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HARM REDUCTION, HUMAN RIGHTS AND THE W.H.O. EXPERT COMMITTEE ON DRUG DEPENDENCE¹

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THE TRADITION OF WHO EXPERT COMMITTEES ON DRUG DEPENDENCE

The 28th Expert Committee on Drug Dependence of the World Health Organization met in Geneva from 28 September to 2 October 1992. Expert Committees are a well-established part of WHO's work. An Expert Committee meeting on a topic may be a one-time affair, or may be just one in a series. In 1992 and early 1993, for instance, WHO published nonrecurring Expert Committee reports on "Recent advances in oral health", on "Rehabilitation after cardiovascular diseases", and on "Health promotion in the workplace: alcohol and drug abuse", and reports from recurring series of Expert Committees on Filariasis, on Rabies, on the Control of Schistosomiasis, on Biological Standardization, on Specifications for Pharmaceutical Preparations, on the Use of Essential Drugs, and on Food Additives. WHO's style is to describe these recurring Expert Committees as if they are a continuing body. But the Expert Committee for each body is chosen for the occasion, and the turnover in composition between one meeting and the next in a series may be substantial.

The membership of an Expert Committee is carefully chosen with an eye to balance by geography, by social system, and by disciplines relevant to its topic. Members of the Expert Committee on Drug Dependence must already have been named to one of four WHO Expert Advisory Panels, on drug dependence and alcohol problems, on mental health, on neurosciences, or on drug evaluation, and may not come from "industrial research units" (for instance in the pharmaceutical industry; WHO, 1990b). In addition to the members of the committee, the meetings will include WHO staff and representatives of other intergovernmental organizations and recognized international nongovernmental groups. Normally, expert committees meet from Monday to Friday, and the report of the committee will be put together during the course of the week. It is a hard-and-fast rule that the committee's report must be adopted by its members before the committee disperses. These exigencies mean that there is thus usually much preparatory work for the meeting, in the form of commissioned papers and draft material from

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WHO staff, on which the Committee can liberally draw in assembling its report. The Committee is at liberty to ignore these and start from scratch, but if it does it will have much work to do.

The form of organization of WHO meetings might be described as a guided democracy. Formally, the selection of the meeting's chair and vice-chair and of the rapporteur (or co-rapporteurs) who will be responsible for the report is democratic, but these choices are in fact organized by WHO staff beforehand. On the other hand, the role of WHO staff members in the committee's proceedings is limited; a staff member is named as secretary, but the committee's decisions are supposed to be autonomous and not constrained or guided by WHO staff. In principle, an Expert Committee's report is published just as the Committee adopted it.

Expert Committees in the Drug Dependence series have been meeting since 1949, the year WHO was founded (the first committee was on Habit-Forming Drugs; the name has changed several times over the years). What drives the continuation of the meetings as a series is WHO's treaty obligations under the various international conventions on psychoactive drugs: WHO has the responsibility of evaluating a drug's dependence potential, its abuse liability, and its medical usefulness, and of recommending whether and in which schedule a drug should be placed under the control of the international drug control machinery (Bruun et al., 1975). This evaluation is carried out under quite elaborate rules which allow for communications from interested parties, including Interpol and the pharmaceutical manufacturers (WHO, 1990b).

In the 1950s and 1960s, Expert Committees on Drug Dependence had often taken a fairly broad view, concerning themselves, for instance, with matters of definition of addiction, habituation and dependence. A landmark report was that of the Twentieth Committee, meeting in 1973, which had taken a broad view of policy and programs, adopting what would now be termed a harm reduction perspective, and had specifically brought alcohol into consideration (WHO, 1974).

The Expert Committees which met between 1977 and 1990 adopted a narrower perspective, focusing mostly on the technical tasks of considering the scheduling of substances and preparations under the international control conventions. This narrower focus might be seen as reflecting the substantial burden of evaluating the many barbiturates, diazepides and other compounds which the 1971 Convention on Psychotropic Substances potentially brought under international control. Psychopharmacology was the dominant expertise; in fact an American pharmacologist, Harris, served as rapporteur or co-rapporteur to six of the seven meetings, and a Japanese pharmacologist, Yanagita, was a member of all seven committees and chair of the last three.

The new WHO Programme on Substance Abuse (PSA), separated from the Mental Health Division just before the 1990 Expert Committee met, had already decided at that time to expand the scope of the committee's work "from reviewing psychoactive substances for recommendations on scheduling to a broader range of technical issues related to the reduction of demand" (WHO, 1991:1). The 1992 Expert Committee therefore met with a dual mandate. As with the immediately preceding committees, it had the duty of giving a preliminary consideration ("pre-review") to ten substances which had been put forward for possible scheduling, and deciding whether they should be given a critical review before the next committee made the decision on scheduling. But it was also given a broader charge, to pick up the thread that had been dropped after the 1973 meeting and "to look at the various strategies and approaches for reducing substance

use and its harmful consequences in the light of the changes that had occurred since the twentieth meeting" (WHO, 1993:1).

The composition of committee reflected the double task it had been assigned. Yanagita and Schuster (U.S.) were retained from the roster of psychopharmacologists on previous committees. Ghodse (U.K.), an addiction psychiatrist, was the only other member who had previously been on an Expert Committee in the Drug Dependence series, although other members had been on other Expert Committees. Several members of the committee were known particularly for epidemiological or policy-oriented work in alcohol problems -- Casswell (New Zealand), Poikolainen (Finland), Room (Canada) -- or for work in both alcohol and drugs -- Edwards (U.K.) and Medina Mora (Mexico). Two members had strong connections with the United National Drug Control Programme in Vienna -- Emafo (Nigeria) and Samarasinghe (Sri Lanka) -- and Ghodse was Chair of the International Narcotics Control Board. The French member, Jean-François, could draw on substantial experience in the national treatment system. No one in attendance at the 28th Committee meeting had been at the 20th Committee meeting (Edwards had been invited to the latter but had been unable to attend).

THE PRODUCTION OF THE 1992 EXPERT COMMITTEE REPORT

Advance preparation for the committee's meeting did not turn out to have provided much in the way of raw materials for the report, except for the section on the pre-review of the ten substances, which was well prepared. The PSA staff were distracted with other concerns, and somewhat split on what approaches to recommend to the committee in its broader task. Other than the pre-review materials, the main documents precirculated to the Committee were the Report of the 1973 committee (WHO, 1974), and four short papers: a 9-page background document on "the health sector's role in addressing drug- and alcohol-related problems", an 11-page document on "WHO's demand reduction strategies", a commissioned working paper on "human rights and licit and illicit drug use", and a three-page note on dependence terminology.

One approach contemplated by some PSA staff members seemed to be simply to adapt the 1973 Committee report. Committee members did not think this appropriate, however, and set out on the task of drafting and adopting the report during the five days of the meeting. The drafting had to proceed around the edge of a committee agenda filled from 9 to 5 on each of the first four days with substantive discussions of an agenda prepared in advance by WHO staff.²

In the event, the report was finished and adopted within the prescribed time, although the Committee was down to its minimum quorum by the time of the final adoption of the report. Much of the draft text was not seen by the Committee until late in the week, leaving those outside the drafting process few options other than accepting or dropping the language that was put forward. A cleaner and more forceful text might have been accomplished if the timetable had allowed another day or two.

Then began a lengthy process of preparing the report for publication. As co-rapporteur, I was sent a copy of the initial editing done by the PSA staff. I sent back a listing of places where in my view the text should be changed back to what the Committee had adopted, and after 15

²The present writer served as co-rapporteur with primary responsibility for the broader agenda of the Committee (other than the pharmacological reviews).

pages of faxes back and forth fair agreement was reached on this. Then the document went into the copy-editing process, a process entirely up to WHO staff. When the report emerged in published form, there had been a large number of subtle changes. As well, a couple of embarrassing errors had been introduced, e.g., a sentence implying that alcohol was subject to international controls (p. 18 of original version).

Expert Committee reports for the year are considered by the Executive Board of WHO at its annual meeting. The Executive Board is an elected executive body responsible to WHO's constituents, national ministries of health. So the 28th Report was considered by the Executive Board in January 1994, shortly after it had been published. The Canadian and the Japanese representative raised a question about the inclusion of an Annex to the Report, entitled "WHO's contribution on drug use to the report United Nations action in the field of human rights". There were technical objections about the document having not fully completed the WHO approval process, but it was clear that there were also objections to raising the issue of human rights at all in the context of drug control. As his objection is summarized in the Summary Record of the meeting, Larivière (Canada) felt that the Annex

was not a technical one, used fuzzy and confusing terms. The report would gain by its omission. In any event, as a WHO contribution to a United Nations report, it should be worded with a view not only to the concerns of the medical profession, but also to those of Member States where illegal drug users often transgressed the criminal code. (WHO, 1994:16)

There was quick agreement to drop the Annex, on the technical grounds that it had been discovered since the Expert Committee met that the document from which it quoted had missed a step in the WHO internal approvals process, and thus did not exist as a properly approved WHO document. However, the recommendation on human rights by the Committee in the main text was retained. The Report was then reprinted for publication without the Annex.³

THEMES IN THE COMMITTEE MEETING AND THE REPORT

Harm Reduction Redivivus

The Committee was conscious that it was picking up a strand which had been dropped after the 20th Report. This was seen in terms of the renewal of a particular perspective as well as in terms of tackling a broader agenda than the intervening reports. As one influential member put

³The two English-language versions differ in the following ways: the omission of the Annex (replaced by a page advertising Technical Report Series numbers 771-789); the omission of Recommendation 9.9.3, which refers to it; the fixing of the sentence on page 18 which had implied that alcohol was covered by the international conventions; and an extra line in the printing record at the bottom of p. ii: "94/9990 - Benteli - 7000". A replacement copy was mailed to those known to have received the earlier version with a slip page stating: "For technical reasons, the first printing of this book has had to be withdrawn. The present volume replaces the earlier copy, which should be destroyed." In the French edition of the report, the "Annexe" was backed by a page of advertising rather than of text, so the French edition was distributed after the Executive Board decision (e.g., at the Vienna Narcotics Commission meetings in May 1994) with the "Annexe" page cut out.

it, "I see the 20th Report as where we're coming back to after an intervening period of supply reduction. We're being forced back to it by the failure of supply reduction."

The 1992 Committee saw the 20th Committee Report as having adopted a harm reduction perspective, although the term had not been used. The adoption of the perspective was explicit in the 28th Committee Report:

The primary goal of national demand reduction programmes should be to minimize the harm associated with the use of alcohol, tobacco and other psychoactive drugs.... The Committee recommended that, for maximum effectiveness, national policies should be oriented to explicitly defined "harm minimization" goals, with both short-term and long-term objectives. (WHO, 1993:35-36)

The Committee endeavoured to escape the dichotomy of supply vs. harm reduction, and did not accept the proposition that its job and the job of the World Health Organization was only to worry about "demand reduction".

The Committee held relatively strongly to this position, but not without some grumbling. The Chair, who had also served as Chair of the International Narcotics Control Board, was initially suspicious of the term and its meaning, but the promised debate on adopting the perspective fizzled out when there was no substantial opposition.

Influenced by the alcohol expertise among its members, however, the Committee adopted a relatively wide-ranging view of harm reduction, so that, for instance, regulation of the supply was seen as among the potential harm reduction strategies.

The Spectrum of Psychoactive Drugs

The Committee was invited to include alcohol in its consideration, and there was no dissent to doing so. Very early in its deliberations, it decided to include tobacco as well. This raised a slight awkwardness from WHO's point of view: the responsibility for tobacco lay elsewhere in the WHO structure than in PSA. But this has since been remedied: by a decision of the WHO Director-General, tobacco has now been transferred to PSA's responsibility.

The Committee raised the issue of including steroids and other performance enhancing drugs in the terms of reference of future Committees, although these drugs are not psychoactive and they are termed "non-dependence producing" in ICD-10 and other nosologies.

"Rational Use" of Drugs

The issue of the underuse of opiates for palliative care in cancer had been identified by another WHO Expert Committee (WHO, 1990a), and was brought forward for discussion by staff of the relevant WHO unit. Discussion of the issue was included in the report without any objection (WHO, 1993:20-21). The formulation in terms of "rational use" is curious but went largely unchallenged; it is a formulation which essentially equates rationality with medical auspices. Implicitly, the formulation includes a critique of overstrenuous drug control -- i.e., drug control which impinges on the decision-making of doctors -- as "irrational". Since dependence tends to be regarded as something bad and to be avoided, proponents of "rational use" tended to want to shift the focus in definitions of dependence away from physical aspects like withdrawal and towards drug-seeking behaviour; this was an argument put forward by the representative of the International Federation of Pharmaceutical Manufacturers Associations in one of her few

interventions. A cancer patient may go through withdrawal but not have drug-seeking behaviour; according to definition in terms of the latter, the patient would not be dependent.

In connection with the discussion of "rational use", WHO staff laid out to the committee the huge variations which exist between developed countries in the medical use of opioids. For instance, in terms of defined daily doses per capita, the use in France is 16 times that in Italy, and the use in Denmark is 10.5 that in the Netherlands. Denmark uses 37 times the amount of morphine per capita that Japan uses, although overall the Japanese spend more per capita on pharmaceuticals (over \$300 per year) than anyone else. It was noted that the idea of "rational use" implies that comparable quantitative indicators of the appropriate level of therapeutic use in a society can be arrived at, but this may not make sense in view of the extent of variation in medical practice.

Traditional use of indigenous psychoactive plant products

This issue came up in connection with a request from South America for a restudy of the dependence-producing potential of coca leaves, with the hope that a way would be found to remove traditional use from international control. Under the 1961 Single Convention on Narcotic Drugs, coca-leaf chewing was supposed to be abolished by 1989, and it is clear that this has not happened and is not likely to happen. The Committee saw no point in recommending a restudy, since coca leaves were undoubtedly a precursor of cocaine, and thus would be covered by the Convention whatever the dependence-producing potential of the leaves themselves. The coca leaf issue touched off a broader discussion of the wisdom of bringing traditional use of indigenous psychoactive plant products under international control. The social and health problems which had resulted from attempts to ban khat in Africa were described. But the international control machinery does not formally take into account the potential adverse effects of control. The Committee, troubled by the possibility that a single complaining country could touch off inclusion of more of these indigenous psychoactive plants products in the international control regime, recommended studies looking towards possible changes in international control provisions concerning these traditional patterns of use (WHO, 1993:19-20). There was considerable correspondence after the meeting about keeping any language in the report which contemplated changes in the drug control conventions; for some WHO staff, this was seen as an inappropriate recommendation for WHO or one of its Expert Committees to make.

Human rights

The Committee held a lively but somewhat confused discussion on the issue of human rights in the drug field. Although there were splits in the WHO staff on whether and how the issue should be brought up, a paper had been commissioned and was circulated. But Committee members felt that the paper tried to apply analyses derived from the AIDS field too mechanically to the drug field. Given the shortness of time and the splits within the Committee on what should be emphasized, the Committee decided to include the text of a WHO document as an Annex,⁴ and

⁴ The text of the Annex follows:

WHO's contribution on drug use to the report *United Nations action in the field of human rights*

included in the text only a brief recommendation which listed issues which, it was felt, particularly needed to be addressed.⁵ As noted above, this touched off the extremely unusual decision of the WHO Executive Board to excise the Annex.

Human rights is a flashpoint in international drug policy debates for two reasons. One is that, almost by definition, it involves the clash between individual rights and state rights, and thus it is easily redefined into an argument about national autonomy. These days, with the significant exception of the United States, it is not by and large developed countries but rather the developing world which has the most extreme symbolic legislative punishments of drug trafficking, often

Drug users represent a specific population in which there is a high risk that human rights and fundamental freedoms will not be respected. WHO recognizes that violations of the human rights of drug users may be considered under the following groupings:

* Persecution: in some countries, there may be specific legislation that denies drug users their basic rights, and may actually sanction the active contravention of human rights through oppression, mistreatment and harassment;

* Discrimination: in many countries, unwritten policies and cultural norms exist which sanction discriminatory practices against drug users; these may take the form of restrictions on freedom of movement (such as obtaining passports and visas), access to employment and access to quality services; and

* Consequences of drug use and drug-using environment: the consequences of drug use may have an impact on the human rights of individuals, their families and the local community. Because of their reduced capacity to earn an income and the need to adopt certain lifestyles to support their drug use, drug users may be unable to fulfil both their own and their families' basic needs, and hence risk exploitation through cheap labour, criminal activity and prostitution. Women and youth are at the greatest risk. The promotion of health-damaging products such as alcohol and tobacco, using misleading information and targeted at high-risk populations, is common practice. Certain WHO projects specifically address these issues. These include projects geared to street children; the consequences of cocaine use by pregnant women; and appropriate drug interventions for indigenous populations that have retained their traditional cultures; and country and regional projects designed to develop national demand-reduction strategies, with due regard to human rights issues.

Although a footnote stated that this was "reproduced from United Nations action in the field of human rights. New York, United Nations, 1993", this publication had in fact been delayed beyond the middle of 1994, and it is reported that the text quoted in the Annex was removed from it.

⁵9.9.1 "WHO should review ethical and human rights issues relating to the status of drug users, their families and others who may be affected by drug use, and encourage appropriate action by Member States on such issues. Particular attention should be paid to issues raised by compulsory treatment, the protection of rights within the penal system, data protection, rights of access to treatment and social assistance, child custody, the implications of drug-testing in the workplace, and the protection of research volunteers."

including the death penalty, and arguments against a human rights agenda are often couched in terms of the autonomy of developing societies. There is considerable irony in this, in view of the nature and history of the international drug control regime, and of the energetic intervention by the U.S. during the Reagan-Bush era in other countries' legislative and policy decisions on drugs.

Human rights is also a flashpoint because, raised from the venue of a health organization, it explicitly challenges the tidy separation between the "soft" approaches of treatment and education and the "hard" approaches of enforcement. The "war on drugs" mentality has always been comfortable with the existence of the "softer" approaches of treatment and education alongside the "tough" approach of law enforcement, but this mentality insists that those responsible for the softer approaches stick to their knitting and not attempt to interfere in the actions of the tough side. In some definitions, harm reduction also breaks down this barrier between demand and supply approaches, but the meaning of the term has been elastic enough that it has been possible for those committed to the supply and demand dichotomy simply to classify harm reduction as a subcategory of demand reduction. The issue of human rights cannot so easily be deflected. Though in part the Committee's recommendation in this area was concerned with human rights in the context of the treatment and welfare systems, it does also refer to "the protection of rights within the penal system". The Annex to the report more directly raised the issue that drug legislation "may actually sanction the active contravention of human rights". This turned out to be a challenge to the autonomy of penal approaches that could not be sustained.

THE CANADIAN ROLE IN INTERNATIONAL DRUG CONTROL

Writing in 1978, Lynn Pan and Kettel Bruun (1979), the historians of the international drug control, saw signs of change in the system in the five years since their earlier book. In particular, there had been an "attempt to reorientate the pursuit of goals towards the reduction of drug demand", and some signs of a greater willingness to discuss alcohol in association with the other drugs. Both of these trends were already presaged in the landmark report of the 20th Expert Committee on Drug Dependence. Unfortunately, these changes in direction of the 1970s were largely swamped by the new wave of drug wars and drug hysteria in the 1980s. Now at last we have started again down the roads laid out in the 20th Report.

Canada played a strong role in the developments of the 1970s. David Archibald, the founding President of the Addiction Research Foundation, was a member of the 1973 Expert Committee, and both in its inclusion and in its substance the section on alcohol in the Committee's report bears the hallmarks of the Foundation's approach. Pan and Bruun document that it was the Canadian delegation to the Commission on Narcotic Drugs which in 1975 "introduced a resolution on measures to reduce illicit demand for drugs which proved crucial for the shift of the focus of theoretical discussion in the Commission away from the supply and law enforcement aspects of drug abuse to the question of drug demand and prevention." Pan and Bruun (1979) conclude concerning the 1970s that

In terms of its contribution to policy-making, Canada has recently been important as an initiator. Because of its own keen espousal of the goal of demand reduction, its principal contribution to policy-making has been the enhanced legitimacy of that goal in the Commission. Canada's influence and membership of the inner circle of powerful countries stems also from the individual inclinations and attributes, including such assets as expert

knowledge and negotiating ability, of its delegates. Furthermore, a key position, that of the Director of the Division [of Narcotic Drugs], is occupied by a Canadian national. Unfortunately, the Canadian role in the international drug arena is now much more equivocal. In view of the generally positive role that Canada has played in the effort to get human rights onto the general international agenda, it is curious and extremely disappointing that the Canadian member of the WHO Executive Board played an instrumental role in securing the removal of the annex on human rights from the 28th Expert Committee Report.

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