlawful," this formally allows medical doctors to report drug users who seek treatment to law enforcement agencies.[63] The prosecutor's office and courts may also seek information on a specific individual in the context of a criminal investigation.[64]

It appears that in some regions regulations continue to exist that oblige doctors at narcological clinics to share information on drug users on the registry with law enforcement. This is, for example, the case in Moscow, where a mayoral order of 1998 instructs the city police and healthcare department to create a system to exchange information about persons who "engage in non-medical use of narcotics."[65] However, Lev Levinson has told Human Rights Watch that narcologists in Moscow had insisted to him that the order is no longer implemented.[66]

(The FNCS has developed a nation-wide database on illicit-drug-related issues. Some newspapers suggested in April 2007 that this database would also include identifying information on individual patients. However, a federal regulation stipulates that only statistical information about users who seek help from narcological clinics is included.[67])

Doctors at narcological clinics in Kazan, Kaliningrad, and Kuznetsk told Human Rights Watch that confidentiality is strictly observed. However, many drug users maintain that breaches of confidentiality, to law enforcement agencies, relatives,

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[62] Article 61 of the Fundamental Principles of Legislation of the Russian Federation on Public Health of 22 July 1993.

[63] Article 6.9 of the Code on Administrative Violations of the Russian Federation of 30 December 2001, as amended on 21 March 2005.

[64] Article 61 of the Fundamental Principles of Legislation of the Russian Federation on Public Health of 22 July 1993.

[65] Order of the mayor of Moscow of 1 September 1998 N. 887-PM "On the confirmation of the regulation on the interdepartmental council on the fight against unlawful circulation of narcotics in the city of Moscow and the plan of initial measures for year 1998."

[66] Human Rights Watch telephone interview with Lev Levinson, July 9, 2007.

[67] Regulation N. 31 of the Government of the Russian Federation of 23 January 2006 "On the creation, keeping, and use of the single database on issues related to the circulation of narcotic substances, psychotropic substances and their precursors, and also the activities to counter their unlawful circulation."

and employers, do occur regularly. For example, a survey of almost 1,000 drug users in 10 regions conducted by the Penza Anti-AIDS Foundation found that about one-third of all drug users believed that narcologists had breached their confidentiality to law enforcement structures or to relatives. The study found considerable regional differences, with 67.5 percent of people surveyed in Penza reporting believed breaches of confidentiality, almost all to law enforcement agencies, while only 8.3 percent of people surveyed in Orenburg said narcological clinics had breached their confidentiality.[68]

Cost of treatment in state clinics

Russia's constitution requires that medical treatment at state and municipal clinics be offered free of charge.[69] State-run narcological clinics accordingly offer treatment free of charge. However, free treatment is not always actually cost-free. In both Kaliningrad and Penza drug users told us that they were charged out-of-pocket fees for medications or had to bring their own. As Bobrova and others observe, the failure to provide stable and adequate funding for narcological clinics "has led to a widespread practice of assessing out-of-pocket fees, which frequently include the costs of medication."[70]

In recent years state narcological clinics have become increasingly commercialized as they have struggled financially due to often insufficient funding from local and federal budgets. This has led to clinics encouraging, or even pushing, drug users to pay for their treatment. In many regions patients who pay for their treatment can count on better conditions than those who make use of free services. Some clinics, like the ones in Kaliningrad and Kazan, have created special wards for paying patients.

These trends are not unique to the narcological system. There is generally a wide gap between the constitutional guarantees of free healthcare services for all and the

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

[69] Government of Russia, The Constitution of the Russian Federation, adopted and entered into force December 12, 1993, http://www.constitution.ru/en/10003000-01.htm (accessed June 27, 2007), art. 41.

[70] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence.*

reality. Patients in many parts of the healthcare system cannot get good healthcare services for free, are assessed out-of-pocket charges, and are pushed toward paid services.

Our research and that of others has found that most drug users are highly apprehensive about being formally registered as a drug user.[71] In some regions, doctors at narcological clinics use the fact of the drug user registry as an indirect way of pushing drug users to pay for their treatment, as drug users only have a right to free treatment if they agree to be entered onto the registry (see also below). Inna Vyshemirskaya, a sociologist and lead Russian researcher in a 2006 assessment of health problems related to illicit drug use and HIV/AIDS in Kaliningrad, explained how this is done in Kaliningrad:[72]

> The narcological clinic is unfortunately strongly oriented toward paid services… When someone comes in for their initial consultation, they [the doctors] mention the possibility of free treatment but [warn that] that leads to [being entered onto the drug user] registry and they explain the consequences of being on the registry. That way they push people toward paid services.[73]

Waiting lists for free treatment, which exist in some regions, also push drug users toward paid services. Human Rights Watch interviewed various drug users who said that they had paid for their treatment so they would not have to wait.

The cost of paid treatment varies from region to region, and sometimes within regions depending on desired treatment conditions. Inhabitants of Tatarstan pay 7,500 rubles (approximately US$300) for a 10-day detoxification course; people from other regions pay 12,000 rubles (about $480) for the same course. In Kaliningrad local experts estimated that drug users paid between 1,800 and 3,000 rubles (about

[71] See, for example, Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence*.

[72] This assessment was conducted with support of the US National Institute of Drug Abuse using the Rapid Policy Assessment and Response intervention. Similar interventions were conducted in 2005 and 2006 in Odessa (Ukraine) and Szczecin (Poland). A summary of the research findings can be found at http://www.temple.edu/lawschool/phrhcs/rpar/about/reports.html (accessed September 12, 2007).

[73] Human Rights Watch interview with Inna Vyshemirskaya and Viktoria Osipenko, Kaliningrad, January 30, 2007.

$72 and $120) per day for detoxification treatment; in Penza, paid treatment costs about 1,200 rubles (about $48) per day; and paid rehabilitation treatment in Kazan costs around 500 rubles (about $20) per day.

Drug dependence treatment is not covered by state health insurance policies in most parts of Russia.[74]

Private drug dependence treatment clinics

There is a small but growing number of private drug dependence clinics in Russia that offer rehabilitation services. Russian law bans private clinics from providing medicated detoxification services but allows them to engage in rehabilitation.[75] Private clinics are mostly commercially run or are faith-based. A number of private treatment centers exist in the regions visited for research on this report: In Kazan a nongovernmental organization called Roza Vetrov offers a free three-month outpatient rehabilitation program that is based on the 12-step model; in Kaliningrad province two private rehabilitation centers currently offer paid long-term inpatient treatment based on the Polish Monar system and two faith-based rehabilitation centers linked to protestant churches offer treatment for a minimal fee or free of charge for those who cannot afford the fee.

Treatment demand

Various studies suggest that there is considerable treatment demand for drug dependence treatment in Russia. The Penza Anti-AIDS Foundation study of almost 1,000 drug users in 10 regions of Russia found that only 7.3 percent of male drug users and 4.9 percent of female drug users it surveyed had never tried to stop using drugs. A total of 63.9 percent of drug users surveyed had made five or more attempts at quitting drugs, whereas only 6.3 percent had made just one attempt. The study found a direct correlation between the number of years a person had used drugs and the number of attempts the person had made to stop using; the longer a respondent

[74] Bobrova and others mention Samara as the only exception. Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence*.

[75] Article 55(2) of the 1998 Federal Act on Narcotic Drugs and Psychoactive Substances limits detoxification treatment to state institutions. Private healthcare facilities are allowed to do diagnostics, examinations, consultation, and rehabilitation. Federal Act on Narcotic and Psychotropic Substances (E/NL.1998/66), 8 January 1998.

used drugs, the more likely he or she was to have made attempts to stop using drugs and the larger the number of such attempts.[76]

Almost every drug user Human Rights Watch interviewed for this report said that he or she wished to stop using drugs. Most had made repeated attempts, either at home or in a healthcare setting, to do so. One drug user from Kazan who had made repeated attempts at home said that he would very much like to overcome his drug dependence but has not been able to so far. He said that he sometimes manages to stop using for a month or two but then relapses: "It is just so difficult to get out of that swamp."[77] A woman from Penza broke out in tears when she told Human Rights Watch that she had relapsed after years of abstinence when she learned that she was HIV infected:

> When I learned the diagnosis … I didn't know what to do. The most terrible thing is that there is no one to turn to in our city. There are no groups that I could attend. I had no one to go to and I needed to talk to someone. I went to a psychotherapist who gave me sibazon [a sedative used to treat anxiety disorders]… At home, I injected several ampoules, started to feel good, and realized I wanted more. So I took heroin…
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> From that time on I periodically use. I don't use systematically but I sometimes feel so very bad. I mean, there is no support… My mother has an alcohol problem. I come home clean and find my mother drunk. I feel horrible and start thinking, "Why not shoot up…?"[78]

Treatment uptake

Despite high treatment demand, only a small percentage of drug users actually make use of state drug dependence treatment services. A 2003 Ministry of Health treatment protocol for rehabilitation of persons dependent on drugs cites an

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

[77] Human Rights Watch interview with Igor I., Kazan, January 23, 2007.

[78] Human Rights Watch interview with Maria M., Penza, April 11, 2007.

estimate of the National Research Institute on Substance Abuse that one in every seven drug users seeks treatment at state narcological clinics.[79] In 2005 UNODC estimated that only about one in every ten drug users in Russia reaches drug abuse treatment services.[80] That year about 70,000 people sought treatment for drug dependence at state clinics.

Uptake of rehabilitation treatment is even lower. Narcologists in Kazan, Kaliningrad, and Kuznetsk told Human Rights Watch that few drug users agree to enter into rehabilitation after detoxification treatment. The chief narcologist in Tatarstan stated that about 5 to 8 percent of patients in his region continue with rehabilitation after detoxification services, despite the availability of several rehabilitation programs.[81] Nikolai Ivanets, Russia's chief narcologist, told Human Rights Watch that numerous rehabilitation beds are unoccupied because, in his opinion, many drug users "simply don't want to be treated." He suggested that the reason why many drug users criticize the narcological services as ineffective was to "justify their own lack of will to get treatment."[82] As will be explained below ("Failure to Facilitate Patient Retention"), the failure of narcological clinics to counsel patients on the importance of rehabilitation treatment and prepare them for such treatment is a key reason for this low uptake.

Treatment effectiveness

Russia's drug dependence treatment system uses a highly rigid system for assessing the effectiveness of its services: it looks at the state of remission of registered patients one year after they entered detoxification treatment. If the patient is in remission and no relapses have been registered, treatment is considered to have been successful. In other cases, it is considered to have failed. Other factors, like the percentage of patients who continue with rehabilitation treatment after detoxification, the average length of patients' stay in treatment, the frequency of relapses, the amount of time that passes before a relapsing drug user seeks help

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[79] Order No. 500 of the Ministry of Health of 22 October 2003, "Treatment Protocol: Rehabilitation of Persons with Drug Dependence Disease," Chapter VI.

[80] UNODC, "Illicit Drug Trends in the Russian Federation 2005."

[81] Human Rights Watch interview with Farit Fattakhov, Kazan, January 25, 2007.

[82] Human Rights Watch interview with Nikolai Ivanets, Moscow, March 7, 2007.

again, changes in the social situation of the patient, or the patient's self-esteem, are not formally considered.[83]

Two monographs on drug dependence treatment by staff of the National Research Institute for Substance Abuse state that between 5 and 9 percent of patients remained abstinent a year after receiving treatment.[84] The Penza Anti-AIDS Foundation survey found that about 90 percent of drug users surveyed said that they had returned to drug use within a year of receiving detoxification treatment.[85] Seven percent reported that they never really stopped using drugs as they continued to use them in the detoxification clinic; 35 percent said that they started using again within a week of finishing detoxification treatment; and another 17 percent said they resumed drug use within one month.[86]

Russian drug dependence treatment experts recognize that detoxification without rehabilitation rarely leads to lasting abstinence. For example, a 2003 Ministry of Health treatment protocol for rehabilitation of persons dependent on drugs states, "With medical [detoxification] interventions alone success can only be achieved among three to five percent of those with drug dependence disease."[87]

Most drug dependence treatment systems use a number of other indicators of treatment effectiveness along with abstinence. These include the percentage of

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[83] In the United Kingdom, for example, drug treatment services work with "a range, or hierarchy of goals of drug treatment." The Independent Expert Working Group report lists these goals as: "- reducing health, social, crime and other problems related to drug misuse; - reducing harmful or risky behaviors associated with the misuse of drugs (e.g. sharing injecting equipment); - reducing health, social or other problems not directly attributable to drug misuse; - attaining controlled, non-dependent or non-problematic drug use; - abstinence from main problem drugs; - abstinence from all drugs…." It explains that "reducing harm from an individual's drug use will be an important element of care, especially during the engagement phase of treatment. The principle of a hierarchy of goals is a useful one in helping patients look at any of their treatment objectives in a systematic manner." Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," p. 49.

[84] N.N. Ivanets and M.A. Vinnikova, *Heroin dependence – disease characteristics and treatment of the post-abstinent syndrome* (*Geroinovaia zavisimost – klinika I lechenie postabstinentnogo syndrome* (Moscow: Medpraktika-M, 2001); and V.V. Chirko and M.V. Demina, *The characteristics of clinical narcology – drug dependence and toxicomania: disease characteristics, development, therapy* (*Ocherki klinicheskoi narkologii – narkomanii I toksikonanii: klinika, techenie, terapia*) (Moscow: Medpraktika-M, 2002). Both monographs are cited in M. Zobin and E. Egorov, "Remission with opioid dependence," published at http://www.narcom.ru/cabinet/online/107.html (accessed July 10, 2007).

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

[86] Ibid.

[87] Order No. 500 of Ministry of Health and Social Development of the Russian Federation of 22 October 2003, "Treatment Protocol: Rehabilitation of Persons with Drug Dependence Disease."

patients who continue with rehabilitation treatment after detoxification and the average amount of time patients stay in treatment. If judged by these indicators, Russia's treatment system also fares poorly. As was mentioned above, only a small percentage of drug users who go through detoxification continue with rehabilitation treatment, resulting in an average length of stay in treatment of only a few weeks for most drug users. Scientific research indicates that for most patients the threshold of significant improvement is reached at about three months in treatment (this and other best practices are discussed in the next chapter).[88]

[88] See NIDA, "Principles of Drug Addiction Treatment; A Research-Based Guide," principle 5.

III. Drug Dependence Treatment Best Practices

Findings of scientific research in the field of drug dependence treatment, and best practice standards formulated on the basis of that research, provide an invaluable framework against which to judge the drug dependence treatment system of a given country. They provide the necessary insights to assess what types of services a state needs to offer, how these services must be offered, and what services are of good quality and medically and ethically appropriate.

In the past few decades a vast amount of scientific research has been conducted into drug dependence treatment services in many countries around the world. Although there are substantial differences in the nature of the patients treated and in the structure and operation of the treatment system in different countries, the United Nations Office for Drugs and Crime concludes in a 2002 review of the evidence base on effective drug dependence treatment that "the findings for the impact of the main forms of structured treatment are remarkably similar across national and cultural divides."[89] On the basis of these similarities, UNODC, various national health agencies, and several other bodies have formulated a series of basic principles and best practice recommendations for effective drug treatment, which are summarized below.[90] A more detailed presentation of these can be found in the Appendix to this report.

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[89] UNODC, *Contemporary Drug Abuse Treatment: A Review of the Evidence Base* (Vienna, United Nations International Drug Control Program, 2002), p. 1.

[90] For this section, we have drawn on the "Treatment and Rehabilitation Toolkit," published by UNODC in 2002, available on the UNODC website, http://www.unodc.org/unodc/en/treatment_toolkit.html (accessed April 30, 2007); the "Principles of Drug Addiction Treatment; A Research Based Guide," published by the United States National Institute on Drug Abuse (NIDA) of the National Institutes of Health, http://www.drugabuse.gov/PDF/PODAT/PODAT.pdf (accessed April 30, 2007); several Treatment Improvement Protocols (TIPS) published by the Center for Substance Abuse Treatment (CSAT, an institution of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the US Department of Health and Human Services), which can be found at http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.part.22441 (accessed July 27, 2007); clinical guidelines of the United Kingdom National Institute for Health and Clinical Excellence on opioid detoxification and psychosocial interventions, available at http://guidance.nice.org.uk/CG51/niceguidance/pdf/English and http://guidance.nice.org.uk/CG52/niceguidance/pdf/English (both accessed September 5, 2007); the 2007 consultation draft of a report of the UK Independent Expert Working Group on clinical guidelines on drug misuse and dependence, available at http://guidance.nice.org.uk/CG52/niceguidance/pdf/English (accessed September 5, 2007); and the detoxification guidance of the Netherlands Institute for Mental Health (Geestelijke Gezondheidszorg Nederland), available at www.ggzkennisnet.nl/ggz/uploaddb/downl_object.asp?atoom=14817&VolgNr=1 – (accessed September 5, 2007).

Basic Principles of Effective Drug Dependence Treatment

Scientific research has shown that observance of a number of basic principles of drug dependence treatment is association with positive treatment outcome.[91] Some of these key principles are:

Drug Dependence is a Chronic and Relapsing Disease

The predominant view of much of the last century—that opioid dependence is a "self-induced and self-inflicted condition that results from a character disorder or moral failing, and that the condition is best handled as a criminal matter"—is wrong.[92] According to the US National Institute for Drug Abuse (NIDA), "relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning…"[93] Nonetheless, research also shows that properly designed and implemented treatment programs can achieve similar results to treatment programs for other chronic diseases, such as asthma and diabetes, with treatment success rates of 40 to 60 percent.

Treatment Must be Readily Available

Individuals who are addicted to drugs may be uncertain about entering treatment. It is thus crucial to "take advantage of opportunities when they [drug-dependent people] are ready for treatment" so potential patients are not lost.[94]

Retention of Patients in Treatment for Adequate Period of Time is Critical

Research has found that good outcomes are contingent on adequate lengths of treatment and that "participation of less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer are often indicated."[95]

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[91] NIDA has developed 13 principles of effective drug dependence treatment. The key principles are summarized in this section. For all principles, see NIDA, "Principles of Drug Addiction Treatment: A Research-Based Guide." These key principles are also at the base of national treatment guidelines in countries like the United States, the United Kingdom, and the Netherlands.

[92] SAMHSA/CSAT, TIP 43, p. 8.

[93] NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide."

[94] Ibid., principle 2.

[95] Ibid., p. 16.

Treatment Plans Must be Tailored to Individual Patients' Needs

Individual treatment plans should be developed for each patient that take into account his or her specific needs and problems, as well as his or her age, gender, ethnicity, and culture. Research has consistently shown that no single treatment is appropriate for all individuals.[96] Individual treatment plans should be assessed continually and modified routinely to ensure that the plan continues to meet the person's changing needs. Patients should be involved in designing the treatment, as research suggests that a "therapeutic alliance" between patient and therapist or doctor—a collaboration, requiring agreement on goals and therapeutic tasks, mutual trust, acceptance, confidence, and a rapport—is a crucial factor in treatment outcomes.[97]

Treatment Must Attend to Multiple Needs of the Patient

Drug dependence can involve virtually every aspect of an individual's functioning—in the family, at work, in the community—and drug users frequently have multiple needs—medical, psychological, social, vocational, or legal—at the time they seek treatment. [98] If these problems or needs are not addressed during treatment, they may undermine treatment outcomes. Drug dependence treatment should thus go beyond the patient's drug use problem and also address his or her other needs, including by providing treatment for coexisting mental disorders, HIV/AIDS, and tuberculosis.[99,100]

Elements of the Effective Treatment System

UNODC describes four phases of drug dependence treatment that can be found in most treatment programs: open access services; detoxification; rehabilitation/relapse prevention; and aftercare.

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[96] Ibid., principle 4.

[97] R. Elovich, "Drug Demand Reduction Program's Treatment and Rehabilitation Improvement Protocol," DDRP, a Project of USAID, p. 16. A copy is on file with Human Rights Watch.

[98] NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide," p. 23.

[99] Ibid., principle 8.

[100] Ibid., principle 12.

Open Access Services

These services "do not provide formal treatment as such but act as important points of first contact for people who have drug-related problems and for those concerned about drug use of another." They are a "critical place" of first contact for drug users who "may be reluctant to resort to specialized drug dependence services."[101] Open access services include self-help groups, family support groups, drop-in centers, telephone hotlines, and harm reduction programs.

Detoxification Treatment

Many drug-dependent people will face withdrawal symptoms after they stop taking drugs, including abdominal cramps, nausea, vomiting, bone and muscle pain, insomnia, and anxiety. The goal of medical detoxification is to help patients "achieve withdrawal in as safe and as comfortable a manner as possible."[102] This is generally done by providing patients with medications that suppress the withdrawal symptoms or relieve the discomfort they cause.

But detoxification on its own is not a rehabilitative treatment for drug dependence. The UNODC "Drug Dependence Treatment Toolkit" observes that detoxification treatment alone is "unlikely to be effective in helping patients achieve lasting recovery; this phase is better seen as a preparation for continued treatment aimed at maintaining abstinence and promoting rehabilitation."[103] Detoxification treatment protocols in the US state that it is thus crucially important that patients are counseled during detoxification on the "importance of following through with the complete substance abuse treatment continuum of care" and that "a primary goal of the detoxification staff should be to build a therapeutic alliance and motivate the patient to enter treatment."[104] This process should start even as the patient is being medically stabilized.[105]

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[101] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," UN E.03.XI.II, 2003, www.unodc.org/pdf/report_2003-07-17_1.pdf (accessed August 28, 2007), Chapter 4, p. IV.2.

[102] Ibid.

[103] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base"; NIDA, "Principles of Effective Drug Addiction Treatment; A Research-Based Guide," principle 9.

[104] This motivational work is one of the three "essential components" of detoxification described in SAMHSA's Treatment Improvement Protocol on detoxification, which describes it as "preparing the patient to enter into substance abuse treatment

As psychosocial factors such as psychological dependence, co-occurring psychiatric and medical conditions, social supports, and environmental conditions critically influence the probability of successful and sustained abstinence from substances, it is important that these factors be addressed already during the detoxification process.[106] Indeed, research indicates that "addressing psychosocial issues during detoxification significantly increases the likelihood that the patient will experience a safe detoxification and go on to participate in substance abuse treatment."[107]

Rehabilitation and Relapse Prevention

The purpose of rehabilitation or relapse prevention programs is to "prevent a return to active substance abuse," "assist the patient in developing control over urges to abuse drugs," and to "assist the patient in regaining or attaining improved personal health and social functioning."[108] As drug dependence is a complex disorder that may be caused by different underlying factors in different people and affects people's lives in different ways, a wide range of treatment strategies and treatments has been developed—and shown to be effective—over the years. A comprehensive drug dependence treatment system will offer a broad range of different interventions so that treatment strategies can be tailored to the specific needs of individual patients. [109]

The UNODC Toolkit discusses two types of pharmacological interventions that are commonly found in rehabilitation programs: maintenance and antagonist pharmacotherapy. Maintenance treatment is discussed below. Antagonist pharmacotherapy involves the prescription of medications that block the euphoric effects of heroin and other opiates on the user, thus preventing him or her from experiencing a high.[110]

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by stressing the importance of following through with the complete substance abuse treatment continuum of care. SAMHSA/CSAT, "Detoxification and Substance Abuse Treatment," TIP 45, pp. 4- 5, 23

[105] Ibid.

[106] Ibid.

[107] Ibid.

[108] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base," p. 5.

[109] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," p. IV.1.

[110] Ibid., p. IV.5.

The Toolkit also lists a large number of different psychosocial interventions. It notes that patients will often benefit from a combination of various different interventions. Some of the most common psychosocial interventions include: cognitive-behavioral therapy, supportive-expressive psychotherapy, individualized drug counseling, and motivational enhancement therapy.[111]

Maintenance Therapy with Methadone or Buprenorphine

Under this treatment modality, a substance like methadone or buprenorphine that is related to the agent that caused the dependence is provided to patients in oral form and under medical supervision. The substance prevents opiate withdrawal, blocks the effects of illicit opiate use, and decreases opiate craving. Once a patient is stabilized on an adequate dose, he or she can function normally.[112]

Maintenance therapy has been controversial in some countries, with critics expressing concern that patients are not cured of their addiction, that it just replaces one opioid with another, and that it is linked to risks of diversion of opioids. However, a huge body of scientific research illustrates beyond any reasonable doubt that maintenance therapy is one of the most effective treatment modalities for opioid drug dependence. The World Health Organization, UNAIDS, and UNODC all support maintenance programs. In a joint position paper on maintenance therapy, the three organizations observed,

> There is consistent evidence from numerous controlled trials, longitudinal studies and programme evaluations, that substitution maintenance therapy for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of HIV transmission.[113]

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[111] NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide," pp. 35-48.

[112] Ibid., p. 24.

[113] World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), Joint United Nations Programme on HIV/AIDS (UNAIDS), *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention* (Geneva: 2004), p. 13.

Studies have shown that maintenance therapy can achieve "high rates of retention in treatment" and helps increase "the time and opportunity for individuals to tackle major health, psychological, family, housing, employment, financial, and legal issues while in contact with treatment services."[114] They have also shown that maintenance treatment is safe and cost-effective, and that diversion to the black market, though a real concern, can be minimized through proper implementation of national and international control procedures and other mechanisms.[115]

The number of countries that use maintenance therapy in drug dependence treatment programs has been increasing steadily over the past few decades. At this writing about 60 countries worldwide, including an increasing number of countries that have significant problems with opioid dependence, have maintenance programs. In recent years several countries of the former Soviet Union have either introduced maintenance therapy or are conducting or planning maintenance therapy pilot programs, as have a number of countries in the Middle East and Asia. Almost a million opioid drug-dependent people are currently receiving maintenance therapy, including around 237,000 people in North America;[116] 530,000 in the European Union;[117] about 39,000 in Australia;[118] about 36,000 in China (which plans to expand its maintenance treatment program considerably);[119] and 15,000 in Iran.[120] In countries like the United Kingdom and the Netherlands, maintenance treatment is the primary form of treatment for opioid dependence.[121]

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[114] Ibid., p. 13.

[115] Ibid., pp. 20, 32.

[116] Office of Applied Studies, United States Substance Abuse and Mental Health Services Administration, "Facilities Operating Opioid Treatment Programs: 2005," *Drugs and Alcohol Services Information System*, Issue 36, 2006, http://www.oas.samhsa.gov/2k6/OTP/OTP.htm (accessed July 18, 2007).

[117] Schering-Plough Market Access data, September 2006, "Suboxone Access Situational Analysis 070302," presentation at the International Harm Reduction Association Conference, Warsaw, Poland, May 15, 2007.

[118] As of June 30, 2005, excluding data for South Australia and the Australian Capital Territory. Australian Institute of Health and Welfare, "Statistics on drug use in Australia 2006," Drug statistics series no. 18, April 12, 2007 http://www.aihw.gov.au/publications/phe/soduia06/soduia06-c01.pdf (accessed July 12, 2007), p. 69.

[119] Wu Zunyou and Zhao Chenghong, "Update of Harm Reduction in China," presentation at the International Harm Reduction Association Conference, East to East Panel, May 13, 2007, http://www.china.org.cn/english/news/203131.htm (accessed July 15, 2007).

[120] "International Experts Call for Greater Commitment to Opiate Substitution Treatment" , International Center for the Advancement of Addiction Treatment, Press Release, October 25, 2006.

[121] See, for example, National Institute for Health and Clinical Excellence, "Drug misuse; Psychosocial interventions," p. 4.

Aftercare Stage

Although not all rehabilitation programs provide for aftercare, the philosophy behind this kind of care is the "intention to provide ongoing support to clients at the level required to maintain the earlier benefits and goals." In aftercare, clients may be in regular phone contact with treatment programs, have scheduled or unscheduled appointments, or participate in self-help groups.[122]

[122] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," p. IV.5.

IV. Findings: Human Rights and Drug Dependence Treatment

The Right to Health

The right to the highest attainable level of physical and mental health is guaranteed in various international human rights treaties to which Russia is a party, in particular the International Covenant on Economic, Social and Cultural Rights (ICESCR).[123] An integral and directly enforceable element of that right is the right to non-discrimination in the enjoyment of the right to health.[124] Respect for the right to health also incorporates respect for other rights, such as the right to privacy and the right to receive and impart information, which are also protected by treaties to which Russia is a party.[125]

Scope of the Right to Health

The right to health under international law imposes an obligation on states to take the necessary steps for the prevention, treatment, and control of epidemics and other diseases. Because states have different levels of resources, international law does not mandate the kind of health care to be provided beyond a certain minimum level. The right to health is considered a right of "progressive realization." By becoming party to the international agreements, a state agrees "to take steps… to the maximum of its available resources" to achieve the full realization of the right to health.

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[123] International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. res. 2200A (XXI), 21 U.N.GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 11; also in the Convention on the Rights of the Child, G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2 1990, ratified by Russia on August 16, 1990, art. 24. The right to health is also guaranteed in the European Social Charter (revised), Council of Europe, ETS 163, Strasbourg, 3.V. 1996, art. 11. Russia signed onto the European Social Charter on September 14, 2000, but has yet to ratify.

[124] See ICESCR, art. 2 ; International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, art. 5; Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, art. 12.

[125] International Covenant on Civil and Political Rights (ICCPR), G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by Russia on October 16, 1973; European Convention on Human Rights (ECHR), 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocol 11 which entered into force on November 1, 1998, ratified by Russia on May 5, 1998.

The Committee on Economic, Social and Cultural Rights (CESCR), the body charged with monitoring compliance with the ICESCR, has identified four essential elements of the right to health:

- Availability;
- Accessibility;
- Acceptability; and
- Quality.

That means that states must make **available in sufficient quantity** "functioning public health and health-care facilities, goods and services, as well as programmes." As for the **accessibility requirement**, the Committee has defined four elements: accessibility without discrimination, physical accessibility, economic accessibility, and information accessibility (people have the opportunity to seek, receive, and impart information and ideas concerning health issues). **Acceptability** refers to the need for health facilities, goods, and services to be respectful of medical ethics and culturally appropriate. Finally, they must be **scientifically and medically appropriate, and of good quality**.[126]

While states should strive to offer the most effective and comprehensive treatment for drug dependence, the CESCR recognizes that the resources of a given state will be an important factor in the exact level of services the state can offer. In order to comply with the right to health, a resource-rich country will generally have to have a more developed treatment system in place than a poor country with a comparable drug dependence problem.[127]

Russia has made an explicit commitment to provide medical treatment to all its subjects. Its constitution states,

[126] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, November 8, 2000, para. 12. The Committee on Economic, Social and Cultural Rights is the UN body responsible for monitoring compliance with the International Covenant on Economic, Social and Cultural Rights.

[127] General Comment No. 14, para. 31.

> Everyone shall have the right to health protection and medical aid. Medical aid in state and municipal health establishments shall be rendered to individuals gratis, at the expense of the corresponding budget, insurance contributions, and other proceeds.[128]

The 1998 Law on Narcotic and Psychotropic Substances stipulates that people affected by drug dependence disease shall be offered medical care for their condition. It specifies that this medical care includes "examination, consultation, diagnostics, [detoxification] treatment and medical-social rehabilitation."[129]

Although Russia's healthcare infrastructure suffered tremendously from the extended economic crisis that followed the collapse of the Soviet Union, since the late 1990s Russia's economy has gone through a period of sustained and rapid growth with billions of dollars entering the economy in oil and gas revenues. Bolstered by this economic good fortune, Russia has recently been making considerable investments into the healthcare system. In September 2005 President Vladimir Putin announced the creation of four national priority projects aimed at developing social welfare in the country. One of these projects concerns public health. A total of 97.3 billion rubles (almost US$4 billion) was allocated to the national health project budget in 2006.[130]

In considering the issue of resources, it should be kept in mind that investment in effective drug dependence treatment can lead to savings in other spheres, as it reduces criminal behavior in patients who are effectively treated, enables patients to lead productive lives, and can prevent new health problems from emerging in patients. In the United States research has repeatedly shown that investments in effective drug dependence treatment are cost effective. For example, NIDA observes,

> According to several conservative estimates, every $1 invested in addiction treatment programs yields a return of between $4 and $7 in

[128] **Constitution of the Russian Federation, art. 41.**

[129] **Ibid., art. 54(1).**

[130] **Presentation by the deputy minister for health and social development, Ruslan Khalfin, at a meeting of healthcare officials on February 16, 2007. A powerpoint presentation can be found at** http://www.mzsrrf.ru/userdata/Nacinl_Prjct.ppt **(accessed July 27, 2007).**

> reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and society also come from significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.[131]

While cost effectiveness ratios will be different in different countries, it remains a factor in assessing available resources that investment in drug dependence treatment can lead to savings in other spheres.

While available resources is a legitimate consideration for states and policy makers when developing and implementing health policy and services, respect for the right to health has other direct implications for how policy is developed that are not resource-related. It requires that policy decisions and choices about health policy are objective, rational, and evidence based. If they are made on criteria that are discriminatory or arbitrary they will be incompatible with respect for the right to health. Similarly, policy choices that have an unjustifiably restrictive or negative impact on the enjoyment of the right to health, in comparison to other available policy options, are also incompatible.

The Availability Requirement

> Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.
>
> —Committee on Economic, Social, and Cultural Rights, General Comment 14 on the Right to Health[132]

Detoxification services are widely available throughout Russia although in some regions patients face waiting lists for admission to treatment. The availability of state

[131] NIDA, "Understanding Drug Abuse and Addiction: What Science Says," slideshow, undated, available at http://www.nida.nih.gov/pubs/teaching/Teaching3/Teachings5.html (accessed August 29, 2007).

[132] CESCR, General Comment 14, art. 12(a).

rehabilitation services remains patchy despite increasing numbers of state and private rehabilitation centers being opened in recent years.

Detoxification Services

With 192 substance abuse clinics that offer a total of more than 28,000 beds for detoxification for alcohol and drug dependence, these services are widely available throughout Russia. Additionally, drug users can also receive detoxification in certain other approved health facilities, such as psychiatric hospitals, should no substance abuse clinic be available in or near their place of residence.

However, our research and that of others suggests that in some regions drug users who cannot pay for their treatment face waits before they can be admitted to clinics for treatment because of a lack of beds for free treatment. This raises concerns about the availability and accessibility of this form of treatment. In contrast, patients who had paid for treatment said that they were admitted immediately. These waiting lists potentially lead to the loss of patients.

One drug user in Kazan was on the waiting list when Human Rights Watch interviewed him in late January 2007. He said that he had signed up on December 20, 2006, and had been told that he could start his treatment on January 25, 2007. While waiting, the drug user hung out at a drop-in center with active drug users and continued using drugs.[133]

A former drug user in Kazan said that when he wanted to check himself into the city detoxification clinic in Kazan several years ago, he was also told he should come back a month-and-a-half later. He told Human Rights Watch,

> What is that person going to do these one-and-a-half months? I had to wait myself. Why would someone like that stop using drugs, easier to just steal money, take the last valuables out of your mother's house…[134]

[133] Human Rights Watch interview with Sergei S., Kazan, January 23, 2007.

[134] Human Rights Watch interview with Anton B., Kazan, January 24, 2007.

The interviewee said that he later learned that if he had paid a 500 ruble bribe he could have skipped the line. Another drug user said that although he was on the drug user registry he paid for detoxification treatment in January 2007 because "there were no beds for free treatment available."[135] Various drug users in Kazan said that they or their relatives had paid bribes to doctors at the detoxification clinic so that they could skip the waiting list.

Inna Vyshemirskaya, the sociologist who conducted a policy assessment related to illicit drug use and health in Kaliningrad in 2006 and interviewed more than a dozen drug users and several dozen experts, told Human Rights Watch that drug users she interviewed who did not have money to pay for their treatment had often told her that they had to wait before they could be admitted.[136] The chief narcologist for Kaliningrad, however, insisted in a meeting with Human Rights Watch that there were no waiting lists in early 2007, which interviewees confirmed.

Fifteen percent of drug users surveyed for the Penza Anti-AIDS Foundation study said that they had been refused treatment by drug dependence treatment services on at least one occasion. A quarter of these people said the reason for this refusal was the lack of beds. A total of 22 percent of the people surveyed said that they had waited "a long time" for their hospitalization in the detoxification clinic. In Kaliningrad more than 40 percent of drug users surveyed reported long waits before admission. In Krasnoyarsk and St. Petersburg more than 30 percent did so. Conversely, only 6 percent of people surveyed in Penza and Orenburg said that they had had to wait a long time.[137]

The chief narcologist of Tatarstan defended the existence of waiting lists, saying that it helped motivate drug users for treatment.[138] This assertion, however, is not supported by science.[139]

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[135] Human Rights Watch interview with Igor Y., Kazan, January 26, 2007.

[136] Human Rights Watch interview with Inna Vyshemirskaya and Viktoria Osipenko, Kaliningrad, January 30, 2007.

[137] Draft report on the survey by the Penza Anti-AIDS Foundation, on file with Human Rights Watch. The questionnaire did not define the term "a long time." As a result, it is impossible to determine how long these people waited before being able to enter into treatment.

[138] Human Rights Watch interview with Farit Fattakhov, Kazan, January 25, 2007.

[139] Elovich, "Drug Demand Reduction Program's Treatment and Rehabilitation Improvement Protocol," p. 16.

Some current regulations on detoxification services unnecessarily limit their availability. Private drug dependence treatment clinics are currently banned from offering medicated detoxification services, apparently due to fears of diversion of restricted substances.[140] In most European and North American countries private clinics successfully provide detoxification treatment. Allowing private clinics to conduct detoxification treatment would increase the availability of these services and would give some drug users a choice of treatment.

State clinics do not currently offer outpatient detoxification treatment, although in many regions narcologists do provide such services unofficially (and often for considerable charge). While a clinical setting will be needed during detoxification treatment for many drug-dependent persons, outpatient treatment would provide an important alternative for some patients and might help enrol people in treatment who cannot or do not want to make use of inpatient facilities.[141]

Methadone or Buprenorphine Maintenance Therapy

Maintenance treatment for drug users is not available at all in Russia, as the use of methadone and buprenorphine for treating drug users is expressly prohibited by law (as already noted above).[142] Despite overwhelming evidence of its effectiveness in treating drug-dependent persons, top health and law enforcement officials as well as policy makers in Russia continue to vehemently oppose maintenance therapy, often on the basis of selective and inaccurate interpretation of research findings. The policy decision not to make methadone and buprenorphine available for the treatment of drug-dependent persons, based on factors that ignore the best available medical evidence as to its effectiveness, can only be described as arbitrary and unreasonable, and as such is a violation of the right to health.

The opponents of maintenance therapy in Russia, led by top officials, reject the vast body of solid scientific evidence compiled over decades through studies in

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[140] Article 55(2) of the 1998 Federal Act on Narcotic Drugs and Psychoactive Substances limits detoxification treatment to state institutions. Federal Act on Narcotic Drugs and Psychotropic Substances, art.55(2).

[141] SAMHSA/CSAT notes, for example, that hospitalization or another form of 24-hour medical care "is often the preferred setting for detoxification" for patients with opioid withdrawal symptoms. SAMHSA/CSAT, TIP 45, p. xvi.

[142] Federal Act on Narcotic and Psychotropic Substances, art. 55(2).

numerous different countries that unequivocally confirms the effectiveness and cost-efficiency of maintenance treatment for drug users. They have dominated public discussion of the topic and managed to sideline scientific evidence in discussions of the issue in mainstream medical journals in Russia. They have variously maintained in these medical journals—in contradiction of the conclusions of the overwhelming majority of research studies—that maintenance therapy is dangerous for patients, ethically unacceptable, a ploy by drug companies to line their pockets, or has recently been shown to be ineffective as treatment.

The most brazen publication of this sort was a memorandum that appeared in *Meditsinskaia gazeta* (Medical Newspaper) and *Voprosy Narkologii* (Issues in Narcology), both widely read among healthcare professionals, in 2005 under the signature of top healthcare officials, including Russia's chief narcologist Nikolai Ivanets and the chair of the Russian Society of Psychiatrists. The memorandum selectively quotes a small number of research studies and articles by a few individual specialists that express concerns about maintenance treatment, while completely ignoring hundreds of studies that confirm its effectiveness and safety. On top of that, many of the citations and references in the memorandum were inaccurate or misleading. Some of the most outrageous assertions in the memorandum include:

- The suggestion that methadone maintenance treatment poses a risk to the health of patients by causing a variety of serious side effects and because of a risk of methadone overdose. However, the memorandum does not provide any references for some of these assertions, while other references are inaccurate and misleading. The memorandum ignores the fact that hundreds of studies have unequivocally shown the safety and efficacy of methadone.
- The suggestion that profit for pharmaceutical companies producing methadone ("this rather expensive narcotic") is the driving factor behind the promotion of maintenance treatment. The memorandum stated that "[r]ecently observed attempts to legalize methadone programs and introduce them into the drug treatment system are not based on therapeutic motives, but rather on economic purposes. The cost of realizing these purely profit-minded aims is the lives and health of drug addicts." The memorandum

ignores the fact that methadone is very cheap to produce and that numerous studies have shown its cost-effectiveness, as compared to providing patients with inpatient treatment.

- The memorandum further stated that "[n]owadays lobbyists of methadone producers and methadone programs do not call attention to the problem of treating drug addiction, but try to represent methadone as a panacea for "saving" from AIDS… At the same time parenteral drug use is not the only, and nowadays, is not the primary way of HIV transmission. Only a low percentage of heroin addicts are HIV-positive, and this is definitely not justification enough to introduce the program of drug supply for all drug addicts." This assertion is completely inaccurate and dangerously downplays the extent of the HIV epidemic in Russia. An estimated 80 percent of all people living with HIV in Russia are current or former drug users who were infected through sharing of injection equipment. Around 10 percent of injection drug users in Russia are infected with HIV, more than 10 times higher than in the general population.[143]
- Finally, the memorandum suggests that various different United Nations bodies have expressed concern about or opposition to maintenance treatment in recent years and that, therefore, the publication of a joint WHO, UNODC, UNAIDS position paper, which endorsed maintenance therapy as an effective method of drug dependence treatment and an effective instrument in preventing HIV transmission among drug users, was a surprise as it "was practically contrary to all previously held research and conventions and decisions of the United Nations." Again, this assertion is inaccurate as, in fact, the position paper simply reaffirms the findings of the majority of researchers who have examined maintenance therapy programs, as well as those of the various international organizations mentioned.[144]

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

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

For a more detailed analysis of the inaccuracies in the memorandum, see a response to it from several dozen drug dependence treatment experts from Europe and North America that was published on the website of the International Center for the Advancement of Addiction Treatment.[145]

In another article, A.V. Nadezhdin of the National Research Institute for Substance Abuse wrote that "after a period of unjustified 'high expectations,' 'hope' and initial successes, countries that had introduced maintenance therapy programs had become disillusioned with them and have started to move away from the methadone programs."[146] However, as was described above, maintenance programs with methadone and buprenorphine, and sometimes also medically prescribed heroin, continue to be introduced in more and more countries and the number of patients has grown rapidly in recent years.

While opponents of maintenance therapy have been able to publish the above memorandum and other writings, despite their gross inaccuracies, in medical journals in Russia, there has been very little space in these publications for articles that discuss the findings of the hundreds of scientific studies that have documented the merits (and challenges) of maintenance therapy. Vladimir Mendelevich, a psychiatrist and advocate of maintenance therapy, has observed that maintenance therapy

> is practically not analyzed [in Russia]. An unspoken prohibition has been imposed on the very discussion of the topic in academic circles. The official Russian narcology is categorically opposed to this method and as a result the number of publication in academic journals, collections of articles, and materials at academic conferences has been negligible. There is no open discussion about the issue.[147]

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[145] See http://www.opiateaddictionrx.info/pdfs/SayNo2MethadoneRealFacts.pdf and http://www.opiateaddictionrx.info/pdfs/SayNo2Methadone.pdf (accessed July 24, 2007).

[146] A.V. Nadezhdin, undated, http://www.drugpolicy.ru/?page=publications/publ_hr61_methadon.

[147] V.D.Mendelevich, "Drug dependence and narcology through the prism of public opinion and professional analysis" ("Narkozavisimost I narkologia cherez prizmu obshestvennogo mnenia I professionalnogo analiza"), Kazan 2006, p. 196.

As if to affirm this assertion, when Mendelevich launched a website on maintenance treatment in February 2006 that was meant to encourage academic debate, the prosecutor's office ordered him in for questioning as it had received a complaint from a member of parliament that the website promoted the use of illicit drug use. The prosecutor's office closed down the website after an expert panel concluded that it contained propaganda for illicit drug use. Mendelevich himself, however, was not charged with any criminal offense.[148]

The willful publication of inaccurate information about maintenance treatment and the monopolization of the discussion on the topic violates the right to health, in particular the obligation to ensure access to accurate information about health issues.[149] Access to appropriate information about health issues that enables individuals to make rational choices about their personal health is also an element of the right to private life protected by the European Convention on Human Rights (ECHR).[150] The European Court of Human Rights has often held that a state has positive obligations that stem from an obligation to ensure effective respect for private life.[151] An aspect of those positive obligations can be to make available and accessible accurate information on health risks.[152] Failure to provide essential information could amount to a violation of the right to effectively protect a person's private life. The ECHR also protects the right to receive information (paragraph 2 of Article 10) and accordingly a government may not arbitrarily restrict a person from receiving information that others wish or may be willing to impart to him.[153]

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[148] Tom Parfitt, "Vladimir Mendelevich: fighting for drug substitution treatment," *The Lancet*, Volume 368: 9532, pp. 279-279.

[149] General Comment No. 14, para. 12.

[150] Article 8 of the European Convention on Human Rights states that "1. Everyone has the right to respect for his private and family life, his home and correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others." European Convention for the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocols Nos 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998, respectively.

[151] European Court of Human Rights, *Airey v. Ireland*, 1979, 2 E.H.R.R. 305, judgment of October 9, 1979, Series A, no. 32, p. 17, section 32.

[152] European Court of Human Rights, *López Ostra v. Spain*, 1994, Application No. 16798/90, judgment of 9 December 1994, Series A, no. 303-C, and *Guerra and others v. Italy*, Application No. 14967/89 judgment of February 19, 1998, Reports 1998-I.

[153] European Court of Human Rights, *Leander v. Sweden*, Application No. 9248/81, Judgement of 26 March 1987, Series A, no. 116, p. 29, section 74.

Rehabilitation Services

Rehabilitation treatment at state clinics is currently available in less than one-third of Russia's regions, although the availability of rehabilitation treatment is gradually growing as regional governments are paying for the creation of centers. Despite the fact that Russian law contains an explicit guarantee that healthcare services, including rehabilitation treatment, must be available to drug users, the Russian federal government has failed to adopt a federal plan with a clear timeline for the creation of new rehabilitation centers and programs in the country's regions and to make the appropriate funding available. Instead, the federal government has left the creation and operation of rehabilitation services to the regions and failed to take appropriate steps to ensure that regions were making rehabilitation services available, as required by law. In some regions, small private rehabilitation programs may be operational but these generally offer few beds, may be too expensive for drug users, or may not suit all potential patients because they are faith-based. The failure of the federal government to make adequate efforts to realize the law guaranteeing rehabilitation services to people affected by drug dependence is inconsistent with the right to health. The discrepancy between the availability of detoxification and rehabilitation treatment also makes no public health or economic sense, as patients in regions without sufficient rehabilitation programs can begin but not continue treatment of their drug dependence, thus severely compromising their chances of recovery.

The limited availability of rehabilitation treatment was a problem in one of the three regions we visited to conduct research for this report. In Kaliningrad there is no state rehabilitation center although the city's narcological clinic does offer a 45-day outpatient rehabilitation program after detoxification treatment. There are a number of private rehabilitation programs, including two that are offered by protestant churches and three nongovernmental centers with a total of about 60 beds. However, the faith-based programs require or expect that patients subscribe to the religious beliefs of the church offering the program. Treatment at the nongovernmental rehabilitation center costs about 7,000 rubles (approximately US$275) per month for six to twelve months of treatment for residents of Kaliningrad and more for people from other regions, putting it outside the budget for many drug users (although recently one of these centers has begun to offer some beds for free treatment). At the

time of Human Rights Watch's visit a substantial portion of these centers' patients were from outside Kaliningrad region. Overall, rehabilitation services were unavailable to many drug-dependent persons in Kaliningrad.

In an interview with a local newspaper, the chief narcologist for Kaliningrad decried the lack of a state rehabilitation center:

> We do a wonderful job curing the body, cleaning it, saving it. But then what? There is no medical rehabilitation center. Camps for social and work readaptation that are run by people who used to be dependent, like Orekhovo, do not save the day. Treatment there is based primarily on work therapy and self-help. Capacity is only 30 people per year. And that on 30 thousand drug-dependent persons! I fight for the creation of a center where each patient would have round-the-clock access to a specialized psychologist.[154]

There have, however, been some important positive developments recently. The Ministry of Labor has awarded the Orekhovo rehabilitation center a grant that will allow it to admit some recovering drug users from Kaliningrad region free of charge. It also appears that in the next few years a rehabilitation center may in fact be established in Kaliningrad. In a regional program of measures to counter the circulation of illicit drugs and "anti-social behavior among youth" for 2007 to 2011, the government of Kaliningrad province has allocated about 1.5 million rubles (approximately US$600,000) to the construction of a regional rehabilitation center.[155]

At first glance, availability of rehabilitation treatments does not appear to be a problem in Tatarstan. The city of Kazan has several rehabilitation programs with a total capacity of about 70 beds. Both state narcological clinics in Kazan run short-

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[154] Marina Selivanova, "Drugs, like diabetes – an illness for life" ("Narkotiki, kak diabet, - bolezn na vsiu zhizn"), *Argumenty i Fakty*, September 6, 2006.

[155] "Program of Kaliningrad province, 'Comprehensive measures to counter the unlawful circulation of narcotic drugs and prevention of anti-social behavior among youth for 2007-2011'" ("Tselevaia programma Kaliningradskoi oblasti 'Kompleksnye mery protivodeistvia nezakonnomu oborotu narkotikov i profilaktiki asotsialnogo povedenia v detsko-molodezhnoi srede na 2007-2011 gody'"), p. 21. A copy of the program is on file with Human Rights Watch.

term inpatient rehabilitation programs that have 12 and 28 beds, some of which are officially slated for free treatment. The region's substance abuse service also has a three-month residential rehabilitation center in Bolshie Kliuchi, outside Kazan, which has about 30 beds and was opened in October 2006. A nongovernmental organization called Roza Vetrov runs a three-month outpatient rehabilitation program—with financial support of, among others, the local ministry of health and narcotic drug control police—with about 20 places. Yet, these rehabilitation programs are the only ones for all of Tatarstan, which has a population of 3.7 million people and an estimated 9,000 drug users in the city of Kazan alone.[156] Furthermore, adjacent Volga regions, like the republics of Bashkortostan, Udmurtia, and Chuvashia, and Ulianovsk and Kirov provinces, do not have their own state rehabilitation centers, although some do have confession-based and commercial programs. The rehabilitation programs in Kazan thus end up serving these regions as well.

Indeed, a number of people in Kazan said that there were waiting lists for non-paying patients who come out of detoxification and want to continue in rehabilitation. For example, Alexander Dmitriev, a psychologist at Roza Vetrov, told Human Rights Watch, "If you are a registered [non-paying] drug user, they can release you from the detoxification clinic and sign you up for 'next week' for rehabilitation. The question is, of course, how [the drug user] will make it through that week..."[157]

In Penza province a state rehabilitation center exists in Russky Ishim. However, the drug users we asked about this rehabilitation center dismissed any possibility of going there, saying it was a place where "homeless alcoholics live." The rehabilitation center does not admit HIV-positive patients.

Many other regions do not have state rehabilitation centers. For example, drug users in Tver province need to travel to Pskov province for rehabilitation, something that, according to a local narcologist, few do.[158] A qualitative study conducted among drug

[156] Interdepartmental commission on the fight against AIDS under the government of the Republic of Tatarstan, "Analysis of the situation of HIV-infection and injection drug use in the city of Kazan," Kazan, 2006.

[157] Human Rights Watch interview with Alexander Dmitriev, Kazan, January 26, 2007.

[158] Human Rights Watch telephone interview with Yuri Ivanov, April 2, 2007.

users by Bobrova and others in the cities of Barnaul, Ekaterinburg, and Volgograd found that only Barnaul had a state-run rehabilitation center, with 25 beds. It observed that in the other cities

> small-scale and independent religious rehabilitation programs (n = 15) that several respondents had used were available. There were a few respondents who could afford to travel to other countries (Ukraine and Kazakhstan) for rehabilitation.[159]

The Accessibility Requirement

The right to health requires that medical goods and services be accessible. As has been described above, this means that these goods and services must be physically accessible, provided without discrimination on any ground, affordable for patients (though not necessarily free of charge), and that information must be available about them. These various requirements are applicable to both detoxification and rehabilitation services. As the vast majority of drug users interviewed for this report had only made use of state detoxification services and had not received rehabilitation treatment, the discussion below focuses mostly on the accessibility of detoxification clinics.

The accessibility requirement is of particular importance in the treatment of drug dependence because drug users are often marginalized, hidden from the public view for fear of criminal law sanctions or because of social stigma attached to drug use. In drug user circles, accurate information about drug dependence treatment options is often not readily available, while myths about it abound. These and other factors may make drug users ambivalent about ending their drug use, and their motivation for treatment may come and go. Ideally, therefore, drug dependence treatment should not just be readily accessible but clinics should also actively reach out to drug user communities to disseminate information and offer them treatment.

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[159] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence.*

In Russia, however, there are a number of barriers caused by state policy that keep drug users away from these services. An obvious and arbitrary barrier (mentioned above and discussed further below) is the fact that drug-dependent persons who voluntarily seek help—behavior that states should clearly encourage—are entered into a drug user registry (unless they pay for their treatment) which is used to impose restrictions on their rights. Other barriers to treatment-seeking behavior include the cost of treatment, and a requirement to collect paperwork on various health conditions prior to admission. These administrative and bureaucratic barriers are compounded by a widespread feeling of mistrust in state narcological clinics among drug users, who do not believe that the services they offer are effective, view the system as corrupt, and are concerned about breaches of confidentiality and poor conditions. State clinics have done little to reach out to potential patients to try to convince them otherwise, and rarely engage in proactive outreach to the drug user community.

Physical Accessibility

In the General Comment on the right to health, the Committee on Economic, Social and Cultural Rights defines the physical accessibility requirement in a literal sense. It states, for example, that "health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups."[160] However, there are also other barriers to access, such as excessively burdensome, and unnecessary, admission procedures that may deter people from seeking treatment and could thus violate the physical accessibility requirement. In Russia, a number of different factors keep people away from substance abuse clinics.

Drug User Registration

The drug user registration system keeps users away from substance abuse clinics by penalizing rather than rewarding treatment-seeking behavior. In dozens of interviews, drug users who are not on the registry told Human Rights Watch that they were highly apprehensive about being registered as they feared that registration would lead to disclosure of their status to law enforcement agencies or others, as well as to

[160] CESCR, General Comment 14, para. 12(b).

restrictions on their rights, particularly their possibility to drive (see also below). Many drug users interviewed for this report said that they or their relatives had tried to collect money in order to pay for so-called "anonymous" services and avoid registration. Avoiding registration by paying for services is a formal practice, provided for by the law.[161] For example, Andrei A. said,

> I didn't want to be on the registry. I was worried about confidentiality, that people will find out that I'm a drug user. So my mother paid money for detoxification treatment.[162]

Igor I., another drug user, said that he had never sought treatment at a drug clinic because of the registry: "I am a driver by profession. They would immediately put me on the registry and I would lose my job."[163] Igor I. said that he did not have the money to pay for "anonymous" treatment.

A qualitative study of 86 drug users in two Russian cities in 2003 also concluded that drug user registration was an obstacle to treatment. It stated that

> almost all of the … participants said that registration was a significant disincentive to accessing treatment and removing this obstacle might increase the number of clients in drug treatment facilities. Drug users' primary concern was employment because it was commonplace in both cities for employers to request a note from drug treatment services concerning registration.[164]

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[161] Paradoxically, while Human Rights Watch found that drug users who are not registered were highly apprehensive about being put on the registry, most drug users who were on the registry told us that they had not come across any restrictions on their rights because of their registration. When asked about obtaining a driver's license, one drug user laughed and said: ""I did get my driver's license, even though I'm on the registry. It's corruption. Anything is for sale." Human Rights Watch interview with Roman R, Kaliningrad, January 31, 2007. But we also interviewed one former drug user whose driver's license had been taken away from him because a traffic police computer had him listed as a registered drug user. The local narcological service had apparently shared his information—and possibly information on everybody on the registry in that town—with the traffic police. Human Rights Watch interview with Anton Blinov, Kazan, January 24, 2007.

[162] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

[163] Human Rights Watch interview with Igor I., Kazan, January 23, 2007.

[164] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence.*

The study said that respondents felt that they were in a "vicious circle" and that registration was perceived as a "stamp on the forehead." The study said that the negative attitude toward registration was also based on potential or experienced breaches of confidentiality toward parents, partners, colleagues, or neighbors. There was also fear that drug treatment services would share lists of registered drug users with the police and that this would lead to harassment by police.[165]

While several narcologists interviewed for this report defended the drug user registry as necessary to ensure public safety, there was also some recognition in the leadership of the drug dependence treatment service that the registry keeps drug users away from treatment services. Evgenia Koshkina, head of the epidemiological department at the Institute of Substance Addiction Research in Moscow, told Human Rights Watch that she and her colleagues were aware of the deterrent effect of the registry and that discussions were underway to change the system to limit categories of drug users who would be officially registered.[166] However, it does not appear that these changes are imminent.

Pre-admission Paperwork

In many regions drug users are required to obtain a variety of certificates regarding health conditions like HIV, hepatitis, TB, and syphilis before they can be admitted to inpatient detoxification treatment. In Irkutsk the narcological clinic even requires a cardiogram.[167] This means that drug-dependent persons who want to get treatment must visit at least one and sometimes various medical institutions in order to undergo the relevant tests, potentially pay money for them, and then wait for test results. As a consequence, drug users who have decided to enter drug dependence treatment are more or less forced to continue their drug use, at least temporarily, to avoid the onset of withdrawal symptoms.

From a public health perspective, it does not make sense to require these health certificates upon admission. The requirement creates an additional hurdle for drug

[165] Ibid.

[166] Human Rights Watch interview with Evgenia Koshina, Moscow, March 7, 2007.

[167] Human Rights Watch email correspondence with Andrei Zlobin of the Community of People Living with HIV/AIDS, July 25, 2007.

users seeking treatment, delays the entry into treatment for people who may be very ill and in need of hospitalization, and may lead to the loss of potential patients. At the same time, there is no compelling public health need to have these tests done prior to admission.[168] Human Rights Watch therefore considers these requirements to be arbitrary hurdles to the accessibility of drug dependence treatment that violate the right to health.

As it is of obvious importance for staff at narcological clinics to know their patients' HIV, hepatitis B and C, and tuberculosis status, the tests that are now required prior to entry into treatment should be conducted after admission as part of the intake medical examination. Where narcological clinics do not have the equipment to conduct these tests, arrangements should be made with other branches of the healthcare system, like AIDS centers and TB hospitals, to facilitate the tests.

A drug user in Kazan told Human Rights Watch that he had paid someone at the narcological clinic a bribe so he would not have to present the certificates because he realized that he might reconsider his decision to enter into treatment if he was not admitted to the clinic right away. He said,

> Call it corruption or something else but I understood perfectly well—and so did my mother—that if I started running around to gather all sorts of certificates, give blood samples, and wait for analyses, that might mean that I would continue to use [drugs] and there would be no guarantee that I would ever return to the detoxification clinic.[169]

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[168] Infectious diseases like HIV, hepatitis, or syphilis spread only through specific risk behaviors, and admitting patients with these diseases without prior knowledge of a patient's status does not pose any additional risk to the health of the clinic's staff or other patients. While active pulmonary TB is highly contagious and can spread through the air, a number of simple steps can be taken to minimize the risk of accidental infection of clinic staff and other patients and admit the person into treatment immediately. Medical doctors should conduct a basic screening of new patients upon admission for signs and symptoms of active TB—loss of appetite, rapid weight loss, night sweats, coughing—to identify high-risk patients. Patients without signs and symptoms of TB should be admitted immediately as the chance that they nonetheless have contagious TB is very small. High-risk patients should immediately be referred for a chest X-ray and, if positive for TB, be admitted to special TB wards at drug treatment clinics, where available, or to TB hospitals. These patients should under no circumstances be denied hospitalization as they pose a risk to the general public and are very sick. Human Rights Watch interviews with Dr. Douglas Bruce, a clinical instructor of medicine at the infectious diseases section of Yale Medical School and medical director of the SouthCentral Rehabilitation Center in New Haven; and Sharon Stancliff, medical director of the Harm Reduction Coalition in New York.

[169] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

The arbitrariness of the requirement is underscored by the fact that not all health facilities offering detoxification treatment for drug users require new patients to present health certificates. In Penza, for example, Human Rights Watch was told that such a requirement does not exist and that the narcological clinic itself conducts HIV, hepatitis, and TB tests. In Irkutsk and St. Petersburg narcological clinics demand certificates for various health conditions upon admission into detoxification treatment, whereas psychiatric hospital #1 in Irkutsk and hospital #9 in St. Petersburg do not.[170]

Distrust of Drug Dependence Treatment Services

Our research and that of others found a pervasive and profound lack of trust in state narcological services among drug users, which keeps many of them from seeking treatment. This distrust appears to be closely linked to the poor effectiveness and efficiency of the drug dependence treatment services offered in Russia. Many drug users also said that they did not trust the state clinics because they saw the clinics and their doctors as corrupt and not committed to their recovery. Although this distrust is not the consequence of a specific state policy that limits access to treatment in an arbitrary or discriminatory manner, Russia does have a positive obligation under the right to health to take steps to counter it. In particular, it needs to ensure that policies pursued by state clinics do not give objective grounds for distrust, which failure to offer effective evidence-based services could do. Furthermore, Russian authorities need to take steps to address the corrupt practices at the clinics that many drug users described.

Human Rights Watch encountered considerable skepticism about the effectiveness of drug treatment provided at state clinics among drug users in each of the cities visited. In Penza this skepticism was particularly pronounced. Many of the drug users there completely dismissed the possibility of going to the narcological clinic for treatment. A worker at the harm reduction program in Penza said that she knows very few drug users who make use of the state clinics, as drug users generally see

[170] Human Rights Watch email correspondence with Roman Muravev of FrontAIDS, Irkutsk, July 25, 2007. Human Rights Watch interviews with various drug users at hospital #9, St. Petersburg, July 2007.

these services as ineffective.[171] Yura Y., a drug user in his fifties who has used drugs for several decades, said that he had never been in the state clinic. He said,

> What's the point? Why go there when you can do the same intravenous drip at home. It's better to turn off your phones and lock yourself in your apartment. That way you have a toilet and water right near you.[172]

Another drug user in Penza said that despite the fact that he had been using drugs for more than 15 years he had never gone to the local narcological clinic for detoxification because "they do nothing to help you there… I'd rather spend the money on drugs than pay 900 rubles [for ineffective treatment]."[173]

We encountered similar sentiments in Kazan and Kaliningrad as well. A 25-year-old female drug user from Kazan who last went through detoxification treatment in March 2006 told Human Rights Watch,

> I'm not going back there. There's no point, they don't cure you. I would go to the detoxification clinic if they actually helped [me] there. I'm sick and tired of injecting. But I can't do it [withdraw] at home. There are too many temptations… I would like to live to 30 at least…[174]

A sociologist in Kaliningrad who conducted research among drug users in 2006 and interviewed 14 drug users and more than two dozen officials and medical personnel who work on drug-use-related issues told Human Rights Watch, "There is a strong distrust of the narcological clinic [in this city] because of perceived ineffectiveness of treatment offered, the registry, and poor conditions."[175]

Perceptions that doctors at state narcological clinics are overwhelmingly corrupt add to the distrust. Several drug users mentioned paying bribes in order to get into

[171] Human Rights Watch interview with Irina I., Penza, April 11, 2007.

[172] Human Rights Watch interview with Yura Y., Penza, April 16, 2007.

[173] Human Rights Watch interview with Sergei S., Penza, April 16, 2007.

[174] Human Rights Watch interview with Svetlana S., Kazan, January 25, 2007.

[175] Human Rights Watch interview with Inna Vyshemirskaya and Viktoria Osipenko, Kaliningrad, January 30, 2007.

clinics without having to wait or to avoid having to bring in the paperwork on other health conditions that is normally required for hospitalization. A number of drug users and workers in harm reduction programs expressed the theory that state alcohol and drug dependence clinics are not interested in the recovery of drug users because they make good money off them as long as they are sick. As long as state clinics have a monopoly on medicated detoxification treatment, drug users have the option of the state clinic or unmedicated withdrawal at home. Echoing this common sentiment, one former drug user said,

> Narcologists are just not at all interested in treating drug users. Treating them in the full sense of the word, I mean, with two-step treatment: first detoxification, then rehabilitation. It is beneficial for narcologists to have people in detoxification constantly.
>
> Paid treatment costs a thousand rubles per day for 10 days. They [the narcologists] don't tell the drug user to go into rehabilitation treatment. It's not beneficial for doctors. After a maximum of 14 days, the drug user leaves the clinic. And [soon] he starts injecting again, his dose increases again. What then? He goes back to them [the narcological clinic], and again pays 10,000 rubles. That's the vicious circle. They [the narcologists] live well; they drive foreign [Western] cars.[176]

Several studies by scientists have also found widespread distrust of the drug dependence treatment system. For example, a study conducted in three Russian cities in 2003 found that

> drug users have little trust in the treatment system, perceive the system to be as much a hindrance as a help, and associate treatment with high failure rates, short remissions, and continuing drug use.[177]

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[176] Human Rights Watch interview with Arkadi A., Kazan, January 24, 2007.

[177] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence.*

The study also found that "treatment was perceived as stigmatized, thus discouraging drug users from using services and potentially leading to the continued use of drugs and/or risky behavior."[178] Another study by the same researchers, conducted in 2003 and 2004, corroborated these findings:

> Negative experiences with service providers were also reported as one of the reasons why IDUs [intravenous drug users] did not come to treatment (or came when the problem was already very serious) and why there is widespread experience of self-treatment… In our study, most participants (68 percent) had negative attitudes toward the current state of drug abuse treatment services in Russia.[179]

Some drug users also associated the drug treatment system with law enforcement. For example, Yura Z. from Penza, a drug user since 1994, expressed the view that "if you go to the clinic, the police will soon put you in jail for drugs." He said that he preferred going through detoxification at home. He had found a narcologist who came to his house for a fee of 1,200 rubles per day, and gave him injections with the sedative relanium.[180]

Economic Accessibility and Non-discrimination

> Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
>
> Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the

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[178] Ibid.

[179] Bobrova et al., "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities."

[180] Human Rights Watch interview with Yura Z., Penza, April 16, 2007.

> population, in law and in fact, without discrimination on any of the prohibited grounds.
>
> —Committee on Economic, Social, and Cultural Rights, General Comment 14[181]

The right to health does not require states to offer drug treatment services free of charge, but these services do have to be "affordable to all," including socially disadvantaged groups—to which most drug-dependent people belong. However, as already noted, Russia's constitution stipulates that "[m]edical aid in state and municipal health establishments shall be rendered to individuals gratis, at the expense of the corresponding budget, insurance contributions, and other proceeds."[182] It is, nevertheless, general practice in Russia that state and municipal clinics offer paid services along with those free of charge.

Although in line with the constitutional requirement narcological clinics formally offer free treatment to patients, the treatment is often in fact not without costs. In many regions narcological clinics are underfunded and try to supplement their budgets by assessing out-of-pocket charges and encouraging patients to opt for paid services. Drug users in both Penza and Kaliningrad told us that they, or their parents, had paid doctors at the clinics for medications or had bought them at pharmacies on their instructions. (By contrast, drug users in Kazan did not complain of being assessed out-of-pocket charges and Albert Zaripov of Roza Vetrov said that in his experience free treatment in Kazan truly meant that treatment was free.[183])

Bobrova and others found in their 2003 study that these fees posed a significant obstacle to treatment for some drug users. Three-quarters of participants in the study mentioned financial difficulties as a barrier to accessing drug treatment. The study found that many drug users in need of treatment were unemployed and unable to pay for their treatment without assistance, and that most relied on their parents' willingness and ability to pay for treatment. Its data also suggested that drug users

[181] CESCR, General Comment 14, para. 12(b).

[182] Constitution of the Russian Federation, art. 41(1).

[183] Human Rights Watch telephone interview with Albert Zaripov, June 29, 2007.

> with longer drug-using careers and with more severe addiction problems found it more difficult to fund their drug treatment than other IDUs did. Their personal resources were mostly allocated to purchasing drugs, they were more likely to be unemployed, and their family resources were most likely to be exhausted or unavailable because of mistrust.[184]

Drug users and NGO workers said that narcological clinics pressured people indirectly to pay for treatment in several different ways. As mentioned above, in Kazan and Kaliningrad only limited numbers of beds are available for free treatment, sometimes resulting in patients having to wait weeks before they can start treatment, while those who pay are admitted immediately.

The fee-for-anonymity system is another way in which drug users are pushed to pay for services. As has been discussed above, our research and that of Bobrova has shown that the vast majority of drug users who are not registered express a high degree of apprehension about being registered and many told Human Rights Watch that they and their relatives tried to find money to pay for treatment to avoid being registered.[185]

As noted above, the cost of treatment varies somewhat from region to region but averages between 750 and 1,000 rubles (US$30 and $40) per day. Ten days in detoxification treatment will thus cost a patient between 7,500 and 10,000 rubles (approximately US$300 and $400), payable at the start of treatment.

The cost of rehabilitation services is even higher, as rehabilitation treatment lasts longer. For example, a standard paid treatment course of 28 days in the state-run rehabilitation program in Kazan costs 16,500 rubles (about US$625). Where no state rehabilitation centers are available, the cost may be even higher.

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[184] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence.*

[185] Ibid.

Poor drug users face a starker choice than those with money: getting treatment but being registered as drug users or remaining off the registry but receiving no treatment. Igor I., a drug user in Kazan, is one of the people we interviewed who faced that choice. A driver by profession and the sole provider for a family of four, he told Human Rights Watch that he would lose his livelihood if he was entered onto the registry but did not have enough money to pay for treatment: "Paid treatment is really expensive. I don't see how anyone could afford that." Igor I. said that he had undertaken numerous attempts to stop using drugs, each time going through withdrawal at home, but was never able to stay abstinent for more than a month or two at a time.[186]

The fact that it is possible to pay for anonymity demonstrates that registration is not objectively necessary, but in fact creates an unnecessary burden only on poor drug users and therefore violates the principle that healthcare services should be accessible without discrimination.

Information Accessibility

> Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
> —Committee on Economic, Social, and Cultural Rights, General Comment 14[187]

States are obliged to ensure that patients can obtain and impart information about treatment services. In light of the considerable stigma attached to drug use and drug dependence treatment and the marginalization of drug users, UNODC and others recommend proactive steps by treatment centers to reach out to drug users with information about treatment through open access services, such as harm reduction programs, family support groups, drop-in centers, and telephone hotlines.

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[186] **Human Rights Watch interview with Igor I., Kazan, January 23, 2007.**

[187] **CESCR, General Comment 14, para. 12(b).**

In the regions Human Rights Watch visited, state narcological clinics did a poor job of making information about treatment available and encouraging drug users to seek treatment. In Kaliningrad, Penza, and Kuznetsk, for example, no adequate information was on display about effective drug dependence treatment modalities in the outpatient wards of state narcological clinics that are visited by many drug users and their families. In Kaliningrad Human Rights Watch researchers found no information about the nature of drug dependence or effective treatment modalities on the walls along a long corridor where drug users and their families wait to be seen by narcologists, let alone pamphlets or brochures with information that people could take home and digest at their leisure. Two pamphlets did invite people to come to individual or group consultations with psychologists and self-help groups, and briefly described the kinds of services that the psychologists offered. In Kuznetsk there were densely hand-written—and very difficult to read—posters about narcotic drugs and alcohol that provided little or no information about effective drug treatment modalities.

In cities where open access services exist, like Kazan and Penza, narcological clinics often adopt a passive attitude: patients who show up at the clinic are seen and offered treatment, and the clinics do not seek to use open access services to reach out to the drug user community with information about treatment options and other relevant services. As a result, harm reduction programs and other open access services do not play the important bridging role they could perform between the drug user and the healthcare community.

An HIV-positive peer counselor on antiretroviral treatment in Kazan told Human Rights Watch about his frustration with the lack of proactive outreach by the local narcological clinic toward drug users. He said that he felt that, as a peer counselor, he does work that the narcological clinics themselves should be doing but are not. He told Human Rights Watch that in the past year he had brought 50 drug users to narcological clinics, and motivated 30 of them to go through a rehabilitation program, seven of whom, he said, are now in a stable remission. Pondering his own situation, he said,

> If they [the narcological service] had extended a helping hand to me a lot earlier, I might not have fallen as far as I had at the moment [I came to them for help myself]… Maybe I would not have been infected with HIV. Maybe there wouldn't have been those years of my life that were lost…[188]

Cooperation between harm reduction programs and state narcological clinics is often limited to harm reduction programs bringing drug users who want to stop using drugs or need to reduce their dose to narcological clinics. In some cases, according to Anya Sarang of the Russian Harm Reduction Network, clinics will admit patients brought to them by harm reduction groups without a wait. Sarang was skeptical about the usefulness of proactive outreach by narcological clinics as long as these clinics offer poor quality services.[189]

Sergei Oleinik of the Foundation Anti-AIDS in Penza, which runs a needle exchange program, told Human Rights Watch that he would be happy to work with the drug treatment service, but only if it offered better treatment services. He said that his harm reduction program had agreed to circulate information about drug treatment services to drug users a number of years ago and had motivated some to enter into the treatment system. However, he said that these drug users came back with such poor assessments of the treatment they had received that he felt forced to abandon the effort out of fear of alienating his clients.[190]

In Kaliningrad street services hardly exist at all as the local authorities are strongly opposed to harm reduction programs that include needle exchange, which complicates accessibility of information about treatment services even more. A sociologist who conducted research among drug users and healthcare specialists told Human Rights Watch, "Because nongovernmental street services are completely non-existent, they [doctors at the narcological clinic] of course have trouble finding clients. There are no links to the [drug user] groups…"[191] Svetlana Prosvirina, a peer

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[188] Human Rights Watch interview with Anton Blinov, Kazan, January 24, 2007.

[189] Human Rights Watch telephone interview with Anya Sarang, Turkey, July 9, 2007.

[190] Human Rights Watch telephone interview with Sergei Oleinik, Penza, June 29, 2007.

[191] Human Rights Watch interview with Inna Vyshemirskaya and Viktoria Osipenko, Kaliningrad, January 30, 2007.

counselor with the AIDS center in Kaliningrad who also leads a Narcotics Anonymous group, told Human Rights Watch that in 2006 she had had access to the inpatient facility of the narcological clinic where she provided patients with information about the group and encouraged them to attend it. But she said that "it ended in complete collapse" after a journalist sneaked into the facility and broadcast an unflattering piece about one of the narcologists. At the time that Human Rights Watch interviewed her, Prosvirina was no longer able to even visit the narcological clinic's inpatient detoxification facility and outpatient rehabilitation program.[192]

In some regions narcological clinics run harm reduction programs or work closely together with them, and have thus established important links to the drug user community. Anya Sarang observed that in these regions drug dependence treatment services are generally more developed. For example, she said, in Toliatti in Samara province needle exchange is one of a series of services that the local narcological clinic has available to drug users. Among the other services offered, she named rehabilitation treatment and an aftercare program.[193]

The Acceptability Requirement

> All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
> —Committee on Economic, Social, and Cultural Rights, General Comment 14[194]

Principles of medical ethics and cultural values are at the core of the acceptability requirement of the right to health. Healthcare goods or services that are inconsistent with these principles and values will also violate the right to health. A core aspect of the acceptability requirement is the right to respect for confidentiality of medical information. This right is also separately protected by the European Convention on

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[192] Human Rights Watch interview with Svetlana Prosvirina, Kaliningrad, February 2, 2007.

[193] Human Rights Watch interview with Anya Sarang, Turkey, July 9, 2007.

[194] CESCR, General Comment 14, para. 12(c).

Human Rights and Fundamental Freedoms and the International Covenant on Civil and Political Rights (ICCPR), to which Russia is also a party.[195]

The European Court of Human Rights has emphasized the importance of medical confidentiality by nothing that

> the protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private life…Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general.
>
> Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community (see Recommendation no. R (89) 14 on "The ethical issues of HIV infection in the health care and social settings", adopted by the Committee of Ministers of the Council of Europe on 24 October 1989, in particular the general observations on confidentiality of medical data in paragraph 165 of the explanatory memorandum).
>
> The domestic law must therefore afford appropriate safeguards to prevent any such communication or disclosure of personal health data as may be inconsistent with the guarantees in Article 8 of the Convention (art. 8) (see, mutatis mutandis, Articles 3 para. 2 (c), 5, 6 and 9 of the Convention for the

[195] Article 8 of the ECHR and Article 17(1) of the ICCPR state, "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation." According to Manfred Nowak in his treatise on the ICCPR, the right to privacy includes a right of intimacy, that is, "to *secrecy* from the public of private characteristics, actions or data." This intimacy is ensured by institutional protections, but also includes generally recognized obligations of confidentiality, such as that of physicians or priests. Moreover, "protection of intimacy goes beyond publication. Every invasion or even mere exploration of the intimacy sphere against the will of the person concerned may constitute unjustified interference" [emphasis in the original]. Manfred Nowak, *UN Covenant on Civil and Political Rights*: *CCPR Commentary* (Kehl am Rein: N.P. Engel, 1993), p. 296.

> Protection of Individuals with Regard to Automatic Processing of Personal Data, European Treaty Series no. 108, Strasbourg, 1981).[196]

While collection of statistical data about drug use, treatment uptake, and results serve an important and legitimate purpose, the evidence collected for this report suggests that in some regions local regulations require narcological clinics to disclose specific information on patients to law enforcement agencies, or that—whether such regulations exist or not—doctors at these clinics do so in practice.

While the right to privacy does not establish an absolute rule of confidentiality of medical information, interference with this rule or breaches of it must be strictly justified. The European Convention on Human Rights stipulates that an interference with privacy is only legitimate if it is

> in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.[197]

Whether a restriction is "necessary" requires an assessment of whether a fair balance has been struck between the legitimate aim being pursued and the interests of the patient in maintaining the confidentiality of such data. The scope of this margin will depend on such factors as the nature and seriousness of the interests at stake and the gravity of the interference.[198] Given that medical data may be highly intimate and sensitive in nature, the necessity for any State measure compelling communication or disclosure of such information without the consent of the patient must be carefully scrutinized and convincingly established.[199]

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[196] European Court of Human Rights (ECtHR), *Z. v. Finland*, Application No. 22009/93, Judgment of 25 February 1997, Reports of Judgments and Decisions 1997-I, para 95.

[197] European Convention on Human Rights and Fundamental Freedoms, art. 8(2).

[198] See for example ECtHR, *Leander v. Sweden*, 1987, p. 25, para. 58; and, mutatis mutandis *Manoussakis et al. v. Greece*, Application No. 18748/91 judgment of 26 September 1996, Reports 1996-IV, p. 1364, para. 44.

[199] ECtHR, *Z v. Finland*, 1997, para. 96.

Provisions, like the 1998 Moscow order, that require the routine sharing of medical information on patients of drug dependence clinics violate Russian law, which holds that doctors may choose to breach confidentiality when a patient's health condition may be due to an unlawful act. Furthermore, such routine sharing of medical information (other than statistical summaries) is unlikely to meet the requirement that it is "necessary in a democratic society."

Individual doctors must exercise careful judgment in making decisions regarding breaches of confidentiality in individual cases, even if Russian law formally allows for such breaches. In making such choices, doctors will need to carefully balance the importance of respecting confidentiality and the other relevant interests. Human Rights Watch believes that disclosure of a drug-dependent patient's medical information because of the sole fact that he or she had voluntarily used an unlawful substance, thus causing harm to his or her body, would violate the right to privacy.

The Quality and Scientific and Medical Appropriateness Requirement

Health services must "be scientifically and medically appropriate and of good quality," which requires, among others, "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[200] But it also means that states must, to the extent possible, employ treatment modalities that have been shown to be effective through sound scientific research, and to integrate evidence-based practices into existing modalities; a treatment modality that has been shown to be ineffective will fail the requirement of scientific appropriateness and quality. The progressive realization of the right to health means that states should periodically evaluate existing treatment modalities in order to identify shortcomings and enact improvements where necessary. Ideally, states should also conduct or fund sound scientific research into treatment modalities so that new, more effective treatments can be identified and introduced.

The drug treatment system Russia inherited in 1992 from the Soviet Union was based more on ideology than on scientific evidence of effective treatment practices.

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[200] CESCR, General Comment 14, para. 12(d).

Although Russia abandoned a number of problematic Soviet-era treatment practices, it neither clearly embraced an evidence-based treatment philosophy nor conducted a thorough review of the treatment system to introduce new practices based on scientific evidence. To this day, many elements of the drug dependence treatment system are clearly not consistent with well established principles of effective treatment of drug dependence. Russia's rejection of maintenance treatment on essentially ideological grounds and its attempts to manipulate opinion about this treatment in the medical community seem to signify a continued willingness to attach greater importance to ideological considerations than to scientific evidence of effective treatment approaches.

Treatment Policy Ignores Nature of Drug Dependence Disease

As was mentioned above, scientific research has clearly established that drug dependence is a chronic and relapsing disease. The requirement of the right to health that health services must be scientifically and medically appropriate means that states should employ treatment modalities that take account of this fact if they are to be consistent with the right to health.

Russia's drug dependence treatment system, however, does not take this into account and insists that patients abstain from drug use immediately, completely, and permanently. When patients relapse treatment is considered to have failed. This policy is not consistent with the chronic and relapsing nature of drug dependence disease. The reality of this health condition is that many drug-dependent people have great difficulty achieving long-term abstinence (especially without maintenance therapy), that recovery from drug dependence rarely follows a linear path, and that relapses are a natural part of the recovery process for most people. Failing to recognize this and integrate it into treatment policy undermines the provision of scientifically and medically appropriate treatment programs.

A treatment policy that insists on a linear path to recovery is not only inconsistent with contemporary scientific evidence but also complicates the treatment process itself. Most importantly, it complicates the treatment system's ability to retain patients in treatment for an adequate amount of time. As has been explained above, patient retention is one of the key factors in treatment success. By placing on

patients expectations that evidence has demonstrated only very few drug-dependent people can meet, and by failing to convey to patients that relapses are a normal part of the recovery process for most people—in fact, it equates relapse with failure—this treatment policy almost inevitably leads to disheartening assessments of treatment success for most patients, and thus undermines patient motivation to stay in treatment. It is also likely to have contributed to the abovementioned sense among many drug users that treatment offered at narcological clinics in Russia is not effective.

The policy furthermore makes it impossible for doctors and their patients to draw up realistic individual treatment plans—another key aspect of evidence-based treatment—as these should anticipate the possibility of relapses, and prepare patients for such an eventuality. None of the people interviewed for this report had received counseling in detoxification treatment on the likelihood of relapses or on tactics they could employ to overcome one should it happen.

Finally, the right to health requires—and best practice standards recommend—that patients in drug dependence treatment are provided with information on prevention of HIV and other blood-borne diseases as well as on the risk of drug overdose (which is particularly high after detoxification treatment) so that they are better able to protect themselves from harm should they return to drug use. As discussed above, such counseling does not currently take place in state narcological clinics in Russia, due, no doubt in part at least, to the system's exclusive focus on abstinence.

Treatment policy focused on patients' complete abstinence from drug use also compromises the ability to evaluate the successes and failures of the treatment system in a meaningful way. Proper evaluation mechanisms are an important element in ensuring the scientific and medical appropriateness and the quality of medical services on offer, as they facilitate progressive improvement of these services. Yet, using abstinence as the only formal criterion does not make public health sense, as, for reasons explained below, it does not provide a meaningful picture of the effectiveness of treatment and yields little useful information that would allow the introduction of improvements into the treatment system.

While sustained abstinence from drug use is the ultimate goal of drug dependence treatment systems in most countries, in recognition of the chronic and relapse-prone nature of drug dependence most treatment systems have developed diversified treatment goals and indicators for treatment success that go beyond just abstinence. These goals and indicators may include, along with abstinence: continued commitment to treatment, continued stay in treatment, the frequency and length of a patient's relapses, the patient's physical and mental well-being, his or her family and employment situation, and changes in the patient's risk behavior during relapses.[201] Russia's current treatment philosophy does not take into account any of these important indicators, and can thus assess treatment success only in a very limited way.

There appears to be increasing recognition in the healthcare community in Russia that the lack of differentiated treatment goals and assessment criteria is problematic. For example, the 2003 treatment protocol for rehabilitation of persons dependent on drugs of the Russian Ministry of Health recognizes that this is the case by stating that the "syndrome of dependence persists during all stages of rehabilitation, and is not reduced completely even in cases of long remissions."[202]

Human Rights Watch found that some drug treatment doctors do apply broader criteria in their work with individual patients, even if they are not part of the formal assessment system. For example, Olga Komarova of the narcological clinic in Kuznetsk told Human Rights Watch,

> We look at interim steps. When a month has gone by, we talk to the person, see how well it's gone. If we see someone is having a difficult time, we tell them to come back sooner. We tell them to take it one day at a time. I will tell them, "You and I together will try to make the periods that you feel good longer."[203]

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[201] NIDA, "Principles of Drug Addiction Treatment: A Research-Based Guide," p. 15.

[202] Order No. 500 of the Ministry of Health of 22 October 2003, "Treatment Protocol: Rehabilitation of Persons with Drug Dependence Disease," Chapter VI (on file with Human Rights Watch).

[203] Human Rights Watch interview with Olga Komarova, Kuznetsk, April 12, 2007.

In an article that appeared in the substance abuse journal *Narkologia* as well as on a website dedicated to illicit drug use in Russia, Mikhail Zobin, the head doctor of a private substance abuse treatment clinic in Moscow, and E. Egorov, a professor of psychiatry at the State University of St. Petersburg, point out that the rigid assessment of the success of treatment for drug dependence is at odds with general practices in Russian psychiatry, where a classification of treatment progress is used that differentiates between full remission and other degrees of progress in the treatment of patients. They state, "The possibility of a spontaneous relapse with schizophrenia, affective disorder, or epilepsy, even when correctly treated, does not raise any question among specialists. If [drug] dependence is a psychiatric disorder then why should its treatment be assessed only according to the first criteria of remission [full remission]?"[204] The authors also note that some drug treatment experts recently have begun to write about incomplete or partial remissions in patients with opioid dependence as showing a positive dynamic.[205]

Failure to Facilitate Patient Retention

As was mentioned above in Chapter III, it is a well established fact that detoxification on its own is unlikely to help drug dependence patients achieve lasting recovery, and that staying an adequate period of time in treatment is crucial to its success. Detoxification should be used not just to withdraw a patient from physical dependence on drugs but also to begin psychosocial interventions aimed at motivating the patient to stay in treatment. The US Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) observes, "detoxification presents a unique opportunity to intervene during a period of crisis and move a client to make changes in the direction of health and recovery."[206] Indeed, research indicates that "addressing psychosocial issues during detoxification significantly increases the likelihood that the patient will experience a safe detoxification and go on to participate in substance abuse treatment."[207]

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[204] M. Zobin and A. Egorov, "Remissions with opiate dependence" ("Remissii pri opioidnykh narkomaniakh"), undated http://www.narcom.ru/cabinet/online/107.html (accessed August 29, 2007).

[205] Ibid.

[206] SAMHSA/CSAT, TIP 45, p. 23.

[207] Ibid.

Russian drug dependence treatment experts recognize the importance of retaining patients in treatment. For example, the 2003 Ministry of Health treatment protocol for rehabilitation of persons dependent on drugs notes specifically that effectiveness of detoxification treatment alone is very low and stresses motivational counseling to retain patients who are in rehabilitation programs.[208] Russian drug treatment doctors complained to Human Rights Watch about the fact that only a small percentage of drug users proceed with rehabilitation treatment after detoxification. As was mentioned above, Nikolai Ivanets, Russia's chief narcologist, suggested to Human Rights Watch that that is the case because many drug users "simply don't want to be treated."[209]

Our research shows, however, that detoxification treatment in Russian state clinics does little to work with drug users on their recovery and motivate them to stay in treatment. It appears that in many detoxification clinics the detoxification process barely goes beyond the narrow process of withdrawing the person from physical dependence and managing symptoms. Drug users and some drug dependence treatment experts identified two principle reasons why state narcological clinics have not been able to motivate more patients to remain in treatment: First, drug users said that they were kept in a heavily sedated state in detoxification treatment and often had trouble clearly recalling their experiences there, which complicates any motivational or other forms of counseling. Secondly, drug users in all three regions told us that, in fact, very little motivational counseling takes place during detoxification, that clinic staff do not involve patients in the development of individualized treatment plans, and that little is done to build a therapeutic alliance between patients and medical staff.

The positive experience of some patients we interviewed who had continued into the rehabilitation phase highlights how regrettable it is that many patients are not being retained and that rehabilitation treatment uptake is low. Andrei A. from Kazan, whose very negative assessment of a detoxification clinic is given below, contrasted that with his experience of a state-run rehabilitation center:

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[208] Order No. 500 of the Ministry of Health of 22 October 2003, "Treatment Protocol: Rehabilitation of Persons with Drug Dependence Disease," Chapter VI (on file with Human Rights Watch).

[209] Human Rights Watch interview with Nikolai Ivanets, Moscow, March 7, 2007.

> It is in the same building. You don't even go outside. You go through a metal door and it's a different world there. It is clean. The attitude of the personnel is completely different. People really want to help you. People try to do something for you, they have empathy. The beds are clean and linens are changed [regularly]. There is a more or less normal shower.[210]

Heavy sedation

Detoxification treatment in Russia is heavily medicated, with patients routinely receiving a cocktail of medications that includes strong sedatives, antipsychotics, pain killers, and antidepressants. Almost all drug users who had been through detoxification treatment told Human Rights Watch that they had been heavily sedated during the first four or five days of their treatment and had been in a semi-comatose condition. They said that sedation in subsequent days was reduced so that they regained consciousness but many said that they remained heavily sedated even then.

A drug user in Kazan, Ilya I., said,

> I took the medications and slept. I thought I'd slept one day. But when I woke up it turned out I had slept for four or five days…. I really don't remember much [about the detoxification clinic] because I was in this kind of semi-comatose state.[211]

Igor Y., another drug user from Kazan, described his January 2007 stay in a local narcological clinic:

> [I was there for 10 days] but it really seemed like four to me because I was under barbiturate and don't remember. About five days I wasn't myself at all. After that, they gave me less strong sedatives: fenazipan,

[210] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

[211] Human Rights Watch interview with Ilya I., Kazan, January 24, 2007.

> relanium for sleep, tramal, so there would be no withdrawal symptoms. But by then I was conscious again.[212]

Dima D., a drug user from Penza, told Human Rights Watch that he was in the local detoxification clinic for two weeks in January 2007 but that he remembers little from those weeks: "I was under tranquillizers the whole time."[213]

The practice of heavy sedation of patients interferes with the ability to engage patients, work on building a therapeutic alliance with them, develop individualized treatment plans that address their various needs, and motivate them to stay in treatment. For example, one former drug user said when asked whether he had received counseling on psychological dependence while in the detoxification clinic,

> Well, there was something of that sort there but I don't remember. As I said, I was so injected with sedatives that I really don't remember what or how.[214]

There is no need for heavy sedation of patients during most of the detoxification process. SAMHSA/CSAT observes that while patients may require bed rest or reduced activity during the first 24 hours of detoxification, patients should generally "be ambulatory and able to participate in rehabilitative activities during detoxification."[215]

Lack of counseling

Although narcologists insisted that they conduct motivational counseling with detoxification patients, drug users described only very limited efforts to do so, often not by doctors or psychologists but by peer counselors from rehabilitation centers or self-help groups.

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[212] Human Rights Watch interview with Igor Y., Kazan, January 26, 2007.

[213] Human Rights Watch interview with Dima D., Penza, April 16, 2007.

[214] Human Rights Watch interview with Anton Blinov, Kazan, January 24, 2007.

[215] SAMHSA/CSAT, TIP 45, p. 74.

The chief narcologists in both Tatarstan and in Kaliningrad said that they offer motivational services. Farit Fattakhov of Tatarstan, for example, told Human Rights Watch, "During detoxification, we motivate people for further therapy. We also conduct family therapy."[216] But asked whether they had received motivational counseling, most drug users said that they had not or that it was very limited. An outreach worker with the AIDS center in Kazan who had most recently been in a detoxification clinic in the summer of 2006 told Human Rights Watch that in his experience "there really is no contact with the doctors, they are not interested in the situation of the patient."[217] Igor Y., a drug user who had last been in a detoxification clinic in Kazan in January 2007, said,

> Well, some woman came by once who said, "If you want, later, when your treatment is over, there are these groups, 12-steps groups, you can go there, and we will listen to you."[218]

Igor Y. said that that was the extent of the motivational counseling he had received. His previous experience in the detoxification clinic, in December 2005, had been similar.

A drug user from Penza said that a psychologist had come to talk to him about his plans for the future when he was in the detoxification clinic in January 2007. He said that he had been asked whether he wanted to enter rehabilitation treatment but that he had said that he did not. That had, according to him, been the extent of the motivational counseling he received. A drug user from Kaliningrad told Human Rights Watch that she had repeatedly gone through detoxification at the local clinic, both free and paid, in 2006 but that she had received no psychological counseling and had never been invited to continue with rehabilitation treatment during any of her stays there.[219]

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[216] Human Rights Watch interview with Farit Fattakhov, Kazan, January 25, 2007.

[217] Human Rights Watch interview with Slava Matiushkin, Kazan, January 23, 2007.

[218] Human Rights Watch interview with Igor Y., Kazan, January 26, 2007.

[219] Human Rights Watch interview with Tatiana T., Kaliningrad, February 1, 2007.

A number of drug users said that after coming out of the semi-comatose state of the first four or five days in detoxification treatment, they had had nothing to do and boredom set in, sometimes triggering a strong desire to use drugs. One drug user described his experience in the Kazan detoxification clinic:

> I can't say much positive about the detoxification clinic. The first five days they gave me injections and I mostly slept or walked around barely conscious. The rest of the time I mostly did nothing there. Consultants from the rehabilitation center came to visit me for maybe a half hour per day. Otherwise, nobody really did anything with me… We had to clean floors… Otherwise, we had nothing to do.[220]

He said that he got very bored in the clinic and started doubting his resolve to stop using drugs. For several days he drank alcohol to drive away the boredom. He said that alcohol-dependent patients, who in contrast to drug-dependent patients were allowed to leave the clinic, bought highly concentrated alcohol at pharmacies which they then diluted with water and consumed.

Another drug user from Kazan, Ilya I., said that both times he received detoxification treatment, procedures were mostly limited to withdrawal from physical dependence. Describing his stay in a city detoxification clinic in Kazan in 2003 he said that, having slept the first four or five days,

> After that, who knows what we did… My neighbor wrote poems. I looked at them, and told him what were good and what wasn't. We just stupidly lay on our beds, smoked cigarettes…[221]

The motivational counseling had been limited to occasional visits by peer counselors from the rehabilitation center:

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[220] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

[221] Human Rights Watch interview with Ilya I., Kazan, January 24, 2007.

> … people from the 12-step program came to talk to us, told us that they had been like us… I saw how well they were dressed. They looked very good [healthy]. But that time, I didn't really pay attention…"[222]

After 10 days Ilya I. was so bored and felt such a strong urge to use drugs that he decided to go home. His doctor initially refused to release him but when Ilya I. threatened to break the rules so he would be forced out, he was indeed released. Ilya I. said that he began using again that same day.

In their qualitative study of 121 drug users in three Russian cities, Bobrova and others found an important contrast between drug users who had received psychological counseling in detoxification clinics and those who had not:

> Approximately a third of the participants perceived service providers' attitudes as mechanical and formal, with no individual or caring approach.
>
> In contrast, respondents who received psychologic counseling had positive perceptions. They felt that psychologists were more caring, listened to their problems, and were not judgmental. Moreover, they perceived psychological help to be useful in dealing with their addiction.[223]

One reason for poor motivational counseling in many clinics may be the fact that the 1998 treatment protocol for detoxification of persons dependent on drugs provides no guidance on the counseling efforts that should take place.[224] In fact, the protocol's silence on this issue leaves the strong impression that such counseling is not an integral and essential part of detoxification treatment. It appears that part of the problem may also be a lack of relevant staff in some clinics. Bobrova, for

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[222] Ibid.

[223] Bobrova et al., "Injection drug users' perceptions of drug treatment services and attitudes toward substitution therapy: A qualitative study in three Russian cities," *Journal of Substance Abuse Treatment*.

[224] Order N. 140 of the Ministry of Health of the Russian Federation of 28 April 1998 "On the confirmation of standards (model protocols) for the diagnostic and treatment of the narcologically ill."

example, observes that some detoxification clinics do not have psychologists or psychotherapists on staff, even though such positions formally exist.[225]

Result: Failure to foster a therapeutic alliance and poor patient retention

While research suggests that a therapeutic alliance may be the single most important factor for treatment outcome, the abovementioned practices in Russian detoxification clinics are not conducive to the establishment of such alliances. As demonstrated by the enormous distrust among drug users toward narcologists, the staff at narcological clinics is often not succeeding in forging good relationships with their patients. The above testimony also suggests that staff at narcological clinics often make little investment in the development of relationships with patients. At the same time, the Bobrova study suggests that where such investments are made patients felt much more positive about their treatment experience.

Counseling on HIV/AIDS and Other Health Conditions

Detoxification provides an important opportunity to counsel patients on HIV/AIDS and other diseases that are prevalent among drug users, as well as about drug overdose prevention. UNODC and NIDA recommend that drug dependence patients in detoxification and rehabilitation treatment are counseled on HIV and AIDS, TB, hepatitis B and C, and other health conditions that are prevalent among injecting drug users. Under the right to health, states have an obligation to take measures to prevent the spread of HIV and other health conditions. This requires that states ensure that people at risk of contracting these conditions should be provided with relevant information about prevention, care, and treatment whenever possible. For HIV, this means that patients must be told about the importance of needle exchange and be referred to needle exchange providers where available.

It does not appear, however, that patients in narcological clinics are routinely provided with such information. For example, Dima D., a drug user from Penza, said that he had not received any counseling on HIV when he was in the narcological clinic in early 2007. As he said that he remembered little of his two weeks in the

[225] Bobrova et al., "Barriers to accessing drug treatment in Russia: a qualitative study among injecting drug users in two cities," *Drug and Alcohol Dependence*.

clinic due to sedation, it was not clear whether the counseling had not taken place at all or whether he did not remember it.[226] A psychologist in Kuznetsk told Human Rights Watch that she does discuss HIV prevention in counseling sessions with drug users, although she admitted that it was at meetings of the self-help group she led a few years ago that HIV was extensively discussed.[227]

Andrei A., a drug user from Kazan, told Human Rights Watch that he was diagnosed with HIV in 2001. He said that he decided at the time to take his diagnosis with him to the grave. For years he did not discuss his HIV status with anyone. He said that it was not until he started treatment in an outpatient rehabilitation program at the NGO Roza Vetrov—having first been through detoxification and the rehabilitation program at the narcological clinic—that he learned that HIV is not a literal or metaphorical death sentence. During the rehabilitation program he heard other HIV-positive people speaking openly about their status, their lives with their status, and antiretroviral treatment. Andrei A. told Human Rights Watch, "I learned that people with HIV can have healthy children, even if both parents are HIV positive! It opened me up. I started talking to people here about my status, I went to the AIDS center for tests."[228]

A female drug user told Human Rights Watch a similar story. She said that she had been diagnosed with HIV in 2005 but had not received any information about the disease at the time. Although she went through detoxification treatment at a clinic in Kazan in August 2006, she told Human Rights Watch that "I only started to learn about HIV here, in rehabilitation [at Roza Vetrov]."[229]

Albert Zaripov of Roza Vetrov told Human Rights Watch that very little counseling on HIV takes place during detoxification treatment for two reasons. First, he said,

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[226] Human Rights Watch interview with Dima D., Penza, April 16, 2007.

[227] Human Rights Watch interview with Olga Komarova, Kuznetsk (Penza province), April 12, 2007.

[228] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

[229] Human Rights Watch interview with Alsu A., Kazan, January 24, 2007.

"It is hard to talk about this in detoxification because people are not of sound mind [due to the sedation]. How do you talk to people like that about avoiding risky behavior, or accepting an HIV diagnosis?"[230]

Secondly, he said, the narcological clinics do not have staff who really know the issue of HIV. In the past Roza Vetrov had employed some peer counselors to visit the detoxification clinic and rehabilitation center to counsel patients on HIV, but that initiative had been discontinued when funding ran out and no new funding could be found.

Conditions at Narcological clinics

Drug users in all three regions also complained of poor conditions at narcological clinics. They spoke of poor material conditions, an often indifferent attitude of the clinic's personnel, and objected to the practice of mixing alcohol- and drug-dependent people. Poor material conditions and indifference on the part of medical staff are by no means unique to the narcological system but are widespread across Russia's healthcare system.

A drug user from Kazan said that conditions in the detoxification clinic reminded him of a prison: "The toilet was horrible. You have to wash yourself with a hose. [As for the food,] I couldn't make out most of the time whether it was porridge or water in the cup. The food was awful."[231]

Several interviewees in Penza described the conditions inside the inpatient clinic there as particularly bad. Dima D., for example, said that although the outside of the building was recently renovated and looks new, on the inside the building is in very poor condition.[232] He and other drug users said that the facility had only one bathroom for all patients, both men and women, and that this room is also used as a smoking room. A woman who had been in the facility in January 2007 told Human Rights Watch that she would go to the bathroom at the facility and would have to ask

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[230] Human Rights Watch telephone interview with Albert Zaripov, Kazan, June 29, 2007.

[231] Human Rights Watch interview with Rustem R., Kazan, January 26, 2007.

[232] Human Rights Watch interview with Dima D., Penza, April 16, 2007.

a group of smoking men to turn around and look the other way so she could use the toilet.[233]

In Kazan and Penza drug users also complained that they were mixed with alcohol patients at detoxification facilities. Many expressed an intense dislike of alcohol patients. For example, Dima D., a drug user from Penza, said, "The alcoholics shit and pee anywhere. They might smear poop on the walls when they are in delirium, they scream."[234] The head of the detoxification clinic in Kuznetsk identified the practice of mixing alcohol and drug patients as one of the key problems in her facility. She said that the two groups do not like each other but that her facility did not allow her to keep them separately.[235]

Andrei A. from Kazan characterized his associations with the local detoxification clinic as "abhorrence, disgust, grayness, dirt." He described the attitude of the medical personnel as generally indifferent, although he said that he had received appropriate relief when he complained about stomach aches and other pains. He recounted an incident that had particularly outraged him:

> They brought in a homeless person from the street. He was lying there, drunk, all disgusting. They pull him in over the floor. And then ask one of the other patients to start cutting his hair and wash him. The lice were running all around. The situation was just horrible.[236]

Conditions for drug users who pay for their treatment are often better than for those who do not pay. In some regions, detoxification clinics have separate wards for paying patients. Farit Fattakhov, the chief narcologist in Tatarstan, told Human Rights Watch that his clinic has private rooms and double rooms available for drug users, for example. An outreach worker in Kazan who said he had been in detoxification clinics eight or nine times over the last 18 years, most recently in the summer of

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[233] Human Rights Watch interview with Maria M., Penza, April 11, 2007.

[234] Human Rights Watch interview with Dima D., Penza, April 16, 2007.

[235] Human Rights Watch interview with Svetlana Maksimova, Kuznetsk (Penza province), April 12, 2007.

[236] Human Rights Watch interview with Andrei A., Kazan, January 24, 2007.

2006, told Human Rights Watch, "If you pay for treatment you get a room, if you don't, you're in the corridor."[237]

Several drug users also said that the attitude of personnel and the medications offered were much better in the ward for paying patients than in the wards for free treatment. A female drug user from Kazan said, "Being in the free ward means a rude attitude of the medical personnel, insufficient medication, and insults. If you pay, you get servility… [The doctors] just gave me medication and then did not check in on me… [One night] I couldn't sleep, went to the nurse but they just sent me away. I cried. The narcologist just sent me off…"[238]

Not all drug users interviewed complained about treatment by doctors and medical personnel. Some said that they had had positive experiences.

Principle of Non-discrimination and Restrictions on the Rights of Drug Users

As has been discussed above, the drug user registry is a barrier that violates the rights of patients by discouraging access to drug treatment and fostering real and perceived breaches of confidentiality of medical information. Our research suggests that the current system of placing restrictions on the rights of registered drug users to obtain driver's licenses and hold specific types of jobs also violates the principle of non-discrimination, as the restrictions are disproportionate in nature and applied selectively against certain groups of drug users.[239]

International law prohibits "any discrimination … on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[240] Policies that treat individuals differently based on a category or status may be lawful but only if the category is not one of the prohibited grounds,

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[237] Human Rights Watch interview with Slava Matiushkin, January 23, 2007.

[238] Human Rights Watch interview with Alsu A., Kazan, January 24, 2007.

[239] The types of jobs that people registered as being dependent on drugs cannot perform include, among others, those that involve work at certain power stations, with any explosive substances or in industries that are high risk for explosions or fire, work as guards who carry arms, driving a car, or work linked to various aspects of the train system.

[240] ICCPR, art. 26.

and the differential treatment is based on objective grounds and criteria, in pursuit of a legitimate goal, and is proportionate and necessary for achieving that goal.

Narcologists and officials justify the restrictions on the rights of drug users as necessary for the public interest. In their opinion, restrictions on the right to obtain a driver's license, for example, are necessary to prevent drug users from causing accidents. There is no doubt that public safety is a legitimate interest that may justify certain restrictions on the rights of specific categories of people. The question is whether these restrictions are necessary and proportional to the legitimate aim pursued.

The proportionality of the restrictions imposed on drug users is questionable. As has been described above, a person on the drug user registry remains on it for at least five years (and longer in case of relapses). During this time the person cannot officially obtain a driver's license or hold certain types of jobs. The restrictions are imposed on the sole basis of a doctor's diagnosis of drug dependence without any attempt to determine whether the restrictions are actually necessary in the individual case. Human rights law generally frowns upon these kinds of blanket restrictions imposed on entire groups, as they almost inevitably lead to unnecessary restrictions on the rights of some members of the group. As with alcohol-dependent persons, many drug users can safely drive cars when they are sober. The question is not so much whether someone is dependent on drugs or alcohol but whether that person makes responsible choices on when to drive and when not. Indeed, most countries do not impose blanket restrictions on the rights of drug- or alcohol-dependent people. Instead, they make decisions on the appropriateness of a job candidate or applicant for a driver's license in individual cases, with the help of reference checks, checks for citations for driving under influence, medical tests, and so on.

Restrictions are imposed for the entire time the person remains on the registry. During this period, there is no periodic review process to determine whether the restrictions should still apply to the specific individual. This means that even people who have successfully stopped using drugs after treatment will not be able to hold certain jobs or obtain a driver's license for a period of five years. That is excessively burdensome.

Furthermore, the restrictions are imposed selectively. In most regions of Russia, patients who can pay for their treatment are not entered onto the registry and therefore do not face any restrictions on their rights. This policy discriminates against socially disadvantaged groups but it also undermines the rationale officials give for the existence of the restrictions system. Put in stark terms, the message of this system is that it is alright for rich drug users to cause car accidents but not for poor ones.

Anton Blinov, a former drug user who currently works as a peer counselor at the AIDS center in Kazan, pointed out the absurdity of this system. Blinov was stripped of his driver's license in 2005 because he was on the drug user registry. Trying to get his license reinstated, he said that he went to the chief narcologist of Kazan with a stack of letters of recommendations from, among others, doctors at the AIDS center that explained that he worked for the AIDS center, needed his car for his work, and did not use drugs anymore. He told Human Rights Watch about his conversation:

> [The narcologist told me,] "I can't give you the driver's license. You are a drug user." I told him, "How can it be, Vasili Nikitovich? Those drug users who pay you money [for paid treatment], who are not in remission, who drive cars like madmen, end up in accidents, knock people of their feet—they do have a right to drive? And I, clean, as I stand before you, not using drugs, with these letters of recommendations—I can't drive? Don't you agree that that is absurd?"

Blinov was not given his driver's license back. Human Rights Watch pointed out this situation to the chief narcologist of Tatarstan. The narcologist shrugged and said, "Well, that's our law…"

Human Rights Watch therefore believes that the restrictions system as it currently exists violates the principle of non-discrimination. It should be abolished or reformed in a way that is nondiscriminatory and does not create a barrier to treatment-seeking behavior.

In any case, our research findings suggest that in practice the functionality of the restrictions system is compromised by corrupt practices in both the traffic police and narcological clinics. A number of drug users who were on the registry told Human Rights Watch that being on the registry had not prevented them from obtaining drivers' licenses. One drug user, who said he had been clean for six years but had not bothered to go to follow-up appointments at the narcological clinic (as required in order to be taken off the registry), said, "I did get my driver's license, even though I'm on the registry. It's corruption. Anything is for sale."[241] Another drug user said that he was not particularly worried about being on the registry: "After all, I can buy a certificate [at the narcological clinic] that I'm not on the registry even if I am. Also, you can buy a driver's license [from the traffic police] without any certificates."[242] Research by the INDEM Foundation, a Russian NGO that has consistently monitored corruption in Russia since its establishment in 1997, shows that corruption is widespread both in healthcare settings and in the traffic police. In a 2005 report it estimated that 37.7 percent of people who had dealings with the healthcare system in 2005 had encountered corruption (up from 23.5 percent in 2001), as had almost 60 percent of people who had dealings with traffic police in that same year.[243]

[241] Human Rights Watch interview with Roman R., Kaliningrad, January 31, 2007.

[242] Human Rights Watch interview with Zhenia Z., Kazan, January 25, 2007.

[243] INDEM Foundation, "Corruption process in Russia: level, structure, trends. Corruption increase rate within four years' period as a result of the recent survey made by the INDEM Fund," 2005, http://www.anti-corr.ru/indem/2005diagnost/2005diag_eng.htm (accessed August 31, 2007).

V. Detailed Recommendations

To the Russian Government

Regarding availability of treatment

- Immediately lift the ban on the medical use of methadone and buprenorphine in the treatment of drug dependence, and introduce maintenance therapy programs.
- Remove the ban on detoxification in private clinics.
- Consider adding capacity to detoxification facilities where waiting lists exist, including by introducing outpatient detoxification services.
- Adopt and fund a federal plan aimed at increasing the availability of rehabilitation treatment by opening new rehabilitation programs and centers in regions that do not currently have any. This plan should have a clear timeline and benchmarks for implementation, and should prioritize regions and towns on the basis of need. These steps should coincide with measures to address the low uptake of rehabilitation treatment, including the introduction of psychosocial counseling during detoxification and steps to end the overmedication of patients in detoxification (see also below).

Regarding accessibility of treatment

- Take steps to ensure drug users can enter treatment without delay. Tests for various health conditions should be conducted at the narcological clinic or through cooperation with other relevant healthcare structures. Steps must be taken to end waiting lists.
- Create conditions at narcological clinics that are conducive to recovery of patients. Proper hygiene should be observed. Medical personnel should be compassionate toward patients. The practice of mixing drug users and alcoholics should be ended.
- Local and federal authorities should, consistent with the requirement of the Russian constitution, provide adequate funding to narcological clinics. Out-of-pocket charges for medications should be ended. Drug

dependence treatment should be covered by health insurance policies. Narcological clinics should clearly display information on the cost of various paid services.

- Narcological clinics should take steps to counter distrust among drug users. These steps should include tough action on corrupt practices and proactive outreach to the drug user community. Clinics should seek active cooperation with harm reduction programs and self-help groups.

Regarding scientific and medical appropriateness and quality of treatment

- Integrate evidence-based drug treatment policies into the drug treatment system.
- Introduce differentiated treatment goals and indicators that take into consideration the chronic nature of drug dependence disease, and the particulars of individual patients.
- End overmedication of patients in detoxification. Review existing treatment protocols and amend them in accordance with research findings on effective detoxification procedures.
- Introduce psychosocial interventions as an integral part of the detoxification procedure. Treatment protocols for detoxification should contain clear guidance on the kinds and frequency of interventions that should take place during detoxification.
- Take steps to ensure all patients in detoxification receive proper counseling on HIV and other diseases that are prevalent among drug users, as well as about overdose prevention. HIV counseling should include information about transmission prevention, including needle exchange, as well as about treatment of HIV. Narcological clinics should work together on this with AIDS centers and HIV/AIDS groups.

Regarding acceptability of treatment and discrimination against drug users

- Reform the drug user registry. Blanket restrictions on rights of people on the registry should be removed. They could be replaced with a system that assesses the need in individual cases.

- Take steps to ensure confidentiality of medical information. All narcologists should be reminded of confidentiality rules. The procuracy should review all regulations on cooperation between narcological services and law enforcement to ensure that they do not require the improper sharing of confidential information.
- The fee-for-anonymity system should be abolished. People should not have to pay for confidentiality of their medical information.
- Create a single document that outlines the rights of patients of narcological clinics.

Other

- Immediately adopt instructions on harm reduction programs that are in line with evidence of best practices.
- Permit and encourage scientific discussion about maintenance therapy.

To the International Community

- The international community, including UNAIDS, WHO, and UNODC, should actively encourage Russia to adopt evidence-based drug dependence treatment practices and implement the recommendations of this report.
- The World Health Organization should develop and widely distribute best practice guidelines on drug dependence treatment.
- The international community should provide funding to NGOs and other structures that provide drug dependence treatment and harm reduction services.

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Appendix: Drug Dependence Treatment Best Practices

In the past few decades a vast amount of scientific research has been conducted into drug dependence treatment services in many countries around the world. Although there are substantial differences in the nature of the patients treated and in the structure and operation of the treatment system in different countries, the United Nations Office for Drugs and Crime concludes in a 2002 review of the evidence base on effective drug dependence treatment that "the findings for the impact of the main forms of structured treatment are remarkably similar across national and cultural divides." On the basis of these similarities, UNODC and several other bodies have formulated a series of basic principles and best practice recommendations for effective drug treatment.[244] Below, we provide a summary of these basic principles and best practice recommendations, for which we draw on several overviews of available scientific evidence, including:

- The "Treatment and Rehabilitation Toolkit," published by UNODC in 2002, which consists of three different publications that, in the words of UNODC, "offer the best current thinking about policy, programme and methodology development."[245] The publications are: "Contemporary Drug Abuse Treatment: A Review of the Evidence Base," "Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers," and "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide."

- The "Principles of Drug Addiction Treatment; A Research Based Guide," published by the United States National Institute on Drug Abuse (NIDA) of the National Institutes of Health, which presents principles of effective drug dependence treatment and provides background on each of the principles.[246]

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[244] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base," p. 1.

[245] The publications are: "Investing in Drug Abuse Treatment: A Discussion Paper for Policy Makers"; "Contemporary Drug Abuse Treatment"; and "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide". All are available on the UNODC website, http://www.unodc.org/unodc/en/treatment_toolkit.html (accessed on April 30, 2007) in English, Spanish, and Russian.

[246] NIDA, "The Principles of Drug Addiction Treatment: A Research Based Guide."

- Several Treatment Improvement Protocols (TIPS) published by the Center for Substance Abuse Treatment (an institution of the Substance Abuse and Mental Health Services Administration, SAMHSA, within the US Department of Health and Human Services). These TIPS are developed to provide "best-practice guidelines for the treatment of substance use disorders" and are drafted by consensus panels, which consist of experts in the field of drug dependence treatment. Their target audiences are public and private treatment facilities in the United States, as well as practitioners in mental health, criminal justice, primary care, and other healthcare and social service settings.[247]

- The clinical guidelines on opioid detoxification and psychosocial interventions issued by the United Kingdom National Institute for Health and Clinical Excellence, an institute of the National Health Service, which provide recommendations for healthcare professionals about the treatment and care of people with drug dependence.[248]

- The 2007 consultation draft of the United Kingdom's Clinical Guidelines on Drug Misuse and Dependence Update 2007, drafted by the Independent Expert Working Group at the request of the Department of Health. The update provides "guidance on the treatment of drug misuse in the UK" and is based on "current evidence and professional consensus on how to provide drug treatment for the majority of patients."[249]

- The 2004 guidance on detoxification treatment "Responsible detoxification in inpatient and outpatient settings" of the Netherlands Institute for Mental Health for healthcare workers treating people with substance dependence.

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[247] See for example SAMHSA/CSAT, TIP 45, p. vii.

[248] National Institute for Health and Clinical Excellence, "Drug misuse; Psychosocial interventions," NICE clinical guideline 51, July 2007, http://guidance.nice.org.uk/CG51/niceguidance/pdf/English, and "Drug misuse; Opioid detoxification," NICE clinical guideline 52, July 2007, http://guidance.nice.org.uk/CG52/niceguidance/pdf/English (both accessed September 5, 2007).

[249] Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/cgl_update0607/consultation.aspx (accessed September 5, 2007).

The guidance is based on a literature study of the available evidence, as well as input from practitioners and patients. It was subsequently tested in two pilot studies for practicability.[250]

Basic Principles of Effective Drug Dependence Treatment

Scientific research has shown that observance of a number of basic principles of drug dependence treatment is association with positive treatment outcome.[251] NIDA in the United States has formulated a series of 13 principles of effective drug treatment, based on international research. Some of these key principles, which are also at the core of drug dependence treatment protocols in countries like the US, UK, and the Netherlands, are:

Drug Dependence is a Chronic and Relapsing Disease

One of the most fundamental lessons drawn from the research is the conclusion that drug dependence is a chronic and relapsing disease. For much of the last century, the predominant view of opioid dependence was that it is a self-induced and self-inflicted condition that results from a character disorder or moral failing, and that the condition is best handled as a criminal matter.[252] Scientific research has shown this popular belief—which maintains currency in many circles even today—to be wrong.

Drug dependence has an important biological component that may help explain drug users' difficulty in achieving and maintaining abstinence. It is a well established fact that long-term drug use leads to significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes to brain function may have "behavioral consequences, including the compulsion to use drugs despite adverse consequences. This biological component may interact with psychological stress from work or family problems, or social cues (such as meeting

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[250] C.A.J. de Jong, A F.M. van Hoek, M. Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings" ("Richtlijn Detox; Verantwoord ontgiften door ambulante of intramurale detoxificatie"), *Geestelijke Gezondheidszorg Nederland*, 2004-278, www.ggzkennisnet.nl/ggz/uploaddb/downl_object.asp?atoom=14817&VolgNr=1 – (accessed September 5, 2007).

[251] NIDA has developed 13 principles of effective drug dependence treatment. The key principles are summarized in this section. For all principles, see "The Principles of Drug Addiction Treatment: A Research Based Guide" available at http://www.drugabuse.gov/PDF/PODAT/PODAT.pdf.

[252] SAMHSA/CSAT, TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, p. 8.

individuals from one's drug-using past), to hinder attainment of sustained abstinence and make relapse more likely."[253]

NIDA therefore concludes that "relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning."[254] Yet, research also shows that properly designed and implemented treatment programs can achieve similar results to treatment programs for other chronic diseases, such as asthma and diabetes, with treatment success rates of 40 to 60 percent.

Treatment Must be Readily Available

Research shows that because "individuals who are addicted to drugs may be uncertain about entering treatment," it is crucial to "take advantage of opportunities when they [drug-dependent people] are ready for treatment."[255] Otherwise, "[p]otential treatment applicants can be lost." Drug dependence treatment should thus be a "low-threshold" service without undue obstacles that may keep people out of treatment.

Retention of Patients in Treatment for Adequate Period of Time is Critical

NIDA observes that although there is no predetermined length of treatment, research has "shown unequivocally that good outcomes are contingent on adequate lengths of treatment" and that "participation [in residential or outpatient treatment] of less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer are often indicated."[256] NIDA therefore concludes that "for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery."[257] The Dutch detoxification guideline states that "the effectiveness increases with a higher starting dose [of methadone or buprenorphine], a longer

[253] NIDA, "The Principles of Drug Addiction Treatment: A Research Based Guide," pp. 12-13.

[254] Ibid., principle 13, p. 5.

[255] Ibid., principle 2, p. 3.

[256] Ibid., p. 16.

[257] Ibid., principle 5, p. 3.

tapering period, and adequate attention to psychosocial factors."[258] Treatment programs must therefore make efforts to engage patients and keep them in treatment.

Treatment Plans Must be Tailored to Individual Patients' Needs

Research has also consistently shown that no single treatment is appropriate for all individuals. Based on this research, NIDA observes that "matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society."[259] Thus, individual treatment plans should be developed for each patient that take into account his or her specific needs and problems, as well as his or her age, gender, ethnicity, and culture.[260] Treatment guidelines from both the UK and Netherlands strongly emphasize the need for an individual approach to treatment.[261]

These individual treatment plans should not be static. Research has shown that these plans must be assessed continually and modified as necessary to ensure that the plan continues to meet the person's changing needs. NIDA observes,

> A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services.[262]

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[258] De Jong, Van Hoek, Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings," p. 23.

[259] Ibid., principle 1, p. 3.

[260] Ibid., principle 4, p. 3.

[261] The Dutch treatment guideline states, "An individualized plan for detoxification is drafted. There are major individual differences between patients in terms of signs and symptoms as a result of withdrawal. A detoxification plan that is tailored to the patient provides the best chance of success." De Jong, Van Hoek, Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings," p. 13; Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," pp. 51-52

[262] Ibid.

The UK Independent Expert Working Group report lists an individual "care or treatment plan which is regularly reviewed" as one of the "essential elements" of treatment provision.[263]

The involvement of the patient in designing the treatment is of crucial importance. UK, US, and Dutch treatment guidelines all stress the need for patient input into the care or treatment plan.[264] Research suggests that a "therapeutic alliance" between patient and therapist or doctor—a collaboration, requiring agreement on goals and therapeutic tasks, mutual trust, acceptance, confidence, and a rapport—is a "pan theoretical" factor associated with treatment outcomes, across many different modalities and therapeutic approaches to treatment of substance abuse.[265] The UK Independent Working Group report states that a therapeutic alliance is "crucial to the delivery of any treatment intervention."[266] Under the UK treatment system, each patient is assigned a so-called key worker, a healthcare worker with prime responsibility for the patient, and maintains close contact with him or her in order to facilitate the development of a strong therapeutic alliance.[267]

Treatment Must Attend to Multiple Needs of the Patient

Drug dependence is a complex disorder that, as NIDA observes, "can involve virtually every aspect of an individual's functioning—in the family, at work, in the community."[268] Drug users frequently have multiple needs—medical, psychological, social, vocational, or legal—at the time they seek treatment. If these problems or needs are not addressed during treatment, they may undermine treatment outcomes. Drug dependence treatment should thus go beyond the patient's drug use problem

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[263] Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," p. 47. The report also states that the care or treatment plan should be agreed with the patient, and should "normally cover patient need as identified in one or more of the following domains: drug and alcohol use; physical and psychological health; criminal involvement; and social functioning" (pp. 51-52).

[264] Ibid., pp. 51-52; and De Jong, Van Hoek, Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings," p. 13.

[265] Elovich, "Drug Demand Reduction Program's Treatment and Rehabilitation Improvement Protocol," p. 16.

[266] Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," p. 64.

[267] Ibid., pp. 53 and 68.

[268] NIDA, "The Principles of Drug Addiction Treatment: A Research Based Guide," p. 23.

and also address his or her other needs. US, UK, and Dutch treatment guidelines all identify the need to address the various needs of the patient.[269]

NIDA particularly recommends that the drug dependence treatment system treat drug-dependent persons with coexisting mental disorders, HIV/AIDS, and/or tuberculosis for each of their conditions. It observes that because "addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder."[270] As for HIV/AIDS and other health conditions prevalent among drug users, NIDA states that "counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness."[271] In addition to testing and treatment or blood-borne diseases like HIV and hepatitis C as part of drug dependence treatment, the UK Independent Expert Working Group report emphasizes that reducing potential harm due to overdose should also be "a part of all patient care."[272]

Elements of the Effective Treatment System

UNODC describes four phases of drug dependence treatment that can be found in most treatment programs: open access services; detoxification; rehabilitation/relapse prevention; and aftercare.

Open Access Services

In the words of the UNODC Toolkit, "open access services" (or "street agencies") "do not provide formal treatment as such but act as important points of first contact for people who have drug-related problems and for those concerned about drug use of another." The importance of these services is, according to UNODC, "hard to overemphasize" as they can be a "critical place" of first contact for drug users who "may be reluctant to resort to specialized drug dependence services."[273] Open

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[269] National Institute for Health and Clinical Excellence, "Drug misuse; Opioid detoxification," p. 10; De Jong, Van Hoek, Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings," p. 153.

[270] NIDA, "The Principles of Drug Addiction Treatment: A Research Based Guide," principle 8, p. 4.

[271] Ibid., principle 12, p. 5.

[272] Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," p. 120.

[273] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," chapter 4, p. IV.2.

access services include self-help groups, family support groups, drop-in centers, telephone hotlines, and harm reduction programs. These services are often provided by nongovernmental organizations.

Detoxification Treatment

Many drug-dependent people will face withdrawal symptoms after they stop taking drugs, including abdominal cramps, nausea, vomiting, bone and muscle pain, insomnia, and anxiety. These symptoms generally start within eight to twelve hours and subside over a period of five to seven days. While withdrawal symptoms from drug dependence, unlike alcohol dependence, are not medically dangerous, they can produce intense discomfort.[274] The goal of medical detoxification is therefore to help patients "achieve withdrawal in as safe and as comfortable a manner as possible."[275] This is generally done by providing patients with medications that suppress the withdrawal symptoms or relieve the discomfort they cause.

But withdrawing the patient from physical dependence is not the only goal of detoxification treatment. Both the UNODC Toolkit and the NIDA Principles warn that detoxification on its own is not a rehabilitative treatment for drug dependence. The UNODC Toolkit observes that detoxification treatment alone is "unlikely to be effective in helping patients achieve lasting recovery; this phase is better seen as a preparation for continued treatment aimed at maintaining abstinence and promoting rehabilitation."[276] The Dutch detoxification guidance notes that "detoxification is not a goal on its own. Stopping [drug use] is generally not difficult; not relapsing is what's difficult."[277] It states that providing detoxification without follow-up treatment is not an inadequate way of treating drug dependence.[278]

SAMHSA's Treatment Improvement Protocol on detoxification treatment states that it is thus crucially important that patients are counseled during detoxification on the

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[274] SAMHSA/CSAT, TIP 45, p. 66.

[275] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," p. IV.2.

[276] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base"; and NIDA "Principles of Effective Drug Addiction Treatment; A Research-Based Guide," principle 9.

[277] De Jong, Van Hoek, Jongerhuis, eds., "Detoxification Guidance; Responsible detoxification in out- and inpatient settings," p. 8.

[278] Ibid., p. 153.

"importance of following through with the complete substance abuse treatment continuum of care."[279] It further observes that "detoxification presents a unique opportunity to intervene during a period of crisis and move a client to make changes in the direction of health and recovery."[280] Therefore, "a primary goal of the detoxification staff should be to build a therapeutic alliance and motivate the patient to enter treatment. This process should start even as the patient is being medically stabilized."[281]

As psychosocial factors such as psychological dependence, co-occurring psychiatric and medical conditions, social supports, and environmental conditions critically influence the probability of successful and sustained abstinence from substances, SAMHSA/CSAT states that it is important that these psychosocial factors be addressed already during the detoxification process.[282] The UK Independent Expert Working Group report emphasizes that "a full programme of psychosocial support needs to be in place during detoxification."[283] Indeed, research indicates that "addressing psychosocial issues during detoxification significantly increases the likelihood that the patient will experience a safe detoxification and go on to participate in substance abuse treatment."[284]

Detoxification can be achieved in various different settings—inpatient facilities, community-based facilities, or as an outpatient—and at different levels of intensity of care, ranging from limited to intensive medical supervision of the process.[285]

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[279] SAMHSA/CSAT, TIP 45: Detoxification and Substance Abuse Treatment," pp. 4- 5. This motivational work is one of the three "essential components" of detoxification described in SAMHSA's Treatment Improvement Protocol on detoxification, which describes it as "preparing the patient to enter into substance abuse treatment by stressing the importance of following through with the complete substance abuse treatment continuum of care."

[280] Ibid., p. 23.

[281] Ibid.

[282] Ibid.

[283] Independent Expert Working Group, "Drug misuse and dependence – guidelines on clinical management: update 2007. Consultation draft June 2007," p. 107.

[284] Ibid.

[285] In the United States, for example, health facilities use five levels of intensity of care for detoxification for substance dependence, ranging from outpatient detoxification without significant medical supervision to intensive inpatient detoxification. Level I-D: Ambulatory Detoxification without Extended Onsite Monitoring; Level II-D: Ambulatory Detoxification With Extended Onsite Monitoring; Level III-D: Clinically Managed Residential Detoxification; Level IV-D: Medically Monitored Inpatient Detoxification; Level V-D: Medically Managed Intensive Inpatient Detoxification.

A number of different medications have been shown to be effective in opioid detoxification, include the opioid methadone, the partial antagonist buprenorphine, and the α2-adrenergic agonists clonidine and lofexidine.[286] (Agonists and antagonists both prevent opiates from engaging the brain receptor that they normally bind to. Antagonists do so by blocking that brain receptor, while agonists bind to the receptor so that other substances, like opiates, simply pass it by.) Some inpatient programs use opioid antagonists under sedation or general anesthesia to accelerate the detoxification process. UNODC's Contemporary Drug Abuse Treatment notes that it has been difficult to evaluate the relative merits of these various medications. As for ultrarapid opioid detoxification under sedation or general anesthesia, UNODC states that it has "some medical risks" and "[does] not confer substantial advantage over existing detoxification methods."[287] In the TIP on detoxification, SAMHSA/CSAT states that "there are few data showing that rapid or ultrarapid methods of opioid detoxification show a positive correlation with likelihood of a patient's being abstinent a few months later."[288] It lists a range of problems that studies of rapid and ultrarapid detoxification have discovered.

Rehabilitation and Relapse Prevention

The purpose of rehabilitation or relapse prevention programs is to "prevent a return to active substance abuse," "assist the patient in developing control over urges to abuse drugs," and "assist the patient in regaining or attaining improved personal health and social functioning."[289] As drug dependence is a complex disorder that may be caused by different underlying factors in different people and affects people's lives in different ways, a wide range of treatment strategies and treatments have been developed—and shown to be effective—over the years. The UNODC Toolkit observes that

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[286] The UK and Netherlands treatment protocols reviewed for this report recommend methadone and buprenorphine as first-line medications for opioid detoxification. The UK treatment guideline advises against the use of clonidine for opioid detoxification treatment because of side effects. National Institute for Health and Clinical Excellence, "Drug misuse; Opioid detoxification," p. 14.

[287] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base," p. 3.

[288] SAMHSA/CSAT, TIP 45, p. 73. The UK clinical guidance on opioid detoxification also advises against the use of rapid and ultra-rapid detoxification because of health risks associated with some of these forms of detoxification and the high levels of nursing and medical supervision required. National Institute for Health and Clinical Excellence, "Drug misuse; Opioid detoxification," p. 16.

[289] UNODC, "Contemporary Drug Abuse Treatment: A Review of the Evidence Base," p. 5.

> these strategies include such diverse elements as … medications to relieve drug craving; substitution pharmacotherapies to attract and rehabilitate patients; group and individual counseling and therapy sessions to provide insight, guidance and support for behavioral changes; and participation in peer help groups … to provide continued support for abstinence.[290]

A comprehensive drug dependence treatment system will offer a broad range of different interventions so that treatment strategies can be tailored to the specific needs of individual patients. The UNODC Toolkit discusses a range of treatments that it says should, ideally, be made available as part of a system of care and rehabilitation. Recognizing that not all states may be in a position to introduce all these elements at once, it recommends a "building-blocks" approach in which the

> basic elements of a comprehensive treatment system—the evidence-based treatments—can be added together over time, depending on the nature and extent of the problem, the level of fiscal resources available and the cultural and political context.[291]

The UNODC Toolkit discusses two types of pharmacological interventions that are commonly found in rehabilitation programs: maintenance and antagonist pharmacotherapy. UNODC also lists a large number of different psychosocial interventions in its Toolkit. It notes that patients will often benefit from a combination of various different psychosocial interventions.

Rehabilitation treatment can take place in a number of different treatment settings. Community or day programs are outpatient programs in which patients are provided with psychotherapy or general counseling. Residential rehabilitation programs are inpatient programs of short and long duration, ranging from a month to a full year. Long-term residential rehabilitation programs are often based on a "therapeutic community" model and usually involve features like communal living with other drug users in recovery, group and individual counseling on relapse prevention, individual

[290] Ibid.

[291] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," p. IV.1.

case management, improved skills for daily living, training and vocational experience, housing and resettlement services, and aftercare support.

Maintenance therapy with Methadone or Buprenorphine

Under this treatment modality, a substance like methadone or buprenorphine that is related to the agent that caused the dependence is provided to patients in oral form and under medical supervision. The substance prevents opiate withdrawal, blocks the effects of illicit opiate use, and decreases opiate craving. Once a patient is stabilized on an adequate dose, he or she can function normally.[292]

Maintenance therapy has been controversial in some countries, with critics expressing concern that patients are not cured of their addiction, that it just replaces one opioid for another, and that it is linked to risks of diversion of opioids. However, a huge body of scientific research—because of the controversial nature of these programs no other treatment modality has been so exhaustively and rigorously researched—illustrates beyond any reasonable doubt that maintenance therapy is one of the most effective treatment modalities for opioid drug dependence. The World Health Organization, UNAIDS, and UNODC all support maintenance programs. In a joint position paper on maintenance therapy, the three organizations observed,

> There is consistent evidence from numerous controlled trials, longitudinal studies and programme evaluations, that substitution maintenance therapy for opioid dependence is associated with generally substantial reductions in illicit opioid use, criminal activity, deaths due to overdose, and behaviors with a high risk of HIV transmission.[293]

Studies have shown that maintenance therapy can achieve "high rates of retention in treatment" and helps increase "the time and opportunity for individuals to tackle major health, psychological, family, housing, employment, financial and legal issues

[292] NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide," p. 24.

[293] WHO/UNODC/UNAIDS, *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, p. 13.

while in contact with treatment services."[294] They have also shown that maintenance treatment is safe and cost-effective, and that diversion to the black market, though a real concern, can be minimized through proper implementation of national and international control procedures and other mechanisms.[295]

The number of countries that use maintenance therapy in drug dependence treatment programs has been increasing steadily over the last few decades. At this writing about 60 countries worldwide, including an increasing number of countries that have significant problems with opioid dependence, have maintenance programs. In recent years, most countries of the former Soviet Union have either introduced maintenance therapy or are conducting or planning maintenance therapy pilot programs, as have a number of countries in the Middle East and Asia. Almost a million opioid drug-dependent people are currently receiving maintenance therapy, including around 237,000 people in North America;[296] 530,000 in the European Union;[297] about 39,000 in Australia;[298] about 36,000 in China (which plans to expand its maintenance treatment program considerably);[299] and 15,000 in Iran.[300] In countries like the UK and the Netherlands, maintenance treatment is the primary form of treatment for opioid dependence.[301]

Antagonist pharmacotherapy

As noted above, this form of treatment involves the prescription of medications that block the euphoric effects of heroin and other opiates on the user, thus preventing

[294] Ibid.

[295] Ibid.

[296] Office of Applied Studies, United States Substance Abuse and Mental Health Services Administration, "Facilities Operating Opioid Treatment Programs: 2005." *Drugs and Alcohol Services Information System*.

[297] Schering-Plough Market Access data, Sept 2006, "Suboxone Access Situational Analysis 070302," Presentation at the International Harm Reduction Association Conference, Warsaw, Poland, May 15, 2007.

[298] As of June 30, 2005, excluding data for South Australia and the Australian Capital Territory. Australian Institute of Health and Welfare, "Statistics on drug use in Australia 2006," Drug statistics series no. 18, April 12, 2007 http://www.aihw.gov.au/publications/phe/soduia06/soduia06-c01.pdf, p. 69. (Accessed July 12, 2007).

[299] Wu Zunyou and Zhao Chenghong. "Update of Harm Reduction in China," Presentation at the International Harm Reduction Association Conference, East to East Panel, May 13, 2007, http://www.china.org.cn/english/news/203131.htm, accessed July 15, 2007.

[300] "International Experts Call for Greater Commitment to Opiate Substitution Treatment", International Center for the Advancement of Addiction Treatment.

[301] See, for example, National Institute for Health and Clinical Excellence, "Drug misuse; Psychosocial interventions," p. 4.

him or her from experiencing a high. While these medications are sometimes used as part of relapse prevention treatment, research shows that compliance with antagonist agents is generally poor, except among people who are highly motivated to remain abstinent, and that such programs regularly suffer from high levels of dropout.[302]

Psychosocial interventions

Some of the most common psychosocial interventions include:[303]

- Cognitive-behavioral therapy. This therapy is based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Participants in this kind of therapy learn to identify and correct problematic behaviors.

- Supportive-expressive Psychotherapy. This is a form of psychotherapy that has been adapted to drug-dependent persons. Its main components are supportive techniques to help patients feel comfortable in discussing their personal experiences, and expressive techniques to help patients identify and work through interpersonal relationship issues.

- Individualized Drug Counseling. This counseling is aimed at helping a patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence.

- Motivational Enhancement Therapy is a client-centered counseling approach for initiating behavior change by helping patients to resolve ambivalence about engaging in treatment and stopping drug use.

[302] NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide," pp. 35-48.

[303] Detailed information on these and other psychosocial interventions can be found in, among others, NIDA, "Principles of Effective Drug Addiction Treatment: A Research-Based Guide," pp. 35-48, and National Institute for Health and Clinical Excellence, "Drug misuse; Psychosocial interventions."

Aftercare Stage

Although not all rehabilitation programs provide for aftercare, the philosophy behind this kind of care is the "intention to provide ongoing support to clients at the level required to maintain the earlier benefits and goals." In aftercare, clients may be in regular phone contact with treatment programs, have scheduled or unscheduled appointments, or participate in self-help groups. The Toolkit notes that "the effectiveness of such services has not been subject to formal evaluation to date but there is a general commitment to their value and availability."[304]

[304] UNODC, "Drug Abuse Treatment and Rehabilitation. A Practical Planning and Implementation Guide," p. IV.5.