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Methadone versus torture: The perspective of the European Court of Human Rights

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Summary

For the first time, the European Court of Human Rights in Strasbourg has addressed the issue of whether persons with a heroin dependence syndrome in custodial settings are entitled to receive opioid agonist treatment (OAT). The court relied on Article 3 of the European Convention on Human Rights, which prohibits torture as well as inhuman or degrading treatment. It concluded that member states of the Council of Europe that refuse access to OAT have the burden of proving that an alternative medical approach would, in the case of an individual patient, be as effective as OAT. Such proof needs to be based on an independent medical opinion. This paper discusses the scope and limitations of the European Court of Human Rights' judgment.

Key Words: Methadone; opioid agonist treatment; prisons; international laws

In the field of psychoactive substance use disorders, few medications have demonstrated their efficacy in the long-term treatment of these disorders as well as agonist medications for opioid dependence syndrome [24]. Indeed, in 2005, both methadone and buprenorphine were added to the WHO model list of essential medicines [23]. ICESCR (International Covenant on Economic, Social and Cultural Rights) considers that any failure to make these two medicines available is a serious breach of the right to enjoy the highest attainable standard of health [9, 18]. Yet, the medicinal status of methadone or buprenorphine remains ambiguous, as they are still subject to special regimes related to the international control of 'narcotic' substances, in most countries [21]. Historically, treatments using opioid agonist medications were the subjects of controversy, as were "risk and harm reduc-

tion" policies and measures, e.g., needle exchanges. The still widespread designation "substitution treatments" (suggesting the replacement of a 'street drug' by a 'state drug') illustrates this ambiguity [20]. In fact, the special regimes mentioned above are accompanied by various restrictions on medical practice, including the need for physicians to hold a State permit, requirements regarding eligible patients, the selection of prescribed opioids and their method of delivery, together with conditions related to professionals and healthcare availability [1, 17]. These restrictions are applied in many jurisdictions. Often they impair or sometimes even block access to these medications [19]. Furthermore, people deprived of liberty are particularly likely to encounter severe restrictions [21].

Recently, the European Court of Human Rights (from now on, more concisely: the Court) in Stras-

bourg explained why access to methadone treatment in prison can indeed constitute a State duty and responsibility. This paper discusses the scope and limitations of this judgment.

1. Mr. Wenner versus Germany, 1st September 2016

In its ruling of September 1, 2016, the Court convincingly explained why the practice of prescribing methadone to detainees, paradoxical as it may seem to some, can constitute a legal obligation of Member States of the Council of Europe. Accordingly, refusal to grant access can constitute a breach of Article 3 of the European Convention on Human Rights (ECHR), which prohibits torture as well as inhuman or degrading treatment.

In this affair, the Court had to decide whether the refusal by the German authorities and the German courts to grant methadone access to an inmate diagnosed with long-standing heroin dependence syndrome was in compliance with the State's obligations under Article 3. The appellant, Mr. Wenner, born in 1955, had been using heroin for 17 years. For more than 16 years (1991-2008), he had benefited from an overall successful treatment with methadone. Sentenced to six years in prison for "drug trafficking", he had asked to continue his methadone-based treatment in prison. The Bavarian prison authorities and courts refused, ordering instead a treatment based solely on abstinence. Abstinence proved to be a failure, and Mr. Wenner continued to consume a range of psychoactive substances available through the prison's black market. He continued to request methadone; as the best alternative, he demanded that his health status and need for treatment be evaluated by external medical specialists. Despite his efforts and appeals, his requests were rejected. It was only when he was released, at the end of 2014, that Mr. Wenner resumed his methadone treatment.

2. States have a particular duty to ensure the health of their detainees

Mr. Wenner brought his complaint before the Court, arguing that the two refusals that he had sustained violated Article 3 of the ECHR. Not only is it forbidden for each member State in the Council of Europe to inflict degrading treatment, so much so that every State is actually required to take positive measures to avoid causing suffering. Yet, not all pain-

ful treatments are viewed as being sufficiently severe to be prohibited by Article 3. Determining whether a treatment is 'sufficiently' degrading will depend upon the circumstances of each case, including the age and health status of each individual involved. With regard to detainees, the State responsible for their incarceration has a special duty to safeguard their health and to ensure that detention conditions, including health care services, remain adequate.

In its judgment of September 2016, the Court held that it did not have to decide whether methadone-based treatments (commonly referred to as 'opioid agonist treatment, or OAT'), or historically as an "opioid substitution treatment" (otherwise OST), are the most appropriate of all for the treatment of heroin dependence syndrome. Instead, it chose to focus on Mr. Wenner's second grievance, i.e. the authorities' duty to assess the therapeutic need for methadone treatment based on the expert opinion of independent medical specialists. On this point, the Court favoured Mr. Wenner, and unanimously condemned Germany. Even if the Court only ruled on the need to resort to independent expert opinion, the grounds for its judgment strongly suggest that a State must provide OAT to any detainee who meets the treatment's criteria foreseen for those who wish to undertake it. This conclusion holds at least in the following circumstances: The detainee has been diagnosed as suffering from long-standing heroin dependence syndrome; previous treatments, including those whose direct objective was abstinence, have failed; doctors who assessed the patient recognize that abstinence-based therapeutic options hold little chance of success; and without OAT, the patient undergoes mental and physical suffering.

Two points should be highlighted at this point. Firstly, the State's obligation to provide methadone does not end once the inmate has undergone the treatment in detention. Heroin dependence syndrome is recognized as a chronic disease, and the fact that the patient is no longer in the acute phase of withdrawal does not mean that he is definitely cured and no longer needs methadone. Secondly, it is the States' responsibility to prove that the treatment being offered in prison is appropriate; the Court wrote: "having regard to the vulnerability of applicants in detention, it is for the Government to provide credible and convincing evidence showing that the applicant concerned had received comprehensive and adequate medical care in detention".

An interesting question is what led the Court to avoid the first issue – does OAT constitute the only

adequate treatment? – and to focus instead on the second issue, namely, the need for independent expertise to determine the most appropriate treatment.

3. The principle of equivalence

The starting point for the Court's reasoning is the principle of equivalence. It is accepted under international law that a person deprived of liberty is entitled, in principle, to the same level of healthcare as a free person. Detention is not a valid reason for providing less extensive or lower-quality care. If OAT were to be regarded as the standard treatment for "ordinary" patients, the same should be true for those in prison. On this point, the Court took the opportunity to refer to a study [25] – there are actually several [6, 8, 13, 24] – endorsed by the German State, which concluded that: "long-term substitution treatment [with methadone] had proved effective in that the primary aims of that treatment (that is, continuity of treatment, survival, reduction of substance consumption, stabilization of comorbidity and securing social participation) were attained". Conversely, there is strong evidence that an opioid abstinence regime without adjunct medicines almost always fails, while often leading to lethal intoxications when patients revert to consumption [3, 15, 24]. In addition, this study states that OAT should be implemented as a long term, or sometimes even permanent, treatment. It should therefore not be interrupted prematurely, particularly for a period of incarceration. The Court also took the opportunity to refer to the statistics on the availability of OAT in Council of Europe member countries: In 2012, 41 of the 47 members offered this therapeutic option, of which 30 (out of 47) offered the treatment equally to detained individuals.

At this point, one might predict that the Court would conclude that OAT is not only "standard", but also the only treatment to be envisaged. The Court, however, chose not to go so far, leaving the State with a margin of latitude to decide on a case-by-case basis. For some opioid-dependent patients, especially those who are highly motivated, a programme of abstinence may be attempted. Thus, the State retains the option of proving that, in the case of a specific patient, medical experts agree that abstinence-based treatment could safely treat the opioid dependence syndrome.

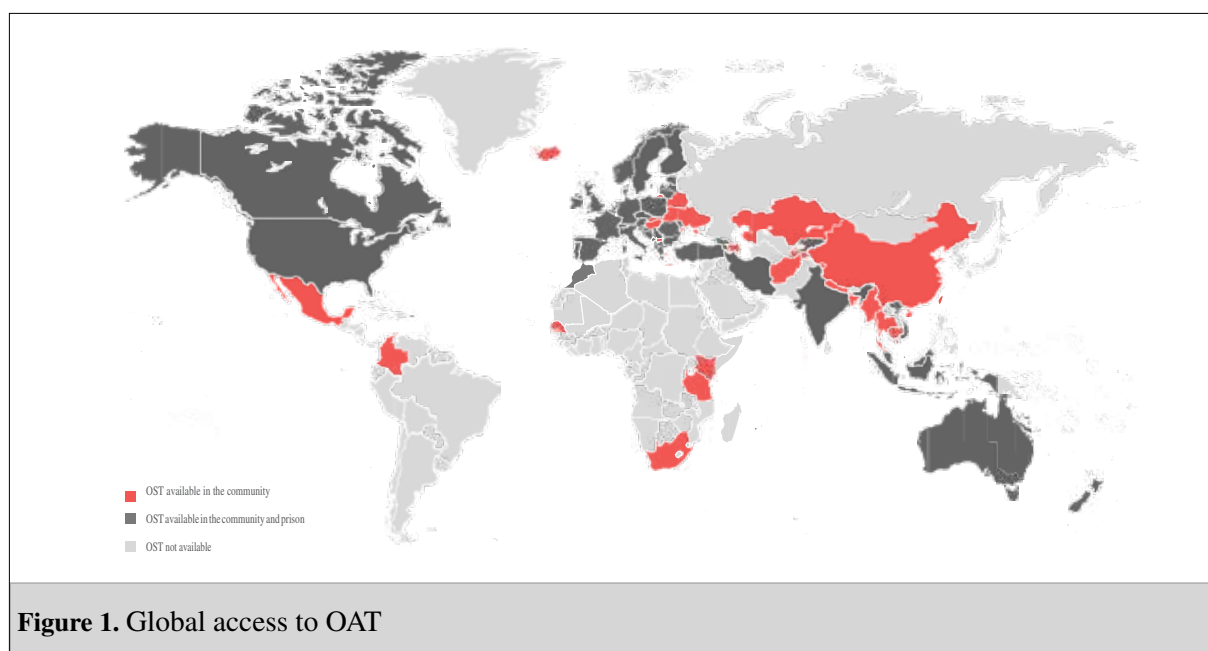
This step in the Court's reasoning deserves further comment. Abstinence-based treatment can only be implemented with the patient's free and informed consent, especially because only motivated patients make good candidates for such an approach. In other

words, if the detainee is not motivated by rapid substance use cessation, such a measure seems a priori devoid of any chance of success. Consequently, in the case of Mr. Wenner, who had decided to reject forced abstinence, the Court could have answered the first question by saying that abstinence-based treatment was in no way appropriate for him, leaving OAT as the only remaining effective and available treatment.

What, then, can explain this reluctance of the Court? The Court often prefers not to encroach on the sphere of doctors' competence. When the question requires technical knowledge, particularly the assessment of various medical options under a risk-benefit approach, the Court considers that experts should be allowed to decide first. This also led the Court to focus on Mr. Wenner's second grievance (the need for one or more independent experts to assess his medical situation). In a rather subtle way, the court sends the following message: since it is up to the States to prove that prison healthcare is adequate, they must also accept responsibility for obtaining independent medical expertise. This is especially true when they seek to (lawfully) impose a treatment different from the one commonly accepted by the medical community and requested by the patient.

4. A global health issue

According to The Global State of Harm Reduction (2016), global access to OAT has improved since 2014; it is actually being proposed in prisons within 52 countries [21] (see Figure 1). However, this progress should not obscure a more complex reality: the implementation of OAT in detention facilities is subject to considerable disparity and problematic medical care implementation, such as delivery of opioid medication directly by prison custody staff due to lack of nursing staff [3]. When OAT is being proposed, the extent of coverage often remains limited, at least in the few countries where such data are available. As an example, only four of the fifty US states reported numbers on OAT's availability in prison, while studies indicate that about 90% of people currently receiving OAT in the USA would have their treatment stopped in a detention context [21]. Only a few countries are deemed to have an optimal availability rate; this is true for Switzerland, where some prisons even propose medical prescription of heroin for patients for whom OAT has consistently failed. However, the Swiss Epidemics Act, in force since 1st January 2016, obliges institutions to make sterile injecting equipment available for detainees [22], even though



only 15 out of 110 prisons have yet implemented this provision [4]. Thus, even in countries that have in place regulatory provisions supporting the principle of equivalence of care, the limited effective availability of treatment calls for a rigorous evaluation effort. OAT and risk reduction measures for prisons remain a considerable public health issue, and subsequently an issue for the improvement of monitoring systems regarding public policy on psychoactive substances.

5. OAT improves patients' physical and mental health

The ECHR's judgment establishes that States must guarantee the availability of OAT for most people with dependence, since it has proved to be the best scientifically identified and tested solution to date. OAT helps patients to stabilize their medical and social status by improving their physical and mental health. It reduces the risk of lethal intoxication, while suppressing the hedonic stimulating effects of additional doses of heroin. By removing the tensions and the dangers associated with obtaining an illegally produced (and sometimes tainted) substance, it allows patients to stay away from the 'drug scene', thus precluding criminal violations and therefore prison. OAT reduces crime related to controlled substances, and therefore reduces the associated judicial and prison costs. It also maintains patients' social ties with their surrounding network and, in the best case, allows them to live without any negative consequences regarding family, social and professional relationships. In terms of public health, OAT minimizes the

transmission of infectious diseases spread by sharing needles for heroin injection: it significantly reduces the rate of HIV and, similarly, hepatitis B and C transmission.

What is true for the general population applies *pari passu* to detained individuals. First, methadone delivery prevents the avoidable withdrawal-associated suffering, without endangering the health of the patient as long as it is prescribed *lege artis*. It is therefore the best medical and ethical solution. For as long as heroin and other controlled substances circulate in prison [11], it is better – both for the individual's health and for public health – that the inmates receive treatment that maximizes their mental and physical state. Lastly, as detainees eventually complete their prison sentences, it is preferable to release them in a stable mental and physical state under OAT – rather than as a consumer in constant need of heroin and at high risk of a lethal intoxication [2, 7, 10, 12, 16].

6. A significant step forward

In summary, the Court's judgment represents a significant step forward in ensuring access to OAT in the Council of Europe's 47 Member States, and possibly beyond. From a legal standpoint, the Court found an elegant answer to the question why access to methadone treatment in prison can indeed constitute a State's duty and responsibility, even though, on an institutional level, it leaves follow some substantial issues concerning the practical application of the equivalence of care principle for other harm reduction and health promotion measures. The key message re-

mains: OAT is currently the most pragmatic therapeutic option – the best tested and the most effective available – both in prisons and, more broadly, in society. For the State, to deny it to an opioid-dependent person is, indeed, a form of inhuman and degrading treatment prohibited by article 3 of the European Convention on Human Rights.

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Footnotes

- the judgment, reference 62303/13, is available from the Court's data base at: <http://hudoc.echr.coe.int/>
- convention for the Protection of Human Rights and Fundamental Freedoms concluded in Rome, 4th November 1950; these texts can be accessed at: http://www.echr.coe.int/documents/convention_eng.pdf
- see Point 58 of the judgment.
- European Committee for the Prevention of Torture

and Inhuman or Degrading Treatment or Punishment (CPT), CPT standards, “Substantive” sections of the CPT’s General Reports, in particular chapter III, “Health care services in prisons”, extract from the 3rd General Report (CPT/Inf [93] 12), published in 1993; World Health Organization (WHO), editors: Stefan Enggist et al., *Prisons and Health* (2014); Cfr. la voce n. 3 della bibliografia: Publications Office of the European Union, Luxembourg] The Committee of Ministers of the Council of Europe, Recommendation No. R (98) 71 concerning the ethical and organizational aspects of health care in prison; Medical-ethical Guidelines of the Swiss Academy of Medical Sciences (SAMS) about medical practice in respect of detained persons (2002, updated 2013) available at: www.samw.ch

e) see Point 31 of the judgment.

f) see Points 36, 37, and 64 of the judgment, which refer to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Prisons and drug abuse in Europe: the problem and responses* (2012). Cfr. la voce n. 3 della bibliografia: Publications Office of the European Union, Luxembourg.

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Conflict of interest

VJ is a member of the Pompidou Group's (Council of Europe) Expert Group on framework and support measures for opioid dependence treatment, including the prescription of agonist medicines. She declares no conflicts of interest.

HW is a member of the Committee for the Prevention of Torture (CPT) of the Council of Europe in the name of Switzerland and also member of the Central Ethics Committee of the Swiss Academy of Medical Sciences. He declares no conflicts of interest.

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Note

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