

The Limits of Equivalence: Ethical Dilemmas in Providing Care in Drug Detention Centers

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ABSTRACT

This article considers the phenomenon of detention centers as a purported means of drug treatment, common throughout much of Asia. It describes the growth of the drug detention center model over the past decade – a system where people suspected of using drugs are rounded up on suspicion of drug use or a positive urine screening, and sent to closed settings without due process or means of appeal. Inside, detainees receive no effective drug treatment, little medical care, and insufficient food. Indeed, they are more likely to face what amounts to torture, cruel, inhuman, and degrading treatment. In some countries, they are forced to work or face severe punishment. This article explores the ethical dilemmas inherent in providing care within an abusive system. For organizations offering health education, food, or even lifesaving medical care inside drug detention centers, what are the limits of providing ethical care, without risking legitimizing the system or building its capacity to detain more people? We explore how organizations might weigh the risks and benefits of their engagement.

INTRODUCTION

A significant amount of attention in prison health has been devoted to the principle of equivalency (UNAIDS et al, 2006; UNGA, 1990; WHO, 1993) – namely the need to provide treatment and prevention of HIV and other medical conditions in state custodial settings when they are available in the surrounding community. Less analysis has been applied to pretrial detention centers generally, a gap this issue seeks to fill. Most limited of all – and most ethically thorny – is consideration of medical care in detention settings that are themselves arbitrary and abusive, or illegal. This article explores the case of detention centers for people who use drugs, common in much of Asia.

As with those detained on grounds of threatening national security or immigrating illegally, detainees in drug detention centers are often held in systems that international law regards as arbitrary – that is, without right of appeal, due process, or clear standards for internment or release. In some cases, these detentions are contrary to processes required by national law (Human Rights Watch, 2010a); in others, terms of detention violate multiple international human rights norms and interna-

tional standards (Human Rights Watch, 2010b). People who use drugs, particularly people who inject drugs, are disproportionately infected with HIV and hepatitis C virus (HCV), with the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimating that a third of new HIV infections outside sub-Saharan Africa are among people who inject drugs (UNGA, 2006); 50%-95% of people who inject drugs may be HCV-infected (EHRN, 2007). Detainees are vulnerable to the same range of health challenges as prisoners, including tuberculosis, with HIV-positive individuals suffering more extreme health consequences of multiple transmissible diseases. In addition, while high-risk behav-

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iors such as drug use and unprotected sex continue in detention centers, means of protection such as sterile injection equipment and condoms are unavailable (Thomson, 2010; Human Rights Watch, 2010b; Wolfe & Saucier, 2010).

The question thus confronting health and penal system professionals is what is the ethical response when detention centers themselves are the biggest obstacle to HIV prevention, treatment and realization of rights? How do we weigh whether our involvement inadvertently supports an abusive system – either by making its continued operation financially feasible, by lending legitimacy, or by building its capacity? One argument may be that the principle of equivalency applies – that is, that detainees are entitled to the same services as those in the community. A counterargument holds that illegality of the detention centers is the most salient fact, and that the provision of some or all services in such settings risks their legitimization. A third, pragmatic view focuses on available resources, and suggests that these should be devoted to actions to close the centers or divert people from detention as the most effective disease prevention measure, and one enhancing the likelihood of treatment.

THE RISE OF THE DRUG DETENTION CENTER MODEL

Drug detention centers are sometimes called compulsory treatment centers, drug rehabilitation centers, or reeducation through labor centers. These are closed settings where people suspected of illicit drug use or those who test positive in urine screenings are sent for detoxification, treatment, and rehabilitation. Today such detention centers for people who use illicit drugs exist in some 11 countries throughout Asia, including China, Vietnam, Cambodia, Thailand, Laos, and Malaysia (Mathers et al., 2010). More than an estimated 400,000 people are detained annually (Mathers et al., 2010). Though there are differences by country and sometimes even by province within a country, the centers are variations on a similar model.

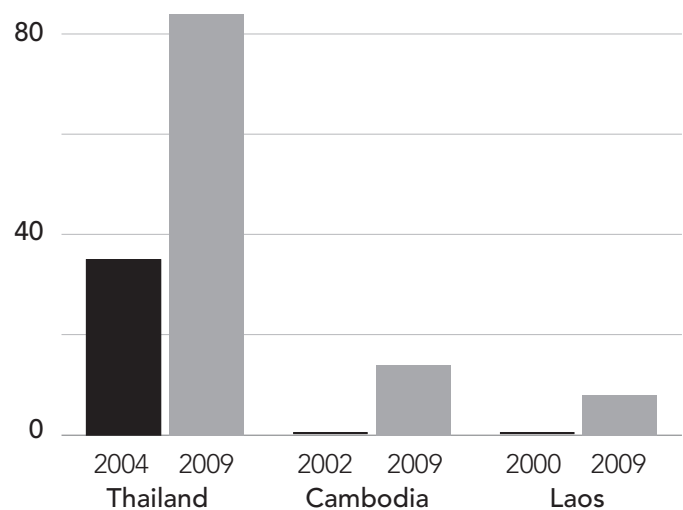
Detention is extrajudicial and most often involuntary. People suspected of using drugs, whether they actually use drugs or are simply swept up in police or military raids are frequently detained for treatment on the basis of mere police suspicion or a single positive urine test. For example, in Cambodia, people who use drugs are picked up by police, sometimes along with people with mental disabilities, sex workers, and the homeless. One former detainee in Cambodia describes the process of his detention: “I got arrested when I was walking with a group of friends. I was told the reason I was arrested was that I was walking with too many people at the same time (12 people). I didn’t go to court or face a trial. I was told that I was a yama [methamphetamine] user and therefore required treatment” (Thomson, 2010). There is no judicial supervision or process for appeal. Some detainees report being able to bribe

their way out of internment (International Harm Reduction Development Program, 2009a). In other cases, people suspected of using drugs may be committed upon the request of a family member or the report of a neighbor. People who use drugs in Vietnam report that even those who enter so-called rehabilitation centers voluntarily find themselves unable to leave and are instead confined for years at a time without due process, with severe beatings and other punishments meted out to those attempting escape (International Harm Reduction Development Program, 2009b; personal communication with Saucier & Wolfe, 2010).

Terms of release are similarly arbitrary: In Cambodia, for example, detainees are sometimes required to recite the Cambodian national drug laws from memory prior to release (International Harm Reduction Development Program, 2009a). In Vietnam, drug detention terms have been extended to two years of “rehabilitation” plus two years of “post rehabilitation management” for most detainees, which in practice is more of the same. In China, detention has also been lengthened to up to two years (Human Rights Watch, 2010b). These extended sentences are a response to relapse rates that even by official estimates range between 60% and 100% (WHO WPRO, 2009); rather than questioning the method, authorities decided more of it was needed.

Despite lack of evidence of effectiveness, the center model has grown exponentially. In 2004, there were 35 drug detention centers in Thailand; currently there are 84. Similarly, in Cambodia the number of centers grew from zero to 14 in eight years; and in Laos from zero to eight in ten years (Thomson, 2010). While some people who use heroin and other drugs are

FIGURE 1 Proliferation of compulsory drug treatment detention centers



also detained in these centers, in most countries they are predominantly filled with people who use methamphetamine (Thomson, 2010). In China and Vietnam, heroin remains the drug that is used predominantly, and most people are detained for using or being suspected of using it. Today China detains some 330,000 people in drug detention centers (Mathers, 2010); Vietnam detains approximately 60,000 of the 135,000 people estimated to use drugs in the country (Mathers, 2010). Plans for the next five years include “encouraging and forcing the majority of drug addicts in big cities and focused provinces to detoxification centers” (Department of Social Evils Prevention, 2010). High relapse rates mean multiple terms in the centers, since repeat offenders are often sent back for more of the same.

Drug detention centers are predominantly managed by either the military or law enforcement, with the regimens implemented there based upon a military “boot camp” type model. Detainees are subjected to early morning wake-ups and physical exercises, and are often indoctrinated with anti-drug rhetoric. In many cases, detainees report inadequate food and shelter. A former detainee in Laos described the living situation in the center where he was held as follows: “There is not enough water for drinking, showering, and washing. The toilets are filthy, and there are bags with shit lying around. We all eat and sleep in the same room, so that’s dirty too. Each room is about seven by five meters, and there are about 35 to 40 people in each room” (Thomson, 2010). A World Health Organization (WHO) report found high rates of skin infections and beriberi amongst detainees in Laos (Thomson, 2010). Qualified health sector personnel are rarely involved in any aspects of drug treatment in the centers. Detainees report degrading treatment and severe physical, mental, and sexual abuse. One detainee in Laos described his experience: “They would attack anyone who tried to be strong or tried to escape. Ten men or so would beat them, kick them. The guards would use their shoes to beat them. I also saw guards make people jump up and down like a frog until they were exhausted, became weak, and fell down” (Thomson, 2010).

In Vietnam and China, so-called rehabilitation centers are in reality forced labor camps where slavery is enforced by violent punishments or torture. Detainees are expected to work long hours without adequate workplace safety provisions, producing goods for private companies (Human Rights Watch, 2010b; International Harm Reduction Development Program, 2009b). Detainees have production quotas, and report beatings and other harsh punishments if daily quotas are not met. One former detainee in China described the situation: “We work until dinner-time. After downing a few mouthfuls of food, we rush back to the workshop, trying to take advantage of the little time we have left. But no matter how much we hurry, there is still a large majority of ‘crooked pears’ [people who fail to meet their production quota]

suffering physical injury by the end of the workday at 9 p.m. After recording how many did not finish their tasks or produced low-quality goods, the Big Brothers [more senior detainees tasked by center authorities with disciplining other detainees] stand at the doors of the workshop, raise long hoes, and take turns viciously beating the ‘crooked pears.’” (International Harm Reduction Development Program, in press).

These punitive approaches are justified in terms of social rehabilitation of those regarded as having profound disorders of consumption and production – people who use drugs are often described both in terms of their inability to stop using drugs and their failure to contribute productively to society (Wolfe, 2007). The detention center model, however, does not constitute effective drug treatment, and is not based in evidence (Mathers, 2010). Further, because of its compulsory and long-term nature, as well as the abuses represented by forced labor, beating, and arbitrary detention, it is at odds with internationally recognized principles. The United Nations Office on Drugs and Crime and the WHO stress that drug treatment must be evidence-informed and respect human rights; neither forced labor nor detention are recognized as scientific methods for treating drug dependence (WHO & UNODC, 2008). Involuntary treatment is justifiable only in emergency short-term situations when the person is an imminent threat to themselves or others (UNODC, 2010).

Health Implications of Compulsory Detention as a Response to Drug Use

Some portion of detainees continues to inject drugs in detention centers, but sterile syringes and other injecting equipment are unavailable (Thomson, 2010; Human Rights Watch, 2010b, Wolfe & Saucier, 2010). Detainees are thus at increased risk for diseases like HIV and hepatitis C, as well as abscesses, endocarditis, or septicemia. For methamphetamine users who are the largest share of detainees in Thailand, Cambodia, and Laos, drug use outside the centers was predominantly via inhalation; once inside a detention center, however, exposure to blood-borne viruses and other infectious diseases may increase (Thomson, 2010). Despite high rates of HIV and tuberculosis, medical treatment for these infections remains largely unavailable (Wolfe & Saucier, 2010). In Southeast Asia, other prevalent behaviors increasing disease risk include tattooing and penile modifications without sterile needles or blades, unprotected sex and rape (Thomson, 2010). While data is not collected by center staff, detention in these facilities – as with incarceration of people who use drugs in prison systems – is likely associated with a host of negative health outcomes, including sexually transmitted infections and blood-borne viruses such as syphilis, herpes, HIV, HCV, and hepatitis B virus (HBV).

PROVISION OF PREVENTION AND TREATMENT INSIDE THE DRUG DETENTION CENTERS

Some nongovernmental organizations have attempted to provide care and services to detainees in the centers. This can range from providing food to detainees, providing antiretroviral treatment or medications for other infections, educating detainees about disease prevention (though provision of prevention paraphernalia such as sterile syringes or condoms is generally prohibited), and engaging in capacity building with center staff. Taken at face value, these activities answer basic needs of those in detention, in keeping with the principle of equivalency. Further, nongovernmental organizations and former detainees point to the importance of showing those detained that they have not been forgotten.

The ethical complications of work to provide treatment and prevention inside the centers, however, become apparent when center administrators or governments seek to use engagement by health professionals to legitimize their approach. Agreement signing ceremonies are prominently displayed on websites; in some centers in Vietnam, directors are purported to have certificates hanging on their walls from a U.S.-based group that engaged in capacity building. In 2008, many were alarmed when a large health organization sent an announcement saying that they were going to help make a notoriously bad drug detention center in Cambodia a “Center of Excellence.”

This same center was widely viewed by most health and human rights organizations as beyond redemption. Additional complications arise when considering testimony by former detainees noting that testing and treatment are complicated by the involuntary nature of the centers, particularly those with the forced labor system. In one interview, for example, a recently released detainee noted that HIV-positive detainees were offered antiretroviral treatment, but only if they agreed to remain working in the detention center for an additional year. Others note that those who participate in HIV testing or who go to peer education sessions are motivated to do so primarily because they are given time off from punishing work regimens (personal communication with Saucier & Wolfe, 2010).

ETHICAL CONSIDERATIONS FOR HEALTH-RELATED ORGANIZATIONS WORKING WITH DRUG DETENTION CENTERS

The care of the sick and the promotion of health are activities that are recognized as ethical activities. We expect good people to do these things, and we believe that human beings need and deserve these social goods. However, ethics also requires the consideration of burdens as well as benefits. An activity ceases to be ethically sound when it harms more than it helps. When health-related resources – including the application of knowl-

edge, as well as personnel, supplies, and funds – are used in ways that perpetuate known harms or that direct limited resources toward the perpetuation of a system that is fundamentally unjust, these resources are supporting interests other than the interests of those who suffer. At some point, these resources are no longer serving health-related ends: we see this starkly in situations in which medical knowledge and skills are applied to interrogation practices that amount to torture. The goal of providing effective health-related services to persons who are in drug detention centers is an ethically sound goal with respect to the treatment of persons. However, attempting to provide these services in this setting presents an ethical dilemma – a situation in which no option is clearly right, and that can be resolved only by determining which option is less wrong than the others. It would be naïve to imagine that there is a “no harm” option in a setting in which human rights violations are known or suspected to be occurring. It would be incorrect to assume that doing something in this setting – in this case, undertaking health-related goals – is better than doing “nothing.” Does progress toward these goals constitute a real benefit to persons in need of care, or are any incremental benefits undermined by the harms that are unavoidable in and integral to this setting?

Following the ethical maxim “ought implies can,” health-related organizations working with drug detention centers have a moral obligation to determine whether they can accomplish health-related goals in such settings, or whether such efforts merely perpetuate inhumane systems, misuse resources that could support better systems, and compromise the moral integrity of personnel on the ground. Personnel may aim to use their knowledge to help detainees, but find themselves experiencing moral distress (the perception that they are powerless to prevent harm or improve conditions) or forced into complicity with neglect and abuse. In health care and public health, the bioethics principles of autonomy, nonmaleficence, beneficence, and justice are well-established as touchstones for analyzing the goals and consequences of activities that aim to relieve suffering or promote the health of individuals and populations, with the recognition that these principles exist in tension with one another. Organizations working with drug detention centers should also seek to do no harm, to do good, to honor the rights of individuals, and to promote fairness, including the rule of law and equitable access to health-related goods. They should also seek to avoid futility – the delivery of burdens without benefit, as when an intervention constitutes “doing to” rather than “doing for” a person or population by prolonging but not alleviating their suffering.

The British Medical Association (2001) and the World Medical Association (2009) have published ethics guidelines for medical professionals providing care to patients in prisons and

others who are detained. There is international consensus that prisoners and other detainees retain “fundamental rights and freedoms subject to the restrictions that are unavoidable in a closed environment” (Cohen & Amon, 2008). As persons in closed systems depend on the system for medical care – they cannot simply leave to obtain care elsewhere – medical professionals in these systems violate their own ethical principles if they provide or participate in providing substandard care to prisoners and detainees when the standard of care could be met. Current medical standards of care require medication-assisted treatment for detainees with opioid dependence. Therefore, failure to provide this care, “poses serious ethical problems for health care providers, violating basic principles of beneficence and non-maleficence” (Cohen & Amon, 2008). This ethical consensus also addresses arbitrary detention and forced labor. Although international law “permits convicted criminals to be required to work as part of their punishment,” this does not extend to people in drug detention centers who have not been convicted of a crime in a court of law (Cohen & Amon, 2008). Drug detention centers that operate outside the rule of law are further compromised by their lack of accountability and transparency. These centers should not be viewed as badly-functioning but legitimate systems, akin to health care centers in which the quality of care is poor, or prisons where conditions are bad. Rather, they are illegitimate systems in which the involvement of health-related organizations may have a legitimizing effect even though opportunities for reform through legal channels may be limited to nonexistent.

Organizations working with drug detention centers must also weigh their desire to help individuals in these centers with concerns about promoting justice and human rights in the particular countries in which the centers are located (Public Health Leadership Society, 2002). Major humanitarian-aid organizations have clear policies and processes for how they organize and provide various forms of lifesaving assistance in regions in which human rights violations are present or suspected, and what circumstances will prompt them to reassess whether or not they should continue a mission. These rules may cover situations in which a humanitarian-aid organization enters a closed system, such as a prison or a detention facility, both to provide care and to bear witness to conditions, including human rights violations. Organizations whose missions are focused on building or strengthening local capacities rather than on the direct provision of lifesaving aid also need ethically sound policies and processes to follow, whether they are considering starting, continuing, or stopping operations. For example, the goal of promoting the health of people who inject drugs in a developing-world nation may be better served by strengthening medical education, providing psychosocial support, or increasing access to antiretroviral drugs, rather than by working with closed sys-

tems that undermine the health of this population through harsh conditions and by limiting detainees’ ability to benefit from services provided only outside of detention centers.

As the outcomes of health-promotion efforts are unlikely to be apparent immediately – another way in which development aid differs from emergency medical care – these organizations must determine how they will collect evidence to assess whether they are doing more good than harm, how they will assess the reliability of this evidence, and how much evidence should constitute a threshold for reassessing a situation and potentially changing course (Slim, 2002). They must also weigh the moral consequences of agreeing to work in a situation in which they do not have full access to the population they seek to benefit. Should they trust data collected under these circumstances? Can a health-related mission be reconciled with rules that limit workers’ ability to observe the real conditions under which detainees live, including the abuse they may suffer?

Avishai Margalit’s (2005) distinction between compromises and rotten compromises offers a useful lens for analyzing the ethical dilemmas arising from continued engagement with drug detention centers. A compromise is an agreement in which the sides to the agreement “make mutual concessions” (Margalit, 2005). A rotten compromise is:

...an agreement that establishes or maintains a political order based on systematic cruelty and humiliation as its permanent features: Needless to say, usually the party that suffers this cruelty is not a party to the agreement. By humiliation I mean dehumanization – treating humans as nonhumans. By cruelty I mean a pattern of behavior that willfully causes pain and distress.” (Margalit, 2005).

Although one should avoid rotten compromises whenever possible, if “a compromise prevents worse cruelty and humiliation,” it may be a “morally justified tradeoff” (Margalit, 2005). Picture a drug detention center that people who inject drugs are forced to enter, without a mechanism for appeal, because officials want to separate them from the rest of society. The center does not provide adequate health care and other basic resources to the detainees, who are wholly dependent on the center for their survival. The center mandates forced labor, and allows guards to abuse detainees physically and psychologically. It would be reasonable to conclude that these centers are characterized by systematic cruelty and humiliation and that providing support for health-related programs in these centers represents a rotten compromise and should be avoided. If, however, these programs were demonstrably capable of promoting detainees’ health and welfare, to the extent that withdrawing program support would impair detainees’ health and welfare, it is possible that the rotten compromise is morally justified on humanitarian grounds.

CONCLUSION

In systems where rights abuses are rampant and the terms of detention are arbitrary, illegal, and clearly at odds with their purported aims of treatment or rehabilitation, it is not the principle of equivalence but Margalit's "rotten compromise" standard that is most relevant. Avoiding the rotten compromise, and honest ethical assessment, requires the leaders of health-related organizations to avoid thinking in better-than-nothing terms when considering engagement with drug detention centers. In situations where systematic cruelty and humiliation are already present, this standard demands evidence of how programs can promote health under these conditions, and also how or whether non-engagement will make conditions much worse. All health-related resources are limited resources – might the resources in this instance be better served by efforts to keep individuals out of detention centers in the first instance? If one argues that urgent medical needs of detainees are paramount, how does one gauge which services are urgent and thus require delivery inside institutions? Is HIV prevention education delivered inside centers that prohibit needles and condoms justified, or might HIV prevention to detainees immediately upon release be as effective and less morally suspect? If food is insufficient and those too tired to work are dragged from their beds and beaten, is initiation of antiretroviral treatment really appropriate? Does it matter if such services are delivered by center staff, who may benefit from or divert resources meant for patients, or by outsiders? Does it matter if center administrators use the collaboration for public relations purposes?

While these questions may seem to burden providers with too many intangibles, in fact those unwilling to consider them are likely inappropriate for work inside drug detention centers. Ethics demands that organizations and their donors question whether investing limited resources in these settings will result in benefits to detainees, or to the inhumane systems in which these individuals are caught.

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